

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

Return of Organization Exempt From Income Tax

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

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

Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No 1545-0047
2018
Open to Public Inspection

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

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

C Name of organization
ANC HEALTHCARE INC
% ANC HEALTHCARE INC
Doing business as
Number and street (or P O box if mail is not delivered to street address) Room/suite
425 W NEW ENGLAND AVE Suite 300
City or town, state or province, country, and ZIP or foreign postal code
WINTER PARK, FL 32789

D Employer identification number
58-1450888

E Telephone number
(847) 583-2804

G Gross receipts \$ 313,523,660

F Name and address of principal officer
MATTHEW RUBIN
425 W NEW ENGLAND AVE300
WINTER PARK, NC 32789

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

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

H(c) Group exemption number ▶

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

J Website: ▶ N/A

K Form of organization Corporation Trust Association Other ▶

L Year of formation 1981

M State of legal domicile NC

Part I Summary

1 Briefly describe the organization's mission or most significant activities
OPERATION OF AN INTEGRATED HEALTH CARE SYSTEM

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

3 Number of voting members of the governing body (Part VI, line 1a)	7
4 Number of independent voting members of the governing body (Part VI, line 1b)	7
5 Total number of individuals employed in calendar year 2018 (Part V, line 2a)	0
6 Total number of volunteers (estimate if necessary)	7
7a Total unrelated business revenue from Part VIII, column (C), line 12	740,816
7b Net unrelated business taxable income from Form 990-T, line 34	0

	Prior Year	Current Year
8 Contributions and grants (Part VIII, line 1h)	567,562	4,427,565
9 Program service revenue (Part VIII, line 2g)	31,368,626	11,338,392
10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	40,725,061	167,162,945
11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	-169,084	128,147
12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	72,492,165	183,057,049
13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	3,564,221	841,582,393
14 Benefits paid to or for members (Part IX, column (A), line 4)	0	0
15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	170,747,317	64,837,341
16a Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b Total fundraising expenses (Part IX, column (D), line 25) ▶0		
17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	-131,592,693	-39,556,446
18 Total expenses Add lines 13-17 (must equal Part IX, column (A), line 25)	42,718,845	866,863,288
19 Revenue less expenses Subtract line 18 from line 12	29,773,320	-683,806,239
	Beginning of Current Year	End of Year
20 Total assets (Part X, line 16)	2,746,061,012	1,158,076,635
21 Total liabilities (Part X, line 26)	964,667,376	184,316,763
22 Net assets or fund balances Subtract line 21 from line 20	1,781,393,636	973,759,872

Part II Signature Block

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

Sign Here
Signature of officer: *****
Date: 2020-08-17
MATTHEW RUBIN CFO
Type or print name and title

Paid Preparer Use Only
Print/Type preparer's name: Grant Thornton LLP
Preparer's signature: [Signature]
Date: [Date]
Check if self-employed
PTIN: P00488037
Firm's EIN: [EIN]
Firm's address: 201 S COLLEGE ST STE 2500 CHARLOTTE, NC 28244
Phone no: (704) 632-3500

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 ORGANIZATION'S MISSION IS TO OPERATE AN INTEGRATED HEALTH DELIVERY SYSTEM FOR THE BENEFIT OF THE RESIDENTS OF WESTERN NORTH CAROLINA

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

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

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

If "Yes," describe these changes on Schedule O

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

4a (Code) (Expenses \$ 996,356,153 including grants of \$ 841,582,393) (Revenue \$ 7,597,479)
See Additional Data

4b (Code) (Expenses \$ 2,442,591 including grants of \$ 0) (Revenue \$ 3,986,970)
See Additional Data

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

4d Other program services (Describe in Schedule O)
(Expenses \$ including grants of \$) (Revenue \$)

4e Total program service expenses ▶ 998,798,744

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

Table with 3 columns: Question/Line Number, Yes, No. Rows include questions 23 through 38 regarding compensation, tax-exempt bonds, excess benefit transactions, and controlled entities.

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Table with 3 columns: Question/Line Number, Yes, No. Rows include 1a (Form 1096), 1b (Forms W-2G), and 1c (gambling winnings).

2a Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return		2a	0		
b If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)		2b			
3a Did the organization have unrelated business gross income of \$1,000 or more during the year?		3a	Yes		
b If "Yes," has it filed a Form 990-T for this year? <i>If "No" to line 3b, provide an explanation in Schedule O</i>		3b	Yes		
4a At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?		4a	Yes		
b If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)					
5a Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		5a		No	
b Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		5b		No	
c If "Yes," to line 5a or 5b, did the organization file Form 8886-T?		5c			
6a Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?		6a		No	
b If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		6b			
7 Organizations that may receive deductible contributions under section 170(c).					
a Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?		7a		No	
b If "Yes," did the organization notify the donor of the value of the goods or services provided?		7b			
c Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		7c		No	
d If "Yes," indicate the number of Forms 8282 filed during the year		7d			
e Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		7e		No	
f Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		7f		No	
g If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		7g			
h If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		7h			
8 Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?		8			
9a Did the sponsoring organization make any taxable distributions under section 4966?		9a			
b Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?		9b			
10 Section 501(c)(7) organizations. Enter					
a Initiation fees and capital contributions included on Part VIII, line 12		10a			
b Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities		10b			
11 Section 501(c)(12) organizations. Enter					
a Gross income from members or shareholders		11a			
b Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)		11b			
12a Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?		12a			
b If "Yes," enter the amount of tax-exempt interest received or accrued during the year		12b			
13 Section 501(c)(29) qualified nonprofit health insurance issuers.					
a Is the organization licensed to issue qualified health plans in more than one state? Note. See the instructions for additional information the organization must report on Schedule O		13a			
b Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans		13b			
c Enter the amount of reserves on hand		13c			
14a Did the organization receive any payments for indoor tanning services during the tax year?		14a		No	
b If "Yes," has it filed a Form 720 to report these payments? <i>If "No," provide an explanation in Schedule O</i>		14b			
15 Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see instructions and file Form 4720, Schedule N		15		No	
16 Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O		16		No	

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



Section A. Governing Body and Management

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

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

Table with 3 columns: Question, Yes, No. Rows include: 10a Did the organization have local chapters, branches, or affiliates?; 10b If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?; 11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?; 11b Describe in Schedule O the process, if any, used by the organization to review this Form 990; 12a Did the organization have a written conflict of interest policy? If "No," go to line 13; 12b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?; 12c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done; 13 Did the organization have a written whistleblower policy?; 14 Did the organization have a written document retention and destruction policy?; 15 Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?; 15a The organization's CEO, Executive Director, or top management official; 15b Other officers or key employees of the organization; 16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?; 16b If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?

Section C. Disclosure

Table with 2 columns: Question, Answer. Rows include: 17 List the States with which a copy of this Form 990 is required to be filed; 18 Section 6104 requires an organization to make its Form 1023 (or 1024-A if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply; 19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year; 20 State the name, address, and telephone number of the person who possesses the organization's books and records.

Part VIII Statement of Revenue

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

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a			
	b Membership dues	1b			
	c Fundraising events	1c			
	d Related organizations	1d	4,427,565		
	e Government grants (contributions)	1e			
	f All other contributions, gifts, grants, and similar amounts not included above	1f			
	g Noncash contributions included in lines 1a - 1f \$ _____				
	h Total. Add lines 1a-1f		4,427,565		

Program Service Revenue			Business Code				
	2a MISSION IMAGING SERVICES		621400	3,986,970	3,986,970		
	b SERVICES TO AFFILIATES		900099	3,869,361	3,869,361		
	c OTHER PROGRAM REVENUE		900099	3,064,397	3,064,397		
	d PREMIER AND OTHER JOINT VENTURES		900099	417,664	391,274	26,390	
	e _____						
	f All other program service revenue						
g Total. Add lines 2a-2f			11,338,392				

Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)			19,470,598	272,446	586,279	18,611,873	
	4 Income from investment of tax-exempt bond proceeds			893			893	
	5 Royalties			0				
	6a Gross rents	(i) Real	(ii) Personal					
			157,789					
		b Less rental expenses		157,789				
		c Rental income or (loss)		0		0		
	d Net rental income or (loss)				0			
	7a Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other					
			166,873,078	110,998,712				
		b Less cost or other basis and sales expenses		130,369,119		-188,783		
		c Gain or (loss)		36,503,959		111,187,495		
	d Net gain or (loss)				147,691,454		147,691,454	
	8a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18	a						
		b Less direct expenses	b		0			
c Net income or (loss) from fundraising events				0				
9a Gross income from gaming activities See Part IV, line 19	a							
	b Less direct expenses	b		0				
	c Net income or (loss) from gaming activities			0				
10a Gross sales of inventory, less returns and allowances	a							
	b Less cost of goods sold	b		256,633				
	c Net income or (loss) from sales of inventory			128,147		128,147		
Miscellaneous Revenue	Business Code							
11a								
b								
c								
d All other revenue								
e Total. Add lines 11a-11d				0				
12 Total revenue. See Instructions				183,057,049	11,584,448	740,816	166,304,220	

