Wayne Memorial Hospital
Hospital Transparency Requirements
Alternative 990 for Non-reporting Hospitals
June 30th

Organization Name	Wayne Memorial Hospital
Doing Business As	Wayne Memorial Hospital
Fiscal Year Start Date	July 1st
Fiscal Year End Date	June 30th
Employer Identification Number (EIN)	58-6011876
Primary Contact	Greg Jones, CFO

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#VALUE!				
(B) Check if applicable		Wayne Memorial Hospital	Wayne Memorial Hospital	(D) Employer Identification Number
Address Change		Wayne Memorial Hospital	Wayne Memorial Hospital	58-011876
Name Change		Number and street (or P.O. box if not delivered to street address	Room/suite	(E) Telephone Number
Initial Return		865 S First Street		912-427-6811
Final return/terminated		City or town, state or province, country, and ZIP or foreign postal code		H(a) Is this a group return for subordinates?
Amended return		Jesup, GA 31545		
Application pending		(F) Name and address of principal filer		H(b) Are all subordinates included?
		Joseph Ierardi		

		Yes/No
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I	No
4	Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II	No
20a	Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H	No
20b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? If "Yes," complete Schedule I, Parts I and II	No
22	Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? If "Yes," complete Schedule I, Parts I and III	No
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5, about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? If "Yes," complete Schedule	No
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? If "Yes," complete Schedule R, Part I	No
34	Was the organization related to any tax-exempt or taxable entity? If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1	No
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	No
35b	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? If "Yes," complete Schedule R, Part V, line 2	
36	Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? If "Yes," complete Schedule R, Part V, line 2	No
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? If "Yes," complete Schedule R, Part VI	No

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Part V	Statements Regarding Other IRS Filings and Tax Compliance			
				Yes/No
1a	Enter the number of reported in box 3 of Form 1096. Enter -0- if not applicable.	1a	0	
b	Enter the number of Forms W-2G included on line 1a. Enter -0- if not applicable.	1b	0	
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winning to prize winners?		1c	
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	**475**	
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?		2b	Yes
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?		3a	No
b	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in the space provided below.		3b	
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	No
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).	4b		
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	No
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	No
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		7h	No
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? If "No," provide an explanation in the space provided below.		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?		15	No

Part V	Additional Comments

Part V Statements Regarding Other IRS Filings and Tax Compliance

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Part VI	**Governance, Management, and Disclosure.** For each "Yes" response to lines 2 through 7b below, and for a "No" response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in the space provided below.			
	Section A. Governing Body and Management			**Yes/No**
1a	Enter the number of voting members of the governing body at the end of the tax year	1a	7	
b	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in the space provided below.	1b	no	
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?		2	No
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, trustees, or key employees to a management company or other person?		3	No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?		4	No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?		5	No
6	Did the organization have members or stockholders?		6	No
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?		7a	No
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?		7b	No
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
a	The governing body?		8a	Yes
b	Each committee with authority to act on behalf of the governing body?		8b	Yes
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in the space provided below.		9	No
	Section B. Policies (This Section B requests information about policies not required by the Internal Revenue Code.)			
10a	Did the organization have local chapters, branches, or affiliates?		10a	No
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?		10b	
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?		11a	
b	Describe on in the space provided below the process, if any, used by the organization to review this Form.			
12a	Did the organization have a written conflict of interest policy? If "No," go to line 13		12a	Yes
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?		12b	Yes
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in the space provided below how this was done		12c	Yes
13	Did the organization have a written whistleblower policy?		13	Yes
14	Did the organization have a written document retention and destruction policy?		14	Yes
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?			
a	The organization's CEO, Executive Director, or top management official. If "Yes" explain in space provided below.		15a	Yes
b	Other officers or key employees of the organization. I. If "Yes" explain in space provided below.		15b	Yes
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?		16a	Yes
b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?		16b	Yes
	Section C. Disclosure			
17	List the states with which a copy of this Form 990 is required to be filed	17	n/a	
18	Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A, if applicable), 990, and 990-T (section 501(c) (3)s only) available for public inspection. Indicate how you made these available. Check all that apply.	18		
	Own Website		n/a	
	Another's Website		n/a	
	Upon Request			
	Other (explain in space provided below.)			

