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Form 990

# Return of Organization Exempt From Income Tax

OMB No 1545-0047  
**2017**  
Open to Public Inspection

Department of the Treasury  
Internal Revenue Service

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  
▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information

1406

**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: KINGMAN HEALTHCARE, INC.  
Doing business as: KINGMAN REGIONAL MEDICAL CENTER  
Number and street (or P.O. box if mail is not delivered to street address): 3269 STOCKTON HILL ROAD  
Room/suite: [blank]  
City or town, state or province, country, and ZIP or foreign postal code: KINGMAN, AZ 86409

**D** Employer identification number: 94-2916102

**E** Telephone number: (928) 757-2101

**F** Name and address of principal officer: BRIAN TURNEY  
3269 STOCKTON HILL ROAD KINGMAN, AZ 86409

**G** Gross receipts \$: 325,101,149.

**H(a)** Is this a group return for subordinates? ☐ Yes ☒ No  
**H(b)** Are all subordinates included? ☐ Yes ☒ No  
If "No," attach a list (see instructions)

**I** Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) ( ) (insert no.) ☐ 4947(a)(1) or ☒ 527

**J** Website: AZKRCM.COM

**K** Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

**L** Year of formation: 1980 **M** State of legal domicile: AZ

## Part I Summary

**1** Briefly describe the organization's mission or most significant activities: OUR VISION IS TO PROVIDE THE REGION'S BEST CLINICAL CARE AND PATIENT SERVICE THROUGH AN ENVIRONMENT THAT FOSTERS RESPECT FOR OTHERS AND PRIDE IN PERFORMANCE.

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

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

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

**5** Total number of individuals employed in calendar year 2017 (Part V, line 2a): 2,372

**6** Total number of volunteers (estimate if necessary): 130

**7a** Total unrelated business revenue from Part VIII, column (C), line 12: 0

**7b** Net unrelated business taxable income from Form 990-T, line 34: 0

	Prior Year	Current Year
<b>8</b> Contributions and grants (Part VIII, line 1h)	89,205.	263,313.
<b>9</b> Program service revenue (Part VIII, line 2g)	302,845,942.	317,773,886.
<b>10</b> Investment income (Part VIII, column (A), lines 3, 4, and 7d)	925,880.	481,795.
<b>11</b> Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	5,289,733.	5,788,923.
<b>12</b> Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	309,150,760.	324,307,917.
<b>13</b> Grants and similar amounts paid (Part IX, column (A), lines 1-3)	417,425.	918,020.
<b>14</b> Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
<b>15</b> Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	149,142,317.	158,732,870.
<b>16a</b> Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
<b>16b</b> Total fundraising expenses (Part IX, column (D), line 25)	0.	0.
<b>17</b> Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	153,025,661.	154,323,447.
<b>18</b> Total expenses - Add lines 13-17 (must equal Part IX, column (A), line 25)	302,585,403.	313,974,337.
<b>19</b> Revenue less expenses - Subtract line 18 from line 12	6,565,357.	10,333,580.

	Beginning of Current Year	End of Year
<b>20</b> Total assets (Part X, line 16)	286,332,303.	317,278,192.
<b>21</b> Total liabilities (Part X, line 26)	47,880,269.	66,450,923.
<b>22</b> Net assets or fund balances - Subtract line 21 from line 20	238,452,034.	250,827,269.

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## 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.

**Signature of officer:** Tim Blanchard **Date:** 5/6/19  
**Type or print name and title:** Chief Financial Officer

**Print/Type preparer's name:** ADAM R SMITH **CPA**  
**Preparer's signature:** Adam Smith **Date:** 4-29-19  
**Check if self-employed:** ☐ **PTIN:** P00958966

**Firm's name:** BKD, LLP  
**Firm's EIN:** 44-0160260  
**Firm's address:** 111 SOUTH TEJON, SUITE 800 COLORADO SPRINGS, CO 80903-9848  
**Phone no:** 719 471-4290

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

For Paperwork Reduction Act Notice, see the separate instructions

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**Part III** Statement of Program Service AccomplishmentsCheck if Schedule O contains a response or note to any line in this Part III ☒ **X****1** Briefly describe the organization's mission

OUR VISION IS TO PROVIDE THE REGION'S BEST CLINICAL CARE AND PATIENT  
SERVICE THROUGH AN ENVIRONMENT THAT FOSTERS RESPECT FOR OTHERS AND  
PRIDE IN PERFORMANCE.

**2** Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? ☐ Yes ☒ No

If "Yes," describe these new services on Schedule O

**3** Did the organization cease conducting, or make significant changes in how it conducts, any program services? ☐ Yes ☒ No

If "Yes," describe these changes on Schedule O

**4** Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported

**4a** (Code ) (Expenses \$ 257,257,097 including grants of \$ 918,020 ) (Revenue \$ 319,569,230 )  
ATTACHMENT 1

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

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

**4d** Other program services (Describe in Schedule O )

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

**4e** Total program service expenses ► 257,257,097.

**Part IV Checklist of Required Schedules**

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

Form **990** (2017)

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

	Yes	No
<b>20a</b> Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H. . . . .	X	
<b>20b</b> If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? . . . . .	X	
<b>21</b> Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? If "Yes," complete Schedule I, Parts I and II. . . . .	X	
<b>22</b> Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? If "Yes," complete Schedule I, Parts I and III. . . . .	X	
<b>23</b> Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? If "Yes," complete Schedule J. . . . .	X	
<b>24a</b> Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a. . . . .	X	
<b>24b</b> Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? . . . . .		
<b>24c</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>24d</b> Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? . . . . .		
<b>25a</b> Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? If "Yes," complete Schedule L, Part I. . . . .		X
<b>25b</b> Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? If "Yes," complete Schedule L, Part I. . . . .		X
<b>26</b> Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? If "Yes," complete Schedule L, Part II. . . . .		X
<b>27</b> Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? If "Yes," complete Schedule L, Part III. . . . .		X
<b>28</b> Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions)		
<b>28a</b> A current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV. . . . .		X
<b>28b</b> A family member of a current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV. . . . .		X
<b>28c</b> An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? If "Yes," complete Schedule L, Part IV. . . . .		X
<b>29</b> Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M. . . . .		X
<b>30</b> Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? If "Yes," complete Schedule M. . . . .		X
<b>31</b> Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, Part I. . . . .		X
<b>32</b> Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? If "Yes," complete Schedule N, Part II. . . . .		X
<b>33</b> Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? If "Yes," complete Schedule R, Part I. . . . .		X
<b>34</b> Was the organization related to any tax-exempt or taxable entity? If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1. . . . .	X	
<b>35a</b> Did the organization have a controlled entity within the meaning of section 512(b)(13)? . . . . .	X	
<b>35b</b> If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? If "Yes," complete Schedule R, Part V, line 2. . . . .	X	
<b>36</b> Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? If "Yes," complete Schedule R, Part V, line 2. . . . .		
<b>37</b> Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? If "Yes," complete Schedule R, Part VI. . . . .		X
<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. . . . .	X	

**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> 279		
<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>		
<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> 2,372		
<b>b</b> If at least one is reported on line 2a, did the organization file all required federal employment tax returns? <b>Note.</b> If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions). . . . . <b>2b</b>	X	
<b>3a</b> Did the organization have unrelated business gross income of \$1,000 or more during the year? . . . . . <b>3a</b>		X
<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>		
<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>		X
<b>b</b> If "Yes," enter the name of the foreign country: See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR) . . . . . <b>4b</b>		
<b>5a</b> Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . . . . . <b>5a</b>		X
<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>		X
<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>		X
<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 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>		X
<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>		X
<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>		X
<b>f</b> Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . . . . . <b>7f</b>		X
<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 Sponsoring organizations maintaining donor advised funds.</b> Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? . . . . . <b>8</b>		
<b>9 Sponsoring organizations maintaining donor advised funds.</b>		
<b>a</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 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 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 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 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>13a</b>		
<b>Note.</b> See the instructions for additional information the organization must report on Schedule O		
<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>		X
<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 line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions. Check if Schedule O contains a response or note to any line in this Part VI ☒ X

**Section A. Governing Body and Management**

	Yes	No
<b>1a</b> Enter the number of voting members of the governing body at the end of the tax year . . . . . If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O	12	
<b>1b</b> Enter the number of voting members included in line 1a, above, who are independent . . . . .	10	
<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? . . . . .		X
<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? . . . . .		X
<b>4</b> Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? . . . . .		X
<b>5</b> Did the organization become aware during the year of a significant diversion of the organization's assets? . . . . .		X
<b>6</b> Did the organization have members or stockholders? . . . . .		X
<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? . . . . .		X
<b>7b</b> Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? . . . . .		X
<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? . . . . .	X	
<b>b</b> Each committee with authority to act on behalf of the governing body? . . . . .	X	
<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 . . . . .		X

**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? . . . . .		X
<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>11a</b> Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? . . . . .	X	
<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 . . . . .	X	
<b>b</b> Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? . . . . .	X	
<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 . . . . .	X	
<b>13</b> Did the organization have a written whistleblower policy? . . . . .	X	
<b>14</b> Did the organization have a written document retention and destruction policy? . . . . .		X
<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 . . . . .	X	
<b>b</b> Other officers or key employees of the organization . . . . .	X	
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? . . . . .		X
<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? . . . . .		

**Section C. Disclosure**

**17** List the states with which a copy of this Form 990 is required to be filed ▶ AZ,

**18** Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.  
☐ Own website ☐ Another's website ☒ Upon request ☐ Other (explain in Schedule O)

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

**20** State the name, address, and telephone number of the person who possesses the organization's books and records ▶  
 KINGMAN HOSPITAL INC 3269 STOCKTON HILL ROAD KINGMAN, AZ 86409 928-757-2101

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

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) DAVID FRENCH CHAIRMAN	1.00 0.	X		X				0.	0.	0.
(2) DONALD VAWTER VICE CHAIRMAN	1.00 0.	X		X				0.	0.	0.
(3) KRYSTAL BURGE SECRETARY	1.00 0.	X		X				0.	0.	0.
(4) JAMES BAKER TREASURER	1.00 0.	X		X				0.	0.	0.
(5) CORAL LOYD DIRECTOR	1.00 0.	X						0.	0.	0.
(6) ROBERT MATHENY, MD DIRECTOR	40.00 0.	X						710,549.	0.	47,617.
(7) SANDY MOON DIRECTOR	1.00 0.	X						0.	0.	0.
(8) CATHY OTT DIRECTOR	1.00 0.	X						0.	0.	0.
(9) KALE BODILY DIRECTOR	1.00 0.	X						0.	0.	0.
(10) SUSAN CHAN DIRECTOR	1.00 0.	X						0.	0.	0.
(11) BRIAN TURNEY CHIEF EXECUTIVE OFFICER	40.00 0.	X		X				677,991.	0.	44,223.
(12) LYNNE PETERSEN DIRECTOR	1.00 0.	X						0.	0.	0.
(13) RYAN KENNEDY CHIEF OPERATING OFFICER	40.00 0.			X				226,764.	0.	33,280.
(14) TIMOTHY BLANCHARD CHIEF FINANCIAL OFFICER	40.00 0.			X				316,337.	0.	42,401.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(15) KIM MIYAUCHI CHIEF NURSING OFFICER	40.00 0.				X			206,588.	0.	27,050.
(16) THOMAS GAUGHAN CHIEF MEDICAL OFFICER	40.00 0.				X			376,305.	0.	32,179.
(17) DENNIS DUNNING PHYSICIAN	40.00 0.					X		1,141,451.	0.	38,845.
(18) ALAIN ASHER PHYSICIAN	40.00 0.					X		809,441.	0.	28,938.
(19) JACOB OLDHAM PHYSICIAN	40.00 0.					X		708,037.	0.	9,617.
(20) JAMAL AL-KHATIB PHYSICIAN	40.00 0.					X		815,202.	0.	40,448.
(21) STAN ALLEN PHYSICIAN	40.00 0.					X		687,852.	0.	35,597.
<b>1b Sub-total</b>								1,931,641.	0.	167,521.
<b>c Total from continuation sheets to Part VII, Section A</b>								4,744,876.	0.	212,674.
<b>d Total (add lines 1b and 1c)</b>								6,676,517.	0.	380,195.

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 196

- 3 Did the organization list any former officer, director, or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual
- 4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? If "Yes," complete Schedule J for such individual
- 5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? If "Yes," complete Schedule J for such person

	Yes	No
3		X
4	X	
5		X

**Section B. Independent Contractors**

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

(A) Name and business address	(B) Description of services	(C) Compensation
ATTACHMENT 2		

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization 49

**Part VIII** Statement of RevenueCheck if Schedule O contains a response or note to any line in this Part VIII. ☐

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	1a	Federated campaigns	1a				
	b	Membership dues	1b				
	c	Fundraising events	1c				
	d	Related organizations	1d				
	e	Government grants (contributions)	1e				
	f	All other contributions, gifts, grants, and similar amounts not included above	1f	263,313			
	g	Noncash contributions included in lines 1a-1f \$					
	h	<b>Total</b> Add lines 1a-1f		263,313			
<b>Program Service Revenue</b>	2a	PATIENT SERVICE REVENUE	561110	144,619,713	144,619,713		
	b	MEDICARE & MEDICAID REVENUE	561110	171,391,002	171,391,002		
	c	EHR/PQRS/MEANINGFUL USE PAYMENTS	900099	84,119	84,119		
	d	WELLNESS CENTER REVENUE	561110	1,468,347	1,468,347		
	e	OTHER PATIENT SERVICE REVENUE	561110	210,705	210,705		
	f	All other program service revenue					
	g	<b>Total</b> Add lines 2a-2f		317,773,886			
	<b>Other Revenue</b>	3	Investment income (including dividends, interest, and other similar amounts)		925,726		
4		Income from investment of tax-exempt bond proceeds		0			
5		Royalties		0			
6a		Gross rents	(i) Real 129,099 (ii) Personal				
b		Less rental expenses					
c		Rental income or (loss)	129,099				
d		Net rental income or (loss)		129,099			129,099
7a		Gross amount from sales of assets other than inventory	(i) Securities (ii) Other 163,625				
b		Less cost or other basis and sales expenses	607,556				
c		Gain or (loss)	-443,931				
d		Net gain or (loss)		-443,931			-443,931
8a		Gross income from fundraising events (not including \$ of contributions reported on line 1c) See Part IV, line 18	a				
b		Less direct expenses	b				
c		Net income or (loss) from fundraising events		0			
9a		Gross income from gaming activities See Part IV, line 19	a				
b	Less direct expenses	b					
c	Net income or (loss) from gaming activities		0				
10a	Gross sales of inventory, less returns and allowances	a 287,108					
b	Less cost of goods sold	b 185,676					
c	Net income or (loss) from sales of inventory		101,432			101,432	
<b>Miscellaneous Revenue</b>			<b>Business Code</b>				
11a	CAFETERIA	722514	2,573,601			2,573,601	
b	340B PHARMACY	446110	711,141	711,141			
c	INCOME FROM EQUITY INVESTEEs	624410	1,011,176	1,011,176			
d	All other revenue	900099	1,262,474	73,027		1,189,447	
e	<b>Total</b> Add lines 11a-11d		5,558,392				
12	<b>Total revenue</b> See instructions		324,307,917	319,569,230		4,475,374	