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

	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.				
1 Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21	841,582,393	841,582,393		
2 Grants and other assistance to domestic individuals See Part IV, line 22	0			
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, line 15 and 16	0			
4 Benefits paid to or for members	0			
5 Compensation of current officers, directors, trustees, and key employees	0		0	0
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0			
7 Other salaries and wages	50,147,625	1,284,708	48,862,917	
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	1,353,387	28,993	1,324,394	
9 Other employee benefits	10,004,186	209,619	9,794,567	
10 Payroll taxes	3,332,143	99,042	3,233,101	
11 Fees for services (non-employees)				
a Management	2,752,941		2,752,941	
b Legal	7,511,996		7,511,996	
c Accounting	1,340,522		1,340,522	
d Lobbying	129,774	129,774		
e Professional fundraising services See Part IV, line 17	0			
f Investment management fees	2,179,946		2,179,946	
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	21,656,289	712,044	20,944,245	
12 Advertising and promotion	673,094		673,094	
13 Office expenses	1,374,401		1,374,401	
14 Information technology	10,946,338	8,757,070	2,189,268	
15 Royalties	0			
16 Occupancy	1,759,367	290,332	1,469,035	
17 Travel	315,006	3,491	311,515	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19 Conferences, conventions, and meetings	0			
20 Interest	3,402,043	2,721,634	680,409	
21 Payments to affiliates	0			
22 Depreciation, depletion, and amortization	10,611,651	8,504,946	2,106,705	
23 Insurance	5,477,761	4,382,209	1,095,552	
24 Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a ALLOCATION TO MEMBERS	-113,275,586	128,362,210	-241,637,796	
b OTHER EXPENSE	2,537,713	862,132	1,675,581	
c EQUIPMENT LEASES	1,050,298	868,147	182,151	
d				
e All other expenses				
25 Total functional expenses. Add lines 1 through 24e	866,863,288	998,798,744	-131,935,456	0
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year	
Assets	1 Cash—non-interest-bearing	27,452,481	1	271,634	
	2 Savings and temporary cash investments	102,785,022	2	500,752,289	
	3 Pledges and grants receivable, net	0	3	0	
	4 Accounts receivable, net	453,060,549	4	43,878,123	
	5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L	0	5	0	
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L	0	6	0	
	7 Notes and loans receivable, net	48,680,379	7	2,331,587	
	8 Inventories for sale or use	46,124	8	0	
	9 Prepaid expenses and deferred charges	358,999	9	2,919,466	
	10a Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	10a			
	b Less accumulated depreciation	10b	13,822,161	10c	0
	11 Investments—publicly traded securities	499,901,932	11	51,168,511	
	12 Investments—other securities See Part IV, line 11	292,295,250	12	449,049,836	
	13 Investments—program-related See Part IV, line 11	1,297,651,616	13	72,672,792	
	14 Intangible assets	7,610,792	14	0	
	15 Other assets See Part IV, line 11	2,395,707	15	35,032,397	
16 Total assets. Add lines 1 through 15 (must equal line 34)	2,746,061,012	16	1,158,076,635		
Liabilities	17 Accounts payable and accrued expenses	384,154,024	17	184,316,763	
	18 Grants payable	0	18	0	
	19 Deferred revenue	0	19	0	
	20 Tax-exempt bond liabilities	302,159,691	20	0	
	21 Escrow or custodial account liability Complete Part IV of Schedule D	0	21	0	
	22 Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L	0	22	0	
	23 Secured mortgages and notes payable to unrelated third parties	38,559,845	23	0	
	24 Unsecured notes and loans payable to unrelated third parties	0	24	0	
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24) Complete Part X of Schedule D	239,793,816	25	0	
	26 Total liabilities. Add lines 17 through 25	964,667,376	26	184,316,763	
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.				
	27 Unrestricted net assets	1,781,393,636	27	973,759,872	
	28 Temporarily restricted net assets	0	28	0	
	29 Permanently restricted net assets	0	29	0	
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.				
	30 Capital stock or trust principal, or current funds		30		
	31 Paid-in or capital surplus, or land, building or equipment fund		31		
	32 Retained earnings, endowment, accumulated income, or other funds		32		
33 Total net assets or fund balances	1,781,393,636	33	973,759,872		
34 Total liabilities and net assets/fund balances	2,746,061,012	34	1,158,076,635		

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	183,057,049
2	Total expenses (must equal Part IX, column (A), line 25)	2	866,863,288
3	Revenue less expenses Subtract line 2 from line 1	3	-683,806,239
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	1,781,393,636
5	Net unrealized gains (losses) on investments	5	-1,128,691
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-122,698,834
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	973,759,872

Part XII Financial Statements and Reporting

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

- 1** Accounting method used to prepare the Form 990 Cash Accrual Other _____
 If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O
- 2a** Were the organization's financial statements compiled or reviewed by an independent accountant?
 If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both
 Separate basis Consolidated basis Both consolidated and separate basis
- b** Were the organization's financial statements audited by an independent accountant?
 If 'Yes,' check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both
 Separate basis Consolidated basis Both consolidated and separate basis
- c** If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?
 If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O
- 3a** As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?
- b** If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits

	Yes	No
2a		No
2b		No
2c		
3a	Yes	
3b	Yes	

Additional Data

Software ID:

Software Version:

EIN: 58-1450888

Name: ANC HEALTHCARE INC

Form 990 (2018)

Form 990, Part III, Line 4a:

THE ORGANIZATION FORMERLY KNOWN AS ANC Healthcare (Fka Mission Health System) PROVIDED ADMINISTRATIVE, LEGAL AND FINANCIAL SERVICES FOR THE MEMBERS OF ANC Healthcare (Fka Mission Health System) IN AREAS SUCH AS CASH, DEBT, INVESTMENT AND BENEFIT MANAGEMENT AND FISCAL, STRATEGIC AND FACILITIES PLANNING THE ORGANIZATION'S DEPARTMENT OF PHILANTHROPY GUIDED AND SUPPORTED ALL OF THE ORGANIZATION'S MEMBER HOSPITALS' INDIVIDUAL FOUNDATIONS THOSE FOUNDATIONS PROVIDED PHILANTHROPIC SUPPORT TO ENABLE MEMBERS TO SERVE THEIR LOCAL COMMUNITIES AND REGIONS

Form 990, Part III, Line 4b:

ANC IMAGING SERVICES, FORMERLY KNOWN AS MISSION IMAGING SERVICES, LLC, A SINGLE MEMBER LLC, PROVIDED MEDICAL IMAGING SERVICES

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JOHN R BALL CHAIR END JAN 2019	5 0	X		X				0	0	0
JOHN W GARRETT MD Chair	2 0	X		X				0	0	0
LAVOY SPOONER JR DIRECTOR	2 0	X						0	0	0
SUZANNE S DEFERIE DIRECTOR	1 0	X						0	0	0
WYATT S STEVENS IMM PAST CHAIR END JAN 2019	2 0	X		X				0	0	0
JANICE W BRUMIT DIRECTOR END JAN 2019	2 0	X						0	0	0
THOMAS MAHER Vice Chair	2 0	X		X				0	0	0
DANIEL A CASSE DIRECTOR END JAN 2019	2 0	X						0	0	0
BRIDGET A ECKERD DIRECTOR END JAN 2019	3 0	X						0	0	0
W LEON ELLISTON MD DIRECTOR END JAN 2019	2 0	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
CHRIS FLANDERS MD DIRECTOR	1 0 0 0	X						0	0	0
WILLIAM S HICKMAN DIRECTOR END JAN 2019	3 0 3 0	X						0	0	0
LYNN KIEFFER DIRECTOR END JAN 2019	2 0 3 0	X						0	0	0
TOM ORECK DIRECTOR END JAN 2019	2 0 2 0	X						0	0	0
ANNE PONDER DIRECTOR END JAN 2019	2 0 2 0	X						0	0	0
KENNETH RACHT DIRECTOR END JAN 2019	2 0 3 0	X						0	0	0
JEFFREY RANKIN DIRECTOR	1 0 0 0	X						0	0	0
ROBBY RUSSELL DIRECTOR END JAN 2019	2 0 3 0	X						0	0	0
KRISTY ELLIOT DIRECTOR END JAN 2019	2 0 2 0	X						0	0	0
RONALD A PAULUS MD SYSTEM PRES & CEO END JAN 2019	30 0 40 0	X		X				0	3,403,218	617,020

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(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Insttutchnal Trustee	Officer	Key employee	Highest compensated employee	Former			
David Worley Director	1 0 0 0	X						0	0	0
PAUL MCDOWELL SVP AND CFO END JAN 2019	30 0 30 0			X				0	885,665	152,503
DONALD ESPOSITO SVP Gen Council END JAN 2019	30 0 30 0			X				0	519,841	105,674
Neil Luria CEO/Chief Wind-Down officeR	18 0 2 0			X				0	0	0
Matthew Rubin CFO / Secretary	18 0 2 0			X				0	0	0
Gregory Hagood Chief Transition OFFICER	10 0 0 0			X				0	0	0
Meg Finnegan VP HR	10 0 0 0			X				0	0	0
Kira Abramovs VP Finance	25 0 0 0			X				0	0	0
Paul Hogan VP Treas & Acct	20 0 0 0			X				0	0	0
MARC MALLOY SVP MISSION HEALTH SOLUTIONS	30 0 30 0				X			0	779,785	103,175

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JONATHAN BROWN CHIEF INFORMATION OFFICER	30 0				X			0	581,105	90,307
DEBRA FOSS SVP ORG TRANSFORMATION	30 0				X			0	824,380	34,177
ROWENA BUFFETT TIMMS SVP GOVT & COMMUNITY RELATIONS	30 0				X			0	442,792	69,945
DR JILL HOGGARD GREEN SVP AND COO	30 0				X			0	1,072,299	188,556
KATHY GUYETTE SVP PATIENT CARE SVCS REGIONAL	25 0 35 0				X			0	665,221	109,967
MARC WESTLE DO SVP INNOVATION ADMIN	30 0				X			0	775,069	130,112
CHRIS DERIENZO CHIEF QUALITY OFFICER	28 0 32 0				X			0	624,002	118,763
JON YEATMAN CHIEF STRATEGY OFFICER	30 0				X			0	492,418	51,251
RHONDA MILLER VP REVENUE CYCLE	30 0				X			0	233,023	38,205
CHARLES SAWYER MD CHIEF MEDICAL INFORMATION OFF	30 0				X			0	528,978	81,835

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
GWEN MCKINNEY CHIEF COMPLIANCE OFFICER	29 0 31 0				X			0	426,622	62,113
WILLIAM HATHAWAY MD CHIEF MEDICAL OFFICER	29 0 31 0				X			0	841,294	126,879
SONYA GRECK SENIOR VICE PRESIDENT	30 0 30 0				X			0	665,002	111,932
RUTH ZYRY CHIEF OPERATIONS OFFICER	29 0 31 0				X			0	455,640	74,747
RITA EDWARDS VICE PRESIDENT	30 0 30 0					X		0	378,655	25,641
SHEILA MEADOWS CHIEF HR OFFICER	30 0 30 0					X		0	356,280	70,017
JOSEPH WOLFGAM Physician	30 0 30 0					X		0	382,362	67,327
LINDA HUMMEL VP - QUALITY & SAFETY	30 0 30 0					X		0	383,632	55,800
Stephanie Baron PHYSICIAN	30 0 30 0					X		0	271,341	55,621
CHARLES F AYSCUE FORMER SVP AND CFO	0 0 0 0						X	0	140,353	1,309

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
ANN YOUNG Former GENERAL COUNSEL	0 0 0 0						X	0	398,834	0

SCHEDULE A
(Form 990 or 990-EZ)

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

2018

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
ANC HEALTHCARE INC

Employer identification number
58-1450888

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

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

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

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1- 10 above (see instructions))	(iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
(A) MISSION HOSPITAL INC	560532141	3	Yes		0	0
(B) MISSION HEALTH SYSTEM FOUNDATION INC	561881331	7	Yes		854,741	0
Total	2				854,741	

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

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

Section A. Public Support

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

Section B. Total Support

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

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

Section C. Computation of Public Support Percentage

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

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

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

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

Section A. Public Support

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

Section B. Total Support

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

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

Section C. Computation of Public Support Percentage

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

Section D. Computation of Investment Income Percentage

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

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

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

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

		Yes	No
11	Has the organization accepted a gift or contribution from any of the following persons?		
a	A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization?		
b	A family member of a person described in (a) above?		
c	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>		
		11a	No
		11b	No
		11c	No

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

1	Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions)		
a	<input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.		
b	<input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
c	<input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).		
2	Activities Test Answer (a) and (b) below.		
a	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <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	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>		
3	Parent of Supported Organizations Answer (a) and (b) below.		
a	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>Provide details in Part VI.</i>		
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>		
		2a	
		2b	
		3a	
		3b	

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

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

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

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

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

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

Additional Data

Software ID:

Software Version:

EIN: 58-1450888

Name: ANC HEALTHCARE INC

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

Facts And Circumstances Test

SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities
For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶Complete if the organization is described below. ▶Attach to Form 990 or Form 990-EZ.
▶Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No 1545-0047

2018
Open to Public Inspection

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

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

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

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

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

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

Name of the organization ANC HEALTHCARE INC	Employer identification number 58-1450888
--	--

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

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

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

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

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

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

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

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

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

	(a)		(b)
	Yes	No	Amount
1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
a Volunteers?		No	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
c Media advertisements?		No	
d Mailings to members, legislators, or the public?		No	
e Publications, or published or broadcast statements?		No	
f Grants to other organizations for lobbying purposes?		No	
g Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i Other activities?	Yes		129,774
j Total. Add lines 1c through 1i			129,774
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

Part IV Supplemental Information

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

Return Reference	Explanation
PART II-B, LINE 1, LOBBYING ACTIVITIES	PAYMENTS MADE TO CONSULTANTS TO ADVOCATE ON HEALTH CARE RELATED ISSUES

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

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

OMB No 1545-0047
2018
Open to Public Inspection

Name of the organization
ANC HEALTHCARE INC

Employer identification number
58-1450888

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

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

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

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

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

Protection of natural habitat Preservation of a certified historic structure

Preservation of open space

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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?

