

# Return of Organization Exempt From Income Tax

OMB No. 1545-0047

Form **990**

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

2017

Department of the Treasury  
Internal Revenue Service

▶ Do not enter Social Security numbers on this form as it may be made public.  
▶ Information about Form 990 and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

**Open to Public Inspection**

**A For the 2017 calendar year, or tax year beginning** 07/01, 2017, and ending 06/30, 2018

<b>B</b> Check if applicable:  <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input checked="" type="checkbox"/> Amended return <input type="checkbox"/> Application pending	<b>C Name of organization</b> WEST GEORGIA MEDICAL CENTER, INC. Doing Business As WELLSTAR WEST GEORGIA MEDICAL CENTER Number and street (or P.O. box if mail is not delivered to street address) Room/suite 793 SAWYER ROAD City or town, state or province, country, and ZIP or foreign postal code MARIETTA, GA 30062-2222			<b>D Employer identification number</b> 20-5497506
	<b>E Telephone number</b> (770) 956-7827			
	<b>F Name and address of principal officer:</b> CANDICE L. SAUNDERS 793 SAWYER ROAD MARIETTA, GA 30062-2222			
	<b>G Gross receipts \$</b> 187,286,148.			
<b>I Tax-exempt status:</b> <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) ( ) ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527			<b>H(a) Is this a group return for subordinates?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>H(b) Are all subordinates included?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions)	
<b>J Website:</b> WWW.WELLSTAR.ORG			<b>H(c) Group exemption number</b> ▶	
<b>K Form of organization:</b> <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶			<b>L Year of formation:</b> 2006 <b>M State of legal domicile:</b> GA	

**Part I Summary**

<b>Activities &amp; Governance</b>	1	Briefly describe the organization's mission or most significant activities: TO PROVIDE WORLD-CLASS CHARITABLE HEALTHCARE TO THE COMMUNITY.		
	2	Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	3	Number of voting members of the governing body (Part VI, line 1a)	<b>3</b>	20.
	4	Number of independent voting members of the governing body (Part VI, line 1b)	<b>4</b>	10.
	5	Total number of individuals employed in calendar year 2017 (Part V, line 2a)	<b>5</b>	1,624.
	6	Total number of volunteers (estimate if necessary)	<b>6</b>	118.
	7a	Total unrelated business revenue from Part VIII, column (C), line 12	<b>7a</b>	25,804.
7b	Net unrelated business taxable income from Form 990-T, line 34	<b>7b</b>	58,962.	
<b>Revenue</b>	8	Contributions and grants (Part VIII, line 1h)	<b>Prior Year</b>	<b>Current Year</b>
	9	Program service revenue (Part VIII, line 2g)	201,400.	150,224.
	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	185,334,849.	180,740,731.
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	5,181,985.	3,303,368.
	12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	3,054,376.	2,744,359.
	12		193,772,610.	186,938,682.
<b>Expenses</b>	13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	219,522.	208,423.
	14	Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
	15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	87,631,557.	86,332,261.
	16a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
	16b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 323,138.		
	17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	89,159,145.	78,042,591.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	177,010,224.	164,583,275.	
19	Revenue less expenses. Subtract line 18 from line 12	16,762,386.	22,355,407.	
<b>Net Assets or Fund Balances</b>	20	Total assets (Part X, line 16)	<b>Beginning of Current Year</b>	<b>End of Year</b>
	21	Total liabilities (Part X, line 26)	179,374,888.	194,498,260.
	22	Net assets or fund balances. Subtract line 21 from line 20	146,517,468.	194,654,546.
22		32,857,420.	-156,286.	

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**Part II Signature Block**

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

<b>Sign Here</b>	Signature of officer 	Date 09/27/2019		
	JAMES M. SWARTZ Type or print name and title VP ACCOUNTING			
<b>Paid Preparer Use Only</b>	Print/Type preparer's name LAUREN E BENNETT	Preparer's signature 	Date 09/27/2019	Check <input type="checkbox"/> if self-employed PTIN P01787029
	Firm's name ▶ PRICEWATERHOUSECOOPERS LLP	Firm's EIN ▶ 13-4008324		Phone no. 267-330-3000
	Firm's address ▶ 2001 MARKET ST, SUITE 1800 PHILADELPHIA, PA 19103			

May the IRS discuss this return with the preparer shown above? (see instructions)  Yes  No

**For Paperwork Reduction Act Notice, see the separate instructions.**

Form **990** (2017)

**Part III Statement of Program Service Accomplishments**

Check if Schedule O contains a response or note to any line in this Part III  Yes  No

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

TO CREATE AND DELIVER HIGH QUALITY HOSPITAL, PHYSICIAN AND OTHER HEALTHCARE RELATED SERVICES THAT IMPROVE THE HEALTH AND WELL-BEING OF THE INDIVIDUALS AND COMMUNITIES WE SERVE.

**2** Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ?  Yes  No  
If "Yes," describe these new services on Schedule O.

**3** Did the organization cease conducting, or make significant changes in how it conducts, any program services?  Yes  No  
If "Yes," describe these changes on Schedule O.

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

**4a** (Code: ) (Expenses \$ 116,493,097. including grants of \$ 208,423. ) (Revenue \$ 180,740,731. )  
SEE SCHEDULE O

**4b** (Code: ) (Expenses \$ including grants of \$ ) (Revenue \$ )

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

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

**4e** Total program service expenses ▶ 116,493,097.

**Part IV Checklist of Required Schedules**

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

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

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Table with columns for line numbers (1a-14b), descriptions of questions, and Yes/No response columns. Includes data for lines 1a (314), 1b (0), 2a (1,624), 3a, 3b, 4a, 5a, 5b, 5c, 6a, 6b, 7a-7h, 8, 9a, 9b, 10a, 10b, 11a, 11b, 12a, 12b, 13a, 13b, 13c, 14a, 14b.

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 Schedule O. See instructions.

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

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include 1a (20), 1b (10), 2, 3, 4, 5, 6, 7a, 7b, 8a, 8b, 9.

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

Table with 3 columns: Question, Yes, No. Rows include 10a, 10b, 11a, 11b, 12a, 12b, 12c, 13, 14, 15a, 15b, 16a, 16b.

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed GA,
18 Section 6104 requires an organization to make its Forms 1023 (or 1024 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.
19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
20 State the name, address, and telephone number of the person who possesses the organization's books and records: ANTHONY J. BUDZINSKI 793 SAWYER ROAD MARIETTA, GA 30062-2222 770-956-7827

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

Check if Schedule O contains a response or note to any line in this Part VII. X

**Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees**

**1a** Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, 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.

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) AMBICA YADAV TRUSTEE	1.00 13.00	X					0.	4,284.	0.	
(2) AVRIL P. BECKFORD, MD TRUSTEE & CHIEF PEDIATRIC OFF.	1.00 49.00	X		X			0.	444,016.	30,191.	
(3) CHARLES J. JONES TRUSTEE	1.00 13.00	X					0.	6,339.	0.	
(4) DAVID H. HAFNER, MD TRUSTEE	1.00 13.00	X					0.	55,331.	0.	
(5) FRANK ROS TRUSTEE	1.00 13.00	X					0.	4,959.	0.	
(6) GARY A. MILLER TRUSTEE	1.00 13.00	X					0.	3,586.	0.	
(7) GREG MORGAN TRUSTEE	1.00 13.00	X					0.	3,104.	0.	
(8) H. SPEER BURDETTE, III TRUSTEE	1.00 13.00	X					0.	3,400.	0.	
(9) JEFFREY L. THARP, MD, MPH TRUSTEE & CHIEF MEDICINE SRVS.	1.00 49.00	X		X			0.	522,885.	80,666.	
(10) MICHAEL B. PATTON TRUSTEE	1.00 13.00	X					0.	4,011.	0.	
(11) MITZI MOORE TRUSTEE	1.00 13.00	X					0.	9,175.	0.	
(12) O. SCOTT SWAYZE, MD TRUSTEE	1.00 13.00	X					0.	5,724.	0.	
(13) OTIS A. BRUMBY, III TRUSTEE	1.00 13.00	X					0.	48,879.	0.	
(14) PAUL DOUGLASS, MD TRUSTEE & PHYSICIAN	1.00 49.00	X					0.	633,707.	41,401.	

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
15) R. RANDALL BENTLEY, SR, ESQ TRUSTEE	1.00 13.00	X						0.	48,405.	0.
16) ROBERT N. CROSS, MD TRUSTEE	1.00 13.00	X						0.	15,971.	0.
17) T. FITZ JOHNSON TRUSTEE	1.00 15.00	X						0.	40,981.	0.
18) THOMAS M. PHILLIPS TRUSTEE	1.00 13.00	X						0.	2,467.	0.
19) W. CHARLES BROCK TRUSTEE	1.00 13.00	X						0.	46,215.	0.
20) WALTER G. ROBINSON TRUSTEE	1.00 13.00	X						0.	8,062.	0.
21) ALAN R. MUSTER, MD SVP SPECIALTY DIVISION WMG	1.00 51.00			X				0.	601,443.	82,349.
22) ALAN WILDE SVP SUPPLY CHAIN (BEG. 6/18)	1.00 49.00			X				0.	0.	0.
23) ANDREW ALBERRY VP INFO TECHNOLOGY OPERATIONS	1.00 49.00			X				0.	155,877.	9,394.
24) ANDREW LEE VP CHIEF DIV. OFF (BEG. 10/17)	1.00 49.00			X				0.	117,476.	2,008.
25) ANTHONY J. BUDZINSKI EVP & CFO	1.00 51.00			X				0.	1,233,070.	71,584.
<b>1b Sub-total</b>								0.	1,749,400.	152,258.
<b>c Total from continuation sheets to Part VII, Section A</b>								2,924,223.	22,937,396.	3,092,887.
<b>d Total (add lines 1b and 1c)</b>								2,924,223.	24,686,796.	3,245,145.

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 **79**

	Yes	No
3 Did the organization list any former officer, director, or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual	X	
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	X	
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 person		X

**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
ATTACHMENT 1		

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization **6**



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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
( 26) ANTHONY M. TRUPIANO SVP SUPPLY CHAIN	1.00 49.00			X				0.	397,653.	49,512.
( 27) BARBARA B. COREY SVP MANAGED CARE	1.00 49.00			X				0.	613,339.	50,336.
( 28) BETH KOST SVP COMPLIANCE CHF PRIVACY OFF	1.00 49.00			X				0.	389,392.	43,110.
( 29) BETHANY ROBERTSON VP/CHIEF LEARN.OFF.(END.4/18)	1.00 49.00			X				0.	279,036.	45,924.
( 30) BRADFORD B. NEWTON VP INFO. TECHNOLOGY ADMIN.	1.00 49.00			X				0.	278,749.	51,740.
( 31) CANDICE L. SAUNDERS PRESIDENT & CEO	1.00 51.00			X				0.	2,121,661.	76,327.
( 32) CAROL M. TODD VP ASST GENERAL COUNSEL	50.00 0.			X				215,923.	0.	46,613.
( 33) CARRIE O. PLIETZ EVP & COO HOSPITAL DIVISION	1.00 49.00			X				0.	884,677.	67,768.
( 34) CHARIS L. ACREE VICE PRESIDENT & COO	50.00 0.			X				348,986.	0.	64,253.
( 35) DAVID W. ANDERSON EVP/HR/OL/CCO	1.00 49.00			X				0.	804,964.	75,727.
( 36) DOUGLAS ARVIN, CPA, MBA SVP FINANCE	1.00 49.00			X				0.	433,489.	29,905.
<b>1b Sub-total</b> . . . . .										
<b>c Total from continuation sheets to Part VII, Section A</b> . . . . .										
<b>d Total (add lines 1b and 1c)</b> . . . . .										

**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 **79**

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

**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

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
( 37) ELIZABETH H. LOUDERMILK VP FINANCIAL PLANNING	1.00 49.00			X				0.	304,210.	50,851.
( 38) ELIZABETH PAPETTI VP OPS HOSPITAL DIVISION	1.00 49.00			X				0.	239,000.	6,136.
( 39) ELLEN LANGFORD SVP WMG AMB. TRANS. (END.4/18)	1.00 49.00			X				0.	434,986.	69,267.
( 40) ELLEN WRIGHT VP HIM CDI & POLICIES	1.00 49.00			X				0.	74,286.	4,329.
( 41) FRED A LYON VP SYSTEM EMERGENCY SERVICES	1.00 49.00			X				0.	243,482.	45,328.
( 42) GERALD N. FULKS SVP HOSPITAL PRESIDENT	48.00 2.00			X				650,237.	0.	55,741.
( 43) JAMES M. SWARTZ VP ACCOUNTING	1.00 49.00			X				0.	282,924.	47,009.
( 44) JASON STEVENS VP DEPUTY GENERAL COUNSEL	1.00 49.00			X				0.	346,099.	42,842.
( 45) JENNIFER GIUSTI VP CLINICAL OUTCOMES	1.00 49.00			X				0.	317,295.	32,617.
( 46) JILL M. CASE-WIRTH SVP NURSING SERVICES	1.00 49.00			X				0.	444,154.	59,112.
( 47) JOHN A. BRENNAN EVP CHIEF CLIN. INTG. OFFICER	1.00 49.00			X				0.	1,091,634.	82,415.
<b>1b Sub-total</b> . . . . .										
<b>c Total from continuation sheets to Part VII, Section A</b> . . . . .										
<b>d Total (add lines 1b and 1c)</b> . . . . .										

**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 **79**

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

**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

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
( 48) JOSEPH L. BRYWCZYNSKI SVP HEALTH PARKS DEVELOPMENT	1.00 49.00			X				0.	442,964.	73,625.
( 49) KEITH BOWERMASTER VP COMMUNICATION	1.00 49.00			X				0.	204,567.	38,658.
( 50) KEM M. MULLINS EVP AMBULATORY & BUS. DEV.	1.00 49.00			X				0.	677,287.	57,343.
( 51) KENT HAYTHORN VP CLNCL. NURSING (END. 10/17)	1.00 49.00			X				0.	115,180.	20,470.
( 52) KEVIN SCHAEFFER, MD VP ONCOLOGY	1.00 49.00			X				0.	315,346.	37,252.
( 53) KIMBERLY W. MENEFFEE SVP STRAT. COMM.DEV.(END.4/18)	1.00 49.00			X				0.	544,245.	51,952.
( 54) KIMBERLY TAACA VP OPS SPECIALTY DIVISION	1.00 49.00			X				0.	227,431.	27,644.
( 55) KRISTEN S. TRICE VP DIAGNOSTIC OUTREACH	1.00 49.00			X				0.	219,064.	42,667.
( 56) LEO E. REICHERT EVP & GENERAL COUNSEL	1.00 49.00			X				0.	751,320.	66,257.
( 57) LIZA FRITCHLEY VP SENIOR CARE SERVICES	50.00 0.			X				197,658.	0.	58,591.
( 58) MARCUS P. CHARLSON, MD VP SURGERY	1.00 49.00			X				0.	196,376.	34,191.
<b>1b Sub-total</b> . . . . .										
<b>c Total from continuation sheets to Part VII, Section A</b> . . . . .										
<b>d Total (add lines 1b and 1c)</b> . . . . .										

