

efile GRAPHIC print - DO NOT PROCESS

As Filed Data -

DLN: 93493135001329

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

2017

Open to Public Inspection

A For the 2017 calendar year, or tax year beginning 07-01-2017 , and ending 06-30-2018

B Check if applicable

☐ Address change

☐ Name change

☐ Initial return

☐ Final return/terminated

☐ Amended return

☐ Application pending

C Name of organization

COMMUNITY UNITED METHODIST HOSPITAL INC

Doing business as

METHODIST HOSPITAL

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

PO BOX 48

Room/suite

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

HENDERSON, KY 424190048

D Employer identification number

61-0461753

E Telephone number

(270) 827-7700

G Gross receipts \$

125,503,649

F Name and address of principal officer

BENNY NOLEN

PO BOX 48

HENDERSON, KY 424190048

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: ▶

METHODISTHOSPITAL.NET

K Form of organization

☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation

1948

M State of legal domicile

KY

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities

IN LINE WITH ITS CHRISTIAN HERITAGE, TO PROVIDE A BROAD BASED HEALTHCARE DELIVERY SYSTEM FOCUSING ON THE COMPASSIONATE, HIGH QUALITY AND COST EFFECTIVE SERVICES THAT ADDRESS MENTAL, SPIRITUAL AND PHYSICAL NEEDS AND WORK TO IMPROVE THE HEALTH STATUS OF THE PEOPLE IN THE COMMUNITIES SERVED

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

3 Number of voting members of the governing body (Part VI, line 1a) . . . . .

4 Number of independent voting members of the governing body (Part VI, line 1b) . . . . .

5 Total number of individuals employed in calendar year 2017 (Part V, line 2a) . . . . .

6 Total number of volunteers (estimate if necessary) . . . . .

7a Total unrelated business revenue from Part VIII, column (C), line 12 . . . . .

7b Net unrelated business taxable income from Form 990-T, line 34 . . . . .

Revenue

8 Contributions and grants (Part VIII, line 1h) . . . . .

9 Program service revenue (Part VIII, line 2g) . . . . .

10 Investment income (Part VIII, column (A), lines 3, 4, and 7d ) . . . . .

11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)

12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)

Expenses

13 Grants and similar amounts paid (Part IX, column (A), lines 1–3 ) . . . . .

14 Benefits paid to or for members (Part IX, column (A), line 4) . . . . .

15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)

16a Professional fundraising fees (Part IX, column (A), line 11e) . . . . .

b Total fundraising expenses (Part IX, column (D), line 25) ▶0

17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e) . . . . .

18 Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)

19 Revenue less expenses Subtract line 18 from line 12 . . . . .

Net Assets or Fund Balances

20 Total assets (Part X, line 16) . . . . .

21 Total liabilities (Part X, line 26) . . . . .

22 Net assets or fund balances Subtract line 21 from line 20 . . . . .

Prior Year

406,733

137,067,902

670,876

4,348,680

142,494,191

216,405

0

82,358,598

0

67,675,244

150,250,247

-7,756,056

130,343,096

65,031,264

65,311,832

Current Year

13,657

120,836,836

1,169,245

3,412,987

125,432,725

216,979

0

70,846,526

0

63,528,776

134,592,281

-9,159,556

112,090,305

56,273,168

55,817,137

Part II Signature Block

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

Sign Here

\*\*\*\*\*

Signature of officer

BENNY NOLEN CEO

Type or print name and title

2019-05-14

Date

Paid Preparer Use Only

Print/Type preparer's name

CARRIE A MERRILL CPA

Preparer's signature

CARRIE A MERRILL CPA

Date

2019-05-14

Check ☐ if self-employed

PTIN

P00832283

Firm's name ▶ BLUE & CO LLC

Firm's EIN ▶ 35-1178661

Firm's address ▶ 2650 EASTPOINT PKWY SUITE 300

LOUISVILLE, KY 40223

Phone no (502) 992-3500

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

☒ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate instructions.

Cat No 11282Y

Form 990 (2017)

**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

IN LINE WITH ITS CHRISTIAN HERITAGE, TO PROVIDE A BROAD BASED HEALTHCARE DELIVERY SYSTEM FOCUSING ON THE COMPASSIONATE, HIGH QUALITY AND COST EFFECTIVE SERVICES THAT ADDRESS MENTAL, SPIRITUAL AND PHYSICAL NEEDS AND WORK TO IMPROVE THE HEALTH STATUS OF THE PEOPLE IN THE COMMUNITIES SERVED

**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

|           |                     |                          |                                |                             |
|-----------|---------------------|--------------------------|--------------------------------|-----------------------------|
| <b>4a</b> | (Code )             | (Expenses \$ 111,933,720 | including grants of \$ 216,979 | ) (Revenue \$ 123,676,768 ) |
|           | See Additional Data |                          |                                |                             |

|           |         |              |                        |                 |
|-----------|---------|--------------|------------------------|-----------------|
| <b>4b</b> | (Code ) | (Expenses \$ | including grants of \$ | ) (Revenue \$ ) |
|-----------|---------|--------------|------------------------|-----------------|

|           |         |              |                        |                 |
|-----------|---------|--------------|------------------------|-----------------|
| <b>4c</b> | (Code ) | (Expenses \$ | including grants of \$ | ) (Revenue \$ ) |
|-----------|---------|--------------|------------------------|-----------------|

|           |  |                        |               |   |
|-----------|--|------------------------|---------------|---|
| <b>4d</b> | Other program services (Describe in Schedule O ) |                        |               |   |
|           | (Expenses \$                                     | including grants of \$ | ) (Revenue \$ | ) |

|           |                                       |             |
|-----------|---------------------------------------|-------------|
| <b>4e</b> | <b>Total program service expenses</b> | 111,933,720 |
|-----------|---------------------------------------|-------------|

**Part IV Checklist of Required Schedules**

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

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

|   | Yes            | No |
|---|----------------|----|
| <b>20a</b> Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i> . . . . .   | <b>20a</b> Yes |    |
| <b>b</b> If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?   | <b>20b</b> Yes |    |
| <b>21</b> Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i> . . . . .  | <b>21</b> Yes  |    |
| <b>22</b> Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i> . . . . .  | <b>22</b> Yes  |    |
| <b>23</b> Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i> . . . . .   | <b>23</b> Yes  |    |
| <b>24a</b> Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i> . . . . .                                  | <b>24a</b> Yes |    |
| <b>b</b> Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? . . . . .  | <b>24b</b>     | No |
| <b>c</b> Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? . . . . .   | <b>24c</b>     | No |
| <b>d</b> Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? . . . . .  | <b>24d</b>     | No |
| <b>25a Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.</b><br>Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i> . . . . .   | <b>25a</b>     | No |
| <b>b</b> Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ?<br><i>If "Yes," complete Schedule L, Part I</i> . . . . .  | <b>25b</b>     | No |
| <b>26</b> Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons?<br><i>If "Yes," complete Schedule L, Part II</i> . . . . .                                     | <b>26</b>      | No |
| <b>27</b> Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i> . . . . .        | <b>27</b>      | No |
| <b>28</b> Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions)<br><b>a</b> A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> . . . . . | <b>28a</b> Yes |    |
| <b>b</b> A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> . . . . .  | <b>28b</b> Yes |    |
| <b>c</b> An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV</i> . . . . .  | <b>28c</b> Yes |    |
| <b>29</b> Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i> . . . . .   | <b>29</b>      | No |
| <b>30</b> Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i> . . . . .   | <b>30</b>      | No |
| <b>31</b> Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i> . . . . .   | <b>31</b>      | No |
| <b>32</b> Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets?<br><i>If "Yes," complete Schedule N, Part II</i> . . . . .  | <b>32</b>      | No |
| <b>33</b> Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I</i> . . . . .   | <b>33</b>      | No |
| <b>34</b> Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i> . . . . .   | <b>34</b> Yes  |    |
| <b>35a</b> Did the organization have a controlled entity within the meaning of section 512(b)(13)?  | <b>35a</b>     | No |
| <b>b</b> If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i> . . . . .   | <b>35b</b>     |    |
| <b>36 Section 501(c)(3) organizations.</b> Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i> . . . . .   | <b>36</b>      | No |
| <b>37</b> Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i>  | <b>37</b>      | No |
| <b>38</b> Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? <b>Note.</b> All Form 990 filers are required to complete Schedule O . . . . .   | <b>38</b> 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    |
|------------|--|------------|-------|
| <b>1a</b>  | Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable . . . . .  | <b>1a</b>  | 284   |
| <b>b</b>   | Enter the number of Forms W-2G included in line 1a Enter -0- if not applicable . . . . .   | <b>1b</b>  | 0     |
| <b>c</b>   | Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? . . . . .   | <b>1c</b>  | Yes   |
| <b>2a</b>  | Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return . . . . .  | <b>2a</b>  | 1,577 |
| <b>b</b>   | If at least one is reported on line 2a, did the organization file all required federal employment tax returns?<br><b>Note.</b> If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)                   | <b>2b</b>  | Yes   |
| <b>3a</b>  | Did the organization have unrelated business gross income of \$1,000 or more during the year? . . . . .  | <b>3a</b>  | Yes   |
| <b>b</b>   | If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O . . . . .  | <b>3b</b>  | Yes   |
| <b>4a</b>  | At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . . . . . | <b>4a</b>  | No    |
| <b>b</b>   | If "Yes," enter the name of the foreign country <b>▶</b> _____<br>See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)   |            |       |
| <b>5a</b>  | Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . . . . .  | <b>5a</b>  | No    |
| <b>b</b>   | Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? . . . . .   | <b>5b</b>  | No    |
| <b>c</b>   | If "Yes," to line 5a or 5b, did the organization file Form 8886-T? . . . . .   | <b>5c</b>  |       |
| <b>6a</b>  | Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . . . .                                    | <b>6a</b>  | No    |
| <b>b</b>   | If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? . . . . .  | <b>6b</b>  |       |
| <b>7</b>   | <b>Organizations that may receive deductible contributions under section 170(c).</b>   |            |       |
| <b>a</b>   | Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor? . . . . .  | <b>7a</b>  | No    |
| <b>b</b>   | If "Yes," did the organization notify the donor of the value of the goods or services provided? . . . . .  | <b>7b</b>  |       |
| <b>c</b>   | Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? . . . . .   | <b>7c</b>  | No    |
| <b>d</b>   | If "Yes," indicate the number of Forms 8282 filed during the year . . . . .  | <b>7d</b>  |       |
| <b>e</b>   | Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? . . . . .  | <b>7e</b>  |       |
| <b>f</b>   | Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . . . . .   | <b>7f</b>  |       |
| <b>g</b>   | If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? . . . . .   | <b>7g</b>  |       |
| <b>h</b>   | If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? . . . . .   | <b>7h</b>  |       |
| <b>8</b>   | <b>Sponsoring organizations maintaining donor advised funds.</b><br>Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? . . . . .  | <b>8</b>   |       |
| <b>9a</b>  | Did the sponsoring organization make any taxable distributions under section 4966? . . . . .   | <b>9a</b>  |       |
| <b>b</b>   | Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . . . .  | <b>9b</b>  |       |
| <b>10</b>  | <b>Section 501(c)(7) organizations.</b> Enter  |            |       |
| <b>a</b>   | Initiation fees and capital contributions included on Part VIII, line 12 . . . . .   | <b>10a</b> |       |
| <b>b</b>   | Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities . . . . .  | <b>10b</b> |       |
| <b>11</b>  | <b>Section 501(c)(12) organizations.</b> Enter   |            |       |
| <b>a</b>   | Gross income from members or shareholders . . . . .  | <b>11a</b> |       |
| <b>b</b>   | Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them ) . . . . .   | <b>11b</b> |       |
| <b>12a</b> | <b>Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041? . . . . .  | <b>12a</b> |       |
| <b>b</b>   | If "Yes," enter the amount of tax-exempt interest received or accrued during the year . . . . .  | <b>12b</b> |       |
| <b>13</b>  | <b>Section 501(c)(29) qualified nonprofit health insurance issuers.</b>  |            |       |
| <b>a</b>   | Is the organization licensed to issue qualified health plans in more than one state? <b>Note.</b> See the instructions for additional information the organization must report on Schedule O . . . . .   | <b>13a</b> |       |
| <b>b</b>   | Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans . . . . .  | <b>13b</b> |       |
| <b>c</b>   | Enter the amount of reserves on hand . . . . .   | <b>13c</b> |       |
| <b>14a</b> | Did the organization receive any payments for indoor tanning services during the tax year? . . . . .   | <b>14a</b> | No    |
| <b>b</b>   | If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O . . . . .  | <b>14b</b> |       |

**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 instructionsCheck if Schedule O contains a response or note to any line in this Part VI ☒**Section A. Governing Body and Management**

|  |              | Yes | No |
|--|--------------|-----|----|
| <b>1a</b> Enter the number of voting members of the governing body at the end of the tax year  | <b>1a</b> 28 |     |    |
| 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>b</b> Enter the number of voting members included in line 1a, above, who are independent  | <b>1b</b> 20 |     |    |
| <b>2</b> Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?   | <b>2</b>     |     | No |
| <b>3</b> Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? | <b>3</b>     |     | No |
| <b>4</b> Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?  | <b>4</b>     |     | No |
| <b>5</b> Did the organization become aware during the year of a significant diversion of the organization's assets?  | <b>5</b>     |     | No |
| <b>6</b> Did the organization have members or stockholders?  | <b>6</b>     | Yes |    |
| <b>7a</b> Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?   | <b>7a</b>    | Yes |    |
| <b>b</b> Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?   | <b>7b</b>    |     | No |
| <b>8</b> Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following  |              |     |    |
| <b>a</b> The governing body?   | <b>8a</b>    | Yes |    |
| <b>b</b> Each committee with authority to act on behalf of the governing body?   | <b>8b</b>    | Yes |    |
| <b>9</b> Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O        | <b>9</b>     |     | No |

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

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

**Section C. Disclosure**

|   |    |
|---|----|
| <b>17</b> List the States with which a copy of this Form 990 is required to be filed  | KY |
| <b>18</b> 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.<br><input type="checkbox"/> Own website <input checked="" type="checkbox"/> Another's website <input checked="" type="checkbox"/> Upon request <input type="checkbox"/> Other (explain in Schedule O) |    |
| <b>19</b> 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  |    |
| <b>20</b> State the name, address, and telephone number of the person who possesses the organization's books and records<br>BENNY NOLEN 1305 NORTH ELM STREET HENDERSON, KY 42419 (270) 827-7700  |    |

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

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

Form **990** (2017)

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

| (A)<br>Name and Title  | (B)<br>Average hours per week (list any hours for related organizations below dotted line) | (C)<br>Position (do not check more than one box, unless person is both an officer and a director/trustee) |                       |         |              |                              |        | (D)<br>Reportable compensation from the organization (W-2/1099-MISC) | (E)<br>Reportable compensation from related organizations (W-2/1099-MISC) | (F)<br>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                                      |  |   |                       |         |              |                              |        |  |   |   |
|  |  |   |                       |         |              |                              |        |  |   |   |
|  |  |   |                       |         |              |                              |        |  |   |   |
|  |  |   |                       |         |              |                              |        |  |   |   |
|  |  |   |                       |         |              |                              |        |  |   |   |
|  |  |   |                       |         |              |                              |        |  |   |   |
|  |  |   |                       |         |              |                              |        |  |   |   |
|  |  |   |                       |         |              |                              |        |  |   |   |
|  |  |   |                       |         |              |                              |        |  |   |   |
|  |  |   |                       |         |              |                              |        |  |   |   |
|  |  |   |                       |         |              |                              |        |  |   |   |
| <b>1b Sub-Total</b>  |  |   |                       |         |              |                              |        |  |   |   |
| <b>c Total from continuation sheets to Part VII, Section A</b> |  |   |                       |         |              |                              |        |  |   |   |
| <b>d Total (add lines 1b and 1c)</b>                           |  |   |                       |         |              |                              |        | 4,721,457  | 0   | 249,487   |

**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 ► 70

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

**Section B. Independent Contractors**

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

| (A)<br>Name and business address                                   | (B)<br>Description of services | (C)<br>Compensation |
|--|--------------------------------|---------------------|
| MAULIK DESAI<br>3015 AUTUMN LAKE COVE<br>OWENSBORO, KY 42303       | ER PHYSICIAN GROUP             | 2,128,694           |
| HUNTZINGER GROUP<br>72 GLENMAURA NATIONAL BLVD<br>MOOSIC, PA 18507 | IT CONSULTANTS                 | 1,102,789           |
| NEIL TROOST,<br>8510 TSCHARNER ROAD<br>HENDERSON, KY 42420         | ER PHYSICIAN                   | 739,510             |
| KEVIN WILKING,<br>8601 RANLEIGHT COURT<br>NEWBURGH, IN 47630       | ANESTHESIOLOGIST               | 600,000             |
| QUEST DIAGNOSTICS<br>14225 NEWBROOK DRIVE<br>CHANTILLY, VA 20151   | CLINICAL LABORATORY            | 594,030             |

**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 ► 59



**Part VIII Statement of Revenue**

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

|  |   |                           | (A)<br>Total revenue | (B)<br>Related or<br>exempt<br>function<br>revenue | (C)<br>Unrelated<br>business<br>revenue | (D)<br>Revenue<br>excluded from<br>tax under sections<br>512-514 |
|--|---|---------------------------|----------------------|--|---|--|
| Contributions, Gifts, Grants<br>and Other Similar Amounts                              | <b>1a</b> Federated campaigns . . .   | <b>1a</b>                 |                      |  |   |  |
|  | <b>b</b> Membership dues . . .  | <b>1b</b>                 |                      |  |   |  |
|  | <b>c</b> Fundraising events . . .   | <b>1c</b>                 |                      |  |   |  |
|  | <b>d</b> Related organizations  | <b>1d</b>                 |                      |  |   |  |
|  | <b>e</b> Government grants (contributions)  | <b>1e</b>                 |                      |  |   |  |
|  | <b>f</b> All other contributions, gifts, grants,<br>and similar amounts not included<br>above   | <b>1f</b>                 | 13,657               |  |   |  |
|  | <b>g</b> Noncash contributions included<br>in lines 1a-1f \$ _____  |                           |                      |  |   |  |
|  | <b>h Total.</b> Add lines 1a-1f . . . . . ▶   | 13,657                    |                      |  |   |  |
| Program Service Revenue  |   |                           | Business Code        |  |   |  |
|  | <b>2a</b> NET PATIENT SERVICES  |                           | 621110               | 120,836,836  | 120,836,836                             |  |
|  | <b>b</b> _____  |                           |                      |  |   |  |
|  | <b>c</b> _____  |                           |                      |  |   |  |
|  | <b>d</b> _____  |                           |                      |  |   |  |
|  | <b>e</b> _____  |                           |                      |  |   |  |
|  | <b>f</b> All other program service revenue  |                           |                      |  |   |  |
|  | <b>g Total.</b> Add lines 2a-2f . . . . . ▶   | 120,836,836               |                      |  |   |  |
| Other Revenue  | <b>3</b> Investment income (including dividends, interest, and other<br>similar amounts) . . . . . ▶  |                           | 697,314              |  |   | 697,314  |
|  | <b>4</b> Income from investment of tax-exempt bond proceeds ▶   |                           |                      |  |   |  |
|  | <b>5</b> Royalties . . . . . ▶  |                           |                      |  |   |  |
|  | <b>6a</b> Gross rents   | (i) Real (ii) Personal    |                      |  |   |  |
|  |   | 18,026                    |                      |  |   |  |
|  | <b>b</b> Less rental expenses   | 0                         |                      |  |   |  |
|  | <b>c</b> Rental income or<br>(loss)   | 18,026                    |                      |  |   |  |
|  | <b>d</b> Net rental income or (loss) . . . . . ▶  |                           | 18,026               |  |   | 18,026   |
|  | <b>7a</b> Gross amount<br>from sales of<br>assets other<br>than inventory   | (i) Securities (ii) Other |                      |  |   |  |
|  |   | 405,749 74,707            |                      |  |   |  |
|  | <b>b</b> Less cost or<br>other basis and<br>sales expenses  | 0 8,525                   |                      |  |   |  |
|  | <b>c</b> Gain or (loss)   | 405,749 66,182            |                      |  |   |  |
|  | <b>d</b> Net gain or (loss) . . . . . ▶   |                           | 471,931              |  |   | 471,931  |
|  | <b>8a</b> Gross income from fundraising events<br>(not including \$ _____ of<br>contributions reported on line 1c)<br>See Part IV, line 18 . . . . . <b>a</b> |                           |                      |  |   |  |
|  | <b>b</b> Less direct expenses . . . . . <b>b</b>  |                           |                      |  |   |  |
|  | <b>c</b> Net income or (loss) from fundraising events . . . . . ▶   |                           |                      |  |   |  |
|  | <b>9a</b> Gross income from gaming activities<br>See Part IV, line 19 . . . . . <b>a</b>  |                           |                      |  |   |  |
| <b>b</b> Less direct expenses . . . . . <b>b</b>                                       |   |                           |                      |  |   |  |
| <b>c</b> Net income or (loss) from gaming activities . . . . . ▶                       |   |                           |                      |  |   |  |
| <b>10a</b> Gross sales of inventory, less<br>returns and allowances . . . . . <b>a</b> |   |                           |                      |  |   |  |
|  | 88,744  |                           |                      |  |   |  |
| <b>b</b> Less cost of goods sold . . . . . <b>b</b>                                    | 62,399  |                           |                      |  |   |  |
| <b>c</b> Net income or (loss) from sales of inventory . . . . . ▶                      |   | 26,345                    |                      |  | 26,345                                  |  |
| Miscellaneous Revenue  |   | Business Code             |                      |  |   |  |
| <b>11a</b> MISCELLANEOUS   | 900099  | 2,839,932                 | 2,839,932            |  |   |  |
| <b>b</b> CAFETERIA   | 900099  | 539,528                   |                      |  | 539,528                                 |  |
| <b>c</b> FOUNDATION  | 900099  | -10,844                   |                      |  | -10,844                                 |  |
| <b>d</b> All other revenue . . . . .   |   |                           |                      |  |   |  |
| <b>e Total.</b> Add lines 11a-11d . . . . . ▶  | 3,368,616   |                           |                      |  |   |  |
| <b>12 Total revenue.</b> See Instructions . . . . . ▶                                  | 125,432,725 123,676,768 0 1,742,300   |                           |                      |  |   |  |