Part VI	Governance, Management, and Disclosure. For each "Yes" response to lines 2 through 7b below, and for a "No" response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in the space provided below.			
19	Describe on in the space provided below 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.		website	
20	State the name, address, and telephone number of the person who possesses the organization's books and records.			
	Name		Debbie Priester	
	Street Address - Line 1		865 S First Street	
	Street Address - Line 2			
	City		Jesup	
	State		Georgia	
	Zip Code		31546	
	Telephone Number		912-427-6811	

Part VI	Additional Comments

All executive salaries are reviewed annually by Sullivan and Kotter

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Part VII	**Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors**
	Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees
1a	Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year. • List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid. • List all of the organization's **current** key employees, if any. See the instructions for definition of "key employee." • List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (box 5 of Form W-2, box 6 of Form 1099-MISC, and/or box 1 of Form 1099-NEC) of more than $100,000 from the organization and any related organizations. • List all of the organization's **former** officers, key employees, and highest compensated employees who received more than $100,000 of reportable compensation from the organization and any related organizations. • List all of the organization's **former** directors or trustees that received, in the capacity as a former director or trustee of the organization, more than $10,000 of reportable compensation from the organization and any related organizations. See the instructions for the order in which to list the persons above.
No	Respond "No" if neither the organization nor any related organization compensated any current officer, director, or trustee.

	(A) Name and Title	(B) Average hours per week (list any hours related to organizations below dotted line)	(C) Positions (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/1099-NEC)	(E) Reportable compensation from related organizations (W-2/1099-MISC/1099-NEC)	(F) Estimated amount of other compensation from the organization and related
			Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1)	J. Pat Perry, Chariman		x						$ -		
(2)	Brenda Purvis, Vice-Chairman		x						$ -		
(3)	David Earl Keith, Member		x						$ -		
(4)	L. Douglas Ellis, Member		x						$ -		
(5)	Melissa Thomas, Member		x						$ -		
(6)	Herman Lewis Jr., Member		x						$ -		
(7)	Dr. Lance Hendrix, Member		x						$ -		
(8)											
(9)											
(10)											
(11)											
(12)											
(13)											
(14)											
(15)											
(16)											
(17)											
(18)											
(19)											

Part VII	Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(20)											
(21)											
(22)											
(23)											
(24)											
(25)											
1b	Subtotal								$ -	$ -	$ -
c	Total from contribution sheets to Part VII, Section A										
d	Total (add lines 1b and 1c)								$ -	$ -	$ -
2	Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization										0

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

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Part VII	**Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors**		
	Section B. Independent Contractors		
1	Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.		
	(A) Name and business address	**(B)** Description of services	**(C)** Compensation
	Robert B. Smith	Part-time In house counsel	$ 144,000.00
2	Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization		1

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Schedule C	**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.		
	Name of organization Wayne Memorial Hospital	Employer identification number (EIN) 58-6011876	
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		0
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?		
4a	Was a correction made?		
b	If "Yes," describe in Part IV		
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.	**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?	No	
j	Total. Add lines 1c through 1i		$ -
2a	Did the activities in line 1 cause the organization to not be 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?		

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Schedule H	**Hospitals**				
	Wayne Memorial Hospital	Employer identification number (EIN)			
	Wayne Memorial Hospital	58-6011876			
Part I	**Financial Assistance and Certain Other Community Benefits at Cost**				
1a	Did the organization have a financial assistance policy (FAP) during the tax year? If "No," skip to question 6a		1a	Yes	
b	If "Yes," was it a written policy?		1b	Yes	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the FAP 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:		3a	Yes	
	100%	X			
	150%	X			
	200%	X			
	Other	X	295%		
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:		3b		
	200%	X			
	250%	X			
	300%				
	350%				
	400%				
	Other				
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 FAP that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?		4	Yes	
5a	Did the organization budget amounts for free or discounted care provided under its FAP during the tax year?		5a	Yes	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?		5b	Yes	
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	No	
6a	Did the organization prepare a community benefit report during the tax year?		6a	No	
b	If "Yes," did the organization make it available to the public?		6b		

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)			$2,091,034	$ -	$204,344	3%
b	Medicaid (from Worksheet 3, column a)			$12,668,445	$11,293,389	$1,375,056	2%
c	Costs of other means-tested government programs (from Worksheet 3, column b)						
d	**Total.** Financial assistance and means-tested government programs	$ -	$ -	$14,759,789	$11,293,389.00	$ 3,466,400.00	4%
	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	$ -	$ -	$ -	$ -	$ -	0%
k	**Total.** Add lines 7d and 7j	$ -	$ -	$14,759,789.00	$11,293,389.00	$ 3,466,400.00	4%

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**	$ -	$ -	$ -	$ -	$ -	0%

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

Section A. Bad Debt Expense

1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	Yes	
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	$ 19,523,910.00	
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's FAP. 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 attached financial statements.			