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 **79**

	Yes	No
3 Did the organization list any <b>former</b> officer, director, or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i> . . . . .	X	
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? <i>If "Yes," complete Schedule J for such individual</i> . . . . .	X	
5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? <i>If "Yes," complete Schedule J for such person</i> . . . . .		X

**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

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
( 59) MARY L. TAVERNARO VP HUMAN RESOURCES OPERATIONS	1.00 49.00			X				0.	302,766.	52,404.
( 60) MAXWELL KAGAN VP FINANCE & CFO	1.00 49.00			X				0.	205,325.	34,929.
( 61) MICHELLE M. ROBINSON VP MARKETING (END. 4/2018)	1.00 49.00			X				0.	269,465.	45,021.
( 62) PAUL MURPHREE VP MEDICAL OUTCOMES	1.00 49.00			X				0.	206,596.	21,621.
( 63) PAUL R. PERROTTI SVP & CFO	16.00 34.00			X				371,400.	0.	65,919.
( 64) PETER R. JUNGBLUT, MD, MBA SVP & MEDICAL DIRECTOR	1.00 49.00			X				0.	344,227.	78,651.
( 65) REBECCA L. RUHL VP FACILITY COMPLIANCE OPS	1.00 49.00			X				0.	191,015.	30,545.
( 66) RICHARD S. SIEGEL VP CARDIOLOGY & CVM ADMIN.	1.00 49.00			X				0.	420,012.	79,761.
( 67) ROB SCHREINER EVP & PRESIDENT MEDICAL GROUP	1.00 49.00			X				0.	260,724.	3,189.
( 68) ROBERT J. DECOUX VP CORPORATE MED STAFF SVCS	1.00 49.00			X				0.	224,236.	53,512.
( 69) ROBIN G. BOEHRINGER VP TOTAL REWARDS (END. 5/2018)	1.00 49.00			X				0.	237,763.	28,362.
<b>1b Sub-total</b> .....										
<b>c Total from continuation sheets to Part VII, Section A</b> .....										
<b>d Total (add lines 1b and 1c)</b> .....										

**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 **▶** 79

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

**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

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
( 70) SANDRA LUCIUS ----- VP INFO TECHNOLOGY APPS	1.00 49.00			X				0.	285,948.	49,910.
( 71) SEAN P. TURNER ----- VP REVENUE CYCLE MANAGEMENT	1.00 49.00			X				0.	368,104.	59,488.
( 72) SNEHAL H. DOSHI ----- VP SYSTEM PHARMACIST	1.00 49.00			X				0.	239,515.	59,995.
( 73) SONYA E. ALDY ----- VP TALENT ACQUISITION	1.00 49.00			X				0.	244,723.	40,030.
( 74) STEPHEN L. BADGER ----- VP WMG STRATEGIC SERVICES	1.00 49.00			X				0.	820,360.	59,117.
( 75) STEPHEN VAULT ----- VP BUSINESS DEVELOPMENT	1.00 49.00			X				0.	215,180.	24,026.
( 76) TIMOTHY HANEY ----- SVP R.E. FAC. & DEV. SRVS.	1.00 49.00			X				0.	599,548.	54,288.
( 77) TOM BONIECKI ----- VP MUSCUSKELETAL NEURO.	1.00 49.00			X				0.	180,342.	75,237.
( 78) TOMMY BRITT ----- VP HUMAN RESOURCES	50.00 0.			X				199,391.	0.	44,910.
( 79) TRACY C. GYNTHYER ----- VICE PRESIDENT, CNO	50.00 0.			X				198,601.	0.	52,213.
( 80) VALERY A. AKOPOV, MD ----- SVP HOSPITAL DIVISION WMG	1.00 49.00			X				0.	574,337.	56,862.
<b>1b Sub-total</b> . . . . .										
<b>c Total from continuation sheets to Part VII, Section A</b> . . . . .										
<b>d Total (add lines 1b and 1c)</b> . . . . .										

**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 **79**

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

**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

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
( 81) VARMA RAMESWAR, MD VP PEDIATRIC OPERATIONS	1.00 49.00			X				0.	225,328.	52,564.
( 82) YVETTE BREWER, MD VP PRIMARY CARE MEDICINE	1.00 49.00			X				0.	227,494.	54,160.
( 83) DON DAVIS DIRECTOR	50.00 0.					X		161,393.	0.	1,988.
( 84) JANICE PAGE PHARMACIST	50.00 0.					X		148,828.	0.	42,649.
( 85) ALFRED MCNAIR ASSOCIATE DIRECTOR	50.00 0.					X		146,465.	0.	18,139.
( 86) JEREAN GRAU PHARMACIST	50.00 0.					X		144,790.	0.	8,231.
( 87) MARY A. SPARROW PHARMACIST	50.00 0.					X		140,551.	0.	33,305.
( 88) DOUGLAS S. FOSTER FORMER VP FINANCIAL PLAN.	0. 0.						X	0.	115,794.	24,995.
( 89) JONATHAN B. MORRIS, MD FORMER SVP CHIEF INFO. OFF.	0. 0.						X	0.	233,817.	16,019.
1b Sub-total										
c Total from continuation 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 **79**

	Yes	No
3 Did the organization list any former officer, director, or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual	X	
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	X	
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 person		X

**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

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

**Part VIII Statement of Revenue**

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

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514	
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<b>1a</b> Federated campaigns . . . . .	<b>1a</b>						
	<b>b</b> Membership dues . . . . .	<b>1b</b>						
	<b>c</b> Fundraising events . . . . .	<b>1c</b>						
	<b>d</b> Related organizations . . . . .	<b>1d</b>	140,000.					
	<b>e</b> Government grants (contributions) . . . . .	<b>1e</b>	10,224.					
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above . . . . .	<b>1f</b>						
	<b>g</b> Noncash contributions included in lines 1a-1f: \$ . . . . .							
	<b>h Total.</b> Add lines 1a-1f . . . . . ▶			150,224.				
<b>Program Service Revenue</b>	<b>2a</b> PATIENT REVENUE	<b>Business Code</b>	621400	180,393,357.	180,393,357.			
	<b>b</b> MEDICAL RECORDS		621900	343,058.	343,058.			
	<b>c</b> PHARMACY REVENUE		621400	300.	300.			
	<b>d</b> LAB TESTS		621400	4,199.	4,199.			
	<b>e</b> PATIENT EDUCATION		621990	-183.	-183.			
	<b>f</b> All other program service revenue . . . . .							
	<b>g Total.</b> Add lines 2a-2f . . . . . ▶			180,740,731.				
<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts). . . . . ▶			3,303,368.			3,303,368.	
	<b>4</b> Income from investment of tax-exempt bond proceeds . ▶			0.				
	<b>5</b> Royalties . . . . . ▶			0.				
	<b>6a</b> Gross rents . . . . .	(i) Real	(ii) Personal					
		404,949.						
	<b>b</b> Less: rental expenses . . . . .							
	<b>c</b> Rental income or (loss) . . . . .		404,949.					
	<b>d</b> Net rental income or (loss) . . . . . ▶			404,949.			404,949.	
	<b>7a</b> Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other					
		<b>d</b> Net gain or (loss) . . . . . ▶			0.			
	<b>8a</b> Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18 . . . . . <b>a</b>							
<b>b</b> Less: direct expenses . . . . . <b>b</b>								
<b>c</b> Net income or (loss) from fundraising events. . . . . ▶				0.				
<b>9a</b> Gross income from gaming activities. See Part IV, line 19 . . . . . <b>a</b>								
	<b>b</b> Less: direct expenses . . . . . <b>b</b>							
	<b>c</b> Net income or (loss) from gaming activities. . . . . ▶			0.				
<b>10a</b> Gross sales of inventory, less returns and allowances . . . . . <b>a</b>			539,803.					
	<b>b</b> Less: cost of goods sold . . . . . <b>b</b>		347,466.					
	<b>c</b> Net income or (loss) from sales of inventory. . . . . ▶			192,337.		25,804.	166,533.	
Miscellaneous Revenue			<b>Business Code</b>					
<b>11a</b> MANAGEMENT FEES			900099	1,042,496.			1,042,496.	
	<b>b</b> CAFETERIA		900099	863,379.			863,379.	
	<b>c</b> OTHER REVENUE		900099	241,198.			241,198.	
	<b>d</b> All other revenue . . . . .							
<b>e Total.</b> Add lines 11a-11d . . . . . ▶				2,147,073.				
<b>12 Total revenue.</b> See instructions. . . . . ▶				186,938,682.	180,740,731.	25,804.	6,021,923.	

**Part IX Statement of Functional Expenses**

Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A).

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

**Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.**

	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 . . . .	208,423.	208,423.		
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22 . . . . .	0.			
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16 . . . . .	0.			
<b>4</b> Benefits paid to or for members . . . . .	0.			
<b>5</b> Compensation of current officers, directors, trustees, and key employees . . . . .	2,437,450.	2,034,323.	403,127.	
<b>6</b> Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) . . . . .	0.			
<b>7</b> Other salaries and wages . . . . .	61,665,286.	51,833,259.	9,633,246.	198,781.
<b>8</b> Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	6,020,686.	5,060,737.	940,541.	19,408.
<b>9</b> Other employee benefits . . . . .	11,643,914.	9,787,387.	1,818,992.	37,535.
<b>10</b> Payroll taxes . . . . .	4,564,925.	3,837,085.	713,125.	14,715.
<b>11</b> Fees for services (non-employees):				
<b>a</b> Management . . . . .	39,571.	26,095.	6,448.	7,028.
<b>b</b> Legal . . . . .	358,510.		358,510.	
<b>c</b> Accounting . . . . .	71,436.	21,375.	50,061.	
<b>d</b> Lobbying . . . . .	0.			
<b>e</b> Professional fundraising services. See Part IV, line 17.	0.			
<b>f</b> Investment management fees . . . . .	0.			
<b>g</b> Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O). <b>ATCH 2</b>	19,135,956.	8,829,286.	10,294,775.	11,895.
<b>12</b> Advertising and promotion . . . . .	295,733.	21,574.	274,004.	155.
<b>13</b> Office expenses . . . . .	6,077,865.	4,908,442.	1,155,488.	13,935.
<b>14</b> Information technology . . . . .	0.			
<b>15</b> Royalties . . . . .	0.			
<b>16</b> Occupancy . . . . .	3,103,261.	505,615.	2,596,208.	1,438.
<b>17</b> Travel . . . . .	255,763.	155,124.	98,382.	2,257.
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials	0.			
<b>19</b> Conferences, conventions, and meetings . . . . .	579,863.	141,657.	435,636.	2,570.
<b>20</b> Interest . . . . .	2,380,065.		2,380,065.	
<b>21</b> Payments to affiliates . . . . .	115,000.	115,000.		
<b>22</b> Depreciation, depletion, and amortization . . . . .	10,220,173.	814,863.	9,405,310.	
<b>23</b> Insurance . . . . .	1,113,443.	132.	1,113,311.	
<b>24</b> Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
<b>a</b> REPAIRS AND MAINTENANCE	9,135,281.	3,478,583.	5,643,428.	13,270.
<b>b</b> MEDICAL SUPPLIES	24,869,321.	24,658,189.	211,126.	6.
<b>c</b> OTHER EXPENSES	291,350.	55,948.	235,257.	145.
<b>d</b> _____				
<b>e</b> All other expenses _____				
<b>25</b> Total functional expenses. Add lines 1 through 24e	164,583,275.	116,493,097.	47,767,040.	323,138.
<b>26</b> Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720) . . . . .	0.			



**Part X Balance Sheet**

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

		(A) Beginning of year		(B) End of year
<b>Assets</b>	<b>1</b> Cash - non-interest-bearing . . . . .	7,670,179.	<b>1</b>	15,675,233.
	<b>2</b> Savings and temporary cash investments . . . . .	0.	<b>2</b>	0.
	<b>3</b> Pledges and grants receivable, net . . . . .	0.	<b>3</b>	0.
	<b>4</b> Accounts receivable, net . . . . .	19,645,116.	<b>4</b>	21,975,473.
	<b>5</b> Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L . . . . .	0.	<b>5</b>	0.
	<b>6</b> Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L . . . . .	0.	<b>6</b>	0.
	<b>7</b> Notes and loans receivable, net . . . . .	0.	<b>7</b>	0.
	<b>8</b> Inventories for sale or use . . . . .	3,155,524.	<b>8</b>	3,756,874.
	<b>9</b> Prepaid expenses and deferred charges . . . . .	4,837,832.	<b>9</b>	660,193.
	<b>10a</b> Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	<b>10a</b> 90,838,279.		
	<b>b</b> Less: accumulated depreciation . . . . .	<b>10b</b> 23,769,644.	69,069,207.	<b>10c</b> 67,068,635.
	<b>11</b> Investments - publicly traded securities . . . . .	69,393,366.	<b>11</b>	79,908,853.
	<b>12</b> Investments - other securities. See Part IV, line 11 . . . . .	0.	<b>12</b>	0.
	<b>13</b> Investments - program-related. See Part IV, line 11 . . . . .	0.	<b>13</b>	0.
	<b>14</b> Intangible assets . . . . .	0.	<b>14</b>	0.
	<b>15</b> Other assets. See Part IV, line 11 . . . . .	5,603,664.	<b>15</b>	5,452,999.
<b>16 Total assets.</b> Add lines 1 through 15 (must equal line 34) . . . . .	179,374,888.	<b>16</b>	194,498,260.	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses . . . . .	14,519,654.	<b>17</b>	11,917,189.
	<b>18</b> Grants payable . . . . .	0.	<b>18</b>	0.
	<b>19</b> Deferred revenue . . . . .	0.	<b>19</b>	0.
	<b>20</b> Tax-exempt bond liabilities . . . . .	61,650,798.	<b>20</b>	0.
	<b>21</b> Escrow or custodial account liability. Complete Part IV of Schedule D . . . . .	0.	<b>21</b>	87,835.
	<b>22</b> Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L . . . . .	0.	<b>22</b>	0.
	<b>23</b> Secured mortgages and notes payable to unrelated third parties . . . . .	0.	<b>23</b>	0.
	<b>24</b> Unsecured notes and loans payable to unrelated third parties . . . . .	0.	<b>24</b>	0.
	<b>25</b> Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D . . . . .	70,347,016.	<b>25</b>	182,649,522.
	<b>26 Total liabilities.</b> Add lines 17 through 25 . . . . .	146,517,468.	<b>26</b>	194,654,546.
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow SFAS 117 (ASC 958), check here</b> <input checked="" type="checkbox"/> <b>and complete lines 27 through 29, and lines 33 and 34.</b>			
	<b>27</b> Unrestricted net assets . . . . .	25,917,929.	<b>27</b>	-5,646,652.
	<b>28</b> Temporarily restricted net assets . . . . .	0.	<b>28</b>	0.
	<b>29</b> Permanently restricted net assets . . . . .	6,939,491.	<b>29</b>	5,490,366.
	<b>Organizations that do not follow SFAS 117 (ASC 958), check here</b> <input type="checkbox"/> <b>and complete lines 30 through 34.</b>			
	<b>30</b> Capital stock or trust principal, or current funds . . . . .		<b>30</b>	
	<b>31</b> Paid-in or capital surplus, or land, building, or equipment fund . . . . .		<b>31</b>	
	<b>32</b> Retained earnings, endowment, accumulated income, or other funds . . . . .		<b>32</b>	
	<b>33</b> Total net assets or fund balances . . . . .	32,857,420.	<b>33</b>	-156,286.
	<b>34</b> Total liabilities and net assets/fund balances . . . . .	179,374,888.	<b>34</b>	194,498,260.