**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)<br>Total expenses | (B)<br>Program service expenses | (C)<br>Management and general expenses | (D)<br>Fundraising expenses |
|---|-----------------------|---------------------------------|--|-----------------------------|
| <b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21.  | 120,000               | 120,000                         |  |                             |
| <b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22.   | 96,979                | 96,979                          |  |                             |
| <b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.   |                       |                                 |  |                             |
| <b>4</b> Benefits paid to or for members.   |                       |                                 |  |                             |
| <b>5</b> Compensation of current officers, directors, trustees, and key employees.  | 1,337,604             | 1,112,523                       | 225,081                                |                             |
| <b>6</b> Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B).   |                       |                                 |  |                             |
| <b>7</b> Other salaries and wages.  | 51,668,153            | 42,973,869                      | 8,694,284                              |                             |
| <b>8</b> Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).   | 1,553,150             | 1,291,799                       | 261,351                                |                             |
| <b>9</b> Other employee benefits.   | 12,555,849            | 10,443,056                      | 2,112,793                              |                             |
| <b>10</b> Payroll taxes.  | 3,731,770             | 3,103,819                       | 627,951                                |                             |
| <b>11</b> Fees for services (non-employees):  |                       |                                 |  |                             |
| <b>a</b> Management.  |                       |                                 |  |                             |
| <b>b</b> Legal.   | 3,300                 | 2,937                           | 363                                    |                             |
| <b>c</b> Accounting.  | 382,722               | 340,623                         | 42,099                                 |                             |
| <b>d</b> Lobbying.  |                       |                                 |  |                             |
| <b>e</b> Professional fundraising services. See Part IV, line 17.   |                       |                                 |  |                             |
| <b>f</b> Investment management fees.  |                       |                                 |  |                             |
| <b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).  | 17,915,481            | 14,900,814                      | 3,014,667                              |                             |
| <b>12</b> Advertising and promotion.  | 220,422               | 183,331                         | 37,091                                 |                             |
| <b>13</b> Office expenses.  | 4,621,854             | 3,844,127                       | 777,727                                |                             |
| <b>14</b> Information technology.   |                       |                                 |  |                             |
| <b>15</b> Royalties.  |                       |                                 |  |                             |
| <b>16</b> Occupancy.  | 1,585,304             | 1,318,542                       | 266,762                                |                             |
| <b>17</b> Travel.   | 163,373               | 135,882                         | 27,491                                 |                             |
| <b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials.   |                       |                                 |  |                             |
| <b>19</b> Conferences, conventions, and meetings.   |                       |                                 |  |                             |
| <b>20</b> Interest.   | 1,137,429             |                                 | 1,137,429                              |                             |
| <b>21</b> Payments to affiliates.   |                       |                                 |  |                             |
| <b>22</b> Depreciation, depletion, and amortization.  | 7,168,342             | 5,962,113                       | 1,206,229                              |                             |
| <b>23</b> Insurance.  | 1,706,510             | 1,419,353                       | 287,157                                |                             |
| <b>24</b> Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O):                                       |                       |                                 |  |                             |
| <b>a</b> DRUGS & GASES  | 9,780,475             | 9,780,475                       |  |                             |
| <b>b</b> MEDICAL SUPPLIES   | 6,958,189             | 6,958,189                       |  |                             |
| <b>c</b> MINOR EQUIPMENT & RENTA  | 2,789,837             | 2,789,837                       |  |                             |
| <b>d</b> REPAIRS & MAINT  | 2,782,817             | 2,314,548                       | 468,269                                |                             |
| <b>e</b> All other expenses   | 6,312,721             | 2,840,904                       | 3,471,817                              |                             |
| <b>25</b> Total functional expenses. Add lines 1 through 24e.   | 134,592,281           | 111,933,720                     | 22,658,561                             | 0                           |
| <b>26</b> Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720). |                       |                                 |  |                             |

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

|                                    |  |   |             | (A)<br>Beginning of year |             | (B)<br>End of year |
|------------------------------------|--|---|-------------|--------------------------|-------------|--------------------|
| <b>Assets</b>                      | <b>1</b>   | Cash—non-interest-bearing . . . . .   |             | 11,906,482               | <b>1</b>    | 4,277,736          |
|                                    | <b>2</b>   | Savings and temporary cash investments . . . . .  |             | 12,994,371               | <b>2</b>    | 13,757,861         |
|                                    | <b>3</b>   | Pledges and grants receivable, net . . . . .  |             |                          | <b>3</b>    |                    |
|                                    | <b>4</b>   | Accounts receivable, net . . . . .  |             | 22,259,630               | <b>4</b>    | 15,549,772         |
|                                    | <b>5</b>   | Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L . . . . .   |             |                          | <b>5</b>    |                    |
|                                    | <b>6</b>   | 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 . . . . . |             |                          | <b>6</b>    |                    |
|                                    | <b>7</b>   | Notes and loans receivable, net . . . . .   |             | 275,000                  | <b>7</b>    | 250,000            |
|                                    | <b>8</b>   | Inventories for sale or use . . . . .   |             | 2,250,059                | <b>8</b>    | 2,524,008          |
|                                    | <b>9</b>   | Prepaid expenses and deferred charges . . . . .   |             | 1,882,875                | <b>9</b>    | 1,634,785          |
|                                    | <b>10a</b>   | Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D.  | <b>10a</b>  | 180,923,723              |             |                    |
|                                    | <b>b</b>   | Less: accumulated depreciation  | <b>10b</b>  | 114,117,933              |             |                    |
|                                    |  |   |             | 70,703,386               | <b>10c</b>  | 66,805,790         |
|                                    | <b>11</b>  | Investments—publicly traded securities . . . . .  |             |                          | <b>11</b>   |                    |
|                                    | <b>12</b>  | Investments—other securities. See Part IV, line 11 . . . . .  |             | 6,327,647                | <b>12</b>   | 6,076,504          |
|                                    | <b>13</b>  | Investments—program-related. See Part IV, line 11 . . . . .   |             |                          | <b>13</b>   |                    |
|                                    | <b>14</b>  | Intangible assets . . . . .   |             |                          | <b>14</b>   |                    |
| <b>15</b>                          | Other assets. See Part IV, line 11 . . . . .   |   | 1,743,646   | <b>15</b>                | 1,213,849   |                    |
| <b>16</b>                          | <b>Total assets.</b> Add lines 1 through 15 (must equal line 34) . . . . .   |   | 130,343,096 | <b>16</b>                | 112,090,305 |                    |
| <b>Liabilities</b>                 | <b>17</b>  | Accounts payable and accrued expenses . . . . .   |             | 17,903,247               | <b>17</b>   | 13,839,036         |
|                                    | <b>18</b>  | Grants payable . . . . .  |             |                          | <b>18</b>   |                    |
|                                    | <b>19</b>  | Deferred revenue . . . . .  |             |                          | <b>19</b>   |                    |
|                                    | <b>20</b>  | Tax-exempt bond liabilities . . . . .   |             | 27,197,532               | <b>20</b>   | 22,899,638         |
|                                    | <b>21</b>  | Escrow or custodial account liability. Complete Part IV of Schedule D . . . . .   |             |                          | <b>21</b>   |                    |
|                                    | <b>22</b>  | 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 . . . . .  |             |                          | <b>22</b>   |                    |
|                                    | <b>23</b>  | Secured mortgages and notes payable to unrelated third parties . . . . .  |             |                          | <b>23</b>   |                    |
|                                    | <b>24</b>  | Unsecured notes and loans payable to unrelated third parties . . . . .  |             |                          | <b>24</b>   |                    |
|                                    | <b>25</b>  | 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 . . . . .   |             | 19,930,485               | <b>25</b>   | 19,534,494         |
|                                    | <b>26</b>  | <b>Total liabilities.</b> Add lines 17 through 25 . . . . .   |             | 65,031,264               | <b>26</b>   | 56,273,168         |
| <b>Net Assets or Fund Balances</b> | <b>Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.</b> |   |             |                          |             |                    |
|                                    | <b>27</b>  | Unrestricted net assets . . . . .   |             | 63,895,620               | <b>27</b>   | 54,411,769         |
|                                    | <b>28</b>  | Temporarily restricted net assets . . . . .   |             | 1,416,212                | <b>28</b>   | 1,405,368          |
|                                    | <b>29</b>  | Permanently restricted net assets . . . . .   |             |                          | <b>29</b>   |                    |
|                                    | <b>Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.</b>                          |   |             |                          |             |                    |
|                                    | <b>30</b>  | Capital stock or trust principal, or current funds . . . . .  |             |                          | <b>30</b>   |                    |
|                                    | <b>31</b>  | Paid-in or capital surplus, or land, building or equipment fund . . . . .   |             |                          | <b>31</b>   |                    |
|                                    | <b>32</b>  | Retained earnings, endowment, accumulated income, or other funds . . . . .  |             |                          | <b>32</b>   |                    |
|                                    | <b>33</b>  | <b>Total net assets or fund balances</b> . . . . .  |             | 65,311,832               | <b>33</b>   | 55,817,137         |
|                                    | <b>34</b>  | <b>Total liabilities and net assets/fund balances</b> . . . . .   |             | 130,343,096              | <b>34</b>   | 112,090,305        |

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

|           |   |           |             |
|-----------|---|-----------|-------------|
| <b>1</b>  | Total revenue (must equal Part VIII, column (A), line 12)   | <b>1</b>  | 125,432,725 |
| <b>2</b>  | Total expenses (must equal Part IX, column (A), line 25)  | <b>2</b>  | 134,592,281 |
| <b>3</b>  | Revenue less expenses Subtract line 2 from line 1   | <b>3</b>  | -9,159,556  |
| <b>4</b>  | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))                     | <b>4</b>  | 65,311,832  |
| <b>5</b>  | Net unrealized gains (losses) on investments  | <b>5</b>  | 408,894     |
| <b>6</b>  | Donated services and use of facilities  | <b>6</b>  |             |
| <b>7</b>  | Investment expenses   | <b>7</b>  |             |
| <b>8</b>  | Prior period adjustments  | <b>8</b>  | -620,233    |
| <b>9</b>  | Other changes in net assets or fund balances (explain in Schedule O)  | <b>9</b>  | -123,800    |
| <b>10</b> | Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | <b>10</b> | 55,817,137  |

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

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

# Additional Data

**Software ID:**  
**Software Version:**  
**EIN:** 61-0461753  
**Name:** COMMUNITY UNITED METHODIST HOSPITAL INC

Form 990 (2017)

**Form 990, Part III, Line 4a:**

COMMUNITY UNITED METHODIST HOSPITAL, INC OFFERS A BROAD RANGE OF INPATIENT AND OUTPATIENT MEDICAL SERVICES INCLUDING EMERGENCY CARE, SURGICAL SERVICES, AMBULATORY CARE, RADIOLOGY SERVICES, PHYSICAL THERAPY, SLEEP DISORDERS, ORTHOPEDIC SERVICES, NICU, SWING BED, DIAGNOSTIC AND THERAPEUTIC SERVICES, AND WOUND CARE THE COMMUNITIES WE SERVE INCLUDE HENDERSON, UNION AND WEBSTER COUNTIES METHODIST HOSPITAL IS AN ACUTE CARE HOSPITAL IN HENDERSON, KY WITH 192 LICENSED BEDS IN FISCAL YEAR 2018, METHODIST HOSPITAL SERVED 3,579 INPATIENTS FOR A TOTAL OF 15,561 INPATIENT DAYS OF SERVICE METHODIST HOSPITAL ALSO PROVIDED 270,915 OUTPATIENT VISITS WHICH INCLUDED 22,939 EMERGENCY ROOM VISITS UNION COUNTY METHODIST HOSPITAL IS A CRITICAL CARE HOSPITAL IN UNION COUNTY, KY IN FISCAL YEAR 2018, UNION COUNTY SERVED 587 INPATIENTS FOR A TOTAL OF 1,126 PATIENT DAYS AND 2,889 SWING BED DAYS UNION COUNTY ALSO PROVIDED 23,601 OUTPATIENT VISITS WHICH INCLUDED 7,080 EMERGENCY ROOM VISITS

| Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors |  |   |                       |         |              |                              |        |   |  |   |
|---|--|---|-----------------------|---------|--------------|------------------------------|--------|---|--|---|
| (A)<br>Name and Title   | (B)<br>Average hours per week (list any hours for related organizations below dotted line) | (C)<br>Position (do not check more than one box, unless person is both an officer and a director/trustee) |                       |         |              |                              |        | (D)<br>Reportable compensation from the organization (W- 2/1099-MISC) | (E)<br>Reportable compensation from related organizations (W- 2/1099-MISC) | (F)<br>Estimated amount of other compensation from the organization and related organizations |
|   |  | Individual trustee or director  | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former |   |  |   |
| DANE SHIELDS<br>.....<br>CHAIRMAN   | 2 00<br>.....  | X   |                       |         |              |                              |        | 0   | 0  | 0   |
| MAYOR STEVE AUSTIN<br>.....<br>VICE CHAIR   | 2 00<br>.....  | X   |                       |         |              |                              |        | 0   | 0  | 0   |
| BILL DILBERT<br>.....<br>TREASURER  | 2 00<br>.....  | X   |                       |         |              |                              |        | 0   | 0  | 0   |
| REV C MICHAEL SWEENEY<br>.....<br>SECRETARY   | 2 00<br>.....  | X   |                       |         |              |                              |        | 0   | 0  | 0   |
| GARLAND CERTAIN<br>.....<br>DIRECTOR  | 2 00<br>.....  | X   |                       |         |              |                              |        | 0   | 0  | 0   |
| JIM CRAFTON<br>.....<br>DIRECTOR  | 2 00<br>.....  | X   |                       |         |              |                              |        | 0   | 0  | 0   |
| DR JAMES FELLOWS<br>.....<br>DIRECTOR   | 10 00<br>.....   | X   |                       |         |              |                              |        | 116,175   | 0  | 0   |
| REV MARK GIBBONS<br>.....<br>DIRECTOR   | 2 00<br>.....  | X   |                       |         |              |                              |        | 0   | 0  | 0   |
| SUSIE GIVENS<br>.....<br>DIRECTOR   | 2 00<br>.....  | X   |                       |         |              |                              |        | 0   | 0  | 0   |
| MIKE HAZELWOOD<br>.....<br>DIRECTOR   | 2 00<br>.....  | X   |                       |         |              |                              |        | 0   | 0  | 0   |

| Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors |  |   |                       |         |              |                              |        |   |  |   |
|---|--|---|-----------------------|---------|--------------|------------------------------|--------|---|--|---|
| (A)<br>Name and Title   | (B)<br>Average hours per week (list any hours for related organizations below dotted line) | (C)<br>Position (do not check more than one box, unless person is both an officer and a director/trustee) |                       |         |              |                              |        | (D)<br>Reportable compensation from the organization (W- 2/1099-MISC) | (E)<br>Reportable compensation from related organizations (W- 2/1099-MISC) | (F)<br>Estimated amount of other compensation from the organization and related organizations |
|   |  | Individual trustee or director  | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former |   |  |   |
| PAUL HENDRICKSON<br>.....<br>DIRECTOR   | 2 00<br>.....  | X   |                       |         |              |                              |        | 0   | 0  | 0   |
| DR VERNON HUMBERT<br>.....<br>DIRECTOR  | 10 00<br>.....   | X   |                       |         |              |                              |        | 62,600  | 0  | 0   |
| MELISSA CLEMENTS<br>.....<br>DIRECTOR   | 2 00<br>.....  | X   |                       |         |              |                              |        | 0   | 0  | 0   |
| REV DAVID LATHAM<br>.....<br>DIRECTOR   | 2 00<br>.....  | X   |                       |         |              |                              |        | 0   | 0  | 0   |
| SHANNA LEE<br>.....<br>DIRECTOR   | 2 00<br>.....  | X   |                       |         |              |                              |        | 0   | 0  | 0   |
| WILLIAM ROBERT JR<br>.....<br>DIRECTOR  | 2 00<br>.....  | X   |                       |         |              |                              |        | 0   | 0  | 0   |
| LIN SHANNON<br>.....<br>DIRECTOR  | 2 00<br>.....  | X   |                       |         |              |                              |        | 0   | 0  | 0   |
| RAY NIX<br>.....<br>DIRECTOR  | 2 00<br>.....  | X   |                       |         |              |                              |        | 0   | 0  | 0   |
| LIBBY PAYNE<br>.....<br>DIRECTOR  | 2 00<br>.....  | X   |                       |         |              |                              |        | 0   | 0  | 0   |
| JIM VINCENT<br>.....<br>DIRECTOR  | 2 00<br>.....  | X   |                       |         |              |                              |        | 0   | 0  | 0   |

| Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors |  |   |                       |         |              |                              |        |   |  |   |
|---|--|---|-----------------------|---------|--------------|------------------------------|--------|---|--|---|
| (A)<br>Name and Title   | (B)<br>Average hours per week (list any hours for related organizations below dotted line) | (C)<br>Position (do not check more than one box, unless person is both an officer and a director/trustee) |                       |         |              |                              |        | (D)<br>Reportable compensation from the organization (W- 2/1099-MISC) | (E)<br>Reportable compensation from related organizations (W- 2/1099-MISC) | (F)<br>Estimated amount of other compensation from the organization and related organizations |
|   |  | Individual trustee or director  | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former |   |  |   |
| CHIP WILLIAMS<br>.....<br>DIRECTOR  | 2 00<br>.....  | X   |                       |         |              |                              |        | 0   | 0  | 0   |
| ANN WHITE<br>.....<br>DIRECTOR  | 2 00<br>.....  | X   |                       |         |              |                              |        | 0   | 0  | 0   |
| PASTOR JIM WOFFORD<br>.....<br>DIRECTOR   | 2 00<br>.....  | X   |                       |         |              |                              |        | 0   | 0  | 0   |
| KRIS WILLIAMS<br>.....<br>DIRECTOR  | 2 00<br>.....  | X   |                       |         |              |                              |        | 0   | 0  | 0   |
| BISHOP LEONARD FAIRLEY<br>.....<br>DIRECTOR   | 2 00<br>.....  | X   |                       |         |              |                              |        | 0   | 0  | 0   |
| JAMES KEMP<br>.....<br>DIRECTOR   | 2 00<br>.....  | X   |                       |         |              |                              |        | 0   | 0  | 0   |
| JIMMY PHILLIPS<br>.....<br>DIRECTOR   | 2 00<br>.....  | X   |                       |         |              |                              |        | 0   | 0  | 0   |
| FRANK TULIPANO<br>.....<br>DIRECTOR   | 2 00<br>.....  | X   |                       |         |              |                              |        | 0   | 0  | 0   |
| BENNY NOLEN<br>.....<br>CEO   | 50 00<br>.....   |   |                       | X       |              |                              |        | 261,482   | 0  | 0   |
| DAVE MASSENGALE<br>.....<br>CFO   | 50 00<br>.....   |   |                       | X       |              |                              |        | 178,189   | 0  | 33,031  |



| Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors |  |   |                       |         |              |                              |        |   |  |   |
|---|--|---|-----------------------|---------|--------------|------------------------------|--------|---|--|---|
| (A)<br>Name and Title   | (B)<br>Average hours per week (list any hours for related organizations below dotted line) | (C)<br>Position (do not check more than one box, unless person is both an officer and a director/trustee) |                       |         |              |                              |        | (D)<br>Reportable compensation from the organization (W- 2/1099-MISC) | (E)<br>Reportable compensation from related organizations (W- 2/1099-MISC) | (F)<br>Estimated amount of other compensation from the organization and related organizations |
|   |  | Individual trustee or director  | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former |   |  |   |
| DAVID B PARK<br>.....<br>VP - GENERAL COUNSEL   | 50 00<br>.....   |   |                       |         | X            |                              |        | 204,613   | 0  | 25,943  |
| ARSHAD I HUSAIN MD<br>.....<br>ONCOLOGIST   | 50 00<br>.....   |   |                       |         |              | X                            |        | 781,830   | 0  | 15,902  |
| JAMES YELTON MD<br>.....<br>ORTHOPEDIC DOCTOR   | 50 00<br>.....   |   |                       |         |              | X                            |        | 651,239   | 0  | 36,815  |
| ALLAN LAM MD<br>.....<br>GASTROENTERO DOCTOR  | 50 00<br>.....   |   |                       |         |              | X                            |        | 603,594   | 0  | 28,835  |
| RICO MADDELA<br>.....<br>FP INTERNAL MED  | 50 00<br>.....   |   |                       |         |              | X                            |        | 409,444   | 0  | 33,306  |
| ALAN TRIPP<br>.....<br>SURGICAL SERVICES  | 50 00<br>.....   |   |                       |         |              | X                            |        | 384,699   | 0  | 31,385  |
| JOHN LOGAN 7117-32918<br>.....<br>MEDICAL DIRECTOR  | 50 00<br>.....   |   |                       |         | X            |                              |        | 220,673   | 0  | 0   |
| LOIS MORGAN 616-517<br>.....<br>FORMER VP CHIEF NURSE   | 50 00<br>.....   |   |                       |         |              |                              | X      | 164,997   | 0  | 20,070  |
| GARY COLBERG 617<br>.....<br>FORMER CEO   | 50 00<br>.....   |   |                       |         |              |                              | X      | 237,250   | 0  | 13,301  |
| BRUCE BEGLEY<br>.....<br>FORMER CEO   | 50 00<br>.....   |   |                       |         |              |                              | X      | 444,672   | 0  | 10,899  |

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](http://www.irs.gov/form990).

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization

COMMUNITY UNITED METHODIST HOSPITAL INC

Employer identification number

61-0461753

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

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

(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<br>(or fiscal year beginning in) ►  | (a) 2013 | (b) 2014 | (c) 2015 | (d) 2016 | (e) 2017 | (f) Total |
|----------|---|----------|----------|----------|----------|----------|-----------|
| <b>1</b> | Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant.")  |          |          |          |          |          |           |
| <b>2</b> | Tax revenues levied for the organization's benefit and either paid to or expended on its behalf   |          |          |          |          |          |           |
| <b>3</b> | The value of services or facilities furnished by a governmental unit to the organization without charge   |          |          |          |          |          |           |
| <b>4</b> | <b>Total.</b> Add lines 1 through 3   |          |          |          |          |          |           |
| <b>5</b> | The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f) |          |          |          |          |          |           |
| <b>6</b> | <b>Public support.</b> Subtract line 5 from line 4  |          |          |          |          |          |           |

**Section B. Total Support**

|           | Calendar year<br>(or fiscal year beginning in) ►   | (a)2013 | (b)2014 | (c)2015 | (d)2016 | (e)2017   | (f)Total |
|-----------|--|---------|---------|---------|---------|-----------|----------|
| <b>7</b>  | Amounts from line 4  |         |         |         |         |           |          |
| <b>8</b>  | Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources |         |         |         |         |           |          |
| <b>9</b>  | Net income from unrelated business activities, whether or not the business is regularly carried on                             |         |         |         |         |           |          |
| <b>10</b> | Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)                                |         |         |         |         |           |          |
| <b>11</b> | <b>Total support.</b> Add lines 7 through 10   |         |         |         |         |           |          |
| <b>12</b> | Gross receipts from related activities, etc. (see instructions)  |         |         |         |         | <b>12</b> |          |

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

|           |  |           |  |
|-----------|--|-----------|--|
| <b>14</b> | Public support percentage for 2017 (line 6, column (f) divided by line 11, column (f)) | <b>14</b> |  |
| <b>15</b> | Public support percentage for 2016 Schedule A, Part II, line 14                        | <b>15</b> |  |

**16a 33 1/3% support test—2017.** 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—2016.** 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—2017.** 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—2016.** 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<br>(or fiscal year beginning in) ►  | (a) 2013 | (b) 2014 | (c) 2015 | (d) 2016 | (e) 2017 | (f) Total |
|---|----------|----------|----------|----------|----------|-----------|
| <b>1</b> Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")  |          |          |          |          |          |           |
| <b>2</b> Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose |          |          |          |          |          |           |
| <b>3</b> Gross receipts from activities that are not an unrelated trade or business under section 513   |          |          |          |          |          |           |
| <b>4</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf  |          |          |          |          |          |           |
| <b>5</b> The value of services or facilities furnished by a governmental unit to the organization without charge  |          |          |          |          |          |           |
| <b>6 Total.</b> Add lines 1 through 5   |          |          |          |          |          |           |
| <b>7a</b> Amounts included on lines 1, 2, and 3 received from disqualified persons  |          |          |          |          |          |           |
| <b>b</b> Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year           |          |          |          |          |          |           |
| <b>c</b> Add lines 7a and 7b  |          |          |          |          |          |           |
| <b>8 Public support.</b> (Subtract line 7c from line 6.)  |          |          |          |          |          |           |

**Section B. Total Support**

| Calendar year<br>(or fiscal year beginning in) ►  | (a) 2013 | (b) 2014 | (c) 2015 | (d) 2016 | (e) 2017 | (f) Total |
|---|----------|----------|----------|----------|----------|-----------|
| <b>9</b> Amounts from line 6  |          |          |          |          |          |           |
| <b>10a</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources |          |          |          |          |          |           |
| <b>b</b> Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975                          |          |          |          |          |          |           |
| <b>c</b> Add lines 10a and 10b  |          |          |          |          |          |           |
| <b>11</b> Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on     |          |          |          |          |          |           |
| <b>12</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)                                 |          |          |          |          |          |           |
| <b>13 Total support.</b> (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**

|  |           |  |
|--|-----------|--|
| <b>15</b> Public support percentage for 2017 (line 8, column (f) divided by line 13, column (f)) | <b>15</b> |  |
| <b>16</b> Public support percentage from 2016 Schedule A, Part III, line 15                      | <b>16</b> |  |

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

|  |           |  |
|--|-----------|--|
| <b>17</b> Investment income percentage for <b>2017</b> (line 10c, column (f) divided by line 13, column (f)) | <b>17</b> |  |
| <b>18</b> Investment income percentage from <b>2016</b> Schedule A, Part III, line 17                        | <b>18</b> |  |

**19a 33 1/3% support tests—2017.** 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—2016.** 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 |
|---|------------|----|
| <b>1</b> Are all of the organization's supported organizations listed by name in the organization's governing documents? <i>If "No," describe in <b>Part VI</b> how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.</i>  | <b>1</b>   |    |
| <b>2</b> Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? <i>If "Yes," explain in <b>Part VI</b> how the organization determined that the supported organization was described in section 509(a)(1) or (2).</i>   | <b>2</b>   |    |
| <b>3a</b> Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? <i>If "Yes," answer (b) and (c) below.</i>  | <b>3a</b>  |    |
| <b>b</b> Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? <i>If "Yes," describe in <b>Part VI</b> when and how the organization made the determination.</i>   | <b>3b</b>  |    |
| <b>c</b> Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? <i>If "Yes," explain in <b>Part VI</b> what controls the organization put in place to ensure such use.</i>  | <b>3c</b>  |    |
| <b>4a</b> Was any supported organization not organized in the United States ("foreign supported organization")? <i>If "Yes" and if you checked 12a or 12b in Part I, answer (b) and (c) below.</i>  | <b>4a</b>  |    |
| <b>b</b> Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? <i>If "Yes," describe in <b>Part VI</b> how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.</i>  | <b>4b</b>  |    |
| <b>c</b> Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? <i>If "Yes," explain in <b>Part VI</b> what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.</i>   | <b>4c</b>  |    |
| <b>5a</b> Did the organization add, substitute, or remove any supported organizations during the tax year? <i>If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in <b>Part VI</b>, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed, (ii) the reasons for each such action, (iii) the authority under the organization's organizing document authorizing such action, and (iv) how the action was accomplished (such as by amendment to the organizing document).</i> | <b>5a</b>  |    |
| <b>b</b> <b>Type I or Type II only.</b> Was any added or substituted supported organization part of a class already designated in the organization's organizing document?   | <b>5b</b>  |    |
| <b>c</b> <b>Substitutions only.</b> Was the substitution the result of an event beyond the organization's control?  | <b>5c</b>  |    |
| <b>6</b> Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (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? <i>If "Yes," provide detail in <b>Part VI</b>.</i>  | <b>6</b>   |    |
| <b>7</b> 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? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>  | <b>7</b>   |    |
| <b>8</b> Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>   | <b>8</b>   |    |
| <b>9a</b> Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? <i>If "Yes," provide detail in <b>Part VI</b>.</i>  | <b>9a</b>  |    |
| <b>b</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? <i>If "Yes," provide detail in <b>Part VI</b>.</i>  | <b>9b</b>  |    |
| <b>c</b> 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? <i>If "Yes," provide detail in <b>Part VI</b>.</i>   | <b>9c</b>  |    |
| <b>10a</b> 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)? <i>If "Yes," answer line 10b below.</i>   | <b>10a</b> |    |
| <b>b</b> Did the organization have any excess business holdings in the tax year? <i>(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)</i>  | <b>10b</b> |    |

**Part IV Supporting Organizations** (continued)

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

**Section B. Type I Supporting Organizations**

|   | Yes      | No |
|---|----------|----|
| <b>1</b> Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? <i>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.</i> |          |    |
|   | <b>1</b> |    |
| <b>2</b> Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? <i>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.</i>  |          |    |
|   | <b>2</b> |    |

**Section C. Type II Supporting Organizations**

|  | Yes      | No |
|--|----------|----|
| <b>1</b> Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? <i>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).</i> |          |    |
|  | <b>1</b> |    |

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

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

**Section E. Type III Functionally-Integrated Supporting Organizations**

|   |           |  |
|---|-----------|--|
| <b>1</b> Check the box next to the method that the organization used to satisfy the Integral Part Test during the year ( <b>see instructions</b> )  |           |  |
| <b>a</b> <input type="checkbox"/> The organization satisfied the Activities Test. Complete <b>line 2</b> below.   |           |  |
| <b>b</b> <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete <b>line 3</b> below.  |           |  |
| <b>c</b> <input type="checkbox"/> The organization supported a governmental entity. Describe in <b>Part VI</b> how you supported a government entity (see instructions).  |           |  |
| <b>2</b> Activities Test. <b>Answer (a) and (b) below.</b>  |           |  |
| <b>a</b> Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <i>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.</i> |           |  |
|   | <b>2a</b> |  |
| <b>b</b> Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? <i>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.</i>  |           |  |
|   | <b>2b</b> |  |
| <b>3</b> Parent of Supported Organizations. <b>Answer (a) and (b) below.</b>  |           |  |
| <b>a</b> Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>Provide details in Part VI.</i>  |           |  |
|   | <b>3a</b> |  |
| <b>b</b> Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i>  |           |  |
|   | <b>3b</b> |  |

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

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

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

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

| <b>Section D - Distributions</b>  | <b>Current Year</b> |
|---|---------------------|
| <b>1</b> Amounts paid to supported organizations to accomplish exempt purposes  |                     |
| <b>2</b> Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity            |                     |
| <b>3</b> Administrative expenses paid to accomplish exempt purposes of supported organizations  |                     |
| <b>4</b> Amounts paid to acquire exempt-use assets  |                     |
| <b>5</b> Qualified set-aside amounts (prior IRS approval required)  |                     |
| <b>6</b> Other distributions (describe in <b>Part VI</b> ) See instructions   |                     |
| <b>7 Total annual distributions.</b> Add lines 1 through 6  |                     |
| <b>8</b> Distributions to attentive supported organizations to which the organization is responsive (provide details in <b>Part VI</b> ) See instructions |                     |
| <b>9</b> Distributable amount for 2017 from Section C, line 6   |                     |
| <b>10</b> Line 8 amount divided by Line 9 amount  |                     |

| <b>Section E - Distribution Allocations (see instructions)</b>   | <b>(i)<br/>Excess Distributions</b> | <b>(ii)<br/>Underdistributions<br/>Pre-2017</b> | <b>(iii)<br/>Distributable<br/>Amount for 2017</b> |
|--|-------------------------------------|---|--|
| <b>1</b> Distributable amount for 2017 from Section C, line 6  |                                     |   |  |
| <b>2</b> Underdistributions, if any, for years prior to 2017 (reasonable cause required-- explain in Part VI) See instructions   |                                     |   |  |
| <b>3</b> Excess distributions carryover, if any, to 2017   |                                     |   |  |
| <b>a</b>   |                                     |   |  |
| <b>b</b> From 2013. . . . .  |                                     |   |  |
| <b>c</b> From 2014. . . . .  |                                     |   |  |
| <b>d</b> From 2015. . . . .  |                                     |   |  |
| <b>e</b> From 2016. . . . .  |                                     |   |  |
| <b>f</b> Total of lines 3a through e   |                                     |   |  |
| <b>g</b> Applied to underdistributions of prior years  |                                     |   |  |
| <b>h</b> Applied to 2017 distributable amount  |                                     |   |  |
| <b>i</b> Carryover from 2012 not applied (see instructions)  |                                     |   |  |
| <b>j</b> Remainder Subtract lines 3g, 3h, and 3i from 3f   |                                     |   |  |
| <b>4</b> Distributions for 2017 from Section D, line 7 \$  |                                     |   |  |
| <b>a</b> Applied to underdistributions of prior years  |                                     |   |  |
| <b>b</b> Applied to 2017 distributable amount  |                                     |   |  |
| <b>c</b> Remainder Subtract lines 4a and 4b from 4   |                                     |   |  |
| <b>5</b> Remaining underdistributions for years prior to 2017, if any Subtract lines 3g and 4a from line 2 If the amount is greater than zero, explain in Part VI See instructions |                                     |   |  |
| <b>6</b> Remaining underdistributions for 2017 Subtract lines 3h and 4b from line 1 If the amount is greater than zero, explain in Part VI See instructions                        |                                     |   |  |
| <b>7 Excess distributions carryover to 2018.</b> Add lines 3j and 4c   |                                     |   |  |
| <b>8</b> Breakdown of line 7   |                                     |   |  |
| <b>a</b> Excess from 2013. . . . .   |                                     |   |  |
| <b>b</b> Excess from 2014. . . . .   |                                     |   |  |
| <b>c</b> Excess from 2015. . . . .   |                                     |   |  |
| <b>d</b> Excess from 2016. . . . .   |                                     |   |  |
| <b>e</b> Excess from 2017. . . . .   |                                     |   |  |



Additional Data

Software ID:  
Software Version:  
EIN: 61-0461753  
Name: COMMUNITY UNITED METHODIST HOSPITAL INC

**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 |
|                              |

**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](http://www.irs.gov/form990).

OMB No 1545-0047

**2017**

**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<br>COMMUNITY UNITED METHODIST HOSPITAL INC | Employer identification number<br>61-0461753 |
|---|--|

**Part I-A**

**Complete if the organization is exempt under section 501(c) or is a section 527 organization.**

- 1 Provide a description of the organization's direct and indirect political campaign activities in Part IV (see instructions for definition of "political campaign activities")
- 2 Political campaign activity expenditures (see instructions) ▶ \$
- 3 Volunteer hours for political campaign activities (see instructions) ▶

**Part I-B**

**Complete if the organization is exempt under section 501(c)(3).**

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

**Part I-C**

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

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

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

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

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

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

**Limits on Lobbying Expenditures**  
(The term "expenditures" means amounts paid or incurred.)**(a)** Filing  
organization's  
totals**(b)** Affiliated  
group totals

**1a** Total lobbying expenditures to influence public opinion (grass roots lobbying)

**b** Total lobbying expenditures to influence a legislative body (direct lobbying)

**c** Total lobbying expenditures (add lines 1a and 1b)

**d** Other exempt purpose expenditures

**e** Total exempt purpose expenditures (add lines 1c and 1d)

**f** Lobbying nontaxable amount Enter the amount from the following table in both columns

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

**g** Grassroots nontaxable amount (enter 25% of line 1f)

**h** Subtract line 1g from line 1a If zero or less, enter -0-

**i** Subtract line 1f from line 1c If zero or less, enter -0-

**j** If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?

☐ **Yes** ☐ **No****4-Year Averaging Period Under section 501(h)**

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

**Lobbying Expenditures During 4-Year Averaging Period**

| Calendar year (or fiscal year beginning in)                         | (a) 2014 | (b) 2015 | (c) 2016 | (d) 2017 | (e) Total |
|---|----------|----------|----------|----------|-----------|
| <b>2a</b> Lobbying nontaxable amount                                |          |          |          |          |           |
| <b>b</b> Lobbying ceiling amount<br>(150% of line 2a, column(e))    |          |          |          |          |           |
| <b>c</b> Total lobbying expenditures                                |          |          |          |          |           |
| <b>d</b> Grassroots nontaxable amount                               |          |          |          |          |           |
| <b>e</b> Grassroots ceiling amount<br>(150% of line 2d, column (e)) |          |          |          |          |           |
| <b>f</b> 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) |    | (b)    |
|-----------|--|-----|----|--------|
|           |  | Yes | No | Amount |
| <b>1</b>  | During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of |     |    |        |
| <b>a</b>  | Volunteers?  |     | No |        |
| <b>b</b>  | Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?   |     | No |        |
| <b>c</b>  | Media advertisements?  |     | No |        |
| <b>d</b>  | Mailings to members, legislators, or the public?   |     | No |        |
| <b>e</b>  | Publications, or published or broadcast statements?  |     | No |        |
| <b>f</b>  | Grants to other organizations for lobbying purposes?   |     | No |        |
| <b>g</b>  | Direct contact with legislators, their staffs, government officials, or a legislative body?  |     | No |        |
| <b>h</b>  | Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?  |     | No |        |
| <b>i</b>  | Other activities?  | Yes |    | 9,601  |
| <b>j</b>  | Total. Add lines 1c through 1i   |     |    | 9,601  |
| <b>2a</b> | Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?  |     | No |        |
| <b>b</b>  | If "Yes," enter the amount of any tax incurred under section 4912  |     |    |        |
| <b>c</b>  | If "Yes," enter the amount of any tax incurred by organization managers under section 4912   |     |    |        |
| <b>d</b>  | If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?   |     |    |        |

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

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

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

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

**Part IV Supplemental Information**

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

| Return Reference  | Explanation  |
|-------------------|--|
| PART II-B, LINE 1 | MEMBERSHIP DUES TO HOSPITAL ASSOCIATIONS OF WHICH A PORTION OF THE DUES ARE USED FOR LOBBYING EXPENSES BY THE TRADE ORGANIZATION |

efile GRAPHIC print - DO NOT PROCESS

As Filed Data -

DLN: 93493135001329

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](http://www.irs.gov/form990).