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	22,748,374	
6	Enter Medicare allowable costs of care relating to payments on line 5	6	28,096,001	
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-5,347,627	
8	Describe in Part VI the extent to which any shortfall reported on 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	Yes	
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b		

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)

Schedule H **Hospitals**

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

	Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility):	Licensed hospital	General medical & surgical	Children's hospital	Critical access hospital	Research facility	ER-24 hours	ER-Other	Other (describe)	Facility reporting group
1	Wayne Memorial Hospital 865 S First Street Jesup, GA 31545 www.wmhweb.com 58-6011876		X							
2										
3										
4										
5										
6										
7										
8										
9										
10										

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

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

	Name and address	Type of facility (describe)
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Part VI **Supplemental Information**

Provide the following information in the space provided below

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 FAP.

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 (for example, open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

Schedule H Hospitals

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Schedule H Part V	**Hospitals**			
	Facility Information			
	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:			Wayne Memorial Hospital
	Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group **(from Part V, Section A)**			1
	Community Health Needs Assessment (CHNA)			**Yes/No**
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**	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		**2**	No
3	During the tax year or either of the 2 immediately preceding tax years, did the hospital facility conduct a CHNA? If "No," skip to line 12. If "Yes," indicate what the CHNA report describes (check all that apply):		**3**	No
a	A definition of the community served by the hospital facility	**3a**		
b	Demographics of the community	**3b**		
c	Existing health care facilities and resources within the community that are available to respond to the health needs of the community	**3c**		
d	How data was obtained	**3d**		
e	The significant health needs of the community	**3e**		
f	Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	**3f**		
g	The process for identifying and prioritizing community health needs and services to meet the community health needs	**3g**		
h	The process for consulting with persons representing the community's interests	**3h**		
i	The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA	**3i**		
j	Other (describe in Section C)	**3j**		
4	Indicate the tax year the hospital facility last conducted a CHNA:		**4**	
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**	
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**	
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**	
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):		**7**	
a	Hospital facility's website (list url)	**7a**		
b	Other website (list url):	**7b**		
c	Made a paper copy available for public inspection without charge at the hospital facility	**7c**		
d	Other (describe in Section C)	**7d**		

Schedule H Part V	Hospitals			
	Facility Information			
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**	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20		**9**	
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?		**10**	
a	If "Yes," list url:	**10a**		
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		**10b**	
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**	No
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?			
	Financial Assistance Policy (FAP)			
	Name of hospital facility or letter of facility reporting group:	Wayne Memorial Hospital		
	Did the hospital facility have in place during the tax year a written FAP that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? 13 If "Yes," indicate the eligibility criteria explained in the FAP:		**13**	Yes
a	FPG, with FPG family income limit for eligibility for free care of and FPG family income limit	**13a**	X	
	for eligibility for discounted care of			
b	Income level other than FPG (describe in Section C below)	**13b**		
c	Asset level	**13c**		
d	Medical indigency	**13d**		
e	Insurance status	**13e**		
f	Underinsurance status	**13f**		
g	Residency	**13g**		
h	Other (describe in Section C below)	**13h**		
14	Explained the basis for calculating amounts charged to patients?		**14**	
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**	
a	Described the information the hospital facility may require an individual to provide as part of their application	**15a**		
b	Described the supporting documentation the hospital facility may require an individual to submit as part of their application	**15b**		
c	Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process	**15c**		
d	Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications	**15d**		
e	Other (describe in Section C below)	**15e**		
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**	
a	www.wmhweb.com	**16a**	X	
b	The FAP application form was widely available on a website (list url): www.wmhweb.com	**16b**	X	
c	A plain language summary of the FAP was widely available on a website (list url): www.wmhweb.com	**16c**	X	
d	The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)	**16d**	X	

Schedule H Part V	Hospitals			
	Facility Information			
e	The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)	**16e**	X	
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)	**16f**	X	
g	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	**16g**	X	
h	Notified members of the community who are most likely to require financial assistance about availability of the FAP	**16h**	X	
i	The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by limited-English proficiency (LEP) populations	**16i**	X	
j	Other (describe in Section C below)	**16j**		
	Billing and Collections			
	Name of hospital facility or letter of facility reporting group:		Wayne Memorial Hospital	
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written 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:		**18**	
a	Reporting to credit agency(ies)	**18a**	X	
b	Selling an individual's debt to another party	**18b**		
c	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	**18c**		
d	Actions that require a legal or judicial process	**18d**		
e	Other similar actions (describe in Section C)	**18e**		
f	None of these actions or other similar actions were permitted	**18f**		
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**	
a	Reporting to credit agency(ies)	**19a**		
b	Selling an individual's debt to another party	**19b**		
c	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	**19c**		
d	Actions that require a legal or judicial process	**19d**		
e	Other similar actions (describe in Section C)	**19e**		
20	Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) on line 19 (check all that apply):			
a	Provided a written notice about upcoming extraordinary collection actions (ECAs) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)		**20a**	Yes
b	Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)		**20b**	
c	Processed incomplete and complete FAP applications (if not, describe in Section C)		**20c**	
d	Made presumptive eligibility determinations (if not, describe in Section C)		**20d**	Yes
e	Other (describe in Section C)		**20e**	
f	None of these efforts were made		**20f**	