**Part IX Statement of Functional Expenses**

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

Check if Schedule O contains a response or note to any line in this Part IX ☐**Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.**

	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21 . . . . .	430,945.	430,945.		
2 Grants and other assistance to domestic individuals See Part IV, line 22 . . . . .	487,075.	487,075.		
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, lines 15 and 16 . . . . .	0.			
4 Benefits paid to or for members . . . . .	0.			
5 Compensation of current officers, directors, trustees, and key employees . . . . .	2,903,336.	2,606,166.	297,170.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) . . . . .	0.			
7 Other salaries and wages . . . . .	124,134,185.	87,187,762.	36,946,423.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions) . . . . .	3,189,239.	2,512,483.	676,756.	
9 Other employee benefits . . . . .	20,531,287.	16,205,352.	4,325,935.	
10 Payroll taxes . . . . .	7,974,823.	6,300,110.	1,674,713.	
11 Fees for services (non-employees)				
a Management . . . . .	0.			
b Legal . . . . .	349,805.		349,805.	
c Accounting . . . . .	179,285.		179,285.	
d Lobbying . . . . .	45,699.		45,699.	
e Professional fundraising services See Part IV, line 17 . . . . .	0.			
f Investment management fees . . . . .	60,487.		60,487.	
9 Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O). <b>ATCH 3.</b>	40,648,081.	36,785,375.	3,862,706.	
12 Advertising and promotion . . . . .	529,506.	418,310.	111,196.	
13 Office expenses . . . . .	5,084,099.	4,016,438.	1,067,661.	
14 Information technology . . . . .	6,776,857.	5,353,717.	1,423,140.	
15 Royalties . . . . .	0.			
16 Occupancy . . . . .	4,647,345.	3,671,403.	975,942.	
17 Travel . . . . .	1,064,889.	841,262.	223,627.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials . . . . .	0.			
19 Conferences, conventions, and meetings . . . . .	0.			
20 Interest . . . . .	635,305.	501,891.	133,414.	
21 Payments to affiliates . . . . .	0.			
22 Depreciation, depletion, and amortization . . . . .	14,504,080.	11,458,223.	3,045,857.	
23 Insurance . . . . .	4,133,672.	3,835,862.	297,810.	
24 Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O)				
a MEDICAL SUPPLIES	49,074,331.	49,074,331.		
b BAD DEBT EXPENSE	17,762,539.	17,762,539.		
c PROVIDER FEE	3,800,244.	3,800,244.		
d FOOD	2,141,368.	1,691,681.	449,687.	
e All other expenses	2,885,855.	2,315,928.	569,927.	
25 Total functional expenses Add lines 1 through 24e	313,974,337.	257,257,097.	56,717,240.	
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720) . . . . .	0.			

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

		(A) Beginning of year		(B) End of year
<b>Assets</b>	<b>1</b> Cash - non-interest-bearing	3,514,637.	<b>1</b>	1,541,958.
	<b>2</b> Savings and temporary cash investments	49,205,177.	<b>2</b>	57,975,693.
	<b>3</b> Pledges and grants receivable, net	0.	<b>3</b>	0.
	<b>4</b> Accounts receivable, net	53,735,924.	<b>4</b>	57,530,209.
	<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	0.	<b>5</b>	0.
	<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	0.	<b>6</b>	0.
	<b>7</b> Notes and loans receivable, net	260,394.	<b>7</b>	224,082.
	<b>8</b> Inventories for sale or use	6,126,413.	<b>8</b>	6,079,092.
	<b>9</b> Prepaid expenses and deferred charges	2,486,160.	<b>9</b>	2,187,815.
	<b>10a</b> Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	<b>10a</b> 270,190,321.		
	<b>b</b> Less accumulated depreciation	<b>10b</b> 156,435,434.		
		100,679,130.	<b>10c</b>	113,754,887.
	<b>11</b> Investments - publicly traded securities	62,150,922.	<b>11</b>	69,579,544.
	<b>12</b> Investments - other securities See Part IV, line 11	5,493,460.	<b>12</b>	5,873,905.
	<b>13</b> Investments - program-related See Part IV, line 11	1,712,080.	<b>13</b>	1,811,270.
	<b>14</b> Intangible assets	0.	<b>14</b>	0.
<b>15</b> Other assets See Part IV, line 11	968,006.	<b>15</b>	719,737.	
<b>16</b> <b>Total assets.</b> Add lines 1 through 15 (must equal line 34)	286,332,303.	<b>16</b>	317,278,192.	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses	23,858,858.	<b>17</b>	25,958,219.
	<b>18</b> Grants payable	0.	<b>18</b>	0.
	<b>19</b> Deferred revenue	81,089.	<b>19</b>	55,764.
	<b>20</b> Tax-exempt bond liabilities	19,337,208.	<b>20</b>	16,649,484.
	<b>21</b> Escrow or custodial account liability Complete Part IV of Schedule D	0.	<b>21</b>	0.
	<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	0.	<b>22</b>	0.
	<b>23</b> Secured mortgages and notes payable to unrelated third parties	633,923.	<b>23</b>	19,120,208.
	<b>24</b> Unsecured notes and loans payable to unrelated third parties	0.	<b>24</b>	0.
	<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	3,969,191.	<b>25</b>	4,667,248.
	<b>26</b> <b>Total liabilities.</b> Add lines 17 through 25	47,880,269.	<b>26</b>	66,450,923.
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow SFAS 117 (ASC 958), check here</b> <input checked="" type="checkbox"/> <b>and complete lines 27 through 29, and lines 33 and 34.</b>			
	<b>27</b> Unrestricted net assets	236,481,642.	<b>27</b>	248,715,936.
	<b>28</b> Temporarily restricted net assets	1,970,392.	<b>28</b>	2,111,333.
	<b>29</b> Permanently restricted net assets	0.	<b>29</b>	0.
	<b>Organizations that do not follow SFAS 117 (ASC 958), check here</b> <input type="checkbox"/> <b>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>	238,452,034.	<b>33</b>	250,827,269.
	<b>34</b> <b>Total liabilities and net assets/fund balances</b>	286,332,303.	<b>34</b>	317,278,192.

Form **990** (2017)

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

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12) . . . . .	<b>1</b>	324,307,917.
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25) . . . . .	<b>2</b>	313,974,337.
<b>3</b>	Revenue less expenses Subtract line 2 from line 1 . . . . .	<b>3</b>	10,333,580.
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) . . . . .	<b>4</b>	238,452,034.
<b>5</b>	Net unrealized gains (losses) on investments . . . . .	<b>5</b>	1,942,465.
<b>6</b>	Donated services and use of facilities . . . . .	<b>6</b>	0.
<b>7</b>	Investment expenses . . . . .	<b>7</b>	0.
<b>8</b>	Prior period adjustments . . . . .	<b>8</b>	0.
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O) . . . . .	<b>9</b>	99,190.
<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>	250,827,269.

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

- 1** Accounting method used to prepare the Form 990 ☐ Cash ☒ Accrual ☐ Other \_\_\_\_\_  
If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O

- 2a** Were the organization's financial statements compiled or reviewed by an independent accountant? . . . . .  
If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both

☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis

- b** Were the organization's financial statements audited by an independent accountant? . . . . .  
If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both

☐ Separate basis ☒ Consolidated basis ☐ Both consolidated and separate basis

- c** If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O

- 3a** As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133? . . . . .

- 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

	Yes	No
<b>2a</b>		X
<b>2b</b>	X	
<b>2c</b>	X	
<b>3a</b>		X
<b>3b</b>		

Form **990** (2017)

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

Department of the Treasury  
Internal Revenue Service

**Public Charity Status and Public Support**

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust  
▶ Attach to Form 990 or Form 990-EZ.  
▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information

OMB No 1545-0047

**2017**

**Open to Public Inspection**

Name of the organization

KINGMAN HEALTHCARE, INC.

Employer identification number

94-2916102

**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)(vii). (Complete Part II.)
- 9 ☐ An agricultural research organization described in section 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		
(A)						
(B)						
(C)						
(D)						
(E)						
<b>Total</b>						

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

Schedule A (Form 990 or 990-EZ) 2017

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

**Section A. Public Support**

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

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
7 Amounts from line 4 . . . . .						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources . . . . .						
9 Net income from unrelated business activities, whether or not the business is regularly carried on . . . . .						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI) . . . . .						
11 Total support. Add lines 7 through 10 . . . . .						
12 Gross receipts from related activities, etc. (see instructions) . . . . .					12	
13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here . . . . .						<input type="checkbox"/>

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

14 Public support percentage for 2017 (line 6, column (f) divided by line 11, column (f)). . . . .	14	%
15 Public support percentage from 2016 Schedule A, Part II, line 14 . . . . .	15	%
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. . . . .		<input type="checkbox"/>
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 . . . . .		<input type="checkbox"/>
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. . . . .		<input type="checkbox"/>
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. . . . .		<input type="checkbox"/>
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 . . . . .		<input type="checkbox"/>

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

(Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II  
If the organization fails to qualify under the tests listed below, please complete Part II.)

**Section A. Public Support**

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

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ▶	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
9 Amounts from line 6. . . . .						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources . . . . .						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975 . . . . .						
c Add lines 10a and 10b . . . . .						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on. . . . .						
12 Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI) . . . . .						
13 Total support (Add lines 9, 10c, 11, and 12) . . . . .						
14 First five years If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here . . . . . ▶ <input type="checkbox"/>						

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

15 Public support percentage for 2017 (line 8, column (f) divided by line 13, column (f)) . . . . .	15	%
16 Public support percentage from 2016 Schedule A, Part III, line 15 . . . . .	16	%

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

17 Investment income percentage for 2017 (line 10c, column (f) divided by line 13, column (f)) . . . . .	17	%
18 Investment income percentage from 2016 Schedule A, Part III, line 17 . . . . .	18	%
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 . ▶ <input type="checkbox"/>		
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 ▶ <input type="checkbox"/>		
20 Private foundation If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ▶ <input type="checkbox"/>		

**Part IV Supporting Organizations**

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

**Section A. All Supporting Organizations**

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

**Part IV Supporting Organizations** (continued)

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

**Section B. Type I Supporting Organizations**

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

**Section C. Type II Supporting Organizations**

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

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

	Yes	No
1 Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?		
1		
2 Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization(s) or (ii) serving on the governing body of a supported organization? If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s)		
2		
3 By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? If "Yes," describe in Part VI the role the organization's supported organizations played in this regard		
3		

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

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions)			
a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below			
b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below			
c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions)			
2 Activities Test. Answer (a) and (b) below.		Yes	No
a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities			
2a			
b Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement			
2b			
3 Parent of Supported Organizations. Answer (a) and (b) below.			
a Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? Provide details in Part VI.			
3a			
b Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? If "Yes," describe in Part VI the role played by the organization in this regard			
3b			

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

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

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

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

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

Schedule A (Form 990 or 990-EZ) 2017

**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.)

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

**Political Campaign and Lobbying Activities**

OMB No 1545-0047

**2017**

**Open to Public  
Inspection**

Department of the Treasury  
Internal Revenue Service

**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**  
▶ **Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.**

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 organization KINGMAN HEALTHCARE, INC.	Employer identification number 94-2916102
--	--

**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)				

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

Schedule C (Form 990 or 990-EZ) 2017

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

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

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)		(a) Filing organization's totals	(b) Affiliated group totals												
1a	Total lobbying expenditures to influence public opinion (grass roots lobbying) . . . . .														
b	Total lobbying expenditures to influence a legislative body (direct lobbying) . . . . .														
c	Total lobbying expenditures (add lines 1a and 1b) . . . . .														
d	Other exempt purpose expenditures . . . . .														
e	Total exempt purpose expenditures (add lines 1c and 1d) . . . . .														
f	Lobbying nontaxable amount Enter the amount from the following table in both columns														
<table border="1"> <thead> <tr> <th>If the amount on line 1e, column (a) or (b) is:</th> <th>The lobbying nontaxable amount is</th> </tr> </thead> <tbody> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000</td> </tr> </tbody> </table>		If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is	Not over \$500,000	20% of the amount on line 1e	Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000	Over \$17,000,000	\$1,000,000		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is														
Not over \$500,000	20% of the amount on line 1e														
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000														
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000														
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000														
Over \$17,000,000	\$1,000,000														
g	Grassroots nontaxable amount (enter 25% of line 1f) . . . . .														
h	Subtract line 1g from line 1a. If zero or less, enter -0- . . . . .														
i	Subtract line 1f from line 1c. If zero or less, enter -0- . . . . .														
j	If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? . . . . .	<input type="checkbox"/> Yes <input type="checkbox"/> 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
2a	Lobbying nontaxable amount				
b	Lobbying ceiling amount (150% of line 2a, column (e))				
c	Total lobbying expenditures				
d	Grassroots nontaxable amount				
e	Grassroots ceiling amount (150% of line 2d, column (e))				
f	Grassroots lobbying expenditures				

Schedule C (Form 990 or 990-EZ) 2017

**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
1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X	
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?	X		45,699
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?		X	
j Total Add lines 1c through 1i			45,699
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

**Part IV Supplemental Information**

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

SCHEDULE C, PART II-B, LINE 1G

LOBBYING:

KINGMAN HOSPITAL PAYS ANNUAL DUES IN WHICH A PERCENTAGE OF THEIR DUES IS

ATTRIBUTABLE TO LOBBYING. THE AMOUNT SHOWN ON THE LINE ABOVE REPRESENTS

THAT PERCENTAGE.

**Part IV** Supplemental Information *(continued)*

SCHEDULE D  
(Form 990)

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

▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information

OMB No 1545-0047

2017

Open to Public  
Inspection

Department of the Treasury  
Internal Revenue Service

Name of the organization

KINGMAN HEALTHCARE, INC.

Employer identification number

94-2916102

**Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.**

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

	(a) Donor advised funds	(b) Funds and other accounts
1 Total number at end of year . . . . .		
2 Aggregate value of contributions to (during year)		
3 Aggregate value of grants from (during year) . .		
4 Aggregate value at end of year . . . . .		
5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? . . . . .	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? . . . . .	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Part II Conservation Easements.**

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

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

<input type="checkbox"/> Preservation of land for public use (e g , recreation or education)	<input type="checkbox"/> Preservation of a historically important land area
<input type="checkbox"/> Protection of natural habitat	<input type="checkbox"/> Preservation of a certified historic structure
<input type="checkbox"/> Preservation of open space	

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

	Held at the End of the Tax Year
a Total number of conservation easements . . . . .	2a
b Total acreage restricted by conservation easements . . . . .	2b
c Number of conservation easements on a certified historic structure included in (a) . . . . .	2c
d Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register . . . . .	2d

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

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

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

6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ▶ \_\_\_\_\_

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

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

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

**Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 8

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

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

(i) Revenue included on Form 990, Part VIII, line 1. . . . . ▶ \$ \_\_\_\_\_

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

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

a Revenue included on Form 990, Part VIII, line 1. . . . . ▶ \$ \_\_\_\_\_

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

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Schedule D (Form 990) 2017

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

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

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

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

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

**Part IV Escrow and Custodial Arrangements.**

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

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

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

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

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

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

(ii) related organizations

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

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

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		21,298,675.		21,298,675.
b Buildings		103,997,257.	62,905,003.	41,092,254.
c Leasehold improvements				
d Equipment		119,184,465.	90,236,689.	28,947,776.
e Other		25,709,924.	3,293,742.	22,416,182.
<b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				113,754,887.