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization  
COMMUNITY UNITED METHODIST HOSPITAL INC

Employer identification number  
61-0461753

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.

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

(a) Donor advised funds

(b) Funds and other accounts

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)

☐ Protection of natural habitat

☐ Preservation of open space

☐ Preservation of an historically important land area

☐ Preservation of a certified historic structure

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

2a

Total number of conservation easements

2b

Total acreage restricted by conservation easements

2c

Number of conservation easements on a certified historic structure included in (a)

2d

Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register

3

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

4

Number of states where property subject to conservation easement is located ►

5

Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?

☐ Yes

☐ No

6

Staff and volunteer hours devoted to monitoring, inspecting, 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

► \$

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

Cat No 52283D

Schedule D (Form 990) 2017

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

c

Beginning balance

d

Additions during the year

e

Distributions during the year

f

Ending balance

|    | Amount |
|----|--------|
| 1c |        |
| 1d |        |
| 1e |        |
| 1f |        |

2a

Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability?

☐ Yes

☐ No

b

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

☐

Part V

Endowment Funds. Complete if the organization answered "Yes" 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

(i) unrelated organizations

3a(i)

Yes

No

(ii) related organizations

3a(ii)

Yes

No

b

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

3b

Yes

No

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   |                                      | 800,816                         |                              | 800,816        |
| b Buildings   |                                      | 104,858,217                     | 50,085,015                   | 54,773,202     |
| c Leasehold improvements  |                                      | 2,732,958                       | 1,992,315                    | 740,643        |
| d Equipment   |                                      | 72,258,687                      | 61,789,364                   | 10,469,323     |
| e Other   |                                      | 273,045                         | 251,239                      | 21,806         |
| Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c)) |                                      |                                 |                              | 66,805,790     |

Schedule D (Form 990) 2017

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<br>(including name of security) | (b) Book value | (c) Method of valuation<br>Cost or end-of-year market value |
|---|----------------|---|
| (1) Financial derivatives . . . . .                                     |                |   |
| (2) Closely-held equity interests . . . . .                             |                |   |
| (3) Other _____   |                |   |
| (A) INVESTMENT IN JOINT VENTURE   | 13,979         | C   |
| (B) INVESTMENT IN PREMIER   | 1,870,777      | C   |
| (C) INVESTMENT IN NET ASSETS OF FOUNDATION                              | 1,405,368      | C   |
| (D) AWUL  | 2,786,380      | C   |
| (E)   |                |   |
| (F)   |                |   |
| (G)   |                |   |
| (H)   |                |   |
| Total. (Column (b) must equal Form 990, Part X, col (B) line 12 ) ▶     | 6,076,504      |   |

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<br>Cost or end-of-year market value |
|---|----------------|---|
| (1)   |                |   |
| (2)   |                |   |
| (3)   |                |   |
| (4)   |                |   |
| (5)   |                |   |
| (6)   |                |   |
| (7)   |                |   |
| (8)   |                |   |
| (9)   |                |   |
| Total. (Column (b) must equal Form 990, Part X, col (B) line 13 ) ▶ |                |   |

Part IX

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

| (a) Description   | (b) Book value |
|---|----------------|
| (1)   |                |
| (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 CURRENT LIABILITIES   | 25,000         |
| PROFESSIONAL LIABILITY CLAIMS                                       | 3,783,189      |
| PENSION LIABILITY   | 14,601,649     |
| THIRD PARTY PAYOR   | 1,124,656      |
| (5)   |                |
| (6)   |                |
| (7)   |                |
| (8)   |                |
| (9)   |                |
| Total. (Column (b) must equal Form 990, Part X, col (B) line 25 ) ▶ | 19,534,494     |

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.

|          |  |           |             |
|----------|--|-----------|-------------|
| <b>1</b> | Total revenue, gains, and other support per audited financial statements . . . . .                       | <b>1</b>  | 125,780,218 |
| <b>2</b> | Amounts included on line 1 but not on Form 990, Part VIII, line 12                                       |           |             |
| <b>a</b> | Net unrealized gains (losses) on investments . . . . .   | <b>2a</b> | 408,894     |
| <b>b</b> | Donated services and use of facilities . . . . .   | <b>2b</b> |             |
| <b>c</b> | Recoveries of prior year grants . . . . .  | <b>2c</b> |             |
| <b>d</b> | Other (Describe in Part XIII ) . . . . .   | <b>2d</b> | -61,401     |
| <b>e</b> | Add lines <b>2a</b> through <b>2d</b> . . . . .  | <b>2e</b> | 347,493     |
| <b>3</b> | Subtract line <b>2e</b> from line <b>1</b> . . . . .   | <b>3</b>  | 125,432,725 |
| <b>4</b> | Amounts included on Form 990, Part VIII, line 12, but not on line <b>1</b>                               |           |             |
| <b>a</b> | Investment expenses not included on Form 990, Part VIII, line 7b . . . . .                               | <b>4a</b> |             |
| <b>b</b> | Other (Describe in Part XIII ) . . . . .   | <b>4b</b> |             |
| <b>c</b> | Add lines <b>4a</b> and <b>4b</b> . . . . .  | <b>4c</b> | 0           |
| <b>5</b> | Total revenue. Add lines <b>3</b> and <b>4c</b> . (This must equal Form 990, Part I, line 12 ) . . . . . | <b>5</b>  | 125,432,725 |

**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.

|          |   |           |             |
|----------|---|-----------|-------------|
| <b>1</b> | Total expenses and losses per audited financial statements . . . . .                                      | <b>1</b>  | 134,654,680 |
| <b>2</b> | Amounts included on line 1 but not on Form 990, Part IX, line 25  |           |             |
| <b>a</b> | Donated services and use of facilities . . . . .  | <b>2a</b> |             |
| <b>b</b> | Prior year adjustments . . . . .  | <b>2b</b> |             |
| <b>c</b> | Other losses . . . . .  | <b>2c</b> |             |
| <b>d</b> | Other (Describe in Part XIII ) . . . . .  | <b>2d</b> | 62,399      |
| <b>e</b> | Add lines <b>2a</b> through <b>2d</b> . . . . .   | <b>2e</b> | 62,399      |
| <b>3</b> | Subtract line <b>2e</b> from line <b>1</b> . . . . .  | <b>3</b>  | 134,592,281 |
| <b>4</b> | Amounts included on Form 990, Part IX, line 25, but not on line <b>1</b> :                                |           |             |
| <b>a</b> | Investment expenses not included on Form 990, Part VIII, line 7b . . . . .                                | <b>4a</b> |             |
| <b>b</b> | Other (Describe in Part XIII ) . . . . .  | <b>4b</b> |             |
| <b>c</b> | Add lines <b>4a</b> and <b>4b</b> . . . . .   | <b>4c</b> | 0           |
| <b>5</b> | Total expenses. Add lines <b>3</b> and <b>4c</b> . (This must equal Form 990, Part I, line 18 ) . . . . . | <b>5</b>  | 134,592,281 |

**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:** 61-0461753  
**Name:** COMMUNITY UNITED METHODIST HOSPITAL INC

**Supplemental Information**

| Return Reference | Explanation   |
|------------------|---|
| PART X, LINE 2   | ACCOUNTING PRINCIPLES GENERALLY ACCEPTED IN THE UNITED STATES OF AMERICA REQUIRE MANAGEMENT TO EVALUATE TAX POSITIONS TAKEN BY THE HOSPITAL AND RECOGNIZE A TAX LIABILITY IF THE HOSPITAL HAS TAKEN AN UNCERTAIN POSITION THAT MORE LIKELY THAN NOT WOULD NOT BE SUSTAINED UPON EXAMINATION BY VARIOUS FEDERAL AND STATE TAXING AUTHORITIES. MANAGEMENT HAS ANALYZED THE TAX POSITIONS TAKEN BY THE HOSPITAL, AND HAS CONCLUDED THAT AS OF JUNE 30, 2018 AND 2017, THERE ARE NO UNCERTAIN POSITIONS TAKEN OR EXPECTED TO BE TAKEN THAT WOULD REQUIRE RECOGNITION OF A LIABILITY OR DISCLOSURE IN THE ACCOMPANYING CONSOLIDATED FINANCIAL STATEMENTS. THE HOSPITAL IS SUBJECT TO ROUTINE AUDITS BY TAXING JURISDICTIONS, HOWEVER, THERE ARE CURRENTLY NO AUDITS FOR ANY TAX PERIODS IN PROGRESS. |

| Supplemental Information             |  |
|--------------------------------------|--|
| Return Reference                     | Explanation  |
| PART XI, LINE 2D - OTHER ADJUSTMENTS | PENSION VALUE CHANGE -257,945 INTEREST RATE SWAP 134,145 COGS 62,399 |

| Supplemental Information                 |             |
|--|-------------|
| Return Reference                         | Explanation |
| PART XII, LINE 2D - OTHER<br>ADJUSTMENTS | COGS 62,399 |

|  |  |  |
|--|--|--|
| <b>SCHEDULE H</b><br><b>(Form 990)</b><br><br>Department of the Treasury<br>Internal Revenue Service | <h2 style="margin:0;">Hospitals</h2> <p>► <b>Complete if the organization answered "Yes" on Form 990, Part IV, question 20.</b><br/>                 ► <b>Attach to Form 990.</b><br/>                 ► <b>Information about Schedule H (Form 990) and its instructions is at <a href="http://www.irs.gov/form990">www.irs.gov/form990</a>.</b></p> | OMB No 1545-0047<br><br><div style="font-size: 2em; font-weight: bold; text-align: center;">2017</div> Open to Public Inspection |
| <b>Name of the organization</b><br>COMMUNITY UNITED METHODIST HOSPITAL INC                           |  | <b>Employer identification number</b><br>61-0461753  |

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

|   |           | Yes | No |
|---|-----------|-----|----|
| <b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a   | <b>1a</b> | Yes |    |
| <b>b</b> If "Yes," was it a written policy? . . . . .   | <b>1b</b> | Yes |    |
| <b>2</b> If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year   |           |     |    |
| <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities<br><input type="checkbox"/> Generally tailored to individual hospital facilities  |           |     |    |
| <b>3</b> Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year  |           |     |    |
| <b>a</b> Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care<br><input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %  | <b>3a</b> | Yes |    |
| <b>b</b> Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care<br><input type="checkbox"/> 200% <input type="checkbox"/> 250% <input checked="" type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ % | <b>3b</b> | Yes |    |
| <b>c</b> If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care   |           |     |    |
| <b>4</b> Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?   | <b>4</b>  | Yes |    |
| <b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?   | <b>5a</b> | Yes |    |
| <b>b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?   | <b>5b</b> | Yes |    |
| <b>c</b> If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?   | <b>5c</b> |     | No |
| <b>6a</b> Did the organization prepare a community benefit report during the tax year?  | <b>6a</b> | Yes |    |
| <b>b</b> If "Yes," did the organization make it available to the public?  | <b>6b</b> | 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 |
|--|---|-------------------------------|-------------------------------------|-------------------------------|-----------------------------------|------------------------------|
| <b>a</b> Financial Assistance at cost (from Worksheet 1)   |   |                               | 1,583,025                           | 662,478                       | 920,547                           | 0 680 %                      |
| <b>b</b> Medicaid (from Worksheet 3, column a)   |   |                               | 31,847,560                          | 27,838,185                    | 4,009,375                         | 2 980 %                      |
| <b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b)              |   |                               |                                     |                               |                                   |                              |
| <b>d Total</b> Financial Assistance and Means-Tested Government Programs                           |   |                               | 33,430,585                          | 28,500,663                    | 4,929,922                         | 3 660 %                      |
| <b>Other Benefits</b>  |   |                               |                                     |                               |                                   |                              |
| <b>e</b> Community health improvement services and community benefit operations (from Worksheet 4) |   |                               | 190,638                             | 1,190                         | 189,448                           | 0 140 %                      |
| <b>f</b> Health professions education (from Worksheet 5)   |   |                               | 1,428,798                           | 417,394                       | 1,011,404                         | 0 750 %                      |
| <b>g</b> Subsidized health services (from Worksheet 6)   |   |                               |                                     |                               |                                   |                              |
| <b>h</b> Research (from Worksheet 7)   |   |                               |                                     |                               |                                   |                              |
| <b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8)                   |   |                               | 249,045                             |                               | 249,045                           | 0 190 %                      |
| <b>j Total.</b> Other Benefits   |   |                               | 1,868,481                           | 418,584                       | 1,449,897                         | 1 080 %                      |
| <b>k Total.</b> Add lines 7d and 7j  |   |                               | 35,299,066                          | 28,919,247                    | 6,379,819                         | 4 740 %                      |

**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 |
|--|---|-------------------------------|--------------------------------------|-------------------------------|------------------------------------|------------------------------|
| <b>1</b> Physical improvements and housing                         |   |                               |                                      |                               |                                    |                              |
| <b>2</b> Economic development                                      |   |                               |                                      |                               |                                    |                              |
| <b>3</b> Community support   |   |                               | 90,736                               | 7,494                         | 83,242                             | 0.060 %                      |
| <b>4</b> Environmental improvements                                |   |                               |                                      |                               |                                    |                              |
| <b>5</b> Leadership development and training for community members |   |                               |                                      |                               |                                    |                              |
| <b>6</b> Coalition building  |   |                               |                                      |                               |                                    |                              |
| <b>7</b> Community health improvement advocacy                     |   |                               |                                      |                               |                                    |                              |
| <b>8</b> Workforce development                                     |   |                               |                                      |                               |                                    |                              |
| <b>9</b> Other   |   |                               |                                      |                               |                                    |                              |
| <b>10 Total</b>  |   |                               | 90,736                               | 7,494                         | 83,242                             | 0.060 %                      |

**Part III Bad Debt, Medicare, & Collection Practices**

**Section A. Bad Debt Expense**

|  |          | Yes       | No |
|--|----------|-----------|----|
| <b>1</b> Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?   | <b>1</b> | Yes       |    |
| <b>2</b> Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.   | <b>2</b> | 2,582,850 |    |
| <b>3</b> 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. | <b>3</b> | 601,869   |    |
| <b>4</b> 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**

|   |  |                                |  |
|---|--|--------------------------------|--|
| <b>5</b> Enter total revenue received from Medicare (including DSH and IME).  | <b>5</b>   | 24,253,787                     |  |
| <b>6</b> Enter Medicare allowable costs of care relating to payments on line 5.   | <b>6</b>   | 25,553,640                     |  |
| <b>7</b> Subtract line 6 from line 5. This is the surplus (or shortfall).   | <b>7</b>   | -1,299,853                     |  |
| <b>8</b> Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used. |  |                                |  |
| <input type="checkbox"/> Cost accounting system   | <input checked="" type="checkbox"/> Cost to charge ratio | <input type="checkbox"/> Other |  |

**Section C. Collection Practices**

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

**Part IV Management Companies and Joint Ventures**

| (a) Name of entity (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions) | (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 % |
|---|---|--|--|---|
| <b>1</b>  |   |  |  |   |
| <b>2</b>  |   |  |  |   |
| <b>3</b>  |   |  |  |   |
| <b>4</b>  |   |  |  |   |
| <b>5</b>  |   |  |  |   |
| <b>6</b>  |   |  |  |   |
| <b>7</b>  |   |  |  |   |
| <b>8</b>  |   |  |  |   |
| <b>9</b>  |   |  |  |   |
| <b>10</b>   |   |  |  |   |
| <b>11</b>   |   |  |  |   |
| <b>12</b>   |   |  |  |   |
| <b>13</b>   |   |  |  |   |

**Part V Facility Information****Section A. Hospital Facilities**

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

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

**2**

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

|                           | Other (describe) | ER-other | ER-24 hours | Research facility | Critical access hospital | Teaching hospital | Children's hospital | General medical & surgical | Licensed hospital |
|---------------------------|------------------|----------|-------------|-------------------|--------------------------|-------------------|---------------------|----------------------------|-------------------|
| 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)

METHODIST HOSPITAL

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

1

**Community Health Needs Assessment**

|   | Yes           | No |
|---|---------------|----|
| <b>1</b> 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? . . . . .   | <b>1</b>      | No |
| <b>2</b> 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 . . . . .  | <b>2</b>      | No |
| <b>3</b> 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 . . . . .<br>If "Yes," indicate what the CHNA report describes (check all that apply)   | <b>3</b> Yes  |    |
| <b>a</b> <input checked="" type="checkbox"/> A definition of the community served by the hospital facility  |               |    |
| <b>b</b> <input checked="" type="checkbox"/> Demographics of the community  |               |    |
| <b>c</b> <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community  |               |    |
| <b>d</b> <input checked="" type="checkbox"/> How data was obtained  |               |    |
| <b>e</b> <input checked="" type="checkbox"/> The significant health needs of the community  |               |    |
| <b>f</b> <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups  |               |    |
| <b>g</b> <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs  |               |    |
| <b>h</b> <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests   |               |    |
| <b>i</b> <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)  |               |    |
| <b>j</b> <input checked="" type="checkbox"/> Other (describe in Section C)  |               |    |
| <b>4</b> Indicate the tax year the hospital facility last conducted a CHNA 20 <u>15</u>   |               |    |
| <b>5</b> 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 . . . . . | <b>5</b> Yes  |    |
| <b>6 a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .   | <b>6a</b> Yes |    |
| <b>b</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 . . . . .  | <b>6b</b> Yes |    |
| <b>7</b> Did the hospital facility make its CHNA report widely available to the public? . . . . .<br>If "Yes," indicate how the CHNA report was made widely available (check all that apply)  | <b>7</b> Yes  |    |
| <b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>WWW.METHODISTHOSPITAL.NET/CHNA.ASPX</u>  |               |    |
| <b>b</b> <input checked="" type="checkbox"/> Other website (list url) <u>GRRHC.WILDAPRICOT.ORG</u>  |               |    |
| <b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility  |               |    |
| <b>d</b> <input checked="" type="checkbox"/> Other (describe in Section C)  |               |    |
| <b>8</b> 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 . . . . .  | <b>8</b> Yes  |    |
| <b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>15</u>   |               |    |
| <b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . .<br>If "Yes" (list url) <u>WWW.METHODISTHOSPITAL.NET/CHNA.ASPX</u>   | <b>10</b> Yes |    |
| <b>a</b>  |               |    |
| <b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .   | <b>10b</b>    |    |
| <b>11</b> 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   |               |    |
| <b>12a</b> Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .  | <b>12a</b>    | No |
| <b>b</b> If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .   | <b>12b</b>    |    |
| <b>c</b> 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)**

METHODIST 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   |           |     |    |
| <b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?<br>If "Yes," indicate the eligibility criteria explained in the FAP   | <b>13</b> | Yes |    |
| a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200 000000000000</u> %<br>and FPG family income limit for eligibility for discounted care of <u>300 000000000000</u> %  |           |     |    |
| b <input type="checkbox"/> Income level other than FPG (describe in Section C)   |           |     |    |
| c <input checked="" type="checkbox"/> Asset level  |           |     |    |
| d <input type="checkbox"/> Medical indigency   |           |     |    |
| e <input type="checkbox"/> Insurance status  |           |     |    |
| f <input type="checkbox"/> Underinsurance discount   |           |     |    |
| g <input type="checkbox"/> Residency   |           |     |    |
| h <input type="checkbox"/> Other (describe in Section C)   |           |     |    |
| <b>14</b> Explained the basis for calculating amounts charged to patients? . . . . .   | <b>14</b> | Yes |    |
| <b>15</b> Explained the method for applying for financial assistance? . . . . .<br>If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)  | <b>15</b> | Yes |    |
| a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application   |           |     |    |
| b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application   |           |     |    |
| c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process   |           |     |    |
| d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications  |           |     |    |
| e <input type="checkbox"/> Other (describe in Section C)   |           |     |    |
| <b>16</b> Was widely publicized within the community served by the hospital facility? . . . . .<br>If "Yes," indicate how the hospital facility publicized the policy (check all that apply)   | <b>16</b> | Yes |    |
| a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url)<br><u>WWW.METHODISTHOSPITAL.NET/PATIENTS-VISITORS/FOR-PATIENTS/FINANCIAL-ASSISTAN</u>   |           |     |    |
| b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url)<br><u>WWW.METHODISTHOSPITAL.NET/PATIENTS-VISITORS/FOR-PATIENTS/FINANCIAL-ASSISTAN</u>  |           |     |    |
| c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url)<br><u>WWW.METHODISTHOSPITAL.NET/PATIENTS-VISITORS/FOR-PATIENTS/FINANCIAL-ASSISTAN</u>   |           |     |    |
| d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)   |           |     |    |
| e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)  |           |     |    |
| f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)   |           |     |    |
| g <input type="checkbox"/> 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 <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP  |           |     |    |
| i <input type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations   |           |     |    |
| j <input type="checkbox"/> Other (describe in Section C)   |           |     |    |

**Part V Facility Information** (continued)**Billing and Collections**

## METHODIST HOSPITAL

Name of hospital facility or letter of facility reporting group

|   | Yes           | No |
|---|---------------|----|
| <b>17</b> Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment? . . . . .   | <b>17</b> Yes |    |
| <b>18</b> Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP   |               |    |
| <b>a</b> <input type="checkbox"/> Reporting to credit agency(ies)<br><b>b</b> <input type="checkbox"/> Selling an individual's debt to another party<br><b>c</b> <input type="checkbox"/> 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<br><b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process<br><b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)<br><b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted   |               |    |
| <b>19</b> 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? . . . . .   | <b>19</b>     | No |
| If "Yes," check all actions in which the hospital facility or a third party engaged   |               |    |
| <b>a</b> <input type="checkbox"/> Reporting to credit agency(ies)<br><b>b</b> <input type="checkbox"/> Selling an individual's debt to another party<br><b>c</b> <input type="checkbox"/> 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<br><b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process<br><b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)   |               |    |
| <b>20</b> 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)  |               |    |
| <b>a</b> <input checked="" type="checkbox"/> 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<br><b>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process<br><b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications<br><b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations<br><b>e</b> <input type="checkbox"/> Other (describe in Section C)<br><b>f</b> <input type="checkbox"/> None of these efforts were made |               |    |

**Policy Relating to Emergency Medical Care**

|  |               |  |
|--|---------------|--|
| <b>21</b> 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? . . . . .  | <b>21</b> Yes |  |
| If "No," indicate why  |               |  |
| <b>a</b> <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions<br><b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing<br><b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)<br><b>d</b> <input type="checkbox"/> Other (describe in Section C) |               |  |

**Part V Facility Information** *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

METHODIST HOSPITAL

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**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? . . . . .