**Part XI Reconciliation of Net Assets**

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

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	186,938,682.
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	164,583,275.
<b>3</b>	Revenue less expenses. Subtract line 2 from line 1	<b>3</b>	22,355,407.
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	32,857,420.
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	0.
<b>6</b>	Donated services and use of facilities	<b>6</b>	0.
<b>7</b>	Investment expenses	<b>7</b>	0.
<b>8</b>	Prior period adjustments	<b>8</b>	0.
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	-55,369,113.
<b>10</b>	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	<b>10</b>	-156,286.

**Part XII Financial Statements and Reporting**

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

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

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

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

Department of the Treasury  
Internal Revenue Service

**Public Charity Status and Public Support**

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

▶ Attach to Form 990 or Form 990-EZ.

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

OMB No. 1545-0047

**2017**

**Open to Public Inspection**

Name of the organization

WEST GEORGIA MEDICAL CENTER, INC.

Employer identification number

20-5497506

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

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

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

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

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

Section A. Public Support

Table with 7 columns: (a) 2013, (b) 2014, (c) 2015, (d) 2016, (e) 2017, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Tax revenues levied for the organization's benefit; 3 The value of services or facilities furnished by a governmental unit; 4 Total. Add lines 1 through 3; 5 The portion of total contributions by each person; 6 Public support. Subtract line 5 from line 4.

Section B. Total Support

Table with 7 columns: (a) 2013, (b) 2014, (c) 2015, (d) 2016, (e) 2017, (f) Total. Rows include: 7 Amounts from line 4; 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources; 9 Net income from unrelated business activities; 10 Other income. Do not include gain or loss from the sale of capital assets; 11 Total support. Add lines 7 through 10; 12 Gross receipts from related activities, etc. (see instructions); 13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here.

Section C. Computation of Public Support Percentage

Table with 3 columns: Line number, Description, and Percentage. Rows include: 14 Public support percentage for 2017; 15 Public support percentage from 2016 Schedule A, Part II, line 14; 16a 33 1/3% support test - 2017; b 33 1/3% support test - 2016; 17a 10%-facts-and-circumstances test - 2017; b 10%-facts-and-circumstances test - 2016; 18 Private foundation.

**Part III Support Schedule for Organizations Described in Section 509(a)(2)**  
 (Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II.  
 If the organization fails to qualify under the tests listed below, please complete Part II.)

**Section A. Public Support**

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

**Section B. Total Support**

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

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

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

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

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

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

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

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

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

**Part IV Supporting Organizations**

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

**Section A. All Supporting Organizations**

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

**Part IV Supporting Organizations** (continued)

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

**Section B. Type I Supporting Organizations**

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

**Section C. Type II Supporting Organizations**

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

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

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

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

<b>1</b> Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions).			
<b>a</b> <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.			
<b>b</b> <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.			
<b>c</b> <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).			
<b>2</b> Activities Test. Answer (a) and (b) below.		Yes	No
<b>a</b> Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <i>If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.</i>	<b>2a</b>		
<b>b</b> Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? <i>If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.</i>	<b>2b</b>		
<b>3</b> Parent of Supported Organizations. Answer (a) and (b) below.			
<b>a</b> Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>Provide details in Part VI.</i>	<b>3a</b>		
<b>b</b> Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i>	<b>3b</b>		

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

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

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

Schedule A (Form 990 or 990-EZ) 2017



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

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

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

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

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# Schedule of Contributors

**2017**

▶ Attach to Form 990, Form 990-EZ, or Form 990-PF.  
▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

<b>Name of the organization</b> WEST GEORGIA MEDICAL CENTER, INC.	<b>Employer identification number</b> 20-5497506
--	---

**Organization type** (check one):

**Filers of:**

**Section:**

Form 990 or 990-EZ

501(c)(3) (enter number) organization

4947(a)(1) nonexempt charitable trust **not** treated as a private foundation

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

4947(a)(1) nonexempt charitable trust treated as a private foundation

501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule**.

**Note:** Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

**General Rule**

For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, contributions totaling \$5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.

**Special Rules**

For an organization described in section 501(c)(3) filing Form 990 or 990-EZ that met the 33 1/3 % support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), that checked Schedule A (Form 990 or 990-EZ), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions of the greater of **(1)** \$5,000; or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h; or (ii) Form 990-EZ, line 1. Complete Parts I and II.

For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than \$1,000 *exclusively* for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals. Complete Parts I, II, and III.

For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc., purposes, but no such contributions totaled more than \$1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Don't complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions totaling \$5,000 or more during the year . . . . . ▶ \$ \_\_\_\_\_

**Caution:** An organization that isn't covered by the General Rule and/or the Special Rules doesn't file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on its Form 990-PF, Part I, line 2, to certify that it doesn't meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization **WEST GEORGIA MEDICAL CENTER, INC.**

Employer identification number  
20-5497506

**Part I** **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	_____ _____ _____	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	_____ _____ _____	\$ 90,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
3	_____ _____ _____	\$ 10,224.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
____	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
____	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
____	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization WEST GEORGIA MEDICAL CENTER, INC.

Employer identification number

20-5497506

**Part II** Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____

Name of organization WEST GEORGIA MEDICAL CENTER, INC.

Employer identification number  
20-5497506

**Part III** *Exclusively* religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than \$1,000 for the year from any one contributor. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of \$1,000 or less for the year. (Enter this information once. See instructions.) ► \$ \_\_\_\_\_  
Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
_____	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
<b>(e) Transfer of gift</b>			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
_____		_____	
_____		_____	
_____		_____	
_____	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
<b>(e) Transfer of gift</b>			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
_____		_____	
_____		_____	
_____		_____	
_____	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
<b>(e) Transfer of gift</b>			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
_____		_____	
_____		_____	
_____		_____	
_____	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
<b>(e) Transfer of gift</b>			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
_____		_____	
_____		_____	
_____		_____	

SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No. 1545-0047

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

2017

Attach to Form 990.

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

Name of the organization

Employer identification number

WEST GEORGIA MEDICAL CENTER, INC.

20-5497506

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

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

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows include: 1 Total number at end of year, 2 Aggregate value of contributions to (during year), 3 Aggregate value of grants from (during year), 4 Aggregate value at end of year, 5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?, 6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?

Part II Conservation Easements.

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

Table with 2 columns: Held at the End of the Tax Year. Rows include: 1 Purpose(s) of conservation easements held by the organization (check all that apply), 2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year, 3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year, 4 Number of states where property subject to conservation easement is located, 5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?, 6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year, 7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year, 8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?, 9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.

Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

Table with 2 columns: Revenue, Assets. Rows include: 1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items. 1b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items: (i) Revenue included on Form 990, Part VIII, line 1. (ii) Assets included in Form 990, Part X. 2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items: a Revenue included on Form 990, Part VIII, line 1. b Assets included in Form 990, Part X.

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

Schedule D (Form 990) 2017

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

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

**Part IV Escrow and Custodial Arrangements.**

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

- 1a** Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?  Yes  No
- b** If "Yes," explain the arrangement in Part XIII and complete the following table:
- |  |           | Amount  |
|--|-----------|---------|
| <b>c</b> Beginning balance             | <b>1c</b> | 68,253. |
| <b>d</b> Additions during the year     | <b>1d</b> | 19,582. |
| <b>e</b> Distributions during the year | <b>1e</b> |         |
| <b>f</b> Ending balance                | <b>1f</b> | 87,835. |
- 2a** Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability?  Yes  No
- b** If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided on Part XIII

**Part V Endowment Funds.**

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
<b>1a</b> Beginning of year balance	6,939,491.	6,939,491.	7,109,298.	7,332,518.	7,563,602.
<b>b</b> Contributions					
<b>c</b> Net investment earnings, gains, and losses					
<b>d</b> Grants or scholarships					
<b>e</b> Other expenditures for facilities and programs	1,449,125.		169,807.	223,220.	231,084.
<b>f</b> Administrative expenses					
<b>g</b> End of year balance	5,490,366.	6,939,491.	6,939,491.	7,109,298.	7,332,518.

- 2** Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
- a** Board designated or quasi-endowment  \_\_\_\_\_ %
  - b** Permanent endowment  100.0000 %
  - c** Temporarily restricted endowment  \_\_\_\_\_ %
- The percentages on lines 2a, 2b, and 2c should equal 100%.

- 3a** Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

	Yes	No
<b>(i)</b> unrelated organizations	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>(ii)</b> related organizations	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>b</b> If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R?	<input type="checkbox"/>	<input type="checkbox"/>

- 4** Describe in Part XIII the intended uses of the organization's endowment funds.

**Part VI Land, Buildings, and Equipment.**

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
<b>1a</b> Land		1,720,000.		1,720,000.
<b>b</b> Buildings		49,307,385.	6,045,839.	43,261,546.
<b>c</b> Leasehold improvements		4,503,440.	1,091,624.	3,411,816.
<b>d</b> Equipment		32,458,325.	16,492,839.	15,965,486.
<b>e</b> Other		2,849,129.	139,342.	2,709,787.
<b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				67,068,635.



**Part VII Investments - Other Securities.**

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

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

**Part VIII Investments - Program Related.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

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

**Part IX Other Assets.**

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

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

**Part X Other Liabilities.**

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

1. (a) Description of liability	(b) Book value	
(1) Federal income taxes		
(2) TAX EXEMPT BOND LIAB. DUE TO WHS	123,901,229.	
(3) ACCRUED PENSION LIABILITY	56,321,008.	
(4) SELF-INSURANCE RESERVES	2,430,846.	
(5) OTHER LONG TERM LIABILITIES	-3,561.	
(6)		
(7)		
(8)		
(9)		
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶		182,649,522.

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



**Part XIII** Supplemental Information (continued)

SCHEDULE D, PART III, LINE 4

DESCRIPTION OF ORGANIZATION'S COLLECTIONS:

WEST GEORGIA MEDICAL CENTER ("WGMC") HOLDS ART COLLECTIONS AND EXHIBITS THEM IN PUBLIC AREAS OF THE FACILITIES. THE EXHIBITS FURTHER WGMC'S EXEMPT PURPOSE BY ENHANCING THE HEALTH CARE EXPERIENCES FOR PATIENTS, PATIENT FAMILIES, AND VISITORS.

SCHEDULE D, PART IV, LINE 1B

CUSTODIAL ACCOUNT ARRANGEMENT:

WEST GEORGIA MEDICAL CENTER SERVED IN A CUSTODIAL ROLE FOR FUNDS HELD FOR ITS NURSING HOME RESIDENTS.

SCHEDULE D, PART V, LINE 4

USE OF ORGANIZATION'S ENDOWMENT FUNDS:

PERMANENT ENDOWMENT FUNDS ARE TO BE USED FOR PROPERTY AND IMPROVEMENTS FOR HOSPITAL PURPOSES.

SCHEDULE D, PART X, LINE 2

THE FOLLOWING FOOTNOTE IS RELATED TO THE ORGANIZATION'S APPLICATION OF FIN 48 (ASC 740):

"WELLSTAR AND ITS AFFILIATES HAVE BEEN RECOGNIZED AS EXEMPT FROM FEDERAL INCOME TAX UNDER INTERNAL REVENUE CODE SECTION 501(A) AS ORGANIZATIONS DESCRIBED IN SECTION 501(C)(3), AND THEREFORE, RELATED INCOME IS GENERALLY NOT SUBJECT TO FEDERAL OR STATE INCOME TAXES, EXCEPT FOR CAC AND WGHP.

WELLSTAR APPLIES FASB ASC 740, INCOME TAXES, WHICH ADDRESSES ACCOUNTING FOR UNCERTAINTIES IN INCOME TAX POSITIONS. IT ALSO PROVIDES GUIDANCE ON

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

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WHEN TAX POSITIONS ARE RECOGNIZED IN AN ENTITY'S FINANCIAL STATEMENTS AND HOW THE VALUES OF THESE POSITIONS ARE DETERMINED. THERE IS NO IMPACT ON WELLSTAR'S COMBINED FINANCIAL STATEMENTS AS A RESULT OF THE APPLICATION OF ASC 740."

**SCHEDULE H  
(Form 990)**

**Hospitals**

OMB No. 1545-0047

**2017**

**Open to Public Inspection**

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, question 20.**

▶ **Attach to Form 990.**

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

WEST GEORGIA MEDICAL CENTER, INC.

Employer identification number

20-5497506

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

	Yes	No
<b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a . . . . .	X	
<b>1b</b> If "Yes," was it a written policy? . . . . .	X	
<b>2</b> If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
<b>3</b> Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
<b>a</b> Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other <u>125.0000</u> %	X	
<b>b</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: . . . . . <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input checked="" type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %	X	
<b>c</b> If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.		
<b>4</b> Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"? . . . . .	X	
<b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
<b>5b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? . . . . .	X	
<b>5c</b> If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care? . . . . .		X
<b>6a</b> Did the organization prepare a community benefit report during the tax year? . . . . .	X	
<b>6b</b> If "Yes," did the organization make it available to the public? . . . . .	X	

**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
<b>a</b> Financial Assistance at cost (from Worksheet 1) . . . . .			14,971,202.		14,971,202.	9.10
<b>b</b> Medicaid (from Worksheet 3, column a) . . . . .			23,120,893.	17,966,648.	5,154,245.	3.13
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b) . . . . .						
<b>d</b> Total Financial Assistance and Means-Tested Government Programs . . . . .			38,092,095.	17,966,648.	20,125,447.	12.23
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4) . . . . .			275,592.		275,592.	.17
<b>f</b> Health professions education (from Worksheet 5) . . . . .						
<b>g</b> Subsidized health services (from Worksheet 6) . . . . .						
<b>h</b> Research (from Worksheet 7)						
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8) . . . . .						
<b>j</b> Total. Other Benefits . . . . .			275,592.		275,592.	.17
<b>k</b> Total. Add lines 7d and 7j. . . . .			38,367,687.	17,966,648.	20,401,039.	12.40

**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						
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development						
9 Other						
10 Total						

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

**Section A. Bad Debt Expense**

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

**Section B. Medicare**

5 Enter total revenue received from Medicare (including DSH and IME) . . . . .	63,237,194.
6 Enter Medicare allowable costs of care relating to payments on line 5 . . . . .	74,895,325.
7 Subtract line 6 from line 5. This is the surplus (or shortfall) . . . . .	-11,658,131.
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other	

**Section C. Collection Practices**

9a Did the organization have a written debt collection policy during the tax year? . . . . .	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 . . . . .	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 %
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

**Part V Facility Information**

**Section A. Hospital Facilities**

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

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

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

**1** WEST GEORGIA MEDICAL CENTER, INC.  
 1514 VERNON ROAD  
 LAGRANGE GA 30240  
 WWW.WELLSTAR.ORG  
 141-661

Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
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 WEST GEORGIA MEDICAL CENTER, INC.

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

**Community Health Needs Assessment**

		Yes	No
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? . . . . .		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 . . . . .		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 . . . . . If "Yes," indicate what the CHNA report describes (check all that apply):	X	
a	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b	<input checked="" type="checkbox"/> Demographics of the community		
c	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input checked="" type="checkbox"/> How data was obtained		
e	<input checked="" type="checkbox"/> The significant health needs of the community		
f	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j	<input checked="" type="checkbox"/> Other (describe in Section C)		
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>15</u>		
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .	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 . . . . .		X
6b	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 . . . . .		X
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):	X	
a	<input checked="" type="checkbox"/> Hospital facility's website (list url): <u>SEE PART V, SECTION C</u>		
b	<input type="checkbox"/> Other website (list url): _____		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 . . . . .	X	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>15</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . .	X	
a	If "Yes," (list url): <u>SEE PART V, SECTION C</u>		
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .		X
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .		
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 WEST GEORGIA MEDICAL CENTER, INC.