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?
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
2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability?
b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII

Table with 2 columns: Description (1c-1f) and Amount

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

Table with 6 columns: (a) Current year, (b) Prior year, (c) Two years back, (d) Three years back, (e) Four years back. Rows include: 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

Table with 3 columns: Question (3a(i), 3a(ii), 3b) and Yes/No

b If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R?
4 Describe in Part XIII the intended uses of the organization's endowment funds

Part VI Land, Buildings, and Equipment.

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

Table with 5 columns: Description of property, (a) Cost or other basis (investment), (b) Cost or other basis (other), (c) Accumulated depreciation, (d) Book value. Rows include: 1a Land, b Buildings, c Leasehold improvements, d Equipment, e Other.

Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c))

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) INVESTMENT IN PARTNERSHIPS	449,049,836	F
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Column (b) must equal Form 990, Part X, col (B) line 12)	449,049,836	

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)	0	

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

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

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

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

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

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

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

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

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

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

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

Part XIII Supplemental Information

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

Return Reference	Explanation	
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Part XIII **Supplemental Information (continued)**

Return Reference	Explanation
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**SCHEDULE F
(Form 990)**

Department of the Treasury
Internal Revenue Service

Statement of Activities Outside the United States

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 14b, 15, or 16.
▶ Attach to Form 990.
▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No 1545-0047
2018
Open to Public Inspection

Name of the organization
ANC HEALTHCARE INC

Employer identification number
58-1450888

Part I **General Information on Activities Outside the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 14b.

- 1 For grantmakers.** Does the organization maintain records to substantiate the amount of its grants and other assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? Yes No
- 2 For grantmakers.** Describe in Part V the organization's procedures for monitoring the use of its grants and other assistance outside the United States
- 3** Activities per Region (The following Part I, line 3 table can be duplicated if additional space is needed)

(a) Region	(b) Number of offices in the region	(c) Number of employees, agents, and independent contractors in region	(d) Activities conducted in region (by type) (e g , fundraising, program services, investments, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for and investments in region
See Add'l Data					
3a Sub-total					69,528,004
b Total from continuation sheets to Part I					
c Totals (add lines 3a and 3b)					69,528,004

Part II Grants and Other Assistance to Organizations or Entities Outside the United States. Complete if the organization answered "Yes" to Form 990, Part IV, line 15, for any recipient who received more than \$5,000. Part II can be duplicated if additional space is needed.

1 (a) Name of organization	(b) IRS code section and EIN (if applicable)	(c) Region	(d) Purpose of grant	(e) Amount of cash grant	(f) Manner of cash disbursement	(g) Amount of non-cash assistance	(h) Description of non-cash assistance	(i) Method of valuation (book, FMV, appraisal, other)

- 2 Enter total number of recipient organizations listed above that are recognized as charities by the foreign country, recognized as tax-exempt by the IRS, or for which the grantee or counsel has provided a section 501(c)(3) equivalency letter ▶ _____
- 3 Enter total number of other organizations or entities ▶ _____

Part IV Foreign Forms

- 1 Was the organization a U S transferor of property to a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 926, Return by a U S Transferor of Property to a Foreign Corporation (see Instructions for Form 926)* Yes No
- 2 Did the organization have an interest in a foreign trust during the tax year? *If "Yes," the organization may be required to separately file Form 3520, Annual Return to Report Transactions with Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U S Owner (see Instructions for Forms 3520 and 3520-A, don't file with Form 990)* Yes No
- 3 Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U S Persons with Respect to Certain Foreign Corporations (see Instructions for Form 5471)* Yes No
- 4 Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? *If "Yes," the organization may be required to file Form 8621, Information Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund (see Instructions for Form 8621)* Yes No
- 5 Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U S Persons with Respect to Certain Foreign Partnerships (see Instructions for Form 8865)* Yes No
- 6 Did the organization have any operations in or related to any boycotting countries during the tax year? *If "Yes," the organization may be required to separately file Form 5713, International Boycott Report (see Instructions for Form 5713, don't file with Form 990)* Yes No

Additional Data

Software ID:

Software Version:

EIN: 58-1450888

Name: ANC HEALTHCARE INC

Form 990 Schedule F Part I - Activities Outside The United States

(a) Region	(b) Number of offices in the region	(c) Number of employees or agents in region	(d) Activities conducted in region (by type) (i.e., fundraising, program services, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for region
Central America and the Caribbean			Investments		65,384,634
Europe (Including Iceland and Greenland)			Investments		4,143,370

SCHEDULE H (Form 990)
 Department of the Treasury
 Internal Revenue Service
Name of the organization
 ANC HEALTHCARE INC

Hospitals

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

Employer identification number
 58-1450888

OMB No 1545-0047
2018
Open to Public Inspection

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

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

7 Financial Assistance and Certain Other Community Benefits at Cost

	(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
Financial Assistance and Means-Tested Government Programs						
a Financial Assistance at cost (from Worksheet 1)						
b Medicaid (from Worksheet 3, column a)						
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs						
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)						
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j Total. Other Benefits						
k Total. Add lines 7d and 7j						

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

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

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

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

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME).	5	2,722,402
6	Enter Medicare allowable costs of care relating to payments on line 5.	6	3,458,010
7	Subtract line 6 from line 5. This is the surplus (or shortfall).	7	-735,608
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other		

Section C. Collection Practices

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

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

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

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

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

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

1

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

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

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group _____

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

		Yes	No
Community Health Needs Assessment			
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	Yes	
a	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b	<input checked="" type="checkbox"/> Demographics of the community		
c	<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		
d	<input checked="" type="checkbox"/> How data was obtained		
e	<input checked="" type="checkbox"/> The significant health needs of the community		
f	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<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)		
j	<input type="checkbox"/> Other (describe in Section C)		
4	Indicate the tax year the hospital facility last conducted a CHNA <u>20 15</u>		
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	Yes	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	Yes	
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	Yes	
7	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	Yes	
a	<input checked="" type="checkbox"/> Hospital facility's website (list url) <u>SEE PART V, SECTION C</u>		
b	<input type="checkbox"/> Other website (list url) _____		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input checked="" type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 16</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) <u>SEE PART V, SECTION C</u>	Yes	
a			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		No
12b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

ASHEVILLE SPECIALTY HOSPITAL

Name of hospital facility or letter of facility reporting group _____

		Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that		
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13 Yes	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>300</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input 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 type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	14 Yes	
15	Explained the method for applying for financial assistance? 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)	15 Yes	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input checked="" type="checkbox"/> Other (describe in Section C)		
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	16 Yes	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
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**

ASHEVILLE SPECIALTY HOSPITAL

Name of hospital facility or letter of facility reporting group _____

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

ASHEVILLE SPECIALTY HOSPITAL

Name of hospital facility or letter of facility reporting group _____

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

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
23		No
24		No

Part V Facility Information (continued)**Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

How many non-hospital health care facilities did the organization operate during the tax year? 5

Name and address	Type of Facility (describe)
1 MISSION IMAGING SERVICES 534 BILTMORE AVENUE ASHEVILLE, NC 28801	OUTPATIENT IMAGING SERVICES
2 MISSION IMAGING SERVICES 2695 HENDERSONVILLE ROAD ARDEN, NC 28704	OUTPATIENT IMAGING SERVICES
3 MISSION IMAGING SERVICES 2 TOWN SQUARE ASHEVILLE, NC 28803	OUTPATIENT IMAGING SERVICES
4 MISSION IMAGING SERVICES 490 HOSPITAL DRIVE CLYDE, NC 28721	OUTPATIENT IMAGING SERVICES
5 MISSION IMAGING SERVICES 149 W PARKER ROAD MORGANTON, NC 28655	OUTPATIENT IMAGING SERVICES
6	
7	
8	
9	
10	

Part VI Supplemental Information

Provide the following information

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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7	Due to the sale of the hospital facility during the current 2018 tax year, the organization does not have information on financial assistance at cost to report PART III, LINE 2 THE COST TO CHARGES RATIO IS APPLIED TO BAD DEBT EXPENSE BASED ON CHARGES AND CONVERTED TO THE COST OF PROVIDING CARE
PART III, LINE 8	THE SHORTFALL REPORTED IS BASED ON USING THE MEDICARE ALLOWABLE COSTS PER THE FORM 990 INSTRUCTIONS, THE MEDICARE COST REPORT IS THE BASIS FOR CALCULATING THE COSTS USING COSTS RELATED TO THE REVENUE REPORTED The HEALTH SYSTEM IS REPORTING 2/3 OF THE TOTAL SHORTFALL AS ITS PRO RATA OWNERSHIP IN ASHEVILLE SPECIALTY HOSPITAL

