

Form **990**  
Department of the Treasury  
Internal Revenue Service

# Return of Organization Exempt From Income Tax

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

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

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

OMB No 1545-0047  
**2018**  
Open to Public Inspection

**A** For the **2019** calendar year, or tax year beginning **10-01-2018**, and ending **09-30-2019**

**B** Check if applicable:  
 Address change  
 Name change  
 Initial return  
 Final return/terminated  
 Amended return  
 Application pending

**C** Name of organization: COXHEALTH  
 % JACOB MCWAY  
 Doing business as

Number and street (or P O box if mail is not delivered to street address) Room/suite  
 1423 N JEFFERSON

City or town, state or province, country, and ZIP or foreign postal code  
 SPRINGFIELD, MO 65802

**D** Employer identification number: 47-1087427

**E** Telephone number: (417) 269-3000

**G** Gross receipts \$ 62,565,602

**F** Name and address of principal officer:  
 STEVE EDWARDS  
 1423 N JEFFERSON  
 SPRINGFIELD, MO 65802

**H(a)** Is this a group return for subordinates?  Yes  No  
**H(b)** Are all subordinates included?  Yes  No  
 If "No," attach a list (see instructions)  
**H(c)** Group exemption number ▶

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

**J** Website: ▶ WWW COXHEALTH COM

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

**L** Year of formation: 2013 **M** State of legal domicile: MO

## Part I Summary

**1** Briefly describe the organization's mission or most significant activities:  
 SUPPORTING ORGANIZATION FOR LESTER E COX MEDICAL CENTERS AND COX MEDICAL GROUP AS WELL AS OPERATIONS OF BARTON COUNTY HOSPITAL THROUGH ITS OWNERSHIP IN CBCH, LLC

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

<b>3</b> Number of voting members of the governing body (Part VI, line 1a)	28
<b>4</b> Number of independent voting members of the governing body (Part VI, line 1b)	22
<b>5</b> Total number of individuals employed in calendar year 2018 (Part V, line 2a)	242
<b>6</b> Total number of volunteers (estimate if necessary)	31
<b>7a</b> Total unrelated business revenue from Part VIII, column (C), line 12	0
<b>7b</b> 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)	33,139	47,599
<b>9</b> Program service revenue (Part VIII, line 2g)	15,419,800	23,471,018
<b>10</b> Investment income (Part VIII, column (A), lines 3, 4, and 7d)	29,327	31,825
<b>11</b> Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	93,268,880	39,015,160
<b>12</b> Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	108,751,146	62,565,602
<b>13</b> Grants and similar amounts paid (Part IX, column (A), lines 1-3)	27,724	0
<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)	10,204,898	13,690,293
<b>16a</b> Professional fundraising fees (Part IX, column (A), line 11e)	0	0
<b>b</b> Total fundraising expenses (Part IX, column (D), line 25) ▶ 0		
<b>17</b> Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	7,863,386	8,681,851
<b>18</b> Total expenses Add lines 13-17 (must equal Part IX, column (A), line 25)	18,096,008	22,372,144
<b>19</b> Revenue less expenses Subtract line 18 from line 12	90,655,138	40,193,458

	Beginning of Current Year	End of Year
<b>20</b> Total assets (Part X, line 16)	927,445,492	965,206,797
<b>21</b> Total liabilities (Part X, line 26)	23,451,123	21,018,970
<b>22</b> Net assets or fund balances Subtract line 21 from line 20	903,994,369	944,187,827

## Part II Signature Block

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

**Sign Here**

Signature of officer: \*\*\*\*\* Date: 2020-08-15

JACOB MCWAY SR VP AND CFO Type or print name and title

**Paid Preparer Use Only**

Print/Type preparer's name: Preparer's signature: Date: Check  if self-employed PTIN: P00422601

Firm's name ▶ BKD LLP Firm's EIN ▶

Firm's address ▶ 910 E ST LOUIS 200/PO BOX 1190 Phone no (417) 865-8701  
 SPRINGFIELD, MO 658062523

**Part III Statement of Program Service Accomplishments**

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

**1** Briefly describe the organization's mission

**MISSION TO IMPROVE THE HEALTH OF THE COMMUNITIES WE SERVE THROUGH QUALITY HEALTH CARE, EDUCATION AND RESEARCH**

**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 \$ 18,430,829 including grants of \$ ) (Revenue \$ 23,471,018 )  
See Additional Data

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

**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** ▶ 18,430,829

Part IV Checklist of Required Schedules

Table with 3 columns: Question ID, Question Text, Yes, No. Rows include questions 1 through 22 regarding organizational requirements, lobbying, political activities, and financial reporting.

Part IV Checklist of Required Schedules (continued)

Table with 3 columns: Question ID, Question Text, Yes, No. Rows include questions 23 through 38 regarding compensation, bond issues, escrow accounts, 501(c)(3) organizations, and other IRS requirements.

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 [ ]

Table with 3 columns: Question ID, Question Text, Yes, No. Rows include questions 1a, 1b, and 1c regarding Form 1096, Forms W-2G, and backup withholding rules.

<p><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 . . . . .</p>	<b>2a</b>	242		
<p><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)</p>			<b>2b</b>	Yes
<p><b>3a</b> Did the organization have unrelated business gross income of \$1,000 or more during the year? . . . . .</p>			<b>3a</b>	No
<p><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 . . . . .</p>			<b>3b</b>	
<p><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)? . . . . .</p>			<b>4a</b>	No
<p><b>b</b> If "Yes," enter the name of the foreign country <span style="border-bottom: 1px solid black; display: inline-block; width: 150px;"></span>                  See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)</p>				
<p><b>5a</b> Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . . . . .</p>			<b>5a</b>	No
<p><b>b</b> Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?</p>			<b>5b</b>	No
<p><b>c</b> If "Yes," to line 5a or 5b, did the organization file Form 8886-T? . . . . .</p>			<b>5c</b>	
<p><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? . . . . .</p>			<b>6a</b>	No
<p><b>b</b> If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? . . . . .</p>			<b>6b</b>	
<b>7 Organizations that may receive deductible contributions under section 170(c).</b>				
<p><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? . . . . .</p>			<b>7a</b>	No
<p><b>b</b> If "Yes," did the organization notify the donor of the value of the goods or services provided? . . . . .</p>			<b>7b</b>	
<p><b>c</b> Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? . . . . .</p>			<b>7c</b>	No
<p><b>d</b> If "Yes," indicate the number of Forms 8282 filed during the year . . . . .</p>	<b>7d</b>			
<p><b>e</b> Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?</p>			<b>7e</b>	No
<p><b>f</b> Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . . . . .</p>			<b>7f</b>	No
<p><b>g</b> If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? . . . . .</p>			<b>7g</b>	
<p><b>h</b> If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? . . . . .</p>			<b>7h</b>	
<b>8 Sponsoring organizations maintaining donor advised funds.</b>				
<p>Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? . . . . .</p>			<b>8</b>	
<p><b>9a</b> Did the sponsoring organization make any taxable distributions under section 4966? . . . . .</p>			<b>9a</b>	
<p><b>b</b> Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . . . .</p>			<b>9b</b>	
<b>10 Section 501(c)(7) organizations.</b> Enter				
<p><b>a</b> Initiation fees and capital contributions included on Part VIII, line 12 . . . . .</p>	<b>10a</b>			
<p><b>b</b> Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities</p>	<b>10b</b>			
<b>11 Section 501(c)(12) organizations.</b> Enter				
<p><b>a</b> Gross income from members or shareholders . . . . .</p>	<b>11a</b>			
<p><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) . . . . .</p>	<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?				
<p><b>b</b> If "Yes," enter the amount of tax-exempt interest received or accrued during the year</p>	<b>12b</b>			
<b>13 Section 501(c)(29) qualified nonprofit health insurance issuers.</b>				
<p><b>a</b> Is the organization licensed to issue qualified health plans in more than one state?  <b>Note.</b> See the instructions for additional information the organization must report on Schedule O</p>			<b>13a</b>	
<p><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 . . . . .</p>	<b>13b</b>			
<p><b>c</b> Enter the amount of reserves on hand . . . . .</p>	<b>13c</b>			
<p><b>14a</b> Did the organization receive any payments for indoor tanning services during the tax year? . . . . .</p>			<b>14a</b>	No
<p><b>b</b> If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O . . . . .</p>			<b>14b</b>	
<p><b>15</b> Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see instructions and file Form 4720, Schedule N . . . . .</p>			<b>15</b>	No
<p><b>16</b> Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O . . . . .</p>			<b>16</b>	No

Part VI Governance, Management, and Disclosure For each "Yes" response to lines 2 through 7b below, and for a "No" response to lines 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O See instructions Check if Schedule O contains a response or note to any line in this Part VI



Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a Enter the number of voting members of the governing body at the end of the tax year (28); 1b Enter the number of voting members included in line 1a, above, who are independent (22); 2 Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee? (Yes); 3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? (No); 4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? (No); 5 Did the organization become aware during the year of a significant diversion of the organization's assets? (No); 6 Did the organization have members or stockholders? (No); 7a Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? (No); 7b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? (No); 8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: a The governing body? (Yes); b Each committee with authority to act on behalf of the governing body? (Yes); 9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O (No)

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

Table with 3 columns: Question, Yes, No. Rows include: 10a Did the organization have local chapters, branches, or affiliates? (No); 10b 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?; 11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? (Yes); 11b Describe in Schedule O the process, if any, used by the organization to review this Form 990; 12a Did the organization have a written conflict of interest policy? If "No," go to line 13 (Yes); 12b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? (Yes); 12c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done (Yes); 13 Did the organization have a written whistleblower policy? (Yes); 14 Did the organization have a written document retention and destruction policy? (Yes); 15 Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision? a The organization's CEO, Executive Director, or top management official (Yes); b Other officers or key employees of the organization (Yes); If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions); 16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year? (No); 16b 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
18 Section 6104 requires an organization to make its Form 1023 (or 1024-A if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection Indicate how you made these available Check all that apply
[ ] Own website [ ] Another's website [x] 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
JACOB MCWAY 3800 S NATIONAL AVE SPRINGFIELD, MO 65807 (417) 269-8811





**Part VIII Statement of Revenue**

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

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<b>1a</b> Federated campaigns . . . . .	<b>1a</b>			
	<b>b</b> Membership dues . . . . .	<b>1b</b>			
	<b>c</b> Fundraising events . . . . .	<b>1c</b>			
	<b>d</b> Related organizations . . . . .	<b>1d</b>	47,599		
	<b>e</b> Government grants (contributions)	<b>1e</b>			
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above	<b>1f</b>			
	<b>g</b> Noncash contributions included in lines 1a - 1f \$ _____				
	<b>h Total.</b> Add lines 1a-1f . . . . .		47,599		

<b>Program Service Revenue</b>			Business Code				
	<b>2a</b> NET PATIENT SERVICE REVENUE		900099	21,784,819	21,784,819		
	<b>b</b> OTHER REVENUE		900099	1,016,776	1,016,776		
	<b>c</b> PHARMACY		446110	620,265	620,265		
	<b>d</b> CAFETERIA REVENUE		722514	49,158	49,158		
	<b>e</b> _____						
	<b>f</b> All other program service revenue						
<b>g Total.</b> Add lines 2a-2f . . . . .			23,471,018				

<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts) . . . . .			31,805			31,805
	<b>4</b> Income from investment of tax-exempt bond proceeds . . . . .			0			
	<b>5</b> Royalties . . . . .			0			
	<b>6a</b> Gross rents	(i) Real	(ii) Personal				
		1,650					
	<b>b</b> Less rental expenses						
	<b>c</b> Rental income or (loss)	1,650	0				
	<b>d</b> Net rental income or (loss) . . . . .			1,650			1,650
	<b>7a</b> Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other				
			20				
	<b>b</b> Less cost or other basis and sales expenses						
	<b>c</b> Gain or (loss)		20				
	<b>d</b> Net gain or (loss) . . . . .			20			20
	<b>8a</b> Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18 . . . . .	<b>a</b>		0			
	<b>b</b> Less direct expenses . . . . .	<b>b</b>		0			
<b>c</b> Net income or (loss) from fundraising events . . . . .			0				
<b>9a</b> Gross income from gaming activities See Part IV, line 19 . . . . .	<b>a</b>		0				
<b>b</b> Less direct expenses . . . . .	<b>b</b>		0				
<b>c</b> Net income or (loss) from gaming activities . . . . .			0				
<b>10a</b> Gross sales of inventory, less returns and allowances . . . . .	<b>a</b>		0				
<b>b</b> Less cost of goods sold . . . . .	<b>b</b>		0				
<b>c</b> Net income or (loss) from sales of inventory . . . . .			0				
Miscellaneous Revenue	Business Code						
<b>11a</b> CHANGE IN INTEREST IN NET ASSETS OF SUB	900099		39,013,510			39,013,510	
<b>b</b> _____							
<b>c</b> _____							
<b>d</b> All other revenue . . . . .							
<b>e Total.</b> Add lines 11a-11d . . . . .			39,013,510				
<b>12 Total revenue.</b> See Instructions . . . . .			62,565,602	23,471,018		39,046,985	

**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
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21.	0			
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22.	0			
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.	0			
<b>4</b> Benefits paid to or for members.	0			
<b>5</b> Compensation of current officers, directors, trustees, and key employees.	0			
<b>6</b> Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B).	0			
<b>7</b> Other salaries and wages.	11,137,584	9,278,581	1,859,003	
<b>8</b> Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).	377,428	314,431	62,997	
<b>9</b> Other employee benefits.	1,484,784	1,236,955	247,829	
<b>10</b> Payroll taxes.	690,497	575,244	115,253	
<b>11</b> Fees for services (non-employees):				
<b>a</b> Management.	708,742		708,742	
<b>b</b> Legal.	19		19	
<b>c</b> Accounting.	65,332		65,332	
<b>d</b> Lobbying.	0			
<b>e</b> Professional fundraising services. See Part IV, line 17.	0			
<b>f</b> Investment management fees.	0			
<b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	2,666,204	2,439,276	226,928	
<b>12</b> Advertising and promotion.	0			
<b>13</b> Office expenses.	1,051,576	806,827	244,749	
<b>14</b> Information technology.	123,384	96,023	27,361	
<b>15</b> Royalties.	0			
<b>16</b> Occupancy.	428,744	333,668	95,076	
<b>17</b> Travel.	40,610	31,605	9,005	
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials.	0			
<b>19</b> Conferences, conventions, and meetings.	26,656	20,745	5,911	
<b>20</b> Interest.	277,462	215,934	61,528	
<b>21</b> Payments to affiliates.	0			
<b>22</b> Depreciation, depletion, and amortization.	856,437	666,518	189,919	
<b>23</b> Insurance.	33,950	26,421	7,529	
<b>24</b> Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O):				
<b>a</b> MEDICAL SUPPLIES & DRUGS	1,527,908	1,527,908		
<b>b</b> PROVIDER TAX	811,089	811,089		
<b>c</b> LICENSES, DUES, SUBSCRIPTIONS	52,404	40,783	11,621	
<b>d</b> All other expenses	11,334	8,821	2,513	
<b>e</b> All other expenses				
<b>25</b> Total functional expenses. Add lines 1 through 24e.	22,372,144	18,430,829	3,941,315	0
<b>26</b> Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