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
<b>13</b>	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	X	
<b>a</b>	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>125.0000</u> % and FPG family income limit for eligibility for discounted care of <u>300.0000</u> %		
<b>b</b>	<input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b>	<input checked="" type="checkbox"/> Asset level		
<b>d</b>	<input checked="" type="checkbox"/> Medical indigency		
<b>e</b>	<input checked="" type="checkbox"/> Insurance status		
<b>f</b>	<input checked="" type="checkbox"/> Underinsurance status		
<b>g</b>	<input type="checkbox"/> Residency		
<b>h</b>	<input checked="" type="checkbox"/> Other (describe in Section C)		
<b>14</b>	Explained the basis for calculating amounts charged to patients? . . . . .	X	
<b>15</b>	Explained the method for applying for financial assistance? . . . . . If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	X	
<b>a</b>	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</b>	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
<b>c</b>	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
<b>d</b>	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b>	<input checked="" type="checkbox"/> Other (describe in Section C)		
<b>16</b>	Was widely publicized within the community served by the hospital facility? . . . . . If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	X	
<b>a</b>	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>SEE PART V, SECTION C</u>		
<b>b</b>	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE PART V, SECTION C</u>		
<b>c</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V, SECTION C</u>		
<b>d</b>	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b>	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>f</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>g</b>	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
<b>h</b>	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b>	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
<b>j</b>	<input checked="" type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information** (continued)

**Billing and Collections**

Name of hospital facility or letter of facility reporting group WEST GEORGIA MEDICAL CENTER, INC.

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

**Policy Relating to Emergency Medical Care**

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

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

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

Name of hospital facility or letter of facility reporting group WEST GEORGIA MEDICAL CENTER, INC.

		Yes	No
<b>22</b>	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.		
	<b>a</b> <input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
	<b>b</b> <input checked="" type="checkbox"/> 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		
	<b>c</b> <input type="checkbox"/> 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		
	<b>d</b> <input type="checkbox"/> The hospital facility used a prospective Medicare or Medicaid method		
<b>23</b>	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.		X
<b>24</b>	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.		X

**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, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

SCHEDULE H, PART V, SECTION B, LINE 3J

OTHER DESCRIPTIONS FROM THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA):

ON APRIL 1, 2016 WEST GEORGIA HEALTH MERGED WITH THE MARIETTA, GEORGIA BASED WELLSTAR HEALTH SYSTEM AND BECAME KNOWN AS WELLSTAR WEST GEORGIA MEDICAL CENTER ("WGMC" OR "WELLSTAR WGMC").

BECAUSE OF WELLSTAR HEALTH SYSTEM'S MERGER WITH WELLSTAR WGMC AND FIVE ADDITIONAL, NEWLY CONVERTED NOT-FOR-PROFIT HOSPITALS ON APRIL 1, 2016, WELLSTAR PLANS TO CONDUCT ITS NEXT COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) AND IMPLEMENTATION STRATEGY REPORTING TO ALIGN WITH THE REQUIREMENTS OF THE NEWLY CONVERTED HOSPITALS BY JUNE 30, 2019.

THIS MEANS THAT ALL HOSPITALS WITHIN WELLSTAR HEALTH SYSTEM WILL SUBMIT CHNA REPORTS AND IMPLEMENTATION STRATEGIES TO MEET THE 501(R) REQUIREMENTS BY YEAR ENDING JUNE 30, 2019.

LOCATED IN LAGRANGE, GEORGIA, WELLSTAR WEST GEORGIA MEDICAL CENTER HAS SERVED TROUP COUNTY FOR NEARLY 80 YEARS. THIS 276-BED FACILITY HAS FOCUSED ON DELIVERING HIGH-QUALITY HEALTHCARE TO ITS COMMUNITY THROUGH TOP RATED SERVICES, RECENTLY BEING NAMED TOP LARGE HOSPITAL IN GEORGIA BY GEORGIA TREND MAGAZINE.

PROUD TO BE PART OF WELLSTAR, THE LARGEST HEALTH SYSTEM IN GEORGIA, KNOWN NATIONALLY FOR ITS INNOVATIVE CARE MODELS, FOCUSED ON IMPROVING QUALITY AND ACCESS TO HEALTHCARE. WELLSTAR ALSO INCLUDES WELLSTAR MEDICAL GROUP,

**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, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

240 MEDICAL OFFICE LOCATIONS, OUTPATIENT CENTERS, HEALTH PARKS, A PEDIATRIC CENTER, NURSING CENTERS, HOSPICE, HOMECARE, AS WELL AS ADDITIONAL INPATIENT HOSPITALS: WELLSTAR DOUGLAS, WELLSTAR ATLANTA MEDICAL CENTER, WELLSTAR ATLANTA MEDICAL CENTER SOUTH, WELLSTAR COBB, WELLSTAR NORTH FULTON, WELLSTAR PAULDING, WELLSTAR SPALDING REGIONAL, WELLSTAR SYLVAN GROVE AND WELLSTAR WINDY HILL HOSPITALS.

THE 2010 AFFORDABLE CARE ACT (ACA) REQUIRES ALL NOT-FOR-PROFIT HOSPITALS TO COMPLETE A COMMUNITY HEALTH NEED ASSESSMENT (CHNA) AND IMPLEMENTATION STRATEGY EVERY THREE YEARS TO BETTER MEET THE HEALTH NEEDS OF UNDER-RESOURCED POPULATIONS LIVING IN THE COMMUNITIES THEY SERVE. WHAT FOLLOWS IS A COMPREHENSIVE CHNA THAT MEETS INDUSTRY STANDARDS INCLUDING IRS FINAL REGULATIONS OF SECTION 501(R) ENTITLED "ADDITIONAL REQUIREMENTS FOR CHARITABLE HOSPITALS."

SCHEDULE H, PART V, SECTION B, LINE 5

INPUT FROM COMMUNITY REPRESENTATIVES & COMMUNITY SOURCES: SECONDARY PUBLIC HEALTH DATA ON DISEASE INCIDENCE AND MORTALITY, AS WELL BEHAVIORAL HEALTH RISK FACTORS, WERE GATHERED FROM NUMEROUS SOURCES, INCLUDING:

- GEORGIA DEPARTMENT OF HEALTH
- HEALTHY COMMUNITIES INSTITUTE
- CENTERS FOR DISEASE CONTROL AND PREVENTION
- HEALTHY PEOPLE 2020
- COUNTY HEALTH RANKINGS

**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, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

-GEORGIA BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (BRFSS), PUBLIC

HEALTH DISTRICT 4

-NIELSON/CLARITAS DEMOGRAPHIC DATABASE

DATA WAS COLLECTED FROM NATIONAL, LOCAL AND REGIONAL SOURCES, AS  
AVAILABLE.

INPUT FROM COMMUNITY REPRESENTATIVES AND COMMUNITY SOURCES:

FOR THE 2016 CHNA, WELLSTAR WGMC RECEIVED AND COLLECTED COMMUNITY INPUT  
THROUGH:

-341 SURVEYS RESPONDENTS

-9 STAKEHOLDER INTERVIEWS

-15 FOCUS GROUPS (SPEAKING WITH 151 PEOPLE)

PARTICIPANTS IN THIS ACTIVITIES REPRESENTED PUBLIC HEALTH REPRESENTATIVES  
INCLUDING:

-BREAST CANCER PATIENTS

-UNITED WAY AGENCY DIRECTORS

-SOCIAL WORKERS

-EMERGENCY DEPARTMENT STAFF

-PRIMARY CARE DOCTORS

-CLINIC ADMINISTRATORS

-DIETITIANS

-TROUP COUNTY CENTER FOR STRATEGIC PLANNING BOARD MEMBERS

-UNDERSERVED POPULATION MEMBERS

-SENIOR CITIZENS

-LAGRANGE/HOGANSVILLE/WEST POINT COMMUNITY MEMBERS

**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, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

-COMMUNITY SERVICE AGENCIES

-TROUP CARES

-TROUP COUNTY SCHOOL BOARD MEMBERS

-CONIFER HEALTH SERVICES (WGMC'S OUTSOURCED VENDOR OVERSEEING PATIENT ACCESS AND FINANCIAL ASSISTANCE)

-REPRESENTATIVES FROM TROUP COUNTY'S HISPANIC COMMUNITY

SCHEDULE H, PART V, SECTION B, LINE 7A

WELLSTAR WEST GEORGIA MEDICAL CENTER'S COMMUNITY HEALTH NEEDS ASSESSMENT

CAN BE FOUND ON THE FOLLOWING WEB ADDRESS: WWW.WELLSTAR.ORG/CHNA AND

CLICKING ON THE 2018 COMMUNITY HEALTH NEEDS ASSESSMENT LINK UNDER THE

WEST GEORGIA HEADER

OR DIRECTLY:

[HTTPS://WWW.WELLSTAR.ORG/ABOUT-US/DOCUMENTS/CHNA/](https://www.wellstar.org/about-us/documents/chna/)

WGMC\_CHNA\_REPORT\_FINAL\_REVISIED\_10-10-10.PDF

AND

[HTTPS://WWW.WELLSTAR.ORG/ABOUT-US/DOCUMENTS/CHNA/](https://www.wellstar.org/about-us/documents/chna/)

WGH\_CHNA\_IMPLEMENTATION\_STRATEGY\_9-13-13.PDF

SCHEDULE H, PART V, SECTION B, LINE 10A

WELLSTAR WEST GEORGIA MEDICAL CENTER'S IMPLEMENTATION STRATEGY CAN BE

FOUND ON THE FOLLOWING WEB ADDRESS: WWW.WELLSTAR.ORG/CHNA AND CLICKING ON

THE 2018 COMMUNITY HEALTH NEEDS ASSESSMENT LINK UNDER THE WEST GEORGIA

HEADER

OR DIRECTLY:

**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, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

[HTTPS://WWW.WELLSTAR.ORG/ABOUT-US/DOCUMENTS/CHNA/](https://www.wellstar.org/about-us/documents/chna/)

WGMC\_CHNA\_REPORT\_FINAL\_REVISIED\_10-10-10.PDF

AND

[HTTPS://WWW.WELLSTAR.ORG/ABOUT-US/DOCUMENTS/CHNA/](https://www.wellstar.org/about-us/documents/chna/)

WGH\_CHNA\_IMPLEMENTATION\_STRATEGY\_9-13-13.PDF

SCHEDULE H, PART V, SECTION B, LINE 11

PROGRAMS & STRATEGIES TO ADDRESS THE NEEDS OF THE COMMUNITY:

DURING JULY AND AUGUST 2016, THE WELLSTAR WEST GEORGIA MEDICAL CENTER COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) STEERING COMMITTEE CONDUCTED AN EVALUATION OF ITS IMPLEMENTATION STRATEGIES FOR THE 2015-2016 FISCAL YEAR ENDING JUNE 30, 2016 (AND BASED ON THE PREVIOUS CHNA CONDUCTED IN 2012-13). IT SHOULD BE NOTED THAT THE AFOREMENTIONED IS FISCAL YEAR ONLY REPRESENTS NINE (9) MONTHS OF ACTIVITIES, DUE TO THE MERGER WITH WELLSTAR HEALTH SYSTEM, WHICH INCLUDED AN ADJUSTMENT IN THE FISCAL YEAR ENDING DATE.

THE EVALUATION PROCESS INCLUDED:

- STATUS REPORT OF ACTIVITIES AND COMPILING YEAR-END OUTCOME/ AND IMPACT METRICS;
- STEERING COMMITTEE MEETING TO RATE THE ACCOMPLISHMENTS OF EACH GOAL AND DETERMINE IF THE CURRENT IMPLEMENTATION STRATEGIES SHOULD BE CONTINUED, DISCONTINUED OR MODIFIED; AND
- ACTION PLAN UPDATE FOR THE UPCOMING FISCAL YEAR, WHICH WAS NOT ONLY BASED ON THE EVALUATION PROCESS, BUT ALSO REFLECTED THE PRIORITY FOCUS



**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, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

AREAS IDENTIFIED IN THE 2016 CHNA.

THE STEERING COMMITTEE MET ON AUGUST 24, 2016 TO REVIEW THE STATUSES, OUTCOMES, AND IMPACTS OF THE VARIOUS IMPLEMENTATION STRATEGIES ACCOMPLISHED THROUGHOUT THE PREVIOUS FISCAL YEAR.

SOME HIGHLIGHTS OF THE OUTCOMES/IMPACT DATA INCLUDED:

GOAL 1: ACCESS

HIGHLIGHTS OF THE PROGRESS AND OUTCOMES INCLUDED:

- WELLSTAR WGMC RECRUITED ONE PULMONARY CRITICAL CARE SPECIALIST IN SEPTEMBER 2015, AS WELL AS A NEW UROLOGIST AND A NEW ENDOCRINOLOGIST, BOTH OF WHOM ARE SCHEDULED TO JOIN WEST GEORGIA PHYSICIANS IN LATE 2016.
- \$52,826,055 FOR UNCOMPENSATED CARE (CHARITY CARE AND BAD DEBT) + \$563,427 IN CARE PROVIDED TO TROUP CARES PATIENTS IN FY 2016.
- THERE ARE CURRENTLY 100 ACTIVE PATIENTS IN COMMUNITY SERVICE CLINIC. WE HAVE NOT BEEN TRACKING SEPARATELY THE OUTCOMES OF PATIENTS COMING INTO OUR CLINIC.
- THE COMMUNITY RESOURCE DIRECTORY IS COMPLETED AND IN THE PROCESS OF BEING PROGRAMMED TO BE AVAILABLE AS AN INTERACTIVE MAP ON THE WEBSITE.
- TRANSPORTATION CONTINUES TO BE A CHALLENGE FOR PATIENTS ACCESSING CARE, PARTICULARLY FROM HOGANSVILLE AND WEST POINT.

GOAL 2: CHRONIC DISEASE PREVENTION AND MANAGEMENT

HIGHLIGHTS OF THE PROGRESS AND OUTCOMES INCLUDED:

- 1,191 PARTICIPANTS COMPLETED SCREENINGS IN THE WELLSTAR WGMC EMPLOYEE

**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, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

WELLNESS PROGRAM (861 EMPLOYEES & 330 SPOUSES).