If "Yes," explain in Section C

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

If "Yes," explain in Section C

|           | Yes | No |
|-----------|-----|----|
| <b>22</b> |     |    |
| <b>23</b> |     | No |
| <b>24</b> | Yes |    |

**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)  
METHODIST HOSPITAL UNION COUNTY**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** \_\_\_\_\_

2

**Community Health Needs Assessment**

|   | Yes           | No |
|---|---------------|----|
| <b>1</b> 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? . . . . .   | <b>1</b>      | No |
| <b>2</b> 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 . . . . .  | <b>2</b>      | No |
| <b>3</b> 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 . . . . .<br>If "Yes," indicate what the CHNA report describes (check all that apply)   | <b>3</b> Yes  |    |
| <b>a</b> <input checked="" type="checkbox"/> A definition of the community served by the hospital facility  |               |    |
| <b>b</b> <input checked="" type="checkbox"/> Demographics of the community  |               |    |
| <b>c</b> <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community  |               |    |
| <b>d</b> <input checked="" type="checkbox"/> How data was obtained  |               |    |
| <b>e</b> <input checked="" type="checkbox"/> The significant health needs of the community  |               |    |
| <b>f</b> <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups  |               |    |
| <b>g</b> <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs  |               |    |
| <b>h</b> <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests   |               |    |
| <b>i</b> <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)  |               |    |
| <b>j</b> <input type="checkbox"/> Other (describe in Section C)   |               |    |
| <b>4</b> Indicate the tax year the hospital facility last conducted a CHNA 20 <u>15</u>   |               |    |
| <b>5</b> 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 . . . . . | <b>5</b> Yes  |    |
| <b>6 a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .   | <b>6a</b> Yes |    |
| <b>b</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 . . . . .  | <b>6b</b> Yes |    |
| <b>7</b> Did the hospital facility make its CHNA report widely available to the public? . . . . .<br>If "Yes," indicate how the CHNA report was made widely available (check all that apply)  | <b>7</b> Yes  |    |
| <b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>WWW.METHODISTHOSPITAL.NET/CHNA.ASPX</u>  |               |    |
| <b>b</b> <input type="checkbox"/> Other website (list url) <u>GRRHC.WILDAPRICOT.ORG</u>   |               |    |
| <b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility  |               |    |
| <b>d</b> <input checked="" type="checkbox"/> Other (describe in Section C)  |               |    |
| <b>8</b> 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 . . . . .  | <b>8</b> Yes  |    |
| <b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>15</u>   |               |    |
| <b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . .<br>If "Yes" (list url) <u>WWW.METHODISTHOSPITAL.NET/CHNA.ASPX</u>   | <b>10</b> Yes |    |
| <b>a</b>  |               |    |
| <b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .   | <b>10b</b>    |    |
| <b>11</b> 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   |               |    |
| <b>12a</b> Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .  | <b>12a</b>    | No |
| <b>b</b> If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .   | <b>12b</b>    |    |
| <b>c</b> 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)**

METHODIST HOSPITAL UNION COUNTY

**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   |           |     |    |
| <b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?<br>If "Yes," indicate the eligibility criteria explained in the FAP   | <b>13</b> | Yes |    |
| a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200 000000000000</u> %<br>and FPG family income limit for eligibility for discounted care of <u>300 000000000000</u> %  |           |     |    |
| b <input type="checkbox"/> Income level other than FPG (describe in Section C)   |           |     |    |
| c <input checked="" type="checkbox"/> Asset level  |           |     |    |
| d <input type="checkbox"/> Medical indigency   |           |     |    |
| e <input type="checkbox"/> Insurance status  |           |     |    |
| f <input type="checkbox"/> Underinsurance discount   |           |     |    |
| g <input type="checkbox"/> Residency   |           |     |    |
| h <input type="checkbox"/> Other (describe in Section C)   |           |     |    |
| <b>14</b> Explained the basis for calculating amounts charged to patients? . . . . .   | <b>14</b> | Yes |    |
| <b>15</b> Explained the method for applying for financial assistance? . . . . .<br>If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)  | <b>15</b> | Yes |    |
| a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application   |           |     |    |
| b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application   |           |     |    |
| c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process   |           |     |    |
| d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications  |           |     |    |
| e <input type="checkbox"/> Other (describe in Section C)   |           |     |    |
| <b>16</b> Was widely publicized within the community served by the hospital facility? . . . . .<br>If "Yes," indicate how the hospital facility publicized the policy (check all that apply)   | <b>16</b> | Yes |    |
| a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url)<br><u>WWW.METHODISTHOSPITAL.NET/PATIENTS-VISITORS/FOR-PATIENTS/FINANCIAL-ASSISTAN</u>   |           |     |    |
| b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url)<br><u>WWW.METHODISTHOSPITAL.NET/PATIENTS-VISITORS/FOR-PATIENTS/FINANCIAL-ASSISTAN</u>  |           |     |    |
| c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url)<br><u>WWW.METHODISTHOSPITAL.NET/PATIENTS-VISITORS/FOR-PATIENTS/FINANCIAL-ASSISTAN</u>   |           |     |    |
| d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)   |           |     |    |
| e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)  |           |     |    |
| f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)   |           |     |    |
| g <input type="checkbox"/> 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 <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP  |           |     |    |
| i <input type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations   |           |     |    |
| j <input type="checkbox"/> Other (describe in Section C)   |           |     |    |

**Part V Facility Information** (continued)**Billing and Collections**

METHODIST HOSPITAL UNION COUNTY

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_

|   | Yes           | No |
|---|---------------|----|
| <b>17</b> Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment? . . . . .   | <b>17</b> Yes |    |
| <b>18</b> Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP   |               |    |
| <b>a</b> <input type="checkbox"/> Reporting to credit agency(ies)<br><b>b</b> <input type="checkbox"/> Selling an individual's debt to another party<br><b>c</b> <input type="checkbox"/> 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<br><b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process<br><b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)<br><b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted   |               |    |
| <b>19</b> 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? . . . . .   | <b>19</b>     | No |
| If "Yes," check all actions in which the hospital facility or a third party engaged   |               |    |
| <b>a</b> <input type="checkbox"/> Reporting to credit agency(ies)<br><b>b</b> <input type="checkbox"/> Selling an individual's debt to another party<br><b>c</b> <input type="checkbox"/> 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<br><b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process<br><b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)   |               |    |
| <b>20</b> 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)  |               |    |
| <b>a</b> <input checked="" type="checkbox"/> 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<br><b>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process<br><b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications<br><b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations<br><b>e</b> <input type="checkbox"/> Other (describe in Section C)<br><b>f</b> <input type="checkbox"/> None of these efforts were made |               |    |

**Policy Relating to Emergency Medical Care**

|  |               |  |
|--|---------------|--|
| <b>21</b> 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? . . . . .  | <b>21</b> Yes |  |
| If "No," indicate why  |               |  |
| <b>a</b> <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions<br><b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing<br><b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)<br><b>d</b> <input type="checkbox"/> Other (describe in Section C) |               |  |

**Part V Facility Information** *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

METHODIST HOSPITAL UNION COUNTY

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**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? . . . . .

If "Yes," explain in Section C

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

If "Yes," explain in Section C

|           | Yes | No |
|-----------|-----|----|
| <b>22</b> |     |    |
| <b>23</b> |     | No |
| <b>24</b> | Yes |    |

**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.

[illegible]



**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? **21**

| Name and address                   | Type of Facility (describe) |
|------------------------------------|-----------------------------|
| <b>1</b> See Additional Data Table |                             |
| <b>2</b>                           |                             |
| <b>3</b>                           |                             |
| <b>4</b>                           |                             |
| <b>5</b>                           |                             |
| <b>6</b>                           |                             |
| <b>7</b>                           |                             |
| <b>8</b>                           |                             |
| <b>9</b>                           |                             |
| <b>10</b>                          |                             |

**Part VI Supplemental Information**

Provide the following information

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

**990 Schedule H, Supplemental Information**

| Form and Line Reference                | Explanation  |
|--|--|
| PART II, COMMUNITY BUILDING ACTIVITIES | COMMUNITY BUILDING ACTIVITIES INCLUDE THE HOSPITAL'S PARTICIPATION WITH GREEN RIVER AREA DISTRICT DEVELOPMENT, A LOCAL GROUP DEDICATED TO ADDRESSING THE HEALTHCARE NEEDS OF COMMUNITIES SERVED ALSO, A PART OF COMUNITY BUILDING ACTIVITIES, VARIOUS HOSPITAL ADMINISTRATION STAFF VOLUNTEER TIME AS BOARD MEMBERS OR MEMBERS OF COMMUNITY ORGANIZATION AND COALITIONS TO KEEP ABREAST OF HEALTHCARE NEEDS, CONCERNS AND ISSUES WITHIN THE AREA |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation  |
|-------------------------|--|
| PART III, LINE 2        | THE HOSPITAL HAS AGREEMENTS WITH THIRD PARTY PAYORS THAT PROVIDE FOR PAYMENTS TO THE HOSPITAL AT AMOUNTS DIFFERENT FROM ITS ESTABLISHED RATES. PAYMENT ARRANGEMENTS INCLUDE PROSPECTIVELY DETERMINED RATES PER DISCHARGE, REIMBURSED COSTS, DISCOUNTED CHARGES, AND PER DIEM PAYMENTS. NET PATIENT SERVICE REVENUE IS REPORTED AT THE ESTIMATED NET REALIZABLE AMOUNTS FROM PATIENTS, THIRD PARTY PAYORS, AND OTHER FOR SERVICES RENDERED, INCLUDING ESTIMATED RETROACTIVE ADJUSTMENTS UNDER REIMBURSEMENT AGREEMENTS WITH THIRD PARTY PAYORS. RETROACTIVE ADJUSTMENTS ARE ACCRUED ON AN ESTIMATED BASIS IN THE PERIOD THE RELATED SERVICES ARE RENDERED AND ADJUSTED IN FUTURE PERIODS AS FINAL SETTLEMENTS ARE DETERMINED. THE HOSPITAL ESTIMATES AN ALLOWANCE FOR UNCOLLECTIBLE PATIENT ACCOUNTS RECEIVABLE BASED ON EVALUATION OF THE AGING OF THE ACCOUNTS, HISTORICAL LOSSES, CURRENT ECONOMIC CONDITIONS AND OTHER FACTORS UNIQUE TO THE SERVICE AREA AND THE HEALTHCARE INDUSTRY. THE COSTING METHODOLOGY USED TO DETERMINE THE AMOUNTS REPORTED ON LINE 2 IS USING THE COST-TO-CHARGE RATIO. THE RATIO WAS CALCULATED FROM WORKSHEET A, ESTIMATED BAD DEBT EXPENSE (AT COST). |

# 990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation   |
|-------------------------|---|
| PART III, LINE 3        | THE AMOUNT OF BAD DEBT ESTIMATED TO HAVE BEEN ELIGIBLE UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY WAS DETERMINED BY USING THE POVERTY RATE FOR HENDERSON COUNTY |

# 990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation  |
|-------------------------|--|
| PART III, LINE 4        | THE FOOTNOTE DESCRIBING THE HOSPITAL'S BAD DEBT EXPENSE CAN BE FOUND ON PAGES 8-10 OF THE MOST RECENT AUDITED FINANCIAL STATEMENTS WHICH ARE ATTACHED WITH THIS SCHEDULE H |

# 990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation   |
|-------------------------|---|
| PART III, LINE 8        | MEDICARE ALLOWABLE COSTS WERE TAKEN DIRECTLY OFF MEDICARE COST REPORT FILED WITH THE 6/30/18 YEAREND THE CALCULATION INCLUDED MEDICARE INPATIENT AND OUTPATIENT CHARGES LESS MEDICARE REIMBURSEMENT LESS GME RECEIVED THE SHORTFALL SHOULD BE TREATED AS COMMUNITY BENEFIT AS THE REIMBURSEMENT RECEIVED DID NOT COVER THE COST OF PROVIDING SERVICES |

## 990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation  |
|-------------------------|--|
| PART III, LINE 9B       | HOSPITAL POLICY ON CHARITY CARE PROVIDES GUIDANCE ON HOW TO PROVIDE FINANCIAL ASSISTANCE FOR PATIENTS IN NEED HOSPITAL POLICY ON INDIGENT CARE OUTLINES THE DISPROPORTIONATE SHARE HOSPITAL (DSH) PROGRAM THROUGH THE STATE OF KENTUCKY TO SERVE THE INDIGENT CARE NEEDS OF ALL PATIENTS WITHOUT ANY TYPE OF HEALTH INSURANCE PATIENTS MUST COMPLETE A DSH APPLICATION AND MEET THE KENTUCKY DEPARTMENT OF MEDICAID SERVICES DSH PROGRAM MANUAL GUIDELINES |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation   |
|-------------------------|---|
| PART VI, LINE 2         | <p>HOSPITAL CONTINUES TO WORK WITH THE GREEN RIVER AREA DISTRICT DEVELOPMENT TO ASSESS THE HEALTHCARE NEEDS OF THE COMMUNITIES SERVED THE MISSION IS TO IMPROVE THE HEALTH AND QUALITY OF LIFE WITHIN OUR REGION THROUGH EDUCATION, MOTIVATION, EVALUATION AND AVAILABILITY THE HOSPITAL HAS A BOARD OF DIRECTORS WHICH CONSIST OF 32 INDIVIDUALS FROM THE HOSPITAL SERVICE AREA ONE PURPOSE OF THIS LARGE BOARD IS TO REPRESENT THE COMMUNITY SAN STAY IN TOUCH WITH COMMUNITY NEEDS THE BOARD HAS ESTABLISHED A COMMUNITY BENEFIT COMMITTEE WHICH SPECIFICALLY ADDRESSES COMMUNITY BENEFITS PROVIDED BY THE HOSPITALS METHODIST HOSPITAL UNION COUNTY HAS AN 8 MEMBER ADVISORY BOARD WHICH IN PART SERVES IN THE ROLE TO DETERMINE COMMUNITY NEEDS AND REPORTS DIRECTLY TO THE BOARD OF METHODIST HOSPITAL THE COMMUNITY BASED HEALTHY HENDERSON COALITION HAS MEMBERS ON THE COMMUNITY BENEFITS COMMITTEE OF THE METHODIST HOSPITAL BOARD OF DIRECTORS</p> |



