SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No. 1545-0047

2014

Open to Public Inspection

Name of the organization: SHENANDOAH MEDICAL CENTER

Employer identification number: 42-1101835

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	1a	X	
b	If "Yes," was it a written policy?	1b	X	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☒ 200% ☐ Other _____ %	3a	X	
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☒ 200% ☐ 250% ☐ 300% ☐ 350% ☐ 400% ☐ Other _____ %	3b	X	
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"?	4	X	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	X	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		X
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?	5c		
6a	Did the organization prepare a community benefit report during the tax year?	6a	X	
b	If "Yes," did the organization make it available to the public?	6b	X	

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			119,693.	0.	119,693.	.38%
b Medicaid (from Worksheet 3, column a)			5099320.	5147316.	-47,996.	.00%
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			5219013.	5147316.	71,697.	.38%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	10	3,275	206,251.	87,267.	118,984.	.37%
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)	11	51,224	19565069.	17801685.	1763384.	5.53%
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)	4	16,500	37,690.	0.	37,690.	.12%
j **Total.** Other Benefits	25	70,999	19809010.	17888952.	1920058.	6.02%
k **Total.** Add lines 7d and 7j	25	70,999	25028023.	23036268.	1991755.	6.40%

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	1	167	48,781.	0.	48,781.	.15%
4	Environmental improvements						
5	Leadership development and training for community members						
6	Coalition building						
7	Community health improvement advocacy	1	153	1,972.	0.	1,972.	.01%
8	Workforce development						
9	Other						
10	Total	2	320	50,753.		50,753.	.16%

Part III Bad Debt, Medicare, & Collection Practices

				Yes	No
Section A. Bad Debt Expense					
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1		X	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2	3,350,700.		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit	3	0.		
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 audited financial statements.				
Section B. Medicare					
5	Enter total revenue received from Medicare (including DSH and IME)	5	10,217,039.		
6	Enter Medicare allowable costs of care relating to payments on line 5	6	10,502,340.		
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-285,301.		
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: ☐ Cost accounting system ☒ Cost to charge ratio ☐ Other				
Section C. Collection Practices					
9a	Did the organization have a written debt collection policy during the tax year?	9a		X	
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b		X	

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

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %

Part V Facility Information

Section A. Hospital Facilities
(list in order of size, from largest to smallest)

How many hospital facilities did the organization operate during the tax year? 1

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)	Licensed hospital	Gen. medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 SHENANDOAH MEDICAL CENTER 300 PERSHING AVE SHENANDOAH, IA 51601 WWW.SMCHOSPITAL.COM 730065H	X	X			X		X			

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group SHENANDOAH MEDICAL CENTER

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?	1		X
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	2		X
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	3	X	
If "Yes," indicate what the CHNA report describes (check all that apply):			
a [X] A definition of the community served by the hospital facility			
b [X] Demographics of the community			
c [X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d [X] How data was obtained			
e [X] The significant health needs of the community			
f [X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g [X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h [X] The process for consulting with persons representing the community's interests			
i [X] Information gaps that limit the hospital facility's ability to assess the community's health needs			
j [X] Other (describe in Section C)			
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 13			
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	5	X	
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a		X
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	6b		X
7 Did the hospital facility make its CHNA report widely available to the public?	7	X	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a [X] Hospital facility's website (list url): WWW.SMCHOSPITAL.COM			
b [ ] Other website (list url):			
c [ ] Made a paper copy available for public inspection without charge at the hospital facility			
d [ ] Other (describe in Section C)			
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	X	
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 14			
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10		X
a If "Yes," (list url):			
b If "No", is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	X	
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)?	12a		X
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group SHENANDOAH MEDICAL CENTER

			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?	13	X	
	If "Yes," indicate the eligibility criteria explained in the FAP:			
a	[X] Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 % and FPG family income limit for eligibility for discounted care of 200 %			
b	[ ] Income level other than FPG (describe in Section C)			
c	[X] Asset level			
d	[X] Medical indigency			
e	[X] Insurance status			
f	[X] Underinsurance status			
g	[ ] Residency			
h	[ ] Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	X	
15	Explained the method for applying for financial assistance?	15	X	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	[X] Described the information the hospital facility may require an individual to provide as part of his or her application			
b	[X] Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	[X] Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	[ ] Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	[ ] Other (describe in Section C)			
16	Included measures to publicize the policy within the community served by the hospital facility?	16	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[X] The FAP was widely available on a website (list url): WWW.SMCHOSPITAL.COM			
b	[ ] The FAP application form was widely available on a website (list url):			
c	[ ] A plain language summary of the FAP was widely available on a website (list url):			
d	[X] The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	[ ] The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	[ ] 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	[ ] Notice of availability of the FAP was conspicuously displayed throughout the hospital facility			
h	[ ] Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	[ ] Other (describe in Section C)			

Billing and Collections

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 non-payment?	17	X	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:			
a	[X] Reporting to credit agency(ies)			
b	[ ] Selling an individual's debt to another party			
c	[ ] Actions that require a legal or judicial process			
d	[ ] Other similar actions (describe in Section C)			
e	[ ] None of these actions or other similar actions were permitted			

Part V Facility Information *(continued)*

Name of hospital facility or letter of facility reporting group SHENANDOAH MEDICAL CENTER