- 541 EMPLOYEES WERE AT GOLD STATUS OR HIGHER BY 12/31/15.
- OUR NEW PULMONARY CRITICAL CARE SPECIALIST, DR. SALMAN FIDAHUSSEIN, HAS ACCEPTED THE ROLE OF PHYSICIAN CHAMPION TO IMPLEMENT A LUNG CT SCREENING PROGRAM.
- 355 SMOKING CESSATION BROCHURES HAVE BEEN ISSUED. 112 SMOKERS RECEIVED 2ND TIER COUNSELING.
- 2600 COLONOSCOPIES HAVE BEEN PERFORMED.
- 158 TOTAL PEOPLE WERE SCREENED IN 3 QUARTERLY HEALTH SCREENINGS AT THE ACTIVE LIFE CENTER.
- 250 PARTICIPANTS IN COMMUNITY AND WORKSITE HEALTH FAIRS.
- PROJECT RED READMISSION RATE FOR 10/1/15-6/30/16= 16.03%.
- 6440 PEOPLE RECEIVED STROKE EDUCATION.
- 100% OF NEWLY DIAGNOSED PATIENTS IN BOTH MEDICAL AND RADIATION ONCOLOGY HAD DISTRESS ASSESSMENTS WITH APPROPRIATE INTERVENTIONS.
- WGMC ACHIEVED 1.79 MEDIAN HOURS FOR THE # MINUTES FROM ACUTE MYOCARDIAL INFARCTION SYMPTOM ONSET TO HOSPITAL PRESENTATION OVER THE PERIOD OF JULY 2015-JUNE 2016. THIS ACHIEVEMENT IS BELOW THE U.S. MEDIAN OF 1.98 HOURS OVER A ROLLING FOUR QUARTER PERIOD.

GOAL 3: HEALTHY YOUTH

THE HIGHLIGHTS OF THE OUTCOMES AND PROGRESS INCLUDED:

- DUE TO POOR ATTENDANCE, THE TEEN PREGNANCY CLASSES WERE NOT OFFERED.
- CIRCLE OF GIRLS CLASSES WERE HELD TWO TIMES DURING THIS REPORTING PERIOD WITH 15 DAUGHTER/MOM COUPLES SERVED.

**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, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

- THE TROUP TEEN PREGNANCY PREVENTION STRATEGY TEAM IS STILL ACTIVE; HOWEVER, IT ONLY MEETS BI-ANNUALLY AT THIS TIME. DURING THE SECOND SEMESTER OF THE 2015-16 SCHOOL YEAR, THE TROUP COUNTY SCHOOL DISTRICT BEGAN TEACHING CURRICULUM RELATED TO UNSAFE BEHAVIORS AND HEALTH EDUCATION.
- NEITHER SEX, TRUTH AND CONSEQUENCES CLASS NOR THE TEEN MAZE CLASS WAS HELD DURING THIS REPORTING PERIOD.
- 352 PATIENTS SCREENED; PERIOD OF PURPLE CRYING DVD GIVEN TO ALL PARENTS SCREENED AND DISCUSSED BY FIRST STEPS PROGRAM. THE COORDINATOR DID NOT UTILIZE THE MEASUREMENT TOOL CREATED TO MEASURE KNOWLEDGE GAINED, BUT THE TEAM WILL STUDY WAYS TO ENSURE IMPLEMENTATION IN FY 2017.

A TOTAL OF 18 STEERING COMMITTEE MEMBERS PARTICIPATED IN THE RATING PROCESS. PROGRESS FOR EACH OF THE GOALS WAS RATED ON A 5-POINT SCALE WHERE 5 = EXCELLENT AND 1 = POOR. THE RESULTS OF THE EVALUATION INCLUDED:

- ACCESS RELATED OBJECTIVES WERE GIVEN AN AVERAGE SCORE OF 3.9, WITH 83% OF THE PARTICIPANTS RATING PROGRESS EXCELLENT OR VERY GOOD. THE MAJORITY (88%) OF PARTICIPANTS INDICATED THAT IT WAS EXTREMELY IMPORTANT TO CONTINUE THESE INTERVENTION STRATEGIES. SUGGESTIONS TO IMPROVE EFFORTS FOR THE UPCOMING YEAR INCLUDED CONTINUING TO REMOVE BARRIERS TO TRANSPORTATION, RECRUITING ADDITIONAL PRIMARY CARE PROVIDERS AND EXPANDING SERVICE HOURS.
- CHRONIC DISEASE MANAGEMENT OBJECTIVES WERE GIVEN AN AVERAGE SCORE OF 3.9 WITH 74% OF THE PARTICIPANTS PROVIDING EXCELLENT OR VERY GOOD

**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, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

RATINGS. SUGGESTIONS TO IMPROVE EFFECTIVENESS INCLUDED FOCUSING ON STRATEGIES TO TRULY EFFECT CHANGE (NOT JUST OFFER PROGRAMS) AND IMPROVE DATA COLLECTION AND COMMUNITY PARTNERSHIP EFFORTS.

- HEALTHY YOUTH RELATED OBJECTIVES WERE NOT RATED BECAUSE THEY WILL NOT CONTINUE TO BE PART OF THE FOCUS AREAS FOR THE 2016 IMPLEMENTATION STRATEGIES.

WGMC IS CONTINUING TO WORK ON THE FOLLOWING ACTION ITEMS THAT COULDN'T BEGIN IN 2016 DUE TO TIME AND/OR RESOURCE CONSTRAINTS:

- ACTIVE RECRUITMENT OF AN INTERVENTIONAL CARDIOLOGIST. RECRUITMENT EFFORTS ARE ON HOLD FOR A DERMATOLOGIST, A SECOND PULMONARY CRITICAL CARE SPECIALIST AND PRIMARY CARE PHYSICIANS ARE ON HOLD UNTIL WE RECEIVE THE RESULTS OF THE NEW PHYSICIAN MANPOWER STUDY CURRENTLY UNDERWAY.

- FINDING A SOLUTION TO INVOLVE MORE DIABETES PATIENTS IN EDUCATIONAL/NUTRITIONAL OUTREACH.

- INCREASING PARTICIPATION IN TEEN PREGNANCY EDUCATION CLASSES AND BEGINNING CLASSES REGARDING TEEN-HEALTH RELATED NEEDS AND ISSUES. DURING THE COURSE OF THE CHNA YEAR 1 EVALUATION IN 2014, IT WAS DETERMINED THAT IMPLEMENTING A MOBILE HEALTH CLINIC, ALONG WITH BREAST CANCER, COLON CANCER, PROSTATE CANCER, DIABETES AND STROKE RISK ASSESSMENT PRODUCTS WERE NOT FINANCIALLY FEASIBLE AND WOULD NOT BE PURSUED FURTHER.

SCHEDULE H, PART V, SECTION B, LINE 13B

FAP ELIGIBILITY CRITERIA - INCOME LEVEL OTHER THAN FPG:

THE HOSPITAL ABIDES BY THE FINANCIAL ASSISTANCE REQUIREMENTS UNDER IRC

**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, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

501(R)(5). IRC 501(R)(5) REQUIRES HEALTH CARE FACILITIES TO LIMIT THE AMOUNTS CHARGED FOR EMERGENCY AND OTHER MEDICALLY NECESSARY CARE THAT IS PROVIDED TO INDIVIDUALS ELIGIBLE FOR ASSISTANCE UNDER THE HEALTH CARE FACILITIES FINANCIAL ASSISTANCE POLICY TO NOT MORE THAN THE AMOUNTS GENERALLY BILLED TO INDIVIDUALS WHO HAVE INSURANCE. THE HOSPITAL EXTENDS ITS SLIDING SCALE FOR FINANCIAL ASSISTANCE POLICY (FAP) ELIGIBILITY WELL BEYOND THE MINIMUM GOVERNMENT LEVELS TO 300% OF FPG. WELLSTAR HAS CHOSEN TO USE THE AVERAGE OF THE THREE BEST NEGOTIATED COMMERCIAL RATES AS THE TRIGGER TO NOT EXCEED IN THE APPLICATION OF THE DISCOUNTS/AMOUNTS CHARGED TO PATIENTS, ON OUR SLIDING SCALE.

SCHEDULE H, PART V, SECTION B, LINE 13H

FAP ELIGIBILITY CRITERIA - OTHER CRITERIA:

OTHER SPECIAL CIRCUMSTANCES MAY QUALIFY A PATIENT FOR FULL INDIGENT OR SLIDING SCALE CHARITY BENEFITS. SPECIAL CIRCUMSTANCES MAY INCLUDE BUT NOT LIMITED TO:

- PATIENT DECEASED, WITH VERIFICATION THAT THERE IS NO ESTATE.
- UNABLE TO CONTACT PATIENT BUT PROPENSITY TO PAY SOFTWARE RETURNS A LOW ABILITY/LOW PROPENSITY DESIGNATION.

SCHEDULE H, PART V, SECTION B, LINE 15E

METHOD FOR APPLYING FOR FINANCIAL ASSISTANCE:

IN ORDER TO QUALIFY FOR FINANCIAL ASSISTANCE, COOPERATION WITH WELLSTAR HEALTH SYSTEM HOSPITAL FINANCIAL ASSISTANCE STAFF IS NECESSARY IN IDENTIFYING AND DETERMINING ALTERNATIVE SOURCES OF PAYMENT OR COVERAGE

**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, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

FROM PUBLIC AND PRIVATE PAYMENT PROGRAMS. IN PARTICULAR, ALL APPLICANTS FILING A FAP APPLICATION FOR FINANCIAL ASSISTANCE MUST PROVIDE PROOF OF HOUSEHOLD INCOME AND HOUSEHOLD ASSETS BY PROVIDING ANY OR ALL OF THE FOLLOWING THAT ARE APPLICABLE:

- PROVIDE THREE (3) MONTHS OF THE MOST RECENT PAYCHECK STUBS OR A STATEMENT FROM EMPLOYER VERIFYING GROSS WAGES
- IRS W-2 ISSUED DURING THE PAST YEAR
- MOST RECENT IRS FORM 1040
- MOST RECENT TWO (2) MONTHS OF BANK STATEMENTS FOR EACH CHECKING, SAVINGS, MONEY MARKET OR OTHER BANK OR INVESTMENT ACCOUNT
- WRITTEN STATEMENTS FOR THE MOST RECENT TWO (2) MONTHS FOR ALL OTHER INCOME (E.G., UNEMPLOYMENT COMPENSATION, DISABILITY, RETIREMENT, STUDENT LOANS, AWARD LETTER FROM SOCIAL SECURITY OFFICE, CURRENT PROFIT AND LOSS REPORT FOR ALL SELF-EMPLOYED APPLICANTS, ALIMONY DOCUMENTATION, CHILD SUPPORT DOCUMENTATION, ETC.)
- UNEMPLOYMENT COMPENSATION DENIAL LETTER
- DOCUMENTATION OF ASSET VALUES, INCLUDING, WITHOUT LIMITATION, PROPERTY TAX STATEMENTS, CERTIFICATES OF DEPOSIT, 401K, 403B, IRA AND OTHER INVESTMENT STATEMENTS
- CONTRIBUTION STATEMENTS FROM INDIVIDUALS WHO CONTRIBUTE INCOME OR IN-KIND ASSISTANCE TO THE PATIENT. FINANCIAL ASSISTANCE POLICY ELIGIBILITY WILL BE DETERMINED BASED ON A THOROUGH REVIEW OF THE SUBMITTED INFORMATION.

**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, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

SCHEDULE H, PART V, SECTION B, LINE 16A

THE WELLSTAR HEALTH SYSTEM COMMUNITY FINANCIAL ASSISTANCE POLICY CAN BE FOUND ON ITS WEBSITE:

[HTTPS://WWW.WELLSTAR.ORG/ABOUT-US/POLICIES-PROCEDURES/PAGES/COMMUNITY-FINANCIAL-ASSISTANCE-POLICY.ASPX](https://www.wellstar.org/about-us/policies-procedures/pages/community-financial-assistance-policy.aspx)

SCHEDULE H, PART V, SECTION B, LINE 16B

THE WELLSTAR HEALTH SYSTEM FINANCIAL ASSISTANCE APPLICATION CAN BE FOUND ON ITS WEBSITE:

[HTTPS://WWW.WELLSTAR.ORG/ABOUT-US/POLICIES-PROCEDURES/PAGES/COMMUNITY-FINANCIAL-ASSISTANCE-POLICY.ASPX](https://www.wellstar.org/about-us/policies-procedures/pages/community-financial-assistance-policy.aspx)

AND CLICKING APPLICATION IN THE RIGHT NAVIGATION BOX TITLED RELATED DOCUMENTS. A WINDOW WILL APPEAR THAT ALLOW YOU TO SCROLL TO THE APPROPRIATE WELLSTAR HOSPITAL AND CLICK FOR A PDF VERSION OF THE APPLICATION TO PRINT OR DOWNLOAD.

SCHEDULE H, PART V, SECTION B, LINE 16C

A PLAIN LANGUAGE SUMMARY OF THE WELLSTAR HEALTH SYSTEM FINANCIAL ASSISTANCE APPLICATION CAN BE FOUND ON ITS WEBSITE:

[HTTPS://WWW.WELLSTAR.ORG/ABOUT-US/POLICIES-PROCEDURES/DOCUMENTS/FAP-PLAIN-LANGUAGE-SUMMARY-WGH.PDF](https://www.wellstar.org/about-us/policies-procedures/documents/fap-plain-language-summary-wgh.pdf)

SCHEDULE H, PART V, SECTION B, LINE 16J

PUBLICATION OF THE FINANCIAL ASSISTANCE POLICY (FAP):

IN ADDITION TO THE OTHER METHODS OF POSTING THE FINANCIAL ASSISTANCE

**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, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

POLICY, THE HOSPITAL MAKES AVAILABLE FOR PATIENTS IN ADMISSIONS AND  
OUTPATIENT REGISTRATION AREAS A PROMINENTLY DISPLAYED SIGN STATING  
FINANCIAL ASSISTANCE IS AVAILABLE AND A BROCHURE INCLUDING FREQUENTLY  
ASKED QUESTIONS.

SCHEDULE H, PART V, SECTION B, LINE 20E

ADDITIONAL EFFORTS MADE BEFORE COLLECTIONS ACTION INITIATED:

THE HOSPITAL FACILITY ALSO NOTIFIED INDIVIDUALS OF THE FINANCIAL  
ASSISTANCE POLICY ONLINE AT:

[HTTP://WWW.WELLSTAR.ORG/PAGES/ONLINE-BILL-PAY.ASPX](http://www.wellstar.org/pages/online-bill-pay.aspx)

FURTHERMORE, THE HOSPITAL FACILITY UTILIZES A PROPENSITY TO PAY SOFTWARE.  
INDIVIDUALS WITH A LOW ABILITY/LOW PROPENSITY DESIGNATION MAY QUALIFY FOR  
FULL INDIGENT OR SLIDING SCALE CHARITY BENEFITS.



**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? 6

Name and address	Type of Facility (describe)
<b>1</b> FLORENCE HAND HOME 200 MEDICAL DRIVE LAGRANGE GA 30240	LONG TERM CARE
<b>2</b> TWIN FOUNTAINS HOME 1400 HOGANSVILLE ROAD LAGRANGE GA 30240	LONG TERM CARE
<b>3</b> HOSPICE LAGRANGE 1510 VERNON ROAD LAGRANGE GA 30240	HOSPICE
<b>4</b> WEST GEORGIA WOUND CARE 1600 VERNON RD. SUITE G LAGRANGE GA 30240	WOUND CARE
<b>5</b> WEST GEORGIA HOME CARE 120 GLEN BASE ROAD LAGRANGE GA 30240	HOME HEALTH; SKILLED NURSING
<b>6</b> WOMEN'S HEALTH CENTER 1420 VERNON ROAD LAGRANGE GA 30240	WOMEN'S CENTER
<b>7</b>  	
<b>8</b>  	
<b>9</b>  	
<b>10</b>  	

**Part VI Supplemental Information**

Provide the following information.