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 9B	<p>PATIENTS WHO QUALIFY FOR FINANCIAL ASSISTANCE AND OTHER CHARITY CARE ARE NOTIFIED USING THE PROCESS DESCRIBED IN THE EDUCATION OF PATIENTS' ELIGIBILITY IN PART VI, ON LINE 3 MISSION'S STATED POLICY WITH RESPECT TO FINANCIAL ASSISTANCE "MISSION HOSPITAL WILL MAKE EVERY EFFORT TO THOROUGHLY SCREEN ALL PATIENTS THAT ARE UNINSURED OR UNDERINSURED IN AN EFFORT TO IDENTIFY A SOURCE OF FINANCIAL SPONSORSHIP ONLY AFTER A FINAL DETERMINATION IS MADE THAT THE PATIENT IS NOT ELIGIBLE FOR ANY SOURCE OF FUNDING TO COVER THE MEDICAL EXPENSES WILL THE ACCOUNT BE ELIGIBLE FOR CONSIDERATION OF FINANCIAL ASSISTANCE " AFTER THE NOTIFICATIONS AND PROCESSES REFERENCED ABOVE HAVE BEEN COMPLETED, STANDARD DEBT COLLECTION POLICIES ARE IN EFFECT FOR THE PORTION OF THE BILL FOR WHICH THE PATIENT IS RESPONSIBLE</p>
PART VI, LINE 2	<p>THE ORGANIZATION'S FACILITY ASHEVILLE SPECIALTY HOSPITAL IS PART OF THE HEALTH SYSTEM THE SYSTEM'S APPROACH TO ASSESSING COMMUNITY HEALTH IS DESCRIBED BELOW WESTERN NORTH CAROLINA IS HOME TO A UNIQUE COLLABORATION BETWEEN HOSPITALS AND HEALTH DEPARTMENTS WORKING TOGETHER TO IDENTIFY HEALTH NEEDS AND IMPROVE HEALTH TOGETHER, The Health System AND OTHER HOSPITALS AND HEALTH DEPARTMENTS IN THE REGION CONDUCT COMMUNITY HEALTH ASSESSMENTS EVERY THREE (3) YEARS TO DETERMINE THE GREATEST HEALTH NEEDS IN THE COMMUNITIES WE SERVE The Health System's HOSPITAL FACILITIES SERVE 18 COUNTIES IN WESTERN NORTH CAROLINA, WITH SEVEN (7) OF THOSE COUNTIES INCLUDED IN OUR PRIMARY SERVICE AREAS REPRESENTATIVES FROM EACH HOSPITAL PARTNER WITH LOCAL HEALTH DEPARTMENTS IN THEIR PRIMARY SERVICE COUNTIES AND WITH WNC HEALTHY IMPACT TO ASSESS AND PRIORITIZE COMMUNITY HEALTH NEEDS, AND PLAN TO ADDRESS THEM HOW WE PLAN TO ADDRESS COMMUNITY HEALTH NEEDS IN THE COMMUNITY HEALTH ASSESSMENT PROCESS, HOSPITALS AND HEALTH DEPARTMENTS PRODUCE PARALLEL REPORTS DETAILING HOW THE COMMUNITY HEALTH NEEDS WERE IDENTIFIED AND PRIORITIZED, AND EACH ENTITY'S STRATEGY FOR ADDRESSING THE IDENTIFIED NEEDS THESE REPORTS ARE MADE PUBLICLY AVAILABLE BY EACH ENTITY (The Health System FACILITY REPORTS ARE LISTED BELOW) REPORTS PRODUCED BY EACH HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) EXECUTIVE SUMMARY HOSPITAL IMPLEMENTATION STRATEGY REPORTS PRODUCED BY EACH COUNTY HEALTH DEPARTMENT COMMUNITY HEALTH ASSESSMENT (CHA) COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) HEALTH PRIORITIES AND REPORTS COMMUNITY HEALTH NEEDS ASSESSMENTS AND IMPLEMENTATION STRATEGIES ARE FACILITY-SPECIFIC AND UNIQUE TO THE COMMUNITIES SERVED BY EACH HOSPITAL IMPLEMENTATION STRATEGIES ARE BASED ON COLLABORATIVE PLANNING, AND OUTLINE THE WAYS EACH HOSPITAL WILL SUPPORT SPECIFIC EFFORTS TO ADDRESS THE IDENTIFIED HEALTH NEEDS AS PART OF A COMMUNITY-WIDE PLAN ASHEVILLE SPECIALTY HOSPITAL'S ABILITY TO ADDRESS ACCESS TO CARE AS A LONG-TERM ACUTE FACILITY THAT PROVIDES ACCESS TO HEALTHCARE FOR ALL THOSE WHO NEED LONG-TERM ACUTE CARE IS AN IMPORTANT RESOURCE IN ADDRESSING THE COMMUNITY'S NEEDS NEEDS OTHER THAN THIS ARE ADDRESSED BY ORGANIZATIONS IN THE COMMUNITY AS WELL AS THROUGH ITS RELATIONSHIPS WITH MISSION HOSPITAL, INC AND COMMUNITY CAREPARTNERS</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 3	The organization's WEBSITE CONTAINS DETAILED INFORMATION AND VARIOUS PAMPHLETS AND SIGNS ARE AVAILABLE AND PROMINENTLY DISPLAYED IN WAITING AREAS. BILLS FOR SERVICES CONTAIN INFORMATION ABOUT FINANCIAL ASSISTANCE AND PATIENTS WHO CALL ARE ALSO INFORMED OF FINANCIAL ASSISTANCE AVAILABLE. EVERY PATIENT IS PROVIDED A COPY OF THE FINANCIAL ASSISTANCE POLICY AS PART OF THE CONSENT TO TREATMENT AND FINANCIAL AUTHORIZATION FORM.
PART VI, LINE 4	MISSION HOSPITAL IS THE FLAGSHIP HOSPITAL FOR THE HEALTH SYSTEM, SERVING 18 COUNTIES IN THE WESTERN NORTH CAROLINA REGION. MISSION HOSPITAL PRIMARILY SERVES BUNCOMBE AND MADISON COUNTIES, HOWEVER, AS THE FACILITY WITH THE REGION'S ONLY DEDICATED LEVEL II TRAUMA CENTER, MISSION HOSPITAL ROUTINELY SERVES RESIDENTS OF ALL 18 COUNTIES. CAREPARTNERS IS THE PRIMARY POST-ACUTE CARE PROVIDER IN WNC SERVING 15 COUNTIES, AND CAREPARTNERS IS AN AFFILIATE OF THE HEALTH SYSTEM. CAREPARTNERS PROVIDES THE FOLLOWING SERVICES IN BUNCOMBE COUNTY, REHABILITATION HOSPITAL, HOME HEALTH, HOSPICE, ADULT DAY, OUTPATIENT REHABILITATION, PRIVATE DUTY, ORTHOTICS AND PROSTHETICS, AND PACE (PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY). DESCRIPTIONS OF THE GEOGRAPHIC AREAS SERVED, BUNCOMBE AND MADISON COUNTIES, CAN BE FOUND IN THE RESPECTIVE COMMUNITY HEALTH ASSESSMENTS FOR THOSE COUNTIES.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 5	<p>THE HEALTH SYSTEM HAS AN OPEN MEDICAL STAFF, A COMMUNITY BOARD AND USES ITS SURPLUS FUNDS TO INVEST IN THE COMMUNITY THROUGH INVESTMENTS IN FACILITIES AND EQUIPMENT FOR PATIENT CARE AND DIRECT DONATIONS TO COMMUNITY ORGANIZATIONS TO PROMOTE THE HEALTH OF THE COMMUNITY ASHEVILLE SPECIALTY HOSPITAL IS A LICENSED LONG TERM ACUTE CARE HOSPITAL SITUATED WITHIN MISSION HOSPITAL ASHEVILLE SPECIALTY HOSPITAL AND MISSION HOSPITAL ARE BOTH PART OF THE HEALTH SYSTEM GROUP OF AFFILIATED ENTITIES PROMOTION OF COMMUNITY HEALTH IS HANDLED BY MISSION HOSPITAL</p>
PART VI, LINE 6	<p>ANC HEALTHCARE, INC (FKA MISSION HEALTH SYSTEM) IS THE PARENT ORGANIZATION FOR THE CHARITABLE ORGANIZATIONS OF MISSION HOSPITAL, INC , MISSION HEALTH SYSTEM FOUNDATION, INC , ANC MISSION MEDICAL ASSOCIATES, INC, ANC BLUE RIDGE HOSPITAL, INC , ANC MCDOWELL HOSPITAL, INC , ANC ANGEL MEDICAL CENTER, INC , ANC TRANSYLVANIA COMMUNITY HOSPITAL, INC , ANC HIGHLANDS-CASHIERS HOSPITAL, INC AND MOUNTAIN CARE, INC (FKA COMMUNITY CAREPARTNERS, INC) THE SYSTEM'S MISSION IS TO OPERATE AN INTEGRATED HEALTH CARE SYSTEM FOR THE BENEFIT OF THE RESIDENTS OF WESTERN NORTH CAROLINA MISSION HOSPITAL, INC IS A REGIONAL INTEGRATED HEALTH FACILITY PROVIDING SUPERIOR CARE AND SERVICE TO PATIENTS AND THEIR FAMILIES THROUGH A FULL CONTINUUM OF INTEGRATED SERVICES, EDUCATION, AND RESEARCH IT SERVES AS A TRAUMA CENTER TO PEOPLE OF WESTERN NORTH CAROLINA AND THE SURROUNDING COUNTIES ANC MISSION MEDICAL ASSOCIATES' MISSION IS TO PROVIDE PHYSICIAN SERVICES IN PREDOMINANTLY RURAL AREAS THAT ARE INSUFFICIENTLY SERVED, THEREBY IMPROVING THE HEALTH CARE OF THE GENERAL PUBLIC IN MANY CASES THIS INVOLVES RECRUITING AND PLACING PRIMARY CARE PHYSICIANS, AS WELL AS PEDIATRIC AND ADULT SPECIALTY SERVICES CLOSE TO WHERE PEOPLE LIVE AND WORK ANC BLUE RIDGE HOSPITAL SERVES AS A COMMUNITY HOSPITAL IN MITCHELL, YANCEY AND SURROUNDING COUNTIES ANC MCDOWELL HOSPITAL SERVES AS A COMMUNITY HOSPITAL IN MCDOWELL AND THE SURROUNDING COUNTIES MISSION HEALTH SYSTEM FOUNDATION, INC SUPPORTS THE MISSION AND PROGRAMS OF MISSION HOSPITAL, INC AND ANC HEALTHCARE, INC (MISSION HEALTH SYSTEM, INC) AND OTHER ORGANIZATIONS THAT ARE TAX EXEMPT UNDER THE PROVISIONS OF SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE AND WORKS TO BENEFIT THE COMMUNITY AND REGION SERVED BY THE ENTITIES LISTED ABOVE ANC ANGEL MEDICAL CENTER, INC SERVES AS A COMMUNITY HOSPITAL IN MACON AND SURROUNDING COUNTIES ANC TRANSYLVANIA COMMUNITY HOSPITAL, INC SERVES AS A COMMUNITY HOSPITAL IN TRANSYLVANIA AND SURROUNDING COUNTIES ANC HIGHLANDS-CASHIERS HOSPITAL, INC SERVES AS A COMMUNITY HOSPITAL FOR JACKSON AND MACON AND SURROUNDING COUNTIES MOUNTAINCARE, INC OPERATES AN INPATIENT FACILITY FOR ACUTE REHABILITATION LOCATED IN ASHEVILLE, NORTH CAROLINA, AND PROVIDES A WIDE VARIETY OF POST-ACUTE CARE SERVICES TO RESIDENTS OF WESTERN NORTH CAROLINA, INCLUDING REHABILITATION, HOME HEALTH, ADULT CARE, AND HOSPICE AND PALLIATIVE CARE MSJHS AND CCP JOINT DEVELOPMENT COMPANY DBA ASHEVILLE SPECIALTY HOSPITAL OPERATES AN INPATIENT FACILITY FOR LONG-TERM ACUTE CARE</p>

Additional Data**Software ID:****Software Version:****EIN:** 58-1450888**Name:** ANC HEALTHCARE INC**Form 990 Schedule H, Part V Section A. Hospital Facilities**

