



**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

THE HOSPITAL'S MISSION IS 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

<b>4a</b>	(Code ) (Expenses \$ 157,428,758 including grants of \$ 372,211 ) (Revenue \$ 194,947,025 )
	See Additional Data

<b>4b</b>	(Code ) (Expenses \$ 32,812,894 including grants of \$ ) (Revenue \$ 20,040,767 )
	See Additional Data

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

<b>4e</b>	<b>Total program service expenses</b> ▶ 190,241,652
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**Part IV Checklist of Required Schedules**

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

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

	Yes	No
<b>20a</b> Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i> . . . . .	<b>20a</b> Yes	
<b>b</b> If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? . . . . .	<b>20b</b> Yes	
<b>21</b> Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i> . . . . .	<b>21</b> Yes	
<b>22</b> Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i> . . . . .	<b>22</b>	No
<b>23</b> Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i> . . . . .	<b>23</b> Yes	
<b>24a</b> Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i> . . . . .	<b>24a</b>	No
<b>b</b> Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? . . . . .	<b>24b</b>	
<b>c</b> Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? . . . . .	<b>24c</b>	
<b>d</b> Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? . . . . .	<b>24d</b>	
<b>25a Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.</b> Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i> . . . . .	<b>25a</b>	No
<b>b</b> Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i> . . . . .	<b>25b</b>	No
<b>26</b> Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? <i>If "Yes," complete Schedule L, Part II</i> . . . . .	<b>26</b>	No
<b>27</b> Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i> . . . . .	<b>27</b>	No
<b>28</b> Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions) <b>a</b> A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> . . . . .	<b>28a</b>	No
<b>b</b> A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> . . . . .	<b>28b</b>	No
<b>c</b> An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV</i> . . . . .	<b>28c</b>	No
<b>29</b> Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i> . . . . .	<b>29</b>	No
<b>30</b> Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i> . . . . .	<b>30</b>	No
<b>31</b> Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i> . . . . .	<b>31</b>	No
<b>32</b> Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i> . . . . .	<b>32</b>	No
<b>33</b> Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I</i> . . . . .	<b>33</b> Yes	
<b>34</b> Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i> . . . . .	<b>34</b> Yes	
<b>35a</b> Did the organization have a controlled entity within the meaning of section 512(b)(13)?	<b>35a</b>	No
<b>b</b> If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i> . . . . .	<b>35b</b>	
<b>36 Section 501(c)(3) organizations.</b> Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i> . . . . .	<b>36</b>	No
<b>37</b> Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i> . . . . .	<b>37</b>	No
<b>38</b> Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? <b>Note.</b> All Form 990 filers are required to complete Schedule O . . . . .	<b>38</b> Yes	

**Part V Statements Regarding Other IRS Filings and Tax Compliance**Check if Schedule O contains a response or note to any line in this Part V ☐

		Yes	No
<b>1a</b>	Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable . . . . .	<b>1a</b>	19
<b>b</b>	Enter the number of Forms W-2G included in line 1a Enter -0- if not applicable . . . . .	<b>1b</b>	0
<b>c</b>	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? . . . . .	<b>1c</b>	Yes
<b>2a</b>	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return . . . . .	<b>2a</b>	1,737
<b>b</b>	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? <b>Note.</b> If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	<b>2b</b>	Yes
<b>3a</b>	Did the organization have unrelated business gross income of \$1,000 or more during the year? . . . . .	<b>3a</b>	Yes
<b>b</b>	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O . . . . .	<b>3b</b>	Yes
<b>4a</b>	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . . . . .	<b>4a</b>	No
<b>b</b>	If "Yes," enter the name of the foreign country <b>▶</b> _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)		
<b>5a</b>	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . . . . .	<b>5a</b>	No
<b>b</b>	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? . . . . .	<b>5b</b>	No
<b>c</b>	If "Yes," to line 5a or 5b, did the organization file Form 8886-T? . . . . .	<b>5c</b>	
<b>6a</b>	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . . . .	<b>6a</b>	No
<b>b</b>	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? . . . . .	<b>6b</b>	
<b>7</b>	<b>Organizations that may receive deductible contributions under section 170(c).</b>		
<b>a</b>	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor? . . . . .	<b>7a</b>	No
<b>b</b>	If "Yes," did the organization notify the donor of the value of the goods or services provided? . . . . .	<b>7b</b>	
<b>c</b>	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? . . . . .	<b>7c</b>	No
<b>d</b>	If "Yes," indicate the number of Forms 8282 filed during the year . . . . .	<b>7d</b>	
<b>e</b>	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? . . . . .	<b>7e</b>	No
<b>f</b>	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . . . . .	<b>7f</b>	No
<b>g</b>	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? . . . . .	<b>7g</b>	
<b>h</b>	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? . . . . .	<b>7h</b>	
<b>8</b>	<b>Sponsoring organizations maintaining donor advised funds.</b> Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? . . . . .	<b>8</b>	
<b>9a</b>	Did the sponsoring organization make any taxable distributions under section 4966? . . . . .	<b>9a</b>	
<b>b</b>	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . . . .	<b>9b</b>	
<b>10</b>	<b>Section 501(c)(7) organizations.</b> Enter		
<b>a</b>	Initiation fees and capital contributions included on Part VIII, line 12 . . . . .	<b>10a</b>	
<b>b</b>	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities . . . . .	<b>10b</b>	
<b>11</b>	<b>Section 501(c)(12) organizations.</b> Enter		
<b>a</b>	Gross income from members or shareholders . . . . .	<b>11a</b>	
<b>b</b>	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them ) . . . . .	<b>11b</b>	
<b>12a</b>	<b>Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041? . . . . .	<b>12a</b>	
<b>b</b>	If "Yes," enter the amount of tax-exempt interest received or accrued during the year . . . . .	<b>12b</b>	
<b>13</b>	<b>Section 501(c)(29) qualified nonprofit health insurance issuers.</b>		
<b>a</b>	Is the organization licensed to issue qualified health plans in more than one state? <b>Note.</b> See the instructions for additional information the organization must report on Schedule O . . . . .	<b>13a</b>	
<b>b</b>	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans . . . . .	<b>13b</b>	
<b>c</b>	Enter the amount of reserves on hand . . . . .	<b>13c</b>	
<b>14a</b>	Did the organization receive any payments for indoor tanning services during the tax year? . . . . .	<b>14a</b>	No
<b>b</b>	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O . . . . .	<b>14b</b>	

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

		Yes	No
<b>1a</b> Enter the number of voting members of the governing body at the end of the tax year	<b>1a</b> 15		
If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.			
<b>b</b> Enter the number of voting members included in line 1a, above, who are independent	<b>1b</b> 11		
<b>2</b> Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	<b>2</b>	Yes	
<b>3</b> Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?	<b>3</b>		No
<b>4</b> Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	<b>4</b>		No
<b>5</b> Did the organization become aware during the year of a significant diversion of the organization's assets?	<b>5</b>		No
<b>6</b> Did the organization have members or stockholders?	<b>6</b>	Yes	
<b>7a</b> Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	<b>7a</b>	Yes	
<b>b</b> Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	<b>7b</b>	Yes	
<b>8</b> Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
<b>a</b> The governing body?	<b>8a</b>	Yes	
<b>b</b> Each committee with authority to act on behalf of the governing body?	<b>8b</b>	Yes	
<b>9</b> Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O.	<b>9</b>		No

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

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

**Section C. Disclosure**

<b>17</b> List the States with which a copy of this Form 990 is required to be filed▶	
<b>18</b> Section 6104 requires an organization to make its Form 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply. <input type="checkbox"/> Own website <input type="checkbox"/> Another's website <input checked="" type="checkbox"/> Upon request <input type="checkbox"/> Other (explain in Schedule O)	
<b>19</b> Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.	
<b>20</b> State the name, address, and telephone number of the person who possesses the organization's books and records. ▶DAVID STRONG 525 BRANSON LANDING BOULEVARD BRANSON, MO 65615 (417) 335-7789	

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

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.

- List all of the organization's **current** key employees, if any. See instructions for definition of "key employee."

- List the organization's five **current** highest compensated employees (other than an officer, director, trustee or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations.

- List all of the organization's **former** officers, key employees, or highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.

- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
(1) STEVE EDWARDS BOARD MEMBER/COXHEALTH CEO	1 0 ..... 39 0	X						0	1,639,010	293,841
(2) JACOB MCWAY BOARD MEMBER/COXHEALTH CFO	1 0 ..... 39 0	X						0	829,516	156,627
(3) CHARITY ELMER BOARD MEMBER	1 0 ..... 39 0	X						0	543,318	114,930
(4) NITA JANE AYRES BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
(5) DENNIS NEWKIRK BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
(6) RICHARD BLUBAUGH BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
(7) SUE HEAD BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
(8) RAEANNE PRESLEY BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
(9) J TRAVIS BRAWNER BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
(10) PHILLIP LOYD BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
(11) BRAD SWOFFORD BOARD MEMBER	1 0 ..... 0 0	X						0	0	0
(12) ROBERT COX TREASURER	1 0 ..... 0 0	X		X				0	0	0
(13) ROBERT MCDOWELL CHAIRMAN	1 0 ..... 0 0	X		X				0	0	0
(14) RICK TODD VICE CHAIRMAN	1 0 ..... 0 0	X		X				0	0	0
(15) HOLLY WHERRY BOARD MEMBER	40 0 ..... 0 0	X						406,088	0	7,282
(16) WILLIAM MAHONEY PRESIDENT	40 0 ..... 0 0			X				572,317	0	75,275
(17) DAVID STRONG CFO	40 0 ..... 0 0			X				340,101	0	56,033

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
(18) BARBARA STEWART SECRETARY	40 0 0 0			X				54,784	0	9,971
(19) SHAWN USERY CMO	40 0 0 0				X			414,287	0	21,911
(20) LYNNE YAGGY CNO	40 0 0 0				X			188,761	0	23,055
(21) CHAD EFIRD PHYSICIAN	40 0 0 0					X		1,200,159	0	46,209
(22) NARIN ARUNAKUL PHYSICIAN	40 0 0 0					X		874,229	0	46,833
(23) PRASER VIJITBENJARONK PHYSICIAN	40 0 0 0					X		652,786	0	46,733
(24) BRIAN CLONTS PHYSICIAN	40 0 0 0					X		710,537	0	46,825
(25) CODY HOEFlickER PHYSICIAN	40 0 0 0					X		535,935	0	28,209
	0 0									

<b>1b Sub-Total</b> . . . . .	▶			
<b>c Total from continuation sheets to Part VII, Section A</b> . . . . .	▶			
<b>d Total (add lines 1b and 1c)</b> . . . . .	▶	5,949,984	3,011,844	973,734

**2** Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization ▶ 85

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

**Section B. Independent Contractors**

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

(A) Name and business address	(B) Description of services	(C) Compensation
WHITE RIVER ANESTHESIA ASSOC, PO BOX 1308 BRANSON, MO 65615	ANESTHESIA SERVICES	210,572
SHIFTWISE, PO BOX 70870 ST PAUL, MN 55170	STAFFING MANAGEMENT	114,578

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



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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<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>	3,345			
	<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>	238,849			
	<b>g</b> Noncash contributions included in lines 1a-1f \$ _____					
	<b>h Total.</b> Add lines 1a-1f . . . . . ▶		242,194			
<b>Program Service Revenue</b>			Business Code			
	<b>2a</b> NET PATIENT SERVICE REVENUE		624100	209,819,832	209,819,832	
	<b>b</b> PHARMACY		446110	1,474,598	1,474,598	
	<b>c</b> CAFETERIA		722514	1,229,611	1,229,611	
	<b>d</b> LAB REVENUE		621500	811,076	780,270	30,806
	<b>e</b> FITNESS CENTER		713940	390,995	390,995	
	<b>f</b> All other program service revenue			1,261,680	1,261,680	
	<b>g Total.</b> Add lines 2a-2f . . . . . ▶		214,987,792			
<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts) . . . . . ▶			986,466		986,466
	<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				
	<b>b</b> Less rental expenses					
	<b>c</b> Rental income or (loss)	0 0				
	<b>d</b> Net rental income or (loss) . . . . . ▶			0		
	<b>7a</b> Gross amount from sales of assets other than inventory	(i) Securities (ii) Other				
	<b>b</b> Less cost or other basis and sales expenses					
	<b>c</b> Gain or (loss)	689,798				
	<b>d</b> Net gain or (loss) . . . . . ▶			689,798		689,798
	<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>						
<b>b</b>						
<b>c</b>						
<b>d</b> All other revenue . . . . .						
<b>e Total.</b> Add lines 11a-11d . . . . . ▶			0			
<b>12 Total revenue.</b> See Instructions . . . . . ▶			216,906,250	214,956,986	30,806	1,676,264