			Yes	No
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?	19	X	
	If "Yes", check all actions in which the hospital facility or a third party engaged:			
a	[X] Reporting to credit agency(ies)			
b	[ ] Selling an individual's debt to another party			
c	[ ] Actions that require a legal or judicial process			
d	[ ] 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	[ ] Notified individuals of the financial assistance policy on admission			
b	[ ] Notified individuals of the financial assistance policy prior to discharge			
c	[X] Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills			
d	[ ] Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy			
e	[ ] Other (describe in Section C)			
f	[ ] Non 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?	21	X	
	If "No," indicate why:			
a	[ ] The hospital facility did not provide care for any emergency medical conditions			
b	[ ] The hospital facility's policy was not in writing			
c	[ ] The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
d	[ ] Other (describe in Section C)			

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

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 its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged			
b	[X] The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged			
c	[ ] The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged			
d	[X] Other (describe in Section C)			
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?	23		X
	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?	24		X
	If "Yes," explain in Section C.			

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

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2" "B, 3," etc.) and name of hospital facility.

SHENANDOAH MEDICAL CENTER:

PART V, SECTION B, LINE 3J: THE NEEDS ASSESSMENT INDICATED THAT AREAS FOR IMPROVEMENT WERE AS FOLLOWS: CHILD AND INFANT IMMUNIZATION, TRANSPORTATION, INTERNET/TELECOMMUNICATIONS INFRASTRUCTURE, UNINSURED/UNDERINSURED, TELEMEDICINE, EYE CARE FOR VETERANS, CARDIOVASCULAR ACCESS, MEDICAL TECHNOLOGY, CATASTROPHIC PLANNING, MEDICARE FRAUD, MAMMOGRAPHY, PRIMARY CARE ACCESS IN FREMONT COUNTY, DRUG ASSISTANCE, ECONOMIC DEVELOPMENT, SENIOR CARE, SUICIDE PREVENTION IN SCHOOL, PHYSICIAN RETENTION, NURSES, PARAMEDICS, DOMESTIC AND SEXUAL ABUSE, EDUCATION OF EXISTING SERVICES, LAYOUT OF SMC, PSYCHIATRIST, PEDIATRICIAN, COLLABORATION BETWEEN SMC AND CLARINDA REGIONAL MEDICAL CENTER, EDUCATION OF EXISTING FACILITIES, OBESITY, TEEN PREGNANCY, SIDEWALKS AROUND SCHOOLS, SAFE WALKING AND BIKING PATH, AND HEALTHY FOOD.

SHENANDOAH MEDICAL CENTER:

PART V, SECTION B, LINE 5: PAGE COUNTY'S TOWN HALL WAS HELD OVER DINNER ON THURSDAY SEPT 6, 2012 AT THE SHENANDOAH CHAMBER AND INDUSTRY, 100 S MAPLE STREET, SHENANDOAH, IA. EXTERNAL CONSULTANTS FACILITATED THIS HOUR AND A HALF SESSION WITH FORTY THREE (43) COMMUNITY ATTENDEES. SMC CONSULTED WITH VVV RESEARCH & DEVELOPMENT, INC. FOR THIS NEEDS ASSESSMENT.

SHENANDOAH MEDICAL CENTER:

PART V, SECTION B, LINE 11: AFTER COLLABORATING WITH COMMUNITY STAKEHOLDERS REGARDING THE HEALTH NEEDS OF ITS COMMUNITY, SHENANDOAH

Part V Facility Information *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e. 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2" "B, 3," etc.) and name of hospital facility.

MEDICAL CENTER (SMC) GATHERED WITH REPRESENTATIVES FROM MANY OTHER ORGANIZATIONS THAT HAD ORIGINALLY WORKED ON THE CHNA TO EVALUATE THE FINDINGS AND COMPOSE AN IMPLEMENTATION STRATEGY. THERE WERE ITEMS CONTAINED WITHIN THE REPORT THAT WERE PRIORITIZED FOR COMPLETION BY SMC, WHICH INCLUDED BUDGETING CASH OUTLAYS TO ADDRESS THE PRIORITIES, WHICH ARE DESCRIBED BELOW. WHILE THERE WERE ITEMS THAT SMC AND OTHER STAKEHOLDERS FELT COULD NOT BE IMPACTED BY THE FACILITY, PLANS WERE DEVELOPED BY OTHER ORGANIZATIONS TO COLLABORATE IN MEETING THOSE NEEDS. OTHER ITEMS, WHICH WERE DETERMINED TO BE OF A LOWER PRIORITY WERE PLANNED TO BE ADDRESSED IN FUTURE YEARS. THE IMPLEMENTATION STRATEGY WAS COLLECTIVELY AGREED UPON AND HAS CONTINUED TO BE MONITORED BY THE ORGANIZATIONS MOVING FORWARD. SMC ASSISTED IN EDUCATING ITS COMMUNITY ON HEALTH REFORM LAW INSURANCE OPTIONS BY UTILIZING ITS FINANCIAL ASSISTANCE COUNSELOR AND SOCIAL SERVICES DIRECTOR TO PROVIDE INSURANCE INFORMATION TO PATIENTS AND ASSIST THEM IN ENROLLMENT IN MEDICAID AND MEDICARE IN ORDER TO LOWER THE UNINSURED AND UNDERINSURED POPULATION. ADDITIONALLY, THE FACILITY INVESTED IN A CONNECTION WITH THE IHIN, WHICH ALLOWS PATIENTS TO ACCESS THEIR MEDICAL INFORMATION FROM NUMEROUS FACILITIES IN IOWA. FURTHERMORE, AN INVESTMENT IN A PATIENT PORTAL THAT IS COMPATIBLE WITH SMC'S ELECTRONIC MEDICAL RECORD SYSTEM ALSO OCCURRED IN ORDER TO ASSIST WITH THE BUILDING OF THE HEALTH INTERNET INFRASTRUCTURE. ANOTHER ITEM OF IMPORTANCE IDENTIFIED BY THE ASSESSMENT WAS THE NEED TO IMPROVE CHILDREN'S ACCESS TO IMMUNIZATIONS. SMC NOW PARTICIPATES IN A PROGRAM TO PROVIDE FREE AND REDUCED PRICE VACCINATIONS FOR CHILDREN AND INFANTS. IN ORDER TO RETAIN AND RECRUIT PROVIDERS, SMC HAS INVESTED NUMEROUS DOLLARS TO ADD THREE ADDITIONAL PHYSICIANS AND ONE ADVANCED REGISTERED NURSE PRACTITIONER DURING 2013. IN ORDER TO SUPPORT VETERAN CARE DELIVERY, THE FACILITY