Section A. Hospital Facilities		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (Describe)	Facility reporting group
(list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? <u>1</u>											
Name, address, primary website address, and state license number											
1	ASHEVILLE SPECIALTY HOSPITAL 428 BILTMORE AVENUE 4TH FLOOR ASHEVILLE, NC 28801 HTTP //WWW ASHLTCH COM/ H0279	X								LONG TERM ACUTE CARE HOSPITAL	

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
ASHEVILLE SPECIALTY HOSPITAL	<p>The hospital facility in this Schedule H was sold February 1, 2019. All information and references in the Schedule H are to the facility names and activities prior to the sale. This organization changed its name to ANC Healthcare, Inc. from Mission Health System after the sale and it no longer owns an interest in this facility. ASHEVILLE SPECIALTY HOSPITAL PART V, SECTION B, LINE 4 CHNA Tax Year. The organizations last CHNA was conducted in tax year 2015. In accordance with IRC Section 501(r)(3)(d)(4), "A hospital organization is not required to meet the requirements of section 501(r)(3) with respect to a hospital facility in a taxable year if, before the end of that taxable year, the hospital organization transfers all ownership of the hospital facility to another organization or otherwise ceases its operation of the hospital facility or the facility ceases to be licensed, registered, or similarly recognized as a hospital by a state." Due to the sale of the hospital facility during the current 2018 tax year, the organization did not conduct a new CHNA. ASHEVILLE SPECIALTY HOSPITAL PART V, SECTION B, LINE 5 COMMUNITY INPUT THROUGHOUT THE COLLABORATIVE HEALTH NEEDS ASSESSMENT PROCESS IN OUR COMMUNITY, INPUT WAS OBTAINED IN A NUMBER OF WAYS. COMMUNITY INPUT IN BUNCOMBE COUNTY IS LED BY THE BUNCOMBE COUNTY COMMUNITY HEALTH IMPROVEMENT PROCESS (CHIP) ADVISORY BOARD, COMPRISED OF 30+ COMMUNITY LEADERS WHO COLLECTIVELY LEAD AND GUIDE THE PROCESS, INCLUDING PRIORITIZING HEALTH CONCERNS AND RECOMMENDING TOP PRIORITIES. COMMUNITY INPUT IN MADISON COUNTY IS COORDINATED THROUGH THE MADISON COMMUNITY HEALTH CONSORTIUM, WHICH HAS BEEN WORKING TO IMPROVE HEALTH IN MADISON COUNTY SINCE 1989. THE CONSORTIUM WORKS WITH COMMUNITY AGENCIES AND GROUPS THROUGHOUT THE NEEDS ASSESSMENT PROCESS, AND CURRENTLY HAS MORE THAN 50 MEMBERS REPRESENTING 25 COMMUNITY ORGANIZATIONS. FURTHER INFORMATION ABOUT COMMUNITY ENGAGEMENT CAN BE FOUND IN THE LOCAL COMMUNITY HEALTH ASSESSMENTS WHICH CAN BE FOUND AT EACH COUNTY'S WEBSITE. OUR COLLABORATIVE HEALTH NEEDS ASSESSMENT PROCESS SOLICITED AND TOOK INTO ACCOUNT INPUT FROM THE FOLLOWING: PUBLIC HEALTH DEPARTMENT IN THE COLLABORATIVE ASSESSMENT PROCESS FOR OUR COMMUNITY, THE BUNCOMBE COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND THE MADISON COUNTY HEALTH DEPARTMENT ARE KEY PARTNERS. THE HEALTH DEPARTMENTS PROVIDED COORDINATION FOR THE LOCAL PROCESS THAT MISSION HOSPITAL AND CAREPARTNERS HELP TO SUPPORT AND IMPLEMENT. MEDICALLY UNDERSERVED, LOW-INCOME, AND MINORITY POPULATIONS. OUR PROCESS INCLUDED INPUT REGARDING THE NEEDS OF MEDICALLY UNDERSERVED, LOW-INCOME, AND MINORITY POPULATIONS IN TWO WAYS: (1) AS PART OF OUR COLLABORATIVE DATA COLLECTION EFFORT, A COMMUNITY-WIDE TELEPHONE SURVEY WAS CONDUCTED TO BETTER UNDERSTAND THE SPECIFIC HEALTH NEEDS AND STATUS OF ALL OF THE COMMUNITY, WHICH INCLUDES THESE SPECIAL POPULATIONS. (2) IN ADDITION, A SURVEY OF KEY INFORMANTS WAS CONDUCTED TO GAIN INPUT FROM THE INDIVIDUALS AND ORGANIZATIONS.</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
ASHEVILLE SPECIALTY HOSPITAL	TIONS IN OUR COMMUNITY REPRESENTING THE INTERESTS OF THESE POPULATIONS IN THEIR LOCAL EFFORTS WRITTEN COMMENTS THROUGH OUR PARTNERS AT MISSION HOSPITAL AND CAREPARTNERS, OUR FACILITY ALSO CONSIDERS ANY WRITTEN COMMENTS RECEIVED SINCE THE LAST CHNA AND IMPLEMENTATION STRATEGY MISSION HOSPITAL MAINTAINS PUBLIC ACCESS TO ITS CHNA AND IMPLEMENTATION STRATEGY ON ITS WEBSITE, AND ACCEPTS COMMENTS THROUGH THE COMMUNITY INVESTMENT OFFICE

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
ASHEVILLE SPECIALTY HOSPITAL	Part V, Section B, Line 6a Mission Hospital, Inc And Community Carepartners, Inc

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
ASHEVILLE SPECIALTY HOSPITAL	Part V, Section B, Line 6b Buncombe County Health And Human Services Mountain Area Health Education Center (MAHEC) WNC Healthy Impact Madison County Health Department

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

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

Form and Line Reference	Explanation
ASHEVILLE SPECIALTY HOSPITAL	Part V, Section B, Line 7d https //missionhealth org/ our-commitment-to-you/ community-investment/our-communitys-health-needs/

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

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 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
ASHEVILLE SPECIALTY HOSPITAL	Part V, Section B, Line 11 Asheville Specialty Hospital (ASH) Is connected to community outreach beyond the limited scope of its clinical services through its affiliation with ANC Healthcare and carepartners Typical of long-term, acute care facilities, ash engages in minimal community outreach and education Obesity & chronic disease prevention and healthy weight needs are addressed through the clinical dietician on staff for routine patient care, and rounds with a multi-disciplinary team four days a week in addition to providing services seven days per week Nutrition assessment administered to every patient within 72 hours of admission Discharge planners/case managers refer patients to community resources to ensure support at discharge or next level of care Mental health and substance abuse are addressed as nearly 15% of ASH patients at any given time are patients referred for medical treatment support due to identified IV drug use Ash provides monitoring while patients receive IV antibiotics Ash works closely with licensed clinical social workers to screen and support these patients through their treatment and identified appropriate services upon discharge Patients are connected with local primary care providers as part of discharge planning to ensure their care continues Due to ash's limited scope of services, and the resources provided through affiliation with The Health System and carepartners, which are better equipped to support community efforts, ash does not have a specific role in addressing intimate partner violence or infant mortality Intimate partner violence and infant mortality are addressed by community partners in buncombe county, as well as hospital implementation strategies by mission hospital and carepartners

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
ASHEVILLE SPECIALTY HOSPITAL	Part V, Section B, Line 15e The organization's staff work in collaboration with the patient and appropriate community health and human services agencies and other organizations that assist people in need of health care services to determine available funding sources

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
ASHEVILLE SPECIALTY HOSPITAL	Part V, Section B, Line 16j Every patient receives the policy as part of the patient consent to treatment and financial authorization form Form 990 schedule h line 10a The website for the implementation strategy adopted in November 2017 truncates on the schedule h form, so the address is listed below https //missionhealth org/wp-content/uploads /2018/04/2017-asheville-specialty-hospital- implementation-strategy pdf FORM 990 SCHEDULE H, LINES 16A,16B AND 16C 16a FAP website https //missionhealth org/wp-content/uploads /2018/05/finassdiscount_policy_04 pdf

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
16B FAP APPLICATION FORM	https://missionhealth.org/wp-content/uploads/2018/05/patient_financial_assistance_page.pdf 16C PLAIN LANGUAGE SUMMARY https://missionhealth.org/wp-content/uploads/2018/03/finassistplain_language_summary_4.pdf

Note: To capture the full content of this document, please select landscape mode (11" x 8.5") when printing.

**Schedule I
(Form 990)**

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

OMB No 1545-0047

2018

**Open to Public
Inspection**

Department of the
Treasury
Internal Revenue Service

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

▶ Attach to Form 990.

▶ Go to www.irs.gov/Form990 for the latest information.

Name of the organization
ANC HEALTHCARE INC

Employer identification number

58-1450888

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 ▶ 14

3 Enter total number of other organizations listed in the line 1 table ▶ 2

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	ANC Healthcare (Fka Mission Health System) provides support to the Mission Healthcare Foundation, INC As part of its exempt purpose The health system has oversight through review of the monthly financials of the foundation to ensure that it continues to operate in accordance with its exempt purpose Other grants are provided to local nonprofits to support activities which benefit the community in the areas of health and education The Organization reviews the activities of nonprofits periodically to evaluate the merits of donating to them

Additional Data

Software ID:
Software Version:
EIN: 58-1450888
Name: ANC HEALTHCARE INC

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
Dogwood Health Trust 890 Hendersonville Rd ASHEVILLE, NC 28803	83-0590696	501(C)(3)	800,857,060				Assistance to local Nonprofit
Nantahala Health Foundation PO Box 1954 FRANKLIN, NC 287441954	83-2682447	501(c)(3)	350,000				Assistance to local Nonprofit

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
AMY Wellness Foundation 890 HENDERSONVILLE RD ASHEVILLE, NC 28803	58-2172660	501(C)(3)	5,036,352				Assistance to local Nonprofit
Gateway Wellness Foundation 890 HENDERSONVILLE RD ASHEVILLE, NC 28803	46-3395393	501(C)(3)	5,030,892				Assistance to local Nonprofit

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
Highlands-Cashiers Foundation PO BOX 190 HIGHLANDS, NC 28741	56-1165833	501(C)(3)	5,000,000				Assistance to local Nonprofit
CarePartners Foundation PO BOX 25338 ASHEVILLE, NC 28813	56-2110357	501(C)(3)	5,000,000				Assistance to local Nonprofit

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
Pisgah Health Foundation 890 HENDERSONVILLE RD ASHEVILLE, NC 28803	56-1458024	501(C)(3)	5,097,467				Assistance to local Nonprofit
Asheville Area Chamber of Commerce FDN PO BOX 1010 ASHEVILLE, NC 28802	56-1762978	501(C)(3)	65,000				Assistance to local Nonprofit

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
Asheville Buncombe Community College 340 VICTORIA ROAD ASHEVILLE, NC 28801	56-0792170	501(C)(3)	150,000				Assistance to local Nonprofit
University of North Carolina Asheville 1 Univ Heights ASHEVILLE, NC 288043251	56-6002370	501(C)(3)	45,000				Assistance to local Nonprofit