**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.	372,211	372,211		
<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.	2,169,865	1,061,384	1,108,481	
<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.	64,104,702	54,561,945	9,542,757	
<b>8</b> Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).	1,727,107	1,727,107		
<b>9</b> Other employee benefits.	7,378,050	7,040,682	337,368	
<b>10</b> Payroll taxes.	4,325,668	4,108,077	217,591	
<b>11</b> Fees for services (non-employees):				
<b>a</b> Management.	0			
<b>b</b> Legal.	2,161		2,161	
<b>c</b> Accounting.	97,934		97,934	
<b>d</b> Lobbying.	0			
<b>e</b> Professional fundraising services. See Part IV, line 17.	0			
<b>f</b> Investment management fees.	289,097	265,207	23,890	
<b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	42,281,442	40,399,412	1,882,030	0
<b>12</b> Advertising and promotion.	32,014	29,368	2,646	
<b>13</b> Office expenses.	4,913,399	4,544,204	369,195	
<b>14</b> Information technology.	1,054,157	967,044	87,113	
<b>15</b> Royalties.	0			
<b>16</b> Occupancy.	4,332,486	3,974,461	358,025	
<b>17</b> Travel.	515,374	472,785	42,589	
<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.	61,092	56,044	5,048	
<b>20</b> Interest.	2,944,297	2,700,989	243,308	
<b>21</b> Payments to affiliates.	0			
<b>22</b> Depreciation, depletion, and amortization.	7,579,284	6,952,953	626,331	
<b>23</b> Insurance.	422,547	387,629	34,918	
<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	30,748,667	30,748,667		
<b>b</b> BAD DEBT	22,103,447	22,103,447		
<b>c</b> STATE PROVIDER TAX	7,531,368	7,531,368		
<b>d</b> LICENSES, DUES, SUBSCRIPTIONS	254,871	233,809	21,062	
<b>e</b> All other expenses	3,116	2,859	257	
<b>25</b> Total functional expenses. Add lines 1 through 24e.	205,244,356	190,241,652	15,002,704	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 . . . . .		13,064,197	<b>1</b>	22,738,958
	<b>2</b>	Savings and temporary cash investments . . . . .		21,072,170	<b>2</b>	27,038,134
	<b>3</b>	Pledges and grants receivable, net . . . . .		0	<b>3</b>	0
	<b>4</b>	Accounts receivable, net . . . . .		24,832,447	<b>4</b>	25,869,170
	<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 . . . . .		2,777,448	<b>8</b>	2,877,378
	<b>9</b>	Prepaid expenses and deferred charges . . . . .		170,064	<b>9</b>	178,384
	<b>10a</b>	Land, buildings, and equipment—cost or other basis. Complete Part VI of Schedule D	<b>10a</b>	136,687,678		
	<b>b</b>	Less: accumulated depreciation	<b>10b</b>	45,179,836		
				96,897,179	<b>10c</b>	91,507,842
	<b>11</b>	Investments—publicly traded securities . . . . .		18,392,962	<b>11</b>	19,324,784
	<b>12</b>	Investments—other securities. See Part IV, line 11 . . . . .		8,825,277	<b>12</b>	9,051,418
	<b>13</b>	Investments—program-related. See Part IV, line 11 . . . . .		7,442,466	<b>13</b>	9,174,807
	<b>14</b>	Intangible assets . . . . .		551,500	<b>14</b>	551,500
<b>15</b>	Other assets. See Part IV, line 11 . . . . .		14,665,605	<b>15</b>	14,749,149	
<b>16</b>	<b>Total assets.</b> Add lines 1 through 15 (must equal line 34) . . . . .		208,691,315	<b>16</b>	223,061,524	
<b>Liabilities</b>	<b>17</b>	Accounts payable and accrued expenses . . . . .		10,636,815	<b>17</b>	11,587,793
	<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 . . . . .		57,377,359	<b>20</b>	56,907,278
	<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 . . . . .		10,345,990	<b>23</b>	8,877,201
	<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		1,352,537	<b>25</b>	1,952,537
	<b>26</b>	<b>Total liabilities.</b> Add lines 17 through 25 . . . . .		79,712,701	<b>26</b>	79,324,809
<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		118,958,544	<b>27</b>	133,543,934
	<b>28</b>	Temporarily restricted net assets . . . . .		1,194,793	<b>28</b>	1,141,363
	<b>29</b>	Permanently restricted net assets		8,825,277	<b>29</b>	9,051,418
	<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>		128,978,614	<b>33</b>	143,736,715
	<b>34</b>	<b>Total liabilities and net assets/fund balances . . . . .</b>		208,691,315	<b>34</b>	223,061,524

**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>	216,906,250
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	205,244,356
<b>3</b>	Revenue less expenses Subtract line 2 from line 1	<b>3</b>	11,661,894
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	128,978,614
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	823,496
<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>	2,272,711
<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>	143,736,715

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

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

# Additional Data

**Software ID:**  
**Software Version:**  
**EIN:** 44-0584290  
**Name:** SKAGGS COMMUNITY HOSPITAL ASSOCIATION

Form 990 (2017)

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

HOSPITAL SERVICES - COX MEDICAL CENTER BRANSON PROVIDES THE FOLLOWING AREAS OF SERVICE CANCER, CARDIAC, DIABETES AND ENDOCRINOLOGY, EAR NOSE AND THROAT, EMERGENCY, URGENT CARE, FAMILY MEDICINE, IMAGING AND RADIOLOGY, LABORATORY AND PATHOLOGY, NEPHROLOGY AND DIALYSIS, NEUROLOGY, OCCUPATIONAL HEALTH, ORTHOPEDICS, PEDIATRICS, PSYCHIATRY, PULMONOLOGY/CRITICAL CARE, REHABILITATION AND THERAPY, RHEUMATOLOGY, SLEEP DISORDER CENTER, SOCIAL SERVICES, SURGERY, UROLOGY, WOMEN'S SERVICES AND WOUND CARE SEE SCHEDULE O FOR MORE INFORMATION

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

CLINIC SERVICES - CLINIC SERVICES INCLUDE FAMILY MEDICINE, OB-GYN SERVICES, GENERAL SURGERY, INTERNAL MEDICINE, INFECTIOUS DISEASE TREATMENT AND  
PULMONOLOGY COORDINATION OF CARE IS ENHANCED BY A PHYSICIAN LIAISON

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SCHEDULE A

(Form 990 or 990EZ)

Department of the Treasury

Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.  
▶ Attach to Form 990 or Form 990-EZ.  
▶ Information about Schedule A (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization

SKAGGS COMMUNITY HOSPITAL ASSOCIATION

Employer identification number

44-0584290

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

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

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

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

Part II

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

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

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

Section C. Computation of Public Support Percentage		
14	Public support percentage for 2017 (line 6, column (f) divided by line 11, column (f))	14
15	Public support percentage for 2016 Schedule A, Part II, line 14	15
16a	<b>33 1/3% support test—2017.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization <span>► <input type="checkbox"/></span>	
b	<b>33 1/3% support test—2016.</b> 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 <b>stop here.</b> The organization qualifies as a publicly supported organization <span>► <input type="checkbox"/></span>	
17a	<b>10%-facts-and-circumstances test—2017.</b> 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 <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization <span>► <input type="checkbox"/></span>	
b	<b>10%-facts-and-circumstances test—2016.</b> 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 <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization <span>► <input type="checkbox"/></span>	
18	<b>Private foundation.</b> If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions <span>► <input type="checkbox"/></span>	



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

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

**Section A. Public Support**

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

**Section B. Total Support**

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

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

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

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

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

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

**19a 33 1/3% support tests—2017.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ► ☐

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

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

**Part IV Supporting Organizations**

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

**Section A. All Supporting Organizations**

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

**Part IV Supporting Organizations** (continued)

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

**Section B. Type I Supporting Organizations**

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

**Section C. Type II Supporting Organizations**

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

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

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

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

- 1** Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (**see instructions**)
- a** ☐ The organization satisfied the Activities Test. Complete **line 2** below.
- b** ☐ The organization is the parent of each of its supported organizations. Complete **line 3** below.
- c** ☐ The organization supported a governmental entity. Describe in **Part VI** how you supported a government entity (see instructions).

**2 Activities Test. Answer (a) and (b) below.**

	Yes	No
<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 Parent of Supported Organizations. Answer (a) and (b) below.</b>		
<b>a</b> Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>Provide details in Part VI.</i>		
	<b>3a</b>	
<b>b</b> Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i>		
	<b>3b</b>	

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

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

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

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

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

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

Additional Data

Software ID:  
Software Version:  
EIN: 44-0584290  
Name: SKAGGS COMMUNITY HOSPITAL ASSOCIATION

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

Facts And Circumstances Test

SCHEDULE C  
(Form 990 or 990-EZ)

Department of the Treasury  
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶Complete if the organization is described below. ▶Attach to Form 990 or Form 990-EZ.  
▶Information about Schedule C (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047

2017

Open to Public Inspection

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

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

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

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

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

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

Name of the organization SKAGGS COMMUNITY HOSPITAL ASSOCIATION	Employer identification number 44-0584290
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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-A** Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).

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

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

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

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

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

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

**d** Other exempt purpose expenditures

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

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

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

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

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

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

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

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

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

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

Calendar year (or fiscal year beginning in)	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) Total
<b>2a</b> Lobbying nontaxable amount					
<b>b</b> Lobbying ceiling amount (150% of line 2a, column(e))					
<b>c</b> Total lobbying expenditures					
<b>d</b> Grassroots nontaxable amount					
<b>e</b> Grassroots ceiling amount (150% of line 2d, column (e))					
<b>f</b> Grassroots lobbying expenditures					



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

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

		(a)		(b)
		Yes	No	Amount
<b>1</b>	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
<b>a</b>	Volunteers?		No	
<b>b</b>	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
<b>c</b>	Media advertisements?		No	
<b>d</b>	Mailings to members, legislators, or the public?		No	
<b>e</b>	Publications, or published or broadcast statements?		No	
<b>f</b>	Grants to other organizations for lobbying purposes?		No	
<b>g</b>	Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
<b>h</b>	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
<b>i</b>	Other activities?	Yes		14,961
<b>j</b>	Total Add lines 1c through 1i			14,961
<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 1 (I)	OTHER LOBBYING ACTIVITIES THE ORGANIZATION PAID DUES OF \$43,474 TO THE MISSOURI HOSPITAL ASSOCIATION AND \$19,319 TO THE AMERICAN HOSPITAL ASSOCIATION, OF WHICH \$10,521 (24.2%) AND \$4,440 (22.98%) RESPECTIVELY IS ATTRIBUTABLE TO LOBBYING PURPOSES

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SCHEDULE D

(Form 990)

Department of the Treasury

Internal Revenue Service

Supplemental Financial Statements

► Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.

► Attach to Form 990.

Information about Schedule D (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization

SKAGGS COMMUNITY HOSPITAL ASSOCIATION

Employer identification number

44-0584290

Part I

Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.

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

1

Total number at end of year

2

Aggregate value of contributions to (during year)

3

Aggregate value of grants from (during year)

4

Aggregate value at end of year

(a) Donor advised funds

(b) Funds and other accounts

5

Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?