Schedule H Part V	Hospitals			
	Facility Information			
	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 FAP? If "No," indicate why:		**21**	Yes
a	The hospital facility did not provide care for any emergency medical conditions	**21a**		
b	The hospital facility's policy was not in writing	**21b**		
c	The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)	**21c**		
d	Other (describe in Section C)	**21d**		
	Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)			
	Name of hospital facility or letter of facility reporting group:			Wayne Memorial Hospital
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:		**22**	
a	The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period	**22a**		
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	**22b**		
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	**22c**		
d	The hospital facility used a prospective Medicare or Medicaid method	**22d**		
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		**23**	Yes
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		**24**	

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

Schedule H	Hospitals
Part V	Facility Information

Wayne Memorial Hospital
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Schedule I	**Grants and Other Assistance to Organizations, Governments, and Individuals In the United States**	
	Wayne Memorial Hospital	Employer identification number (EIN)
	Wayne Memorial Hospital	58-6011876
Part I	**General Information on Grants and Assistance**	
		Yes/No
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
2	Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.	
Part IV	**We purchase capital equipment with any funds we receive and keep it separate in a file.**	

Wayne Memorial Hospital
Hospital Transparency Requirements
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Schedule I	**Grants and Other Assistance to Organizations, Governments, and Individuals In the United States**							
Part II	**Grants and Other Assistance to Domestic Organizations and Domestic Governments.** Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than $5,000. Part II can be duplicated if additional space is needed.							
1	(a) Name and address of organization or government	(b) EIN	(c) IRC Section if applicable (ex. 501c3)	(d) Amount of cash grant	(e) Amount of Noncash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
(1)								
(2)								
(3)								
(4)								
(5)								
(6)								
(7)								
(8)								
(9)								
(10)								
(11)								
(12)								
2	Enter total number of section 501(c)(3) and government organizations listed in the line 1 table							
3	Enter total number of other organizations listed in the line 1 table							

Wayne Memorial Hospital
Hospital Transparency Requirements
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Schedule I Part III	**Grants and Other Assistance to Organizations, Governments, and Individuals In the United States** **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 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 non-cash assistance
1						
2						
3						
4						
5						
6						
7						

Wayne Memorial Hospital
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Schedule J	**Compensation Information**		
	Name of organization		Employer identification number (EIN)
	Wayne Memorial Hospital		58-6011876
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 on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items		
	First-class or charter travel		no
	Travel for companions		no
	Tax indemnification and gross-up payments		no
	Discretionary spending account		no
	Housing allowance or residence for personal use		no
	Payments for business use of personal residence		no
	Health or social club dues or initiation fees		no
	Personal services (such as maid, chauffeur, chef)		no
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	**1b**	
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	**2**	Yes
3	Indicate which, if any, of the following the 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		
	Compensation committee		
	Independent compensation consultant	X	
	Form 990 of other organizations		
	Written employment contract		
	Compensation survey or study	X	
	Approval by the board or compensation committee	X	
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: If "Yes" to any of lines 4a–c, list the persons and provide the applicable amounts for each item in Part III.		
a	Receive a severance payment or change-of-control payment?	**4a**	No
b	Participate in or receive payment from a supplemental nonqualified retirement plan?	**4b**	No
c	Participate in or receive payment from an equity-based compensation arrangement?	**4c**	No
	Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5–9.		
5	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of: If "Yes" on line 5a or 5b, describe in Part III.		
a	The organization?	**5a**	No
b	Any related organization?	**5b**	No
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: If "Yes" on line 6a or 6b, describe in Part III.		
a	The organization?	**6a**	No
b	Any related organization?	**6b**	No
7	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described on lines 5 and 6? If "Yes," describe in Part III	**7**	No
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	**8**	No
9	If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	**9**	
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 in the space provided below. Also complete this part for any additional information.		