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

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2" "B, 3," etc.) and name of hospital facility.

BECAME A PREFERRED PROVIDER TO CONDUCT VETERANS' DISABILITY EXAMS AND ALSO EXPANDED ITS HOME HEALTH AND HOSPICE COVERAGE TO VETERANS THROUGH THE "WE HONOR VETERANS" PROGRAM. ADDITIONAL EDUCATION IN WORKING WITH MENTAL HEALTH PATIENTS HAS BEEN PROVIDED TO STAFF MEMBERS IN THE EMERGENCY ROOM AND PRIMARY CARE CLINICS TO HELP EXPAND THE MENTAL HEALTH DELIVERY IN PAGE AND FREMONT COUNTIES. TO HELP FIGHT DRUG ABUSE, NUMEROUS EDUCATIONAL SESSIONS ON THE APPROPRIATE MAINTENANCE OF PATIENTS WITH OPIATES PRESCRIPTIONS WERE HELD WITH PROVIDERS. NEEDS THAT DID NOT GET DIRECTLY ADDRESSED INCLUDE SUPPORTING COMMUNITY ECONOMIC DEVELOPMENT OUTSIDE OF THE NUMBER OF JOBS ADDED AT SHENANDOAH MEDICAL CENTER IN 2014. ADDITIONALLY, SMC DID NOT WORK ON BUILDING A SAFE WALKING/BIKING PATH IN THE COMMUNITY OR REDUCING TEEN PREGNANCY IN OUR SERVICE AREA. OTHER ITEMS THAT DID NOT GET ADDRESSED BY SMC THIS YEAR WERE THE BUILDING OF A SCHOOL SUICIDE PREVENTION PROGRAM AND FIGHTING DOMESTIC AND SEXUAL ABUSE. ALL ITEMS NOT ADDRESSED WERE CONSIDERED NOT RELATED TO THE FACILITY'S MISSION CRITICAL OPERATIONS. AS A RESULT, SMC WILL CONTINUE TO HELP SUPPORT COMMUNITY PARTNERS TO ADDRESS THOSE NEEDS.

SHENANDOAH MEDICAL CENTER:

PART V, SECTION B, LINE 22D: THE INDIVIDUALS WHO DID NOT HAVE INSURANCE ARE GIVEN A 30% UNINSURED DISCOUNT. ANY INDIVIDUAL COMPLETING THE FINANCIAL ASSISTANCE APPLICATION ALSO RECEIVED AN AUTOMATIC ADDITIONAL 20% DISCOUNT TO ENSURE THAT THE HOSPITAL WAS CHARGING NO MORE THAN THE AVERAGE OF ITS THREE LOWEST NEGOTIATED COMMERCIAL INSURANCE RATES.

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 ELM HEIGHTS CARE CENTER 1204 SOUTH ELM STREET SHENANDOAH, IA 51601	NURSING HOME
2 SHENANDOAH MEDICAL CENTER 300 PARK AVENUE SHENANDOAH, IA 51601	MEDICAL CLINIC
3 FREMONT COUNTY MEDICAL CENTER 802 ILLINOIS STREET FREMONT, IA 52561	SIDNEY CLINIC
4 SHENANDOAH MEDICAL CENTER 2 JACK FOSTER DRIVE SHENANDOAH, IA 51601	WELLNESS CENTER
5 ESSEX HEALTH CENTER 527 IOWA AVENUE ESSEX, IA 51638	ESSEX CLINIC

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.

PART I, LINE 3C:

NOT APPLICABLE

PART I, LINE 6A:

THE ANNUAL COMMUNITY BENEFIT REPORT WAS NOT PREPARED BY A RELATED ORGANIZATION.

PART I, LN 7 COL(F):

THE BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25, BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGE IN THIS COLUMN IS $3,350,700.