**Part X Balance Sheet**

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

			(A) Beginning of year		(B) End of year
<b>Assets</b>	<b>1</b>	Cash—non-interest-bearing . . . . .	850	<b>1</b>	1,100
	<b>2</b>	Savings and temporary cash investments . . . . .	3,336,266	<b>2</b>	1,673,937
	<b>3</b>	Pledges and grants receivable, net . . . . .	0	<b>3</b>	0
	<b>4</b>	Accounts receivable, net . . . . .	2,711,761	<b>4</b>	3,362,677
	<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 . . . . .	0	<b>7</b>	0
	<b>8</b>	Inventories for sale or use . . . . .	310,491	<b>8</b>	184,322
	<b>9</b>	Prepaid expenses and deferred charges . . . . .	63,754	<b>9</b>	12,302
	<b>10a</b>	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	<b>10a</b> 14,204,499		
	<b>b</b>	Less accumulated depreciation	<b>10b</b> 1,811,316	13,111,394	<b>10c</b> 12,393,183
	<b>11</b>	Investments—publicly traded securities . . . . .	0	<b>11</b>	0
	<b>12</b>	Investments—other securities See Part IV, line 11 . . . . .	0	<b>12</b>	0
	<b>13</b>	Investments—program-related See Part IV, line 11 . . . . .	907,137,258	<b>13</b>	946,150,497
	<b>14</b>	Intangible assets . . . . .	0	<b>14</b>	0
	<b>15</b>	Other assets See Part IV, line 11 . . . . .	773,718	<b>15</b>	1,428,779
<b>16</b>	<b>Total assets.</b> Add lines 1 through 15 (must equal line 34) . . . . .	927,445,492	<b>16</b>	965,206,797	
<b>Liabilities</b>	<b>17</b>	Accounts payable and accrued expenses . . . . .	1,476,234	<b>17</b>	1,667,061
	<b>18</b>	Grants payable . . . . .	0	<b>18</b>	0
	<b>19</b>	Deferred revenue . . . . .	0	<b>19</b>	0
	<b>20</b>	Tax-exempt bond liabilities . . . . .	0	<b>20</b>	0
	<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 . . . . .	14,814,171	<b>23</b>	14,177,598
	<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 . . . . .	7,160,718	<b>25</b>	5,174,311
	<b>26</b>	<b>Total liabilities.</b> Add lines 17 through 25 . . . . .	23,451,123	<b>26</b>	21,018,970
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.</b>				
	<b>27</b>	Unrestricted net assets	860,735,915	<b>27</b>	896,620,396
	<b>28</b>	Temporarily restricted net assets . . . . .	22,758,801	<b>28</b>	26,942,077
	<b>29</b>	Permanently restricted net assets	20,499,653	<b>29</b>	20,625,354
	<b>Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.</b>				
	<b>30</b>	Capital stock or trust principal, or current funds . . . . .		<b>30</b>	
	<b>31</b>	Paid-in or capital surplus, or land, building or equipment fund . . . . .		<b>31</b>	
	<b>32</b>	Retained earnings, endowment, accumulated income, or other funds		<b>32</b>	
<b>33</b>	<b>Total net assets or fund balances</b> . . . . .	903,994,369	<b>33</b>	944,187,827	
<b>34</b>	<b>Total liabilities and net assets/fund balances</b> . . . . .	927,445,492	<b>34</b>	965,206,797	

**Part XI Reconciliation of Net Assets**

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

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	62,565,602
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	22,372,144
<b>3</b>	Revenue less expenses Subtract line 2 from line 1	<b>3</b>	40,193,458
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	903,994,369
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	
<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>	944,187,827

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

## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 47-1087427

**Name:** COXHEALTH

Form 990 (2018)

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

COXHEALTH IS THE SOLE CORPORATE MEMBER OF CBCH, LLC, WHICH OPERATES BARTON COUNTY HOSPITAL. IN OCTOBER 2017, COXHEALTH SIGNED A LETTER OF INTENT WITH BARTON COUNTY MEMORIAL HOSPITAL (BCMh) TO ACQUIRE ITS OPERATIONS AND TO LEASE ITS PROPERTY. THE ACQUISITION ALLOWS FOR THE PATIENTS PREVIOUSLY SERVED BY BCMh TO BECOME A PART OF THE COXHEALTH SYSTEM. COX BARTON COUNTY WILL CONTINUE THE SERVICES PREVIOUSLY PROVIDED BY BCMh AND INTENDS TO EXPAND THESE SERVICES FURTHER IN THE FUTURE. TO COMPLETE THE TRANSACTION, COXHEALTH FORMED TWO ENTITIES, COX BARTON COUNTY HOSPITAL, AND CBCH, LLC. THE OPERATIONS OF THE HOSPITAL FROM OCTOBER 1, 2018, THROUGH SEPTEMBER 30, 2019 ARE REPORTED ON THIS 990.

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

PROVIDE THE ADMINISTRATIVE AND FUNCTIONAL SUPPORT FOR SUBORDINATE ENTITIES TO IMPROVE THE HEALTH OF THE COMMUNITY. SPECIFIC DETAILS CAN BE FOUND ON THE 990 RETURNS OF THESE ENTITIES, INCLUDING LESTER E COX MEDICAL CENTERS AND COX MEDICAL GROUP

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
ROBERT FULP ..... 2ND VICE CHAIR OF THE BOARD	10 .....	X		X				0	0	0
JANICE HARRIS ..... BOARD MEMBER	10 .....	X						0	0	0
HAL HIGDON ..... 3RD VICE CHAIR OF THE BOARD	10 .....	X		X				0	0	0
PHILLIP LOYD ..... BOARD MEMBER	10 .....	X						0	0	0
JOHN JACK PRIM ..... BOARD MEMBER	10 .....	X						0	0	0
JOSEPH TURNER ..... BOARD MEMBER	10 .....	X						0	0	0
JEFFERSON TYNES ..... BOARD MEMBER	10 .....	X						0	0	0
THOMAS AUNER ..... BOARD MEMBER	10 .....	X						0	0	0
CHARLES CHUCK CHALENDER ..... 1ST VICE CHAIR OF THE BOARD	10 .....	X		X				0	0	0
HOWARD FISK ..... BOARD MEMBER	10 .....	X						0	0	0

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Insttutchnal Trustee	Officer	Key employee	Highest compensated employee	Former			
DENNIS HEIM ..... CHAIRMAN OF THE BOARD	1 0 .....	X		X				0	0	0
KURT HELLWEG ..... BOARD MEMBER	1 0 .....	X						0	0	0
ROBERT MCDOWELL ..... BOARD MEMBER	1 0 .....	X						0	0	0
JAN BAUMGARTNER ..... BOARD MEMBER	1 0 .....	X						0	0	0
TIMOTHY CLOYD ..... BOARD MEMBER	1 0 .....	X						0	0	0
SALLY HARGIS ..... BOARD MEMBER	1 0 .....	X						0	0	0
JAMES HUTCHESON ..... BOARD MEMBER	1 0 .....	X						0	0	0
BRIAN JARED ..... BOARD MEMBER	1 0 .....	X						0	0	0
HOWARD JARVIS MD ..... BOARD MEMBER	1 0 40 0	X						0	381,224	16,320
ROBERT MAHAFFEY ..... BOARD MEMBER END 03/2019	1 0 .....	X						0	0	0

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
CAROL TAYLOR ..... BOARD MEMBER	1 0 ..... 40 0	X						0	0	0
BRAD ERWIN ..... BOARD MEMBER	1 0 ..... 40 0	X						0	0	0
DAVID ZOLFAGHARI MD ..... BOARD MEMBER	1 0 ..... 40 0	X						0	1,125,716	16,320
IBRAHIM ABE ABDALLA MD ..... BOARD MEMBER	1 0 ..... 40 0	X						0	983,315	16,320
JAMES GIBSON MD ..... BOARD MEMBER	1 0 ..... 40 0	X						0	496,586	14,272
JULIA FLAX MD ..... BOARD MEMBER	1 0 ..... 40 0	X						0	381,558	25,316
PATRICIA DIX MD ..... BOARD MEMBER	1 0 ..... 40 0	X						0	363,260	41,496
LARRY LIPSCOMB ..... BOARD MEMBER	1 0 ..... 40 0	X						0	0	0
ROBIN ROBESON ..... BOARD MEMBER	1 0 ..... 40 0	X						0	0	0
STEVE EDWARDS ..... PRESIDENT AND CEO	40 0 ..... 5 0			X				1,501,873	0	295,293

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JACOB MCWAY ..... SR VP AND CFO	40 0 ..... 5 0			X				891,941	0	168,179
VICKIE NELSON ..... SECRETARY	40 0 ..... 5 0			X				65,580	0	10,982
WENDY DUVALL ..... PRESIDENT CBCH END 10/2018	40 0 ..... 0 0			X				115,299	0	13,693
DARREN BASS ..... INTERIM PRESIDENT END 01/2019	40 0 ..... 0 0			X				0	157,586	21,073
CHRISTOPHER WYATT ..... PRESIDENT BEGIN 02/2019	40 0 ..... 0 0			X				0	0	0
CHARITY ELMER ..... SR VP AND GENERAL COUNSEL	40 0 ..... 0 0				X			586,278	0	125,714
JAMES ANDERSON ..... VP LEGISLATIVE AFFAIRS	8 0 ..... 0 0				X			103,450	0	5,173
JANN HOLLAND ..... VP MARKETING	40 0 ..... 0 0				X			248,013	0	29,147
BETTY BRESHEARS ..... VP CORPORATE COMPLIANCE	40 0 ..... 0 0				X			214,581	0	19,075
ANDREW HEDGPETH ..... VP HR	40 0 ..... 0 0				X			240,958	0	24,394

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
TIMOTHY JONES DO ..... JOC CHAIR	40 0 ..... 0 0				X			397,107	0	29,760
DAVID RANEY ..... VP COXHEALTH NETWORK	40 0 ..... 0 0				X			268,537	0	30,154
BRUCE ROBISON ..... CIO	40 0 ..... 0 0				X			203,909	0	25,341
RODNEY SCHAFFER ..... VP FACILITIES MGMT	40 0 ..... 0 0				X			260,159	0	21,247
DAVID TAYLOR ..... VP CORPORATE SERVICES	40 0 ..... 0 0				X			315,348	0	43,285
STACI NIEMOTH ..... JOC CHAIR	40 0 ..... 0 0				X			571,029	0	16,320

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

**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 the latest information.

**2018**

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

Name of the organization  
COXHEALTH

Employer identification number

47-1087427

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

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

- 1  A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
- 2  A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ) )
- 3  A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- 4  A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state \_\_\_\_\_
- 5  An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II )
- 6  A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- 7  An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II )
- 8  A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II )
- 9  An agricultural research organization described in **170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture See instructions Enter the name, city, and state of the college or university \_\_\_\_\_
- 10  An organization that normally receives (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2).** (Complete Part III )
- 11  An organization organized and operated exclusively to test for public safety See **section 509(a)(4).**
- 12  An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g
  - a  **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization **You must complete Part IV, Sections A and B.**
  - b  **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s) **You must complete Part IV, Sections A and C.**
  - c  **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions) **You must complete Part IV, Sections A, D, and E.**
  - d  **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions) **You must complete Part IV, Sections A and D, and Part V.**
  - e  Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization
  - f Enter the number of supported organizations 2
  - 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) LEST E COX MC	440577118	3	Yes		0	0
(B) COX MED GROUP	471087566	10	Yes		0	0
<b>Total</b>	2				0	0

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

(Complete only if you checked the box on line 5, 7, 8, or 9 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ►		(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
<b>1</b>	Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant")						
<b>2</b>	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
<b>3</b>	The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>4</b>	<b>Total.</b> Add lines 1 through 3						
<b>5</b>	The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
<b>6</b>	<b>Public support.</b> Subtract line 5 from line 4						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►		(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
<b>7</b>	Amounts from line 4						
<b>8</b>	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
<b>9</b>	Net income from unrelated business activities, whether or not the business is regularly carried on						
<b>10</b>	Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI )						
<b>11</b>	<b>Total support.</b> Add lines 7 through 10						
<b>12</b>	Gross receipts from related activities, etc (see instructions)					<b>12</b>	

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

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

<b>14</b>	Public support percentage for 2018 (line 6, column (f) divided by line 11, column (f))	<b>14</b>	
<b>15</b>	Public support percentage for 2017 Schedule A, Part II, line 14	<b>15</b>	

- 16a 33 1/3% support test—2018.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ►
- b 33 1/3% support test—2017.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ►
- 17a 10%-facts-and-circumstances test—2018.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ►
- b 10%-facts-and-circumstances test—2017.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ►
- 18 Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ►

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

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

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ►		(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
<b>1</b>	Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
<b>2</b>	Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
<b>3</b>	Gross receipts from activities that are not an unrelated trade or business under section 513						
<b>4</b>	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
<b>5</b>	The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>6</b>	<b>Total.</b> Add lines 1 through 5						
<b>7a</b>	Amounts included on lines 1, 2, and 3 received from disqualified persons						
<b>b</b>	Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
<b>c</b>	Add lines 7a and 7b						
<b>8</b>	<b>Public support.</b> (Subtract line 7c from line 6)						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►		(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
<b>9</b>	Amounts from line 6						
<b>10a</b>	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
<b>b</b>	Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
<b>c</b>	Add lines 10a and 10b						
<b>11</b>	Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
<b>12</b>	Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
<b>13</b>	<b>Total support.</b> (Add lines 9, 10c, 11, and 12.)						

**14 First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ►

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

<b>15</b>	Public support percentage for 2018 (line 8, column (f) divided by line 13, column (f))	<b>15</b>	
<b>16</b>	Public support percentage from 2017 Schedule A, Part III, line 15	<b>16</b>	

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

<b>17</b>	Investment income percentage for <b>2018</b> (line 10c, column (f) divided by line 13, column (f))	<b>17</b>	
<b>18</b>	Investment income percentage from <b>2017</b> Schedule A, Part III, line 17	<b>18</b>	

**19a 33 1/3% support tests—2018.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ►

**b 33 1/3% support tests—2017.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ►

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

**Part IV Supporting Organizations**

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

**Section A. All Supporting Organizations**

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

**Part IV Supporting Organizations** (continued)

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

**Section B. Type I Supporting Organizations**

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

**Section C. Type II Supporting Organizations**

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

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

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

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

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

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

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

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

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

<b>Section D - Distributions</b>	<b>Current Year</b>
<b>1</b> Amounts paid to supported organizations to accomplish exempt purposes	
<b>2</b> Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
<b>3</b> Administrative expenses paid to accomplish exempt purposes of supported organizations	
<b>4</b> Amounts paid to acquire exempt-use assets	
<b>5</b> Qualified set-aside amounts (prior IRS approval required)	
<b>6</b> Other distributions (describe in <b>Part VI</b> ) See instructions	
<b>7 Total annual distributions.</b> Add lines 1 through 6	
<b>8</b> Distributions to attentive supported organizations to which the organization is responsive (provide details in <b>Part VI</b> ) See instructions	
<b>9</b> Distributable amount for 2018 from Section C, line 6	
<b>10</b> Line 8 amount divided by Line 9 amount	

<b>Section E - Distribution Allocations (see instructions)</b>	<b>(i) Excess Distributions</b>	<b>(ii) Underdistributions Pre-2018</b>	<b>(iii) Distributable Amount for 2018</b>
<b>1</b> Distributable amount for 2018 from Section C, line 6			
<b>2</b> Underdistributions, if any, for years prior to 2018 (reasonable cause required-- explain in Part VI) See instructions			
<b>3</b> Excess distributions carryover, if any, to 2018			
<b>a</b> From 2013. . . . .			
<b>b</b> From 2014. . . . .			
<b>c</b> From 2015. . . . .			
<b>d</b> From 2016. . . . .			
<b>e</b> From 2017. . . . .			
<b>f Total</b> of lines 3a through e			
<b>g</b> Applied to underdistributions of prior years			
<b>h</b> Applied to 2018 distributable amount			
<b>i</b> Carryover from 2013 not applied (see instructions)			
<b>j</b> Remainder Subtract lines 3g, 3h, and 3i from 3f			
<b>4</b> Distributions for 2018 from Section D, line 7			
\$			
<b>a</b> Applied to underdistributions of prior years			
<b>b</b> Applied to 2018 distributable amount			
<b>c</b> Remainder Subtract lines 4a and 4b from 4			
<b>5</b> Remaining underdistributions for years prior to 2018, if any Subtract lines 3g and 4a from line 2 If the amount is greater than zero, explain in Part VI See instructions			
<b>6</b> Remaining underdistributions for 2018 Subtract lines 3h and 4b from line 1 If the amount is greater than zero, explain in Part VI See instructions			
<b>7 Excess distributions carryover to 2019.</b> Add lines 3j and 4c			
<b>8</b> Breakdown of line 7			
<b>a</b> Excess from 2014. . . . .			
<b>b</b> Excess from 2015. . . . .			
<b>c</b> Excess from 2016. . . . .			
<b>d</b> Excess from 2017. . . . .			
<b>e</b> Excess from 2018. . . . .			

## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 47-1087427

**Name:** COXHEALTH

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

**Facts And Circumstances Test**

**SCHEDULE C**  
(Form 990 or 990-EZ)  
  
Department of the Treasury  
Internal Revenue Service

**Political Campaign and Lobbying Activities**  
For Organizations Exempt From Income Tax Under section 501(c) and section 527  
  
▶Complete if the organization is described below. ▶Attach to Form 990 or Form 990-EZ.  
▶Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No 1545-0047  
  
**2018**  
**Open to Public Inspection**

**If the organization answered "Yes" on Form 990, Part IV, Line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then**

- Section 501(c)(3) organizations Complete Parts I-A and B Do not complete Part I-C
- Section 501(c) (other than section 501(c)(3)) organizations Complete Parts I-A and C below Do not complete Part I-B
- Section 527 organizations Complete Part I-A only

**If the organization answered "Yes" on Form 990, Part IV, Line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then**

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)) Complete Part II-A Do not complete Part II-B
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)) Complete Part II-B Do not complete Part II-A

**If the organization answered "Yes" on Form 990, Part IV, Line 5 (Proxy Tax) (see separate instructions) or Form 990-EZ, Part V, line 35c (Proxy Tax) (see separate instructions), then**

- Section 501(c)(4), (5), or (6) organizations Complete Part III

Name of the organization COXHEALTH	Employer identification number 47-1087427
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**Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.**

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

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

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

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

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

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



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

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity

	(a)		(b)
	Yes	No	Amount
<b>1</b> During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
<b>a</b> Volunteers?		No	
<b>b</b> Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
<b>c</b> Media advertisements?		No	
<b>d</b> Mailings to members, legislators, or the public?		No	
<b>e</b> Publications, or published or broadcast statements?		No	
<b>f</b> Grants to other organizations for lobbying purposes?		No	
<b>g</b> Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
<b>h</b> Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
<b>i</b> Other activities?	Yes		8,578
<b>j</b> Total Add lines 1c through 1i			8,578
<b>2a</b> Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
<b>b</b> If "Yes," enter the amount of any tax incurred under section 4912			
<b>c</b> If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
<b>d</b> If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

**Part IV Supplemental Information**

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

Return Reference	Explanation
SCHEDULE C, PART II-B, LINE 11	OTHER LOBBYING ACTIVITIES PORTIONS OF DUES PAID TO THE MISSOURI HOSPITAL ASSOCIATION (MHA) ARE USED FOR LOBBYING PURPOSES FOR THE FISCAL YEAR 2019, THE AMOUNT ATTRIBUTABLE TO LOBBYING WAS \$8,578 PAID BY CBCH, LLC

**SCHEDULE D**  
(Form 990)  
  
Department of the Treasury  
Internal Revenue Service

# Supplemental Financial Statements

▶ Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.  
▶ Attach to Form 990.  
▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No 1545-0047  
**2018**  
**Open to Public Inspection**

**Name of the organization**  
COXHEALTH

**Employer identification number**  
47-1087427

**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
<b>1</b> Total number at end of year		
<b>2</b> Aggregate value of contributions to (during year)		
<b>3</b> Aggregate value of grants from (during year)		
<b>4</b> Aggregate value at end of year		

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

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

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

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

Preservation of land for public use (e g , recreation or education)  Preservation of an historically important land area

Protection of natural habitat  Preservation of a certified historic structure

Preservation of open space

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 3** Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply)
- a**  Public exhibition
  - b**  Scholarly research
  - c**  Preservation for future generations
  - d**  Loan or exchange programs
  - e**  Other
- 4** Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII
- 5** During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection?  Yes  No

**Part IV Escrow and Custodial Arrangements.**

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

- 1a** Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?  Yes  No
- b** If "Yes," explain the arrangement in Part XIII and complete the following table
- |  | Amount |
|--|--------|
| <b>c</b> Beginning balance             |        |
| <b>d</b> Additions during the year     |        |
| <b>e</b> Distributions during the year |        |
| <b>f</b> Ending balance                |        |
- 2a** Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? . . .  Yes  No
- b** If "Yes," explain the arrangement in Part XIII Check here if the explanation has been provided in Part XIII . . . .

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
<b>1a</b> Beginning of year balance . . . . .					
<b>b</b> Contributions . . . . .					
<b>c</b> Net investment earnings, gains, and losses					
<b>d</b> Grants or scholarships . . . . .					
<b>e</b> Other expenditures for facilities and programs . . . . .					
<b>f</b> Administrative expenses . . . . .					
<b>g</b> 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
- |  |     |    |
|--|-----|----|
| <b>(i)</b> unrelated organizations . . . . .   | Yes | No |
| <b>(ii)</b> related organizations . . . . .  |     |    |
| <b>b</b> If "Yes" on 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
<b>1a</b> Land . . . . .		180,000		180,000
<b>b</b> Buildings . . . . .		11,700,849	587,795	11,113,054
<b>c</b> Leasehold improvements				
<b>d</b> Equipment . . . . .		2,323,650	1,223,521	1,100,129
<b>e</b> Other . . . . .				
<b>Total.</b> Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c)) . . . ▶				12,393,183

**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)		
<b>Total.</b> (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) INT IN NA OF TAX EXEMPT SUBS	946,150,497	C
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
<b>Total.</b> (Column (b) must equal Form 990, Part X, col (B) line 13 )	946,150,497	

**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)	
<b>Total.</b> (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	0
DUE TO THIRD PARTY	1,999,175
DUE TO AFFILIATE	3,175,136
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col (B) line 25 )	5,174,311

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

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

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

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

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

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

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

**Part XIII Supplemental Information**

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

Return Reference	Explanation
See Additional Data Table	



## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 47-1087427

**Name:** COXHEALTH

## Supplemental Information

Return Reference	Explanation
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 H (Form 990)**  
 Department of the Treasury  
 Internal Revenue Service

# Hospitals

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, question 20.**  
 ▶ **Attach to Form 990.**  
 ▶ **Go to [www.irs.gov/Form990EZ](http://www.irs.gov/Form990EZ) for instructions and the latest information.**

OMB No 1545-0047  
2018  
**Open to Public Inspection**

**Name of the organization**  
 COXHEALTH

**Employer identification number**  
 47-1087427

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

		Yes	No
<b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	<b>1a</b>	Yes	
<b>b</b> If "Yes," was it a written policy? . . . . .	<b>1b</b>	Yes	
<b>2</b> If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities			
<b>3</b> Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year <b>a</b> Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input type="checkbox"/> Other _____ %	<b>3a</b>		No
<b>b</b> Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input checked="" type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %	<b>3b</b>	Yes	
<b>c</b> If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care			
<b>4</b> Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	<b>4</b>	Yes	
<b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	<b>5a</b>	Yes	
<b>b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	<b>5b</b>		No
<b>c</b> If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	<b>5c</b>		
<b>6a</b> Did the organization prepare a community benefit report during the tax year?	<b>6a</b>	Yes	
<b>b</b> If "Yes," did the organization make it available to the public?	<b>6b</b>	Yes	

**7 Financial Assistance and Certain Other Community Benefits at Cost**

	(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>Financial Assistance and Means-Tested Government Programs</b>						
<b>a</b> Financial Assistance at cost (from Worksheet 1)			1,359,547		1,359,547	6.080 %
<b>b</b> Medicaid (from Worksheet 3, column a)			3,594,056	2,581,910	1,012,146	4.520 %
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b)						
<b>d Total</b> Financial Assistance and Means-Tested Government Programs			4,953,603	2,581,910	2,371,693	10.600 %
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4)						
<b>f</b> Health professions education (from Worksheet 5)						
<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)						
<b>j Total.</b> Other Benefits						
<b>k Total.</b> Add lines 7d and 7j			4,953,603	2,581,910	2,371,693	10.600 %

**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						
<b>10 Total</b>						

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

**Section A. Bad Debt Expense**

		Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?		No
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.		
			2,672,395
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.		
			416,894
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	13,599,719
6	Enter Medicare allowable costs of care relating to payments on line 5.	6	11,288,837
7	Subtract line 6 from line 5. This is the surplus (or shortfall).	7	2,310,882
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.  <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other		

**Section C. Collection Practices**

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

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

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

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

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

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

**1**

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

See Additional Data Table	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

**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)  
 COX BARTON COUNTY HOSPITAL

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

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): \_\_\_\_\_ 1

		Yes	No
<b>Community Health Needs Assessment</b>			
<b>1</b>	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? . . . . .		No
<b>2</b>	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C . . . . .		No
<b>3</b>	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 . . . . . If "Yes," indicate what the CHNA report describes (check all that apply)	Yes	
<b>a</b>	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b>	<input checked="" type="checkbox"/> Demographics of the community		
<b>c</b>	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b>	<input checked="" type="checkbox"/> How data was obtained		
<b>e</b>	<input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b>	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b>	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b>	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b>	<input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>4</b>	Indicate the tax year the hospital facility last conducted a CHNA <u>20 18</u>		
<b>5</b>	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .	Yes	
<b>6 a</b>	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	Yes	
<b>b</b>	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C . . . . .	Yes	
<b>7</b>	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)	Yes	
<b>a</b>	<input checked="" type="checkbox"/> Hospital facility's website (list url) <u>SEE PART V, SECTION C</u>		
<b>b</b>	<input checked="" type="checkbox"/> Other website (list url) <u>SEE PART V, SECTION C</u>		
<b>c</b>	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b>	<input checked="" type="checkbox"/> Other (describe in Section C)		
<b>8</b>	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 . . . . .	Yes	
<b>9</b>	Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 18</u>		
<b>10</b>	Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url) <u>SEE PART V, SECTION C</u>	Yes	
<b>a</b>			
<b>b</b>	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .		
<b>11</b>	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
<b>12a</b>	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .		No
<b>12b</b>	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .		
<b>c</b>	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

**Part V Facility Information** (continued)

**Financial Assistance Policy (FAP)**

COX BARTON COUNTY HOSPITAL

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

		Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that		
<b>13</b>	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	<b>13</b> Yes	
<b>a</b>	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 0 _____ % and FPG family income limit for eligibility for discounted care of 300 _____ %		
<b>b</b>	<input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b>	<input checked="" type="checkbox"/> Asset level		
<b>d</b>	<input checked="" type="checkbox"/> Medical indigency		
<b>e</b>	<input checked="" type="checkbox"/> Insurance status		
<b>f</b>	<input checked="" type="checkbox"/> Underinsurance discount		
<b>g</b>	<input checked="" type="checkbox"/> Residency		
<b>h</b>	<input checked="" type="checkbox"/> Other (describe in Section C)		
<b>14</b>	Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b> Yes	
<b>15</b>	Explained the method for applying for financial assistance? . . . . . If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	<b>15</b> Yes	
<b>a</b>	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</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		
<b>c</b>	<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		
<b>d</b>	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b>	<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)	<b>16</b> Yes	
<b>a</b>	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
<b>b</b>	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
<b>c</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
<b>d</b>	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b>	<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)		
<b>f</b>	<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)		
<b>g</b>	<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		
<b>h</b>	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b>	<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		
<b>j</b>	<input checked="" type="checkbox"/> Other (describe in Section C)		

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

COX BARTON COUNTY HOSPITAL

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

		Yes	No	
<b>17</b>	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment? . . . . .	17	Yes	
<b>18</b>	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP			
<b>a</b>	<input type="checkbox"/> Reporting to credit agency(ies)			
<b>b</b>	<input type="checkbox"/> Selling an individual's debt to another party			
<b>c</b>	<input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
<b>d</b>	<input type="checkbox"/> Actions that require a legal or judicial process			
<b>e</b>	<input type="checkbox"/> Other similar actions (describe in Section C)			
<b>f</b>	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted			
<b>19</b>	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? . . . . . If "Yes," check all actions in which the hospital facility or a third party engaged	19		No
<b>a</b>	<input type="checkbox"/> Reporting to credit agency(ies)			
<b>b</b>	<input type="checkbox"/> Selling an individual's debt to another party			
<b>c</b>	<input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
<b>d</b>	<input type="checkbox"/> Actions that require a legal or judicial process			
<b>e</b>	<input type="checkbox"/> Other similar actions (describe in Section C)			
<b>20</b>	Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply)			
<b>a</b>	<input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs			
<b>b</b>	<input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process			
<b>c</b>	<input checked="" type="checkbox"/> Processed incomplete and complete FAP applications			
<b>d</b>	<input checked="" type="checkbox"/> Made presumptive eligibility determinations			
<b>e</b>	<input type="checkbox"/> Other (describe in Section C)			
<b>f</b>	<input type="checkbox"/> None of these efforts were made			

**Policy Relating to Emergency Medical Care**

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

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

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

COX BARTON COUNTY HOSPITAL

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

**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

- a  The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b  The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- c  The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- d  The hospital facility used a prospective Medicare or Medicaid method

**23** During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? . . . . .

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
<b>23</b>		No
<b>24</b>		No



**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? 2

Name and address	Type of Facility (describe)
<b>1</b> GOLDEN CITY CLINIC 407 MAIN ST GOLDEN CITY, MO 64748	RURAL HEALTH CLINIC
<b>2</b> MEDICAL ONE CLINIC 29 NW 1ST LANE LAMAR, MO 64759	RURAL HEALTH CLINIC
<b>3</b>	
<b>4</b>	
<b>5</b>	
<b>6</b>	
<b>7</b>	
<b>8</b>	
<b>9</b>	
<b>10</b>	

**Part VI Supplemental Information**

Provide the following information

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

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H, PART I, LINE 3C	ELIGIBILITY FOR FREE CARE IN GENERAL, THE ORGANIZATION'S CHARITY CARE POLICY DOES NOT PROVIDE FOR DISCOUNTS OF 100% THEREFORE, IT IS EXPECTED THAT THE PATIENT OR GUARANTOR WILL HOLD A RESPONSIBILITY FOR PAYMENT OF AT LEAST A PORTION OF THE SERVICES, REGARDLESS OF THE LEVEL OF ELIGIBILITY IT IS OUR INTENTION TO WORK WITH INDIVIDUALS ON THEIR OUT-OF-POCKET RESPONSIBILITY TO ESTABLISH FEASIBLE MONTHLY PAYMENTS WHEN NECESSARY IN THE EVENT THAT A PATIENT OR GUARANTOR IS DETERMINED TO HAVE NO MEANS OF PAYING THE AMOUNT INDICATED AS THEIR RESPONSIBILITY DUE TO EXTENUATING CIRCUMSTANCES, CONSIDERATION MAY BE GIVEN TO WAIVING DEDUCTIBLES AND/OR INCREASING THE DISCOUNT AMOUNT UP TO A 100% DISCOUNT OF THE PATIENT PORTION THESE EXTENUATING CASES ARE SUBJECT TO THE DISCRETION AND APPROVAL OF THE PFS DIRECTOR AND/OR THE CHIEF FINANCIAL OFFICER WITHIN THE APPROVAL LIMITS DEFINED AT THE END OF THE POLICY
SCHEDULE H, PART I, LINE 7, COLUMN F	PERCENT OF TOTAL EXPENSE THE PERCENT OF TOTAL EXPENSE ON SCHEDULE H, PART I, LINE 7, COLUMN (F), WAS CALCULATED USING TOTAL EXPENSES ON FORM 990, PART IX, LINE 25, COLUMN (A)