Schedule J **Compensation Information**

Wayne Memorial Hospital
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Schedule J	**Compensation Information**
Part II	**Officers.** Use duplicate copies if additional space is needed.
	For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that aren't listed on Form 990, Part VII.
	Note: The sum of columns (B)(i)–(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual 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 and/or 1099-NEC 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
			(i) Base compensation	(II) Bonus & incentive compensation	(iii) Other reportable compensation				
1	J	(i)							
		(ii)						$ -	
2		(i)							
		(ii)						$ -	
3		(i)							
		(ii)						$ -	
4		(i)							
		(ii)						$ -	
5		(i)							
		(ii)						$ -	
6		(i)							
		(ii)						$ -	
7		(i)							
		(ii)						$ -	
8		(i)							
		(ii)						$ -	
9		(i)							
		(ii)						$ -	
10		(i)							
		(ii)						$ -	
11		(i)							
		(ii)						$ -	
12		(i)							
		(ii)						$ -	
13		(i)							
		(ii)						$ -	
14		(i)							
		(ii)						$ -	
15		(i)							
		(ii)						$ -	
16		(i)							
		(ii)						$ -	

Wayne Memorial Hospital
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Schedule J	**Compensation Information**
Part II	**Directors & Trustees.** Use duplicate copies if additional space is needed.
	For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that aren't listed on Form 990, Part VII.
	Note: The sum of columns (B)(i)–(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual 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 and/or 1099-NEC 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
			(i) Base compensation	(II) Bonus & incentive compensation	(iii) Other reportable compensation				
1	J. Pat Perry, Chairman	(i)							
		(ii)	0					$ -	
2	Brend Purvis, Vice Chair	(i)							
		(ii)	0					$ -	
3	L. Douglas Ellis, Member	(i)							
		(ii)	0					$ -	
4	David Earl Keith, Member	(i)							
		(ii)	0					$ -	
5	Melissa Thomas, Member	(i)							
		(ii)	0					$ -	
6	Herman Lewis, Member	(i)							
		(ii)	0					$ -	
7	Dr. Lance Hendrix	(i)							
		(ii)	0					$ -	
8		(i)							
		(ii)						$ -	
9		(i)							
		(ii)						$ -	
10		(i)							
		(ii)						$ -	
11		(i)							
		(ii)						$ -	
12		(i)							
		(ii)						$ -	
13		(i)							
		(ii)						$ -	
14		(i)							
		(ii)						$ -	
15		(i)							
		(ii)						$ -	
16		(i)							
		(ii)						$ -	

Wayne Memorial Hospital
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Schedule J	**Compensation Information**
Part II	**Key Employees.** Use duplicate copies if additional space is needed.
	For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that aren't listed on Form 990, Part VII.
	Note: The sum of columns (B)(i)–(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual 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 and/or 1099-NEC 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
			(i) Base compensation	(II) Bonus & incentive compensation	(iii) Other reportable compensation				
1	CEO	(i)							
		(ii)	293556					$ 293,556.00	
2	CFO	(i)							
		(ii)	206441					$ 206,441.00	
3	CNO	(i)							
		(ii)	159029					$ 159,029.00	
4	Dir Phmarmacy	(i)							
		(ii)	115579					$ 115,579.00	
5	Dir OR	(i)							
		(ii)	107106					$ 107,106.00	
6	Oncology Pharm	(i)							
		(ii)	107015					$ 107,015.00	
7	CHC Director	(i)							
		(ii)	105241					$ 105,241.00	
8	QA	(i)							
		(ii)	101132					$ 101,132.00	
9	IC	(i)							
		(ii)	100115					$ 100,115.00	
10	Head Nurse	(i)							
		(ii)	100041					$ 100,041.00	
11		(i)							
		(ii)						$ -	
12		(i)							
		(ii)						$ -	
13		(i)							
		(ii)						$ -	
14		(i)							
		(ii)						$ -	
15		(i)							
		(ii)						$ -	
16		(i)							
		(ii)						$ -	
17		(i)							
		(ii)						$ -	
18		(i)							
		(ii)						$ -	
19		(i)							
		(ii)						$ -	
20		(i)							
		(ii)						$ -	