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

SCHEDULE H, PART I, LINE 6A

PUBLICATION OF COMMUNITY BENEFIT REPORT:

WEST GEORGIA MEDICAL CENTER, INC. IS AN AFFILIATE OF WELLSTAR HEALTH SYSTEM, INC. WHICH ON AN ANNUAL BASIS ISSUES A COMMUNITY BENEFIT REPORT. THIS REPORT IS SUBSEQUENTLY DISTRIBUTED IN AND AROUND THE FIVE-COUNTY PRIMARY SERVICE AREA OF THE HEALTH SYSTEM.

ON AN ANNUAL BASIS THE HOSPITAL REPORTS ITS COMMUNITY HEALTH BENEFITS REPORT TO THE GEORGIA HOSPITAL ASSOCIATION (GHA). GHA AGGREGATES THE HOSPITAL SPECIFIC REPORTS INTO A STATEWIDE COMMUNITY HEALTH BENEFIT REPORT. THE STATE OF GEORGIA ALSO REQUIRES HOSPITALS TO FILE THE HOSPITAL FINANCIAL SURVEY AND THE INDIGENT CARE TRUST FUND SURVEY SO THAT IT CAN COLLECT INFORMATION ON HOSPITAL FINANCIAL CLASS CATEGORIES AND ALSO TO DETERMINE THE AMOUNT OF UNCOMPENSATED CARE BY HOSPITAL.

THE COMMUNITY BENEFIT REPORT CAN BE FOUND AT THE FOLLOWING LINK:

[HTTPS://WWW.WELLSTAR.ORG/COMMUNITY/DOCUMENTS/WELLSTAR-COMMUNITY-BENEFITS-REPORT.PDF](https://www.wellstar.org/community/documents/wellstar-community-benefits-report.pdf)

**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.

SCHEDULE H, PART I, LINE 7

COST TO CHARGE RATIO:

FOR PURPOSES OF THE IRS FORM 990, SCHEDULE H, WELLSTAR HEALTH SYSTEM AND AFFILIATES (INCLUDING WEST GEORGIA MEDICAL CENTER, INC.) HAVE ESTIMATED THE CURRENT YEAR COST TO CHARGE RATIO FOR EACH HOSPITAL AS IT IS REPORTED IN THE ANNUAL COMMUNITY BENEFIT REPORT AND AS IT WILL BE REPORTED IN THE STATE'S ANNUAL HOSPITAL FINANCIAL SURVEY.

SCHEDULE H, PART III, SECTION A, LINE 2

METHODOLOGY USED TO ESTIMATE BAD DEBT:

THE REPORTED BAD DEBT CHARGES IS DERIVED FROM THE UNPAID BALANCES OF PATIENT ACCOUNTS THAT ARE DEEMED UNCOLLECTIBLE AFTER 120 DAYS OF COLLECTION EFFORT BY THE HOSPITAL'S PATIENT FINANCIAL SERVICES STAFF. THE UNPAID PATIENT ACCOUNTS ARE THEN SENT TO COLLECTION AGENCIES AND ANY COLLECTED AMOUNT IS DEEMED AS BAD DEBT RECOVERY. THE SOURCE OF THIS DATA IS THE HOSPITAL'S DETAILED FINANCIAL TRIAL BALANCE. THE NET REPORTED BAD DEBT CHARGES ARE THEN MULTIPLIED BY THE HOSPITAL FINANCIAL SURVEY

**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.

CALCULATED COST TO CHARGE RATIO TO ARRIVE AT THE ESTIMATED BAD DEBT  
EXPENSE.

SCHEDULE H, PART III, SECTION B, LINE 8

MEDICARE SHORTFALLS:

WELLSTAR WEST GEORGIA MEDICAL CENTER, INC. IS A PROVIDER OF INPATIENT AND  
OUTPATIENT SERVICES TO MEDICARE PROGRAM BENEFICIARIES AT DETERMINED  
RATES. WITHOUT THE PARTICIPATION IN THE MEDICARE PROGRAM THESE PATIENTS  
MAY NOT HAVE HAD CONVENIENT ACCESS TO THOSE SERVICES.

THE MEDICARE SHORTFALL ON SCHEDULE H, PART III, SECTION B, LINE 7  
REPRESENTS THE UNCOMPENSATED DIFFERENCE BETWEEN THE EXPECTED  
REIMBURSEMENT AND THE MEDICARE CHARGES FOR THOSE SERVICES STATED AT COST.  
WE DETERMINE A COST TO CHARGE RATIO FOR MEDICARE PATIENTS AS PART OF THE  
ANNUAL FILING OF THE MEDICARE COST REPORT.

SCHEDULE H, PART III, SECTION C, LINE 9B

COLLECTION PRACTICES:

THE POLICY WRITTEN FOR COLLECTION PRACTICES THAT APPLIES TO ALL WELLSTAR

**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.
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- 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.

HEALTH SYSTEM ENTITIES INCORPORATES GUIDELINES FOR PERSONNEL IN THE ADMISSIONS AND PATIENT ACCESS AREAS TO BE TRAINED IN IDENTIFYING PATIENTS THAT MIGHT QUALIFY FOR FINANCIAL ASSISTANCE. IT IS ALSO THE POLICY OF ALL WELLSTAR FACILITIES TO HAVE AT LEAST ONE EMPLOYEE OR CONTRACTOR AVAILABLE AT ALL TIMES, ESPECIALLY IN THE HOSPITALS WITH EMERGENCY ROOMS, WHO CAN PROVIDE ASSISTANCE WITH THE PAPERWORK NECESSARY TO HELP PATIENTS WHO WOULD QUALIFY FOR GOVERNMENTAL AND OTHER ASSISTANCE PROGRAMS.

SCHEDULE H, PART VI, LINE 2

NEEDS ASSESSMENT:

FOR ITS 2016 COMMUNITY HEALTH NEEDS ASSESSMENT, WEST GEORGIA MEDICAL CENTER IDENTIFIED AND ASSESSED THE HEALTH NEEDS OF THE COMMUNITY THROUGH THE FOLLOWING STEPS.

- 1.) THE MEMBERS OF THE EXISTING CHNA STEERING COMMITTEE ESTABLISHED IN 2012 CONTINUED THEIR SERVICE ON THE 2016 CHNA STEERING COMMITTEE.
- 2.) THE COMMITTEE DEFINED THE COMMUNITY AS ITS PRIMARY SERVICE AREA - TROUP COUNTY, GA.
- 3.) THE COMMITTEE IDENTIFIED AND ENGAGED COMMUNITY LEADERS AND

**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.
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- 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.

STAKEHOLDERS IN LAGRANGE, WEST POINT AND HOGANSVILLE, GA, AS WELL AS MEMBERS OF UNDERSERVED POPULATIONS, SENIOR CITIZENS, PUBLIC HEALTH REPRESENTATIVES, PHYSICIANS, SOCIAL WORKERS, DIETITIANS, EMERGENCY MEDICAL PERSONNEL AND TROUP COUNTY SCHOOL BOARD MEMBERS.

4.) WGMC WORKED WITH CONSULTANTS FROM STRATEGY SOLUTIONS TO CREATE A COMMUNITY HEALTH PROFILE THAT ADDRESSED ACCESS TO PREVENTIVE HEALTH SERVICES, UNDERLYING CAUSES OF HEALTH PROBLEMS, AND MAJOR CHRONIC DISEASES OF THE POPULATION. SECONDARY DATA CAME FROM A VARIETY OF SOURCES INCLUDING VITAL RECORDS, STATE AND NATIONAL HEALTH STATUS DATA AND HOSPITAL UTILIZATION DATA.

5.) THE TEAM GAINED COMMUNITY INPUT VIA MEETINGS WITH COMMUNITY LEADERS AND STAKEHOLDERS AND OTHERS REPRESENTING VARIOUS POPULATIONS, AS WELL AND AN ELECTRONIC SURVEY.

6.) THE TEAM DEVELOPED A PRIORITIZATION OF NEEDS TO ADDRESS.

7.) THE TEAM DEVELOPED IMPLEMENTATION STRATEGIES TO ADDRESS THE IDENTIFIED NEEDS. THE WGMC BOARD OF TRUSTEES APPROVED THE CHNA ON JUNE 20, 2016 AND THE IMPLEMENTATION STRATEGIES ON OCTOBER 17, 2016 AND SENT THESE DOCUMENTS TO THE WELLSTAR HEALTH SYSTEM BOARD OF TRUSTEES FOR ITS

**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.
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- 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.

APPROVAL ON NOVEMBER 3, 2016.

SCHEDULE H, PART VI, LINE 3

PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE:

WEST GEORGIA MEDICAL CENTER, INC. PROVIDES NOTICE OF THE AVAILABILITY OF  
COMMUNITY FINANCIAL ASSISTANCE THROUGH THE FINANCIAL ASSISTANCE POLICY

(FAP) VIA:

-SIGNAGE

-PATIENT BROCHURE

-BILLING STATEMENT

-COLLECTION ACTION LETTER

-ONLINE AT:

[HTTPS://WWW.WELLSTAR.ORG/ABOUT-US/POLICIES-](https://www.wellstar.org/about-us/policies-)

[PROCEDURES/PAGES/COMMUNITY-FINANCIAL-ASSISTANCE-POLICY.ASPX](https://www.wellstar.org/about-us/policies-procedures/pages/community-financial-assistance-policy.aspx)

WEST GEORGIA MEDICAL CENTER, INC. PROVIDES ITS PATIENTS WITH HOSPITAL  
PERSONNEL OR CONTRACTED PERSONNEL WHO ARE TRAINED IN ALL ASPECTS OF  
GOVERNMENTAL PROGRAMS, PAYMENTS PLANS, CHARITY DISCOUNTS, AND OTHER

**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.
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- 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.

FINANCIAL ASSISTANCE OFFERED TO ASSIST THEM IN THEIR HOSPITAL BILLS. IF THE PATIENT IS ELIGIBLE FOR FEDERAL OR STATE ASSISTANCE PROGRAMS, A STAFF MEMBER IS KNOWLEDGEABLE IN THE STEPS NECESSARY TO QUALIFY THOSE INDIVIDUALS. IF A PATIENT IS INDIGENT OR CHARITY ELIGIBLE THEY WILL BE OFFERED ASSISTANCE THROUGH THE HOSPITAL'S CHARITY AND INDIGENT CARE POLICY INCLUDING THE STATE'S INDIGENT CARE TRUST FUND. IF THE PATIENT HAS NO OTHER INSURANCE AND FAILS TO QUALIFY FOR INDIGENT CARE ASSISTANCE, THE FINANCIAL COUNSELOR CAN THEN OFFER THE PATIENT AN OPPORTUNITY TO ACCEPT A PAYMENT PLAN WITH DISCOUNTED PAYMENT OPTIONS BASED ON THEIR ABILITY TO PAY IMMEDIATELY OR OVER TIME. ALL PATIENTS ARE AFFORDED THESE OPPORTUNITIES.

SCHEDULE H, PART VI, LINE 4

COMMUNITY INFORMATION:

WELLSTAR WEST GEORGIA MEDICAL CENTER, INC. ("WGMC") IS A 558-BED FACILITY LOCATED IN LAGRANGE, GEORGIA, APPROXIMATELY 70 MILES SOUTH OF ATLANTA. WGMC'S PRIMARY SERVICE AREA IS TROUP COUNTY WITH A POPULATION OF APPROXIMATELY 70,000 BUT, IT ALSO SERVES OTHER COUNTIES IN WEST CENTRAL



**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.
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- 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.

GEORGIA AND EAST CENTRAL ALABAMA.

APPROXIMATELY 19.3% OF THE POPULATION IN THE SERVICE AREA LIVE AT POVERTY LEVEL. ALMOST 25% OF THE POPULATION IS UNDER 18 YEARS OLD AND ABOUT 14% OF THE POPULATION IN THE SERVICE AREA IS OVER THE AGE OF 65. THE MEDIAN HOUSEHOLD INCOME IN THE PRIMARY SERVICE AREA IS APPROXIMATELY \$41,000.

SCHEDULE H, PART VI, LINE 5

PROMOTION OF COMMUNITY HEALTH:

AS STATED IN THE WELLSTAR HEALTH SYSTEM, INC. AND AFFILIATES AUDITED FINANCIAL STATEMENTS FOR THE PERIOD ENDED 6/30/2018 WEST GEORGIA MEDICAL CENTER, INC. (AN AFFILIATE OF WELLSTAR HEALTH SYSTEM, INC.) OPERATES AS A CHARITABLE ORGANIZATION CONSISTENT WITH THE REQUIREMENTS OF INTERNAL REVENUE CODE SECTION 501(C)(3) AND THE "COMMUNITY BENEFIT STANDARD" OF IRS RULING 69-545. IN THIS REGARD, THE GOVERNING BODY OF THE ORGANIZATION AND/OR ITS PARENT IS COMPOSED OF PROMINENT CITIZENS IN THE COMMUNITY, MEDICAL STAFF PRIVILEGES IN THE HOSPITAL ARE AVAILABLE TO ALL QUALIFIED PHYSICIANS IN THE AREA CONSISTENT WITH THE SIZE AND NATURE OF THE

**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.
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- 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.

FACILITY; WGMC OPERATES A FULL-TIME EMERGENCY ROOM OPEN TO ALL REGARDLESS OF ABILITY TO PAY; WGMC PROVIDES CARE TO THE NEEDY MEMBERS OF THE COMMUNITY CONSISTENT WITH ITS CHARITY CARE POLICY. THE HOSPITAL'S EXCESS FUNDS ARE GENERALLY APPLIED TO EXPANSION AND REPLACEMENT OF EXISTING FACILITIES AND EQUIPMENT, AMORTIZATION OF INDEBTEDNESS, IMPROVEMENT OF PATIENT CARE, COMMUNITY BENEFIT ACTIVITIES INCLUDING HEALTH EDUCATION, PREVENTIVE SCREENINGS AND HEALTH FAIRS, RESEARCH, SUBSIDIZED HEALTH SERVICES, AND CHARITY CARE. WEST GEORGIA MEDICAL CENTER, INC. COMMITTED APPROXIMATELY \$8.9 MILLION IN CAPITAL EXPENDITURES FOR THE YEAR TO MEET TECHNOLOGY AND PROGRAM NEEDS OF THE COMMUNITY IT SERVES.

SCHEDULE H, PART VI, LINE 6

AFFILIATED HEALTH CARE SYSTEM:

WELLSTAR HEALTH SYSTEM, THE LARGEST HEALTH SYSTEM IN GEORGIA, IS KNOWN NATIONALLY FOR ITS INNOVATIVE CARE MODELS, FOCUSED ON IMPROVING QUALITY AND ACCESS TO HEALTHCARE. WELLSTAR CONSISTS OF WELLSTAR MEDICAL GROUP, 240 MEDICAL OFFICE LOCATIONS, OUTPATIENT CENTERS, HEALTH PARKS, A PEDIATRIC CENTER, NURSING CENTERS, HOSPICE, HOMECARE, AS WELL AS 11

**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.
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- 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.