Yes

No

6

Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?

Yes

No

Part II

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

1

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

☐ Preservation of land for public use (e g , recreation or education)

☐ 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

2a

2b

2c

2d

Held at the End of the Year

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

1b

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

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

► \$

(ii) Assets included in Form 990, Part X

► \$

2

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

a

Revenue included on Form 990, Part VIII, line 1

► \$

b

Assets included in Form 990, Part X

► \$

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

Cat No 52283D

Schedule D (Form 990) 2017

Part III

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

3

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

a

☐ Public exhibition

b

☐ Scholarly research

c

☐ Preservation for future generations

d

☐ Loan or exchange programs

e

☐ Other

4

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

5

During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection?

☐ Yes

☐ No

Part IV

Escrow and Custodial Arrangements.

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

1a

Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?

☐ Yes

☐ No

b

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

c

Beginning balance

d

Additions during the year

e

Distributions during the year

f

Ending balance

	Amount
1c	
1d	
1e	
1f	

2a

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

☐ Yes

☐ No

b

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

☐

Part V

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

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

2

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

a

Board designated or quasi-endowment

b

Permanent endowment

c

Temporarily restricted endowment

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

3a

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

(i) unrelated organizations

(ii) related organizations

b

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

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

4

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

Part VI

Land, Buildings, and Equipment.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		5,522,712		5,522,712
b Buildings		60,189,356	11,489,326	48,700,030
c Leasehold improvements		4,334,390	956,023	3,378,367
d Equipment		59,190,668	30,729,979	28,460,689
e Other		7,450,552	2,004,508	5,446,044
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c))				91,507,842

Part VII

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

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

Part VIII

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

(a) Description of investment	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. (Column (b) must equal Form 990, Part X, col (B) line 13 ) ▶		

Part IX

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

(a) Description	(b) Book value
(1) DUE FROM THIRD-PARTY PAYERS	182,702
(2) OTHER RECEIVABLES	691,855
(3) INTEREST RECEIVABLE	548
(4) DUE FROM RELATED PARTY	13,874,044
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 15 ) . . . . . ▶	14,749,149

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.

(a) Description of liability	(b) Book value
(1) Federal income taxes	0
DUE TO THIRD PARTY	1,952,537
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 25 ) ▶	1,952,537

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 <b>1</b>			
<b>a</b>	Investment expenses not included on Form 990, Part VIII, line 7b . . . . .	<b>4a</b>		
<b>b</b>	Other (Describe in Part XIII ) . . . . .	<b>4b</b>		
<b>c</b>	Add lines <b>4a</b> and <b>4b</b> . . . . .		<b>4c</b>	
<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 <b>1</b> :			
<b>a</b>	Investment expenses not included on Form 990, Part VIII, line 7b . . . . .	<b>4a</b>		
<b>b</b>	Other (Describe in Part XIII ) . . . . .	<b>4b</b>		
<b>c</b>	Add lines <b>4a</b> and <b>4b</b> . . . . .		<b>4c</b>	
<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	

**Part XIII** Supplemental Information *(continued)*

Return Reference	Explanation

**Additional Data**

**Software ID:**  
**Software Version:**  
**EIN:** 44-0584290  
**Name:** SKAGGS COMMUNITY HOSPITAL ASSOCIATION

**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

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SCHEDULE H  
(Form 990)

Hospitals

OMB No 1545-0047

2017

Open to Public Inspection

Department of the Treasury

Internal Revenue Service

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

Name of the organization

SKAGGS COMMUNITY HOSPITAL ASSOCIATION

Employer identification number

44-0584290

Part IFinancial Assistance and Certain Other Community Benefits at Cost

1a

Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a

1a

Yes

1b

If "Yes," was it a written policy?

1b

Yes

2

If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year

☒ Applied uniformly to all hospital facilities

☐ Applied uniformly to most hospital facilities

☐ Generally tailored to individual hospital facilities

3

Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year

3a

Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care

☐ 100%

☐ 150%

☐ 200%

☐ Other

%

3b

Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care

☐ 200%

☐ 250%

☒ 300%

☐ 350%

☐ 400%

☐ Other

%

3c

If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care

4

Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?

4

Yes

5a

Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?

5a

Yes

5b

If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?

5b

Yes

5c

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?

5c

No

6a

Did the organization prepare a community benefit report during the tax year?

6a

Yes

6b

If "Yes," did the organization make it available to the public?

6b

Yes

Complete the following table using the worksheets provided in the Schedule H instructions Do not submit these worksheets with the Schedule H

7Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			10,162,002		10,162,002	5 550 %
b Medicaid (from Worksheet 3, column a)			28,164,456	25,870,234	2,294,222	1 250 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			38,326,458	25,870,234	12,456,224	6 800 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			17,709		17,709	0 010 %
f Health professions education (from Worksheet 5)			82,989		82,989	0 050 %
g Subsidized health services (from Worksheet 6)			10,047,894	4,612,368	5,435,526	2 970 %
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			504,260		504,260	0 280 %
j Total. Other Benefits			10,652,852	4,612,368	6,040,484	3 310 %
k Total. Add lines 7d and 7j			48,979,310	30,482,602	18,496,708	10 110 %

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

Cat No 50192T

Schedule H (Form 990) 2017



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

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

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

**Section A. Bad Debt Expense**

		Yes	No
<b>1</b> Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	<b>1</b>		No
<b>2</b> Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	<b>2</b>		
	22,103,447		
<b>3</b> Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	<b>3</b>		
	3,238,155		
<b>4</b> Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

**Section B. Medicare**

<b>5</b>	Enter total revenue received from Medicare (including DSH and IME) . . . . .	<b>5</b>	100,039,998
<b>6</b>	Enter Medicare allowable costs of care relating to payments on line 5 . . . . .	<b>6</b>	87,943,917
<b>7</b>	Subtract line 6 from line 5 This is the surplus (or shortfall) . . . . .	<b>7</b>	12,096,081
<b>8</b>	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6 Check the box that describes the method used		
	<input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other		

**Section C. Collection Practices**

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

**Part IV Management Companies and Joint Ventures**

(a) Name of entity (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
<b>1</b>				
<b>2</b>				
<b>3</b>				
<b>4</b>				
<b>5</b>				
<b>6</b>				
<b>7</b>				
<b>8</b>				
<b>9</b>				
<b>10</b>				
<b>11</b>				
<b>12</b>				
<b>13</b>				

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

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

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

	Other (describe)	ER-other	ER-24 hours	Research facility	Critical access hospital	Teaching hospital	Children's hospital	General medical & surgical	Licensed hospital	Facility reporting group
See Additional Data Table										

**Part V Facility Information** (continued)**Section B. Facility Policies and Practices**(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)  
SKAGGS COMMUNITY HEALTH CENTER**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** \_\_\_\_\_

1

**Community Health Needs Assessment**

	Yes	No
<b>1</b> Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? . . . . .	<b>1</b>	No
<b>2</b> Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C . . . . .	<b>2</b>	No
<b>3</b> During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 . . . . . If "Yes," indicate what the CHNA report describes (check all that apply)	<b>3</b> Yes	
<b>a</b> <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b> <input checked="" type="checkbox"/> Demographics of the community		
<b>c</b> <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b> <input checked="" type="checkbox"/> How data was obtained		
<b>e</b> <input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b> <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b> <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b> <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b> <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA 20 <u>15</u>		
<b>5</b> In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .	<b>5</b> Yes	
<b>6 a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b> Yes	
<b>b</b> Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C . . . . .	<b>6b</b> Yes	
<b>7</b> Did the hospital facility make its CHNA report widely available to the public? . . . . . If "Yes," indicate how the CHNA report was made widely available (check all that apply)	<b>7</b> Yes	
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>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 . . . . .	<b>8</b> Yes	
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>15</u>		
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url) <u>SEE PART V, SECTION C</u>	<b>10</b> Yes	
<b>a</b>		
<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b> Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
<b>12a</b> Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .	<b>12a</b>	No
<b>b</b> If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b> If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

**Part V Facility Information** (continued)**Financial Assistance Policy (FAP)**

SKAGGS COMMUNITY HEALTH CENTER

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

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
<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	
a <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 <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input checked="" type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input checked="" type="checkbox"/> Underinsurance discount			
g <input checked="" type="checkbox"/> Residency			
h <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? . . . . .	<b>15</b>	Yes	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)			
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e <input type="checkbox"/> Other (describe in Section C)			
<b>16</b> Was widely publicized within the community served by the hospital facility? . . . . .	<b>16</b>	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) SEE PART V, SECTION C			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) SEE PART V, SECTION C			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) SEE PART V, SECTION C			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j <input checked="" type="checkbox"/> Other (describe in Section C)			

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

SKAGGS COMMUNITY HEALTH CENTER

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

	Yes	No
<b>17</b> Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment? . . . . .	<b>17</b> Yes	
<b>18</b> Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <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? . . . . .	<b>19</b>	No
If "Yes," check all actions in which the hospital facility or a third party engaged		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <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? . . . . .	<b>21</b> Yes	
If "No," indicate why		
<b>a</b> <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions <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)**

SKAGGS COMMUNITY HEALTH CENTER

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

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

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

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

[illegible]

**Part V** **Facility Information** *(continued)***Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**  
(list in order of size, from largest to smallest)How many non-hospital health care facilities did the organization operate during the tax year? 24

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



**Part VI Supplemental Information**

Provide the following information

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

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
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 THIS POLICY
SCHEUDLE H, PART I, LINE 7, COLUMN F	PERCENT OF TOTAL EXPENSE TO ARRIVE AT THE PERCENT OF TOTAL EXPENSES, THE DENOMINATOR WHICH EQUALS TOTAL OPERATING EXPENSES PER FORM 990, PART IX, LINE 25 WAS REDUCED BY BAD DEBT EXPENSE OF \$22,103,447

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H, PART I, LINE 7	COST TO CHARGE RATIO THE COST TO CHARGE RATIO COMPUTED ON IRS WORKSHEET 2 WAS USED IN THE CALCULATIONS ON IRS WORKSHEET 1 AND 3 WORKSHEET 6 USED INTERNAL COST CALCULATIONS
SCHEDULE H, PART I, LINE 7G	SUBSIDIZED SERVICES THE ORGANIZATION HAS INCLUDED COSTS ASSOCIATED WITH RURAL HEALTH CENTERS (RHC) IN THE CALCULATION OF SUBSIDIZED SERVICES ON LINE 7G, WITH A NET SUBSIDY FROM RHCS OF \$5,435,527 COX MEDICAL CENTER BRANSON PROVIDES PRIMARY CARE SERVICES TO THE SURROUNDING COMMUNITIES AT THE CENTERS THESE SERVICES ARE PROVIDED IN RURAL AREAS WHERE THERE WOULD BE A SHORTAGE OF QUALITY MEDICAL CARE WITHOUT THE SERVICES COX MEDICAL CENTER BRANSON CONTINUES TO PROVIDE THESE SERVICES AS A BENEFIT TO THE COMMUNITY DESPITE KNOWING THAT FINANCIAL SHORTFALLS WILL BE SUSTAINED

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H, PART III, SECTION A, LINE 2	BAD DEBT EXPENSE THE ORGANIZATION CALCULATED BAD DEBT EXPENSE USING THE AMOUNTS CALCULATED IN THE ORGANIZATION'S AUDITED FINANCIAL STATEMENTS
SCHEDULE H, PART VI, LINE 3	BAD DEBT EXPENSE ATTRIBUTABLE TO CHARITY CARE BAD DEBT ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE ORGANIZATION'S CHARITY CARE POLICY WAS ESTIMATED USING THE PERCENTAGE OF THE POPULATION THAT IS BELOW THE POVERTY LINE IN THE HOSPITAL'S SERVICE AREA