Wayne Memorial Hospital
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Schedule J	**Compensation Information**
Part II	**Highest Compensated Employees.** Use duplicate copies if additional space is needed.
	For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that aren't listed on Form 990, Part VII.
	Note: The sum of columns (B)(i)–(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual 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 and/or 1099-NEC 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
			(i) Base compensation	(II) Bonus & incentive compensation	(iii) Other reportable compensation				
1	CEO	(i)							
		(ii)	293566					$ 293,566.00	
2	CFO	(i)							
		(ii)	206441					$ 206,441.00	
3	CNO	(i)							
		(ii)	159029					$ 159,029.00	
4		(i)							
		(ii)						$ -	
5		(i)							
		(ii)						$ -	
6		(i)							
		(ii)						$ -	
7		(i)							
		(ii)						$ -	
8		(i)							
		(ii)						$ -	
9		(i)							
		(ii)						$ -	
10		(i)							
		(ii)						$ -	
11		(i)							
		(ii)						$ -	
12		(i)							
		(ii)						$ -	
13		(i)							
		(ii)						$ -	
14		(i)							
		(ii)						$ -	
15		(i)							
		(ii)						$ -	
16		(i)							
		(ii)						$ -	

Wayne Memorial Hospital
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Schedule R	**Related Organization and Unrelated Partnerships**					
	Name of organization			Employer identification number (EIN)		
	Wayne Memorial Hospital			58-6011876		
Part I	**Identification of Disregarded Entities.** Complete if the organization answered "Yes" on Form 990, Part IV, line 33.					
	(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)						
(2)						
(3)						
(4)						
(5)						
(6)						

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Schedule R	**Related Organization and Unrelated Partnerships**						
Part II	**Identification of Related Tax-Exempt Organizations.** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it hadone 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?
(1)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							

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Schedule R	**Related Organization and Unrelated Partnerships**											
Part III	**Identification of Related Organizations Taxable as a Partnership.** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it had one or more related organizations treated as a partnership during the tax year.											
	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512—514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?	(i) Code V—UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?	(k) Percentage ownership
(1)											
(2)											
(3)											
(4)											
(5)											
(6)											
(7)											

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Schedule R	**Related Organization and Unrelated Partnerships**								
Part IV	Identification of Related Organizations Taxable as a Corporation or Trust. Complete if the organization answered "Yes" on Form 990, Part IV,line 34, because it had one or more related organizations treated as a corporation or trust during the tax year.								
	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) percentage ownership	(i) Section 512(b)(13) controlled entity?
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									

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Schedule R Part V	**Related Organization and Unrelated Partnerships**		
	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**	No
b	Gift, grant or capital contribution to related organizations?	**1b**	No
c	Gift, grant or capital contribution from related organizations?	**1c**	No
d	Loans or loan guarantees to or for related organizations?	**1d**	No
e	Loans or loan guarantees by related organizations?	**1e**	No
f	Dividends from related organizations?	**1f**	No
g	Sale of assets to related organizations?	**1g**	No
h	Purchase of assets from related organizations?	**1h**	No
i	Exchange of assets?	**1i**	No
j	Lease of facilities, equipment or other assets to related organizations?	**1j**	No
k	Lease of facilities, equipment or other assets from related organizations?	**1k**	No
l	Performance of services or membership or fundraising solicitations for related organizations?	**1l**	No
m	Performance of services or membership or fundraising solicitations by related organizations?	**1m**	No
n	Sharing of facilities, equipment, mailing lists or other assets?	**1n**	No
o	Sharing of paid employees?	**1o**	No
p	Reimbursement paid to related organizations for expenses?	**1p**	No
q	Reimbursement paid by related organizations for expenses?	**1q**	No
r	Other transfer of cash or property to related organizations?	**1r**	No
s	Other transfer of cash or property from related organizations?	**1s**	No

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 controlled organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
1				
2				
3				
4				
5				
6				

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Schedule R **Related Organization and Unrelated Partnerships**

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	(e) Are all partners section 501c)(3) organizations?	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?	(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?	(k) Percentage ownership
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											

Part VII **Supplemental Information** Provide additional information for responses to questions on Schedule R in the space provided below. See instructions.

Schedule R

Related Organization and Unrelated Partnerships

Worksheet 1 Financial Assistance at Cost (Part I, line 7a)	Schedule H Total
Gross patient Charges	
1 Amount of gross patient charges written off under financial assistance policies	$ 16,663,708.00
Total community benefit expense	
2 Ratio of patient care cost to charges (from Worksheet 2, if used)	
3 Estimated cost (multiply line 1 by line 2, or obtain from cost accounting)	$ 2,091,344.00
4 Medicaid provider taxes, fees, and assessments	$ 1,349,105.00
5 **Total community benefit expense** (add lines 3 and 4; enter in Part I, line 7a, column (c))	$ 3,440,449.00
Direct offseting revenue	
6 Revenue from uncompensated care pools or programs	$ -
7 Other direct offsetting revenue	
8 **Total direct offsetting revenue** (add lines 6 and 7; enter in Part I, line 7a, column (d))	$ -
9 **Net community benefit expense (subtract line 8 from line 5; enter in Part I, line 7a, column (e))**	$ 3,440,449.00
10 Total expense (enter amount from Form 990, Part IX, line 25, column (A), including the organization's share of joint venture expenses, and excluding any bad debt expense included on Part IX, line 25)	$ 78,637,479.00
11 **Percent of total expense** (divide line 9 by line 10; enter in Part I, line 7a, column (f))	4%