**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation   |
|-------------------------|---|
| PART VI, LINE 3         | <p>HOSPITAL HAS FINANCIAL COUNSELORS TO INTERVIEW PATIENTS WHO MAY HAVE FINANCIAL NEED THE PROCESS IS PART OF PATIENT REGISTRATION AN INTERVIEW CAN TAKE PLACE AT ANY TIME THE PATIENT IS IN THE HOSPITAL AFTER THE PATIENT LEAVES THE HOSPITAL, CONTACT IS MADE IN AN EFFORT TO ASSIST THE INDIVIDUAL WITH APPLYING FOR GOVERNMENT ENTITLEMENT PROGRAMS EACH PATIENT REGISTERED AS A SELF-PAY AUTOMATICALLY RECEIVES PRINTED INFORMATION TITLED "ELIGIBILITY FOR FINANCIAL ASSISTANCE " THIS DOCUMENT EXPLAINS ABOUT THE KENTUCKY MEDICAID DISPROPORTIONATE SHARE HOSPITAL DSH PROGRAM IT CONTAINS A LIST OF INFORMATION THE PATIENT IS REQUIRED TO PROVIDE WITH THE DSH APPLICATION, ELIGIBILITY FOR THE PROGRAM IS DETERMINED FROM THE SUBMITTED DOCUMENTS IF THE PATIENT DOES NOT QUALIFY FOR THE DSH PROGRAM THEN THE DOCUMENTATION IS USED BY THE HOSPITAL FOR FINANCIAL ASSISTANCE DETERMINATION IN ADDITION, DISCUSSION WITH PATIENTS CONCERNING VARIOUS PROGRAMS, HOSPITAL ASSISTANCE, ETC</p> |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation   |
|-------------------------|---|
| PART VI, LINE 4         | <p>HOSPITAL IS LOCATED IN THE GREEN RIVER AREA DEVELOPMENT DISTRICT (GRADD) IN THE NORTHWESTERN PORTION OF KENTUCKY ALONG THE OHIO RIVER AND DIVIDED BY THE GREEN RIVER THE TOTAL POPULATION OF GRADD IS APPROXIMATELY 215,217 AND IS PROJECTED TO HAVE MINOR GROWTH OF 1-2% OVER THE NEXT FIVE YEARS METHODIST HOSPITAL'S PRIMARY SERVICE AREA COVERS PATIENTS FROM THE COUNTIES OF HENDERSON, UNION AND WEBSTER AND INCLUDES A SECONDARY MARKET OF PATIENTS FROM EACH OF THE SURROUNDING COUNTIES AND SOUTHERN INDIANAN AND SOUTHERN ILLINOIS THE TOTAL POPULATION IN THE PRIMARY AND SECONDARY SERVICE AREA IS APPROXIMATELY 75,000 THIS ORGANIZATION OWNS METHODIST HOSPITAL IN HENDERSON COUNTY AND METHODIST HOSPITAL UNION COUNTY, A CRITICAL ACCESS HOSPITAL IN UNION COUNTY, THE ONLY TWO HOSPITALS IN THE PRIMARY SERVICE AREA THE PRIMARY SERVICE AREA INCLUDES DESIGNATED MEDICALLY UNDERSERVED COUNTIES AND METHODIST HOSPITAL HAS SUPPORTED THE MEDICAL CARE IN THOSE COMMUNITIES BY PROVIDING TWO PRIMARY CARE CLINICS IN WEBSTER COUNTY AND TWO IN UNION COUNTY AS WELL AS SIX OTHER PRIMARY CARE CLINICS IN HENDERSON COUNTY WITH PHYSICIANS AND NURSE PRACTITIONERS</p> |

| Form and Line Reference | Explanation  |
|-------------------------|--|
| PART VI, LINE 5         | <p>METHODIST HOSPITAL, IN KEEPING WITH ITS CHRISTIAN HERITAGE, EXISTS TO PROVIDE A BROAD BASE D HEALTHCARE DELIVERY SYSTEM IN PARTNERSHIP WITH OUR MEDICAL STAFF, THE FOCUS WILL BE ON T HE COMPASSIONATE, HIGH QUALITY, AND COST EFFECTIVE SERVICES THAT ADDRESS MENTAL, SPIRITUAL , AND PHYSICAL NEEDS, AND WORKS TO IMPROVE THE HEALTH STATUS OF THE PEOPLE IN THE COMMUNIT IES THE MAJORITY OF COMMUNITY UNITED METHODIST HOSPITAL'S BOARD OF DIRECTORS IS COMPRISED OF INDIVIDUALS WHO LIVE AND WORK IN THE HOSPITAL SERVICES AREA THE HOSPITAL EXTENDS MEDC AL STAFF PRIVILEGES TO ALL QUALIFIED PHYSICIANS IN THE COMMUNITY DURING THE FISCAL YEAR E NDED JUNE 30, 2017, COMMUNITY UNITED METHODIST HOSPITAL, INC AS PART OF ITS MISSION CONTI NUES TO PROVIDE UNCOMPENSATED CARE TO THE RESIDENTS OF THE AREA EXAMPLES OF SERVICES PROV IDED FOR THE BENEFIT OF THE COMMUNITY ARE AS FOLLOWS - ADULT AND PEDIATRIC CPR COURSES OFF ERED FREE OR AT A NOMINALCOST -SMOKING CESSATION PROGRAM OFFERED AT NOMINAL COST TO PARTIC IPANTS - CHILDBIRTH EDUCATION CLASSES (INCLUDING PREPARED CHILDBIRTH, BREAST FEEDING, ETC) OFFERED TO THE PUBLIC AT A NOMINAL COST - OUTREACH PROGRAMS AT LOCAL ELEMENTARY AND JUNIO R HIGH SCHOOLS TO EDUCATE YOUNG PEOPLE ON A VARIETY OF TOPICS, INCLUDING CHEMICAL DEPENDEN CY AND CHILDBIRTH -PROVIDE EDUCATION TO WOMEN'S ADDICTION RECOVERY MANOR CENTER 3-4 TIMES PER YEAR FOR EDUCATIONAL SESSIONS UPON REQUEST - BROCHURES ON A WIDE VARIETY OF MEDICAL TO PICS ARE AVAILABLE TO THE PUBLIC AT NO CHARGE - MULTI-DISCIPLINARY CONTINUING EDUCATION PR OGRAMS FOR OTHER MEDICAL PROFESSIONALS AND ANCILLARY PERSONNEL - COMMUNITY EDUCATION PROGR AMS PROVIDED FREE TO THE PUBLIC ON VARIOUS HEALTHCARE TOPICS CANCER, STROKE, HEART ATTACK, DIABETES, STRESS, LIFESTYLE, ETC - PROMOTION OF HEALTHCARE PROFESSIONALS THROUGH ASSOCIA TION WITH HENDERSON COMMUNITY COLLEGE, ITT BRECKENRIDGE, MADISONVILLE COMMUNITY COLLEGE, A ND WITH INTERNSHIP SAND CLINICAL AFFILIATIONS WITH OTHER UNIVERSITIES FOR PHARMACY, PHYSIC AL THERAPY, RADIOLOGY, HEALTHCARE ADMINISTRATION AND DIETETICS -FREE CHOLESTEROL SCREENING S PROVIDED THE FIRST THURSDAY OF EVERY MONTH TO THE GENERAL PUBLIC - BLOOD PRESSURE SCREEN INGS DONE MONTHLY AT PLEASANT POINT AND TWICE A YEAR AT SENIOR CITIZEN COMPLEXES -BLOOD SU GAR SCREENING PROVIDED MONTHLY AT PLEASANT POINT AND COLONIAL ASSISTED LIVING - HEALTH FAI RS ARE HELD FOR LOCAL INDUSTRY AS WELL AS THE GENERAL PUBLIC, PROVIDING A WIDE RANGE OF SC REENING TESTS AND EDUCATIONAL MATERIALS IN HENDERSON, UNION AND WEBSTER COUNTIES -SPEAKERS PROVIDED TO COMMUNITY ORGANIZATIONS FOR PRESENTATIONS ON SUCH HEALTHCARE TOPICS AS CANCER , ALZHEIMER'S DISEASE, BLOOD PRESSURE, CHOLESTEROL, ETC - WELLNESS PROGRAM OFFERED TO LOC AL BUSINESSES INCLUDES ONSITE HEALTH FAIRS, RISK APPRAISAL, NURSE VISITS, DIABETES, WEIGHT LOSS, AND EDUCATIONAL PROGRAMS - FLU SHOTS PROVIDED TO INDUSTRY AND SCHOOLS - DISCOUNT OF 50% OFFERED ON FIRST MAMMOGRAPHY SCREENING DURING BREAST CANCER AWARENESS MONTH - A DISCO UNT AGREEMENT WITH THE HEALTH DEPARTMENT ON MAMMOGRAPHY REFERRALS - NEONATAL SERVICES PROV IDED A REDUCED RATE FOR LOW INCOME WOMEN - OUTPATIENT LACTATION CONSULTING FEES WAIVED FOR LOW INCOME MOTHERS - METHODIST HOSPITAL ALSO PROVIDES FOR ADULTS WHO HAVE CHRONIC HEALTH CARE NEEDS THROUGH THE CONTINUITY CARE CLINIC THIS CLINIC OPERATES 4 DAYS PER WEEK WITH ME DICAL RESIDENTS AND THEIR SUPERVISORS - METHODIST HOSPITAL SERVES AS A PRECEPTOR SITE FOR VARIOUS UNIVERSITIES AND COLLEGES FOR ADMINISTRATIVE, PHYSICAL AND OCCUPATIONAL THERAPIES, AND NURSING STUDENTS - HOSPITAL MANAGEMENT PARTICIPATES IN AND ROUTINELY DONATES USE OF T HE HOSPITAL FACILITY TO VARIOUS NON-PROFIT COMMUNITY ORGANIZATIONS SUCH AS YMCA, SALVATION ARMY, UNITED WAY, JUNIOR PRO BALL, ETC EMPLOYEES ARE MEMBERS OF VARIOUS COMMUNITY ORGANI ZATIONS AND REGULARLY ATTEND MEETINGS TO KEEP MH ACTIVELY INVOLVED IN THE COMMUNITY - AMER ICAN HEART ASSOCIATION, KENTUCKY CANCER PROGRAM, DIABETES COALITION, HEALTHY HENDERSON FOR EXAMPLE - ASSISTED IN PLANNING AND ORGANIZING OF VARIOUS ACTIVITIES FOR COMMUNITY ORGANIZ ATIONS RELAY FOR LIFE (AMERICAN CANCER SOCIETY), RACE FOR THE CURE (BREAST CANCER), REGION AL SENIOR GAMES, HUNTING DOWN DIABETES - BUILDING, MAINTENANCE , COMPUTER EQUIPMENT, AND S OME MEDICAL EQUIPMENT PROVIDED TO THE HENDERSON CITY/COUNTY AMBULANCE SERVICE AT NO CHARGE - PROVIDE FOR TRANSPORTATION COSTS FOR PATIENTS NEEDING ASSISTANCE TO THEIR HOMES FROM TH E HOSPITAL - CASH AND IN IN-KIND CONTRIBUTIONS TO SUPPORT VARIOUS OTHER NON-PROFITS LOCATE D IN HENDERSON, WEBSTER AND UNION COUNTIES - CASH DONATION TO ECONOMIC DEVELOPMENT ENTITY TO FOSTER DEVELOPMENT IN THE AREA - PLEDGE SUPPORT OF NURSING PROGRAM AT LOCAL COLLEGE - S CHOLARSHIPS OFFERED TO NURSING, PHYSICAL THERAPY, RADIOLOGY AND PHARMACY STUDENTS - PARTIC IPATION IN LOCAL CAREER DAYS TO PROVIDE INFORMATION ON HEALTH CAREERS TO HIGH SCHOOL, COLL EGE, AND TECHNICAL SCHOOL STUDENTS - HIGH SCHOOL AND COLLEGE STUDENTS GAIN VALUABLE EXPERI ENCE THROUGH THE HEALTH CAREERS PROGRAM THAT PUTS</p> |

| Form and Line Reference | Explanation  |
|-------------------------|--|
| PART VI, LINE 5         | THEM IN A HOSPITAL SETTING WHILE EXPLORING HEALTHCARE CAREERS - PRESENTATIONS MADE TO LOCAL HIGH SCHOOLS TO PROMOTE HEALTH CAREERS AND LECTURE ON HEALTHCARE TOPICS - HOSTED BI-ANNUAL BLOOD DRIVES FOR THE AMERICAN RED CROSS |

| 990 Schedule H, Supplemental Information      |             |
|---|-------------|
| Form and Line Reference                       | Explanation |
| PART VI, LINE 7, REPORTS FILED<br>WITH STATES | KY          |

**Schedule H (Form 990) 2017**

**Additional Data**

**Software ID:**  
**Software Version:**  
**EIN:** 61-0461753  
**Name:** COMMUNITY UNITED METHODIST HOSPITAL INC

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

| <b>Section A. Hospital Facilities</b><br><br>(list in order of size from largest to smallest—see instructions)<br>How many hospital facilities did the organization operate during the tax year?<br><b>2</b> |  | 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  | METHODIST HOSPITAL<br>1305 N ELM STREET<br>HENDERSON, KY 42420<br>100173               | X                 | X                          |                     |                   |                          |                   | X           |          |                  |                          |
| 2  | METHODIST HOSPITAL UNION COUNTY<br>4604 US HWY 60 W<br>MORGANFIELD, KY 42437<br>600057 | 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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

| Form and Line Reference         | Explanation  |
|---------------------------------|--|
| METHODIST HOSPITAL              | PART V, SECTION B, LINE 5 THE PROCESS INCLUDED A THREE STEP PROCESS OF DATA ANALYSIS, PUBLIC COMMENT VIA WRITTEN AND ELECTRONIC SURVEYS AND INDIVIDUAL COUNTY PUBLIC FORUMS IN ORDER TO ASSURE ACCESS TO ALL CITIZENS, INCLUDING THE MOST VULNERABLE, COPIES OF MANUAL SURVEYS WERE PROVIDED TO LOCAL HEALTH DEPARTMENTS HEALTHY HENDERSON, A COALITION OF HEALTH AND COMMUNITY LEADERS FROM ACROSS THE SERVICE REGION, WAS ALSO CREATED THE PURPOSE OF HEALTHY HENDERSON IS TO PROMOTE HEALTH AND WELLNESS THROUGHOUT THE COMMUNITY |
| METHODIST HOSPITAL UNION COUNTY | PART V, SECTION B, LINE 5 THE PROCESS INCLUDED A THREE STEP PROCESS OF DATA ANALYSIS, PUBLIC COMMENT VIA WRITTEN AND ELECTRONIC SURVEYS AND INDIVIDUAL COUNTY PUBLIC FORUMS IN ORDER TO ASSURE ACCESS TO ALL CITIZENS, INCLUDING THE MOST VULNERABLE, COPIES OF MANUAL SURVEYS WERE PROVIDED TO LOCAL HEALTH DEPARTMENTS HEALTHY HENDERSON, A COALITION OF HEALTH AND COMMUNITY LEADERS FROM ACROSS THE SERVICE REGION, WAS ALSO CREATED THE PURPOSE OF HEALTHY HENDERSON IS TO PROMOTE HEALTH AND WELLNESS THROUGHOUT THE COMMUNITY |



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

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

| Form and Line Reference         | Explanation  |
|---------------------------------|--|
| METHODIST HOSPITAL              | PART V, SECTION B, LINE 6A METHODIST HOSPITAL AND METHODIST HOSPITAL UNION COUNTY CONDUCTED THEIR OWN CHNAS, BUT ALSO PARTNERED WITH THE GREEN RIVER AREA DEVELOPMENT DISTRICT WHICH INCLUDES THE OWENSBORO HEALTH SYSTEM AND OHIO COUNTY HOSPITAL |
| METHODIST HOSPITAL UNION COUNTY | PART V, SECTION B, LINE 6A METHODIST HOSPITAL AND METHODIST HOSPITAL UNION COUNTY CONDUCTED THEIR OWN CHNAS, BUT ALSO PARTNERED WITH THE GREEN RIVER AREA DEVELOPMENT DISTRICT WHICH INCLUDES THE OWENSBORO HEALTH SYSTEM AND OHIO COUNTY HOSPITAL |

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

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

| Form and Line Reference         | Explanation  |
|---------------------------------|--|
| METHODIST HOSPITAL              | PART V, SECTION B, LINE 6B METHODIST HOSPITAL AND METHODIST HOSPITAL UNION COUNTY CONDUCTED THEIR OWN CHNAS, BUT ALSO PARTNERED WITH THE GREEN RIVER AREA DEVELOPMENT DISTRICT WHICH INCLUDES THE OWENSBORO HEALTH SYSTEM AND OHIO COUNTY HOSPITAL |
| METHODIST HOSPITAL UNION COUNTY | PART V, SECTION B, LINE 6B METHODIST HOSPITAL AND METHODIST HOSPITAL UNION COUNTY CONDUCTED THEIR OWN CHNAS, BUT ALSO PARTNERED WITH THE GREEN RIVER AREA DEVELOPMENT DISTRICT WHICH INCLUDES THE OWENSBORO HEALTH SYSTEM AND OHIO COUNTY HOSPITAL |

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

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

| Form and Line Reference         | Explanation  |
|---------------------------------|--|
| METHODIST HOSPITAL              | PART V, SECTION B, LINE 7D METHODIST HOSPITAL PRESENTED ITS CHNA TO THE HENDERSON REGIONAL HOSPITAL FOUNDATION, THE HENDERSON HEALTH COALITION AND THE GREEN RIVER AREA HEALTH COUNCIL METHODIST HOSPITAL UNION COUNTY PRESENTED ITS CHNA TO THE UNION COUNTY HEALTH COALITION |
| METHODIST HOSPITAL UNION COUNTY | PART V, SECTION B, LINE 7D METHODIST HOSPITAL PRESENTED ITS CHNA TO THE HENDERSON REGIONAL HOSPITAL FOUNDATION, THE HENDERSON HEALTH COALITION AND THE GREEN RIVER AREA HEALTH COUNCIL METHODIST HOSPITAL UNION COUNTY PRESENTED ITS CHNA TO THE UNION COUNTY HEALTH COALITION |

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

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

| Form and Line Reference         | Explanation  |
|---------------------------------|--|
| METHODIST HOSPITAL              | PART V, SECTION B, LINE 11 HENDERSON COUNTY HEALTHY HENDERSON COALITION SERVES AS THE ACCOUNTABILITY GROUP FOR THE COMMUNITY HEALTH IMPROVEMENT INITIATIVES, USING A STRONG NETWORK OF COMMUNITY PARTNERS WITHIN THE COMMUNITY TO AFFECT CHANGE SELECTED NEEDS IDENTIFIED THROUGH OUR CHNA WERE TEEN ISSUES, REDUCING OBESITY AND DIABETES, TOBACCO CESSATION INCLUDING E-CIGARETTES, AND REDUCING SUBSTANCE ABUSE PARTNER WITH LOCAL ORGANIZATIONS TO OFFER DIABETES EDUCATION, AWARENESS, AND PREVENTION THROUGHOUT THE COMMUNITY (ABC'S OF DIABETES PRESENTATION), ANNUAL EVENTS INCLUDE DIABETES ALERT DAY WITH FREE A1CS AND HUNTING DOWN DIABETES WALK/RUN HAVE IMPLEMENTED A FOOD NUTRITION CHOICE OPTION AT OUR LOCAL COMMUNITY BALL PARK, PARTNERED WITH LOCAL PROGRAMS TO OFFER CHRONIC DISEASE MANAGEMENT (DIABETES IN PARTICULAR) THROUGHOUT THE COMMUNITY WE HAVE PROVIDED SMOKING CESSATION PROGRAMS IN OUR FACILITIES FOR EMPLOYEES OF THE HOSPITAL AND ALSO THE COMMUNITY, PARTICIPATED IN OUR PHYSICIAN RESIDENCY PROGRAM FOR EDUCATION AND RESEARCH WITH SMOKING CESSATION WE ALSO HAVE OFFERED FREE PROSTATE SCREENING, FREE A1C TESTING, AND FREE COLONOSCOPIES TO PARTICIPANTS IN A WALK/RUN EVENT UNION COUNTY FOCUSED ON ACCESS TO HEALTHCARE BY EDUCATING THE PUBLIC ABOUT SERVICES ARE AVAILABLE IN THE COUNTY, REDUCED SMOKING VIA EDUCATION AND SMOKE-FREE INITIATIVES ALONG WITH E-CIG EDUCATION, AND FOCUS ON REDUCING OBESITY AND INCREASE PHYSICAL ACTIVITY VIA GARDEN PROGRAM AND CURRICULUM, BEST BITES CAMPAIGN FOR HEALTHY FOOD CHOICES DIABETES SUPPORT CLASSES, ACTIVE HEALTHY KIDS DAY AND A GRANT TO EXTEND THE CITY WALKING PATH IN CONNECTION WITH THE CITY OF MORGANFIELD FREE INSULIN TESTING GIVEN AT THE HOSPITAL |
| METHODIST HOSPITAL UNION COUNTY | PART V, SECTION B, LINE 11 HENDERSON COUNTY HEALTHY HENDERSON COALITION SERVES AS THE ACCOUNTABILITY GROUP FOR THE COMMUNITY HEALTH IMPROVEMENT INITIATIVES, USING A STRONG NETWORK OF COMMUNITY PARTNERS WITHIN THE COMMUNITY TO AFFECT CHANGE SELECTED NEEDS IDENTIFIED THROUGH OUR CHNA WERE TEEN ISSUES, REDUCING OBESITY AND DIABETES, TOBACCO CESSATION INCLUDING E-CIGARETTES, AND REDUCING SUBSTANCE ABUSE PARTNER WITH LOCAL ORGANIZATIONS TO OFFER DIABETES EDUCATION, AWARENESS, AND PREVENTION THROUGHOUT THE COMMUNITY (ABC'S OF DIABETES PRESENTATION), ANNUAL EVENTS INCLUDE DIABETES ALERT DAY WITH FREE A1CS AND HUNTING DOWN DIABETES WALK/RUN HAVE IMPLEMENTED A FOOD NUTRITION CHOICE OPTION AT OUR LOCAL COMMUNITY BALL PARK, PARTNERED WITH LOCAL PROGRAMS TO OFFER CHRONIC DISEASE MANAGEMENT (DIABETES IN PARTICULAR) THROUGHOUT THE COMMUNITY WE HAVE PROVIDED SMOKING CESSATION PROGRAMS IN OUR FACILITIES FOR EMPLOYEES OF THE HOSPITAL AND ALSO THE COMMUNITY, PARTICIPATED IN OUR PHYSICIAN RESIDENCY PROGRAM FOR EDUCATION AND RESEARCH WITH SMOKING CESSATION WE ALSO HAVE OFFERED FREE PROSTATE SCREENING, FREE A1C TESTING, AND FREE COLONOSCOPIES TO PARTICIPANTS IN A WALK/RUN EVENT UNION COUNTY FOCUSED ON ACCESS TO HEALTHCARE BY EDUCATING THE PUBLIC ABOUT SERVICES ARE AVAILABLE IN THE COUNTY, REDUCED SMOKING VIA EDUCATION AND SMOKE-FREE INITIATIVES ALONG WITH E-CIG EDUCATION, AND FOCUS ON REDUCING OBESITY AND INCREASE PHYSICAL ACTIVITY VIA GARDEN PROGRAM AND CURRICULUM, BEST BITES CAMPAIGN FOR HEALTHY FOOD CHOICES DIABETES SUPPORT CLASSES, ACTIVE HEALTHY KIDS DAY AND A GRANT TO EXTEND THE CITY WALKING PATH IN CONNECTION WITH THE CITY OF MORGANFIELD FREE INSULIN TESTING GIVEN AT THE HOSPITAL |