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
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 ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FOR DOUBTFUL ACCOUNTS IN EVALUATING THE COLLECTABILITY OF ACCOUNTS RECEIVABLE, THE HEALTH SYSTEM ANALYZES ITS PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYER SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR DOUBTFUL ACCOUNTS AND PROVISION FOR UNCOLLECTIBLE ACCOUNTS MANAGEMENT REGULARLY REVIEWS DATA ABOUT THESE MAJOR PAYER SOURCES OF REVENUE IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, THE HEALTH SYSTEM ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND A PROVISION FOR UNCOLLECTIBLE ACCOUNTS, IF NECESSARY (FOR EXAMPLE, FOR EXPECTED UNCOLLECTIBLE DEDUCTIBLES AND COPAYMENTS ON ACCOUNTS FOR WHICH THE THIRD-PARTY PAYER HAS NOT YET PAID, OR FOR PAYERS WHO ARE KNOWN TO BE HAVING FINANCIAL DIFFICULTIES THAT MAKE THE REALIZATION OF AMOUNTS DUE UNLIKELY) FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS (WHICH INCLUDES BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND COPAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL), THE HEALTH SYSTEM RECORDS A SIGNIFICANT PROVISION FOR UNCOLLECTIBLE ACCOUNTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATES THAT MANY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE THE DIFFERENCE BETWEEN THE STANDARD RATES (OR THE DISCOUNTED RATES IF NEGOTIATED OR PROVIDED BY POLICY) AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS CHARGED OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS
SCHEDULE H, PART III, SECTION B, LINE 8	COMMUNITY BENEFIT RATIONALE THE HOSPITAL IS DESIGNATED BY MEDICARE AS A SOLE COMMUNITY HOSPITAL AND AS SUCH, IS THE SOLE SOURCE OF HOSPITAL CARE WITHIN A 35-MILE RADIUS AS A LARGE RURAL HOSPITAL, MINIMUM STAFFING MUST BE MAINTAINED REGARDLESS OF SWINGS IN PATIENT VOLUME WITHOUT THE HOSPITAL, MEDICARE PATIENTS WOULD NEED TO TRAVEL SIGNIFICANT DISTANCES TO RECEIVE HOSPITAL CARE 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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART III, SECTION C, LINE 9B	COLLECTION POLICY (A) COX WILL NOT PURSUE LEGAL ACTION FOR NONPAYMENT OF ANY AMOUNTS DISCOUNTED AS A RESULT OF AN APPROVED OR PARTIAL APPROVED REQUEST FOR FINANCIAL ASSISTANCE BALANCES REMAINING AFTER SUCH DISCOUNTS ARE APPLIED WILL, HOWEVER, BE SUBJECT TO COLLECTION ACTIVITY, INCLUDING LEGAL ACTION (B) COX WILL NOT CHARGE INTEREST ON THE BALANCE REMAINING AFTER APPLYING THE FINANCIAL ASSISTANCE DISCOUNT HOWEVER, COX 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
SCHEDULE H, PART VI, LINE 2	NEEDS ASSESSMENT RECOGNIZING THE VALUE OF ASSESSING AND ACTING TOGETHER ON LOCAL HEALTH ISSUES, KEY PLAYERS FROM LOCAL HOSPITAL SYSTEMS, PUBLIC HEALTH ENTITIES, BEHAVIORAL HEALTH SYSTEMS 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, A COLLABORATION SPANNING 51 COUNTIES AND FOUR HOSPITAL SYSTEMS IN MISSOURI, OKLAHOMA, ARKANSAS, AND KANSAS THE 2015 COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) WAS REPLACED BY THE 2016 CHNA CONDUCTED BY THE OZARKS HEALTH COMMISSION (OHC) THIS LARGER, CONCERTED APPROACH WILL LEVERAGE COMMON STRENGTHS AND STRATEGIES TO MOVE IN THE SAME DIRECTION ON SIGNIFICANT HEALTH CONCERNS THIS ASSESSMENT, ALONG WITH THE RESULTING IMPLEMENTATION PLAN, WILL ALLOW DECISION-MAKERS TO HAVE A MORE HOLISTIC AND UP-TO-DATE PICTURE WITH WHICH TO STRATEGICALLY ADDRESS COMMUNITY HEALTH CONCERNS IN THEIR OWN JURISDICTIONS IN JULY 2016, OHC MEMBERS AGREED UPON COMMON GOALS FOR THE THREE HEALTH PRIORITIES IDENTIFIED COXHEALTH FORMED A STEERING COMMITTEE WHOSE PURPOSE WAS TO IDENTIFY BOTH SYSTEM-WIDE INITIATIVES AND HOSPITAL-SPECIFIC INITIATIVES THAT MAXIMIZE RESOURCES AND ENSURE CONSISTENCY AND HIGH RELIABILITY IN THE COMMUNITIES WE SERVE THE STEERING COMMITTEE INCLUDED EXECUTIVE LEADERS FROM SPRINGFIELD, BRANSON, AND MONETT, AND SERVICE LINE LEADERS IN THE AREAS OF CARDIOVASCULAR, PULMONARY, AND MENTAL/BEHAVIORAL HEALTH THE STEERING COMMITTEE APPOINTED A REPRESENTATIVE FROM EACH COMMUNITY WHO WAS RESPONSIBLE TO COORDINATE HOSPITAL INITIATIVES WITH INTERNAL RESOURCES AND COMMUNITY PARTNERS INITIATIVE SELECTION WAS FINALIZED AUGUST 2016 THE COMMUNITY HEALTH IMPLEMENTATION PLAN (CHIP) WAS APPROVED BY THE COX MEDICAL CENTER BRANSON (CMCB) BOARD OF DIRECTORS OCTOBER 27, 2016 CMCB WILL IMPLEMENT, TRACK, AND EVALUATE THE DOCUMENTED CHIP INITIATIVES THROUGH SEPTEMBER 2019 DURING THIS PERIOD, WE WILL CONTINUE OUR COLLABORATIVE EFFORTS UNDER THE OZARKS HEALTH COMMISSION TO HARNESS THE VALUE OF IDENTIFYING AND ACTING UPON COMMON STRATEGIES FOR IMPROVING THE HEALTH OF OUR COMMUNITIES IMPROVING THE HEALTH OF OUR COMMUNITIES IMPROVING THE HEALTH OF OUR COMMUNITIES IMPROVING THE HEALTH OF OUR COMMUNITIES IMPROVING THE HEALTH OF OUR COMMUNITIES

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 3	PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE LESTER E COX MEDICAL CENTERS, PARENT ORGANIZATION, 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 - LESTER E COX MEDICAL CENTERS 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 LESTER E COX MEDICAL CENTERS 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
SCHEDULE H, PART VI, LINE 4	COMMUNITY INFORMATION CMCB CONSIDERS TANEY AND STONE COUNTIES AS ITS PRIMARY SERVICE AREA WITH CHRISTIAN COUNTY, BOONE COUNTY AND PARTS OF CARROLL COUNTY IN NORTHERN ARKANSAS AS ITS SECONDARY SERVICE AREA THE TOTAL POPULATION OF ZIP CODES SERVED BY CMCB IS APPROXIMATELY 144,000 THE PROJECTED POPULATION GROWTH IN THESE AREAS, ESPECIALLY THE CONTINUING MIGRATION INTO THE AREA OF RETIREES, IS A SIGNIFICANT FACTOR IN THE EVER-INCREASING NEED FOR HIGH-TECH MEDICAL SERVICES

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 5	PROMOTION OF COMMUNITY HEALTH CMCB HAS A 15-MEMBER BOARD OF DIRECTORS SEVERAL THOUSANDS OF DOLLARS ARE SPENT EACH YEAR OFFERING FREE LOW-COST SCREENINGS TO THE COMMUNITY AND EDUCATIONAL PROGRAMS CMCB PHYSICIANS AND STAFF ARE COMMITTED TO EDUCATING THE COMMUNITY TO HELP ENSURE A HEALTHIER FUTURE CPR CLASSES, SMOKING CESSATION CLASSES, PRENATAL CLASSES, ETC ARE ALL FOCUSED ON GIVING OUR COMMUNITY MEMBERS THE RESOURCES THEY NEED TO MAKE INFORMED DECISIONS
SCHEDULE H, PART VI, LINE 6	AFFILIATED HEALTH CARE SYSTEM CMCB IS PART OF THE COXHEALTH SYSTEM, WHICH INCLUDES THE FOLLOWING -LESTER E COX MEDICAL CENTERS, WHICH 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 THE HEALTH SYSTEM PRIMARILY EARNS REVENUES BY PROVIDING INPATIENT, OUTPATIENT, EMERGENCY CARE, INPATIENT REHABILITATION, HOME CARE, PHYSICIAN SERVICES AND HEALTH INSURANCE PRODUCTS TO PATIENTS AND EMPLOYERS IN SPRINGFIELD, MISSOURI, AND THE SURROUNDING SOUTHWEST MISSOURI AREA -COX HEALTH SYSTEMS HMO, INC -MEDICAL DEVELOPMENTS, INC -INSURANCE COMPANY OF SPRINGFIELD, INC -COXHEALTH ALLIANCE, LLC -COX-MONETT HOSPITAL -COXHEALTH FOUNDATION -COX HPS OF THE OZARKS, INC -COX ALTERNATIVE CARE OF THE OZARKS, INC , HEALTHCARE SERVICES OF THE OZARKS, INC AND COX HEALTHCARE SERVICES OF THE MIDWEST, INC COLLECTIVELY REFERRED TO AS OXFORD HOME HEALTH CARE -PRIMROSE PLACE, INC -COXHEALTH IS THE PARENT COMPANY FOR LESTER E COX MEDICAL CENTERS AND ITS WHOLLY OWNED AFFILIATES, AND COX MEDICAL GROUP -COX MEDICAL GROUP IS THE SOLE MEMBER OF THE COX TAXABLE CLOSE CORPORATION, A FOR-PROFIT ENTITY THAT IS THE SOLE SHAREHOLDER OF FDCI -COX BARTON COUNTY

**Schedule H (Form 990) 2017**



**Additional Data**

**Software ID:**  
**Software Version:**  
**EIN:** 44-0584290  
**Name:** SKAGGS COMMUNITY HOSPITAL ASSOCIATION

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

<b>Section A. Hospital Facilities</b>  (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? <b>1</b>		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER—24 hours	ER—other	Other (Describe)	Facility reporting group
1	SKAGGS COMMUNITY HEALTH CENTER 251 SKAGGS RD BRANSON, MO 65616 WWW COXHEALTH COM 52-57	X	X					X			