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H, PART I, LINE 7	COSTING METHODOLOGY THE COST TO CHARGE RATIO CALCULATED ON IRS WORKSHEET 2 WAS USED IN THE CALCULATION OF COST ON IRS WORKSHEETS 1 AND 3
SCHEDULE H, PART III, SECTION A, LINE 2	BAD DEBT EXPENSE THE HOSPITAL HAS ADOPTED THE NEW REVENUE RECOGNITION STANDARD ASU 014-09 UNDER ASU 2014-09, THE ESTIMATED AMOUNTS DUE FROM PATIENTS FOR WHICH THE HEALTH SYSTEM DOES NOT EXPECT TO BE ENTITLED OR COLLECT FROM THE PATIENTS ARE CONSIDERED IMPLICIT PRICE CONCESSIONS AND EXCLUDED FROM THE HEALTH SYSTEM'S ESTIMATION OF THE TRANSACTION PRICE OR REVENUE RECORDED BAD DEBT EXPENSE WAS NOT SIGNIFICANT TO THE AUDITED FINANCIAL STATEMENTS FOR THE YEAR ENDED SEPTEMBER 30 2019 HOWEVER, THE HOSPITAL INTERNALLY TRACKS BAD DEBT EXPENSE CONSISTENT WITH HISTORICAL PRACTICES AND THAT AMOUNT HAS BEEN REPORTED ON SCHEDULE H, PART III, SECTION A, LINE 2

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H, PART III, SECTION A, LINE 3	BAD DEBT EXPENSE ATTRIBUTABLE TO CHARITY CARE THE BAD DEBT ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE ORGANIZATION'S CHARITY CARE POLICY WAS DETERMINED USING POVERTY LIMIT DEMOGRAPHIC INFORMATION OBTAINED THROUGH THE US CENSUS BUREAU USING DATA FROM SCHEDULE 2014-2018, APPROXIMATELY 15.6 PERCENT OF BARTON COUNTY WAS CONSIDERED TO LIVE IN POVERTY
SCHEDULE H, PART III, SECTION A, LINE 4	BAD DEBT EXPENSE FOOTNOTE THE AUDITED FINANCIAL STATEMENTS DO NOT CONTAIN A FOOTNOTE THAT DESCRIBES BAD DEBT EXPENSE THEY DO, HOWEVER, CONTAIN A FOOTNOTE THAT DESCRIBES PATIENT ACCOUNTS RECEIVABLE, THAT NOTE CAN BE FOUND ON PAGE 11 OF THE ATTACHED AUDITED FINANCIAL STATEMENTS

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H, PART III, SECTION B, LINE 8	COMMUNITY BENEFIT SERVING PATIENTS WITH GOVERNMENT HEALTH BENEFITS, SUCH AS MEDICARE, IS A COMPONENT OF THE COMMUNITY BENEFIT STANDARD THAT TAX-EXEMPT HOSPITALS ARE HELD TO THIS IMPLIES THAT SERVING MEDICARE PATIENTS IS A COMMUNITY BENEFIT AND THAT THE HOSPITAL OPERATES TO PROMOTE THE HEALTH OF THE COMMUNITY
SCHEDULE H, PART III, SECTION C, LINE 9B	COLLECTION POLICY THE ORGANIZATION WILL NOT PURSUE LEGAL ACTION FOR NONPAYMENT OF ANY AMOUNTS DISCOUNTED AS A RESULT OF AN APPROVED OR PARTIALLY APPROVED REQUEST FOR FINANCIAL ASSISTANCE BALANCES REMAINING AFTER SUCH DISCOUNTS ARE APPLIED WILL, HOWEVER, BE SUBJECT TO COLLECTION ACTIVITY, INCLUDING LEGAL ACTION IN ADDITION, THE ORGANIZATION WILL NOT CHARGE INTEREST ON THE BALANCE REMAINING AFTER APPLYING THE FINANCIAL ASSISTANCE DISCOUNT HOWEVER, THE ORGANIZATION MAY, IN ITS SOLE DISCRETION, CHARGE INTEREST ON THE BALANCE OWED IF 1) THE GUARANTOR DEFAULTS ON HIS OR HER PAYMENT AGREEMENT OR 2) THE BALANCE IS REFERRED TO THE COLLECTION AGENCY FOR COLLECTION

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
<p>SCHEDULE H, PART VI, LINE 2</p>	<p>NEEDS ASSESSMENT LESTER E COX MEDICAL CENTERS HAS PERFORMED AN ENVIRONMENTAL SCAN ANNUALLY SINCE 2006 COMMUNITY HEALTH NEEDS ASSESSMENTS AS REQUIRED BY THE IRS WERE COMPLETED IN EARLY 2016 A PUBLIC PERCEPTION STUDY OF AREA HEADS OF HOUSEHOLDS IS CONDUCTED ANNUALLY THE MOST RECENT STUDY SURVEYED 876 HOUSEHOLDS IN OUR SERVICE AREA TO DETERMINE WHAT SERVICES ARE NEEDED WE ALSO PERFORM A PUBLIC HEALTH SURVEY, WHICH ASKS COMMUNITY LEADERS AND HEALTH PROFESSIONALS WHAT THEIR PRIORITIES ARE AND WHAT HEALTH SERVICES ARE LACKING IN THEIR COMMUNITY THE PUBLIC HEALTH SURVEY IS SENT TO COUNTY PUBLIC HEALTH DEPARTMENTS, LOCAL AGENCIES, REGIONAL SERVICES CLINICS, MENTAL HEALTH FACILITIES, AND PUBLIC SCHOOLS THROUGHOUT THE TOTAL SERVICE AREA LESTER E COX MEDICAL CENTERS REFERENCES UNITED HEALTH FOUNDATION STATE-BY-STATE HEALTH RANKINGS AS WELL AS ROBERT WOOD JOHNSON AND UNIVERSITY OF WISCONSIN POPULATION HEALTH INSTITUTE COUNTY HEALTH RANK FOR HEALTH OUTCOMES AND HEALTH FACTORS COXHEALTH ALSO REFERENCES "ASSESSING THE HEALTH OF THE COMMUNITY", WHICH IS AN ANALYSIS OF BEHAVIORS AND OUTCOMES FOR THE SPECIFIC COUNTIES OF THE SERVICE AREA BY THE MISSOURI HOSPITAL ASSOCIATION DEMOGRAPHIC AND ECONOMIC ANALYSIS IS PERFORMED FOR THE 22-COUNTY SERVICE AREA NIELSEN CLARITAS DEMOGRAPHIC ESTIMATES AND PROJECTIONS ARE USED TO EVALUATE THE CHANGE IN POPULATION CHARACTERISTICS UNEMPLOYMENT, HOME FORECLOSURE, AND INPATIENT PAYER DATA IS ALSO ASSESSED IN 2016, COXHEALTH PERFORMED A COMMUNITY HEALTH NEEDS ASSESSMENT AS PART OF A COLLABORATIVE EFFORT, CONSISTING OF A VARIETY OF ORGANIZATIONS ACROSS THE OZARKS, TO BETTER UNDERSTAND THE HEALTH STATUS, BEHAVIORS, AND NEEDS OF THE POPULATIONS WE SERVE UNDER THE UMBRELLA OF THE LOCAL OZARKS HEALTH COMMISSION, THIS FIRST-TIME COLLABORATION WAS THE LARGEST IN THE REGION SPANNING FOUR STATES-MISSOURI, OKLAHOMA, ARKANSAS AND KANSAS-29 COUNTIES AND THREE HOSPITAL SYSTEMS THE WORKING GROUP SAW THE VALUE OF USING A SYSTEMATIC, DATA-DRIVEN ASSESSMENT TO INFORM DECISIONS AND GUIDE EFFORTS TO IMPROVE COMMUNITY HEALTH AND WELLNESS ON A REGIONAL LEVEL THIS LARGER, CONCERTED APPROACH WILL LEVERAGE COMMON STRENGTHS AND STRATEGIES TO MOVE IN THE SAME DIRECTION ON SIGNIFICANT HEALTH CONCERNS THE 2019 ASSESSMENT PROCESS BUILDS ON THE METHODOLOGY DEVELOPED DURING THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT IT INCLUDES MORE THAN 140 HOSPITAL AND COMMUNITY DATA INDICATORS THIS DATA WAS COMPARED TO THE NATION AND PAST PERFORMANCE AND USED TO IDENTIFY THE SIX ASSESSED HEALTH ISSUES (AHI) CANCER, LUNG DISEASE, CARDIOVASCULAR DISEASE, MENTAL HEALTH, DIABETES, AND ORAL HEALTH LOCAL STAKEHOLDERS UTILIZED A COMBINATION OF PUBLIC HEALTH AND HOSPITAL DATA, ALONG WITH A COMMUNITY SURVEY DATA, TO PRIORITIZE THE AHI BASED ON FEASIBILITY AND COMMUNITY READINESS THIS PRIORITIZATION PROCESS RESULTED IN THREE PRIORITIES FOR THE SPRINGFIELD COMMUNITY LUNG DISEASE, CARDIOVASCULAR DISEASE AND MENTAL HEALTH ALTHOUGH OTHER AHI WERE IDENTIFIED AS HEALTH ISSUES FOR THE SPRINGFIELD COMMUNITY, RESOURCES WOULD BE DILUTED IN AN EFFORT TO ADDRESS SEVERAL HEALTH ISSUES, THUS MINIMIZING THE ABILITY TO CREATE MEANINGFUL IMPACT BY PRIORITIZING THE AHI BY FEASIBILITY AND COMMUNITY READINESS, THE COMMUNITY WILL BE ABLE TO HAVE A GREATER IMPACT ON OVERALL COMMUNITY HEALTH THROUGH EFFICIENT AND EFFECTIVE RESOURCE ALLOCATION</p>
<p>SCHEDULE H, PART VI, LINE 3</p>	<p>PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE COX BARTON COUNTY HOSPITAL USES A VARIETY OF METHODS TO INFORM AND EDUCATE PATIENTS ABOUT THEIR ELIGIBILITY FOR ASSISTANCE UNDER FEDERAL, STATE PROGRAMS OR UNDER THE ORGANIZATION'S POLICY - AVAILABILITY OF FINANCIAL ASSISTANCE THROUGH THE ORGANIZATION IS COMMUNICATED TO PATIENTS THROUGH THE USE OF SIGNAGE AND BROCHURES/INFORMATION PACKETS AVAILABLE AT CHECK-IN LOCATIONS COX BARTON COUNTY HOSPITAL ALSO PROACTIVELY COMMUNICATES THE AVAILABILITY OF FINANCIAL ASSISTANCE ON PATIENT BILLS AND STATEMENTS, AND ITS EARLY-OUT VENDOR RESPONSIBLE FOR PATIENT BALANCE COLLECTIONS IS EXPECTED TO PROACTIVELY INFORM SELF PAY PATIENTS OF THE AVAILABILITY WHEN SPEAKING TO THEM ON THE PHONE FOR ASSISTANCE UNDER FEDERAL AND STATE PROGRAMS COX BARTON COUNTY HOSPITAL UTILIZES AN OUTSOURCE ELIGIBILITY VENDOR WHO MEETS WITH SELF PAY INPATIENTS AT THE BEDSIDE TO COMPLETE AN ELIGIBILITY SCREENING, INFORM THE PATIENTS OF POTENTIAL AVAILABILITY, AND WILL WORK WITH THE PATIENT TO HELP THEM THROUGH THE PROCESS OUTPATIENTS ARE REFERRED TO THE VENDOR AFTER CARE AND THOSE ARE WORKED IN A SIMILAR FASHION WITH THE EXPECTATION THAT THE FIRST CONTACT IS THROUGH MAIL OR PHONE RATHER THAN AT THE BEDSIDE</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
<p>SCHEDULE H, PART VI, LINE 4</p>	<p>COMMUNITY INFORMATION THE PRIMARY SERVICE AREA COUNTIES SERVED BY COX BARTON COUNTY HOSPITAL ARE BARTON, DADE, CEDAR AND VERNON COUNTIES WITH THE MAJORITY RESIDING IN BARTON COUNTY BARTON COUNTY IS A RURAL, PRIMARILY FARMING COMMUNITY WITH THREE SMALL TOWNS, ALL OF WHICH HAVE SCHOOL SYSTEMS LAMAR, A TOWN OF 7,809, IS THE COUNTY SEAT THE COUNTY OF BARTON HAS A TOTAL OF 11,720 PERSONS WHO LIVE IN A 591 76 SQUARE MILE AREA DIVERSITY IS LOW AS 95% OF THE POPULATION IS WHITE ALONE ACCORDING TO THE ROBERT WOOD JOHNSON COUNTY HEALTH RANKINGS, BARTON COUNTY RANKS 47 OUT OF 115 COUNTIES FOR HEALTH OUTCOMES AND 70 OUT OF 115 COUNTIES FOR HEALTH FACTORS THE LOWER THE RANKING INDICATES BETTER PERFORMANCE IN THE RESPECTIVE SUMMARY RANKINGS BARTON COUNTY'S MEDIAN HOUSEHOLD INCOME AND UNEMPLOYMENT RATES ARE BELOW STATE AND NATIONAL AVERAGES BARTON COUNTY QUALIFIES AS A HEALTH PROFESSIONAL SHORTAGE AREA ACCORDING TO THE NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION THE PERCENT OF ADULTS IN BARTON COUNTY WITH BMI GREATER THAN 30 IS 52 9% BELOW BOTH STATE AND NATIONAL AVERAGES THE PERCENT OF UNINSURED POPULATION IS 14 4% AND IS HIGHER THAN STATE AND NATIONAL AVERAGES</p>
<p>SCHEDULE H, PART VI, LINE 5</p>	<p>PROMOTION OF COMMUNITY HEALTH COX BARTON COUNTY HOSPITAL'S MISSION IS TO IMPROVE THE HEALTH OF THE COMMUNITIES WE SERVE THROUGH QUALITY HEALTHCARE, EDUCATION AND RESEARCH WE ACTIVELY LIVE THIS MISSION BY PROVIDING QUALITY HEALTH CARE WITH A HOSPITAL IN LAMAR AND TWO ACCESS POINTS TO RURAL HEALTH CLINICS WITHIN OUR SERVICE AREA OUR GOAL IS TO PROVIDE QUALITY, AFFORDABLE HEALTHCARE TO THE COMMUNITIES WE SERVE COMMUNITY INVOLVEMENT IS ACHIEVED IN A VARIETY OF WAYS TO ADDRESS THE ABOVE AVERAGE OBESITY RATE (32%) COMPARED TO THE STATE AVERAGE (30%) COX BARTON COUNTY HOSPITAL PARTNERS WITH THE BARTON COUNTY HEALTH DEPARTMENT TO PROVIDE PROGRAMS AND CHALLENGES IN HEALTHY LIVING AS WELL AS A FREE DIABETES SELF MANAGEMENT PROGRAM OUR REGISTERED DIETITIAN PROVIDES EDUCATION AT SCHOOL HEALTH FAIRS, CARDIAC REHABILITATION PROGRAM, AND IN COMMUNITY SUPPORT GROUPS COX BARTON COUNTY PROVIDES ANNUAL COMMUNITY HEALTH FAIR WITH MULTIPLE FREE SCREENINGS AND HEALTH EDUCATION FOR THE COMMUNITY COX BARTON COUNTY PROVIDES OUTREACH THROUGH FREE OR LOW COST HEALTH EDUCATION AND SCREENINGS TO LOCAL BUSINESSES COX BARTON COUNTY HOSTS A MONTHLY DIABETES SUPPORT GROUP AT NO COST TO ATTENDEES OUR CLINIC PROVIDERS PROVIDED FREE PHYSICALS TO SIX AREA SCHOOLS WE PARTNER WITH HOPE FOR YOU TO PROVIDE MAMMOGRAMS AT LITTLE TO NO COST COX BARTON COUNTY HOSPITAL PARTNERS WITH THE BARTON COUNTY HEALTH DEPARTMENT TO PROVIDE WOMENS HEALTH SERVICES THROUGH THE SHOW ME HEALTHY WOMEN PROGRAM HOSPITAL EMPLOYEES PROVIDE TWICE MONTHLY BLOOD PRESSURE CHECKS AT THE SENIOR CITIZENS CENTER HEALTHY FOOD DONATIONS ARE PROVIDED ON A MONTHLY BASIS TO A LOCAL AGENCY THAT PROVIDES SUMMER AND AFTER SCHOOL PROGRAMS TO CHILDREN COX BARTON COUNTY HOSPITAL ALSO PARTNERS WITH THE TRUMAN AREA TRANSPORTATION SYSTEM TO PROVIDE TRANSPORTATION TO LOCAL RESIDENTS FOR HEALTHCARE APPOINTMENTS AND OTHER NEEDS COX BARTON LEADERS PARTICIPATE IN CIVIC ORGANIZATIONS AND ARE ELECTED TO MEMBERS TO BOARDS WHOSE PURPOSE IS TO IMPROVE THE LIVES OF COMMUNITY MEMBERS EXAMPLES INCLUDE ROTARY, CHAMBER OF COMMERCE, AMBULANCE BOARD, METRO, LAMAR SCHOOL BOARD AND UNIVERSITY OF MISSOURI EXTENSION</p>