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

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

| Form and Line Reference         | Explanation   |
|---------------------------------|---|
| METHODIST HOSPITAL              | PART V, SECTION B, LINE 24 ALL PAYERS, INCLUDING ENTITLEMENT PROGRAMS, INSURANCE COMPANIES AND PATIENTS WITHOUT INSURANCE ARE BILLED AT HOSPITAL'S STANDARD RATE REIMBURSEMENT AND DISCOUNTS ARE BASED ON ENTITLEMENT ALLOWABLE CONTRACTUALLY, MUTUALLY AGREEABLE REDUCTIONS OF CHARGES WITH INSURANCE COMPANIES AND MUTUALLY AGREEABLE REDUCTIONS OF CHARGES WITH PATIENTS |
| METHODIST HOSPITAL UNION COUNTY | PART V, SECTION B, LINE 24 ALL PAYERS, INCLUDING ENTITLEMENT PROGRAMS, INSURANCE COMPANIES AND PATIENTS WITHOUT INSURANCE ARE BILLED AT HOSPITAL'S STANDARD RATE REIMBURSEMENT AND DISCOUNTS ARE BASED ON ENTITLEMENT ALLOWABLE CONTRACTUALLY, MUTUALLY AGREEABLE REDUCTIONS OF CHARGES WITH INSURANCE COMPANIES AND MUTUALLY AGREEABLE REDUCTIONS OF CHARGES WITH PATIENTS |

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

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

| Form and Line Reference                 | Explanation  |
|---|--|
| SCH H PART V PART B LINE 16<br>A, B & C | THE FAP, THE FAP APPLICATION AND THE FAP PLAIN LANGUAGE SUMMARY ARE AVAIALABLE AT<br><a href="https://www.methodisthospital.net/patients-visitors/for-patients/financial-assistance.aspx">HTTPS //WWW METHODISTHOSPITAL NET/PATIENTS-VISITORS/FOR-PATIENTS/FINANCIAL-ASSISTANCE ASPX</a> |

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

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

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

| Name and address   | Type of Facility (describe)     |
|--|---------------------------------|
| 1 1 - METHODIST PEDIATRICS - IMPERIAL<br>110 THIRD STREET SUITE 180<br>HENDERSON, KY 42420         | PEDIATRIC PHYSICIAN SVCS        |
| 1 2 - METHODIST GASTROENTEROLOGY<br>1305 N ELM STREET<br>HENDERSON, KY 42420                       | GASTROENTEROLOGY PHYSICIAN SVCS |
| 2 3 - METHODIST FAMILY PRACTICE<br>1284 US HWY 60 WEST<br>MORGANFIELD, KY 42437                    | FAMILY PRACTICE PHYSICIAN SVCS  |
| 3 4 - WOMEN'S HEALTH SERVICES-HENDERSON<br>736 ELM STREET<br>HENDERSON, KY 42420                   | WOMEN'S HEALTH PHYSICIAN SVCS   |
| 4 5 - METHODIST ORTHOPEDIC SERVICES<br>471 KLUTEY PARK PLAZA<br>HENDERSON, KY 42420                | ORTHOPEDIC PHYSICIAN SVCS       |
| 5 6 - METHODIST SURGICAL SERVICES<br>110 THIRD STREET SUITE 105<br>HENDERSON, KY 42420             | SURGICAL PHYSICIAN SVCS         |
| 6 7 - METHODIST PEDIATRICS - ELM<br>2000 N ELM STREET SUITE 1B<br>HENDERSON, KY 42420              | PEDIATRIC PHYSICIAN SVCS        |
| 7 8 - METHODIST FAMILY MEDICINE - STURGIS<br>9064 US HWY 60<br>STURGIS, KY 42459                   | FAMILY MEDICINE PHYSICIAN SVCS  |
| 8 9 - METHODIST FAMILY MEDICINE - IMPERIAL<br>110 THIRD STREET SUITE 250<br>HENDERSON, KY 42420    | FAMILY MEDICINE PHYSICIAN SVCS  |
| 9 10 - METHODIST FAMILY MEDICINE - ATKINSON<br>1413 N ELM STREET SUITE 204<br>HENDERSON, KY 42420  | FAMILY MEDICINE PHYSICIAN SVCS  |
| 10 12 - WOMEN'S HEALTH SERVICES - MADISONVILLE<br>44 MCCOY AVENUE<br>MADISONVILLE, KY 42431        | WOMEN'S HEALTH PHYSICIAN SVCS   |
| 11 13 - METHODIST FAMILY MEDICINE - NORTH ELM<br>2000 N ELM STREET SUITE 1A<br>HENDERSON, KY 42420 | FAMILY MEDICINE PHYSICIAN SVCS  |
| 12 14 - METHODIST FAMILY MEDICINE - 8TH ST<br>319 8TH STREET SUITE 1<br>HENDERSON, KY 42420        | FAMILY MEDICINE PHYSICIAN SVCS  |
| 13 15 - METHODIST FAMILY MEDICINE - SEBREE<br>47 W WEBSTER STREET<br>SEBREE, KY 42455              | FAMILY MEDICINE PHYSICIAN SVCS  |
| 14 16 - CONTINUITY CARE CLINIC<br>411 LETCHER ST<br>HENDERSON, KY 42420                            | RESIDENT/ FAMILY MEDICAL CLINIC |

**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)       |
|--|-----------------------------------|
| <b>16</b> 17 - METHODIST HEMATOLOGY ONCOLOGY<br>110 WATER STREET<br>HENDERSON, KY 42420            | ONCOLOGY PHYSICIAN SVCS           |
| <b>1</b> 18 - WEBSTER COUNTY FAMILY MEDICINE<br>1355 HWY 41-A SOUTH<br>DIXON, KY 42409             | FAMILY MEDICINE PHYSICIAN SVCS    |
| <b>2</b> 19 - METHODIST HOSPITAL AUXILLARY<br>1305 N ELM STREET<br>HENDERSON, KY 42420             | HOSPITAL AUXILLARY PHYSICIAN SVCS |
| <b>3</b> 20 - METHODIST OCCUPATIONAL MEDICINE<br>110 THIRD STREET SUITE 120<br>HENDERSON, KY 42420 | OCCUPATIONAL PHYSICIAN SVCS       |
| <b>4</b> 21 - MULTI-SPECIALTY CLINIC<br>110 2ND STREET<br>HENDERSON, KY 42420                      | HEMOCARE PHYSICIAN SVCS           |
| <b>5</b> 22 - METHODIST CONVENIENT CARE<br>110 2ND STREET<br>HENDERSON, KY 42420                   | CONVENIENT CARE CLINIC            |



Schedule I  
(Form 990)

Department of the Treasury  
Internal Revenue Service

Name of the organization  
COMMUNITY UNITED METHODIST HOSPITAL INC

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](http://www.irs.gov/form990).

OMB No 1545-0047

2017

Open to Public Inspection

Employer identification number  
61-0461753

Part I

General Information on Grants and Assistance

- 1

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

☐ Yes

☒ No
- 2

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

Part II

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

| (a) Name and address of organization or government                          | (b) EIN    | (c) IRC section (if applicable) | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of noncash assistance | (h) Purpose of grant or assistance |
|---|------------|---------------------------------|--------------------------|-----------------------------------|---|---------------------------------------|------------------------------------|
| (1) KYNDLE<br>PO BOX 764<br>HENDERSON, KY 42419                             | 61-0463069 | 501(C)3                         |                          | 50,000                            |   |                                       | ECONOMIC DEVELOPMENT               |
| (2)<br>COLLEGE FOUNDATION INC<br>2660 S GREEN STREET<br>HENDERSON, KY 42419 | 61-6035281 | 501(C)3                         |                          | 70,000                            |   |                                       | TO SUPPORT NURSING PROGRAM         |

2

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

2

3

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

0

**Part III** **Grants and Other Assistance to Domestic Individuals.** Complete if the organization answered "Yes" on Form 990, Part IV, line 22

Part III can be duplicated if additional space is needed

| (a) Type of grant or assistance | (b) Number of recipients | (c) Amount of cash grant | (d) Amount of noncash assistance | (e) Method of valuation (book, FMV, appraisal, other) | (f) Description of noncash assistance |
|---------------------------------|--------------------------|--------------------------|----------------------------------|---|---------------------------------------|
| (1) EDUCATIONAL ASSISTANCE      | 35                       | 96,979                   |                                  |   |                                       |
| (2)                             |                          |                          |                                  |   |                                       |
| (3)                             |                          |                          |                                  |   |                                       |
| (4)                             |                          |                          |                                  |   |                                       |
| (5)                             |                          |                          |                                  |   |                                       |
| (6)                             |                          |                          |                                  |   |                                       |
| (7)                             |                          |                          |                                  |   |                                       |

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

| Return Reference     | Explanation   |
|----------------------|---|
| SCHEDULE I, PART III | PART III -EDUCATIONAL ASSISTANCE- EACH RECEIPIENT MUST FILL OUT AN APPLICATION FOR EDUCATIONAL ASSISTANCE AND IT IS SENT TO A COMMITTEE TO BE APPROVED OR DENIED ONCE THE APPLICATION IS APPROVED THE EMPLOYEE IS NOTIFIED ONCE THE APPLICANT FINISHES HIS/HER CLASS WITH A PASSING GRADE OF A C OR BETTER, THE HOSPITAL WILL REIMBURSE THE EMPLOYEE FOR THE COST OF BOOKS, TUITION AND LAB FEES UP TO 3,000 FOR ASSOCIATES AND 4,000 FOR BACHELORS OR MASTERS PER CALENDAR YEAR IF THE EMPLOYEE LEAVES EMPLOYMENT THEY ARE REQUIRED TO PAY BACK ANY FUNDS REIMBURSED WITHIN THE LAST YEAR RETROACTIVE SCHOLARSHIP THE SCHOLARSHIP IS APPROVED AFTER DISCUSSION BETWEEN RECRUITERS, DEPARTMENT DIRECTORS AND HR DIRECTOR BASED ON THE POSITION, HOW HARD IT WAS TO FILL, AND THAT THE APPLICANT WOULD NOT ACCEPT OFFER IF THEY DID NOT GET THE RETRO PAYMENT MUST COMPLETE A 2 YEAR WORK AGREEMENT WITH METHODIST HOSPITAL OR FUNDS ARE REQUIRED TO BE REPAID |

**Schedule J**  
(Form 990)

**Compensation Information**

OMB No 1545-0047

**For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees**  
**▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23.**  
**▶ Attach to Form 990.**  
**▶ Information about Schedule J (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).**

**2017**

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

|   |  |
|---|--|
| Name of the organization<br>COMMUNITY UNITED METHODIST HOSPITAL INC | Employer identification number<br>61-0461753 |
|---|--|

**Part I Questions Regarding Compensation**

|  | Yes       | No  |
|--|-----------|-----|
| <b>1a</b> Check the appropriate 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. <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> First-class or charter travel<br/> <input type="checkbox"/> Travel for companions<br/> <input type="checkbox"/> Tax indemnification and gross-up payments<br/> <input type="checkbox"/> Discretionary spending account                 </div> <div> <input type="checkbox"/> Housing allowance or residence for personal use<br/> <input type="checkbox"/> Payments for business use of personal residence<br/> <input type="checkbox"/> Health or social club dues or initiation fees<br/> <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)                 </div> </div> |           |     |
| <b>b</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  | <b>1b</b> |     |
| <b>2</b> 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?  | <b>2</b>  | Yes |
| <b>3</b> 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. <div style="display: flex; justify-content: space-between;"> <div> <input checked="" type="checkbox"/> Compensation committee<br/> <input type="checkbox"/> Independent compensation consultant<br/> <input checked="" type="checkbox"/> Form 990 of other organizations                 </div> <div> <input type="checkbox"/> Written employment contract<br/> <input checked="" type="checkbox"/> Compensation survey or study<br/> <input checked="" type="checkbox"/> Approval by the board or compensation committee                 </div> </div>   |           |     |
| <b>4</b> 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:  |           |     |
| <b>a</b> Receive a severance payment or change-of-control payment?   | <b>4a</b> | Yes |
| <b>b</b> Participate in, or receive payment from, a supplemental nonqualified retirement plan?   | <b>4b</b> | No  |
| <b>c</b> Participate in, or receive payment from, an equity-based compensation arrangement?  | <b>4c</b> | No  |
| If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.  |           |     |
| <b>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</b>  |           |     |
| <b>5</b> 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:  |           |     |
| <b>a</b> The organization?   | <b>5a</b> | No  |
| <b>b</b> Any related organization?   | <b>5b</b> | No  |
| If "Yes," on line 5a or 5b, describe in Part III.  |           |     |
| <b>6</b> 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:  |           |     |
| <b>a</b> The organization?   | <b>6a</b> | No  |
| <b>b</b> Any related organization?   | <b>6b</b> | No  |
| If "Yes," on line 6a or 6b, describe in Part III.  |           |     |
| <b>7</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III.  | <b>7</b>  | No  |
| <b>8</b> Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III.  | <b>8</b>  | No  |
| <b>9</b> If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?  | <b>9</b>  |     |

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.

See Additional Data Table

[illegible]

**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 |
|------------------|-------------|
|------------------|-------------|

Additional Data

Software ID:  
Software Version:  
EIN: 61-0461753  
Name: COMMUNITY UNITED METHODIST HOSPITAL INC

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

| (A) Name and Title                            |      | (B) Breakdown of W-2 and/or 1099-MISC compensation |                                     |                                     | (C) Retirement and other deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation in column (B) reported as deferred on prior Form 990 |
|---|------|--|-------------------------------------|-------------------------------------|--|-------------------------|---------------------------------|---|
|   |      | (i) Base Compensation                              | (ii) Bonus & incentive compensation | (iii) Other reportable compensation |  |                         |                                 |   |
| 1BENNY NOLEN<br>CEO                           | (i)  | 261,482  | 0                                   | 0                                   | 0  | 0                       | 261,482                         | 0   |
|   | (ii) | 0  | 0                                   | 0                                   | 0  | 0                       | 0                               | 0   |
| 1DAVE MASSENGALE<br>CFO                       | (i)  | 178,189  | 0                                   | 0                                   | 4,196  | 28,835                  | 211,220                         | 0   |
|   | (ii) | 0  | 0                                   | 0                                   | 0  | 0                       | 0                               | 0   |
| 2DAVID B PARK<br>VP - GENERAL COUNSEL         | (i)  | 193,091  | 0                                   | 11,522                              | 4,118  | 21,825                  | 230,556                         | 0   |
|   | (ii) | 0  | 0                                   | 0                                   | 0  | 0                       | 0                               | 0   |
| 3ARSHAD I HUSAIN MD<br>ONCOLOGIST             | (i)  | 458,559  | 305,271                             | 18,000                              | 6,480  | 9,422                   | 797,732                         | 0   |
|   | (ii) | 0  | 0                                   | 0                                   | 0  | 0                       | 0                               | 0   |
| 4JAMES YELTON MD<br>ORTHOPEDIC DOCTOR         | (i)  | 649,963  | 1,276                               | 0                                   | 6,480  | 30,335                  | 688,054                         | 0   |
|   | (ii) | 0  | 0                                   | 0                                   | 0  | 0                       | 0                               | 0   |
| 5ALLAN LAM MD<br>GASTROENTERO DOCTOR          | (i)  | 504,181  | 99,413                              | 0                                   | 0  | 28,835                  | 632,429                         | 0   |
|   | (ii) | 0  | 0                                   | 0                                   | 0  | 0                       | 0                               | 0   |
| 6RICO MADDELA<br>FP INTERNAL MED              | (i)  | 409,444  | 0                                   | 0                                   | 4,471  | 28,835                  | 442,750                         | 0   |
|   | (ii) | 0  | 0                                   | 0                                   | 0  | 0                       | 0                               | 0   |
| 7ALAN TRIPP<br>SURGICAL SERVICES              | (i)  | 384,699  | 0                                   | 0                                   | 0  | 31,385                  | 416,084                         | 0   |
|   | (ii) | 0  | 0                                   | 0                                   | 0  | 0                       | 0                               | 0   |
| 8JOHN LOGAN 7117-32918<br>MEDICAL DIRECTOR    | (i)  | 220,673  | 0                                   | 0                                   | 0  | 0                       | 220,673                         | 0   |
|   | (ii) | 0  | 0                                   | 0                                   | 0  | 0                       | 0                               | 0   |
| 9LOIS MORGAN 616-517<br>FORMER VP CHIEF NURSE | (i)  | 144,975  | 0                                   | 20,022                              | 2,026  | 18,044                  | 185,067                         | 0   |
|   | (ii) | 0  | 0                                   | 0                                   | 0  | 0                       | 0                               | 0   |
| 10GARY COLBERG 617<br>FORMER CEO              | (i)  | 237,250  | 0                                   | 0                                   | 0  | 13,301                  | 250,551                         | 0   |
|   | (ii) | 0  | 0                                   | 0                                   | 0  | 0                       | 0                               | 0   |
| 11BRUCE BEGLEY<br>FORMER CEO                  | (i)  | 444,672  | 0                                   | 0                                   | 0  | 10,899                  | 455,571                         | 0   |
|   | (ii) | 0  | 0                                   | 0                                   | 0  | 0                       | 0                               | 0   |

Schedule K  
(Form 990)

Department of the Treasury  
Internal Revenue Service

Name of the organization  
COMMUNITY UNITED METHODIST HOSPITAL INC

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](http://www.irs.gov/form990).