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
Glory Hound Inc PO Box 19256 Asheville, NC 28815	26-3668441		8,400				Assistance to local Nonprofit
United States Tennis Association incorporated 70 W RED OAK LANE WHITE PLAINS, NY 10604	13-5459420	501(C)(6)	30,000				Assistance to local Nonprofit

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
Community Foundation of Western NC INC 4 vanderbilt pk drive asheville, NC 28803	56-1223384	501(C)(3)	10,000				Assistance to local Nonprofit
Homeward Bound of Western Asheville PO BOX 1166 ASHEEVILLE, NC 28802	56-1568917	501(C)(3)	10,000				Assistance to local Nonprofit

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
Mission Health System Foundation 890 Hendersonville Rd ASHEVILLE, NC 28803	56-1881331	501(C)(3)	854,741				Support of Mission Healthcare Fndn
ANC MISSION MEDICAL ASSOCIATES INC 425 W New England ave winter park, FL 32789	26-3627231	501(c)(3)	14,000,000				Operational Support

Schedule J
(Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

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

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
ANC HEALTHCARE INC

Employer identification number
58-1450888

Part I Questions Regarding Compensation

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

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

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

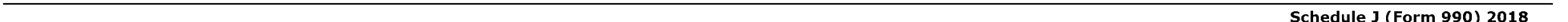
Note. The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

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

Part III Supplemental Information

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

Return Reference	Explanation
PART I, LINE 4B	<p>Persons who participated in a supplemental non-qualified retirement plan are listed below. The contributions to the supplemental non-qualified retirement plan are included on Schedule J, Part II, Column C as part of deferred compensation: Ronald Paulus \$573,201; Jill Hoggard Green \$155,500; Kathy Guyette \$84,776; Rowena Buffett Timms \$47,681; Chris Derienzo \$81,750; Sonya Greck \$87,972; Marc Westle \$85,633; William Hathaway \$96,772; Paul Mcdowell \$112,000; Jonathan Brown \$58,365; Marc Malloy \$84,191; Jon Yeatman \$41,604; Rhonda Miller \$22,650; Charles Sawyer \$56,643; Gwen Mckinney \$36,021; Donald Esposito \$75,750; Sheila Meadows \$35,805; Linda Hummel \$27,269; Joseph Wolfgram \$36,934; Stephanie Baron \$25,135; Ruth Zyry \$56,100. Persons who received a payment from a supplemental nonqualified retirement plan are listed below. The payments are included on Schedule J, Part II, Column B (iii): Ronald Paulus \$1,138,532; Charles Ayscue \$71,744; Jill Hoggard Green \$153,374; Kathy Guyette \$93,564; Rowena Buffett Timms \$52,985; Marc Westle \$69,036; Chris Derienzo \$53,373; Paul Mcdowell \$68,245; Jonathan Brown \$33,564; Jon Yeatman \$37,581; Marc Malloy \$79,934; Rhonda Miller \$39,998; William Hathaway \$70,863; Sonya Greck \$69,744; Gwen Mckinney \$24,040; Sheila Meadows \$20,074; Linda Hummel \$26,483; Stephanie Baron \$9,617; Ruth Zyry \$16,316.</p>



Additional Data

Software ID:
Software Version:
EIN: 58-1450888
Name: ANC HEALTHCARE INC

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
RONALD A PAULUS MD SYSTEM PRES & CEO END JAN 2019	(i)	0	0	0	0	0	0	0
	(ii)	1,103,073	1,154,710	1,145,435	586,951	30,069	4,020,238	1,138,532
ANN YOUNG Former GENERAL COUNSEL	(i)	0	0	0	0	0	0	0
	(ii)	245,546	153,288	0	0	0	398,834	0
MARC MALLOY SVP MISSION HEALTH SOLUTIONS	(i)	0	0	0	0	0	0	0
	(ii)	407,325	288,581	83,879	92,441	10,734	882,960	79,934
PAUL MCDOWELL SVP AND CFO END JAN 2019	(i)	0	0	0	0	0	0	0
	(ii)	496,701	317,479	71,485	125,750	26,753	1,038,168	68,245
JONATHAN BROWN CHIEF INFORMATION OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	337,347	207,254	36,504	72,115	18,192	671,412	33,564
DEBRA FOSS SVP ORG TRANSFORMATION	(i)	0	0	0	0	0	0	0
	(ii)	414,881	312,045	97,454	13,750	20,427	858,557	0
ROWENA BUFFETT TIMMS SVP GOVT & COMMUNITY RELATIONS	(i)	0	0	0	0	0	0	0
	(ii)	276,979	110,149	55,664	58,446	11,499	512,737	52,985
DR JILL HOGGARD GREEN SVP AND COO	(i)	0	0	0	0	0	0	0
	(ii)	652,986	253,400	165,913	169,250	19,306	1,260,855	153,374
KATHY GUYETTE SVP PATIENT CARE SVCS REGIONAL	(i)	0	0	0	0	0	0	0
	(ii)	406,499	157,955	100,767	101,276	8,691	775,188	93,564
MARC WESTLE DO SVP INNOVATION ADMIN	(i)	0	0	0	0	0	0	0
	(ii)	404,487	297,406	73,176	102,133	27,979	905,181	69,036
CHRIS DERIENZO CHIEF QUALITY OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	431,770	137,018	55,214	92,750	26,013	742,765	53,373
JON YEATMAN CHIEF STRATEGY OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	278,796	174,209	39,413	49,343	1,908	543,669	37,581
RHONDA MILLER VP REVENUE CYCLE	(i)	0	0	0	0	0	0	0
	(ii)	191,160	110	41,753	34,134	4,071	271,228	39,998
CHARLES SAWYER MD CHIEF MEDICAL INFORMATION OFF	(i)	0	0	0	0	0	0	0
	(ii)	330,169	191,902	6,907	62,435	19,400	610,813	0
GWEN MCKINNEY CHIEF COMPLIANCE OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	241,221	157,904	27,497	50,589	11,524	488,735	24,040
WILLIAM HATHAWAY MD CHIEF MEDICAL OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	445,542	320,356	75,396	113,272	13,607	968,173	70,863
SONYA GRECK SENIOR VICE PRESIDENT	(i)	0	0	0	0	0	0	0
	(ii)	418,324	171,439	75,239	104,472	7,460	776,934	69,744
RUTH ZYRY CHIEF OPERATIONS OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	330,063	104,728	20,849	59,443	15,304	530,387	16,316
DONALD ESPOSITO SVP Gen Council END JAN 2019	(i)	0	0	0	0	0	0	0
	(ii)	370,781	147,000	2,060	77,139	28,535	625,515	0
RITA EDWARDS VICE PRESIDENT	(i)	0	0	0	0	0	0	0
	(ii)	290,850	84,375	3,430	7,634	18,007	404,296	0

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				
SHEILA MEADOWS CHIEF HR OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	242,250	86,110	27,920	50,516	19,501	426,297	20,074
JOSEPH WOLFGRAM Physician	(i)	0	0	0	0	0	0	0
	(ii)	240,737	140,353	1,272	44,417	22,910	449,689	0
LINDA HUMMEL VP - QUALITY & SAFETY	(i)	0	0	0	0	0	0	0
	(ii)	228,230	125,781	29,621	36,656	19,144	439,432	26,483
CHARLES F AYSCUE FORMER SVP AND CFO	(i)	0	0	0	0	0	0	0
	(ii)	43,389	20,033	76,931	1,184	125	141,662	71,744
Stephanie Baron PHYSICIAN	(i)	0	0	0	0	0	0	0
	(ii)	208,957	51,276	11,108	31,501	24,120	326,962	9,617

Schedule L
(Form 990 or 990-EZ)

Transactions with Interested Persons

OMB No 1545-0047

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, lines 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.**
 ▶ **Attach to Form 990 or Form 990-EZ.**
 ▶ **Go to www.irs.gov/Form990 for the latest information.**

2018

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization ANC HEALTHCARE INC	Employer identification number 58-1450888
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Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 501(c)(29) organizations only)
 Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b

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

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

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

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

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

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

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

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) WYATT STEVENS	BOARD MEMBER	244,420	PARTNERSHIP		No

Part V Supplemental Information

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

Return Reference	Explanation
SCH L, PART IV, BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS	(A) Name of person Wyatt Stevens (B) Relationship between interested person and organization Board member (C) Amount of transaction \$244,420 (D) Description of transaction partnership in a law firm, including the board member and a family member, which performs legal services for the organization The organization engages the law firm for legal services in arms-length transactions at fair market value The board member is not involved in negotiating the pricing for the services rendered, nor does he perform any of the services engaged by the hospital (E) Sharing of organization revenues? = no

Note: To capture the full content of this document, please select landscape mode (11" x 8.5") when printing.

SCHEDULE N (Form 990 or 990-EZ)

Liquidation, Termination, Dissolution, or Significant Disposition of Assets

OMB No 1545-0047

2018

Open to Public Inspection

- Complete if the organization answered "Yes" on Form 990, Part IV, lines 31 or 32; or Form 990-EZ, line 36.
Attach certified copies of any articles of dissolution, resolutions, or plans.
Attach to Form 990 or 990-EZ.
Go to www.irs.gov/Form990 for the latest information.

Department of the Treasury Internal Revenue Service

Name of the organization ANC HEALTHCARE INC

Employer identification number

58-1450888

Part I Liquidation, Termination, or Dissolution. Complete this part if the organization answered "Yes" on Form 990, Part IV, line 31, or Form 990-EZ, line 36. Part I can be duplicated if additional space is needed.

Table with 7 columns: (a) Description of asset(s) distributed or transaction expenses paid, (b) Date of distribution, (c) Fair market value of asset(s) distributed or amount of transaction expenses, (d) Method of determining FMV for asset(s) distributed or transaction expenses, (e) EIN of recipient, (f) Name and address of recipient, (g) IRC section of recipient(s) (if tax-exempt) or type of entity.

Table with 3 columns: Question (2a-2d), Yes, No. Questions include: Did or will any officer, director, trustee, or key employee of the organization become a director or trustee of a successor or transferee organization? etc.

Part I Liquidation, Termination, or Dissolution (continued)

Note. If the organization distributed all of its assets during the tax year, then Form 990, Part X, column (B), line 16 (Total assets), and line 26 (Total liabilities), should equal -0-

Yes	No
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- 3** Did the organization distribute its assets in accordance with its governing instrument(s)? If "No," describe in Part III
- 4a** Is the organization required to notify the attorney general or other appropriate state official of its intent to dissolve, liquidate, or terminate?
- b** If "Yes," did the organization provide such notice?
- 5** Did the organization discharge or pay all of its liabilities in accordance with state laws?
- 6a** Did the organization have any tax-exempt bonds outstanding during the year?
- b** If "Yes" on line 6a, did the organization discharge or defease all of its tax-exempt bond liabilities during the tax year in accordance with the Internal Revenue Code and state laws?
- c** If "Yes" on line 6b, describe in Part III how the organization defeased or otherwise settled these liabilities. If "No" on line 6b, explain in Part III

3		
4a		
4b		
5		
6a		
6b		

Part II Sale, Exchange, Disposition, or Other Transfer of More Than 25% of the Organization's Assets.