INPATIENT HOSPITALS: WELLSTAR ATLANTA MEDICAL CENTER, WELLSTAR ATLANTA  
 MEDICAL CENTER SOUTH, WELLSTAR KENNESTONE REGIONAL MEDICAL CENTER  
 (ANCHORED BY WELLSTAR KENNESTONE HOSPITAL), WELLSTAR WEST GEORGIA MEDICAL  
 CENTER, AND WELLSTAR COBB, DOUGLAS, NORTH FULTON, PAULDING, SPALDING  
 REGIONAL, SYLVAN GROVE AND WINDY HILL HOSPITALS. AS A NOT-FOR-PROFIT,  
 WELLSTAR CONTINUES TO REINVEST IN THE HEALTH OF THE COMMUNITIES IT SERVES  
 WITH NEW TECHNOLOGIES AND TREATMENTS. FOR MORE INFORMATION, VISIT:  
[HTTPS://WWW.WELLSTAR.ORG/PAGES/DEFAULT.ASPX](https://www.wellstar.org/pages/default.aspx)

SCHEDULE H, PART VI, LINE 7

STATE FILING OF COMMUNITY HEALTH BENEFIT REPORT:

ON AN ANNUAL BASIS THE HOSPITAL REPORTS ITS COMMUNITY HEALTH BENEFITS  
 REPORT TO THE GEORGIA HOSPITAL ASSOCIATION (GHA). GHA AGGREGATES THE  
 HOSPITAL SPECIFIC REPORTS INTO A STATEWIDE COMMUNITY HEALTH BENEFIT  
 REPORT. THE STATE OF GEORGIA ALSO REQUIRES HOSPITALS TO FILE THE HOSPITAL  
 FINANCIAL SURVEY AND THE INDIGENT CARE TRUST FUND SURVEY SO THAT IT CAN  
 COLLECT INFORMATION ON HOSPITAL FINANCIAL CLASS CATEGORIES AND ALSO TO  
 DETERMINE THE AMOUNT OF UNCOMPENSATED CARE BY HOSPITAL.

**SCHEDULE I  
(Form 990)**

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

OMB No. 1545-0047

**2017**

**Open to Public  
Inspection**

Department of the Treasury  
Internal Revenue Service

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

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

Name of the organization

WEST GEORGIA MEDICAL CENTER, INC.

Employer identification number

20-5497506

**Part I General Information on Grants and Assistance**

- 1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance?  Yes  No
- 2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

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

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 noncash assistance	(h) Purpose of grant or assistance
(1) TROUP COUNTY CENTER FOR STRATEGIC PLANNING 100 RIDLEY AVE STE 2200 LAGRANGE, GA 30240	27-0863139	501(C)(3)	30,000.		FMV	N/A	SPONSORSHIP
(2) TROUP COUNTY BOARD OF COMMISSIONERS 1220 LAFAYETTE PKWY LAGRANGE, GA 30241	58-6000896	GOV'T	10,000.		FMV	N/A	SPONSORSHIP
(3) TROUP COUNTY COLLEGE & CAREER ACADEMY INC. 1 COLLEGE CIRCLE LAGRANGE, GA 30240	46-3697983	501(C)(3)	15,000.		FMV	N/A	SPONSORSHIP
(4) TROUP CARES INC 301 MEDICAL DR. # 501 LAGRANGE, GA 30240	20-9176300	501(C)(3)	65,000.		FMV	N/A	SPONSORSHIP
(5) WEST GEORGIA HEALTH FOUNDATION 1514 VERNON ROAD LAGRANGE, GA 30240	20-0936376	501(C)(3)	70,000.		FMV	N/A	SPONSORSHIP
(6) LAGRANGE TROUP CO CHAMBER OF COMMERCE P O BOX 636 LAGRANGE, GA 30241-0636	58-0318810	501(C)(6)	8,423.		FMV	N/A	SPONSORSHIP
(7) DOWNTOWN LAGRANGE DEVELOPMENT SWEETLAND AMPHITHEATRE 200 MAIN ST STE 1B	58-2075688	GOV'T	10,000.		FMV	N/A	SPONSORSHIP
(8)							
(9)							
(10)							
(11)							
(12)							

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table ▶ 6.

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

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

Schedule I (Form 990) (2017)

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

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

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

SCHEDULE I, PART I, LINE 2

PROCEDURE FOR MONITORING THE USE OF GRANTS/SCHOLARSHIP FUNDS:

WELLSTAR HEALTH SYSTEM, INC. AND ITS AFFILIATES HAVE SET ASIDE FUNDS FOR CONTRIBUTIONS AND SPONSORSHIPS ON AN ANNUAL BASIS THAT PROVIDE ASSISTANCE TO NATIONAL AND LOCAL ORGANIZATIONS AND INDIVIDUALS IN THE FURTHERANCE OF THE COMMUNITY NEEDS.

WELLSTAR ALSO HAS SEVERAL AGREEMENTS WITH AREA COLLEGES AND UNIVERSITIES TO PROMOTE HEALTHCARE RELATED CAREER OPPORTUNITIES. ALL SCHOLARSHIPS ARE AWARDED BASED ON SPECIFIC QUALIFICATIONS WITHOUT REGARD TO AGE, GENDER, OR ETHNICITY.

**SCHEDULE J  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Compensation Information**

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

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

OMB No. 1545-0047

**2017**

**Open to Public Inspection**

Name of the organization

WEST GEORGIA MEDICAL CENTER, INC.

Employer identification number

20-5497506

**Part I Questions Regarding Compensation**

**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.

- |   |   |
|---|---|
| <input type="checkbox"/> First-class or charter travel                        | <input checked="" type="checkbox"/> Housing allowance or residence for personal use |
| <input checked="" type="checkbox"/> Travel for companions                     | <input type="checkbox"/> Payments for business use of personal residence            |
| <input checked="" type="checkbox"/> Tax indemnification and gross-up payments | <input checked="" type="checkbox"/> Health or social club dues or initiation fees   |
| <input checked="" type="checkbox"/> Discretionary spending account            | <input type="checkbox"/> Personal services (such as, 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

**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 on line 1a?

**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.

- |   |   |
|---|---|
| <input checked="" type="checkbox"/> Compensation committee              | <input checked="" type="checkbox"/> Written employment contract                     |
| <input checked="" type="checkbox"/> Independent compensation consultant | <input checked="" type="checkbox"/> Compensation survey or study                    |
| <input checked="" type="checkbox"/> Form 990 of other organizations     | <input checked="" type="checkbox"/> Approval by the board or compensation committee |

**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:

- a** Receive a severance payment or change-of-control payment?
  - b** Participate in, or receive payment from, a supplemental nonqualified retirement plan?
  - c** Participate in, or receive payment from, an equity-based compensation arrangement?
- If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.

**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:

- a** The organization?
  - b** Any related organization?
- If "Yes" on line 5a or 5b, describe in Part III.

**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:

- a** The organization?
  - b** Any related organization?
- If "Yes" on line 6a or 6b, describe in Part III.

**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.

**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.

**9** If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?

	Yes	No
<b>1a</b>		
<b>1b</b>		X
<b>2</b>	X	
<b>3</b>		
<b>4a</b>	X	
<b>4b</b>	X	
<b>4c</b>		X
<b>5a</b>		X
<b>5b</b>		X
<b>6a</b>		X
<b>6b</b>		X
<b>7</b>	X	
<b>8</b>		X
<b>9</b>		

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

Schedule J (Form 990) 2017

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 ALAN R. MUSTER, MD SVP SPECIALTY DIVISION WMG	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	452,852.	127,755.	20,836.	47,400.	34,949.	683,792.	0.
2 ANDREW ALBERRY VP INFO TECHNOLOGY OPERATIONS	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	115,774.	35,000.	5,103.	0.	9,394.	165,271.	0.
3 ANTHONY J. BUDZINSKI EVP & CFO	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	647,939.	160,698.	424,433.	47,400.	24,184.	1,304,654.	398,890.
4 ANTHONY M. TRUPIANO SVP SUPPLY CHAIN	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	315,664.	63,812.	18,177.	47,400.	2,112.	447,165.	0.
5 AVRIL P. BECKFORD, MD TRUSTEE & CHIEF PEDIATRIC OFF.	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	250,218.	190,568.	3,230.	28,516.	1,675.	474,207.	0.
6 BARBARA B. COREY SVP MANAGED CARE	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	351,440.	71,045.	190,854.	29,398.	20,938.	663,675.	177,832.
7 BETH KOST SVP COMPLIANCE CHF PRIVACY OFF	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	311,960.	65,013.	12,419.	21,884.	21,226.	432,502.	0.
8 BETHANY ROBERTSON VP/CHIEF LEARN.OFF.(END.4/18)	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	206,746.	34,469.	37,821.	14,995.	30,929.	324,960.	28,401.
9 BRADFORD B. NEWTON VP INFO. TECHNOLOGY ADMIN.	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	217,246.	52,306.	9,197.	22,820.	28,920.	330,489.	0.
10 CANDICE L. SAUNDERS PRESIDENT & CEO	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	1,256,117.	524,447.	341,097.	44,900.	31,427.	2,197,988.	324,125.
11 CAROL M. TODD VP ASST GENERAL COUNSEL	(i)	180,250.	26,363.	9,310.	18,388.	28,225.	262,536.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
12 CARRIE O. PLIETZ EVP & COO HOSPITAL DIVISION	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	669,407.	201,166.	14,104.	36,400.	31,368.	952,445.	0.
13 CHARIS L. ACREE VICE PRESIDENT & COO	(i)	270,890.	39,489.	38,607.	41,975.	22,278.	413,239.	26,300.
	(ii)	0.	0.	0.	0.	0.	0.	0.
14 DAVID W. ANDERSON EVP/HR/OL/CCO	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	504,065.	151,479.	149,420.	47,149.	28,578.	880,691.	126,016.
15 DOUGLAS ARVIN, CPA, MBA SVP FINANCE	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	350,002.	68,566.	14,921.	4,163.	25,742.	463,394.	0.
16 DOUGLAS S. FOSTER FORMER VP FINANCIAL PLAN.	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	110,776.	0.	5,018.	19,582.	5,413.	140,789.	0.

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 ELIZABETH H. LOUDERMILK VP FINANCIAL PLANNING	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	254,861.	39,942.	9,407.	23,400.	27,451.	355,061.	0.
2 ELIZABETH PAPETTI VP OPS HOSPITAL DIVISION	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	203,900.	26,222.	8,878.	4,776.	1,360.	245,136.	0.
3 ELLEN LANGFORD SVP WMG AMB. TRANS. (END.4/18)	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	272,189.	55,024.	107,773.	44,200.	25,067.	504,253.	95,982.
4 FRED A LYON VP SYSTEM EMERGENCY SERVICES	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	202,524.	30,195.	10,763.	15,521.	29,807.	288,810.	0.
5 GERALD N. FULKS SVP HOSPITAL PRESIDENT	(i)	463,500.	81,746.	104,991.	34,800.	20,941.	705,978.	90,000.
	(ii)	0.	0.	0.	0.	0.	0.	0.
6 JAMES M. SWARTZ VP ACCOUNTING	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	233,763.	40,142.	9,019.	19,530.	27,479.	329,933.	0.
7 JASON STEVENS VP DEPUTY GENERAL COUNSEL	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	236,931.	99,073.	10,095.	23,400.	19,442.	388,941.	0.
8 JEFFREY L. THARP, MD, M TRUSTEE & CHIEF MEDICINE SRVS.	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	316,299.	201,272.	5,314.	46,785.	33,881.	603,551.	0.
9 JENNIFER GIUSTI VP CLINICAL OUTCOMES	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	224,713.	85,231.	7,351.	26,087.	6,530.	349,912.	0.
10 JILL M. CASE-WIRTH SVP NURSING SERVICES	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	354,247.	73,826.	16,081.	47,400.	11,712.	503,266.	0.
11 JOHN A. BRENNAN EVP CHIEF CLIN. INTG. OFFICER	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	829,182.	246,421.	16,031.	47,400.	35,015.	1,174,049.	0.
12 JONATHAN B. MORRIS, MD FORMER SVP CHIEF INFO. OFF.	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	116,457.	0.	117,360.	7,164.	8,855.	249,836.	0.
13 JOSEPH L. BRYWCZYNSKI SVP HEALTH PARKS DEVELOPMENT	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	302,686.	55,514.	84,764.	47,400.	26,225.	516,589.	60,537.
14 KEITH BOWERMASTER VP COMMUNICATION	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	185,774.	11,074.	7,719.	18,383.	20,275.	243,225.	0.
15 KEM M. MULLINS EVP AMBULATORY & BUS. DEV.	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	516,012.	146,039.	15,236.	23,400.	33,943.	734,630.	0.
16 KEVIN SCHAEFFER, MD VP ONCOLOGY	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	225,000.	81,191.	9,155.	28,013.	9,239.	352,598.	0.



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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990	
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation					
1	KIMBERLY W. MENELEE SVP STRAT. COMM.DEV.(END.4/18)	(i)	0.	0.	0.	0.	0.	0.	
		(ii)	318,585.	68,385.	157,275.	29,400.	22,552.	596,197.	143,040.
2	KIMBERLY TAACA VP OPS SPECIALTY DIVISION	(i)	0.	0.	0.	0.	0.	0.	
		(ii)	150,000.	70,710.	6,721.	14,665.	12,979.	255,075.	0.
3	KRISTEN S. TRICE VP DIAGNOSTIC OUTREACH	(i)	0.	0.	0.	0.	0.	0.	
		(ii)	179,395.	30,806.	8,863.	15,323.	27,344.	261,731.	0.
4	LEO E. REICHERT EVP & GENERAL COUNSEL	(i)	0.	0.	0.	0.	0.	0.	
		(ii)	570,403.	161,432.	19,485.	29,400.	36,857.	817,577.	0.
5	LIZA FRITCHLEY VP SENIOR CARE SERVICES	(i)	164,800.	23,921.	8,937.	25,897.	32,694.	256,249.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
6	MARCUS P. CHARLSON, MD VP SURGERY	(i)	0.	0.	0.	0.	0.	0.	
		(ii)	160,014.	27,478.	8,884.	11,772.	22,419.	230,567.	0.
7	MARY L. TAVERNARO VP HUMAN RESOURCES OPERATIONS	(i)	0.	0.	0.	0.	0.	0.	
		(ii)	249,538.	42,851.	10,377.	29,400.	23,004.	355,170.	0.
8	MAXWELL KAGAN VP FINANCE & CFO	(i)	0.	0.	0.	0.	0.	0.	
		(ii)	163,472.	36,000.	5,853.	19,597.	15,332.	240,254.	0.
9	MICHELLE M. ROBINSON VP MARKETING (END. 4/2018)	(i)	0.	0.	0.	0.	0.	0.	
		(ii)	221,433.	38,025.	10,007.	16,089.	28,932.	314,486.	0.
10	PAUL DOUGLASS, MD TRUSTEE & PHYSICIAN	(i)	0.	0.	0.	0.	0.	0.	
		(ii)	485,040.	144,525.	4,142.	32,100.	9,301.	675,108.	0.
11	PAUL MURPHREE VP MEDICAL OUTCOMES	(i)	0.	0.	0.	0.	0.	0.	
		(ii)	166,080.	35,932.	4,584.	13,506.	8,115.	228,217.	0.
12	PAUL R. PERROTTI SVP & CFO	(i)	303,850.	55,130.	12,420.	35,052.	30,867.	437,319.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
13	PETER R. JUNGBLUT, MD, SVP & MEDICAL DIRECTOR	(i)	0.	0.	0.	0.	0.	0.	
		(ii)	328,499.	3,000.	12,728.	47,400.	31,251.	422,878.	0.
14	REBECCA L. RUHL VP FACILITY COMPLIANCE OPS	(i)	0.	0.	0.	0.	0.	0.	
		(ii)	154,856.	26,592.	9,567.	3,900.	26,645.	221,560.	0.
15	RICHARD S. SIEGEL VP CARDIOLOGY & CVM ADMIN.	(i)	0.	0.	0.	0.	0.	0.	
		(ii)	308,998.	53,732.	57,282.	45,890.	33,871.	499,773.	43,143.
16	ROB SCHREINER EVP & PRESIDENT MEDICAL GROUP	(i)	0.	0.	0.	0.	0.	0.	
		(ii)	253,846.	0.	6,878.	0.	3,189.	263,913.	0.