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

**Part VIII Investments - Program Related.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 11c See Form 990, Part X, line 13

(a) Description of investment	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1) . . . . .		
(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	
(2) ESTIMATED SELF-INSURANCE COSTS	1,234,000.
(3) ACCRUED RETIREMENT OBLIGATION	3,433,248.
(4) . . . . .	
(5) . . . . .	
(6) . . . . .	
(7) . . . . .	
(8) . . . . .	
(9) . . . . .	
Total (Column (b) must equal Form 990, Part X, col (B) line 25) ►	
	4,667,248.

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

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

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

1	Total revenue, gains, and other support per audited financial statements . . . . .		1	307,495,703.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12			
a	Net unrealized gains (losses) on investments . . . . .	2a	1,942,465.	
b	Donated services and use of facilities . . . . .	2b		
c	Recoveries of prior year grants . . . . .	2c		
d	Other (Describe in Part XIII) . . . . .	2d	111,880.	
e	Add lines 2a through 2d . . . . .	2e		2,054,345.
3	Subtract line 2e from line 1 . . . . .	3		305,441,358.
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1			
a	Investment expenses not included on Form 990, Part VIII, line 7b . . . . .	4a	60,487.	
b	Other (Describe in Part XIII) . . . . .	4b	18,806,072.	
c	Add lines 4a and 4b . . . . .	4c		18,866,559.
5	Total revenue. Add lines 3 and 4c. (This must equal Form 990, Part I, line 12) . . . . .	5		324,307,917.

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

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

1	Total expenses and losses per audited financial statements . . . . .		1	295,120,468.
2	Amounts included on line 1 but not on Form 990, Part IX, line 25			
a	Donated services and use of facilities . . . . .	2a		
b	Prior year adjustments . . . . .	2b		
c	Other losses . . . . .	2c		
d	Other (Describe in Part XIII) . . . . .	2d	12,690.	
e	Add lines 2a through 2d . . . . .	2e		12,690.
3	Subtract line 2e from line 1 . . . . .	3		295,107,778.
4	Amounts included on Form 990, Part IX, line 25, but not on line 1			
a	Investment expenses not included on Form 990, Part VIII, line 7b . . . . .	4a	60,487.	
b	Other (Describe in Part XIII) . . . . .	4b	18,806,072.	
c	Add lines 4a and 4b . . . . .	4c		18,866,559.
5	Total expenses. Add lines 3 and 4c. (This must equal Form 990, Part I, line 18) . . . . .	5		313,974,337.

**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.

SEE PAGE 5

**Part XIII** Supplemental Information (continued)

## SCHEDULE D, PART X, LINE 2

UNCERTAIN TAX POSITIONS: MANAGEMENT HAS EVALUATED THEIR INCOME TAX POSITIONS UNDER THE GUIDANCE INCLUDED IN ASC 740. BASED ON THEIR REVIEW, MANAGEMENT HAS NOT IDENTIFIED ANY MATERIAL UNCERTAIN TAX POSITIONS TO BE RECORDED OR DISCLOSED IN THE FINANCIAL STATEMENTS.

## SCHEDULE D, PART XI, LINE 2D

## REVENUE ON BOOKS, NOT ON RETURN:

COST OF GOODS SOLD	12,690
CHANGE IN NET ASSETS OF KRMC FOUNDATION	99,190
TOTAL	111,880

## SCHEDULE D, PART XI, LINE 4B

## REVENUE ON RETURN, NOT ON BOOKS:

## BAD DEBT NET WITH REVENUE ON FINANCIALS, TREATED AS

EXPENSE ON TAX RETURN	17,762,539
ACTIVITY OF NARIC INCLUDED IN CONSOLIDATED FINANCIALS, REMOVED FOR TAX RETURN	1,043,533
TOTAL	18,806,072

## SCHEDULE D, PART XII, LINE 2D

## EXPENSE ON BOOKS, NOT ON RETURN:

COST OF GOODS SOLD	12,690
--------------------	--------

**Part XIII** Supplemental Information (continued)

SCHEDULE D, PART XII LINE 4B

EXPENSE ON RETURN, NOT ON BOOKS:

BAD DEBT NET WITH REVENUE ON FINANCIALS, TREATED AS

EXPENSE ON TAX RETURN

17,762,539

ACTIVITY OF NARIC INCLUDED IN CONSOLIDATED FINANCIALS,

REMOVED FOR TAX RETURN

1,043,533

TOTAL

18,806,072

**SCHEDULE H  
(Form 990)**

**Hospitals**

OMB No 1545-0047

**2017**

**Open to Public  
Inspection**

Department of the Treasury  
Internal Revenue Service

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

▶ Attach to Form 990.

▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

Name of the organization

KINGMAN HEALTHCARE, INC.

Employer identification number

94-2916102

**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 . . . . .	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>1b</b> If "Yes," was it a written policy? . . . . .	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<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		
<input type="checkbox"/> Generally tailored to individual hospital facilities		
<b>3</b> Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year		
<b>a</b> Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care		
<input type="checkbox"/> 100% <input checked="" type="checkbox"/> 150% <input type="checkbox"/> 200% <input type="checkbox"/> Other _____ %		
<b>b</b> Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care . . . . .		
<input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input checked="" type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %		
<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"? . . . . .	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>5b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? . . . . .	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>5c</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? . . . . .	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>6a</b> Did the organization prepare a community benefit report during the tax year? . . . . .	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>6b</b> If "Yes," did the organization make it available to the public? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>

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) . . . . .			711,138.		711,138.	.24
<b>b</b> Medicaid (from Worksheet 3, column a) . . . . .			67,109,810.	39,949,872.	27,159,938.	9.17
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b) . . . . .						
<b>d</b> Total Financial Assistance and Means-Tested Government Programs . . . . .			67,820,948.	39,949,872.	27,871,076.	9.41
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4) . . . . .			700,604.		700,604.	.24
<b>f</b> Health professions education (from Worksheet 5) . . . . .			3,150,321.	4,294,287.		
<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) . . . . .			669,766.		669,766.	.23
<b>j</b> Total Other Benefits . . . . .			4,520,691.	4,294,287.	1,370,370.	.47
<b>k</b> Total Add lines 7d and 7j. . . . .			72,341,639.	44,244,159.	29,241,446.	9.88

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Schedule H (Form 990) 2017

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

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

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

**Section A. Bad Debt Expense**

- 1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? . . . . . **1** X
- 2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount. . . . . **2** 17,762,539.
- 3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit. . . . . **3**
- 4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements

**Section B. Medicare**

- 5 Enter total revenue received from Medicare (including DSH and IME) . . . . . **5** 74,519,524.
- 6 Enter Medicare allowable costs of care relating to payments on line 5 . . . . . **6** 74,339,366.
- 7 Subtract line 6 from line 5. This is the surplus (or shortfall) . . . . . **7** 180,158.
- 8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:
- ☒ Cost accounting system ☐ Cost to charge ratio ☐ Other

**Section C. Collection Practices**

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

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

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

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

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

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

	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
<b>1</b> KINGMAN REGIONAL MEDICAL CENTER 3269 STOCKTON HILL ROAD KINGMAN AZ 86409 WWW.AZKPMC.COM H-0010	X	X		X			X		CANCER CENTER CARDIAC CATH LAB ACUTE REHAB UNIT	1
<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 V Facility Information (continued)****Section B. Facility Policies and Practices**

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

Name of hospital facility or letter of facility reporting group KINGMAN REGIONAL MEDICAL CENTER

Line number of hospital facility, or line numbers of hospital

facilities in a facility reporting group (from Part V, Section A): 1**Community Health Needs Assessment**

- 1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? . . . . .
- 2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C . . . . .
- 3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 . . . . .  
If "Yes," indicate what the CHNA report describes (check all that apply)
- a ☒ A definition of the community served by the hospital facility
- b ☒ Demographics of the community
- c ☒ Existing health care facilities and resources within the community that are available to respond to the health needs of the community
- d ☒ How data was obtained
- e ☒ The significant health needs of the community
- f ☒ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups
- g ☒ The process for identifying and prioritizing community health needs and services to meet the community health needs
- h ☒ The process for consulting with persons representing the community's interests
- i ☒ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)
- j ☐ Other (describe in Section C)
- 4 Indicate the tax year the hospital facility last conducted a CHNA 20 15
- 5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .
- 6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .
- b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C . . . . .
- 7 Did the hospital facility make its CHNA report widely available to the public? . . . . .  
If "Yes," indicate how the CHNA report was made widely available (check all that apply)
- a ☒ Hospital facility's website (list url) SEE PART V, SECTION C FOR URL
- b ☐ Other website (list url) \_\_\_\_\_
- c ☒ Made a paper copy available for public inspection without charge at the hospital facility
- d ☐ Other (describe in Section C)
- 8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 . . . . .
- 9 Indicate the tax year the hospital facility last adopted an implementation strategy 2015
- 10 Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . .
- a If "Yes," (list url) \_\_\_\_\_
- b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .
- 11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed
- 12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .
- b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .
- c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$

	Yes	No
1		X
2		X
3	X	
4		
5	X	
6a		X
6b	X	
7	X	
8	X	
9		
10		X
10b	X	
11		
12a		X
12b		

**Part V Facility Information (continued)****Financial Assistance Policy (FAP)**Name of hospital facility or letter of facility reporting group KINGMAN REGIONAL MEDICAL CENTER

	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? If "Yes," indicate the eligibility criteria explained in the FAP	X	
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>150 0000</u> % and FPG family income limit for eligibility for discounted care of <u>350 0000</u> %		
b <input type="checkbox"/> Income level other than FPG (describe in Section C)		
c <input checked="" type="checkbox"/> Asset level		
d <input checked="" type="checkbox"/> Medical indigency		
e <input checked="" type="checkbox"/> Insurance status		
f <input checked="" type="checkbox"/> Underinsurance status		
g <input type="checkbox"/> Residency		
h <input type="checkbox"/> Other (describe in Section C)		
<b>14</b> Explained the basis for calculating amounts charged to patients?	X	
<b>15</b> Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	X	
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e <input type="checkbox"/> Other (describe in Section C)		
<b>16</b> Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	X	
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>SEE PART V, SECTION C FOR URL</u>		
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>SEE PART V, SECTION C FOR URL</u>		
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>PART V, SECTION C FOR URL</u>		
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g <input checked="" type="checkbox"/> 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 checked="" 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)		

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**Part V Facility Information (continued)****Billing and Collections**Name of hospital facility or letter of facility reporting group KINGMAN REGIONAL MEDICAL CENTER

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

**Policy Relating to Emergency Medical Care**

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

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**Part V Facility Information** (continued)**Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**Name of hospital facility or letter of facility reporting group KINGMAN REGIONAL MEDICAL CENTER**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>		X
<b>24</b>		X

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**Part V Facility Information (continued)**

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

SCHEDULE H, PART V, SECTION B, LINE 10A

DIRECT URL WHERE IMPLEMENTATION PLAN IS MADE WIDELY AVAILABLE:

[HTTP://WWW.AZKRMC.COM/MOHAVE-COUNTY-COMMUNITY-HEALTH-IMPROVEMENT-INITIATIVE/](http://www.azkrmc.com/mohave-county-community-health-improvement-initiative/)

E/

SCHEDULE H, PART V, SECTION B, LINE 11

IN 2016, KINGMAN HOSPITAL INC. (KHI), IN PARTNERSHIP WITH THE MOHAVE COUNTY DEPARTMENT OF PUBLIC HEALTH (MCDPH), BEGAN THE ONGOING COMMUNITY HEALTH ASSESSMENT AND COMMUNITY HEALTH IMPROVEMENT PLANNING PROCESS IN MOHAVE COUNTY, AZ. SINCE THEN, KHI HAS ACTIVELY PARTICIPATED WITH COMMUNITY STAKEHOLDERS TO IDENTIFY AND ADDRESS HEALTH AND QUALITY OF LIFE ISSUES IN MOHAVE COUNTY, AZ. OUR PROCESS INVOLVES PERFORMING A COMMUNITY HEALTH ASSESSMENT AND DEVELOPING A COMMUNITY HEALTH IMPROVEMENT PLAN EVERY THREE YEARS.

AS A RESULT OF OUR INITIAL COMMUNITY HEALTH ASSESSMENT, WHICH WAS PUBLISHED IN 2013, KHI AND MCDPH HAVE LED A COALITION OF COMMUNITY STAKEHOLDERS IN IDENTIFYING PRIORITY HEALTH ISSUES AND IN FORMULATING COMMUNITY TASK FORCES TO ADDRESS THE ISSUES. THESE TASK FORCES CONTINUE TO MEET ON A REGULAR BASIS TO SET GOALS, OBJECTIVES, AND IMPLEMENT ACTIONS FOR IMPROVEMENT. KHI CONTINUES TO LEAD AND BE AN ACTIVE PARTICIPANT IN THE COMMUNITY TASK FORCES TO ADDRESS PRIORITY HEALTH ISSUES SELECTED BY COMMUNITY STAKEHOLDERS AND ASSIST HOWEVER POSSIBLE IN MEETING COMMUNITY-DIRECTED GOALS.

**Part V Facility Information (continued)**

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

THE CURRENT ISSUES SELECTED BY COMMUNITY STAKEHOLDERS, CORRESPONDING TASK FORCES, GOALS, AND KHI ACTIVITIES ARE DESCRIBED BELOW.

A. ECONOMIC CONDITIONS ECONOMIC INSECURITY IS OFTEN ASSOCIATED WITH POOR HEALTH. MOHAVE COUNTY'S HIGH RATES OF POVERTY, UNEMPLOYMENT, AND LACK OF EDUCATIONAL ACHIEVEMENT CREATE BARRIERS FOR ACCESSING HEALTH SERVICES, HEALTHY FOOD, RECREATION, AND OTHER NECESSITIES THAT CONTRIBUTE TO A HEALTHY LIFESTYLE.

MOHAVE COUNTY ECONOMIC TASK FORCE GOAL: STRENGTHEN NEW AND EXISTING BUSINESSES WITHIN MOHAVE COUNTY THROUGH EDUCATION AND ONE-ON-ONE ASSISTANCE UTILIZING EXISTING ECONOMIC DEVELOPMENT AGENCIES.