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 6	<p>AFFILIATED HEALTH CARE SYSTEM COXHEALTH IS THE PARENT OF LESTER E COX MEDICAL CENTERS AND ITS WHOLLY OWNED SUBSIDIARIES PLUS CERTAIN AFFILIATED NOT-FOR-PROFIT ENTITIES AND IS COLLECTIVELY REFERRED TO AS COXHEALTH COXHEALTH (THE HEALTH SYSTEM) OPERATES AS AN INTEGRATED DELIVERY SYSTEM INCLUDING FOUR HOSPITALS, A SURGICAL CENTER, AN INPATIENT REHABILITATION FACILITY, HOME CARE COMPANIES, PHYSICIAN SERVICES, MENTAL HEALTH SERVICES, INSURANCE COMPANIES AND A FOUNDATION COXHEALTH'S HOME CARE SERVICES ARE PROVIDED BY OXFORD HEALTHCARE, HOME PARENTERAL SERVICES (INFUSION THERAPY) AND HOME SUPPORT (DURABLE MEDICAL EQUIPMENT) OXFORD HEALTHCARE SUPPORTED THE COMMUNITY THROUGH MONTHLY NUTRITION AND FALL PREVENTION SEMINARS AT 20 AREA SENIOR CENTERS THROUGHOUT SOUTHWEST MISSOURI OXFORD ALSO PROVIDED FREE BONE DENSITY SCREENINGS AT 34 COMMUNITY EVENTS, AND VITAL SIGN SCREENINGS AT MANY MORE HOME PARENTERAL SERVICES RECEIVED A SECOND GRANT AWARD FROM THE MISSOURI FOUNDATION FOR HEALTH ORGANIZATION THIS GRANT ALLOWS HPS TO SERVE PATIENTS THAT FALL THROUGH THE CRACKS DUE TO HAVING NO REIMBURSEMENT OF ANY KIND, SERVING PATIENTS THROUGHOUT SOUTHERN MISSOURI COX-MONETT HOSPITAL SUPPORTS THE MONETT, MISSOURI AND SURROUNDING COMMUNITY BY PROVIDING A VARIETY OF SERVICES WHICH INCLUDE UROLOGY, ENT (EAR, NOSE AND THROAT), PULMONOLOGY, ORTHOPEDICS, CARDIOLOGY, PODIATRY, OBSTETRICS, RADIOLOGY (CT, MRI, NUCLEAR MEDICINE AND MAMMOGRAPHY), LABORATORY, 24-HOUR EMERGENCY CENTER, GENERAL SURGICAL SERVICES, SAME-DAY SURGERY, DIABETES CENTER, SLEEP CENTER, CARDIOPULMONARY REHAB, MEDICAL-SURGICAL UNIT, PHARMACY AND COMMUNITY WELLNESS COXHEALTH FOUNDATION SUPPORTS THE COMMUNITY BY RAISING FUNDS TO DISPERSE TO PATIENTS FOR THOSE NEEDS FOR WHICH THEY HAVE NO RESOURCES OR FUNDING, BUT WHICH ARE CRITICAL TO THE PATIENT'S HEALTH AND WELL BEING COXHEALTH AUXILIARY SUPPORTS THE COMMUNITY THROUGH FINANCIAL AND NON-FINANCIAL MEANS THE ORGANIZATION PROVIDES SCHOLARSHIPS TO NURSING AND MEDICAL TECHNOLOGY STUDENTS AT COX COLLEGE IN ADDITION, THE AUXILIARY PROVIDES SLEEP SACKS TO ALL NEWBORNS BORN AT LESTER E COX MEDICAL CENTERS AND CAR SEATS TO THOSE IN NEED TO ENSURE THE SAFETY OF ANY NEWBORN LEAVING LESTER E COX MEDICAL CENTERS IN JANUARY 2013, SKAGGS COMMUNITY HOSPITAL ASSOCIATION D/B/A COX MEDICAL CENTER BRANSON (CMCB) BECAME A PART OF THE COXHEALTH NETWORK UNDER THE AGREEMENT, A MEMBER SUBSTITUTION MODEL, CMCB CONTINUES TO MAINTAIN ITS OWN HOSPITAL BOARD WHILE BECOMING A SUBSIDIARY OF COXHEALTH COXHEALTH, AS THE PARENT COMPANY, ASSUMES THE RESPONSIBILITIES PREVIOUSLY HELD BY THE CMCB BOARD OF TRUSTEES THE CMCB BOARD WILL HAVE REPRESENTATION ON THE COXHEALTH BOARD THIS ALLOWS BOTH PARTIES TO ACT TOGETHER AS ONE ENTITY FOR THE PURPOSES OF CONTRACTING, RECRUITMENT AND GROWTH CMCB HAS BEEN SERVING SOUTHWEST MISSOURI RESIDENTS FOR MORE THAN 63 YEARS AND OFFERS OVER 25 MAJOR SERVICE AREAS THE HOSPITAL'S AVERAGE DAILY PATIENT CENSUS EXCEEDS 90 WITH 165 LICENSED HOSPITAL BEDS A STAFF OF OVER 1,000 PERSONNEL IS REQUIRED TO OPERATE THE HOSPITAL AND ITS NUMEROUS CLINICS COXHEALTH ADDED A FOURTH HOSPITAL IN 2018, COX BARTON COUNTY HOSPITAL (COX BARTON COUNTY) THE FACILITY WAS A COUNTY HOSPITAL OWNED AND OPERATED BY BARTON COUNTY MEMORIAL HOSPITAL (BCMh) IT WAS BUILT IN 2007 AND IS A 25-BED CRITICAL ACCESS HOSPITAL IN LAMAR, MISSOURI OFFERING AN EMERGENCY DEPARTMENT, AS WELL AS SPECIALIZED CARE IN DIABETES, CARDIOLOGY, ORTHOPEDICS AND SPORTS MEDICINE, NEUROLOGY, WOMEN'S HEALTH AND MORE IN OCTOBER 2017, COXHEALTH SIGNED A LETTER OF INTENT WITH BCMH TO ACQUIRE ITS OPERATION AND TO LEASE ITS PROPERTY BCMH WAS STRUGGLING AS A RURAL HOSPITAL TO KEEP UP WITH DECLINING REVENUE COXHEALTH'S ACQUISITION ALLOWS FOR THE PATIENTS PREVIOUSLY SERVED BY BCMH TO BECOME A PART OF THE COXHEALTH SYSTEM COX BARTON COUNTY WILL CONTINUE THE SERVICES PREVIOUSLY PROVIDED BY BCMH AND INTENDS TO EXPAND THESE SERVICES FURTHER IN THE FUTURE AS WELL TO COMPLETE THE TRANSACTION, COXHEALTH FORMED TWO ENTITIES, COX BARTON COUNTY HOSPITAL, A MISSOURI NONPROFIT CORPORATION, AND CBCH, LLC, A MISSOURI LIMITED LIABILITY COMPANY BOTH ENTITIES HAVE THE SAME CORPORATE PARENT, COXHEALTH, WHICH IS A MISSOURI NONPROFIT CORPORATION THE OPERATION AND ASSETS OF THE HOSPITAL HAVE BEEN HELD BY CBCH, LLC SINCE JANUARY 1, 2018 AND WILL BE TRANSFERRED TO COX BARTON COUNTY HOSPITAL EFFECTIVE OCTOBER 1, 2019</p>

**Additional Data****Software ID:****Software Version:****EIN:** 47-1087427**Name:** COXHEALTH**Form 990 Schedule H, Part V Section A. Hospital Facilities**

<b>Section A. Hospital Facilities</b>		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (Describe)	Facility reporting group
(list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? <u>1</u>											
Name, address, primary website address, and state license number											
1	COX BARTON COUNTY HOSPITAL 29 NW 1ST LANE LAMAR, MO 64759 COXHEALTH.COM 247	X	X			X		X			1

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

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 5	<p>COMMUNITY INPUT IN 2017, A VARIETY OF ORGANIZATIONS ACROSS THE OZARKS RECONVENED UNDER THE UMBRELLA OF THE OZARKS HEALTH COMMISSION TO ASSESS THE HEALTH NEEDS OF OUR REGION BUILDING UPON THE SUCCESS OF THE 2016 REGIONAL HEALTH ASSESSMENT, PARTNERS AGAIN SOUGHT TO BETTER UNDERSTAND THE HEALTH STATUS, BEHAVIORS AND NEEDS OF THE POPULATIONS THEY SERVE THIS 2019 ASSESSMENT COMBINES MORE THAN 140 HOSPITAL AND COMMUNITY DATA INDICATORS AS WELL AS FEEDBACK FROM STAKEHOLDERS AND THE BROADER COMMUNITY THIS PROCESS RESULTED IN THREE PRIORITIES LUNG DISEASE, CARDIOVASCULAR DISEASE AND MENTAL HEALTH WEAVING AMONG THE ISSUES IDENTIFIED WERE FIVE COMMON THREADS ACCESS TO HEALTH CARE, MENTAL HEALTH, PHYSICAL ACTIVITY, SOCIAL DETERMINANTS OF HEALTH AND TOBACCO USE ADDITIONALLY, THE HEALTH STATUS OF POPULATIONS OF INTEREST - SUCH AS PEOPLE IN POVERTY, MINORITIES AND THE ELDERLY--WERE ALSO ANALYZED RECOGNIZING THE VALUE OF ASSESSING AND ACTING TOGETHER ON LOCAL HEALTH ISSUES, KEY PLAYERS FROM LOCAL HOSPITAL SYSTEMS, PUBLIC HEALTH ENTITIES, AND OTHERS FORMED A WORKING GROUP TO BEGIN THE TASK OF A REGIONAL HEALTH ASSESSMENT THIS GROUP GREW UNDER THE UMBRELLA OF THE LOCAL OZARKS HEALTH COMMISSION (OHC) AND PUBLISHED THE FIRST ASSESSMENTS IN 2016 SINCE THAT TIME, THE PROCESS HAS BEEN RECOGNIZED AT THE ANNUAL MEETING OF THE AMERICAN PUBLIC HEALTH ASSOCIATION, HONORED AS A PROMISING PRACTICE BY THE NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICIALS, AND AWARDED THE GROUP MERIT AWARD FROM THE MISSOURI PUBLIC HEALTH ASSOCIATION COLLECTIVELY, THE ASSESSMENTS SPAN FOUR STATES - MISSOURI, OKLAHOMA, ARKANSAS, AND KANSAS, 29 COUNTIES AND THREE HOSPITAL SYSTEMS THIS FOOTPRINT WILL BE REFERRED TO THROUGHOUT THE REPORT AS THE OHC REGION PRIORITIZATION PROCESS INCLUDED THE FOLLOWING STAKEHOLDERS CITY OF SPRINGFIELD - PLANNING DEPARTMENT -COMMUNITY PARTNERSHIP OF THE OZARKS -COXHEALTH -DREW LEWIS FOUNDATION -MERCY -MISSOURI ALLIANCE OF YMCA -MISSOURI STATE UNIVERSITY -MISSOURI JOB CENTER -OZARKS FOOD HARVEST -OZARK GREENWAYS -SPRINGFIELD AREA CHAMBER OF COMMERCE -SPRINGFIELD-GREENE COUNTY HEALTH DEPARTMENT -SPRINGFIELD-GREENE COUNTY PARKS</p>

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

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 6A	CHNA CONDUCTED WITH OTHER HOSPITALS THE CHNA WAS CONDUCTED WITH THE FOLLOWING HOSPITAL FACILITY PARTNERS -FREEMAN HEALTH SYSTEM -MERCY -LESTER E COX MEDICAL CENTERS -COX-MONETT HOSPITAL, INC -SKAGGS COMMUNITY HOSPITAL ASSOCIATION

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

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 6B	CHNA CONDUCTED WITH OTHER ORGANIZATIONS THE CHNA WAS ALSO CONDUCTED WITH THE FOLLOWING OTHER NON-HOSPITAL ORGANIZATIONS -JASPER COUNTY HEALTH DEPARTMENT -JOPLIN HEALTH DEPARTMENT -SPRINGFIELD GREENE COUNTY HEALTH DEPARTMENT -TANEY COUNTY HEALTH DEPARTMENT

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

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 7A	CHNA HOSPITAL FACILITY'S WEBSITE <a href="https://www.coxhealth.com/about-us/community-health-needs-assessments/">HTTPS //WWW COXHEALTH COM/ABOUT-US/COMMUNITY-HEALTH-NEEDS-ASSESSMENTS/</a>

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

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 7B	CHNA OTHER WEBSITES HTTP //WWW OZARKSHEALTHCOMMISSION ORG HTTP //WWW MERCY NET HTTP //WWW COXHEALTH COM HTTP //WWW FREEMANHEALTH COM

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

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 7D	OTHER METHODS TO MAKE THE CHNA REPORT AVAILABLE TO THE PUBLIC PRINTED COPIES ARE AVAILABLE BY REQUEST THROUGH HOSPITAL OR PUBLIC HEALTH PARTNERS OR AT OZARKSHEALTHCOMMISSION ORG AND NEWS RELEASE WAS SENT OUT TO ENCOURAGE MEDIA COVERAGE WITH LINKS TO THE REPORT AND KEY MESSAGES FOR THE PUBLIC

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

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 10A	IMPLEMENTATION STRATEGY WEBSITE <a href="https://www.coxhealth.com/about-us/community-health-needs-assessments/">HTTPS //WWW COXHEALTH COM/ABOUT-US/COMMUNITY-HEALTH-NEEDS-ASSESSMENTS/</a>