**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 A COMMITTEE WAS FORMED TO CREATE AND IMPLEMENT THE SURVEY USED IN THE ASS ESSMENT THE COMMITTEE BEGAN MEETING IN JUNE 2015 AND WAS COMPRISED OF HOSPITAL, ACADEMIC AND PUBLIC HEALTH PARTNERS THE COMMITTEE CREATED A SURVEY AND THE FOCUS OF THIS SURVEY WA S TO GARNER FEEDBACK FROM RESIDENTS IN THE REGION ON PRIORITIZING ISSUES THAT ARE BARRIERS TO IMPROVED HEALTH IN ADDITION, THE COMMITTEE DETERMINED THAT THERE WAS SIGNIFICANT VALU E IN OBTAINING PERSPECTIVES ON HEALTH FROM BOTH INDIVIDUALS AND ORGANIZATIONS THAT PROVIDE SERVICES TO THE COMMUNITY AS A RESULT, AN ADDITIONAL SURVEY THAT HAD MINOR ADJUSTMENTS M ADE FOR THE ORGANIZATIONAL PERSPECTIVE WAS ALSO ADMINISTERED AFTER THE SURVEY WAS DEVELOP ED, IT WAS APPROVED THROUGH THE INTUITIONAL REVIEW BOARD THROUGH THE OFFICE OF RESEARCH AD MINISTRATION AT MISSOURI STATE UNIVERSITY AND TRANSLATED INTO SPANISH THE FULL SURVEY CAN BE FOUND IN THE APPENDIX J OF THE REPORT SURVEY MONKEY WAS USED TO STREAMLINE THE DATA C OLLECTION, COMPILATION AND ANALYSIS THE SURVEY INCLUDED FOUR POTENTIAL PATHS BASED ON 2 L INKS (ENGLISH AND SPANISH) AND THE FIRST QUESTION (INDIVIDUAL OR ORGANIZATION) THE ANNOUN CEMENT OF THE SURVEY WAS MADE THROUGH A JOINT EFFORT OF ALL PARTICIPATING PARTNERS WITH A COORDINATED PRESS RELEASE INDIVIDUAL ORGANIZATIONS PROMOTED THE COMPLETION OF THE SURVEY THROUGH EMAIL, NETWORKING, SOCIAL MEDIA AND PROMOTION AT POINT OF SERVICE WITHIN FACILITIE S INCENTIVES WERE NOT OFFERED TO PARTICIPANTS AT ANY POINT OF SURVEY COLLECTION TO MAXIM IZE THE RESPONSE RATE, THE SURVEY WAS KEPT OPEN AND PROMOTED FROM AUGUST 2015 UNTIL DECEMB ER 2015 PRELIMINARY RESULTS WERE COLLECTED AT THE BEGINNING OF NOVEMBER 2015 TO INFORM TH E LINE OF QUESTIONING DEVELOPED FOR THE FOCUS GROUPS FINAL RESULTS WERE THEN TABULATED IN DECEMBER 2015 AND JANUARY 2016 FOCUS GROUPS WERE ALSO USED TARGETING UNDERSERVED, CHRONI CALLY ILL AND LOW-POPULATIONS IN EACH COMMUNITY A RESEARCHER FROM MISSOURI STATE UNIVERSI TY'S SOCIOLOGY DEPARTMENT WAS CONTRACTED TO COMPLETE THE FOCUS GROUPS THE RESEARCHER HAS EXPERIENCE WITH HEALTHCARE AND FOCUS GROUPS THE RESEARCHER ALSO SERVED ON THE SURVEY COMM ITTEE AND WAS AN INTEGRAL PART OF THE PROCESS AFTER THE TOPICS OF FOCUS WERE IDENTIFIED I N AUGUST 2015, THE RESEARCHER DEVELOPED THE FOCUS GROUP QUESTIONS AND SUBMITTED THEM TO TH E SURVEY COMMITTEE AND THE STEERING COMMITTEE TO REVIEW AND PROVIDE FEEDBACK THE SURVEY C OMMITTEE ALSO HELPED DETERMINE THE NUMBER OF FOCUS GROUPS AND THE TARGET AUDIENCE FOR THE FOCUS GROUPS THE COMMITTEE DETERMINED THAT RESIDENTS WERE THE MOST IMPORTANT GROUP FROM W HICH TO RECEIVE IN-DEPTH FEEDBACK ADDITIONALLY, THE COMMITTEE DETERMINED THAT IT WAS NECE SSARY TO CONDUCT FOCUS GROUPS IN EACH OF THE NINE COMMUNITIES DUE TO VARIANCES IN LOCAL PE RCEPTIONS AND BARRIERS FOCUS GROUP FACILITATOR TRAININGS WERE CONDUCTED IN SEPTEMBER AND OCTOBER 2015, WITH FOCUS GROUPS OCCURRING IN NOVEMBER AND DECEMBER 2015 IN ADDITION, SECO NDARY DATA WAS COLLECTED FROM</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 5	COMMUNITYCOMMONS ORG AND OTHER SOURCES AND EMERGENCY DEPARTMENT DATA WAS OBTAINED FROM HOS PITAL PARTNERS

**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 -CITIZENS MEMORIAL HEALTHCARE -FREEMAN HEALTH SYSTEM -MERCY -LESTER E COX MEDICAL CENTERS -COX-MONETT HOSPITAL

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

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

Form and Line Reference	Explanation
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 -BURRELL BEHAVIORAL HEALTH -JASPER COUNTY HEALTH DEPARTMENT -JOPLIN HEALTH DEPARTMENT -POLK COUNTY HEALTH CENTER -SPRINGFIELD GREENE COUNTY HEALTH DEPARTMENT -TANEY COUNTY HEALTH DEPARTMENT

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
<b>Section C. Supplemental Information for Part V, Section B.</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 HTTP //WWW CITIZENSMEMORIAL COM

<b>Form 990 Part V Section C Supplemental Information for Part V, Section B.</b>	
<b>Section C. Supplemental Information for Part V, Section B.</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.	
<b>Section C. Supplemental Information for Part V, Section B.</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	IMPLEMENTATON 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
SCHEDULE H, PART V, SECTION B, LINE 11	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, MEDICAL NUTRITION THERAPY, AND ADVANCE CARE PLANNING THEY PROVIDE TOOLS DESIGNED TO INCREASE SELF-MANAGEMENT OF CHRONIC CONDITIONS INCLUDING DIABETES, AUTOIMMUNE DISORDERS, METABOLIC SYNDROME, 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 REFINED THE SCOPE OF OFFERINGS TO AN EVIDENCE-BASED, TARGETED PROGRAM SUITE THAT FOCUSES HEAVILY ON IMPROVING CHRONIC CONDITION MANAGEMENT OF PATIENTS -IN ADDITION TO THE PROGRAMS ALREADY OFFERED, THE CENTER FOR HEALTH IMPROVEMENT ADDED A NEW SIX-WEEK, EVIDENCE-BASED COURSE FOCUSED ON CHRONIC PAIN CONDITIONS -THE NURSING EDUCATION DEPARTMENT AND THE JOINT REPLACEMENT EDUCATORS AT MEYER ORTHOPEDIC 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 -TIGR VIDEO VIEWS INCREASED FROM 4,694 VIEWS IN MAY 2018 TO 6,284 IN MAY 2019 2 REDUCE AVOIDABLE HOSPITAL READMISSIONS - COXHEALTH NURSING ADMINISTRATION BEGAN TRAINING NURSES ON LIGHT DUTY TO COMPLETE PATIENT READMISSION INTERVIEW FORMS IN 2018 WHEN A PATIENT IS READMITTED WITHIN THIRTY DAYS, A CASE MANAGER MEETS WITH THE PATIENT TO DISCUSS THE READMISSION TOPICS COVERED IN THE INTERVIEW INCLUDE >FREQUENCY OF GOOD COMMUNICATION IN THE HOSPITAL REGARDING DIAGNOSIS AND MEDICATIONS >COMMUNICATION ABOUT DISCHARGE INSTRUCTIONS AND ABILITY TO UNDERSTAND INSTRUCTIONS >MEDICATION COMPLIANCE AND REASONS FOR ANY DIFFICULTY REMAINING COMPLIANT >FOLLOW UP APPOINTMENTS WITH A PCP BEING SCHEDULED AND ATTENDED >REASONS FOR READMISSION, FROM THE PATIENTS PERSPECTIVE >>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 >COXHEALTH HIRED TRANSITIONAL CARE PHARMACISTS WHO DEDICATE THEIR TIME WORKING WITH PATIENTS BEING DISCHARGED TO ENSURE THE PATIENT LEAVES THE HOSPITAL WITH THEIR MEDICATIONS >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 IN-90 PROJECT >THE CLINIC SUPPORT TEAM HAS BEEN INSTRUMENTAL IN SCHEDULING FOLLOW-UP APPOINTMENTS WITH PATIENTS THE MAJORITY OF INPATIENT UNITS ARE COVERED BY THE CLINIC SUPPORT TEAM, WHICH MEANS MO

**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	ST PATIENTS HAVE A FOLLOW UP APPOINTMENT SCHEDULED PRIOR TO LEAVING THE HOSPITAL >A SUBGR OUP COMPRISED OF FRONTLINE STAFF, LEADERS, AND QUALITY IMPROVEMENT EXPERTS HAS BEEN FORMED TO FOCUS SPECIFICALLY ON REDUCING HEART FAILURE READMISSIONS THE GROUP WILL USE DATA TO INFORM DECISIONS ON HOW TO BEST MANAGE OUR PATIENTS WITH FREQUENT INPATIENT STAYS DUE TO H EART FAILURE 3 INCREASE ACCESS TO TOBACCO CESSATION RESOURCES FOR PATIENTS AND FAMILIES PRESENTING TO OUR HOSPITALS AND CLINICS -AN ASSET ASSESSMENT AND GAP ANALYSIS OF THE SYSTE MS TOBACCO TREATMENT OFFERINGS WAS CONDUCTED RECOMMENDATIONS FROM THAT ASSESSMENT INCLUDE D CREATION AND IMPLEMENTATION OF A CLEARLY OUTLINED REFERRAL PROCESS AND DEFINED RESOURCES AND PROMOTION OF THE ASK, ADVISE, ACT/REFER MODEL TO INITIATE INTERVENTION -IN MAY 2018, WE PROVIDED TRAINING TO 12 KEY COXHEALTH STAFF MEMBERS AND 3 COMMUNITY EDUCATORS COMPLET ION OF THE UMASS MEDICAL SCHOOL EDUCATION CURRICULUM, REQUIRED EXAMS, AND PRACTICE HOURS M ADE CLASS PARTICIPANTS ELIGIBLE FOR CERTIFICATION AS TOBACCO TREATMENT SPECIALISTS AS A R ESULT OF THIS EDUCATION, THE NUMBER OF CESSATION RESOURCES AVAILABLE WITHIN THE SYSTEM INC REASED THE TRAINING WILL BE OFFERED AGAIN IN OCTOBER 2019 TO FURTHER INCREASE RESOURCES -THE QUIT RATE FOR OUR TOBACCO CESSATION PROGRAM HAS CONTINUED TO SHOW POSITIVE RESULTS SI NCE ITS INCEPTION IN 2013, WITH THE CURRENT QUIT RATE FOR 2019 TO DATE AT 64% AVERAGING A CROSS THE HISTORY OF THE PROGRAM, THE AGGREGATED QUIT RATE IS 55% -DUE TO THE SUCCESS OF THIS PROGRAM, FOLLOWING THE STONE AND TANAY COUNTY MFH TOBACCO GRANTS END ON MAY 31, 2018, WE WERE ABLE TO HIRE A FULL TIME TOBACCO CESSATION COORDINATOR WHO IS RESPONSIBLE FOR COO RDINATING SYSTEM EFFORTS TO STANDARDIZE POLICIES AND REFERRAL PROCESSES ACROSS ALL CAMPUSE S AND SETTINGS 4 DECREASE CHILDHOOD OBESITY -THE CARDIAC KIDS PROGRAM IS IMPLEMENTED IN 13 RURAL SCHOOLS IN THE COXHEALTH SERVICE AREA ITS MAIN OBJECTIVE IS TO SCREEN 5TH GRADE STUDENTS FOR HEALTH INDICATORS THAT PUT THEM AT HIGH RISK FOR DEVELOPING CARDIAC DISEASE SCREENING BY COXHEALTH STAFF INCLUDES HEIGHT AND WEIGHT MEASUREMENT, BMI CONSULT, AND HEAL TH/NUTRITION EDUCATION -APPROXIMATELY 400 CHILDREN ARE SCREENED ANNUALLY THOSE WHO ARE D EEMED HIGH RISK ARE REFERRED TO THE COMMITTED TO KIDS PROGRAM THIS 8-WEEK PROGRAM IS AN I NTENSIVE INTERVENTION FOR AT-RISK CHILDREN AND THEIR FAMILIES FOCUSING ON HEALTHY BEHAVIOR AND NUTRITION EDUCATION 5 INCREASE THE NUMBER OF WOMEN WHO BREASTFEED THEIR INFANTS AFT ER DELIVERY -COXHEALTH AND THE SPRINGFIELD-GREENE COUNTY HEALTH DEPARTMENT ARE CURRENTLY E NGAGED IN A COMMUNITY BREASTFEEDING COALITION WITH THE GOAL OF STRATEGICALLY ALIGNING EFFO RTS TO HELP MOVE THE CHIP INITIATIVE FORWARD -IN ADDITION TO EDUCATION PRESENTED IN OUR G ENERAL PRENATAL CLASSES, THE COXHEALTH LACTATION CONSULTANTS FACILITATE A MONTHLY BREASTFE EDING SUPPORT GROUP CALLED THE LACTATION CLUB 6 INCREASE DETECTION AND TREATMENT OF THE EARLIEST STAGES OF LUNG CANCER