KHI STRATEGIES:

1) MAINTAIN HOSPITAL GROWTH AND VIABILITY. A HEALTHY, GROWING HOSPITAL WITH MORE PHYSICIANS AND HEALTHCARE SERVICES IS VITAL TO THE ECONOMY OF KINGMAN AND SURROUNDING COMMUNITIES. AS THE LARGEST PRIVATE EMPLOYER IN MOHAVE COUNTY, KHI HAS ADDED 800 JOBS TO THE KINGMAN ECONOMY OVER THE PAST 10 YEARS.

2) PURCHASE GOODS AND SERVICES FROM LOCAL VENDORS. KHI GIVES PRIORITY TO LOCAL BUSINESSES WHEN PROCURING GOODS AND SERVICES FOR VARIOUS HOSPITAL FUNCTIONS, ADVERTISING AND PROMOTION, FACILITY EXPANSION, AND OTHER HOSPITAL OPERATIONS. KHI SPENDS OVER \$10 MILLION ANNUALLY WITH LOCAL VENDORS.

**Part V Facility Information** (continued)

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

SCHEDULE H, PART V, SECTION B, LINE 5

AS PART OF THE COMMUNITY HEALTH ASSESSMENT PROCESS, MEMBERS OF THE MOHAVE  
COUNTY COMMUNITY HEALTH COALITION CONDUCTED INTERVIEWS WITH INDIVIDUALS  
WHO REPRESENT:

- A) BROAD INTERESTS OF THE COMMUNITY,
- B) POPULATIONS OF NEED, AND
- C) PERSONS WITH SPECIALIZED KNOWLEDGE IN PUBLIC HEALTH.

THESE INDIVIDUALS CAME FROM THE FOLLOWING COMMUNITY SECTORS:

- SOCIAL SERVICE AGENCIES
- LOCAL SCHOOL SYSTEM AND COMMUNITY COLLEGE
- LOCAL CITY AND COUNTY GOVERNMENT
- PUBLIC HEALTH AGENCIES
- INDUSTRY
- FAITH COMMUNITY
- MEDICAL PROVIDERS

SCHEDULE H, PART V, SECTION B, LINE 6B

THE CHNA FOR KINGMAN HOSPITAL INC. WAS CONDUCTED WITH MOHAVE COUNTY,  
ARIZONA.

SCHEDULE H, PART V, SECTION B, LINE 7A

DIRECT URL WHERE CHNA REPORT IS MADE WIDELY AVAILABLE ON THE  
ORGANIZATION'S WEBSITE:

[HTTP://WWW.AZKRMC.COM/WP-CONTENT/UPLOADS/2016/10/KRMC\\_MOHAVE-COUNTY-DEPART  
MENT-OF-PUBLIC-HEALTH\\_CHA-REPORT\\_FINAL.PDF](http://www.azkrmc.com/wp-content/uploads/2016/10/KRMC_MOHAVE-COUNTY-DEPARTMENT-OF-PUBLIC-HEALTH_CHA-REPORT_FINAL.PDF)

**Part V Facility Information (continued)**

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

3) EDUCATE AND EMPLOY LOCAL TALENT. KHI GIVES PRIORITY TO HIRING LOCAL APPLICANTS WHEN FILLING OPEN HOSPITAL POSITIONS. WE COORDINATE WITH LOCAL HIGH SCHOOLS TO INFORM STUDENTS OF CAREER OPPORTUNITIES AND PARTNER WITH MOHAVE COMMUNITY COLLEGE AND STATE UNIVERSITIES TO HIRE HEALTHCARE WORKERS (NURSES, MEDICAL TECHNICIANS, ETC.) TRAINED THROUGH THEIR RESPECTIVE PROGRAMS. KHI FUNDS SCHOLARSHIPS TO HELP LOCAL STUDENTS WHO ARE PURSUING CAREERS IN HEALTHCARE WITH THEIR EDUCATIONAL COSTS. WE ALSO PROVIDE TUITION REIMBURSEMENT TO CURRENT EMPLOYEES SEEKING FURTHER EDUCATION TO ADVANCE THEIR CAREERS.

4) SUPPORT ECONOMIC DEVELOPMENT, EDUCATION, AND JOB TRAINING EFFORTS IN OUR COMMUNITY. KHI IS AN ACTIVE MEMBER OF THE KINGMAN CHAMBER OF COMMERCE, PARTICIPATES IN VARIOUS COMMITTEES THAT FOCUS ON BUSINESS DEVELOPMENT, AND SUPPORTS EDUCATION AND JOB TRAINING EFFORTS VIA SCHOLARSHIPS, JOB SHADOWING AND SUPPORT OF STUDENT ORGANIZATIONS, SUCH AS HOSA (HEALTH OCCUPATION STUDENT ASSOCIATION) IN OUR LOCAL HIGH SCHOOLS.

B. YOUTH RISK/PROTECTIVE FACTORS THE RESULTS OF THE COMMUNITY HEALTH ASSESSMENT AS REPORTED IN THE COMMUNITY HEALTH PROFILE FOR MOHAVE COUNTY, 2016 SHOW HIGH RATES OF SUBSTANCE ABUSE, ANTISOCIAL BEHAVIOR, AND DELINQUENCY AMONG MOHAVE COUNTY YOUTH AS COMPARED TO STATE AND NATIONAL STATISTICS. THEREFORE, OUR COMMUNITY COALITION HAS CHOSEN TO ADDRESS RISK FACTORS THAT CAN LEAD TO PROBLEM BEHAVIORS AMONG CHILDREN AND ADOLESCENTS IN OUR COMMUNITY. MOHAVE COUNTY YOUTH TASK FORCE GOAL: REDUCE YOUTH RISK

**Part V Facility Information (continued)**

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

FACTORS AND INCREASE YOUTH PROTECTIVE FACTORS IN MOHAVE COUNTY.

KHI STRATEGIES:

1) PROVIDE TRAINING AND EDUCATION TO NEW PARENTS. KHI PROVIDES CULTURALLY-APPROPRIATE INFORMATION AND EDUCATION TO NEW PARENTS IN OUR COMMUNITY TO HELP INCREASE FAMILY BONDING AND OTHER PROTECTIVE FACTORS IN THEIR CHILD'S LIFE.

2) PROVIDE OUTREACH IN SCHOOLS TO EDUCATE CHILDREN ON HEALTHY LIVING SKILLS. THROUGH KHI'S KARE BEAR PROGRAM, WE USE A FUN AND ENGAGING APPROACH TO EDUCATE LOCAL CHILDREN ON THE IMPORTANCE OF LIVING HEALTHY. KARE BEAR VISITS LOCAL CLASSROOMS TO TALK ABOUT AND DEMONSTRATE SUCH TOPICS AS SUN SAFETY, HAND HYGIENE, BIKE SAFETY AND HELMET USE, WATER SAFETY, COUGH ETIQUETTE, ORAL HYGIENE.

3) ENCOURAGE PHYSICAL FITNESS AT COMMUNITY ELEMENTARY SCHOOLS. KHI SPONSORS A PHYSICAL EDUCATION PROGRAM CALLED PROJECT FIT AMERICA AT FIVE ELEMENTARY SCHOOLS IN KINGMAN. THE PROGRAM INCLUDES EQUIPMENT, TEACHER TRAINING, CURRICULUM, AND OTHER RESOURCES TO HELP KIDS BE ACTIVE AND HEALTHY.

4) PROVIDE FREE GENERAL HEALTH SCREENINGS AT LOCAL SCHOOLS AND AT SPECIAL OUTREACH EVENTS. RESIDENT DOCTORS WITH KHI'S FAMILY PRACTICE RESIDENCY PROGRAM VISIT EACH OF KINGMAN'S MIDDLE SCHOOLS AND HIGH SCHOOLS DURING THE SCHOOL YEAR PROVIDING STUDENTS A FREE BASIC PHYSICAL, AS WELL AS

**Part V Facility Information** (continued)

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

INFORMATION ON MAKING GOOD HEALTHCARE CHOICES AND PROVIDING A FORUM FOR THE STUDENTS TO TALK ABOUT THEIR HEALTH CONCERNS. THEY ALSO PROVIDE FREE IMMUNIZATIONS, HEIGHT AND WEIGHT MEASUREMENTS AT THE HOSPITALS ANNUAL "KIDS DAY HEALTH EXPO" WHERE AN AVERAGE 700 CHILDREN PARTICIPATE.

5) PROVIDE YOUTH OPPORTUNITIES FOR POSITIVE COMMUNITY ENGAGEMENT THROUGH THE KHI VOLUNTEER PROGRAM. KHI'S YOUTH VOLUNTEER PROGRAM (VOLUNTEERS) PROVIDES HIGH SCHOOL STUDENTS (AGES 14 TO 19) AN OPPORTUNITY TO SERVE THE COMMUNITY IN MANY AREAS OF KHI- NURSING, WELLNESS CENTER, LABORATORY, PHYSICIAN OFFICES, NUTRITION SERVICES, AND DAY CARE CENTER.

6) PROVIDE JOB SHADOWING TO STUDENTS INTERESTED IN HEALTH-RELATED OCCUPATIONS. IN PARTNERSHIP WITH KINGMAN HIGH SCHOOL'S HOSA (HEALTH OCCUPATIONS STUDENTS OF AMERICA) PROGRAM, KHI HOSTS HUNDREDS OF HIGH SCHOOL STUDENTS EVERY FEBRUARY WHO SPEND A DAY WITH HOSPITAL TECHNOLOGISTS, NURSES, DOCTORS, OR ADMINISTRATORS TO OBSERVE THEIR WORK ACTIVITIES.

7) ENCOURAGE YOUTH RESPONSIBILITY AND SAFETY THROUGH THE SAFE SITTER PROGRAM. KHI PROVIDES SAFE SITTER TRAINING TO AREA YOUTH. THIS WELL-ROUNDED YOUTH DEVELOPMENT PROGRAM AIMS TO REDUCE THE NUMBER OF AVOIDABLE AND UNINTENTIONAL DEATHS AMONG CHILDREN BEING CARED FOR BY BABYSITTERS. PROGRAM GRADUATES ARE ABLE TO HANDLE EMERGENCIES WHEN CARING FOR YOUNGER CHILDREN AND ARE EQUALLY EQUIPPED WITH THE TOOLS NEEDED TO STAY SAFE WHEN HOME ALONE.

**Part V Facility Information (continued)**

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

8) PROVIDE FINANCIAL SUPPORT TO COMMUNITY YOUTH ORGANIZATIONS AND ACTIVITIES. KHI PROVIDES DONATIONS AND OTHER SUPPORT TO MANY COMMUNITY ORGANIZATIONS THAT PROVIDE PROGRAMS, SERVICES, AND SUPPORT TO LOCAL CHILDREN AND FAMILIES.

C. SUBSTANCE ABUSE & MENTAL HEALTH THE RESULTS OF THE COMMUNITY HEALTH ASSESSMENT AS REPORTED IN THE COMMUNITY HEALTH PROFILE FOR MOHAVE COUNTY, 2016 SHOW HIGH RATES OF SUBSTANCE ABUSE AND MENTAL HEALTH PROBLEMS AMONG MOHAVE COUNTY ADULTS AS COMPARED TO STATE AND NATIONAL STATISTICS. UNFORTUNATELY, MOST OF RURAL AMERICA IS WITHOUT THE NECESSARY RESOURCES TO ADEQUATELY ADDRESS THE PANDEMIC INCREASE IN PEOPLE WHO ARE IMPACTED BY MENTAL HEALTH AND SUBSTANCE ABUSE PROBLEMS. SINCE THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT WAS COMPLETED KPMC/KHI WAS ABLE TO UTILIZE FUNDING THROUGH THE STR/SOR GRANT (STATE TARGETED RESPONSE, NOW CALLED THE STATE OPIOID RESPONSE) AND THE TL GRANT (TARGETED INVESTMENT FOR BEHAVIORAL HEALTH IN PRIMARY CARE CLINICS).

THIS FUNDING HAS ALLOWED US TO EXPAND THE FOCUS AND REACH OF SCREENING, TREATMENT, EDUCATION AND REFERRALS IN THE AREA OF SUBSTANCE ABUSE AND MENTAL HEALTH AT KPMC.

IT HAS ALLOWED FOR INCREASED STAFF INCLUDING COUNSELORS, PSYCHIATRIC NURSES AND PROVIDERS IN OUR PRIMARY CARE CLINICS, PAIN CLINIC, AND THE EMERGENCY DEPARTMENT. WE HAVE PLANS FOR OUR OB SERVICES IN THE NEAR

**Part V Facility Information** (continued)

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

FUTURE.

WE HAVE BEEN ABLE TO TRAIN STAFF AND INITIATE THE USE OF STANDARDIZED SCREENING TOOLS FOR MENTAL HEALTH AND SUBSTANCE ABUSE. THESE SCREENINGS HAVE ALLOWED US TO IDENTIFY THE PATIENTS THAT ARE AT HIGH RISK OF MENTAL HEALTH OR SUBSTANCE ABUSE ISSUES AND TREAT ACCORDINGLY.

ADDITIONAL KHI'S STRATEGIES FOR ADDRESSING SUBSTANCE ABUSE AND MENTAL HEALTH ISSUES IN OUR COMMUNITY INCLUDE:

1) PROVIDE FINANCIAL SUPPORT AND PARTICIPATE ON COMMUNITY INITIATIVES THAT ADDRESS SUBSTANCE ABUSE IN OUR COMMUNITY. KHI IS ACTIVELY INVOLVED IN THE FOLLOWING COMMUNITY INITIATIVES; PROVIDING LEADERSHIP, FINANCIAL DONATIONS, AND OTHER RESOURCES.

2) MAINTAIN A SMOKE-FREE CAMPUS AT KHI. KHI IS COMMITTED TO PROMOTING GOOD HEALTH, WHICH INCLUDES PREVENTING AS WELL AS TREATING DISEASE. SMOKING RELATED ILLNESSES (INCLUDING THOSE RELATED TO ENVIRONMENTAL TOBACCO SMOKE) COMPRISE THE LARGEST PROPORTION OF PREVENTABLE DISEASES. THEREFORE, KHI PROHIBITS SMOKING AT ALL ITS FACILITIES AND ON HOSPITAL GROUNDS, INCLUDING PARKING LOTS AND RAMPS.

D. ACCESSIBLE/AFFORDABLE HEALTHCARE ACCESS TO HEALTH RESOURCES IS CRITICAL TO THE HEALTH OF OUR COMMUNITY'S RESIDENTS. THE RESULTS OF THE COMMUNITY HEALTH ASSESSMENT AS REPORTED IN THE COMMUNITY HEALTH PROFILE

**Part V Facility Information (continued)**

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

FOR MOHAVE COUNTY, 2016 SHOW THAT THERE ARE NUMBER OF SPECIFIC BARRIERS  
TO OBTAINING PROPER HEALTHCARE IN MOHAVE COUNTY.