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

Form and Line Reference	Explanation
<p>SCHEDULE H, PART V, SECTION B, LINE 11</p>	<p>ADDRESSING IDENTIFIED NEEDS 1 INCREASE PATIENT ENGAGEMENT IN CHRONIC CONDITION SELF-MANAGEMENT -THE CENTER FOR HEALTH IMPROVEMENT EMPLOYS A SKILLED TEAM OF HEALTHCARE PROFESSIONALS WHO DELIVER SUPPORT AND EDUCATION FOR CHRONIC DISEASE MANAGEMENT, NUTRITION SERVICES, AND ADVANCED CARE PLANNING THEY PROVIDE TOOLS DESIGNED TO INCREASE SELF-MANAGEMENT OF CHRONIC CONDITIONS INCLUDING DIABETES, LUNG DISEASE, CHRONIC PAIN, AND MORE -IN THE FIRST QUARTER CALENDAR YEAR 2018, A CURRENT STATE ASSESSMENT OF THE CENTER FOR HEALTH IMPROVEMENT WAS CONDUCTED TO DETERMINE THE EFFICACY OF VARIOUS PROGRAMS AS A RESULT OF THE ASSESSMENT, THE TEAM IS REFINING THE SCOPE OF OFFERINGS TO AN EVIDENCE-BASED, TARGETED PROGRAM SUITE THAT FOCUSES HEAVILY ON IMPROVING CHRONIC CONDITION MANAGEMENT OF PATIENTS THIS REORGANIZATION AND RESTRUCTURE REMAINS IN PROCESS WITH PLANS FOR FULL IMPLEMENTATION IN THE NEAR FUTURE -THE NURSING EDUCATION DEPARTMENT AND THE JOINT REPLACEMENT EDUCATORS AT MEYER ORTHO PEDIC CENTER DEVELOPED A PROCESS TO INCREASE TIGR VIDEO EDUCATION VIEWS MANDATORY EDUCATION WAS EXPANDED TO INCLUDE ALL ADULT PATIENTS WITH A DIAGNOSIS OF PNEUMONIA, HEART FAILURE, ACUTE MI, TOTAL HIP/KNEE REPLACEMENT, OR COPD TO HELP ACHIEVE BEST OUTCOMES WHILE REDUCING READMISSIONS -AS A RESULT OF THIS INTERVENTION, TIGR VIDEO VIEWS INCREASED FROM 1,618 VIEWS IN JUNE 2017, TO 4,694 VIEWS IN MAY 2018 2 REDUCE AVOIDABLE HOSPITAL READMISSIONS -IN FEBRUARY 2017, COXHEALTH IMPLEMENTED A PATIENT READMISSION INTERVIEW FORM WHEN A PATIENT IS READMITTED WITHIN THIRTY DAYS, A CASE MANAGER MEETS WITH THE PATIENT TO DISCUSS THE READMISSION TO INCREASE THE NUMBER OF PATIENTS INTERVIEWED, COXHEALTH NURSING ADMINISTRATION BEGAN TRAINING NURSES ON LIGHT DUTY TO COMPLETE THE INTERVIEWS IN 2018 TOPICS COVERED IN THE INTERVIEW INCLUDE &gt;FREQUENCY OF GOOD COMMUNICATION IN THE HOSPITAL REGARDING DIAGNOSIS AND MEDICATIONS &gt;COMMUNICATION ABOUT DISCHARGE INSTRUCTIONS AND ABILITY TO UNDERSTAND INSTRUCTIONS &gt;MEDICATION COMPLIANCE AND REASONS FOR ANY DIFFICULTY REMAINING COMPLIANT &gt;FOLLOW UP APPOINTMENTS WITH A PCP BEING SCHEDULED AND ATTENDED &gt;REASONS FOR READMISSION, FROM THE PATIENT'S PERSPECTIVE &gt;&gt;THE INFORMATION GATHERED BY THE CASE MANAGER COMES DIRECTLY FROM THE PATIENT AND IS ENTERED INTO REPORTABLE FIELDS THAT ALLOW FOR DATA COLLECTION COMMON THEMES FOR AVOIDABLE READMISSIONS WILL BE EASIER TO IDENTIFY AND PREVENT THROUGH THIS PROCESS -EVIDENCE-BASED BEST PRACTICES TO REDUCE AVOIDABLE READMISSIONS HAVE BEEN IMPLEMENTED AND CONTINUE TO EXPAND &gt;COXHEALTH HIRED TRANSITIONAL CARE PHARMACISTS WHO DEDICATE THEIR TIME WORKING WITH PATIENTS BEING DISCHARGED TO ENSURE THE PATIENT LEAVES THE HOSPITAL WITH THEIR MEDICATIONS &gt;NEW EFFORTS ARE IN PLACE TO INCREASE THE NUMBER OF PATIENTS WHO LEAVE THE HOSPITAL WITH THEIR MEDICATIONS THROUGH THE USE OF A FOCUSED, FAST-PACED I-90 PROJECT &gt;THE CLINIC SUPPORT TEAM HAS BEEN INSTRUMENTAL IN SCHEDULING FOLLOW-UP APPOINTMENTS WITH PATIENTS THE MA</p>

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 11	<p>JORITY OF INPATIENT UNITS ARE COVERED BY THE CLINIC SUPPORT TEAM, WHICH MEANS MOST PATIENT S HAVE A FOLLOW UP APPOINTMENT SCHEDULED PRIOR TO LEAVING THE HOSPITAL &gt;A SUBGROUP COMPRI SED OF FRONTLINE STAFF, LEADERS, AND QUALITY IMPROVEMENT EXPERTS HAS FORMED TO FOCUS SPECI FICALLY ON REDUCING HEART FAILURE READMISSIONS THE GROUP WILL USE DATA TO INFORM DECISION S ON HOW TO BEST MANAGE OUR PATIENTS WITH FREQUENT INPATIENT STAYS DUE TO HEART FAILURE 3 INCREASE ACCESS TO TOBACCO CESSATION RESOURCES FOR PATIENTS AND FAMILIES PRESENTING TO O UR HOSPITALS AND CLINICS -AN ASSET ASSESSMENT AND GAP ANALYSIS OF THE SYSTEM'S CURRENT TOB ACCO TREATMENT OFFERINGS WAS CONDUCTED EARLIER THIS YEAR RECOMMENDATIONS FROM THAT ASSESS MENT INCLUDE CREATION AND IMPLEMENTATION OF A CLEARLY OUTLINED REFERRAL PROCESS AND DEFINE D RESOURCES, PROMOTION OF THE ASK, ADVISE, ACT/REFER MODEL TO INITIATE INTERVENTION, DEVEL OPMENT AND IMPLEMENTATION OF PREOPERATIVE PROTOCOL TO PROMOTE TOBACCO CESSATION 12 HOURS P RE- AND POST-SURGERY -EARLIER THIS YEAR, WE PROVIDED TRAINING TO 12 KEY COXHEALTH STAFF M EMBERS AND 3 COMMUNITY EDUCATORS COMPLETION OF THE UMASS EDUCATION CURRICULUM, REQUIRED E XAMS, AND PRACTICE HOURS MAKE CLASS PARTICIPANTS ELIGIBLE FOR CERTIFICATION AS TOBACCO TRE ATMENT SPECIALISTS AS A RESULT OF THIS EDUCATION, THERE WILL BE A LARGE INCREASE IN THE A MOUNT OF CESSATION RESOURCES AVAILABLE WITHIN THE SYSTEM -THE QUIT RATE FOR OUR MFH STONE AND TANEY COUNTIES TOBACCO CESSATION GRANT HAS STEADILY INCREASED SINCE ITS INCEPTION IN 2013, WITH THE CURRENT QUIT RATE FOR 2018 TO DATE AT 75% AVERAGING ACROSS THE HISTORY OF THE PROGRAM, THE AGGREGATED QUIT RATE IS 53% -DUE TO THE SUCCESS OF THIS PROGRAM, FOLLOWI NG THE GRANT'S END ON MAY 31, 2018, WE WERE ABLE TO HIRE A FULL TIME TOBACCO CESSATION COO RDINATOR WHO WILL BE RESPONSIBLE FOR COORDINATING SYSTEM EFFORTS TO STANDARDIZE POLICIES A ND REFERRAL PROCESSES ACROSS ALL CAMPUSES AND SETTINGS 4 DECREASE CHILDHOOD OBESITY -THE CARDIAC KIDS PROGRAM IS IMPLEMENTED IN 13 RURAL SCHOOLS IN THE COXHEALTH SERVICE AREA IT S MAIN OBJECTIVE IS TO SCREEN 5TH GRADE STUDENTS FOR HEALTH INDICATORS THAT PUT THEM AT HI GH RISK FOR DEVELOPING CARDIAC DISEASE SCREENING BY COXHEALTH STAFF INCLUDES HEIGHT AND W EIGHT MEASUREMENT, BMI CONSULT, AND HEALTH/NUTRITION EDUCATION -APPROXIMATELY 400 CHILDR E N ARE SCREENED ANNUALLY THOSE WHO ARE DEEMED HIGH RISK ARE REFERRED TO THE COMMITTED TO K IDS PROGRAM THIS 8-WEEK PROGRAM IS AN INTENSIVE INTERVENTION FOR AT-RISK CHILDREN AND THE IR FAMILIES FOCUSING ON HEATHY BEHAVIOR AND NUTRITION EDUCATION -PLANS ARE IN PLACE TO FU RTHER INTEGRATE THE TWO PROGRAMS TO PROVIDE A COHESIVE UNIT AND BETTER UTILIZE RESOURCES T O SERVE AT-RISK COMMUNITIES 5 INCREASE THE NUMBER OF WOMEN WHO BREASTFEED THEIR INFANTS AFTER DELIVERY -COXHEALTH AND THE SPRINGFIELD-GREENE COUNTY HEALTH DEPARTMENT ARE CURRENTL Y ENGAGED IN A COMMUNITY BREASTFEEDING COALITION WITH THE GOAL OF STRATEGICALLY ALIGNING E FFORTS TO HELP MOVE THE CHIP I</p>

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

Form and Line Reference	Explanation
<p>SCHEDULE H, PART V, SECTION B, LINE 11</p>	<p>INITIATIVE FORWARD -IN ADDITION TO EDUCATION PRESENTED IN OUR GENERAL PRENATAL CLASSES, TH E COXHEALTH LACTATION CONSULTANTS FACILITATE A MONTHLY BREASTFEEDING SUPPORT GROUP CALLED THE LACTATION CLUB -THE ANNUAL COXHEALTH BABY FAIR IS A FREE EVENT THAT FEATURES VENDOR D ISPLAYS, DEMONSTRATIONS, DOOR PRIZES, AND CLASSES WITH A VARIETY OF TOPICS INCLUDING BREAS TFEEDING 6 INCREASE DETECTION AND TREATMENT OF THE EARLIEST STAGES OF LUNG CANCER NODULE S -COXHEALTH OFFERS LOW-DOSE CT SCANS AS A DIAGNOSTIC SCREENING FOR LUNG CANCER LOW-DOSE CT SCANS USE LOWER AMOUNTS OF RADIATION TO HELP IDENTIFY LUNG NODULES IN THE EARLIEST STAG ES OF LUNG CANCER WHEN IT IS MOST TREATABLE STUDIES HAVE SHOWN THAT PATIENTS WHO PARTICIP ATE IN A LOW-DOSE CT LUNG CANCER PROGRAM ARE 20% LESS LIKELY TO DIE FROM LUNG CANCER THAN THOSE WHO WERE NOT SCREENED WHEN APPROPRIATE -SINCE THE PROGRAM BEGAN, THE NUMBER OF INDI VIDUALS WHO HAD A LOW-DOSE CT SCAN COMPLETED HAS INCREASED NEARLY THREE-FOLD AS A RESULT, 354 PEOPLE HAVE BEEN SCREENED FOR EARLY STAGE LUNG CANCER USING LOW-DOSE CT SCAN TECHNOLO GY -THE GOAL OF DEVELOPING A REFERRAL PATHWAY BETWEEN THE CLINIC AND SYSTEM TOBACCO CESSA TION RESOURCES IS UNDERWAY 7 INCREASE REFERRALS TO COMMUNITY ORAL HEALTH RESOURCES FOR P ATIENTS PRESENTING TO THE ED FOR DENTAL ISSUES -COMMUNITY PARTNERSHIPS WITH LOCAL RESOURCE S HAVE BEEN STRENGTHENED AND REFINED TO ENSURE STAFF FEEL EMPOWERED TO REFER PATIENTS TO F ACILITIES LIKE THE JORDAN VALLEY COMMUNITY HEALTH CENTER (JVCHC) FOR THE APPROPRIATE LEVEL OF CARE FOR ORAL HEALTH ISSUES -WHEN EVALUATING THE CHIEF COMPLAINTS OF PATIENTS THAT PR ESENTED TO THE EMERGENCY DEPARTMENT (ED) FIVE OR MORE TIMES IN A 12-MONTH PERIOD FOR NON-E MERGENT CARE, DENTAL COMPLAINTS RANKED AMONG THE HIGHEST -PROTOCOLS WERE DEVELOPED FOR PA TIENTS THAT PRESENT WITH TOOTH PAIN IN THE ED AFTER THE MEDICAL SCREENING EXAM COMPLETION , THE PATIENT IS TRANSITIONED TO JVCHC FOR IMMEDIATE DENTAL CARE -COXHEALTH WORKED IN COL LABORATION WITH JVCHC TO APPLY FOR A GRANT THAT ALLOWED FOR THE HIRE OF ADDITIONAL DENTIST S TO ENSURE SAME-DAY OR NEXT DAY APPOINTMENTS, THE DENTAL CLINIC EXPANDED TO ADD SATURDAY HOURS -QUICK ACCESS TO THE DENTAL CLINIC ALLOWED COXHEALTH ED PHYSICIANS TO DISCONTINUE PRESCRIBING NARCOTICS TO PATIENTS WHO PRESENTED WITH TOOTH PAIN IN 2017, 2,098 INDIVIDUAL S WHO PRESENTED TO THE SPRINGFIELD ED WITH NON-EMERGENT DENTAL PAIN WERE REFERRED TO JORDA N VALLEY FOR TREATMENT OF THOSE INDIVIDUALS, 1,061 (50 5%) RECEIVED TREATMENT -FOLLOWING A JOINT EFFORT BETWEEN PROGRAM ADMINISTRATORS AT COXHEALTH AND JORDAN VALLEY TO IMPROVE C OMMUNICATION AND DATA REPORTING, THE MONTHLY REFERRAL COMPLETION RATE TO DATE HAS INCREASE D EXPONENTIALLY TO 91 0% -IN 2017, OF THE 612 INDIVIDUALS WHO PRESENTED TO COX BRANSON ED WITH DENTAL PAIN, 426 WERE REFERRED TO APPROPRIATE DENTAL CARE OF THOSE REFERRAL PATIENT S WHO COULD BE REACHED FOR FOLLOW-UP, 31 5% HAD FULFILLED THEIR REFERRAL APPOINTMENT THE LOW COMPLETION RATE CAN BE COR</p>

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

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Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 13A	ELIGIBILITY FOR FREE CARE IN GENERAL, THE ORGANIZATION'S CHARITY CARE POLICY DOES NOT PROVIDE FOR DISCOUNTS OF 100% THEREFORE, IT IS EXPECTED THAT THE PATIENT OR GUARANTOR WILL HOLD A RESPONSIBILITY FOR PAYMENT OF AT LEAST A PORTION OF THE SERVICES, REGARDLESS OF THE LEVEL OF ELIGIBILITY IT IS OUR INTENTION TO WORK WITH INDIVIDUALS ON THEIR OUT-OF-POCKET RESPONSIBILITY TO ESTABLISH FEASIBLE MONTHLY PAYMENTS WHEN NECESSARY IN THE EVENT THAT A PATIENT OR GUARANTOR IS DETERMINED TO HAVE NO MEANS OF PAYING THE AMOUNT INDICATED AS THEIR RESPONSIBILITY DUE TO EXTENUATING CIRCUMSTANCES, CONSIDERATION MAY BE GIVEN TO WAIVING DEDUCTIBLES AND/OR INCREASING THE DISCOUNT AMOUNT UP TO A 100% DISCOUNT OF THE PATIENT PORTION THESE EXTENUATING CASES ARE SUBJECT TO THE DISCRETION AND APPROVAL OF THE PFS DIRECTOR AND/OR THE CHIEF FINANCIAL OFFICER WITHIN THE APPROVAL LIMITS DEFINED AT THE END OF THE POLICY