**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>NODULES -COXHEALTH OFFERS LOW-DOSE CT SCANS AS A DIAGNOSTIC SCREENING FOR LUNG CANCER LO W-DOSE CT SCANS USE LOWER AMOUNTS OF RADIATION TO HELP IDENTIFY LUNG NODULES IN THE EARLIE ST STAGES OF LUNG CANCER WHEN IT IS MOST TREATABLE STUDIES HAVE SHOWN THAT PATIENTS WHO P ARTICIPATE IN A LOW-DOSE CT LUNG CANCER PROGRAM ARE 20% LESS LIKELY TO DIE FROM LUNG CANCE R THAN THOSE WHO WERE NOT SCREENED WHEN APPROPRIATE -SINCE THE PROGRAM BEGAN, THE NUMBER OF INDIVIDUALS WHO HAD A LOW-DOSE CT SCAN COMPLETED HAS CONTINUED TO INCREASE 7 INCREASE REFERRALS TO COMMUNITY ORAL HEALTH RESOURCES FOR PATIENTS PRESENTING TO THE ED FOR DENTAL ISSUES -COMMUNITY PARTNERSHIPS WITH LOCAL RESOURCES HAVE BEEN STRENGTHENED AND REFINED TO ENSURE STAFF FEEL EMPOWERED TO REFER PATIENTS TO FACILITIES LIKE THE JORDAN VALLEY COMMUN ITY HEALTH CENTER (JVCHC) FOR THE APPROPRIATE LEVEL OF CARE FOR ORAL HEALTH ISSUES -WHEN EVALUATING THE CHIEF COMPLAINTS OF PATIENTS THAT PRESENTED TO THE EMERGENCY DEPARTMENT (ED ) FIVE OR MORE TIMES IN A 12-MONTH PERIOD FOR NON-EMERGENT CARE, DENTAL COMPLAINTS RANKED AMONG THE HIGHEST -PROTOCOLS WERE DEVELOPED FOR PATIENTS THAT PRESENT WITH 'TOOTH PAIN' I N THE ED AFTER THE MEDICAL SCREENING EXAM COMPLETION, THE PATIENT IS TRANSITIONED TO JVCH C FOR IMMEDIATE DENTAL CARE -COXHEALTH WORKED IN COLLABORATION WITH JVCHC TO APPLY FOR A GRANT THAT ALLOWED FOR THE HIRE OF ADDITIONAL DENTISTS TO ENSURE SAME-DAY OR NEXT DAY APP OINTMENTS, THE DENTAL CLINIC EXPANDED TO ADD SATURDAY HOURS -QUICK ACCESS TO THE DENTAL C LINIC ALLOWED COXHEALTH ED PHYSICIANS TO DISCONTINUE PRESCRIBING NARCOTICS TO PATIENTS WHO PRESENTED WITH TOOTH PAIN</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 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.	
<b>Section C. Supplemental Information for Part V, Section B.</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 AVAILABILITY THE FINANCIAL ASSISTANCE POLICY IS AVAILABLE AT THE FOLLOWING URL <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.	
<b>Section C. Supplemental Information for Part V, Section B.</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 AVAILABILITY THE FINANCIAL ASSISTANCE POLICY APPLICATION FORM IS AVAILABLE AT THE FOLLOWING URL <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	FINANCIAL ASSISTANCE POLICY PLAIN LANGUAGE SUMMARY AVAILABILITY THE PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY IS AVAILABLE AT THE FOLLOWING URL <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

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

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

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

Name and address	Type of Facility (describe)
1 SKAGGS ORTHONEURO CENTER 101 CAHILL RD BRANSON, MO 65616	OUTPATIENT DEPTS PHYSICIAN CLINICS
1 CMCB OUTPATIENT CENTER 545 N BRANSON LANDING BLVD BRANSON, MO 65616	OUTPATIENT DEPTS PHYSICIAN CLINICS
2 MARY'S WELL HOUSE 5136 HWY 265 BRANSON, MO 65616	PHYSICIAN CLINIC
3 CMCB HEART CENTER 1150 STATE HWY 248 SUITE 202 BRANSON, MO 65616	CLINIC
4 COXHEALTH HOSPITALIST 525 BRANSON LANDING BLVD BRANSON, MO 65616	CLINIC
5 FDC UROLOGYGI 525 BRANSON LANDING BLVD BRANSON, MO 65616	CLINIC
6 COXHEALTH FAMILY MEDICINE AND OB 525 BRANSON LANDING BLVD BRANSON, MO 65616	CLINIC
7 COXHEALTH FAMILY MEDICINE 248 1150 STATE HWY 248 SUITE 202 BRANSON, MO 65616	CLINIC
8 COXHEALTH FORSYTH 13852 US HWY 160 FORSYTH, MO 65653	CLINIC
9 COXHEALTH GENERAL SURGERY 525 BRANSON LANDING BLVD BRANSON, MO 65616	CLINIC
10 COXHEALTH DIABETES AND ENDOCRINOLOGY 1150 HWY 248 SUITE 312 BRANSON, MO 65616	CLINIC
11 COXHEALTH INTERN MEDINFECTIOUS DISEASE 525 BRANSON LANDING BLVD BRANSON, MO 65616	CLINIC
12 COXHEALTH ORTHOPEDICS 121 CAHILL ROAD SUITE 206 BRANSON, MO 65616	CLINIC
13 COXHEALTH PAIN AND NEUROLOGY 121 CAHILL ROAD SUITE 204 BRANSON, MO 65616	CLINIC
14 COXHEALTH PULMONOLOGY AND SLEEP MEDICINE 525 BRANSON LANDING BLVD SUITE 306 BRANSON, MO 65616	CLINIC

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

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

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

Name and address	Type of Facility (describe)
<b>16</b> COX HYPERBARIC MEDICINE AND WOUND CARE 101 SKAGGS ROAD SUITE 103 BRANSON, MO 65616	CLINIC
<b>1</b> COXHEALTH URGENT CARE 525 BRANSON LANDING BLVD SUITE 100 BRANSON, MO 65616	CLINIC
<b>2</b> COXHEALTH OCCUPATIONAL HEALTH 121 CAHILL ROAD SUITE 201 BRANSON, MO 65616	CLINIC
<b>3</b> COXHEALTH RHEUMATOLOGY 525 BRANSON LANDING BLVD SUITE 301 BRANSON, MO 65616	CLINIC
<b>4</b> COXHEALTH BRANSON WEST 18452 BUSINESS HWY 13 BRANSON WEST, MO 65737	CLINIC
<b>5</b> FITNESS CENTER BRANSON 1500 BRANSON HILLS PARKWAY BRANSON, MO 65616	FITNESS CENTER
<b>6</b> COXHEALTH ACCESS CLINIC 1150 STATE HWY 248 STE 102 BRANSON, MO 65616	CLINIC
<b>7</b> COXHEALTH WOMEN'S CENTER BRANSON 525 BRANSON LANDING BLVD SUITE 40 BRANSON, MO 65616	CLINIC
<b>8</b> COXHEALTH PSYCHIATRY SERVICES BRANSON 525 BRANSON LANDING BLVD BRANSON, MO 65616	CLINIC

Schedule I  
(Form 990)

Department of the Treasury  
Internal Revenue Service

Name of the organization  
SKAGGS COMMUNITY HOSPITAL ASSOCIATION

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

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

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

OMB No 1545-0047

2017

Open to Public Inspection

Employer identification number  
44-0584290

Part I

General Information on Grants and Assistance

- 1

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

☒ Yes ☐ No
- 2

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

Part II

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

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

2

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

3

3

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

1

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

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

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

Return Reference	Explanation
PART I, LINE 2	PROCEDURES FOR MONITORING THE USE OF GRANT FUNDS IN THE U S THE HOSPITAL MONITORS THE USE OF THE FUNDS DONATED TO SKAGGS FOUNDATION BY REVIEWING THE EXPENSES INCURRED BY THE FOUNDATION ON A MONTHLY BASIS TO ENSURE THE FUNDS WERE PROPERLY DISTRIBUTED AND USED FOR THE INTENDED PURPOSE

Additional Data

Software ID:  
Software Version:  
EIN: 44-0584290  
Name: SKAGGS COMMUNITY HOSPITAL ASSOCIATION

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
SKAGGS FOUNDATION 101 SKAGGS ROAD STE 404 BRANSON, MO 65616	30-0107007	501(C)(3)	249,171				SUPPORT
BRANSON LAKES AREA CHAMBER OF COMMERCE PO BOX 1897 BRANSON, MO 65616	44-0586242	501(C)(6)	10,000				SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MHA HEALTH INSTITUTE PO BOX 60 JEFFERSON CITY, MO 65102	43-0898947	501(C)(3)	19,331				SUPPORT



<b>Schedule J</b> (Form 990)	<b>Compensation Information</b>  <b>For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees</b> <b>▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23.</b> <b>▶ Attach to Form 990.</b> <b>▶ Information about Schedule J (Form 990) and its instructions is at <a href="http://www.irs.gov/form990">www.irs.gov/form990</a>.</b>	OMB No 1545-0047  <div style="font-size: 2em; font-weight: bold; text-align: center;">2017</div> <div style="background-color: black; color: white; text-align: center; padding: 5px;"> <b>Open to Public Inspection</b> </div>	
	Department of the Treasury Internal Revenue Service		
	Name of the organization SKAGGS COMMUNITY HOSPITAL ASSOCIATION	Employer identification number  44-0584290	

Part I Questions Regarding Compensation		Yes	No
<b>1a</b> Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a Complete Part III to provide any relevant information regarding these items			
<div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <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                         </div> <div style="width: 48%;"> <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)                         </div> </div>			
<b>b</b> If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	<b>1b</b>	Yes	
<b>2</b> Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?	<b>2</b>	Yes	
<b>3</b> Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director Check all that apply Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III			
<div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <input checked="" type="checkbox"/> Compensation committee  <input checked="" type="checkbox"/> Independent compensation consultant  <input type="checkbox"/> Form 990 of other organizations                         </div> <div style="width: 48%;"> <input checked="" type="checkbox"/> Written employment contract  <input checked="" type="checkbox"/> Compensation survey or study  <input checked="" type="checkbox"/> Approval by the board or compensation committee                         </div> </div>			
<b>4</b> During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization			
<b>a</b> Receive a severance payment or change-of-control payment?	<b>4a</b>		No
<b>b</b> Participate in, or receive payment from, a supplemental nonqualified retirement plan?	<b>4b</b>	Yes	
<b>c</b> Participate in, or receive payment from, an equity-based compensation arrangement? If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III	<b>4c</b>		No
<b>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</b>			
<b>5</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of			
<b>a</b> The organization?	<b>5a</b>		No
<b>b</b> Any related organization? If "Yes," on line 5a or 5b, describe in Part III	<b>5b</b>		No
<b>6</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of			
<b>a</b> The organization?	<b>6a</b>	Yes	
<b>b</b> Any related organization? If "Yes," on line 6a or 6b, describe in Part III	<b>6b</b>		No
<b>7</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III	<b>7</b>		No
<b>8</b> Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	<b>8</b>		No
<b>9</b> If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	<b>9</b>		