Worksheet 2
Ratio of Patient Care Cost to Cost to Charges (can be used for other worksheets)

Patient Care Cost		
1	Total operating expense	$ 78,637,479.00
Less: Adjustments		
2	Non-patient-care activities	$ 157,941.00
3	Medicaid or provider taxes	$ 1,349,105.00
4	Total community benefit expense	
5	Total community building expense	
6	Total adjustments (add lines 2 through 5)	$ 1,507,046.00
7	Adjusted patient care cost (subtract line 6 from line 1)	$ 77,130,433.00
Patient Care Charges		
8	Gross patient charges	$ 301,996,145.00
Less: Adjustments		
9	Gross charges for community benefit programs	
10	Adjusted patient care charges (subtract line 9 from line 8)	$ 301,996,145.00
Calculation of Ratio of Patient Care Costs to Charges		
11	Ratio of patient care cost to charges (divide line 7 by line 10; enter on the applicable lines of Worksheets 1, 3, or	26%

Worksheet 3 Medicaid and Other Means-Tested Government Health Programs (Part I, lines 7b and 7c)	Scheudle H Total	
	Medicaid	Other means tested
	(A)	(B)
Goss patient charges		$ 22,748,374.00
1 Gross patient charges from the programs		
Total community benefit expense		
2 Ratio of patient cost to charges (from Worksheet 2, if used)		
3 Cost (multiply line 1 by line 2, or obtain from cost accounting)	$ -	$ 28,096,001.00
4 Medicaid provider taxes, fees, and assessments	$ 1,349,105.00	$ -
5 **Total community benefit expense** (add lines 3 and 4; enter amount from column (A) in Part I, line 7b, column (c); and enter amount from column (B) in Part I, line 7c, column (c))	$ 1,349,105.00	$ 28,096,001.00
Direct offsetting revenue		
6 Net patient service revenue		
7 Payments from uncompensated care pools or programs		
8 Other revenue		
9 Total direct offsetting revenue (add lines 6 through 8; enter amount from column (A) in Part I, line 7b, column (d), and enter amount from column (B) in Part I, line 7c, column (d))	$ -	$ -
10 **Net community benefit expense** (subtract line 9 from line 5; enter amount from column (A) in Part I, line 7b, column (e); enter amount from column (B) in Part I, line 7c, column (e))	$ 1,349,105.00	$ 28,096,001.00
11 **Total expense** (enter amount from Form 990, Part IX, line 25, column (A), including the organization's share of joint venture expenses, and excluding any bad debt expense included in Part IX, line 25, in both columns (A) and (B))		
12 **Percent of total expense** (line 10 divided by line 11; enter amount from column (A) in Part I, line 7b, column (f); enter amount from column (B) in Part I, line 7c, column (f))	0%	0%

Worksheet 4 Community Health Improvement Services and Community Benefit Operations - Schedule H, Part I, line 7e		Total Community Benefit Expense (A)	Direct Offsetting Revenue (B)	Net Community Benefit Expense (C)=(A)-(B)
1	Community Health Improvement Services			
a	Athletic Trainer WCHS	$ 113,541.00		$ 113,541.00
b	Diversity Health Clinic	$ 18,000.00		$ 18,000.00
c	Pierce County Health Center	$ 26,400.00		$ 26,400.00
d				$ -
e				$ -
f				$ -
g				$ -
h				$ -
i				$ -
j				$ -
2	Worksheet Subtotal (add lines 1a through 1j)	$ 157,941.00	$ -	$ 157,941.00
3	Community Benefit Operations			
a				$ -
b				$ -
c				$ -
d				$ -
4	Worksheet Subtotal (add lines 3a through 3d)	$ -	$ -	$ -
5	**Worksheet Total** (add lines 2 and 4)	$ 157,941.00	$ -	$ 157,941.00
6	**Total expense** (enter amount from Form 990, Part IX, line 25, column (A), including the organization's share of joint venture expenses, and excluding any bad debt expense included on Part IX, line 25)			
7	**Percent of total expense** (line 5, column (C) divided by line 6; enter amount in Part I, line 7e, column (f))			0%