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

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 13H	OTHER CRITERIA USED TO DETERMINE FINANCIAL ASSISTANCE ELIGIBILITY MEDICAL HARDSHIP MAY ALSO BE USED TO DETERMINE FINANCIAL ELIGIBILITY COXHEALTH SHALL MAKE A DECISION ABOUT A PATIENT/GUARANTOR'S MEDICAL HARDSHIP BY REVIEWING THE FINANCIAL ASSISTANCE APPLICATION, INCLUDING ACCOMPANYING FINANCIAL DOCUMENTATION, IN ADDITION TO OTHER RELEVANT DOCUMENTATION THAT SUPPORTS THE MEDICAL HARDSHIP OF THE PATIENT

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

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 16A	FINANCIAL ASSISTANCE POLICY WEBSITE <a href="https://www.coxhealth.com/patients-and-visitors/financial-assistance/">HTTPS //WWW COXHEALTH COM/PATIENTS-AND-VISITORS/FINANCIAL-ASSISTANCE/</a>

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

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 16B	FINANCIAL ASSISTANCE POLICY APPLICATION FORM WEBSITE <a href="https://www.coxhealth.com/patients-and-visitors/financial-assistance/">HTTPS //WWW COXHEALTH COM/PATIENTS-AND-VISITORS/FINANCIAL-ASSISTANCE/</a>

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

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 16C	PLAIN LANGUAGE SUMMARY WEBSITE <a href="https://www.coxhealth.com/patients-and-visitors/financial-assistance/">HTTPS //WWW COXHEALTH COM/PATIENTS-AND-VISITORS/FINANCIAL-ASSISTANCE/</a>

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

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 16J	MEASURES TO PUBLICIZE THE POLICY FINANCIAL ASSISTANCE AVAILABILITY IS PROACTIVELY COMMUNICATED TO UNINSURED PATIENTS BY CUSTOMER SERVICE STAFF AND BY OUR EARLY OUT AND BAD DEBT VENDORS, ANYONE RECOGNIZED AS UNINSURED IS TOLD ABOUT THE FA AVAILABILITY AND ENCOURAGED TO PARTICIPATE

**Schedule J**  
(Form 990)

Department of the Treasury  
Internal Revenue Service

## Compensation Information

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

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 23.**  
▶ **Attach to Form 990.**  
▶ **Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.**

OMB No 1545-0047

# 2018

**Open to Public Inspection**

Name of the organization  
COXHEALTH

Employer identification number  
47-1087427

**Part I Questions Regarding Compensation**

		Yes	No		
<p><b>1a</b> Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input checked="" type="checkbox"/> First-class or charter travel  <input type="checkbox"/> Travel for companions  <input type="checkbox"/> Tax indemnification and gross-up payments  <input type="checkbox"/> Discretionary spending account                 </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Housing allowance or residence for personal use  <input type="checkbox"/> Payments for business use of personal residence  <input type="checkbox"/> Health or social club dues or initiation fees  <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)                 </td> </tr> </table>	<input checked="" type="checkbox"/> First-class or charter travel <input type="checkbox"/> Travel for companions <input type="checkbox"/> Tax indemnification and gross-up payments <input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Housing allowance or residence for personal use <input type="checkbox"/> Payments for business use of personal residence <input type="checkbox"/> Health or social club dues or initiation fees <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)			
<input checked="" type="checkbox"/> First-class or charter travel <input type="checkbox"/> Travel for companions <input type="checkbox"/> Tax indemnification and gross-up payments <input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Housing allowance or residence for personal use <input type="checkbox"/> Payments for business use of personal residence <input type="checkbox"/> Health or social club dues or initiation fees <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)				
<p><b>b</b> If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain.</p>	<b>1b</b>	Yes			
<p><b>2</b> Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?</p>	<b>2</b>	Yes			
<p><b>3</b> Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Compensation committee  <input type="checkbox"/> Independent compensation consultant  <input type="checkbox"/> Form 990 of other organizations                 </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Written employment contract  <input type="checkbox"/> Compensation survey or study  <input type="checkbox"/> Approval by the board or compensation committee                 </td> </tr> </table>	<input type="checkbox"/> Compensation committee <input type="checkbox"/> Independent compensation consultant <input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Written employment contract <input type="checkbox"/> Compensation survey or study <input type="checkbox"/> Approval by the board or compensation committee			
<input type="checkbox"/> Compensation committee <input type="checkbox"/> Independent compensation consultant <input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Written employment contract <input type="checkbox"/> Compensation survey or study <input type="checkbox"/> Approval by the board or compensation committee				
<p><b>4</b> During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:</p> <p><b>a</b> Receive a severance payment or change-of-control payment?</p> <p><b>b</b> Participate in, or receive payment from, a supplemental nonqualified retirement plan?</p> <p><b>c</b> Participate in, or receive payment from, an equity-based compensation arrangement?</p> <p>If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.</p>	<b>4a</b>		No		
	<b>4b</b>	Yes			
	<b>4c</b>		No		
<p><b>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</b></p> <p><b>5</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:</p> <p><b>a</b> The organization?</p> <p><b>b</b> Any related organization?</p> <p>If "Yes," on line 5a or 5b, describe in Part III.</p>	<b>5a</b>		No		
	<b>5b</b>		No		
<p><b>6</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:</p> <p><b>a</b> The organization?</p> <p><b>b</b> Any related organization?</p> <p>If "Yes," on line 6a or 6b, describe in Part III.</p>	<b>6a</b>		No		
	<b>6b</b>		No		
<p><b>7</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III.</p>	<b>7</b>		No		
<p><b>8</b> Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III.</p>	<b>8</b>		No		
<p><b>9</b> If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?</p>	<b>9</b>				



**Part III Supplemental Information**

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

Return Reference	Explanation
SCHEDULE J, PART I, LINE 1B	FIRST CLASS OR CHARTER TRAVEL STEVE EDWARDS, JAKE MCWAY AND DENNIS HEIM UTILIZE CHARTER TRAVEL IN CONNECTION WITH JOB DUTIES FOR COXHEALTH TO EXPEDITE TRAVEL TO COLLABORATIVE MEETINGS AT MEMBER HOSPITALS ACROSS THE MIDWEST

<b>Return Reference</b>	<b>Explanation</b>
SCHEDULE J, PART I, LINE 3	ESTABLISHMENT OF TOP MANAGEMENT OFFICIAL COMPENSATION LESTER E COX MEDICAL CENTERS, A RELATED PARTY OF THE ORGANIZATION, USES THE FOLLOWING TO ESTABLISH THE COMPENSATION OF THE COXHEALTH TOP MANAGEMENT OFFICIAL COMPENSATION COMMITTEE, INDEPENDENT COMPENSATION CONSULTANT, WRITTEN EMPLOYMENT CONTRACT, COMPENSATION SURVEY OR STUDY, AND APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE

<b>Return Reference</b>	<b>Explanation</b>
SCHEDULE J, PART I, LINE 4B	SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN STEVE EDWARDS, JACOB MCWAY, AND CHARITY ELMER PARTICIPATE IN A 457(F) NONQUALIFIED RETIREMENT PLAN WITH LESTER E COX MEDICAL CENTERS, A RELATED ORGANIZATION - STEVE EDWARDS RECEIVED AN EXECUTIVE 457(F) CONTRIBUTION OF \$255,977 - JACOB MCWAY RECEIVED AN EXECUTIVE 457(F) CONTRIBUTION OF \$113,098 - JACOB MCWAY RECEIVED A 457(F) DISTRIBUTION OF \$126,919, WHICH WAS REPORTED AS DEFERRED COMPENSATION ON A PRIOR FORM 990 - CHARITY ELMER RECEIVED AN EXECUTIVE 457(F) CONTRIBUTION OF \$71,194 - CHARITY ELMER RECEIVED A 457(F) DISTRIBUTION OF \$50,259, WHICH WAS REPORTED AS DEFERRED COMPENSATION ON A PRIOR FORM 990

<b>Return Reference</b>	<b>Explanation</b>
SCHEDULE J, PART II, AND FORM 990, PART VII	BOARD MEMBER COMPENSATION NO COMPENSATION WAS PROVIDED FOR RESPONSIBILITIES ASSOCIATED WITH BEING A BOARD DIRECTOR COMPENSATION REPORTED FOR SEVERAL BOARD MEMBERS LISTED ON SCHEDULE J REPRESENTS EMPLOYEE OR INDEPENDENT CONTRACTOR COMPENSATION UNRELATED TO SERVICE AS A BOARD MEMBER

<b>Return Reference</b>	<b>Explanation</b>
SCHEDULE J, PART II, COLUMN F	COMPENSATION REPORTED ON PRIOR FORM 990 COMPENSATION IS REPORTED ON THE FORM 990 IN THE YEAR THAT THE COMPENSATION IS EARNED BY OR AWARDED TO AN INDIVIDUAL, EVEN IF THE COMPENSATION IS NOT PAID TO THE INDIVIDUAL, IS NOT FULLY VESTED, OR IS SUBJECT TO SUBSTANTIAL RISK OF FORFEITURE IF COMPENSATION IS EARNED OR AWARDED IN ONE YEAR BUT PAID IN A LATER YEAR, THEN THE COMPENSATION IS REPORTED A SECOND TIME ON THE FORM 990 IN THE YEAR THE COMPENSATION IS VESTED OR PAID TO THE INDIVIDUAL



**Additional Data**

**Software ID:**  
**Software Version:**  
**EIN:** 47-1087427  
**Name:** COXHEALTH

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
STEVE EDWARDS PRESIDENT AND CEO	(i)	1,113,707	377,807	10,359	269,727	25,566	1,797,166	0
	(ii)	0	0	0	0	0	0	0
JACOB MCWAY SR VP AND CFO	(i)	605,649	148,486	137,806	144,963	23,216	1,060,120	126,919
	(ii)	0	0	0	0	0	0	0
HOWARD JARVIS MD BOARD MEMBER	(i)	0	0	0	0	0	0	0
	(ii)	381,224	0	0	0	16,320	397,544	0
DAVID ZOLFAGHARI MD BOARD MEMBER	(i)	0	0	0	0	0	0	0
	(ii)	1,125,716	0	0	0	16,320	1,142,036	0
IBRAHIM ABE ABDALLA MD BOARD MEMBER	(i)	0	0	0	0	0	0	0
	(ii)	983,315	0	0	0	16,320	999,635	0
JAMES GIBSON MD BOARD MEMBER	(i)	0	0	0	0	0	0	0
	(ii)	496,586	0	0	0	14,272	510,858	0
JULIA FLAX MD BOARD MEMBER	(i)	0	0	0	0	0	0	0
	(ii)	381,108	0	450	13,365	11,951	406,874	0
PATRICIA DIX MD BOARD MEMBER	(i)	0	0	0	0	0	0	0
	(ii)	360,417	0	2,843	26,750	14,746	404,756	0
DARREN BASS INTERIM PRESIDENT END 01/2019	(i)	0	0	0	0	0	0	0
	(ii)	146,899	10,393	294	8,178	12,895	178,659	0
CHARITY ELMER SR VP AND GENERAL COUNSEL	(i)	469,875	58,237	58,166	103,444	22,270	711,992	50,259
	(ii)	0	0	0	0	0	0	0
JAMES ANDERSON VP LEGISLATIVE AFFAIRS	(i)	93,724	9,726	0	5,173	0	108,623	0
	(ii)	0	0	0	0	0	0	0
JANN HOLLAND VP MARKETING	(i)	239,082	8,241	690	12,794	16,353	277,160	0
	(ii)	0	0	0	0	0	0	0
BETTY BRESHEARS VP CORPORATE COMPLIANCE	(i)	197,845	14,756	1,980	10,879	8,196	233,656	0
	(ii)	0	0	0	0	0	0	0
ANDREW HEDGPETH VP HR	(i)	224,651	16,037	270	12,462	11,932	265,352	0
	(ii)	0	0	0	0	0	0	0
TIMOTHY JONES DO JOC CHAIR	(i)	381,999	14,658	450	13,365	16,395	426,867	0
	(ii)	0	0	0	0	0	0	0
DAVID RANEY VP COXHEALTH NETWORK	(i)	250,792	17,295	450	13,750	16,404	298,691	0
	(ii)	0	0	0	0	0	0	0
BRUCE ROBISON CIO	(i)	188,687	13,242	1,980	10,600	14,741	229,250	0
	(ii)	0	0	0	0	0	0	0
RODNEY SCHAFFER VP FACILITIES MGMT	(i)	243,993	14,186	1,980	13,088	8,159	281,406	0
	(ii)	0	0	0	0	0	0	0
DAVID TAYLOR VP CORPORATE SERVICES	(i)	289,766	21,187	4,395	26,750	16,535	358,633	0
	(ii)	0	0	0	0	0	0	0
STACI NIEMOTH JOC CHAIR	(i)	571,029	0	0	0	16,320	587,349	0
	(ii)	0	0	0	0	0	0	0

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

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

**2018****Open to Public Inspection**

Department of the Treasury

Name of the organization

COXHEALTH

Employer identification number

47-1087427

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART I, LINE 6	NUMBER OF VOLUNTEERS THE ORGANIZATION'S BOARD OF DIRECTORS IS A VOLUNTEER BOARD

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART V, LINE 2A & PART VII, SECTION A, COLUMN D	W-2 COMPENSATION THE ORGANIZATION'S CEO, CFO, AND SEVERAL CORPORATE KEY EMPLOYEES RECEIVE W-2 COMPENSATION ISSUED BY LESTER E COX MEDICAL CENTERS, A RELATED ORGANIZATION, FOR THE IR WORK WHICH IS PERFORMED MOSTLY FOR THE BENEFIT OF COXHEALTH THIS COMPENSATION IS APPROVED VIA THE COXHEALTH BOARD, AS DESCRIBED IN THE NARRATIVE FOR PART VI, SECTION B, LINES 15A & 15B

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, SECTION A, LINE 2	BUSINESS RELATIONSHIPS BOARD MEMBERS JAN BAUMGARTNER, AND ROBERT FULP HAVE A BUSINESS RELATIONSHIP BOARD MEMBERS THOMAS AUNER AND TIMOTHY CLOYD HAVE A BUSINESS RELATIONSHIP BOARD MEMBERS WHO RECEIVE COMPENSATION, OFFICERS, AND KEY EMPLOYEES ARE EMPLOYED BY COXHEALTH AND ITS AFFILIATES AND THEREFORE SHARE A BUSINESS RELATIONSHIP

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, SECTION B, LINE 11B	990 REVIEW POLICY THE FORM 990 IS PREPARED BY AN INDEPENDENT ACCOUNTING FIRM BASED ON THE AUDITED FINANCIAL STATEMENTS AND INFORMATION PROVIDED BY THE ACCOUNTING DEPARTMENT OF THE ORGANIZATION PRIOR TO FILING, FORM 990 IS FIRST REVIEWED BY MEMBERS OF TOP MANAGEMENT ONCE THEY HAVE APPROVED THE DRAFT, A FINAL COPY IS PROVIDED TO THE BOARD OF DIRECTORS THROUGH THE ONLINE BOARD PORTAL PRIOR TO FILING