PART II, COMMUNITY BUILDING ACTIVITIES:

SHENANDOAH MEDICAL CENTER PROVIDES JOB SHADOWING TO STUDENTS OF SHENANDOAH, PHLEBOTOMY STUDENT ROTATIONS, CLARKSON/METHODIST STUDENTS JOB SHADOWING, CNA CLASSES FOR SHENANDOAH HIGH SCHOOL STUDENTS, MENTORING OF STUDENTS BY SMC STAFF, AND IS INVOLVED IN THE FREMONT/PAGE COUNTY PREVENT CHILD ABUSE GROUP AND BREAST CANCER AWARENESS. THESE ACTIVITIES HELP TO

Part VI Supplemental Information *(Continuation)*

FURTHER THE EDUCATION OF THE COMMUNITY ON HEALTH IMPROVEMENT AND MAINTENANCE AND ALSO ASSIST IN THE DEVELOPMENT OF LOCAL INDIVIDUALS IN BECOMING HEALTH CARE PROFESSIONALS.

PART III, LINE 2:

ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FOR DOUBTFUL ACCOUNTS. IN EVALUATING THE COLLECTIBILITY OF ACCOUNTS RECEIVABLE, THE MEDICAL CENTER ANALYZES ITS PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYER SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR DOUBTFUL ACCOUNTS AND PROVISION FOR BAD DEBTS. MANAGEMENT REGULARLY REVIEWS DATA ABOUT THESE MAJOR PAYER SOURCES OF REVENUE IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS.

PART III, LINE 3:

THE MEDICAL CENTER PROVIDES CHARITY CARE TO PATIENTS WHO ARE FINANCIALLY UNABLE TO PAY FOR THE HEALTHCARE SERVICES THEY RECEIVE. IT IS THE POLICY OF THE MEDICAL CENTER NOT TO PURSUE COLLECTION OF AMOUNTS DETERMINED TO QUALIFY AS CHARITY CARE. ACCORDINGLY, THE MEDICAL CENTER DOES NOT REPORT THESE AMOUNTS IN NET PATIENT SERVICE REVENUE OR IN THE ALLOWANCE FOR DOUBTFUL ACCOUNTS. THE MEDICAL CENTER DETERMINES THE COSTS ASSOCIATED WITH PROVIDING CHARITY CARE BY AGGREGATING THE DIRECT AND INDIRECT COSTS, INCLUDING SALARIES, BENEFITS, SUPPLIES, AND OTHER OPERATING EXPENSES, BASED ON AN OVERALL COST TO CHARGE RATIO.

PART III, LINE 4:

THE ORGANIZATION'S FINANCIAL STATEMENTS DO NOT CONTAIN A SPECIFIC FOOTNOTE DESCRIBING BAD DEBT. HOWEVER, THE FOLLOWING IS THE TEXT OF THE FOOTNOTES TITLED "PATIENT ACCOUNTS RECEIVABLE," "NET PATIENT SERVICE REVENUE," AND

Part VI Supplemental Information (Continuation)

"CHARITY CARE":

PATIENT ACCOUNTS RECEIVABLE:

THE MEDICAL CENTER REPORTS PATIENT ACCOUNTS RECEIVABLE FOR SERVICES RENDERED AT NET REALIZABLE AMOUNTS FROM THIRD-PARTY PAYERS, PATIENTS, AND OTHERS. ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FOR DOUBTFUL ACCOUNTS. IN EVALUATING THE COLLECTIBILITY OF ACCOUNTS RECEIVABLE, THE MEDICAL CENTER ANALYZES ITS PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYER SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR DOUBTFUL ACCOUNTS AND PROVISION FOR BAD DEBTS. MANAGEMENT REGULARLY REVIEWS DATA ABOUT THESE MAJOR PAYER SOURCES OF REVENUE IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS.

FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, THE MEDICAL CENTER ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND A PROVISION FOR BAD DEBTS FOR THOSE ACCOUNTS OVER A CERTAIN AGE BASED ON DISCHARGE THAT MAKE THE REALIZATION OF AMOUNTS DUE UNLIKELY. FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS (WHICH INCLUDES BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND COPAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL), THE MEDICAL CENTER RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATES THAT MANY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE. THE DIFFERENCE BETWEEN THE STANDARD RATES (OR THE DISCOUNTED RATES IF NEGOTIATED) AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN

Part VI Supplemental Information *(Continuation)*

EXHAUSTED IS CHARGED OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS.

NET PATIENT SERVICE REVENUE:

THE MEDICAL CENTER HAS AGREEMENTS WITH THIRD-PARTY PAYORS THAT PROVIDE FOR PAYMENTS TO THE MEDICAL CENTER AT AMOUNTS DIFFERENT FROM ITS ESTABLISHED RATES. PAYMENT ARRANGEMENTS INCLUDE PROSPECTIVELY DETERMINED RATES PER DISCHARGE, REIMBURSED COSTS, DISCOUNTED CHARGES, AND PER DIEM PAYMENTS. NET PATIENT SERVICE REVENUE IS REPORTED AT THE ESTIMATED NET REALIZABLE AMOUNTS FROM PATIENTS, THIRD-PARTY PAYORS, AND OTHERS FOR SERVICES RENDERED, INCLUDING ESTIMATED RETROACTIVE ADJUSTMENTS UNDER REIMBURSEMENT AGREEMENTS WITH THIRD-PARTY PAYORS. RETROACTIVE ADJUSTMENTS ARE ACCRUED ON AN ESTIMATED BASIS IN THE PERIOD THE RELATED SERVICES ARE RENDERED AND ADJUSTED IN FUTURE PERIODS AS FINAL SETTLEMENTS ARE DETERMINED.