MOHAVE COUNTY ACCESSIBLE/AFFORDABLE HEALTHCARE TASK FORCE GOAL: INCREASE  
PROVIDER AVAILABILITY AND REDUCE FINANCIAL, CULTURAL, AND TRANSPORTATION  
BARRIERS THAT IMPEDE ACCESS TO HEALTHCARE IN MOHAVE COUNTY.

KHI STRATEGIES:

- 1) RELIEVE FINANCIAL HARDSHIP FROM HEALTHCARE BILLS. AS THE ONLY  
NON-PROFIT MEDICAL CENTER IN MOHAVE COUNTY, KHI PROVIDES CHARITY  
HEALTHCARE SERVICES TO LOW-INCOME PATIENTS WITH NO HEALTH INSURANCE. WE  
ALSO PROVIDE ASSISTANCE TO LOW-INCOME PATIENTS WITH BALANCES AFTER  
MEDICARE OR COMMERCIAL HEALTH INSURANCE CARRIERS HAVE MADE PAYMENT.
- 2) RECRUIT MORE PHYSICIANS AND OTHER HEALTHCARE PROVIDERS TO OUR AREA. TO  
MEET OUR COMMUNITY'S HEALTHCARE NEEDS, KHI ACTIVELY WORKS TO ATTRACT  
HIGHLY-SKILLED DOCTORS, NURSES, AND OTHER MEDICAL PROFESSIONALS TO OUR  
AREA. TO DO SO, WE OFFER HIGHLY-COMPETITIVE SALARIES, BENEFITS, AND  
RELOCATION PACKAGES.
- 3) CONTINUE AS A TEACHING HOSPITAL FOR PHYSICIANS IN EMERGENCY MEDICINE  
AND FAMILY MEDICINE. WHILE TRAINING HERE, RESIDENT DOCTORS SERVE LOCAL  
PATIENTS UNDER THE SUPERVISION OF LICENSED DOCTORS, WHICH HELPS MEET OUR  
COMMUNITY'S NEED FOR EMERGENCY AND PRIMARY CARE PROVIDERS. ADDITIONALLY,  
MANY OF THESE DOCTORS CHOOSE TO ESTABLISH THEIR PRACTICES IN OUR REGION

**Part V Facility Information** (continued)

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

AFTER GRADUATING OUR PROGRAM.

4) COLLABORATE WITH MAYO CLINIC. AS A MEMBER OF THE MAYO CLINIC CARE NETWORK, KHI HEALTHCARE PROVIDERS HAVE DIRECT ACCESS TO MAYO CLINIC MEDICAL EXPERTISE AND RESEARCH. THE RELATIONSHIP ENABLES KRMC TO ADDRESS MORE TYPES OF MEDICAL CONDITIONS AT A LOCAL LEVEL.

5) UTILIZE TELEMEDICINE TECHNOLOGY. AS A RURAL HOSPITAL, KHI UTILIZES TELEMEDICINE TECHNOLOGY TO PROVIDE ACCESS TO MEDICAL SPECIALISTS AT LARGER URBAN CENTERS.

6) PROVIDE URGENT CARE SERVICES. KHI OPERATES WALK-IN URGENT CARE CLINIC TO HELP IN SITUATIONS WHERE PEOPLE NEED TO SEE A DOCTOR RIGHT AWAY FOR AN ILLNESS OR MINOR INJURY. THESE CLINICS OFFER MEDICAL CARE SERVICES SEVEN-DAYS-A-WEEK WITHOUT AN APPOINTMENT.

7) PROVIDE HOME HEALTH SERVICES. TO HELP MEET THE HEALTHCARE ACCESS NEEDS OF PEOPLE IN OUR COMMUNITY WHO ARE HOMEBOUND, KHI PROVIDES SKILLED NURSING CARE AND REHABILITATION THERAPIES AT PATIENTS' HOMES IN KINGMAN, GOLDEN VALLEY, CHLORIDE, DOLAN SPRINGS, AND MEADVIEW.

8) PROVIDE FREE OR REDUCED-COST WOMEN'S HEALTH SERVICES. KHI WORKS IN COLLABORATION WITH THE FEDERAL- AND STATE-FUNDED PROGRAMS AND GRANT AGENCIES TO PROVIDE FREE MAMMOGRAMS AND OTHER WOMEN'S HEALTHCARE SERVICES (CLINICAL BREAST EXAMS, PELVIC EXAMS, AND PAP TESTS) TO

**Part V Facility Information (continued)**

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

UNINSURED/UNDERINSURED WOMEN WHO QUALIFY.

9) PROVIDE LOW-INCOME PATIENTS ACCESS TO EXERCISE AND FITNESS PROGRAMS.

KHI PROVIDES SCHOLARSHIPS FOR MEMBERSHIPS TO OUR DEL. E. WEBB WELLNESS CENTER TO QUALIFIED LOW-INCOME PATIENTS WHO NEED TO IMPROVE A HEALTH CONDITION WITH EXERCISE AND ARE UNABLE TO AFFORD A MEMBERSHIP.

10) PROVIDE PUBLIC OUTREACH AND EDUCATION ON DISEASE PREVENTION AND OTHER IMPORTANT HEALTH MATTERS. WITH THE BELIEF THAT HEALTH EDUCATION IS VITAL IN ACHIEVING A HEALTHIER COMMUNITY, KHI PROVIDES MANY PUBLIC LEARNING OPPORTUNITIES AND FREE HEALTH SCREENINGS (E.G., BONE DENSITY TESTING, HEARING TESTING, CHOLESTEROL SCREENING, ETC.) AS APPROPRIATE A FIVE PUBLIC HEALTH FAIRS PER YEAR.

11) ALLEVIATE TRANSPORTATION BARRIERS TO HEALTHCARE SERVICES. KHI IS A MEMBER OF THE WESTERN ARIZONA COUNCIL OF GOVERNMENTS (WACOG) TRANSPORTATION COORDINATION COUNCIL, WHICH WORKS TO PROVIDE AFFORDABLE TRANSPORTATION SERVICES TO COMMUNITIES THROUGHOUT MOHAVE COUNTY AND COORDINATE SERVICES AMONG AREA TRANSPORTATION PROVIDERS. ADDITIONALLY, KHI OPERATES A PATIENT TRANSPORT VAN, WHICH PROVIDES FREE TRANSPORTATION SERVICES TO ELDERLY AND DISABLED PATIENTS IN MOHAVE COUNTY WHO HAVE NO OTHER MEANS OF TRAVEL TO OUR FACILITIES FOR NEEDED MEDICAL SERVICES.

KHI STRATEGIES TO ADDRESS MAJOR CAUSES OF DEATH IN MOHAVE COUNTY

**Part V Facility Information** (continued)

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

THE COMMUNITY HEALTH PROFILE FOR MOHAVE COUNTY, 2016 SHOWS THAT MOHAVE COUNTY RANKS POORLY IN MOST HEALTH INDICATORS FOR CHRONIC DISEASE IN COMPARISON TO STATE AND NATIONAL STATISTICS. THE MOST NOTABLE ARE CARDIOVASCULAR DISEASE, CANCER, AND LUNG DISEASE; WHICH ARE THE LEADING CAUSES OF DEATH IN OUR COMMUNITY. THE MOHAVE COUNTY COMMUNITY HEALTH COALITION DID NOT ELECT TO ADDRESS THESE ISSUES AT THIS TIME, BUT INSTEAD SELECTED PRIORITIES (SUCH AS ACCESSIBILITY AND AFFORDABILITY OF HEALTHCARE), WHICH WHEN ADDRESSED, SHOULD HAVE A POSITIVE IMPACT ON MOHAVE COUNTY'S CHRONIC DISEASE INDICATORS. HOWEVER, AS THE REGION'S LARGEST MEDICAL CENTER, KHI DEALS DIRECTLY WITH THESE LIFE-THREATENING DISEASES AND HAS DEVELOPED STRATEGIES AND APPROACHES FOR ADDRESSING THEM.

**KHI STRATEGIES:**

1) EDUCATE THE COMMUNITY ON HOW TO REDUCE RISKS OF CHRONIC DISEASE THROUGH HEALTHY LIFESTYLE CHOICES (PROPER DIET, EXERCISE, NOT SMOKING, ETC.). WE HAVE DEVELOPED KEY MESSAGES ON THESE TOPICS, WHICH ARE INCLUDED IN OUR PUBLICATIONS, ADVERTISING, HEALTH FAIRS, HEALTH LECTURES, AND OTHER PUBLIC COMMUNICATIONS. ADDITIONALLY, SPECIFIC INFORMATION IS PROVIDED TO PATIENTS DURING VISITS WITH THEIR PRIMARY CARE PROVIDER.

2) BUILD MULTI-DISCIPLINARY TEAMS FOR DIAGNOSING, TREATING, AND SURVIVING CHRONIC DISEASE. KHI IS IMPLEMENTING A MULTIDISCIPLINARY TEAM APPROACH TO FOCUS ON THE PATIENT'S HEALTH PROBLEM FROM MULTIPLE PERSPECTIVES. AS THE NAME IMPLIES, MULTIDISCIPLINARY TEAMS ARE COMPRISED OF HEALTHCARE

**Part V Facility Information (continued)**

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

PROFESSIONALS WITH EXPERTISE IN DIFFERENT MEDICAL DISCIPLINES, SUCH AS  
PRIMARY CARE DOCTORS, PHYSICIAN SPECIALISTS, NURSES, PHARMACISTS,  
DIETICIANS, AND REHABILITATION THERAPISTS. EACH TEAM MEMBER CONTRIBUTES  
THEIR INDIVIDUAL EXPERTISE, BUT ALSO COLLABORATES WITH THE OTHER  
PROFESSIONALS TO ADDRESS THE PATIENT'S SPECIFIC CONDITION AND NEEDS.  
BASED ON THE MAJOR CAUSES OF DEATH IN OUR COMMUNITY, OUR FOCUS IS  
BUILDING MULTI-DISCIPLINARY TEAMS IN THREE CLINICAL AREAS: CARDIOVASCULAR  
CARE, CANCER CARE, AND PULMONOLOGY.

NEEDS NOT ADDRESSED IN THE CHNA: THERE WERE MANY OTHER HEALTH ISSUES  
IDENTIFIED IN THE COMMUNITY HEALTH NEEDS ASSESSMENT FOR MOHAVE COUNTY,  
2016 THAT ARE CLEARLY IMPORTANT TO IMPROVING THE HEALTH OF THE COMMUNITY.  
THE MOST NOTABLE HEALTH ISSUES NOT SPECIFICALLY ADDRESSED AT THIS TIME  
ARE DIABETES, INFANT MORTALITY, OBESITY, AND TEEN PREGNANCY. THESE  
ISSUES ARE NOT BEING SPECIFICALLY ADDRESSED IN OUR CURRENT STRATEGIES  
BECAUSE OUR COMMUNITY STAKEHOLDERS DEEMED THEM AS HAVING LESS IMMEDIATE  
IMPACT ON COMMUNITY HEALTH THAN THE OTHER ISSUES THEY SELECTED. HOWEVER,  
AS DESCRIBED THROUGHOUT THIS REPORT, KHI PROVIDES MANY PROGRAMS AND  
SERVICES THAT DIRECTLY OR INDIRECTLY HELP TO IMPROVE OUTCOMES IN THESE  
HEALTH AREAS.

ADDITIONALLY, WE DID NOT ADDRESS DENTAL HEALTH OR MOTOR VEHICLE ACCIDENTS  
BECAUSE THESE ISSUES WERE DEEMED LOWER PRIORITY BY THE COMMUNITY  
COALITION AND BECAUSE THEY ARE OUTSIDE THE SCOPE OF CURRENT KHI  
OPERATIONS.

**Part V Facility Information (continued)**

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

SCHEDULE H, PART V, SECTION B, LINE 16A - 16C

DIRECT URL FOR FAP POLICY, AND PLAN LANGUAGE SUMMARY:

<HTTPS://AZKPMC.ELLUCID.COM/DOCUMENTS/VIEW/2507/?SECURITY=D3F302E5C4B6592FA>

FD6426CQ38D133E69A18E9B

DIRECT URL FOR FAP APPLICATION FORM:

<HTTPS://AZKPMC.ELLUCID.COM/DOCUMENTS/VIEW/2896/?SECURITY=10BBCD6BCFBE5E62B>

384D66A5BA639BECD1790AB

SCHEDULE H, PART V, SECTION B, LINE 16I

TRANSLATION OF FAP INTO PRIMARY LANGUAGE SPOKEN BY LEP POPULATIONS:

KINGMAN HOSPITAL, INC., HAS TRANSLATED THE FAP INTO SPANISH AND HAS PROVIDED THE POLICY IN PAPER AND ON THEIR WEBSITE. KINGMAN HOSPITAL, INC., WOULD CONSIDER TRANSLATING INTO ANOTHER LANGUAGE WHEN IT IS KNOWN THAT PATIENTS WILL NEED THE TRANSLATION AND ARE NOT SERVED BY THE CURRENT FORMS AND STATEMENTS. KINGMAN HOSPITAL, INC. USES DEMOGRAPHIC DATA FROM THEIR SYSTEM AND THE COUNTIES TO DETERMINE IF A PATIENT POPULATION EXISTS THAT IS OVER 1,000 INDIVIDUALS THAT DO NOT SPEAK ENGLISH OR SPANISH.

SCHEDULE H, PART V, SECTION B, LINE 22B

KINGMAN REGIONAL MEDICAL CENTER WILL NOT CHARGE PATIENTS WHO ARE ELIGIBLE FOR FINANCIAL ASSISTANCE MORE FOR EMERGENCY CARE THAN THE AMOUNTS GENERALLY BILLED (AGB) TO INSURED PATIENTS. AGB IS CALCULATED USING THE "LOOK-BACK" METHOD BASED ON CLAIMS SENT TO MEDICARE FEE-FOR-SERVICE AND ALL PRIVATE COMMERCIAL INSURERS FOR EMERGENCY AND MEDICALLY NECESSARY

**Part V Facility Information** (continued)

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

CARE.