Complete this part if the organization answered "Yes" on Form 990, Part IV, line 32, or Form 990-EZ, line 36. Part II can be duplicated if additional space is needed.

See Additional Data Table

1	(a) Description of asset(s) distributed or transaction expenses paid	(b) Date of distribution	(c) Fair market value of asset(s) distributed or amount of transaction expenses	(d) Method of determining FMV for asset(s) distributed or transaction expenses	(e) EIN of recipient	(f) Name and address of recipient	(g) IRC section of recipient(s) (if tax-exempt) or type of entity

- 2** Did or will any officer, director, trustee, or key employee of the organization
 - a** Become a director or trustee of a successor or transferee organization?
 - b** Become an employee of, or independent contractor for, a successor or transferee organization?
 - c** Become a direct or indirect owner of a successor or transferee organization?
 - d** Receive, or become entitled to, compensation or other similar payments as a result of the organization's liquidation, termination, or dissolution?
 - e** If the organization answered "Yes" to any of the questions on lines 2a through 2d, provide the name of the person involved and explain in Part III ►

Yes	No
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2a		
2b		
2c		
2d		

Part III Supplemental Information.

Provide the information required by Part I, lines 2e and 6c, and Part II, line 2e. Also complete this part to provide any additional information.

Return Reference	Explanation
SCHEDULE N, PART II, LINE 1	ASSUMPTION OF LIABILITIES As a part of the sale, purchasers also took over the liabilities amounting to \$43,115,818
SCHEDULE N, PART II, LINE 2B	SUCCESSOR ORGANIZATION EMPLOYEES THE FOLLOWING DIRECTORS AND OFFICERS BECAME EMPLOYEES OF A COMPANY THAT IS RELATED TO MH MASTER HOLDINGS, LLLP, THE ENTITY WHICH PURCHASED THE ASSETS Chris Flanders, M D Debra Foss Donald Esposito Dr Jill Hoggard Green Gwen Mckinney Jon Yeatman Jonathan Brown Kathy Guyette Marc Malloy Marc Westle, D O Paul Mcdowell Rita Edwards Rowena Buffett Timms Ruth Zyry Sonya Greck William Hathaway, M D NONE ARE DIRECTORS OR OFFICERS OF THE SUCCESSOR COMPANY RONALD A PAULUS, M D BECAME AN INDEPENDENT CONTRACTOR OF THE SUCCESSOR ORGANIZATION

Additional Data

Software ID:
Software Version:
EIN: 58-1450888
Name: ANC HEALTHCARE INC

Form 990, Schedule N, Part II - Sale, Exchange, Disposition or Other Transfer of more than 25% of the Organization's Assets. Complete this part if the organization answered "Yes" on Form 990, Part IV, line 32, or Form 990-EZ, line 36. Part II can be duplicated if additional space is needed.

1	(a) Description of asset(s) distributed or transaction expenses paid	(b) Date of distribution	(c) Fair market value of asset(s) distributed or amount of transaction expenses	(d) Method of determining FMV for asset(s) distributed or transaction expenses	(e) Ein of recipient	(f) Name and address of recipient	(g) IRC Code section recipient(s) (if tax-exempt) or type of entity
	Cash	02-01-2019	616,134	BOOK VALUE	38-4091276	MH Master Holdings LLLP PO Box 570 NASHVILLE, TN 37202	LLLP
	Property, Plant, and Equipment	02-01-2019	31,944,691	SALE VALUATION	38-4091276	MH Master Holdings LLLP PO Box 570 NASHVILLE, TN 37202	LLLP
	Investment in Sub & Partnerships	02-01-2019	9,268,662	SALE VALUATION	38-4091276	MH Master Holdings LLLP PO Box 570 NASHVILLE, TN 37202	LLLP
	Investment in Sub & Partnerships	02-01-2019	745,277	SALE VALUATION	83-1616567	MH Hospital Holdings Inc PO Box 570 NASHVILLE, TN 37202	CORPORATION
	Cash	02-01-2019	5,412,516	BOOK VALUE	36-4907465	MH Hospital Manager LLC PO Box 570 NASHVILLE, TN 37202	LLC
	AccountS Receivable	02-01-2019	4,931,088	SALE VALUATION	36-4907465	MH Hospital Manager LLC PO Box 570 NASHVILLE, TN 37202	LLC
	Inventory	02-01-2019	52,046	SALE VALUATION	36-4907465	MH Hospital Manager LLC PO Box 570 NASHVILLE, TN 37202	LLC
	Prepaid Expenses	02-01-2019	5,187,456	SALE VALUATION	36-4907465	MH Hospital Manager LLC PO Box 570 NASHVILLE, TN 37202	LLC

SCHEDULE O
(Form 990 or 990-EZ)

Supplemental Information to Form 990 or 990-EZ

OMB No 1545-0047

2018

Open to Public Inspection

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

▶ Attach to Form 990 or 990-EZ.

▶ Go to www.irs.gov/Form990 for the latest information.

Department of the Treasury

Name of the organization
ANC HEALTHCARE INC

Employer identification number

58-1450888

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part III, Line 3	<p>THE ENTITY SOLD A SUBSTANTIAL PORTION OF THE FACILITIES AND OTHER OPERATING ASSETS OF THE HEALTH SYSTEM, INCLUDING THOSE OF ITS SUBSIDIARIES, ON 2/1/2019 THE ORGANIZATION CONTINUE S TO MAINTAIN OVERSITE OF ITS SUBSIDIARIES DURING THE PROCESS OF LIQUIDATION AND EVENTUAL TERMINATION FORM 990, PART IV, LINE 20B The organization did not have an audit performed for the filing period since it sold a substantial portion of the facilities and other operating assets on 2/1/2019 A copy of the most recent audited consolidated financial statements for the period ended September 30, 2018 is attached to this return FORM 990, PART VI , SECTION A, LINE 4 MISSION HEALTH SYSTEM, INC CHANGED ITS NAME TO ANC HEALTHCARE, INC DURING CALENDAR YEAR 2019 THE FILING ORGANIZATION WILL HEREBY BE REFERRED TO AS "THE ORGANIZATION" THROUGHOUT THE RETURN UNLESS OTHERWISE INDICATED BY ITS OLD NAME, MISSION HEALTH SYSTEM, INC INDICATED BY ITS OLD NAME, MISSION HEALTH SYSTEM, INC</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	THE FORM 990 IS PREPARED BY AN INDEPENDENT ACCOUNTING FIRM A FINAL COPY OF THE FORM 990 W AS PROVIDED TO THE BOARD OF DIRECTORS THE WEEK AFTER FILING WITH THE IRS

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	<p>THE ORGANIZATION'S CONFLICT OF INTEREST POLICY IS REVIEWED AND UPDATED ANNUALLY. EDUCATION ABOUT THE POLICY AND THE RESPONSIBILITIES OF A BOARD MEMBER INCLUDING CONFLICTS OF INTEREST IS PROVIDED DURING ORIENTATION FOR NEW BOARD MEMBERS. BOARD MEETINGS BEGIN WITH A COMMENT SUMMARIZING THE CONFLICT OF INTEREST POLICY AND THE DUTY TO DISCLOSE CONFLICTS. IF A CONFLICT OF INTEREST IS IDENTIFIED, THE INTERESTED PERSON DOES NOT PARTICIPATE IN ANY DECISION RELATING TO THE TRANSACTION ISSUE. A CONFLICT OF INTEREST IS A PARTICULAR RELATIONSHIP OR ARRANGEMENT THAT WOULD REASONABLY BE EXPECTED TO EXERT AN INFLUENCE ON THE INDIVIDUAL'S JUDGMENT AND PRECLUDE THE INDIVIDUAL FROM BEING AN INDEPENDENT DIRECTOR OR BEING INDEPENDENT WITH RESPECT TO THE TRANSACTION UNDER CONSIDERATION. IN ADDITION TO BOARD MEMBERS, THE ORGANIZATION'S CONFLICT OF INTEREST POLICY APPLIES TO MEMBERS OF SENIOR LEADERSHIP, MEDICAL STAFF, CLINICAL SERVICE LINE LEADERS, ELECTED MEDICAL STAFF LEADERS, DEPARTMENTAL DIRECTORS, STAFF MEMBERS WORKING IN THE PURCHASING DEPARTMENT, AND ALL OTHER STAFF MEMBERS WITH PURCHASING AUTHORITY, AS WELL AS IMMEDIATE FAMILY MEMBERS OF SUCH INTERESTED PERSONS AND ENTITIES IN WHICH INTERESTED PERSONS HAVE A MATERIAL FINANCIAL INTEREST. THE ORGANIZATION'S POLICY IS FOR ALL INTERESTED PERSONS TO DISCLOSE ANY AND ALL CONFLICTS OF INTEREST IN ACCORDANCE WITH THE IRS GUIDELINES FOR TAX-EXEMPT ENTITIES AS WELL AS ANY OTHER APPLICABLE STATE OR FEDERAL LAW. UPON INITIAL ASSUMPTION OF DUTIES, INTERESTED PERSONS ARE PROVIDED WITH A COPY OF THE CONFLICT OF INTEREST POLICY AND SUBMIT A CONFLICT OF INTEREST DISCLOSURE STATEMENT. THEREAFTER, THE STATEMENTS WILL BE COMPLETED ANNUALLY. PERIODICALLY ALL STAFF MEMBERS ARE ASKED TO COMPLETE A CONFLICT OF INTEREST DISCLOSURE STATEMENT. INTERNAL AND EXTERNAL AUDITORS, GENERAL COUNSEL OR OUTSIDE COUNSEL WILL PERIODICALLY CONDUCT A REVIEW OF THE DISCLOSURE PROCESS TO DETERMINE WHETHER THE ORGANIZATION IS IN COMPLIANCE WITH THE POLICY.</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15	THE ORGANIZATION DRAWS WAGE COMPARISON DATA FROM OUTSIDE EXECUTIVE COMPENSATION CONSULTANTS TO ENSURE COMPENSATION LEVELS ARE AT FAIR MARKET VALUE. THE HUMAN RESOURCES AND COMPENSATION COMMITTEE OF THE RELATED ORGANIZATION (COMMITTEE) REVIEWS THIS DATA AND RECOMMENDS TO THE BOARD OF THE RELATED ORGANIZATION ANY REVISIONS TO THE OVERALL PHILOSOPHY AND POLICY TO GUIDE THE DETERMINATION OF COMPENSATION AND BENEFIT PACKAGES FOR EXECUTIVES WHICH INCLUDES THE CEO, THE CFO, AND PRESIDENT AS WELL AS ALL OTHER EXECUTIVES, WHICH WOULD INCLUDE ALL KEY EMPLOYEES. THE COMMITTEE KEEPS AND DISTRIBUTES MINUTES OF ALL ITS MEETINGS TO ITS MEMBERS. ITEMS OF A SENSITIVE NATURE ARE REFERENCED IN THE MINUTES WITH DETAILED, SUPPORTING DOCUMENTATION RETAINED ON FILE. THE COMMITTEE ALSO DISCLOSES ANY POTENTIAL CONFLICTS OF INTEREST SITUATIONS TO THE COMMITTEE CHAIRMAN THAT MAY AFFECT THEIR INDEPENDENT DIRECTORS' STATUS AS SOON AS THEY ARISE, AND MAINTAINS COMPLETE DOCUMENTATION OF ALL MATTERS DISCUSSED BY THE COMMITTEE. THE COMMITTEE OBTAINS EDUCATION AND TRAINING TO EXERCISE ALL RESPONSIBILITIES EFFECTIVELY AND KEEPS ABREAST OF SIGNIFICANT DEVELOPMENTS IN EXECUTIVE COMPENSATION PRACTICES AND REGULATIONS, AND ENSURES THAT ALL ASPECTS OF THE HEALTH SYSTEM AND HOSPITAL EXECUTIVE COMPENSATION ADHERE TO ALL RELEVANT REGULATORY REQUIREMENTS, AND REVIEWS THE COMMITTEE CHARTER ANNUALLY REVISING AS APPROPRIATE AND CONDUCTS AN ANNUAL EVALUATION OF THE COMMITTEE'S PERFORMANCE.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	The organization prepares an annual report to the community and makes its financial statements and significant accomplishments available on the organization's website. The articles of incorporation are available to the public through the North Carolina secretary of state website. Conflict of interest policy and by-laws are available upon request.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS	TRANSFER OF NET ASSETS FROM RELATED SUBSIDIARIES (SALE PROCEEDS, CASH, RECEIVABLES, LIABILITIES, AND OTHER ASSETS), AND OTHER ADJUSTMENTS TO THE BALANCE SHEET AND NET ASSETS AS A RESULT OF THE SALE (\$122,698,834)