CHARITY CARE:

THE MEDICAL CENTER PROVIDES CARE TO PATIENTS WHO MEET CERTAIN CRITERIA UNDER ITS CHARITY CARE POLICY WITHOUT CHARGE OR AT AMOUNTS LESS THAN ITS ESTABLISHED RATES. BECAUSE THE MEDICAL CENTER DOES NOT PURSUE COLLECTION OF AMOUNTS DETERMINED TO QUALIFY AS CHARITY CARE, THEY ARE NOT REPORTED AS REVENUE.

THE MEDICAL CENTER IS DEDICATED TO PROVIDING COMPREHENSIVE HEALTHCARE SERVICES TO ALL SEGMENTS OF SOCIETY, INCLUDING THE AGED AND OTHERWISE ECONOMICALLY DISADVANTAGED. IN ADDITION, THE MEDICAL CENTER PROVIDES A VARIETY OF COMMUNITY HEALTH SERVICES AT OR BELOW COST.

PART III, LINE 8:

Part VI Supplemental Information *(Continuation)*

THE MEDICARE SHORTFALL SHOULD BE CONSIDERED A COMMUNITY BENEFIT BECAUSE IT REPRESENTS UNCOMPENSATED CARE PROVIDED TO INDIVIDUALS IN THE SHENANDOAH AND SURROUNDING COMMUNITIES. IT HAS BEEN DETERMINED BASED ON THE OVERALL MEDICARE ALLOWABLE COST AS A PERCENT OF TOTAL CHARGES, APPLIED TO THE TOTAL MEDICARE CHARGES.

PART III, LINE 9B:

ONCE A PATIENT HAS BEEN DEEMED ELIGIBLE FOR FINANCIAL ASSISTANCE, THE PATIENT'S ACCOUNT IS UPDATED WITH THE APPROPRIATE AMOUNT OF FINANCIAL ASSISTANCE. IF A PATIENT HAS HAD ALL ACCOUNTS GRANTED FULL FINANCIAL ASSISTANCE, THE PATIENT RECEIVES NOTICE THAT ALL OBLIGATIONS HAVE BEEN SATISFIED. IF THERE IS A REMAINING PATIENT BALANCE, SMC'S FINANCIAL COUNSELOR WORKS CLOSELY WITH THE PATIENT TO AGREE UPON A PAYMENT PLAN THAT IS FINANCIALLY FEASIBLE FOR THE PATIENT.

PART VI, LINE 2:

THE ORGANIZATION'S LEADERSHIP INFORMALLY MEETS WITH LEADERS IN THE COMMUNITY TO DISCUSS COMMUNITY ISSUES, AS WELL AS ATTEMPTS TO IDENTIFY AREAS WHERE SMC CAN BE OF SERVICE TO THE EMPLOYERS IN THE COMMUNITY.

PART VI, LINE 3:

THE FINANCIAL ASSISTANCE APPLICATION IS PROVIDED TO ALL PATIENTS ON THE WEBSITE. ADDITIONALLY, OUR THIRD PARTY SELF-PAY ORGANIZATION MAILS APPLICATIONS TO THOSE PATIENTS WHO INDICATE THAT THEY DO NOT HAVE THE MEANS TO PAY THEIR ACCOUNTS. UPON CONTACT AT SMC, OUR SOCIAL SERVICES REPRESENTATIVE AND PATIENT ACCOUNT COUNSELOR DISCUSS OPTIONS WITH PATIENTS AND ALSO ASSIST IN THE COMPLETION OF THE FINANCIAL ASSISTANCE APPLICATIONS, MEDICARE AND MEDICAID APPLICATIONS IF APPLICABLE, AND MAKING

Part VI Supplemental Information *(Continuation)*

ANY OTHER ARRANGEMENTS NECESSARY TO ASSIST PATIENTS IN FINANCIALLY SATISFYING THEIR OBLIGATIONS.

PART VI, LINE 4:

THE MEDIAN HOUSEHOLD INCOME WAS $43,010 AND $50,520 FOR PAGE AND FREMONT COUNTIES, RESPECTIVELY IN 2013, AS COMPARED TO THE STATE MEDIAN HOUSEHOLD INCOME OF $51,843. AS A BYPRODUCT OF THE MEDIAN HOUSEHOLD INCOME IN THE SERVICE AREA, SHENANDOAH MEDICAL CENTER TREATS A SIGNIFICANT NUMBER OF MEDICAID, UNINSURED, AND UNDERINSURED PATIENTS. THE AREA POPULATION IS PREDOMINATELY WHITE, NON-HISPANIC.

PART VI, LINE 5:

IN ADDITION TO ITS EFFORTS TO ADDRESS THE NEEDS IDENTIFIED BY ITS COMMUNITY HEALTH NEEDS ASSESSMENT, THE FACILITY ALSO HAS AN ACTIVE INTERNAL WELLNESS PROGRAM THAT IT IS ATTEMPTING TO ROLL-OUT IN ITS COMMUNITY. ADDITIONALLY, THE HOSPITAL OPERATES A WELLNESS CENTER THAT PROVIDES VERY AFFORDABLE MEMBERSHIP RATES AND PERSONAL TRAINING OPTIONS TO HELP PROMOTE WELLNESS IN THE COMMUNITY.