**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? 29

Name and address	Type of Facility (describe)
<b>1</b> OUTPATIENT IMAGING CENTER 1033 SYCAMORE KINGMAN AZ 86409	IMAGING CENTER
<b>2</b> KINGMAN CARDIOVASCULAR ASSOC 1739 BEVERLY AVE. SUITE 217 KINGMAN AZ 86409	CARDIOLOGY PHYSICIANS
<b>3</b> KINGMAN UROLOGY CLINIC 1712 SYCAMORE KINGMAN AZ 86409	UROLOGIST
<b>4</b> GME RESIDENT CLINIC 2202 STOCKTON HILL RD SUITE 101 KINGMAN AZ 86401	FAMILY MEDICINE
<b>5</b> KINGMAN ENT CLINIC 1739 BEVERLY AVE. SUITE 108 KINGMAN AZ 86409	EAR, NOSE & THROAT PHYSICIANS
<b>6</b> KINGMAN PULMONARY CLINIC 1739 BEVERLY AVE. SUITE 203 KINGMAN AZ 86409	PULMONARY MEDICINE
<b>7</b> MOHAVE SURGICAL SPECIALISTS 3104 STOCKTON HILL ROAD KINGMAN AZ 86401	GENERAL SURGEON
<b>8</b> KRMC CARDIOTHORACIC SURGERY 1739 BEVERLY AVE. SUITE 218 KINGMAN AZ 86409	CARDIOTHORACIC SURGEON
<b>9</b> KINGMAN ORTHOPEDICS 1739 BEVERLY AVE. SUITE 102 KINGMAN AZ 86409	ORTHOPEDIC PHYSICIANS
<b>10</b> HIGH DESERT GASTROENTEROLGY 1739 BEVERLY AVE. SUITE 101 KINGMAN AZ 86409	GASTROENTEROLOGIST

Schedule H (Form 990) 2017

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

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

Name and address	Type of Facility (describe)
1 KINGMAN FAMILY PRACTICE 1739 BEVERLY AVE. SUITE 209 KINGMAN AZ 86409	FAMILY MEDICINE
2 HILLCREST SURGICAL 3939 STOCKTON HILL ROAD KINGMAN AZ 86409	GENERAL SURGEON
3 EMPLOYEE & OCCUPATIONAL HEALTH 1739 BEVERLY AVE. SUITE 118 KINGMAN AZ 86409	OCCUPATIONAL MEDICINE
4 KRMC PRIMARY CARE 2226 HUALAPAI MTN ROAD KINGMAN AZ 86401	PRIMARY CARE PHYSICIANS
5 GOLDEN VALLEY CLINIC 4995 W. HWY 68 GOLDEN VALLEY AZ 86413	FAMILY MEDICINE
6 SUNSHINE CANYON HEALTHCARE 2202 STOCKTON HILL RD SUITE 100 KINGMAN AZ 86401	FAMILY MEDICINE
7 KINGMAN OB/GYN ASSOCIATES 1739 BEVERLY AVE. SUITE 200 KINGMAN AZ 86409	OBSTETRICS/GYNECOLOGY
8 KRMC URGENT CARE 1726 BEVERLY AVE KINGMAN AZ 86401	URGENT CARE
9 KRMC PRE-OP CLINIC 1739 BEVERLY AVE. SUITE 103 KINGMAN AZ 86409	PRE-OP CARE FACILITY
10 POST HOSPITAL CARE CLINIC 3116 STOCKTON HILL ROAD KINGMAN AZ 86409	POST HOSPITAL CARE

Schedule H (Form 990) 2017

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

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

Name and address			Type of Facility (describe)
1	KRMC PHYSIATRY 3801 SANTA ROSA KINGMAN AZ 86401		PHYSICAL MEDICINE & REHAB
2	KINGMAN RHEUMATOLOGY 1739 BEVERLY AVE. SUITE 209 KINGMAN AZ 86409		RHEUMATOLOGIST
3	JOSHUA TREE PEDIATRICS 1739 BEVERLY AVE. SUITE 204 KINGMAN AZ 86409		PEDIATRICIAN
4	KRMC DISEASE MANAGEMENT CLINIC 3801 SANTA ROSA KINGMAN AZ 86401		DISEASE MANAGEMENT
5	KRMC PAIN MANAGEMENT CLINIC 3801 SANTA ROSA KINGMAN AZ 86409		PAIN MANAGEMENT
6	KRMC HOSPICE 3269 STOCKTON HILL ROAD KINGMAN AZ 86409		HOSPICE SERVICES
7	KRMC HUALAPAI CAMPUS 3801 SANTA ROSA KINGMAN AZ 86401		ACUTE REHABILITATION
8	BEHAVIORAL HEALTH INTEGRATION 3801 SANTA ROSA KINGMAN AZ 86401		BEHAVIORAL HEALTH
9	OUTPATIENT NUTRITION & DIABETES EDUC. 3801 SANTA ROSA SUITE D KINGMAN AZ 86401		NUTRITION EDUCATION
10			

Schedule H (Form 990) 2017

**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

SCHEDULE H, PART I, LINE 7

THE ORGANIZATION USED A COST-TO-CHARGE RATIO FOR LINES 7A AND 7B. THE  
COST-TO-CHARGE RATIO WAS DERIVED FROM WORKSHEET 2, RATIO OF PATIENT CARE  
COST-TO-CHARGES.

THE INFORMATION FOR LINES 7E THROUGH 7I WAS DERIVED FROM INFORMATION IN  
THE GENERAL LEDGER AND OTHER FINANCIAL DATA RELATED SPECIFICALLY TO THE  
VARIOUS TYPES OF COMMUNITY BENEFITS.

SCHEDULE H, PART I, LINE 7, COLUMN (F)

BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25 BUT EXCLUDED FOR  
PURPOSES OF CALCULATING PERCENTAGES IN THIS COLUMN EQUAL \$17,762,539.

SCHEDULE H, PART III, SECTION A, LINE 2

THE MEDICAL CENTER ANALYZES ITS PAST HISTORY AND IDENTIFIES TRENDS FOR  
EACH OF ITS MAJOR PAYER SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE  
ALLOWANCE FOR DOUBTFUL ACCOUNTS AND PROVISION FOR UNCOLLECTIBLE ACCOUNTS

**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

SCHEDULE H, PART III, SECTION A, LINE 3

THE ORGANIZATION DOES NOT CONSIDER ANY OF ITS BAD DEBT EXPENSE TO BE ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY.

SCHEDULE H, PART III, SECTION A, LINE 4

THE FOOTNOTE TO THE ORGANIZATION'S FINANCIAL STATEMENTS THAT DESCRIBES BAD DEBT EXPENSES IS LOCATED IN FOOTNOTE 1 ON PAGE 10 OF THE ATTACHED FINANCIAL STATEMENTS.

SCHEDULE H, PART III, SECTION B, LINE 8

THE ORGANIZATION IS A SOLE COMMUNITY NOT-FORPROFIT HOSPITAL THAT PROVIDES HEALTHCARE SERVICES TO COMMUNITY RESIDENTS AND VISITORS IN A RURAL SETTING WITH LIMITED ACCESS TO SPECIALIST CARE. ACCESSIBLE, HIGH-QUALITY HEALTHCARE SERVICE IS IMPORTANT FOR THE OVERALL HEALTH OF ALL RESIDENTS AND NOT FULLY AVAILABLE IN MOST RURAL SETTINGS. WHERE MEDICARE IS CALCULATED TO PAY AT EXPECTED COST, RURAL CARE IS OFTEN MORE EXPENSIVE AS PATIENTS TEND TO HAVE A HIGHER THAN AVERAGE ACUITY AND LENGTH OF STAY DUE

**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
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- 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

TO LIMITED SPECIALIST CARE IN THE TREATMENT AND PATIENT CARE FOLLOW UP  
PROCESS.

ADDITIONALLY, PATIENT VOLUMES ARE MORE RESTRICTED AND SEASONALLY IMPACTED  
IN RURAL SETTINGS AS COMPARED TO METROPOLITAN SETTINGS, WHICH AFFECTS THE  
HOSPITAL'S OPPORTUNITY TO SPREAD THE FIXED COSTS OVER MORE PATIENT CARE  
EXPERIENCES. ALSO RELATIVE TO THE SEASONAL PATIENT FLUCTUATIONS, RURAL  
HOSPITALS TEND TO HAVE A HIGHER NEED FOR AGENCY TRAVEL NURSES TO  
SUPPLEMENT THE HIGHER CENSUS TIMES WHICH IS 40% HIGHER COSTS THAN  
EMPLOYED STAFF. PHYSICIAN RECRUITMENT IS ALSO A MAJOR CHALLENGE FOR SOLE  
COMMUNITY PROVIDERS AND THEREFORE MUST UTILIZE LOCUM TENENS PHYSICIANS AT  
A MUCH HIGHER COST THAN EMPLOYED PHYSICIANS. MEDICARE SHORTFALLS IN RURAL  
SETTINGS REFLECT THE EXCESS COST OF REQUIRED CARE OVER THE CALCULATED  
AVERAGE EXPECTED COST FOR PARTICIPANTS IN THE MEDICARE PROGRAM. FOR THESE  
REASONS, MEDICARE SHORTFALLS SHOULD BE CONSIDERED PART OF THE COMMUNITY  
BENEFIT PROVIDED.

**Part VI Supplemental Information**

Provide the following information

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- 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

SCHEDULE H, PART III, SECTION C, LINE 9B

ONCE THE PATIENT IS BILLED AND CONTACTED, THEY ARE INFORMED OF OPTIONS AND OF THE FINANCIAL ASSISTANCE POLICY (FAP). THE OTHER OPTIONS INCLUDE PAYING UP FRONT OR NO INTEREST PAYMENTS WITHIN A SCHEDULED NUMBER OF DAYS. A CASH DISCOUNT IS AVAILABLE TO THE PATIENT. IF QUALIFIED FOR THE FAP, THE APPROPRIATE QUALIFYING AMOUNT IS ADJUSTED TO CHARITY CARE. IF A BALANCE REMAINS THAT DOES NOT QUALIFY, THE PATIENT HAS CASH DISCOUNT AND NO INTEREST PAYMENT PLAN AS DESCRIBED ABOVE. FOR PATIENTS THAT THE HOSPITAL IS UNABLE TO CONTACT:

- EIGHT ACCOUNT STATEMENTS ARE SENT.
- THREE LETTERS EXPLAINING THAT IF THE PATIENT FAILS TO CONTACT PATIENT FINANCIAL SERVICES, COLLECTION EFFORTS WILL BE PASSED TO AN AGENCY.

THE ABOVE IS A MINIMUM OF 120 DAY PROCESS FOR ALL PATIENT PAYER TYPES. ONCE THE PATIENT ACCOUNT IS SUBMITTED TO A COLLECTION AGENCY, IT IS ADJUSTED TO BAD DEBT.

**Part VI Supplemental Information**

Provide the following information

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- 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

SCHEDULE H, PART VI, LINE 2

NEEDS ASSESSMENT:

SINCE 2011, KRMC, IN PARTNERSHIP WITH THE MOHAVE COUNTY DEPARTMENT OF PUBLIC HEALTH, HAS LED A MAJOR COMMUNITY INITIATIVE TO IMPROVE HEALTH AND QUALITY OF LIFE IN MOHAVE COUNTY. THE MOHAVE COUNTY COMMUNITY HEALTH IMPROVEMENT INITIATIVE INVOLVES PERFORMING A COMMUNITY HEALTH ASSESSMENT AND DEVELOPING A COMMUNITY HEALTH IMPROVEMENT PLAN EVERY THREE YEARS. A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) FOR MOHAVE COUNTY WAS COMPLETED IN THE SPRING OF 2016 AND THE FINDINGS ARE DOCUMENTED IN THE COMMUNITY HEALTH PROFILE FOR MOHAVE COUNTY, ARIZONA, WHICH DETAILS HEALTH AND WELLNESS STATISTICS AND COMMUNITY NEEDS FOR HEALTH SERVICES IN MOHAVE COUNTY COMMUNITIES.

ADDITIONALLY, KRMC DEVELOPED GOALS AND STRATEGIES FOR ADDRESSING THE PRIORITY HEALTH ISSUES IDENTIFIED IN THE COMMUNITY HEALTH ASSESSMENT, WHICH ARE DOCUMENTED IN THE KINGMAN REGIONAL MEDICAL CENTER IMPLEMENTATION PLAN FOR THE MOHAVE COUNTY COMMUNITY HEALTH IMPROVEMENT INITIATIVE. THE CHNA AND IMPLEMENTATION PLAN ARE AVAILABLE FOR THE PUBLIC

**Part VI Supplemental Information**

Provide the following information

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7, Part II and Part III, lines 2, 3, 4, 8 and 9b
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ON THE KRMC WEBSITE [HTTP://WWW.AZKRMC.COM](http://www.azkrmc.com)

SCHEDULE H, PART VI, LINE 3

PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE:

KRMC HAS POLICIES ONLINE TO EXPLAIN OUR FAP APPLICATION AS WELL AS ON OUR STATEMENTS. THERE IS INFORMATION ABOUT THE AFFORDABLE CARE ACT DURING OPEN ENROLLMENT AND WE PROVIDE A FAIR TO ASSIST. PUBLIC RELATIONS SENDS OUT ADS AS WELL AS POSTING ON TWITTER AND FACEBOOK. EACH PATIENT SERVICE REPRESENTATIVE HAS BEEN EDUCATED ABOUT OUR ASSISTANCE PROGRAMS AS WELL. WE ALSO HAVE A VENDOR ON SITE TO ASSIST WITH AHCCCS AND OTHER PROGRAMS FOR ASSISTANCE.

SCHEDULE H, PART VI, LINE 4

COMMUNITY INFORMATION:

KRMC SERVES AN APPROXIMATE 1500 SQUARE MILE GEOGRAPHIC AREA IN MOHAVE COUNTY ARIZONA, CALLED HOSPITAL DISTRICT #1 OF MOHAVE COUNTY. THE DISTRICT INCLUDES THE CITY OF KINGMAN (POP. 29,742) AND NUMEROUS SMALLER OUTLYING COMMUNITIES. THE TOTAL ESTIMATED POPULATION OF THE DISTRICT IS

**Part VI Supplemental Information**

Provide the following information

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79,000, WITH AN ESTIMATED 11.6 PERSONS PER SQUARE MILE.

ACCORDING TO THE LATEST STATISTICS OF THE U.S. CENSUS BUREAU, THE RACIAL MIX OF THE POPULATION IS 78.3% CAUCASIAN, 1.5% AFRICAN AMERICAN, 3.4% NATIVE AMERICAN AND 13% HISPANIC OR LATINO ORIGIN. U.S. CENSUS BUREAU STATISTICS FOR 2018 SHOW 19.4% OF MOHAVE COUNTY'S POPULATION IS 100% BELOW THE FEDERAL POVERTY LEVEL. THE MEDIAN HOUSEHOLD INCOME IS \$44,092.00. THE CURRENT UNEMPLOYMENT RATE IN MOHAVE COUNTY IS 10.4% (AS OF JUNE 2018). APPROXIMATELY 87.2% OF THE COUNTY'S POPULATION OVER AGE 25 ARE HIGH SCHOOL GRADUATES, WITH 15.3% OF THE POPULATION OVER AGE 35 HOLDING A BACHELOR'S DEGREE OR HIGHER.

SCHEDULE H, PART VI, LINE 5

PROMOTION OF COMMUNITY HEALTH:

KINGMAN HOSPITAL INCORPORATED IS ORGANIZED EXCLUSIVELY FOR CHARITABLE, SCIENTIFIC, AND EDUCATIONAL PURPOSES RELATING TO HEALTHCARE IN HOSPITAL DISTRICT #1 OF MOHAVE COUNTY. ITS PRIMARY FUNCTION IS TO OPERATE KINGMAN REGIONAL MEDICAL CENTER (KRMC).