OMB No 1545-0047

2017

Open to Public Inspection

Employer identification number  
61-0461753

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 COUNTY OF HENDERSON KY<br>SERIES 2009A | 61-6000814     |             | 12-30-2009      | 12,000,000      | SEE PART VI                |              | X  |                         | X  |                    | X  |
| B COUNTY OF HENDERSON KY<br>SERIES 2009B | 61-6000814     |             | 12-30-2009      | 18,000,000      | SEE PART VI                |              | X  |                         | X  |                    | X  |
| C COUNTY OF HENDERSON KY<br>SERIES 2010  | 61-6000814     |             | 02-16-2010      | 14,210,000      | SEE PART VI                |              | X  |                         | X  |                    | X  |
| D COUNTY OF HENDERSON KY<br>SERIES 2013  | 61-6000814     |             | 01-25-2013      | 7,000,000       | SEE PART VI                |              | X  |                         | X  |                    | X  |

Part II

Proceeds

|    |  |  |  |  | A          |    | B          |    | C          |    | D         |    |
|----|--|--|--|--|------------|----|------------|----|------------|----|-----------|----|
| 1  | Amount of bonds retired . . . . .  |  |  |  |            |    |            |    |            |    |           |    |
| 2  | Amount of bonds legally defeased . . . . .   |  |  |  |            |    |            |    |            |    |           |    |
| 3  | Total proceeds of issue . . . . .  |  |  |  | 12,000,000 |    | 18,000,000 |    | 14,210,000 |    | 7,000,000 |    |
| 4  | Gross proceeds in reserve funds . . . . .  |  |  |  |            |    |            |    |            |    |           |    |
| 5  | Capitalized interest from proceeds . . . . .   |  |  |  |            |    |            |    |            |    |           |    |
| 6  | Proceeds in refunding escrows . . . . .  |  |  |  |            |    |            |    |            |    |           |    |
| 7  | Issuance costs from proceeds . . . . .   |  |  |  |            |    | 102,783    |    |            |    |           |    |
| 8  | Credit enhancement from proceeds . . . . .   |  |  |  |            |    |            |    |            |    |           |    |
| 9  | Working capital expenditures from proceeds . . . . .   |  |  |  |            |    |            |    |            |    |           |    |
| 10 | Capital expenditures from proceeds . . . . .   |  |  |  |            |    |            |    |            |    | 6,914,642 |    |
| 11 | Other spent proceeds . . . . .   |  |  |  | 12,000,000 |    | 17,897,217 |    | 14,210,000 |    |           |    |
| 12 | Other unspent proceeds . . . . .   |  |  |  |            |    |            |    |            |    | 85,358    |    |
| 13 | Year of substantial completion . . . . .   |  |  |  | 2010       |    | 2010       |    | 2010       |    | 2013      |    |
|    |  |  |  |  | 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)

|   | <b>A</b>   |           | <b>B</b>   |           | <b>C</b>   |           | <b>D</b>   |           |
|---|------------|-----------|------------|-----------|------------|-----------|------------|-----------|
|   | <b>Yes</b> | <b>No</b> | <b>Yes</b> | <b>No</b> | <b>Yes</b> | <b>No</b> | <b>Yes</b> | <b>No</b> |
| <b>3a</b> Are there any management or service contracts that may result in private business use of bond-financed property? . . . . .  | X          |           | X          |           | X          |           |            | X         |
| <b>b</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         |            |           |
| <b>c</b> Are there any research agreements that may result in private business use of bond-financed property? . . . . .   |            | X         |            | X         |            | X         |            | X         |
| <b>d</b> 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?   |            |           |            |           |            |           |            |           |
| <b>4</b> 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 . . . . ▶  |            |           |            |           |            |           |            |           |
| <b>5</b> 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 . . . . . ▶ |            |           |            |           |            |           |            |           |
| <b>6</b> Total of lines 4 and 5 . . . . .   |            |           |            |           |            |           |            |           |
| <b>7</b> Does the bond issue meet the private security or payment test? . . .   |            | X         |            | X         |            | X         |            | X         |
| <b>8a</b> 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>b</b> If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of . .  |            |           |            |           |            |           |            |           |
| <b>c</b> If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2? . . . . .  |            |           |            |           |            |           |            |           |
| <b>9</b> 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**

|   | <b>A</b>   |           | <b>B</b>         |           | <b>C</b>         |           | <b>D</b>   |           |
|---|------------|-----------|------------------|-----------|------------------|-----------|------------|-----------|
|   | <b>Yes</b> | <b>No</b> | <b>Yes</b>       | <b>No</b> | <b>Yes</b>       | <b>No</b> | <b>Yes</b> | <b>No</b> |
| <b>1</b> Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate? . . . |            | X         |                  | X         |                  | X         |            | X         |
| <b>2</b> If "No" to line 1, did the following apply? . . . .  |            |           |                  |           |                  |           |            |           |
| <b>a</b> Rebate not due yet? . . . . .  |            | X         |                  | X         |                  | X         |            | X         |
| <b>b</b> Exception to rebate? . . . . .   |            | X         |                  | X         |                  | X         |            | X         |
| <b>c</b> No rebate due? . . . . .   |            | X         |                  | X         |                  | X         |            | X         |
| If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed . . . . .                             |            |           |                  |           |                  |           |            |           |
| <b>3</b> Is the bond issue a variable rate issue? . . . . .   |            | X         | X                |           | X                |           |            | X         |
| <b>4a</b> Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?    |            | X         | X                |           | X                |           |            | X         |
| <b>b</b> Name of provider . . . . .   |            |           | FIFTH THIRD BANK |           | FIFTH THIRD BANK |           |            |           |
| <b>c</b> Term of hedge . . . . .  |            |           | 500 0000000000 % |           | 500 0000000000 % |           |            |           |
| <b>d</b> Was the hedge superintegrated? . . . . .   |            |           |                  | X         |                  | X         |            |           |
| <b>e</b> Was the hedge terminated? . . . . .  |            |           |                  | X         |                  | X         |            |           |



**Part IV Arbitrage** (Continued)

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

**Part V Procedures To Undertake Corrective Action**

|  | <b>A</b>   |           | <b>B</b>   |           | <b>C</b>   |           | <b>D</b>   |           |
|--|------------|-----------|------------|-----------|------------|-----------|------------|-----------|
|  | <b>Yes</b> | <b>No</b> | <b>Yes</b> | <b>No</b> | <b>Yes</b> | <b>No</b> | <b>Yes</b> | <b>No</b> |
| 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).

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](http://www.irs.gov/form990).

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization  
COMMUNITY UNITED METHODIST HOSPITAL INC

Employer identification number

61-0461753

Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 501(c)(29) organizations only)  
Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b

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

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

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

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

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

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

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

**Part IV Business Transactions Involving Interested Persons.**

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

| (a) Name of interested person | (b) Relationship between interested person and the organization | (c) Amount of transaction | (d) Description of transaction | (e) Sharing of organization's revenues? |    |
|-------------------------------|---|---------------------------|--------------------------------|---|----|
|                               |   |                           |                                | Yes                                     | No |
| See Additional Data Table     |   |                           |                                |   |    |
|                               |   |                           |                                |   |    |
|                               |   |                           |                                |   |    |
|                               |   |                           |                                |   |    |
|                               |   |                           |                                |   |    |
|                               |   |                           |                                |   |    |

**Part V Supplemental Information**

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

| Return Reference | Explanation |
|------------------|-------------|
|------------------|-------------|

Additional Data

Software ID:  
Software Version:  
EIN: 61-0461753  
Name: COMMUNITY UNITED METHODIST HOSPITAL INC

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 |
| (1) HALEY HALBIG              | RELATED KEY EMPLOYEE  | 25,640                    | HALEY HALBIG IS AN EMPLOYEE OF THE HOSPITAL SHE IS ALSO RELATED TO LOIS MORGAN, A KEY EMPLOYEE        |   | No |
| (1) AMY DAVENPORT             | RELATED BOARD MEMBER  | 14,187                    | AMY DAVENPORT IS AN EMPLOYEE OF THE HOSPITAL SHE IS ALSO RELATED TO DR VERNON HUMBERT, A BOARD MEMBER |   | 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 |
| (3) EM FORD COMPANY           | BOARD MEMBER/OWNER  | 318,760                   | BOARD MEMBER MIKE HAZELWOOD IS THE OWNER OF EM FORD & COMPANY EM FORD & COMPANY PROVIDES INSURANCE COVERAGE TO THE HOSPITAL AND THE EXPENSE IS 318,760 |   | No |
| (1) BETTY TEER                | RELATED OFFICER   | 58,668                    | BETTY TEER IS AN EMPLOYEE OF THE HOSPITAL SHE IS RELATED TO BRUCE BEGLEY, A FORMER OFFICER OF THE HOSPITAL   |   | 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 |
| (5) MELANIE HUMBERT           | RELATED BOARD MEMBER  | 40,769                    | MELANIE HUMBERT IS AN EMPLOYEE OF THE HOSPITAL SHE IS ALSO RELATED TO DR VERNON HUMBERT, A BOARD MEMBER |   | No |
| (1) SHARON SHIELDS            | RELATED BOARD MEMBER  | 197,502                   | SHARON SHIELDS IS AN EMPLOYEE OF THE HOSPITAL SHE IS RELATED TO DANE SHIELDS, A BOARD MEMBER            |   | 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 |
| (7) TONIA LILES  | RELATED BOARD MEMBER  | 71,099                    | TONIA LILES IS AN EMPLOYEE OF THE HOSPITAL SHE IS ALSO RELATED TO DR VERNON HUMBERT, A BOARD MEMBER   |   | No |
| (1) ROBERTA PHILLIPS   | RELATED BOARD MEMBER  | 45,709                    | ROBERTA PHILLIPS IS AN EMPLOYEE OF THE HOSPITAL SHE IS ALSO RELATED TO JIMMY PHILLIPS, A BOARD MEMBER |   | 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 |
| (9) JENNIFER PHILLIPS  | RELATED BOARD MEMBER  | 44,050                    | JENNIFER PHILLIPS IS AN EMPLOYEE OF THE HOSPITAL SHE IS ALSO RELATED TO JIMMY PHILLIPS, A BOARD MEMBER |   | No |
| (1) TIMOTHY BARRON   | RELATED BOARD MEMBER  | 70,874                    | TIMOTHY BARRON IS AN EMPLOYEE OF THE HOSPITAL HE IS RELATED TO STEVE AUSTIN, A BOARD MEMBER            |   | 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 |
| (11) DREW CLEMENTS   | RELATED BOARD MEMBER  | 93,264                    | DREW CLEMENTS IS AN EMPLOYEE OF THE HOSPITAL HE IS RELATED TO MELISSA CLEMENTS, A BOARD MEMBER |   | No |
| (1) JOHN LEE   | RELATED BOARD MEMBER  | 255,021                   | JOHN LEE IS AN EMPLOYEE OF THE HOSPITAL HE IS RELATED TO SHANNA LEE, A BOARD MEMBER            |   | No |

**SCHEDULE O**  
(Form 990 or 990-EZ)

Department of the Treasury  
Internal Revenue Service

Name of the organization

COMMUNITY UNITED METHODIST HOSPITAL INC

**Supplemental Information to Form 990 or 990-EZ**

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No 1545-0047

**2017**

**Open to Public Inspection**

**Employer identification number**

61-0461753

**990 Schedule O, Supplemental Information**

| Return Reference                     | Explanation  |
|--------------------------------------|--|
| FORM 990, PART VI, SECTION A, LINE 6 | COMMUNITY UNITED METHODIST HOSPITAL, INC IS GOVERNED BY A BOARD OF DIRECTORS |

**990 Schedule O, Supplemental Information**

| Return<br>Reference                            | Explanation   |
|--|---|
| FORM 990,<br>PART VI,<br>SECTION A,<br>LINE 7A | THE NOMINATING COMMITTEE OF THE BOARD OF DIRECTORS CONSIDER THE APPROPRIATE BOARD MEMBER C<br>ANDIDATES BASED ON CRITERIA THE COMMITTEE MAKES BOARD MEMBER RECOMMENDATIONS TO THE BOARD<br>WHICH VOTES AT A REGULARLY SCHEDULED MEETING |

## 990 Schedule O, Supplemental Information

| Return Reference                                | Explanation  |
|---|--|
| FORM 990,<br>PART VI,<br>SECTION B,<br>LINE 11B | THE FORM 990 INFORMATION IS COMPILED BY HOSPITAL MANAGEMENT AND THE RETURN IS PREPARED BY AN INDPENDENT THIRD PARTY CERTIFIED PUBLIC ACCOUNTING FIRM FAMILIAR WITH HOSPITAL OPERATIONS, POLICIES, AND COMMITTEE/BOARD ACTIONS THE FINAL RETURN IS REVIEWED BY THE DIRECTOR OF FINANCE, CFO, AND BY THE FINANCE COMMITTEE (OF THE BOARD OF DIRECTORS) ONCE THE RETURNS HAVE BEEN REVIEWED, THEY ARE SENT TO THE FULL BOARD OF DIRECTORS FOR APPROVAL THE BOARD OF DIRECTORS ARE INFORMED THAT THE FORM 990 IS AVAILABLE IN ITS ENTIRETY |

# 990 Schedule O, Supplemental Information

| Return<br>Reference                             | Explanation   |
|---|---|
| FORM 990,<br>PART VI,<br>SECTION B,<br>LINE 12C | ONGOING MONITORING BY THE COMPLIANCE OFFICER (MH CHIEF OPERATING OFFICER) |

## 990 Schedule O, Supplemental Information

| Return Reference                               | Explanation  |
|--|--|
| FORM 990,<br>PART VI,<br>SECTION B,<br>LINE 15 | EVERY YEAR SURVEYS ARE SENT TO THE BOARD MEMBERS, MEDICAL STAFF, AND DIRECTORS SURVEYS ARE RETURNED AND TABULATED CONFIDENTIALLY AND THE AGGREGATED RESPONSES ARE SHARED WITH THE COMPENSATION COMMITTEE AND THE BOARD COMPENSATION IS REVIEWED BY USING THIRD PARTY EXECUTIVE COMPENSATION SURVEYS CURRENTLY COMPENSATION AND THIRD PARTY EXECUTIVE COMPENSATION SURVEYS ARE THEN REVIEWED BY THE ADMINISTRATIVE PERSONNEL COMMITTEE WHO THEN RECOMMENDS APPROVAL TO THE INDEPENDENT BOARD THE BOARD HAS FINAL APPROVAL ON COMPENSATION FOR THE CEO |

**990 Schedule O, Supplemental Information**

| Return<br>Reference                            | Explanation  |
|--|--|
| FORM 990,<br>PART VI,<br>SECTION C,<br>LINE 19 | THE ORGANIZATION MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC UPON REQUEST |

**990 Schedule O, Supplemental Information**

| Return<br>Reference               | Explanation   |
|-----------------------------------|---|
| FORM 990,<br>PART IX,<br>LINE 11G | MEDICAL FEES PROGRAM SERVICE EXPENSES 11,332,745 MANAGEMENT AND GENERAL EXPENSES 2,265,746 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 13,598,491 LEGAL & PROFESSIONAL FEES PROGRAM SERVICE EXPENSES 2,944,092 MANAGEMENT AND GENERAL EXPENSES 622,681 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 3,566,773 CONTRACT SERVICES PROGRAM SERVICE EXPENSES 499,977 MANAGEMENT AND GENERAL EXPENSES 101,153 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 601,130 TEMPORARY SERVICES PROGRAM SERVICE EXPENSES 122,886 MANAGEMENT AND GENERAL EXPENSES 24,862 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 147,748 OTHER FEES-MNGMNT-990 PROGRAM SERVICE EXPENSES 1,114 MANAGEMENT AND GENERAL EXPENSES 225 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 1,339 |



**990 Schedule O, Supplemental Information**

| Return<br>Reference             | Explanation  |
|---------------------------------|--|
| FORM 990,<br>PART XI,<br>LINE 9 | CHANGE IN PENSION LIABILITY -257,945    CHANGE IN INTEREST RATE SWAP 134,145 |

**990 Schedule O, Supplemental Information**

| Return<br>Reference   | Explanation   |
|-----------------------|---|
| FORM 990,<br>PART XII | THE BOARD OF DIRECTORS ASSUMES RESPONSIBILITY FOR OVERSIGHT OF THE AUDIT OF THE FINANCIAL STATEMENTS AND SELECTION OF THE INDEPENDENT ACCOUNTANT, AND NO PROCESSES HAVE CHANGED FROM PRIOR YEAR |

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](http://www.irs.gov/form990).

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization  
COMMUNITY UNITED METHODIST HOSPITAL INC

Employer identification number  
61-0461753

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

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

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

| (a)<br>Name, address, and EIN of related organization   | (b)<br>Primary activity | (c)<br>Legal domicile (state or foreign country) | (d)<br>Exempt Code section | (e)<br>Public charity status (if section 501(c)(3)) | (f)<br>Direct controlling entity | (g)<br>Section 512(b)(13) controlled entity? |    |
|---|-------------------------|--|----------------------------|---|----------------------------------|--|----|
|   |                         |  |                            |   |                                  | Yes  | No |
| (1)HENDERSON REGIONAL HOSPITAL FOUNDATION<br>1305 NORTH ELM ST<br><br>HENDERSON, KY 42420<br>61-0944432         | SUPPORT THE HOSPITAL    | KY   | 501(C)3                    | LINE 11<br><br>N/A                                  |                                  |  | No |
| (2)UNION COUNTY METHODIST HOSPITAL FOUNDATION<br>4604 US HWY 60 WEST<br><br>MORGANFIELD, KY 42437<br>61-1230297 | SUPPORT THE HOSPITAL    | KY   | 501(C)3                    | LINE 11<br><br>N/A                                  |                                  |  | 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)<br>Name, address, and EIN of<br>related organization  | (b)<br>Primary<br>activity | (c)<br>Legal<br>domicile<br>(state<br>or<br>foreign<br>country) | (d)<br>Direct<br>controlling<br>entity | (e)<br>Predominant<br>income(related,<br>unrelated,<br>excluded from<br>tax under<br>sections 512-<br>514) | (f)<br>Share of<br>total income | (g)<br>Share of end-<br>of-year<br>assets | (h)<br>Disproportionate<br>allocations? |    | (i)<br>Code V-UBI<br>amount in<br>box 20 of<br>Schedule K-1<br>(Form 1065) | (j)<br>General or<br>managing<br>partner? |    | (k)<br>Percentage<br>ownership |
|---|----------------------------|---|--|--|---------------------------------|---|---|----|--|---|----|--------------------------------|
|   |                            |   |  |  |                                 |   | Yes                                     | No |  | Yes                                       | No |                                |
| <b>(1)</b> KENTUCKY HOMECARE OF HENDERSON LLC<br>420 WEST PINHOOK ROAD<br>LAFAYETTE, LA 70503<br>26-4812417 | HOME HEALTH                | KY  | N/A                                    | RELATED  | 25,980                          | 368,991                                   |   | 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)<br>Name, address, and EIN of<br>related organization  | (b)<br>Primary activity | (c)<br>Legal<br>domicile<br>(state or foreign<br>country) | (d)<br>Direct controlling<br>entity | (e)<br>Type of entity<br>(C corp, S corp,<br>or trust) | (f)<br>Share of total<br>income | (g)<br>Share of end-of-<br>year<br>assets | (h)<br>Percentage<br>ownership | (i)<br>Section 512(b)<br>(13) controlled<br>entity? |    |
|---|-------------------------|---|-------------------------------------|--|---------------------------------|---|--------------------------------|---|----|
|   |                         |   |                                     |  |                                 |   |                                | Yes   | No |
| <b>(1)</b> COMMUNITY CARE NETWORK INC<br>220 A SECOND STREET<br>HENDERSON, KY 42420<br>61-1254545 | HOSPITAL NETWORK        | KY  | N/A                                 | C  | 52,261                          |   | 100 000 %                      |   | 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

**1** During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?

**a** Receipt of **(i)** interest, **(ii)** annuities, **(iii)** royalties, or **(iv)** rent from a controlled entity . . . . .

**b** Gift, grant, or capital contribution to related organization(s) . . . . .

**c** Gift, grant, or capital contribution from related organization(s) . . . . .

**d** Loans or loan guarantees to or for related organization(s) . . . . .

**e** Loans or loan guarantees by related organization(s) . . . . .

**f** Dividends from related organization(s) . . . . .

**g** Sale of assets to related organization(s) . . . . .

**h** Purchase of assets from related organization(s) . . . . .

**i** Exchange of assets with related organization(s) . . . . .

**j** Lease of facilities, equipment, or other assets to related organization(s) . . . . .

**k** Lease of facilities, equipment, or other assets from related organization(s) . . . . .

**l** Performance of services or membership or fundraising solicitations for related organization(s) . . . . .

**m** Performance of services or membership or fundraising solicitations by related organization(s) . . . . .

**n** Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) . . . . .

**o** Sharing of paid employees with related organization(s) . . . . .

**p** Reimbursement paid to related organization(s) for expenses . . . . .

**q** Reimbursement paid by related organization(s) for expenses . . . . .

**r** Other transfer of cash or property to related organization(s) . . . . .

**s** Other transfer of cash or property from related organization(s) . . . . .

Yes

No

1a

No

1b

No

1c

No

1d

No

1e

No

1f

No

1g

No

1h

No

1i

No

1j

No

1k

No

1l

No

1m

Yes

1n

Yes

1o

Yes

1p

No

1q

Yes

1r

No

1s

Yes

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

| (a)<br>Name of related organization | (b)<br>Transaction<br>type (a-s) | (c)<br>Amount involved | (d)<br>Method of determining amount involved |
|-------------------------------------|----------------------------------|------------------------|--|
|                                     |                                  |                        |  |
|                                     |                                  |                        |  |
|                                     |                                  |                        |  |
|                                     |                                  |                        |  |
|                                     |                                  |                        |  |
|                                     |                                  |                        |  |

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.

[illegible]

**Part VII** **Supplemental Information**

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