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

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

See Additional Data Table

**Schedule J (Form 990) 2017**

**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 1A	INFORMATION REGARDING BENEFITS PROVIDED CHARTER TRAVEL IS PROVIDED FOR STEVE EDWARDS AND JACOB MCWAY FOR TRAVEL TO COLLABORATIVE MEETINGS REPRESENTING COXHEALTH FOR EXPEDIENCY AS THERE WAS NO PERSONAL USE PORTION OF THIS BENEFIT, NONE WAS INCLUDED IN TAXABLE WAGES
SCHEDULE J, PART I, LINE 4B	SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN STEVE EDWARDS, CHARITY ELMER, JACOB MCWAY, WILLIAM MAHONEY, AND DAVID STRONG PARTICIPATE IN A 457(F) NONQUALIFIED RETIREMENT PLAN THROUGH COXHEALTH AND RELATED AFFILIATES - STEVE EDWARDS RECEIVED AN EXECUTIVE 457(F) CONTRIBUTION OF \$255,977 - STEVE EDWARDS RECEIVED A 457(F) DISTRIBUTION OF \$226,957, WHICH WAS REPORTED AS DEFERRED COMPENSATION ON A PRIOR FORM 990 - JACOB MCWAY RECEIVED AN EXECUTIVE 457(F) CONTRIBUTION OF \$103,113 - JACOB MCWAY RECEIVED A 457(F) DISTRIBUTION OF \$104,612, WHICH WAS REPORTED AS DEFERRED COMPENSATION ON A PRIOR FORM 990 - CHARITY ELMER RECEIVED AN EXECUTIVE 457(F) CONTRIBUTION OF \$62,286 - CHARITY ELMER RECEIVED A 457(F) DISTRIBUTION OF \$47,688, WHICH WAS REPORTED AS DEFERRED COMPENSATION ON A PRIOR FORM 990 - WILLIAM MAHONEY RECEIVED AN EXECUTIVE 457(F) CONTRIBUTION OF \$46,542 - WILLIAM MAHONEY RECEIVED A 457(F) DISTRIBUTION OF \$42,931, WHICH WAS REPORTED AS DEFERRED COMPENSATION ON A PRIOR FORM 990 - DAVID STRONG RECEIVED AN EXECUTIVE 457(F) CONTRIBUTION OF \$27,200 - DAVID STRONG RECEIVED A 457(F) DISTRIBUTION OF \$27,849, WHICH WAS REPORTED AS DEFERRED COMPENSATION ON A PRIOR FORM 990
SCHEDULE J, PART I, LINE 6A	COMPENSATION CONTINGENT ON THE NET EARNINGS OF THE ORGANIZATION KEY EMPLOYEES HAVE NET EARNINGS AS ONE COMPONENT OF A BALANCED SCORECARD METRIC CONTAINED WITHIN A BONUS PROGRAM EMPLOYED PHYSICIANS ARE PAID BASED ON A SALARY, A FORMULA USING COLLECTIONS AND EXPENSES, AN AMOUNT PER RVU, OR A COMBINATION OF THESE EXECUTIVE LEVEL STAFF ARE ELIGIBLE FOR ADDITIONAL COMPENSATION BASED ON A VARIETY OF PERFORMANCE INDICATORS IN QUALITY, CUSTOMER AND EMPLOYEE SATISFACTION AND BUSINESS PERFORMANCE MEASURES

Additional Data

Software ID:  
Software Version:  
EIN: 44-0584290  
Name: SKAGGS COMMUNITY HOSPITAL ASSOCIATION

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				
1STEVE EDWARDS BOARD MEMBER/COXHEALTH CEO	(i)	0	0	0	0	0	0	0
	(ii)	1,046,683	354,990	237,337	269,477	24,364	1,932,851	226,957
1JACOB MCWAY BOARD MEMBER/COXHEALTH CFO	(i)	0	0	0	0	0	0	0
	(ii)	563,540	150,695	115,281	134,613	22,014	986,143	104,612
2CHARITY ELMER BOARD MEMBER	(i)	0	0	0	0	0	0	
	(ii)	427,672	60,050	55,596	92,827	22,103	658,248	47,688
3WILLIAM MAHONEY PRESIDENT	(i)	456,046	66,650	49,621	60,042	15,233	647,592	42,931
	(ii)	0	0	0	0	0	0	0
4DAVID STRONG CFO	(i)	266,088	38,874	35,139	40,700	15,333	396,134	27,849
	(ii)	0	0	0	0	0	0	0
5HOLLY WHERRY BOARD MEMBER	(i)	405,788	0	300	0	7,282	413,370	0
	(ii)	0	0	0	0	0	0	0
6CHAD EFIRD PHYSICIAN	(i)	1,199,859	0	300	31,041	15,168	1,246,368	0
	(ii)	0	0	0	0	0	0	0
7NARIN ARUNAKUL PHYSICIAN	(i)	872,939	0	1,290	31,500	15,333	921,062	0
	(ii)	0	0	0	0	0	0	0
8PRASER VIJITBENJARONK PHYSICIAN	(i)	652,096	0	690	31,500	15,233	699,519	0
	(ii)	0	0	0	0	0	0	0
9BRIAN CLONTS PHYSICIAN	(i)	709,295	0	1,242	31,500	15,325	757,362	0
	(ii)	0	0	0	0	0	0	0
10CODY HOEFlickER PHYSICIAN	(i)	535,395	0	540	13,041	15,168	564,144	0
	(ii)	0	0	0	0	0	0	0
11SHAWN USERY CMO	(i)	414,030	0	257	6,750	15,161	436,198	0
	(ii)	0	0	0	0	0	0	0
12LYNNE YAGGY CNO	(i)	176,987	11,084	690	7,827	15,228	211,816	0
	(ii)	0	0	0	0	0	0	0

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

Name of the organization

SKAGGS COMMUNITY HOSPITAL ASSOCIATION

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No 1545-0047

**2017****Open to Public  
Inspection****Employer identification number**

44-0584290

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART I, LINE 1	ORGANIZATION'S MISSION VISION THE HOSPITAL'S VISION IS TO BE THE BEST FOR THOSE WHO NEED US WE VALUE SAFETY, COMPASSION, RESPECT AND INTEGRITY THE HOSPITAL HAS BEEN SERVING SOUTHWEST MISSOURI FOR MORE THAN 65 YEARS AND OFFERS OVER 25 MAJOR SERVICE AREAS THE HOSPITAL'S AVERAGE DAILY PATIENT CENSUS EXCEEDS 80 PATIENTS WITH 157 LICENSED HOSPITAL BEDS A STAFF OF OVER 1,100 PERSONNEL OPERATE THE HOSPITAL AND ITS NUMEROUS CLINICS

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III, LINE 4A	<p>PROGRAM SERVICE ACHIEVEMENT #1 CMCB DESIGNATED AS A LEVEL II STEMI CENTER BY THE MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES THE MEDICAL CENTER IS ONLY ONE OF 19 IN THE STATE TO RECEIVE THIS CLASSIFICATION THIS MEANS THE HOSPITAL IS EQUIPPED TO PROVIDE CARE FOR A LARGE NUMBER OF STEMI PATIENTS, PERFORMS A MINIMUM NUMBER OF CARDIAC PROCEDURES A YEAR, HAS 24/7 CATH LAB SERVICES AVAILABLE WITHIN 30 MINUTES OR LESS AND HAS PROCESSES IN PLACE TO QUICKLY AND SAFELY TRANSFER PATIENTS FOR HEART SURGERY IF NEEDED FOR THE SECOND YEAR IN A ROW, CMCB RECEIVED ONE OF THE HIGHEST RECOGNITIONS FOR OUTSTANDING STROKE CARE BY RECEIVING THE AMERICAN HEART ASSOCIATION/STROKE ASSOCIATIONS GET WITH THE GUIDELINES STROKE GOLD PLUS ACHIEVEMENT AWARD WITH TARGET STROKE HONOR ROLL ELITE THE AWARD RECOGNIZES THE HOSPITALS COMMITMENT TO PROVIDING THE MOST APPROPRIATE STROKE TREATMENT ACCORDING TO NATIONALLY RECOGNIZED RESEARCH-BASED GUIDELINES BASED ON THE LATEST SCIENTIFIC EVIDENCE CMCBs ACUTE REHAB UNIT WAS AWARDED A NUMBER SEVEN RANKING AMONG 106 OTHER REHAB UNITS AT THE KIDNEY REHABILITATION SERVICES NATIONAL MEETING IN NASHVILLE THE RANKING IS BASED ON A PERFORMANCE EVALUATION MODEL (PEM) WHICH USES INDICATORS OF EFFICIENCY AND EFFECTIVENESS TO MEASURE HIGH-PERFORMING FACILITIES FOR THEIR DELIVERY OF QUALITY CARE WHEN COMPARED TO ALL FACILITIES CMCBs PUBLIC SAFETY TEAM HAS BECOME THE FIRST HOSPITAL IN THE STATE TO RECEIVE THE INTERNATIONAL ASSOCIATION FOR HEALTHCARE SECURITY AND SAFETY'S PROGRAM OF DISTINCTION AWARD ONLY 40 HOSPITALS IN THE UNITED STATES AND CANADA HAVE RECEIVED THIS HONOR THIS MEANS THAT 70% OF THE HOSPITALS OFFICERS, GUARDS, MANAGERS AND DIRECTORS STUDIED AND PASSED THE IAHS INTENSIVE CERTIFICATION EXAM U.S. NEWS &amp; WORLD REPORT NAMES CMCB AS HIGH PERFORMING IN THE CARE OF PATIENTS WITH CHRONIC OBSTRUCTIVE PULMONARY DISEASE JANUARY OF 2019 COXHEALTH SYSTEM RECEIVED THE ISO-9001 QUALITY MANAGEMENT SYSTEM STANDARD CERTIFICATION WHICH ASSESSES BUSINESS PRACTICE PERFORMANCE TO MEET CUSTOMER NEEDS COXHEALTH DIABETES AND ENDOCRINOLOGY IN BRANSON HAS EARNED RECOGNITION BY THE NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) AS A LEVEL III PATIENT-CENTERED SPECIALTY PRACTICE ACCORDING TO NCQA, LEVEL III STATUS IS THE HIGHEST LEVEL OF RECOGNITION FOR SPECIALTY PRACTICES THAT ARE COMMITTED TO ACCESS, COMMUNICATION AND CARE COORDINATION</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART IV, LINE 24A	TAX EXEMPT BONDS LESTER E COX MEDICAL CENTERS, A RELATED ORGANIZATION, REPORTS BONDS REL ATED TO COX BRANSON ON ITS FORM 990, SCHEDULE K AN ALLOCATION OF COX BRANSON'S PORTION OF RELATED BONDS IS REPORTED ON PART X, LINE 20

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 2	BUSINESS RELATIONSHIPS BOARD MEMBERS WHO RECEIVE COMPENSATION, OFFICERS, AND KEY EMPLOYEE S ARE EMPLOYED BY COXHEALTH AND ITS AFFILIATES AND THEREFORE SHARE A BUSINESS RELATIONSHIP



**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 6	MEMBERS THE ORGANIZATION HAS ONLY ONE MEMBER - LESTER E COX MEDICAL CENTERS

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7A	MEMBER'S POWER TO ELECT GOVERNING BODY THE BOARD SHALL BE ELECTED BY THE MEMBER NO LATER THAN SEPTEMBER 1 OF EACH YEAR, THE BOARD SHALL NOMINATE A SLATE OF PERSONS FOR ELECTION AS COX BRANSON DIRECTORS AND OFFICERS TO SUBMIT TO THE LESTER E COX MEDICAL CENTERS BOARD FOR APPOINTMENT THE LESTER E COX MEDICAL CENTERS BOARD WILL ACT IN GOOD FAITH AND NOT UNREASONABLY WITHHOLD APPOINTMENT IF FOR ANY REASON A NOMINATED PERSON IS NOT APPOINTED BY THE LESTER E COX MEDICAL CENTERS BOARD, THE BOARD HAS THE RIGHT TO NOMINATE ANOTHER PERSON FOR CONSIDERATION