PART VI, LINE 6:

SMC IS NOT PART OF AN AFFILIATED HEALTH CARE SYSTEM.

SCHEDULE I
(Form 990)

Department of the Treasury
Internal Revenue Service

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

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

▶ Attach to Form 990.

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

OMB No. 1545-0047

2014

Open to Public Inspection

Name of the organization
SHENANDOAH MEDICAL CENTER

Employer identification number
42-1101835

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? ..... [X] 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" to Form 990, Part IV, line 21, for any recipient that received more than $5,000. Part II can be duplicated if additional space is needed.

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
SHENANDOAH HEALTH CARE FOUNDATION 300 PARK AVENUE SHENANDOAH, IA 51601	42-1471184	501(C)(3)	69,130.	0.			GENERAL SUPPORT

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

3 Enter total number of other organizations listed in the line 1 table ..... ▶ 0.

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

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

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

PART I, LINE 2:

SHENANDOAH MEDICAL CENTER OVERSEES THE OPERATING EXPENSES OF THE FOUNDATION, THEREFORE, IT DIRECTLY MONITORS THE USE OF THE GRANT FUNDS.

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.

▶ Information about Schedule J (Form 990) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2014

Open to Public Inspection

Name of the organization: SHENANDOAH MEDICAL CENTER

Employer identification number: 42-1101835

Part I Questions Regarding Compensation

		Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.		
	☐ First-class or charter travel		
	☐ Travel for companions		
	☐ Tax indemnification and gross-up payments		
	☐ Discretionary spending account		
	☒ Housing allowance or residence for personal use		
	☐ Payments for business use of personal residence		
	☐ Health or social club dues or initiation fees		
	☐ Personal services (e.g., maid, chauffeur, chef)		
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain 1b	X	
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked in line 1a? 2	X	
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.		
	☐ Compensation committee		
	☐ Independent compensation consultant		
	☐ Form 990 of other organizations		
	☐ Written employment contract		
	☒ Compensation survey or study		
	☒ Approval by the board or compensation committee		
4	During the year, did any person listed in Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:		
a	Receive a severance payment or change-of-control payment? 4a		X
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan? 4b		X
c	Participate in, or receive payment from, an equity-based compensation arrangement? 4c		X
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.		
	Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.		
5	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:		
a	The organization? 5a	X	
b	Any related organization? 5b		X
	If "Yes" to line 5a or 5b, describe in Part III.		
6	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:		
a	The organization? 6a		X
b	Any related organization? 6b		X
	If "Yes" to line 6a or 6b, describe in Part III.		
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III 7		X
8	Were any amounts reported in 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 8		X
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)? 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 in 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 in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) KAREN COLE	(i)	201,132.	40,000.	1,919.	12,429.	20,662.	276,142.	0.
CEO	(ii)	0.	0.	0.	0.	0.	0.	0.
(2) MATTHEW SELLS	(i)	104,463.	28,714.	88.	2,721.	23,008.	158,994.	0.
CFO	(ii)	0.	0.	0.	0.	0.	0.	0.
(3) SCOTT R KING	(i)	239,864.	196,112.	2,420.	13,097.	25,391.	476,884.	0.
PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.
(4) REBECCA ROSE	(i)	350,400.	44,478.	1,174.	0.	13,935.	409,987.	0.
PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.
(5) SANTOSH KUMAR	(i)	270,766.	0.	239.	11,226.	21,601.	303,832.	0.
PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.
(6) MICHAEL WOODS	(i)	309,784.	0.	2,094.	3,959.	32,190.	348,027.	0.
PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.
(7) SATYA THIPPAREDDI	(i)	218,766.	20,000.	688.	10,590.	6,492.	256,536.	0.
PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

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.

PART I, LINE 1A:

THE MEDICAL CENTER OFFERS TEMPORARY HOUSING TO CERTAIN NEW EMPLOYEES TO ASSIST THEM IN RELOCATING TO SHENANDOAH WHILE THEY FIND SUITABLE HOUSING. THE TEMPORARY HOUSING WAS USED BY DENNIS CUMMINGS AND WAYNE JOHNSON DURING 2014. THE FAIR VALUE OF THE HOUSING PROVIDED WAS TREATED AS TAXABLE INCOME TO THEM.

PART I, LINE 5:

DR. SCOTT KING RECEIVED A BONUS BASED ON REVENUES. THE FORMULA FOR CALCULATING DR. KING'S BONUS IS: GROSS CHARGES X .317 LESS COMPENSATION, BENEFITS AND CONTINUING MEDICAL EDUCATION EXPENSES.

SCHEDULE L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.
▶ Attach to Form 990 or Form 990-EZ.
▶ Information about Schedule L (Form 990 or 990-EZ) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2014

Open To Public Inspection

Name of the organization: SHENANDOAH MEDICAL CENTER

Employer identification number: 42-1101835

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	(d) Corrected? No

2 Enter the amount of tax incurred by the 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? To	(d) Loan to or from the organization? From	(e) Original principal amount	(f) Balance due	(g) In default? Yes	(g) In default? No	(h) Approved by board or committee? Yes	(h) Approved by board or committee? No	(i) Written agreement? Yes	(i) Written agreement? 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	(e) Sharing of organization's revenues? No
ALICIA SELLS	EMPLOYEE OF ORGANIZ	38,472.	EMPLOYEES W		X
CODY AUGUSTINE	EMPLOYEE OF ORGANIZ	10,994.	EMPLOYEES W		X