Worksheet 5 Health Professions Education (Part I, line 7f)	Schedule H Total
Total community benefit expense	
1 Medical students	$ -
2 Interns, Residents and Fellows	$ -
3 Nursing	$ 38,115.00
4 Other allied health professions, students	$ 7,500.00
5 Continuing health professions education	$ -
6 Other students	$ -
7 **Total community benefit expense** (add lines 1 through 6; enter in Part I, line 7f, column (c))	$ 45,615.00
Direct offsetting revenue	
8 Medicare reimbursement for direct GME	$ -
9 Medicaid reimbursement for direct GME	$ -
10 Continuing health professions education reimbursement/tuition	$ -
11 Other revenue	$ -
12 **Total direct offsetting revenue** (add lines 8 through 11; enter in Part I, line 7f, column (d))	$ -
13 **Net community benefit expense** (line 7 minus line 12; enter in Part I, line 7f, column (e))	$ 45,615.00
15 Total expense (enter amount from Form 990, Part IX, line 25, column (A), including the organization's share of joint venture expenses, and excluding any bad debt expense included on Part IX, line 25)	$ 45,615.00
16 **Percent of total expense** (line 13 divided by line 14; enter amount in Part I, line 7f, column (f	100%

Worksheet 6 **Subsidized Health Services (Part I, line 7g)** **Program Name:**	**Total Subsidized Health Service Program** **(A)**	**Bad Debt** **(B)**	**Medicaid and Other Means Tested Government Programs** **(C)**	**Financial Assistance** **(D)**	**Schedule H Amount** **(E)=(A)-(B)-(C)-(D)**
Gross patient charges		10,582,333	30,746,229	16,633,708	57,962,270
1 Gross patient charges from program(s)					
Total community benefit expense					
2 Ratio of patient cost to charges (from Worksheet 2, if used)	26%				
3 **Total community benefit expense** (multiply line 1 by line 2, or obtain from cost accounting; enter column (E) in Part I, line 7g, column (c))					$ 15,070,190.00
Direct offsetting revenue					
4 Net patient services revenue					
5 Other revenue					
6 **Total direct offsetting revenue** (add lines 4 and 5; enter column (E) in Part I, line 7g, column (d))	$ -	$ -	$ -	$ -	$ -
7 **Net community benefit expense** (subtract line 6 from line 3; enter column (E) in Part I, line 7g, column (e))	$ -	$ -	$ -	$ -	$ 15,070,190.00
8 Total expense (enter amount from Form 990, Part IX, line 25, column (A), including the organization's share of joint venture expenses, and excluding any bad debt expense included on Part IX, line 25)					
9 **Percent of total expense** (line 7, column (E) divided by line 8; enter in Part I, line 7g, column (f))					

Worksheet 7 Research (Part I, line 7h)	Schedule H Total
Total community benefit expense	
1 Direct costs	$ -
2 Indirect costs	$ -
3 **Total community benefit expense** (add lines 1 and 2; enter in Part I, line 7h, column (c))	$ -
Direct offsetting revenue	
4 License fees and royalties	$ -
5 Other revenue	$ -
6 **Total direct offsetting revenue** (add lines 4 and 5; enter in Part I, line 7h, column (d))	$ -
7 **Net community benefit expense** (subtract line 6 from line 3; enter in Part I, line 7h, column (e)) (line 3 minus line 4)	$ -
8 Total expense (enter amount from Form 990, Part IX, line 25, column (A), including the organization's share of joint venture expenses, and excluding any bad debt expense included on Part IX,	$ -
9 **Percent of total expense** (divide line 7 by line 8; enter in Part I, line 7h, column (f))	0%

Worksheet 8 Cash and In-Kind Contributions for Community Benefit (Part I, line 7i)	Cash Contributions (A)	In-kind Contributions (B)	Schedule H Total (C)=(A)+(B)
1 **Total community benefit expense** (enter amount from column (C) in Part I, line 7i, column (c))	$ 18,550.00	$ 11,750.00	$ 30,300.00
2 **Direct offsetting revenue** (enter amount from column (C) in Part I, line 7i, column (d)) (enter amount from column (C) in Part I, line 7i, column (d))	$ -	$ -	
3 **Net community benefit expense** (subtract line 2 from line 1; enter in Part I, line 7i, column (e))	$ 18,550.00	$ 11,750.00	$ 30,300.00
4 Total expense (enter amount from Form 990, Part IX, line 25, column (A), including the organization's share of joint venture expenses, and excluding any bad debt expense included on Part IX,			$ 30,300.00
5 **Percent of total expense** (divide line 3 by line 4; enter in Part I, line 7i, column (f))			4%