**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
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KRMC'S BOARD OF DIRECTORS CONSISTS OF 13 MEMBERS HOLDING TERMS OF THREE YEARS. ALL BOARD MEMBERS ARE COMMUNITY-MINDED INDIVIDUALS WHO DO NOT RECEIVE COMPENSATION FOR THEIR SERVICES ON THE KRMC BOARD. ALL EXCESS FUNDS ARE KEPT FOR THE BENEFIT AND DEVELOPMENT OF THE COMMUNITY'S HEALTH SERVICES AS DETERMINED BY OUR LOCAL BOARD. WITH THIS, OUR HOSPITAL AVERAGE INPATIENT CHARGES HAVE REMAINED SIGNIFICANTLY BELOW THE ARIZONA AVERAGE FOR THE SAME TYPES OF PATIENTS. ADDITIONALLY, EXCESS FUNDS ACCUMULATED SINCE KRMC WAS ORGANIZED, HAVE BEEN UTILIZED TO PAY CAMPUS EXPANSION / IMPROVEMENTS, STATE-OF-THE-INDUSTRY TECHNOLOGY, AND COMPETITIVE SALARIES FOR EMPLOYEES.

KRMC CONTINUALLY INVESTS IN ADVANCED MEDICAL TECHNOLOGIES. FROM SPECIALIZED DIAGNOSTIC CAPABILITIES TO ADVANCED TREATMENTS IN CARDIAC CARE AND CANCER, PATIENTS AT KRMC BENEFIT FROM SOME OF THE MOST SOPHISTICATED MEDICAL TECHNOLOGIES IN THE REGION. IN 2007, KRMC RECEIVED THE GOVERNOR'S ARIZONA INNOVATION AWARD IN RECOGNITION FOR ITS INVESTMENT IN TECHNOLOGY AND SERVICES NOT NORMALLY SEEN IN A RURAL COMMUNITY.

**Part VI Supplemental Information**

Provide the following information

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KRMC IS A MAJOR COMMUNITY PARTNER DEDICATED TO ENHANCING THE OVERALL QUALITY-OF-LIFE IN NORTHWEST ARIZONA. WE OFFER MANY SERVICES AND PROGRAMS TO BENEFIT THE COMMUNITY, ESPECIALLY OUR MOST VULNERABLE CITIZENS- CHILDREN, ELDERLY, THOSE IN ILL HEALTH, AND THOSE IN SOCIO-ECONOMIC DISTRESS. EXAMPLES OF OUR COMMUNITY BUILDING ACTIVITIES INCLUDE:

- CONDUCTING PUBLIC HEALTH LECTURES AT THE HOSPITAL AND AT AREA NURSING HOMES AND BUSINESSES (MONTHLY).
- CONDUCTING HEALTH FAIRS, WHICH ARE FREE AND OPEN TO THE PUBLIC (8 HEALTH FAIRS PER YEAR) - OFFERING A VARIETY OF FREE SUPPORT GROUPS TO HELP PEOPLE WHO ARE WORKING TO CHANGE A BEHAVIOR OR WHO ARE DEALING WITH A LOSS, CONDITION, OR DISEASE.
- PUBLISHING A QUARTERLY 8-PAGE NEWSLETTER (CALLED HEALTHWISE), WHICH CONTAINS IMPORTANT HEALTH INFORMATION FOR THE PUBLIC. THE NEWSLETTER IS FREE AND DISTRIBUTED THROUGHOUT NORTHWEST ARIZONA.
- PROVIDING FREE GROWTH MATS AND CAR SEATS FOR BABIES BORN AT KRMC.
- SPONSORING PHYSICAL FITNESS PROGRAMS AT COMMUNITY ELEMENTARY SCHOOLS TO

**Part VI Supplemental Information**

Provide the following information

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HELP KIDS BE ACTIVE, FIT, AND HEALTHY.

- PLACING DEFIBULATORS IN OUR COMMUNITY'S HIGH

-TRAFFIC PUBLIC PLACES TO PROVIDE IMMEDIATE LIFESAVING TREATMENT TO

SOMEONE WITH CARDIAC ARREST.

- PROVIDING FREE OR LOW COST MAMMOGRAMS TO UNINSURED OR UNDERINSURED

WOMEN RESIDING IN THE HOSPITAL DISTRICT OF MOHAVE COUNTY.

- PROVIDING SCHOLARSHIPS FOR QUALIFIED INDIVIDUALS WHO CANNOT AFFORD A  
MEMBERSHIP TO KRMC'S DEL E. WEBB WELLNESS CENTER.

- PROVIDING SCHOLARSHIPS TO HELP NURSING STUDENTS WITH THEIR EDUCATIONAL  
COSTS.

- PROVIDING CASH CONTRIBUTIONS, FREE SERVICES, OR OTHER SUPPORT TO OVER  
40 LOCAL ORGANIZATIONS THAT SERVE THE NEEDS OF OUR COMMUNITY (E.G., BOYS  
AND GIRLS CLUB, KINGMAN FOOD BANK, SARAH'S HOUSE, ETC.).

- HELPING UNINSURED/UNDERINSURED PATIENTS WITH THEIR HEALTHCARE COSTS  
THROUGH KRMC'S CHARITY CARE PROGRAM.

ADDITIONALLY, KRMC IS ONE OF THE AREA'S LARGEST CONTRIBUTORS TO THE LOCAL  
ECONOMY. WE EMPLOY OVER 1800 PEOPLE AND DURING THE PAST YEAR SPENT OVER

**Part VI Supplemental Information**

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\$10,000,000 WITH LOCAL BUSINESSES.

SCHEDULE I  
(Form 990)

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.

Department of the Treasury  
Internal Revenue Service

OMB No 1545-0047

2017

Open to Public  
Inspection

Name of the organization

KINGMAN HEALTHCARE, INC.

Employer identification number

94-2916102

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

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
(1) BOYS & GIRLS CLUB OF KINGMAN 301 N 1ST STREET KINGMAN, AZ 86401	86-0743950	501(C)(3)	15,000				PROVIDES EDUCATION & MEALS TO CHILDREN
(2) CORNERSTONE MISSION 3049 SYCAMORE KINGMAN, AZ 86409	86-0960036	501(C)(3)	14,500				HOMELESS SHELTER FOR MEN
(3) ARIZONA YOUTH PARTNERSHIP 1902 PACIFIC AVE KINGMAN, AZ 86401	86-0669087	501(C)(3)	6,000				SUPPORT HOMELESS SHELTER FOR TEENAGE
(4) KINGMAN AID TO ABUSED PEOPLE 1770 AIRWAY AVE KINGMAN, AZ 86409	86-0601113	501(C)(3)	24,000				SUPPORT FOR SHELTER FOR ABUSED PEOPLE
(5) KINGMAN CANCER CARE P O BOX 3014 KINGMAN, AZ 86402	86-0753651	501(C)(3)	10,000				ASSISTS CANCER PATIENTS
(6) KATHERINE HEIDENREICH ADULT CENTER 1776 AIRWAY AVE KINGMAN, AZ 86401	86-0397271	501(C)(3)	15,000				TRANSPORTATION AND MEALS FOR ELDERLY
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							

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

7

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

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

Schedule I (Form 990) (2017)

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

	(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
1	SCHOLARSHIPS	101	487,075			
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

SCHEDULE I, PART I, LINE 2

ORGANIZATION'S PROCEDURES FOR MONITORING THE USE OF GRANT FUNDS:

FUND USAGE IS PREDETERMINED BY THE BOARD OF DIRECTORS OF KINGMAN REGIONAL MEDICAL CENTER (KRMC). SCHOLARSHIPS ARE PROVIDED TO STUDENTS IN THE U.S.

FOR TUITION AND RELATED EDUCATIONAL EXPENSES ONLY.

**SCHEDULE J  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

Name of the organization

KINGMAN HEALTHCARE, INC.

**Compensation Information**

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

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

▶ Attach to Form 990.

▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information

OMB No 1545-0047

**2017**

**Open to Public  
Inspection**

Employer identification number

94-2916102

**Part I Questions Regarding Compensation**

**1a** Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items

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

**b** If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain

**2** Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked on line 1a?

**3** Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III

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

**4** During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization

- a** Receive a severance payment or change-of-control payment? . . . . .
- b** Participate in, or receive payment from, a supplemental nonqualified retirement plan? . . . . .
- c** Participate in, or receive payment from, an equity-based compensation arrangement? . . . . .
- If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III

**Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.**

**5** For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of

- a** The organization? . . . . .
- b** Any related organization? . . . . .
- If "Yes" on line 5a or 5b, describe in Part III

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

- a** The organization? . . . . .
- b** Any related organization? . . . . .
- If "Yes" on line 6a or 6b, describe in Part III

**7** For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described on lines 5 and 6? If "Yes," describe in Part III. . . . .

**8** 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 . . . . .

**9** If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)? . . . . .

	Yes	No
1a		
1b		
2		
3		
4a		X
4b		X
4c		X
5a		X
5b		X
6a	X	
6b		X
7		X
8		X
9		

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

Schedule J (Form 990) 2017

Schedule J (Form 990) 2017

Page 2

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

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

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

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation				(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation	(iv) Other reportable compensation				
1 ROBERT MATHENY, MD	(i) 680,087.	0.	0.	30,462.	16,200.	31,417.	758,166.	
2 DIRECTOR	(ii) 0.	0.	0.	0.				
DENNIS DUNNING	(i) 735,243.	406,208.	0.	0.	16,200.	22,645.	1,180,296.	
3 PHYSICIAN	(ii) 0.	0.	0.	0.				
ALAIN ASHER	(i) 791,441.	0.	0.	18,000.	5,503.	23,435.	838,379.	
4 PHYSICIAN	(ii) 0.	0.	0.	0.				
JACOB OLDHAM	(i) 651,641.	38,396.	18,000.	0.	7,980.	1,637.	717,654.	
5 PHYSICIAN	(ii) 0.	0.	0.	0.				
JAMAL AL-KHATIB	(i) 624,225.	190,977.	0.	0.	8,100.	32,348.	855,650.	
6 PHYSICIAN	(ii) 0.	0.	0.	0.				
BRIAN TURNEY	(i) 641,991.	18,000.	18,000.	0.	16,200.	28,023.	722,214.	
7 CHIEF EXECUTIVE OFFICER	(ii) 0.	0.	0.	0.				
KIM MIYAUCHI	(i) 191,887.	14,701.	0.	0.	8,560.	18,490.	233,638.	
8 CHIEF NURSING OFFICER	(ii) 0.	0.	0.	0.				
RYAN KENNEDY	(i) 226,764.	0.	0.	0.	10,115.	23,165.	260,044.	
9 CHIEF OPERATING OFFICER	(ii) 0.	0.	0.	0.				
THOMAS GAUGHAN	(i) 332,350.	25,955.	18,000.	0.	8,651.	23,528.	408,484.	
10 CHIEF MEDICAL OFFICER	(ii) 0.	0.	0.	0.				
TIMOTHY BLANCHARD	(i) 298,803.	17,534.	0.	0.	13,417.	28,984.	358,738.	
11 CHIEF FINANCIAL OFFICER	(ii) 0.	0.	0.	0.				
STAN ALLEN	(i) 648,910.	0.	38,942.	0.	16,200.	19,397.	723,449.	
12 PHYSICIAN	(ii) 0.	0.	0.	0.				
13	(i) 0.	0.	0.	0.				
14	(ii) 0.	0.	0.	0.				
15	(i) 0.	0.	0.	0.				
16	(ii) 0.	0.	0.	0.				

Schedule J (Form 990) 2017

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**Part III Supplemental Information**

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

SCHEDULE J, PART I, LINE 6A

COMPENSATION CONTINGENT ON NET EARNINGS OF THE ORGANIZATION:

EMPLOYED PHYSICIANS ARE ELIGIBLE FOR BONUSES BASED ON EITHER REVENUES OR

BUSINESS LINE INCOME DEPENDING ON THEIR INDIVIDUAL EMPLOYMENT CONTRACTS.

**SCHEDULE K  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

Name of the organization

KINGMAN HEALTHCARE, INC.

ARIZONA INDUSTRIAL DEVELOPMENT AUTHORITY

**Supplemental Information on Tax-Exempt Bonds**

► Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.

► Attach to Form 990.

► Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No 1545-0047

**2017**

Open to Public  
Inspection

Employer identification number

94-2916102

**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) Pooled financing
						Yes	No	Yes	No	Yes
<b>A</b> ARIZONA INDUSTRIAL DEVELOPMENT AUTHORITY	81-3526584		03/31/2017	20,000,000	CAPITAL PROJECTS		X		X	X
<b>B</b> ARIZONA INDUSTRIAL DEVELOPMENT AUTHORITY	81-3526584		12/29/2017	20,000,000	CAPITAL PROJECTS		X		X	X
<b>C</b>										
<b>D</b>										

**Part II Proceeds**

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Amount of bonds retired . . . . .		3,350,516.		889,352.				
2 Amount of bonds legally defeased . . . . .								
3 Total proceeds of issue . . . . .		20,000,000.		20,000,000.				
4 Gross proceeds in reserve funds . . . . .								
5 Capitalized interest from proceeds . . . . .								
6 Proceeds in refunding escrows . . . . .								
7 Issuance costs from proceeds . . . . .		103,200.		89,500.				
8 Credit enhancement from proceeds . . . . .								
9 Working capital expenditures from proceeds . . . . .								
10 Capital expenditures from proceeds . . . . .		16,436,713.		15,967,865.				
11 Other spent proceeds . . . . .								
12 Other unspent proceeds . . . . .		3,460,087.		3,942,635.				
13 Year of substantial completion . . . . .		2018		2018				
14 Were the bonds issued as part of a current refunding issue? . . . . .	Yes	No	Yes	No	Yes	No	Yes	No
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

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**Part III Private Business Use (Continued)**

## ARIZONA INDUSTRIAL DEVELOPMENT AUTHORITY

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
<b>3a</b> Are there any management or service contracts that may result in private business use of bond-financed property? . . . . .		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? . . . . .								
<b>c</b> Are there any research agreements that may result in private business use of bond-financed property? . . . . .		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				
<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				
<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					

**Part IV Arbitrage**

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

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Part IV Arbitrage (Continued)

5a Were gross proceeds invested in a guaranteed investment contract (GIC)?

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

Part V Procedures To Undertake Corrective Action

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 isn't available under applicable regulations?

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
	X		X					

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

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

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

KINGMAN HEALTHCARE, 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

94-2916102

FORM 990, PART VI, SECTION B, LINE 11B

PROCESS TO REVIEW THE FORM 990:

THE FORM 990 IS PREPARED BY A THIRD PARTY PREPARER WITH A DETAIL REVIEW  
BEING CONDUCTED BY THE GENERAL ACCOUNTING MANAGER AND ACCOUNTANT OF THE  
ORGANIZATION. A FINAL COPY OF THE FORM 990 IS THEN E-MAILED TO THE BOARD  
OF DIRECTORS BEFORE THE RETURN IS FILED WITH THE IRS.