Part V Supplemental Information

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

SCH L, PART IV, BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS:

(A) NAME OF PERSON: ALICIA SELLS

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

EMPLOYEE OF ORGANIZATION AND WIFE OF MATTHEW SELLS, CFO

(D) DESCRIPTION OF TRANSACTION: EMPLOYEES W-2 WAGES

(A) NAME OF PERSON: CODY AUGUSTINE

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

EMPLOYEE OF ORGANIZATION AND SON OF TIM AUGUSTINE, BOARD MEMBER

(D) DESCRIPTION OF TRANSACTION: EMPLOYEES W-2 WAGES

SCHEDULE O (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2014

Open to Public Inspection

Name of the organization: SHENANDOAH MEDICAL CENTER

Employer identification number: 42-1101835

FORM 990, PART I, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

COMMUNITIES WITHOUT REGARD FOR ABILITY TO PAY AND WITHOUT DISCRIMINATION.

FORM 990, PART VI, SECTION A, LINE 6:

THE CORPORATION SHALL HAVE TWO CLASSES OF MEMBERS, DESIGNATED CLASS A MEMBERS AND CLASS B MEMBERS. THE CLASS A MEMBERS SHALL BE ALL OF THOSE INDIVIDUALS THEN SERVING AS DULY ELECTED MEMBERS OF THE BOARD OF DIRECTORS OF THE CORPORATION, EXCEPT FOR THAT PERSON NOMINATED TO THE BOARD OF DIRECTORS BY THE CLASS B MEMBER. THE CLASS B MEMBER SHALL BE SHENANDOAH/NHS REGIONAL VENTURES, LLC, AN IOWA LIMITED LIABILITY COMPANY.

FORM 990, PART VI, SECTION A, LINE 7A:

THE CLASS B MEMBER SHALL HAVE THE RIGHT TO NOMINATE ONE PERSON TO SERVE ON THE BOARD OF DIRECTORS OF THE CORPORATION. THE PERSON SO NOMINATED SHALL BE A PHYSICIAN HAVING ACTIVE STAFF PRIVILEGES AT THE CORPORATION'S HOSPITAL, WHO RESIDES IN MILLS, PAGE, FREMONT, MONTGOMERY OR TAYLOR COUNTIES, IOWA, OR ATHISON OR HOLT COUNTIES, MISSOURI.

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

THE FORM 990 WAS REVIEWED BY THE CEO, CFO, AND GOVERNING BOARD PRIOR TO FILING WITH THE IRS.

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

THE ORGANIZATION'S CONFLICT OF INTEREST POLICY IS ENFORCED BY THE CEO AND COMPLIANCE OFFICER. ALL BOARD MEMBERS AND EXECUTIVES ARE REQUIRED TO

Name of the organization: SHENANDOAH MEDICAL CENTER | Employer identification number: 42-1101835

DISCLOSE ANY CONFLICTS OF INTEREST THAT ARE PRESENTED. ON AN ANNUAL BASIS, A SUMMARY OF ALL CONFLICTS IDENTIFIED DURING THE YEAR ARE PRESENTED TO THE BOARD OF DIRECTORS FOR REVIEW AS PART OF THE ANNUAL COMPLIANCE SUMMARY. WHEN A CONFLICT OF INTEREST IS IDENTIFIED, THE INDIVIDUAL POSSESSING THE CONFLICT IS NOT ALLOWED TO PROVIDE INPUT ON THE SUBJECT AND IS REQUIRED TO ABSTAIN FROM ANY RELATED VOTING.

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

THE COMPENSATION OF THE ORGANIZATION'S CEO WAS REVIEWED AND AUTHORIZED BY THE BOARD OF DIRECTORS. SMC ALSO PARTICIPATES IN THE IOWA HOSPITAL ASSOCIATION SALARY SURVEY AND THE RESULTS ARE SHARED WITH THE BOARD OF DIRECTORS WHEN SETTING THE COMPENSATION FOR THE CEO.

FORM 990, PART VI, SECTION C, LINE 19:

THE ORGANIZATION MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS AVAILABLE FOR PUBLIC INSPECTION UPON REQUEST.

FORM 990, PART IX, LINE 11G, OTHER FEES:

LAB FEES:

PROGRAM SERVICE EXPENSES	302,621.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	302,621.

CONTRACT LABOR:

PROGRAM SERVICE EXPENSES	832,523.
MANAGEMENT AND GENERAL EXPENSES	13,160.

Name of the organization: SHENANDOAH MEDICAL CENTER

Employer identification number: 42-1101835

FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	845,683.
PROFESSIONAL FEES:	
PROGRAM SERVICE EXPENSES	3,660.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	3,660.
CONSULTING FEES:	
PROGRAM SERVICE EXPENSES	50,942.
MANAGEMENT AND GENERAL EXPENSES	109,451.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	160,393.
OTHER FEES FOR SERVICE:	
PROGRAM SERVICE EXPENSES	1,392,958.
MANAGEMENT AND GENERAL EXPENSES	1,017,465.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	2,410,423.
TOTAL OTHER FEES ON FORM 990, PART IX, LINE 11G, COL A	3,722,780.
FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:	
CHANGE IN VALUE OF BENEFICIAL INTEREST IN PERPETUAL TRUST	83,056.
GAIN ON EQUITY IN SHENANDOAH AMBULANCE SERVICE	11,623.
TOTAL TO FORM 990, PART XI, LINE 9	94,679.
FORM 990, PART XII, LINE 2C:	

Name of the organization: SHENANDOAH MEDICAL CENTER

Employer identification number: 42-1101835

THE BOARD OF DIRECTORS ASSUMES THE RESPONSIBILITY FOR OVERSIGHT OF THE AUDIT OF SMC'S FINANCIAL STATEMENTS AND THE SELECTION OF AN INDEPENDENT ACCOUNTANT. THIS PROCESS HAS NOT CHANGED FROM THE PRIOR YEAR.