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B	<p>GOVERNANCE DECISIONS RESERVED TO MEMBERS THE FOLLOWING CORPORATE POWERS AND RESPONSIBILITIES SHALL BE SOLELY AND SPECIFICALLY RESERVED TO THE MEMBER, A ELECTION, APPOINTMENT AND REMOVAL OF COX BRANSON BOARD OF DIRECTORS ("BOARD") AFTER NOMINATION BY THE BOARD, B APPOINTMENT AND REMOVAL OF THE PRESIDENT AND CHIEF EXECUTIVE OFFICER OF COX BRANSON ("PRESIDENT AND CEO OF COX BRANSON") AFTER RECOMMENDATION BY/CONSULTATION WITH THE BOARD, C APPROVAL OF COX BRANSON'S UNBUDGETED DEBT AND CAPITAL EXPENDITURES EXCEEDING \$250,000, D APPROVAL OF COX BRANSON'S OPERATING AND CAPITAL BUDGETS AND FINANCIAL REPORTS, MERGERS, CONSOLIDATIONS, ACQUISITIONS, AFFILIATIONS, AND REORGANIZATION OR DISPOSITION OF ASSETS EXCEEDING THE THEN FAIR VALUE OF \$250,000, E AMENDMENT, REPEAL OR ADOPTION OF COX BRANSON'S ARTICLES OF INCORPORATION AND BYLAWS EXCEPT AS OTHERWISE PROVIDED IN THE BYLAWS FINAL DECISIONS MADE BY THE BOARD OF THE DIRECTORS MUST ALSO BE APPROVED BY THE LESTER E COX MEDICAL CENTERS BOARD AS WELL THE MEMBER SHALL NOT EXERCISE ITS POWERS WITHOUT FIRST OBTAINING APPROVAL FROM TWO-THIRDS (2/3) MAJORITY OF THE BOARD IN THE FOLLOWING CIRCUMSTANCES A TRANSFER ANY OF ITS COX BRANSON MEMBERSHIP TO ANY OTHER ENTITY, B SELL OR LEASE ALL OR SUBSTANTIALLY ALL OF COX BRANSON'S ASSETS, AND C ENTER INTO A MANAGEMENT AGREEMENT FOR ALL OR SUBSTANTIALLY ALL OF COX BRANSON'S OPERATION THE MEMBER MAY NOT TERMINATE OR SUBSTANTIALLY LIMIT THE FOLLOWING COX BRANSON SERVICE LINES WITHOUT FIRST OBTAINING APPROVAL FROM TWO-THIRDS (2/3) MAJORITY OF THE BOARD EMERGENCY DEPARTMENT, CARDIOLOGY, ORTHOPEDICS, PRIMARY CARE, RADIATION AND MEDICAL ONCOLOGY, RADIOLOGY, PATHOLOGY, ANESTHESIA, GENERAL SURGERY, ICU, MEDICAL/SURGICAL SERVICES, ACUTE REHABILITATION SERVICES, WOMEN'S HEALTH SERVICES, GERIATRICS, NEUROSCIENCES, PAIN MANAGEMENT, PSYCHIATRY, UROLOGY AND ENDOCRINOLOGY NOTWITHSTANDING THE ABOVE MENTIONED LIMITATION, THESE SERVICE LINES MAY BE TERMINATED OR SUBSTANTIALLY LIMITED BY THE MEMBER WITHOUT TWO-THIRDS (2/3) MAJORITY OF THE COX BRANSON BOARD IF (I) THERE IS A LOSS OF A LICENSE OR ACCREDITATION REQUIRED TO MAINTAIN SUCH SERVICE, OR A LOSS OF MEDICARE OR MEDICAID CERTIFICATION REQUIRED FOR SUCH SERVICE, IN EACH CASE, OTHER THAN DUE TO THE ACTIONS OR INACTIONS OF THE MEMBER OR COX BRANSON OR (II) THERE IS DESTRUCTION OR MATERIAL DAMAGE TO A FACILITY (PENDING THE PERFORMANCE OR REPAIR OR REPLACEMENT EFFORTS) (PENDING THE PERFORMANCE OR REPAIR OR REPLACEMENT EFFORTS)</p>

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	REVIEW OF FORM 990 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 A DRAFT VERSION OF THE FORM 990 IS PROVIDED TO THE BOARD OF DIRECTORS PRIOR TO SUBMISSION WHILE THE DRAFT IS PROVIDED TO ALL BOARD MEMBERS, IT IS THE MEMBERS OF THE FINANCE COMMITTEE THAT GO THROUGH AND REVIEW THE RETURN IN DETAIL UPON RECEIVING THE APPROVAL OF THE BOARD OF DIRECTORS, THE DRAFT IS THEN FINALIZED AND SUBMITTED TO THE IRS

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	<p>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 COXHEALTH 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 COX MEDICAL CENTER BRANSON</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINES 15A & 15B	COMPENSATION REVIEW COX MEDICAL CENTERS EMPLOY 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 THREE EXECUTIVES TIERS OF THE ORGANIZATION, THE CEO, CFO AND SENIOR VPS 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 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

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	DOCUMENT DISCLOSURE THE ORGANIZATION'S GOVERNING DOCUMENTS, FINANCIAL STATEMENTS, AND CONFLICT OF INTEREST POLICY ARE NOT MADE AVAILABLE TO THE PUBLIC

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VII, SECTION A	BOARD MEMBER COMPENSATION STEVE EDWARDS, JACOB MCWAY, HOLLY WHERRY, AND CHARITY ELMER ARE RECEIVING COMPENSATION RELATED TO THEIR ROLES AS EMPLOYEES UNDER COXHEALTH AND RELATED AF FILIATES NO BOARD MEMBERS RECEIVE COMPENSATION FOR THEIR DUTIES AS BOARD MEMBERS



# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9	OTHER CHANGES IN NET ASSETS \$ 2,046,570 CHANGE IN INVESTMENT IN SKAGGS FOUNDATION 226,141 CHANGE IN BENEFICIAL INTEREST IN TRUST ----- \$ 2,272,711

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION OTHER CONTRACTED SERVICES TOTAL FEES 24357628

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION CONTRACTED LABOR TOTAL FEES 15220894

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION CONTRACTED BILLING SERVICES TOTAL FEES 1123829

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION CONTRACTED RADIOLOGY SERVICES TOTAL FEES 528875

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION CONTRACTED LAB SERVICES TOTAL FEES 277740

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION CONTRACTED LAUNDRY SERVICES TOTAL FEES 271990

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION CONTRACTED COLLECTION SERVICES TOTAL FEES 172908



**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION CONTRACTED HOUSEKEEPING TOTAL FEES 159880

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION CONTRACTED CONSULTING SERVICES TOTAL FEES 93631

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION CONTRACTED COURIER SERVICES TOTAL FEES 65534

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION TRANSCRIPTION SERVICES TOTAL FEES 8533

SCHEDULE R  
(Form 990)

Department of the Treasury  
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.  
▶ Attach to Form 990.  
▶ Information about Schedule R (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization  
SKAGGS COMMUNITY HOSPITAL ASSOCIATION

Employer identification number  
44-0584290

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) SKAGGS EMERGENCY PHYSICIANS PO BOX 650 BRANSON, MO 65615 35-2275232	BILLING	MO	0	0	CMCB
(2) BRANSON HEART CENTER PO BOX 650 BRANSON, MO 65615 30-0497209	BILLING	MO	0	0	CMCB
(3) SKAGGS OCCUPATIONAL HEALTH PO BOX 650 BRANSON, MO 65615 38-3774737	BILLING	MO	0	0	CMCB
(4) BRANSON FAMILY MEDICINE CLINIC PO BOX 650 BRANSON, MO 65615 32-2331834	BILLING	MO	0	0	CMCB
(5) BRANSON ORTHONEURO CENTER LLC PO BOX 650 BRANSON, MO 65615 17-1952089	MED BLDG	MO	0	0	CMCB

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 AVE SPRINGFIELD, MO 65802 43-1622182	PHARMACY	MO	LESTER E COX	C CORP					No
<b>(2)</b> INSURANCE COMPANY OF SPRINGFIELD INC GRAND PAVILION CORPORATE CENTRE GRAND CAYMAN KY1-110 CJ	CAPTIVE INSURANCE	CJ	LESTER E COX	C CORP					No
<b>(3)</b> COX TAXABLE CLOSE CORPORATION 1423 N JEFFERSON SPRINGFIELD, MO 65802 47-2573263	MEDICAL CLINIC	MO	COX MED GROUP	C CORP					No
<b>(4)</b> FERRELL-DUNCAN CLINIC INC 1001 E PRIMROSE SPRINGFIELD, MO 65808 43-0991578	PHYSICIANS	MO	CTCC	C CORP					No

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Yes

No

1a

No

1b

No

1c

Yes

1d

No

1e

No

1f

No

1g

No

1h

No

1i

No

1j

Yes

1k

Yes

1l

No

1m

No

1n

No

1o

No

1p

Yes

1q

Yes

1r

Yes

1s

Yes

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

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

Schedule R (Form 990) 2017

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

[illegible]



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

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

**Additional Data**

**Software ID:**  
**Software Version:**  
**EIN:** 44-0584290  
**Name:** SKAGGS COMMUNITY HOSPITAL ASSOCIATION

**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		No
3525 S NATIONAL SUITE 204 SPRINGFIELD, MO 65807 43-6810485	FUNDRAISING	MO	501(C)(3)	12 A I	LESTER E COX		No
PO BOX 10939 SPRINGFIELD, MO 65808 26-4781194	HOME HEALTH	MO	501(C)(3)	10	LESTER E COX		No
2220 W SUNSET SPRINGFIELD, MO 65807 43-1641927	HOME HEALTH	MO	501(C)(3)	10	LESTER E COX		No
801 LINCOLN AVE MONETT, MO 65708 43-1656689	HOSPITAL	MO	501(C)(3)	3	LESTER E COX		No
801 LINCOLN AVE MONETT, MO 65708 43-1852817	FUNDRAISING	MO	501(C)(3)	10	LESTER E COX		No
3801 S NATIONAL SPRINGFIELD, MO 65807 36-3263313	MED SERVICES	MO	501(C)(3)	7	LESTER E COX		No
PO BOX 10939 SPRINGFIELD, MO 65808 43-1641928	HOME HEALTH	MO	501(C)(3)	10	LESTER E COX		No
1115 E PRIMROSE SPRINGFIELD, MO 65807 43-1183783	SUPPORT	MO	501(C)(3)	12 A I	LESTER E COX		No
3801 S NATIONAL SPRINGFIELD, MO 65807 43-1090590	SUPPORT	MO	501(C)(3)	10	LESTER E COX		No
1423 N JEFFERSON SPRINGFIELD, MO 65802 36-6668576	SELF-INSURAN	MO	501(C)(3)	12 A I	LESTER E COX		No
1423 N JEFFERSON ST SPRINGFIELD, MO 65802 44-0577118	HOSPITAL	MO	501(C)(3)	3	COXHEALTH		No
1423 N JEFFERSON ST SPRINGFIELD, MO 65802 47-1087427	HOLDING CO	MO	501(C)(3)	12 B II	NA		No
1423 N JEFFERSON ST SPRINGFIELD, MO 65802 41-1087566	PHYSICIANS	MO	501(C)(3)	10	COXHEALTH		No
PO BOX 5750 SPRINGFIELD, MO 658015750 43-1757075	HMO	MO	501(C)(4)		LESTER E COX		No
1423 N JEFFERSON SPRINGFIELD, MO 65802 47-5148345	EDUCATION	MO	501(C)(3)	2	LESTER E COX		No
3801 S NATIONAL SPRINGFIELD, MO 65807 37-1830627	HEALTHCARE	MO	501(C)(3)	10	COXHEALTH		No
PO BOX 5750 SPRINGFIELD, MO 65801 43-1684044	INSURANCE	MO	501(C)(4)		LESTER E COX		No
1423 N JEFFERSON AVE SPRINGFIELD, MO 65802 82-3300758	HOSPITAL	MO	501(C)(3)	3	COXHEALTH		No