FORM 990, PART VI, SECTION B, LINE 12C

PROCESS FOR MONITORING COMPLIANCE WITH CONFLICT OF INTEREST POLICY:

THE EXECUTIVE ASSISTANT TO THE CEO ANNUALLY DISTRIBUTES THE POLICY  
DOCUMENTS AND FORMS TO ALL MANAGERS AND BOARD MEMBERS. THE RELATED FORMS  
CONTAIN WRITTEN EXPLANATIONS BY MANAGERS AND BOARD MEMBERS. IF A  
POTENTIAL CONFLICT ARISES, THE SITUATION IS THEN REVIEWED BY THE CEO. IF  
A CONFLICT OF INTEREST COVERED BY THIS POLICY EXISTS, WHETHER OR NOT  
LISTED ON A DISCLOSURE FORM, THEN THE PERSON INVOLVED WITH THE POTENTIAL  
CONFLICT OF INTEREST RECUSES THEMSELF FROM VOTING ON THE MATTER.

FORM 990, PART VI, SECTION B, LINE 15A

REVIEW OF CEO OR TOP MGMT OFFICIAL COMPENSATION:

A BENEFITS AND COMPENSATION ANALYST PREPARES A STUDY BASED ON EXTERNAL  
COMPARISONS OF SIMILAR POSITIONS IN SIMILAR SIZED ORGANIZATIONS IN THE  
INDUSTRY. THE STUDY IS REVIEWED BY A COMPENSATION COMMITTEE THEN  
SUBMITTED TO THE EXECUTIVE BOARD FOR FINAL APPROVAL. CONTEMPORANEOUS  
DOCUMENTATION AND RECORDKEEPING WITH RESPECT TO DELIBERATIONS AND

Name of the organization

KINGMAN HEALTHCARE, INC.

Employer identification number

94-2916102

DECISIONS REGARDING THE COMPENSATION PROCESS ARE KEPT ON FILE. THIS STUDY  
IS CONDUCTED ANNUALLY.

FORM 990, PART VI, SECTION B, LINE 15B

REVIEW OF OTHER OFFICER OR KEY EMPLOYEES COMPENSATION:

A BENEFITS AND COMPENSATION ANALYST PREPARES A STUDY BASED ON EXTERNAL  
COMPARISONS OF SIMILAR POSITIONS IN SIMILAR SIZED ORGANIZATIONS IN THE  
INDUSTRY. THE STUDY IS REVIEWED BY A COMPENSATION COMMITTEE THEN  
SUBMITTED TO THE KHI BOARD OF DIRECTORS FOR FINAL APPROVAL.

CONTEMPORANEOUS DOCUMENTATION AND RECORDKEEPING WITH RESPECT TO  
DELIBERATIONS AND DECISIONS REGARDING THE COMPENSATION PROCESS ARE KEPT  
ON FILE. THIS STUDY IS CONDUCTED ANNUALLY.

FORM 990, PART VI, SECTION C, LINE 19

DESCRIBE HOW GOVERNING DOCUMENTS ARE MADE AVAILABLE TO THE PUBLIC:

THE ORGANIZATION MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST  
POLICY AND FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC UPON REQUEST FOR  
A VALID BUSINESS PURPOSE.

FORM 990, PART XI, LINE 9

OTHER CHANGES IN NET ASSETS:

CHANGE IN NET ASSETS OF KRMC FOUNDATION 99,190

Name of the organization

KINGMAN HEALTHCARE, INC.

Employer identification number

94-2916102

ATTACHMENT 1FORM 990, PART III - PROGRAM SERVICE, LINE 4A

MOHAVE COUNTY IS ONE OF THE FASTEST GROWING COUNTIES IN ARIZONA. THE AREA AROUND KINGMAN WHICH IS THE COUNTY SEAT IS EXPECTED TO CONTINUE GROWING STEADILY IN THE COMING YEARS. IN RESPONSE TO THE GROWTH, KINGMAN REGIONAL MEDICAL CENTER (KPMC) HAS CONTINUED TO EXPAND ITS SERVICES. WE NOW OFFER A FULL RANGE OF HEALTH AND WELLNESS SERVICES, INCLUDING A WELLNESS AND FITNESS CENTER, MULTIPLE PRIMARY CARE PHYSICIAN PRACTICES, ADVANCED MEDICAL PROGRAMS IN CARDIOLOGY, CANCER, AND REHABILITATION, AND HOME HEALTH AND HOSPICE CARE. MOREOVER, WE ARE HONORED TO SERVE AS A TEACHING HOSPITAL IN AFFILIATION WITH MIDWESTERN UNIVERSITY TO TRAIN DOCTORS SPECIALIZING IN FAMILY PRACTICE, AND EMERGENCY MEDICINE.

WITH THE GROWING POPULATION, WE ARE EXPERIENCING A HIGHER VOLUME OF SELF-PAY AND MEDICAID PATIENTS WHO ARE WAITING TO SEEK MEDICAL CARE UNTIL THE TIME THAT THEY MUST GO TO THE EMERGENCY ROOM. OUR MEDICAID POPULATION IS 20.6% OF OUR TOTAL PATIENT POPULATION. OUR MEDICARE POPULATION IS 57.2% OF TOTAL PATIENT POPULATION. MAJOR STRATEGIES TO ADDRESS IDENTIFIED NEEDS AND PROBLEMS INCLUDE:

- WE HAVE INCREASED RECRUITMENT EFFORTS OF RN'S, THERAPISTS AND SKILLED TECHNICIANS TO MEET THE GROWING NEEDS OF THE COMMUNITY.
- WE CONTINUE TO RECRUIT PHYSICIANS OF VARIOUS SPECIALTIES TO THE AREA.
- WE CONTINUE TO EXPAND OUR FACILITIES TO MEET THE NEEDS OF THE COMMUNITY.

KPMC IS COLLABORATING WITH COMMUNITY ORGANIZATIONS TO IMPROVE

Name of the organization

KINGMAN HEALTHCARE, INC.

Employer identification number

94-2916102

ATTACHMENT 1 (CONT'D)

COMMUNITY HEALTH, EXPAND ACCESS TO HEALTH CARE, OR IN OTHER WAYS

BENEFIT THE COMMUNITY. SOME EXAMPLES ARE:

- WE WORK WITH THE WOMEN'S HEALTH ORGANIZATION TO PROVIDE

DISCOUNTED MAMMOGRAPHY TO SELF-PAY PATIENTS.

- WE WORK WITH THE FOSTER GRANDPARENTS ASSOCIATION AND PROVIDE

FREE PHYSICAL EXAMS.

- WE PAY 50% AND WRITE OFF THE OTHER 50% FOR VICTIMS OF CRIME

COLLABORATING WITH THE MOHAVE COUNTY ATTORNEY'S OFFICE.

KRMC IS A TEACHING HOSPITAL WITH A GME PROGRAM IN ASSOCIATION WITH

MIDWESTERN UNIVERSITY. KRMC OPERATES SEVERAL PHYSICIAN PRACTICES

AND A CONTINUITY CLINIC. THERE ARE PLANS TO EXPAND THESE SERVICES

TO THE OUTLYING AREAS OF OUR COMMUNITY.

IN RECENT YEARS, KRMC HAS EXPANDED SERVICES TO INCLUDE SERVICES

THAT ARE NOT USUALLY FOUND IN A RURAL COMMUNITY SUCH AS;

INTERVENTIONAL CARDIOLOGY; CANCER DIAGNOSIS AND TREATMENT WITH A

STATE-OF-THE-ART CANCER CENTER (CLINICAL AND RADIATION ONCOLOGY);

A NEW OUTPATIENT IMAGING AND WOMEN'S HEALTH CENTER; ACUTE

REHABILITATION UNIT; CARDIAC SURGICAL UNIT FOR OPEN HEART SURGERY;

WOUND CARE AND HYPERBARIC CHAMBER THERAPY.

OUR UNCOMPENSATED CARE POLICY IS CALLED QUALIFYING DISCOUNT

PROGRAM. OUR PROGRAM IS DEFINED AS CHARITY CARE SERVICES PROVIDED

FOR WHICH PAYMENT IS NOT ANTICIPATED BECAUSE OF AN INABILITY TO

PAY, AND MAY APPLY TO AN ENTIRE ACCOUNT BALANCE OR A PORTION OF

IT. CHARITY CARE IS SEPARATE AND DISTINCT FROM BAD DEBTS, WHICH

ARE ACCOUNTS FOR WHICH CREDIT WAS EXTENDED AND PAYMENT IS

Name of the organization

KINGMAN HEALTHCARE, INC.

Employer identification number

94-2916102

ATTACHMENT 1 (CONT'D)

ANTICIPATED, BUT NOT RECEIVED. OUR QUALIFYING DISCOUNT PROGRAM IS BASED ON A PERCENTAGE OF THE FEDERAL POVERTY LEVEL. KRMC HAS UPDATED ITS CHARITY CARE POLICY TO INCLUDE THOSE PATIENTS WHOSE HOUSEHOLD INCOME IS UP TO 350% OF THE FEDERAL POVERTY LEVEL. THIS PROGRAM IS FOR ALL PATIENTS REGARDLESS OF THEIR PRIMARY INSURANCE STATUS AND IS BASED ON THEIR FAMILY SIZE AND INCOME FROM ALL SOURCES.

ORGANIZATIONAL DESCRIPTION FOR TAX EXEMPTION: KRMC OPERATES AN EMERGENCY DEPARTMENT THAT IS OPEN TO ALL PERSONS REGARDLESS OF THEIR ABILITY TO PAY AND COMPLIES WITH ALL EMTALA REGULATIONS. WE HAVE NOTICES IN THE EMERGENCY ROOM THAT INFORMS THE PATIENTS OF THIS FACT; OUR ADMISSIONS STAFF ADVISES ALL PATIENTS WHO PRESENT FOR SERVICES THAT WE ARE CALLING FOR A NURSE AND WILL PERFORM A MEDICAL SCREENING EXAM REGARDLESS OF THEIR ABILITY TO PAY. WE ASSIST THEM AFTER THE MEDICAL SCREENING EXAM WITH DES APPLICATIONS AND IN-SERVICE THEM ON OUR CHARITY PROGRAM IF SHOULD THEY HAVE AN INABILITY TO PAY. KRMC HAS AN OPEN MEDICAL STAFF WITH PRIVILEGES AVAILABLE TO ALL QUALIFIED PHYSICIANS IN THE AREA.

ATTACHMENT 2990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
HIGH DESERT RADIOLOGY 695 COUNTRY CLUB DRIVE KINGMAN, AZ 86402	RADIOLOGISTS	10,570,860.
MEDLIANT 969-G EDGEWATER BLVD. # 698	NURSE AGENCY	3,025,045.

Name of the organization KINGMAN HEALTHCARE, INC.	Employer identification number 94-2916102
--	--

ATTACHMENT 2 (CONT'D)990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
FOSTER CITY, CA 94404		
AMN HEALTHCARE P. O. BOX 281939 ATLANTA, GA 30384-1939	NURSE AGENCY	2,196,220.
LEIDOS HEALTH HOLDINGS INC P.O. BOX 22386 PITTSBURG, PA 15251-2866	CONSULTANTS	6,959,780.
T.R. ORR 3965 N. BANK STREET KINGMAN, AZ 86409	CONTRACTOR	2,311,060.

ATTACHMENT 3FORM 990, PART IX - OTHER FEES

<u>DESCRIPTION</u>	<u>(A) TOTAL FEES</u>	<u>(B) PROGRAM SERVICE EXP.</u>	<u>(C) MANAGEMENT AND GENERAL</u>	<u>(D) FUNDRAISING EXPENSES</u>
COLLECTION CLAIMS	636,076.	469,244.	166,832.	
CONSULTING	693,938.	548,211.	145,727.	
CONTRACTING SERVICES	13,333,924.	10,533,803.	2,800,121.	
EQUIPMENT SERVICE CONTRACTS	3,074,201.	2,428,617.	645,584.	
INSTRUCTOR FEES	59,742.	57,811.	1,931.	
NURSE REGISTRY	6,885,015.	6,885,015.		
PHYSICIAN FEES	14,916,346.	14,877,724.	38,622.	
RELAY HEALTH FEES	154,843.	154,843.		
RECRUITING	38,068.	30,074.	7,994.	
BILLING	67,130.	67,130.		
TESTING	788,798.	732,903.	55,895.	

Name of the organization  
KINGMAN HEALTHCARE, INC.

Employer identification number  
94-2916102

ATTACHMENT 3 (CONT'D)

FORM 990, PART IX - OTHER FEES

<u>DESCRIPTION</u>	(A) <u>TOTAL</u> <u>FEES</u>	(B) <u>PROGRAM</u> <u>SERVICE EXP.</u>	(C) <u>MANAGEMENT</u> <u>AND GENERAL</u>	(D) <u>FUNDRAISING</u> <u>EXPENSES</u>
TOTALS	<u>40,648,081.</u>	<u>36,785,375.</u>	<u>3,862,706.</u>	

**SCHEDULE R**  
**(Form 990)****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

Department of the Treasury  
Internal Revenue Service

Name of the organization

KINGMAN HEALTHCARE, INC.

▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information

Employer identification number

94-2916102

OMB No. 1545-0047

**2017**Open to Public  
Inspection**Part I Identification of Disregarded Entities.** Complete if the organization answered "Yes" on Form 990, Part IV, line 33

	(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)						
(2)						
(3)						
(4)						
(5)						
(6)						

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

	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?
							Yes No
(1)	NORTHWESTERN ARIZONA REGIONAL INSURANCE 20-8081486 4041 N CENTRAL AVE PHOENIX, AZ 85012	INSURER	AZ	501(C)(3)	LINE 12A	KRMC	X
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							

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Schedule R (Form 990) 2017

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(f) Share of total income	(g) Share of end-of- year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(u) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1)												
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?
(1)								Yes No
(2)								
(3)								
(4)								
(5)								
(6)								
(7)								

**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
<b>1a</b>		X
<b>1b</b>		X
<b>1c</b>		X
<b>1d</b>	X	
<b>1e</b>		X
<b>1f</b>		
<b>1g</b>		X
<b>1h</b>		X
<b>1i</b>		X
<b>1j</b>		X
<b>1k</b>		X
<b>1l</b>		X
<b>1m</b>	X	
<b>1n</b>		X
<b>1o</b>	X	
<b>1p</b>		X
<b>1q</b>		X
<b>1r</b>	X	
<b>1s</b>		X

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

	(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)	NORTHWESTERN ARIZONA REGIONAL INSURANCE	D	213,196.	INTERCO AMOUNT
(2)	NORTHWESTERN ARIZONA REGIONAL INSURANCE	M & R	2,539,940.	INTERCO AMOUNT
(3)				
(4)				
(5)				
(6)				

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners section 501(c)(3) organizations?		(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
				Yes	No			Yes	No		Yes	No	
(1)													
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
(9)													
(10)													
(11)													
(12)													
(13)													
(14)													
(15)													
(16)													

JSA

Schedule R (Form 990) 2017

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

Provide additional information for responses to questions on Schedule R. See instructions.