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, SECTION B, LINE 12C	MONITORING COMPLIANCE WITH CONFLICT OF INTEREST POLICY COXHEALTH OFFICERS, DIRECTORS AND KEY EMPLOYEES, AS WELL AS OFFICERS, DIRECTORS AND KEY EMPLOYEES OF THE COXHEALTH AFFILIATES AND/OR COMMITTEES WITH DELEGATED AUTHORITY TO MAKE DECISIONS, ARE ANNUALLY REQUIRED TO DISCLOSE POTENTIAL CONFLICTS OF INTEREST FOLLOWING THE POLICY SET FORTH BELOW THE POLICY REQUIRES THAT BOARD MEMBERS MAKE DECISIONS THAT ARE CONFLICT FREE, OR IF A CONFLICT IS PRESENT, THAT IT IS FULLY DISCLOSED FOR THE BOARD'S CONSIDERATION COXHEALTH'S EMPLOYEES AND BOARD MEMBERS MUST AVOID ALL ACTIVITIES, ASSOCIATIONS OR INTERESTS THAT CREATE A CONFLICT OF INTEREST CONFLICTS OF INTEREST FOR EMPLOYEES MUST BE REPORTED TO THE CORPORATE INTEGRITY DEPARTMENT A FILE WILL BE MAINTAINED OF ALL REPORTED CONFLICTS OF INTEREST FOR MEDICAL STAFF MEMBERS, THE CONFLICT OF INTEREST PROCESS MAY BE ACCESSED THROUGH THE MEDICAL STAFF OFFICE FOR BOARD MEMBERS, THE CONFLICT OF INTEREST PROCESS IS HANDLED THROUGH THE GOVERNANCE SUB-COMMITTEE OF THE BOARD WITH THE ASSISTANCE OF THE EXECUTIVE OFFICE AND IS DEFINED IN THE CHARTER OF THE GOVERNANCE SUB-COMMITTEE IF ANY OFFICER OR DIRECTOR IS FOUND TO HAVE A CONFLICT OF INTEREST, SUCH PERSON SHALL NEITHER VOTE NOR USE HIS OR HER INFLUENCE TO AFFECT ANY DECISION RELATING TO THE CONFLICT, AND SUCH PERSON SHOULD NOT BE INCLUDED IN DETERMINING WHETHER A QUORUM PARTICIPATED IN THE DECISION SUCH PERSON IS PERMITTED TO BRIEFLY STATE HIS OR HER POSITION ON THE MATTER, AND ANSWER PERTINENT QUESTIONS ABOUT IT, IF HIS OR HER KNOWLEDGE OR EXPERTISE COULD ASSIST THOSE PARTICIPATING IN THE DECISION FOR VENDORS, THE POLICY IS DISTRIBUTED WITH THEIR INITIAL CONTRACT WITH COXHEALTH

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, SECTION B, LINE 15A & 15B	COMPENSATION REVIEW POLICY COXHEALTH EMPLOYS A DEFINED GOVERNANCE STRUCTURE AROUND EXECUTIVE COMPENSATION THE BOARD OF DIRECTORS MAINTAINS A COMPENSATION COMMITTEE THAT IS CHARGED WITH CARRYING OUT THE FUNCTIONS OF EVALUATING AND SETTING EXECUTIVE COMPENSATION THROUGH FORMAL DOCUMENTED MEETINGS THAT OCCUR SEVERAL TIMES DURING THE YEAR THE COMPENSATION COMMITTEE UTILIZES A WELL RESPECTED INDEPENDENT EXTERNAL ADVISOR TO PROVIDE THIRD PARTY ASSESSMENT AND RECOMMENDATIONS REGARDING COMPENSATION LEVELS AND BENEFIT PROGRAMS FOR THE TOP EXECUTIVES OF THE ORGANIZATION TO ENSURE THE COMPENSATION PROGRAM IS COMPETITIVE AND WITHIN FAIR MARKET VALUE AFTER A FULL REVIEW OF THE DATA AND THOROUGH DISCUSSION THE COMMITTEE MAKES A SELF DETERMINATION OF COMPENSATION LEVELS SET JANUARY 1 OF EACH YEAR ANNUALLY THE STEPS NECESSARY TO DOCUMENT REBUTTABLE PRESUMPTION ARE TAKEN AND RECORDED ADDITIONALLY, COMPENSATION LEVELS FOR THE VICE PRESIDENT TIER OF MANAGEMENT IS OVERSEEN BY THE CEO USING EXTERNAL COMPARABLE DATA FOR ASSESSMENT AND IS PROVIDED TO THE COMPENSATION COMMITTEE FOR REVIEW ON AN ANNUAL BASIS

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, SECTION C, LINE 19	DOCUMENT DISCLOSURE COXHEALTH MAKES AVAILABLE ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY AND FINANCIAL STATEMENTS AVAILABLE FOR ALL LEGITIMATE BUSINESS PURPOSES AS DETERMINED BY MANAGEMENT IN ADDITION, AS A CONTINUING DISCLOSURE REQUIREMENT OF CERTAIN DEBT COVENANTS THE ORGANIZATION PROVIDES ITS AUDITED FINANCIAL STATEMENTS AND SPECIFIC QUARTERLY FINANCIAL INFORMATION TO DEFINED REPOSITORIES FOR REVIEW BY PARTIES OR INDIVIDUALS INTERESTED IN THE INFORMATION

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VII, SECTION A	BOARD MEMBER COMPENSATION DRS JARVIS, DIX, FLAX, ABDALLA, GIBSON AND ZOLFAGHARI ARE COMPENSATED RELATED TO THEIR ROLES AS EMPLOYEES UNDER COXHEALTH AND RELATED AFFILIATES NO BOARD MEMBERS RECEIVE COMPENSATION FOR THEIR DUTIES AS BOARD MEMBERS

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990 PART IX LINE 11G	DESCRIPTION PHYSICIAN REMUNERATION TOTAL FEES 897250

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990 PART IX LINE 11G	DESCRIPTION EQUIPMENT SERVICE CONTRACTS TOTAL FEES 712569

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990 PART IX LINE 11G	DESCRIPTION PROFESSIONAL CONTRACT LABOR TOTAL FEES 302483

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990 PART IX LINE 11G	DESCRIPTION BILLING SERVICES TOTAL FEES 178262

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990 PART IX LINE 11G	DESCRIPTION OUTSIDE RADIOLOGY TOTAL FEES 171374

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990 PART IX LINE 11G	DESCRIPTION ANESTHESIA SERVICES TOTAL FEES 155788

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990 PART IX LINE 11G	DESCRIPTION OUTSIDE LABORATORY TOTAL FEES 135572

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990 PART IX LINE 11G	DESCRIPTION MEDICAL DIRECTOR TOTAL FEES 42508

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990 PART IX LINE 11G	DESCRIPTION COLLECTIONS SERVICES TOTAL FEES 41038

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990 PART IX LINE 11G	DESCRIPTION MEDICAL TRANSCRIPTION SERVICES TOTAL FEES 16652

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990 PART IX LINE 11G	DESCRIPTION CONSULTING SERVICES TOTAL FEES 8275

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990 PART IX LINE 11G	DESCRIPTION COURIER SERVICES TOTAL FEES 2333

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990 PART IX LINE 11G	DESCRIPTION LAUNDRY SERVICES TOTAL FEES 2100

**SCHEDULE R  
(Form 990)**

**Related Organizations and Unrelated Partnerships**

OMB No 1545-0047

**2018**

**Open to Public  
Inspection**

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.**  
▶ **Attach to Form 990.**  
▶ **Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.**

Department of the Treasury  
Internal Revenue Service

Name of the organization  
COXHEALTH

**Employer identification number**

47-1087427

**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
<b>(1)</b> COXHEALTH ACCOUNTABLE CARE LLC 1423 N JEFFERSON AVE SPRINGFIELD, MO 65802 36-4880517	ACO	MO	0	0	COXHEALTH
<b>(2)</b> CBCH LLC 3850 S NATIONAL AVE STE 500 SPRINGFIELD, MO 65807 36-4882772	HOSPITAL	MO	26,224,487	19,056,300	COXHEALTH

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

See Additional Data Table

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) 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	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
<b>(1)</b> MEDICAL DEVELOPMENTS INC 1423 N JEFFERSON SPRINGFIELD, MO 65802 43-1622182	PHARMACY	MO	LESTER E COX	C CORP				Yes	
<b>(2)</b> COX TAXABLE CLOSE CORPORATION 1423 N JEFFERSON SPRINGFIELD, MO 65802 47-2573263	MEDICAL CLINIC	MO	COX MED GROUP	C CORP				Yes	
<b>(3)</b> INSURANCE CO OF SPRINGFIELD INC GRAND PAVILION CORPORATE CENTRE GRAND CAYMAN, KY1-110 CJ 43-0991578	CAPTIVE INSURANCE	CJ	LESTER E COX	C CORP				Yes	
<b>(4)</b> FERRELL DUNCAN CLINIC INC 1001 PRIMROSE AVE SPRINGFIELD, MO 65807 43-0991578	PHYSICIANS	MO	CTCC	C CORP				Yes	

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

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

	Yes	No
<b>1</b> 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?		
<b>a</b> Receipt of <b>(i)</b> interest, <b>(ii)</b> annuities, <b>(iii)</b> royalties, or <b>(iv)</b> rent from a controlled entity . . . . .	<b>1a</b>	No
<b>b</b> Gift, grant, or capital contribution to related organization(s) . . . . .	<b>1b</b>	No
<b>c</b> Gift, grant, or capital contribution from related organization(s) . . . . .	<b>1c</b>	Yes
<b>d</b> Loans or loan guarantees to or for related organization(s) . . . . .	<b>1d</b>	No
<b>e</b> Loans or loan guarantees by related organization(s) . . . . .	<b>1e</b>	No
<b>f</b> Dividends from related organization(s) . . . . .	<b>1f</b>	No
<b>g</b> Sale of assets to related organization(s) . . . . .	<b>1g</b>	No
<b>h</b> Purchase of assets from related organization(s) . . . . .	<b>1h</b>	No
<b>i</b> Exchange of assets with related organization(s) . . . . .	<b>1i</b>	No
<b>j</b> Lease of facilities, equipment, or other assets to related organization(s) . . . . .	<b>1j</b>	No
<b>k</b> Lease of facilities, equipment, or other assets from related organization(s) . . . . .	<b>1k</b>	No
<b>l</b> Performance of services or membership or fundraising solicitations for related organization(s) . . . . .	<b>1l</b>	Yes
<b>m</b> Performance of services or membership or fundraising solicitations by related organization(s) . . . . .	<b>1m</b>	No
<b>n</b> Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) . . . . .	<b>1n</b>	Yes
<b>o</b> Sharing of paid employees with related organization(s) . . . . .	<b>1o</b>	Yes
<b>p</b> Reimbursement paid to related organization(s) for expenses . . . . .	<b>1p</b>	Yes
<b>q</b> Reimbursement paid by related organization(s) for expenses . . . . .	<b>1q</b>	Yes
<b>r</b> Other transfer of cash or property to related organization(s) . . . . .	<b>1r</b>	No
<b>s</b> Other transfer of cash or property from related organization(s) . . . . .	<b>1s</b>	Yes

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

See Additional Data Table

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



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

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

<b>Return Reference</b>	<b>Explanation</b>

**Additional Data**

**Software ID:**  
**Software Version:**  
**EIN:** 47-1087427  
**Name:** COXHEALTH

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
PO BOX 10939 SPRINGFIELD, MO 65808 43-1641925	HOME HEALTH	MO	501(C)(3)	10	LESTER E COX	Yes	
3525 S NATIONAL SUITE 204 SPRINGFIELD, MO 65807 43-6810485	FUNDRAISING	MO	501(C)(3)	12 A I	LESTER E COX	Yes	
PO BOX 10939 SPRINGFIELD, MO 65808 26-4781194	HOME HEALTH	MO	501(C)(3)	10	LESTER E COX	Yes	
2220 W SUNSET SPRINGFIELD, MO 65807 43-1641927	HOME HEALTH	MO	501(C)(3)	10	LESTER E COX	Yes	
801 N LINCOLN AVE MONETT, MO 65708 43-1656689	HOSPITAL	MO	501(C)(3)	3	LESTER E COX	Yes	
3801 S NATIONAL SPRINGFIELD, MO 65807 36-3263313	MED SERVICES	MO	501(C)(3)	7	LESTER E COX	Yes	
PO BOX 5750 SPRINGFIELD, MO 658015750 43-1757075	HMO	MO	501(C)(4)		LESTER E COX	Yes	
1423 N JEFFERSON SPRINGFIELD, MO 65802 47-5148345	EDUCATION	MO	501(C)(3)	2	LESTER E COX	Yes	
3801 S NATIONAL SPRINGFIELD, MO 65807 37-1830627	HEALTHCARE	MO	501(C)(3)	10	COXHEALTH	Yes	
PO BOX 5750 SPRINGFIELD, MO 65801 43-1684044	INSURANCE	MO	501(C)(4)		LESTER E COX	Yes	
PO BOX 10939 SPRINGFIELD, MO 65808 43-1641928	HOME HEALTH	MO	501(C)(3)	10	LESTER E COX	Yes	
1115 E PRIMROSE SPRINGFIELD, MO 65807 43-1183783	SUPPORT	MO	501(C)(3)	12 A I	LESTER E COX	Yes	
1423 N JEFFERSON SPRINGFIELD, MO 65802 36-6668576	SELF INSURANC	MO	501(C)(3)	12 A I	LESTER E COX	Yes	
DBA COX MC BRANSON 525 BRANSON LAND BRANSON, MO 65616 44-0584290	HOSPITAL	MO	501(C)(3)	3	LESTER E COX	Yes	
1423 N JEFFERSON SPRINGFIELD, MO 65802 44-0577118	HOSPITAL	MO	501(C)(3)	3	COXHEALTH	Yes	
1423 N JEFFERSON SPRINGFIELD, MO 65802 47-1087566	PHYSICIANS	MO	501(C)(3)	10	COXHEALTH	Yes	
1423 N JEFFERSON SPRINGFIELD, MO 65802 82-3300758	HOSPITAL	MO	501(C)(3)	3	COXHEALTH	Yes	

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

	<b>(a)</b>	<b>(b)</b>	<b>(c)</b>	<b>(d)</b>
	Name of related organization	Transaction type(a-s)	Amount Involved	Method of determining amount involved
<b>(1)</b>	LESTER E COX MEDICAL CENTERS	P	178,079,823	COST
<b>(1)</b>	SKAGGS COMM HOSP ASSOC DBA COX MED CTR BRNSN	P	2,685,557	COST
<b>(2)</b>	COX COLLEGE	P	114,130	COST
<b>(3)</b>	COX-MONETT HOSPITAL INC	P	142,627	COST
<b>(4)</b>	COX BARTON COUNTY HOSPITAL	P	412,688	COST
<b>(5)</b>	LESTER E COX MEDICAL CENTERS	Q	167,025,613	COST
<b>(6)</b>	SKAGGS COMM HOSP ASSOC DBA COX MED CTR BRNSN	Q	25,409,622	COST
<b>(7)</b>	COX COLLEGE	Q	189,312	COST
<b>(8)</b>	COX HPS OF THE OZARKS INC	Q	242,893	COST
<b>(9)</b>	HEALTHCARE SERVICES OF THE OZARKS INC	Q	410,598	COST
<b>(10)</b>	COX-MONETT HOSPITAL INC	Q	5,738,621	COST
<b>(11)</b>	MEDICAL DEVELOPMENTS INC	Q	352,436	COST
<b>(12)</b>	LESTER E COX MEDICAL CENTERS	S	1,124,480	COST
<b>(13)</b>	SKAGGS COMM HOSP ASSOC DBA COX MED CTR BRNSN	S	183,450	COST