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No 1545-0047

2018

**Open to Public
Inspection**

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

Department of the Treasury
Internal Revenue Service

Name of the organization
ANC HEALTHCARE INC

Employer identification number

58-1450888

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) ANC Imaging Services LLC 509 BILTMORE AVENUE asheville, NC 28801 46-5181350	MEDI IMAGING	NC	1,452,178	16,297,126	ANC INC
(2) WNC CARESOURCE LLC 509 BILTMORE AVENUE Asheville, NC 28801 58-1450888	SUPPORT	NC	10,967	1,240,325	ANC INC

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.

See Additional Data Table

(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
(1) DOGWOOD INSURANCE COMPANY LTD PO BOX 3060 GRAND CAYMAN CJ	CAPTIVE INSURAN	CJ	ANC INC	C CORP	0	0	100 000 %	Yes	
(2) TRANSYLVANIA SERVICES INC 425 W NEW ENGLAND AVENUE NO 300 WINTER PARK, FL 32789 56-1448199	REAL ESTATE	NC	NA	C CORP	0	0		Yes	
(3) MISSION HEALTH PARTNERS INC PO BOX 570 NASHVILLE, TN 37202 46-5566095	CLINICALLY INTEGR	NC	ANC INC	C CORP	-738,018	0	100 000 %	Yes	
(4) HEALTHY STATE INC PO BOX 570 NASHVILLE, TN 37202 81-2108613	ADMINISTRATIVE	NC	ANC INC	C CORP	25,917	0	100 000 %	Yes	
(5) AVENU HEALTH INC 425 W NEW ENGLAND AVENUE NO 300 WINTER PARK, FL 32789 82-3337055	HEALTH CARE CLINI	NC	ANC INC	C CORP	-550,655	894,785	100 000 %	Yes	

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

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

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

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

See Additional Data Table

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

Part VII **Supplemental Information**

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

Return Reference	Explanation

Additional Data

Software ID:
Software Version:
EIN: 58-1450888
Name: ANC HEALTHCARE INC

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
425 W NEW ENGLAND AVE NO 300 WINTER PARK, FL 32789 56-0509400	HOSPITAL	NC	501(C)(3)	LINE 3	ANC INC	Yes	
425 W NEW ENGLAND AVE NO 300 WINTER PARK, FL 32789 56-0532141	HOSPITAL	NC	501(C)(3)	LINE 3	ANC INC	Yes	
425 W NEW ENGLAND AVE NO 300 WINTER PARK, FL 32789 56-1881331	FOUNDATION	NC	501(C)(3)	LINE 7	ANC INC	Yes	
425 W NEW ENGLAND AVE NO 300 WINTER PARK, FL 32789 26-3627231	PHYSICIAN GRP	NC	501(C)(3)	LINE 10	ANC INC	Yes	
425 W NEW ENGLAND AVE NO 300 WINTER PARK, FL 32789 56-0623938	HOSPITAL	NC	501(C)(3)	LINE 3	ANC INC	Yes	
425 W NEW ENGLAND AVE NO 300 WINTER PARK, FL 32789 56-1025032	HOSPITAL	NC	501(C)(3)	LINE 3	ANC INC	Yes	
31 CROSS STREET STE 266 SPRUCE PINE, NC 28777 58-2172660	FOUNDATION	NC	501(C)(3)	LINE 12A, I	BRH INC		No
425 W NEW ENGLAND AVE NO 300 WINTER PARK, FL 32789 56-0562293	HOSPITAL	NC	501(C)(3)	LINE 3	ANC INC	Yes	
153 WEST JORDAN STREET BREVARD, NC 28712 56-1458024	FOUNDATION	NC	501(C)(3)	LINE 12A, I	TCH INC		No
425 W NEW ENGLAND AVE NO 300 WINTER PARK, FL 32789 56-1920816	PHYSICIAN SER	NC	501(C)(3)	LINE 3	TCH INC		No
425 W NEW ENGLAND AVE NO 300 WINTER PARK, FL 32789 58-6000064	HOSPITAL	NC	501(C)(3)	LINE 3	ANC INC	Yes	
PO BOX 1209 FRANKLIN, NC 28744 56-2133719	SUPPORTING	NC	501(C)(3)	LINE 12A, I	AMC INC		No
68 SWEETEN CREEK ROAD ASHEVILLE, NC 28803 56-2005198	ADULT DAYCARE	NC	501(C)(3)	LINE 10	ANC INC	Yes	
135 SOUTH MAIN STREET MARION, NC 28752 46-3395393	FOUNDATION	NC	501(C)(3)	LINE 7	TMH INC		No
425 W NEW ENGLAND AVE NO 300 WINTER PARK, FL 32789 45-2422428	PHYSICIAN SER	NC	501(C)(3)	LINE 12A, I	HCH INC		No

Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership												
(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	
(1) ASHEVILLE IMAGING LLP 534 BILTMORE AVENUE ASHEVILLE, NC 28801 56-1907203	DISCONTINUED OPRTN	NC	NA	N/A	0	0		No	0		No	0 %
(1) ASHEVILLE MRI PO BOX 2959 ASHEVILLE, NC 28801 56-1665863	DISCONTINUED OPRTN	NC	NA	N/A	0	0		No	0		No	0 %
(2) BLUE RIDGE DME LLC 425 W NEW ENGLAND AVENUE NO 300 WINTER PARK, FL 32789 26-3570174	EQUIPMENT SALES	NC	NA	N/A	0	0		No	0		No	0 %
(3) BLUE RIDGE-TKC LLC 5935 CARNEGIE BLVD CHARLOTTE, NC 02880 47-1382912	REAL ESTATE RENT	NC	NA	N/A	0	0		No	0		No	0 %
(4) HEALTHCARE III LIMITED PARTNER 425 W NEW ENGLAND AVENUE NO 300 WINTER PARK, FL 32789 56-1599596	RENTAL	NC	NA	N/A	0	0		No	0		No	0 %
(5) HEALTHCARE LIMITED LIABILITY COMPANY VII 425 W NEW ENGLAND AVENUE NO 300 WINTER PARK, FL 32789 20-0343455	RENTAL	NC	NA	N/A	0	0		No	0		No	0 %
(6) IMAGING REALTY LLP 534 BILTMORE AVENUE ASHEVILLE, NC 28801 56-1907203	MEDICAL BUILDING	NC	ANC INC	RELATED	0	0		No	0	Yes		69 000 %
(7) MSJHS & CCP JOINT DEVELOPMENT CO INC 425 W NEW ENGLAND AVENUE NO 300 WINTER PARK, FL 32789 56-2250464	LT ACUTE CARE	NC	ANC INC	RELATED	0	0		No	0	Yes		67 000 %
(8) SPRUCE PINE HEALTHCARE LLC 5935 CARNEGIE BLVD CHARLOTTE, NC 28209 47-1390107	REAL ESTATE	NC	NA	N/A	0	0		No	0		No	0 %
(9) TRANSYLVANIA HEALTHCARE II LP 2 MEDICAL PARK DRIVE BREVARD, NC 28712 20-0333230	RENTAL	NC	NA	N/A	0	0		No	0		No	0 %
(10) WESTERN NC HEALTHCARE INNOVATORS LLC 5935 CARNEGIE BLVD CHARLOTTE, NC 28209 80-0787882	REAL ESTATE RENT	NC	ANC INC	Related	0	0		No	0	Yes		80 000 %
(11) WNC STONE CENTER 509 BILTMORE AVENUE ASHEVILLE, NC 28801 27-2152974	LITHOTRIPTER RENT	NC	NA	N/A	0	0		No	0		No	0 %

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

	(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
(1)	Mission Health System Foundation	C	4,427,565	CASH VALUE
(1)	AMY Wellness Foundation	B	5,036,352	CASH VALUE
(2)	Gateway Wellness Foundation	B	5,030,892	CASH VALUE
(3)	Highlands-Cashiers Foundation	B	5,000,000	CASH VALUE
(4)	CarePartners Foundation	B	5,000,000	CASH VALUE
(5)	Pisgah Health Foundation	B	5,097,467	CASH VALUE
(6)	Mission Health System Foundation	B	854,741	CASH VALUE
(7)	ANC Mission Medical Associates Inc	B	14,000,000	CASH VALUE
(8)	ANC HIGHLANDS-CASHIERS HOSPITAL INC	S	677,529	CASH VALUE
(9)	MISSION HOSPITAL INC	S	37,679,216	CASH VALUE
(10)	MISSION HEALTH SYSTEM FOUNDATION INC	R	3,084,094	CASH VALUE
(11)	ANC MEDICAL ASSOCIATES INC	R	21,049,182	CASH VALUE
(12)	ANC MCDOWELL HOSPITAL INC	S	5,264,611	CASH VALUE
(13)	ANC BLUE RIDGE HOSPITAL INC	S	1,115,866	CASH VALUE
(14)	ANC TRANSYLVANIA COMMUNITY HOSPITAL INC	S	3,416,200	CASH VALUE
(15)	PISGAH HEALTH FOUNDATION	R	2,341,737	CASH VALUE
(16)	ANC TRANSYLVANIA PHYSICIAN SERVICES INC	R	993,464	CASH VALUE
(17)	ANC ANGEL MEDICAL CENTER INC	S	429,411	CASH VALUE
(18)	MOUNTAINCARE INC	S	2,068,862	CASH VALUE