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.

▶ Attach to Form 990.

▶Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990

OMB No. 1545-0047

2014

Open to Public Inspection

Name of the organization

SHENANDOAH MEDICAL CENTER

Employer identification number

42-1101835

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) No
SHENANDOAH MEDICAL CENTER FOUNDATION - 42-1471184, 300 PERSHING AVENUE, SHENANDOAH, IA 51601	SUPPORT SHENANDOAH MEDICAL CENTER	IOWA	501(C)(3)	LINE 11A, I	SHENANDOAH MEDICAL CENTER	X	

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

Schedule R (Form 990) 2014

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

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

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	(i) No

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

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

			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		X
b	Gift, grant, or capital contribution to related organization(s)	1b	X	
c	Gift, grant, or capital contribution from related organization(s)	1c	X	
d	Loans or loan guarantees to or for related organization(s)	1d		X
e	Loans or loan guarantees by related organization(s)	1e		X
f	Dividends from related organization(s)	1f		X
g	Sale of assets to related organization(s)	1g		X
h	Purchase of assets from related organization(s)	1h		X
i	Exchange of assets with related organization(s)	1i		X
j	Lease of facilities, equipment, or other assets to related organization(s)	1j		X
k	Lease of facilities, equipment, or other assets from related organization(s)	1k		X
l	Performance of services or membership or fundraising solicitations for related organization(s)	1l		X
m	Performance of services or membership or fundraising solicitations by related organization(s)	1m		X
n	Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n	X	
o	Sharing of paid employees with related organization(s)	1o	X	
p	Reimbursement paid to related organization(s) for expenses	1p		X
q	Reimbursement paid by related organization(s) for expenses	1q		X
r	Other transfer of cash or property to related organization(s)	1r		X
s	Other transfer of cash or property from related organization(s)	1s		X

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

	(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)	SHENANDOAH MEDICAL CENTER FOUNDATION	B	69,130.	CASH - FMV
(2)				
(3)				
(4)				
(5)				
(6)				

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners sec. 501(c)(3) orgs.? Yes	(e) No	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership

Part VII Supplemental Information

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

- If you are filing for an **Additional (Not Automatic) 3-Month Extension, complete only Part II** and check this box ▶ X

Note. Only complete Part II if you have already been granted an automatic 3-month extension on a previously filed Form 8868.

- If you are filing for an **Automatic 3-Month Extension, complete only Part I** (on page 1).

Part II Additional (Not Automatic) 3-Month Extension of Time. Only file the original (no copies needed).

Enter filer's identifying number, see instructions

Type or print File by the due date for filing your return. See instructions.	Name of exempt organization or other filer, see instructions.	Employer identification number (EIN) or
	SHENANDOAH MEDICAL CENTER	42-1101835
	Number, street, and room or suite no. If a P.O. box, see instructions. 300 PERSHING AVENUE	Social security number (SSN)
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. SHENANDOAH, IA 51601	

Enter the Return code for the return that this application is for (file a separate application for each return) 0 1

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01		
Form 990-BL	02	Form 1041-A	08
Form 4720 (individual)	03	Form 4720 (other than individual)	09
Form 990-PF	04	Form 5227	10
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 6069	11
Form 990-T (trust other than above)	06	Form 8870	12

STOP! Do not complete Part II if you were not already granted an automatic 3-month extension on a previously filed Form 8868.

- The books are in the care of ▶ MATTHEW SELLS, CFO 300 PERSHING AVENUE - SHENANDOAH, IA 51601
  Telephone No. ▶ 712-246-1230 Fax No. ▶
- If the organization does not have an office or place of business in the United States, check this box ▶ ☐
- If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) _____. If this is for the whole group, check this box ▶ ☐. If it is for part of the group, check this box ▶ ☐ and attach a list with the names and EINs of all members the extension is for.

4 I request an additional 3-month extension of time until NOVEMBER 15, 2015.

5 For calendar year 2014, or other tax year beginning _____, and ending _____.

6 If the tax year entered in line 5 is for less than 12 months, check reason: ☐ Initial return ☐ Final return
☐ Change in accounting period

7 State in detail why you need the extension
ALL OF THE INFORMATION NECESSARY TO FILE A COMPLETE AND ACCURATE RETURN IS NOT YET AVAILABLE.

8a	If this application is for Forms 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	8a	$	0.
b	If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit and any amount paid previously with Form 8868.	8b	$	0.
c	**Balance due.** Subtract line 8b from line 8a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	8c	$	0.

Signature and Verification must be completed for Part II only.

Under penalties of perjury, I declare that I have examined this form, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete, and that I am authorized to prepare this form.

Signature ▶ Title ▶ CPA Date ▶