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(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1	ROBERT J. DECOUX VP CORPORATE MED STAFF SVCS	(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
	(ii) 183,688.	30,625.	9,923.	27,057.	26,455.	277,748.	0.	
2	ROBIN G. BOEHRINGER VP TOTAL REWARDS (END. 5/2018)	(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
	(ii) 195,243.	33,528.	8,992.	18,998.	9,364.	266,125.	0.	
3	SANDRA LUCIUS VP INFO TECHNOLOGY APPS	(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
	(ii) 224,713.	48,688.	12,547.	47,260.	2,650.	335,858.	0.	
4	SEAN P. TURNER VP REVENUE CYCLE MANAGEMENT	(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
	(ii) 301,913.	51,845.	14,346.	29,175.	30,313.	427,592.	0.	
5	SNEHAL H. DOSHI VP SYSTEM PHARMACIST	(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
	(ii) 196,088.	32,692.	10,735.	29,119.	30,876.	299,510.	0.	
6	SONYA E. ALDY VP TALENT ACQUISITION	(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
	(ii) 210,000.	24,700.	10,023.	11,700.	28,330.	284,753.	0.	
7	STEPHEN L. BADGER VP WMG STRATEGIC SERVICES	(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
	(ii) 569,392.	120,638.	130,330.	23,400.	35,717.	879,477.	112,403.	
8	STEPHEN VAULT VP BUSINESS DEVELOPMENT	(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
	(ii) 184,999.	21,126.	9,055.	12,890.	11,136.	239,206.	0.	
9	TIMOTHY HANEY SVP R.E. FAC. & DEV. SRVS.	(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
	(ii) 334,270.	105,128.	160,150.	28,630.	25,658.	653,836.	143,033.	
10	TOM BONIECKI VP MUSCUSKELETAL NEURO.	(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
	(ii) 162,078.	15,564.	2,700.	39,607.	35,630.	255,579.	0.	
11	TOMMY BRITT VP HUMAN RESOURCES	(i) 164,800.	(ii) 24,845.	(iii) 9,746.	17,896.	27,014.	244,301.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.	
12	TRACY C. GYNTHNER VICE PRESIDENT, CNO	(i) 164,800.	(ii) 24,745.	(iii) 9,056.	25,772.	26,441.	250,814.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.	
13	VALERY A. AKOPOV, MD SVP HOSPITAL DIVISION WMG	(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
	(ii) 464,408.	88,401.	21,528.	29,400.	27,462.	631,199.	0.	
14	VARMA RAMESWAR, MD VP PEDIATRIC OPERATIONS	(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
	(ii) 188,219.	27,320.	9,789.	40,496.	12,068.	277,892.	0.	
15	YVETTE BREWER, MD VP PRIMARY CARE MEDICINE	(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
	(ii) 191,006.	24,084.	12,404.	33,126.	21,034.	281,654.	0.	
16	DON DAVIS DIRECTOR	(i) 153,028.	(ii) 6,994.	(iii) 1,371.	0.	1,988.	163,381.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.	

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 JANICE PAGE PHARMACIST	(i)	148,539.	0.	289.	13,368.	29,281.	191,477.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
2 ALFRED MCNAIR ASSOCIATE DIRECTOR	(i)	140,982.	4,249.	1,234.	0.	18,139.	164,604.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
3 JEREAN GRAU PHARMACIST	(i)	142,548.	0.	2,242.	0.	8,231.	153,021.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
4 MARY A. SPARROW PHARMACIST	(i)	139,762.	0.	789.	24,885.	8,420.	173,856.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
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)							

**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.

SCHEDULE J, PART I, LINE 1A

THE ITEMS, AS INDICATED IN LINE 1A, WERE PROVIDED, IN SOME INSTANCES, TO BOARD MEMBERS AND TO CERTAIN EMPLOYED INDIVIDUALS LISTED IN FORM 990, PART VII BY THE ORGANIZATION. THE ORGANIZATION FOLLOWS IRS GUIDELINES AND THESE ITEMS WERE ADDED AS TAXABLE INCOME AS APPROPRIATE.

SCHEDULE J, PART I, LINE 1B

REIMBURSEMENT POLICY:

WHILE WELLSTAR HEALTH SYSTEM AND ITS AFFILIATES DO NOT HAVE A WRITTEN POLICY REGARDING PAYMENT OR REIMBURSEMENT OF THE ITEMS LISTED IN SCHEDULE J, PART I, LINE 1A, THE ORGANIZATION FOLLOWS IRS GUIDELINES IN THE PAYMENT OF ANY OF THESE ITEMS TO INDIVIDUALS LISTED IN FORM 990, PART VII, SECTION A. THESE ITEMS ARE ADDED AS TAXABLE WAGES ON THE INDIVIDUAL'S FORM W-2 AS APPROPRIATE.

SCHEDULE J, PART I, LINE 4A

SEVERANCE PAYMENTS:

PURSUANT TO THEIR RESPECTIVE EMPLOYMENT AGREEMENTS, THE FOLLOWING GROUPS OF OFFICERS ARE ENTITLED TO SEVERANCE PAYMENTS BASED ON THEIR

**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.

COMPENSATION AT THAT TIME IN THE EVENT OF CERTAIN IDENTIFIED  
CIRCUMSTANCES.

THE SEVERANCE PAYMENT PERIODS ARE 24 MONTHS FOR EXECUTIVE VICE  
PRESIDENTS, 18 MONTHS FOR SENIOR VICE PRESIDENTS, AND 12 MONTHS FOR VICE  
PRESIDENTS.

THE FOLLOWING OFFICER RECEIVED SEVERANCE PAY DURING THE 2017 CALENDAR  
YEAR FROM EITHER THE ORGANIZATION OR A RELATED ORGANIZATION:

JONATHAN B. MORRIS, MD        \$113,177

SCHEDULE J, PART I, LINE 4B

PARTICIPATION IN A SUPPLEMENTAL NON-QUALIFIED RETIREMENT PLAN:

DURING THE YEAR, VICE PRESIDENTS, SENIOR VICE PRESIDENTS, EXECUTIVE VICE  
PRESIDENTS AND CERTAIN PHYSICIANS PARTICIPATED IN A SUPPLEMENTAL  
NONQUALIFIED RETIREMENT PLAN SPONSORED BY WELLSTAR HEALTH SYSTEM, INC.

THE AMOUNTS RELATED TO THIS PLAN ARE INCLUDED IN SCHEDULE J, PART II,  
COLUMN (C). THE FOLLOWING INDIVIDUALS RECEIVED PAYMENTS FROM THE PLAN  
INCLUDED IN SCHEDULE J, PART II, COLUMN (B):

ANTHONY J. BUDZINSKI        \$398,890

**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.

BARBARA B. COREY	177,832
BETHANY ROBERTSON	28,401
CANDICE L. SAUNDERS	324,125
CHARIS L. ACREE	26,300
DAVID W. ANDERSON	126,016
ELLEN LANGFORD	95,982
GERALD N. FULKS	90,000
JOSEPH L. BRYWCZYNSKI	60,537
KIMBERLY W. MENEFFEE	143,040
RICHARD S. SIEGEL	43,143
STEPHEN L. BADGER	112,403
TIMOTHY HANEY	143,033

SCHEDULE J, PART I, LINE 7

NON-FIXED PAYMENTS TO OFFICERS:

AS PART OF THE WELLSTAR EXECUTIVE COMPENSATION PHILOSOPHY A PERFORMANCE  
 PAY PLAN WAS INSTITUTED SEVERAL YEARS AGO WHEREBY THE WELLSTAR BOARD OF  
 TRUSTEES APPROVES AN ANNUAL INCENTIVE PLAN WHICH CONSISTS OF SEVERAL

**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.

PERFORMANCE GOALS OR FACTORS THAT UPON ATTAINMENT WILL RESULT IN PAYOUTS

TO ELIGIBLE PLAN PARTICIPANTS. THOSE FACTORS ARE:

(1) PEOPLE & CUSTOMER SERVICE GOAL FOR EMPLOYEE "TRUST INDEX";

(2) QUALITY & SAFETY GOAL FOR CLINICAL EXCELLENCE AND PATIENT

SATISFACTION; AND

(3) FINANCIAL GOAL FOR ATTAINING A POSITIVE OPERATING MARGIN.

CONFIRMATION OF ACHIEVING THESE GOALS IS TYPICALLY RECEIVED THROUGH THE

ANNUAL EXTERNAL AUDIT PROCESS AND APPROVED BY THE BOARD OF TRUSTEES AT

THAT TIME.

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

WEST GEORGIA MEDICAL CENTER, INC.

**Supplemental Information to Form 990 or 990-EZ**

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

**2017**

**Open to Public  
Inspection**

Employer identification number

20-5497506

FORM 990, HEADING, ITEM B, AMENDED RETURN

THE WEST GEORGIA MEDICAL CENTER, INC. 2017 FORM 990 HAS BEEN AMENDED TO  
UPDATE TRANSACTIONS BETWEEN AFFILIATES.

FORM 990, PART III, LINE 4A

PROGRAM SERVICE ACCOMPLISHMENTS

WELLSTAR HEALTH SYSTEM IS A VERTICALLY INTEGRATED HEALTH CARE DELIVERY  
SYSTEM WHICH PROVIDES THROUGH AFFILIATED BUSINESS ORGANIZATIONS A FULL  
SPECTRUM OF HEALTH SERVICES, INCLUDING WELLNESS PROGRAMS, PHYSICIAN  
OFFICE VISITS, OUTPATIENT CARE, INPATIENT CARE, AND POST-ACUTE SERVICES  
SUCH AS HOME HEALTH, HOSPICE AND LONG-TERM NURSING CARE. THE SYSTEM  
THROUGH ITS AFFILIATED BUSINESS ORGANIZATIONS OPERATES 11 HOSPITALS  
(KENNESTONE, COBB, PAULDING MEDICAL CENTER, DOUGLAS, WINDY HILL, ATLANTA  
MEDICAL CENTER - DOWNTOWN AND SOUTH, NORTH FULTON, SPALDING, SYLVAN GROVE  
AND WEST GEORGIA), MULTIPLE PHYSICIAN OFFICES, PRIMARY CARE CENTERS,  
OUTPATIENT CARE FACILITIES, A NURSING HOME AND OTHER HEALTH RELATED  
SERVICES INCLUDING TWO INPATIENT HOSPICE FACILITIES.

THE SYSTEM IS SUPPORTED FINANCIALLY BY A FUNDRAISING ORGANIZATION,  
WELLSTAR FOUNDATION, INC. THE SERVICE AREA FOR THE SYSTEM ENCOMPASSES  
PARTS OF THE NORTHWESTERN, CENTRAL AND WESTERN SECTIONS OF THE STATE OF  
GEORGIA - THE PRIMARY AREA BEING IN BARTOW, CHEROKEE, COBB, DOUGLAS,  
PAULDING, FULTON, BUTTS, SPALDING AND TROUP COUNTIES. APPROXIMATELY MORE  
THAN 90% OF INPATIENT DISCHARGES AND OUTPATIENTS SERVED ARE FROM THE



Name of the organization WEST GEORGIA MEDICAL CENTER, INC.	Employer identification number 20-5497506
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AFOREMENTIONED COUNTIES. THE WELLSTAR VISION IS TO DELIVER WORLD CLASS HEALTHCARE. OUR MISSION IS TO CREATE AND DELIVER HIGH QUALITY HOSPITAL, PHYSICIAN AND OTHER HEALTHCARE RELATED SERVICES THAT IMPROVE THE HEALTH AND WELL-BEING OF THE INDIVIDUALS AND COMMUNITIES WE SERVE.

#### HISTORY

IN 1993, WHAT WAS THEN KNOWN AS THE COBB HEALTH SYSTEM, THE KENNESTONE REGIONAL HEALTH CARE SYSTEM, AND THE DOUGLAS GENERAL HOSPITAL AFFILIATED TO FORM THE NORTHWEST GEORGIA HEALTH SYSTEM. PAULDING MEMORIAL MEDICAL CENTER AFFILIATED WITH NORTHWEST GEORGIA HEALTH SYSTEM IN 1994. IN 1994, THE NORTHWEST GEORGIA HEALTH SYSTEM HELPED FORM THE PROMINA HEALTH SYSTEM AND CHANGED ITS NAME TO PROMINA NORTHWEST HEALTH SYSTEM. IN 1998, PROMINA NORTHWEST HEALTH SYSTEM CHANGED ITS NAME TO WELLSTAR HEALTH SYSTEM. WELLSTAR DISASSOCIATED FROM AND BECAME TOTALLY INDEPENDENT OF PROMINA IN 1999. IN 2016 WELLSTAR ACQUIRED ATLANTA MEDICAL CENTER, NORTH FULTON HOSPITAL, SPALDING HOSPITAL, SYLVAN GROVE HOSPITAL AND WEST GEORGIA MEDICAL CENTER. WELLSTAR HEALTH SYSTEM IS A PARENT CORPORATION, WHICH PROVIDES OVERALL COORDINATION INCLUDING GOVERNING BODY TO ITS 11

#### AFFILIATES:

- COBB HOSPITAL, INC.;
- CHS FOUNDATION, INC. (INVESTMENT MANAGEMENT);
- DOUGLAS HOSPITAL INC.;
- KENNESTONE HOSPITAL, INC.;
- PAULDING MEDICAL CENTER, INC.;
- WELLSTAR FOUNDATION INC.;

Name of the organization WEST GEORGIA MEDICAL CENTER, INC.	Employer identification number 20-5497506
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- WELLSTAR ATLANTA MEDICAL CENTER, INC.;
- WELLSTAR NORTH FULTON HOSPITAL, INC.;
- WELLSTAR SPALDING REGIONAL HOSPITAL, INC.;
- WELLSTAR SYLVAN GROVE HOSPITAL, INC.;
- WELLSTAR WEST GEORGIA HEALTH SERVICES, INC.

#### SERVICES

WELLSTAR HEALTH SYSTEM IS ABLE TO OFFER A FULL RANGE OF HEALTHCARE SERVICES THROUGH ITS AFFILIATES. THE SERVICES OFFERED INCLUDE BUT ARE NOT LIMITED TO:

- MOST MAJOR INPATIENT CLINICAL SERVICES,
- OUTPATIENT SERVICES,
- DIAGNOSTIC AND THERAPEUTIC SERVICES,
- ANCILLARY AND SUPPORT SERVICES,
- URGENT CARE SERVICES,
- HOME HEALTH SERVICES,
- SKILLED NURSING SERVICES AND
- HOSPICE SERVICES.

THE 11 HOSPITAL LOCATIONS ARE ACUTE CARE FACILITIES WITH INPATIENT, OUTPATIENT, AND EMERGENCY SERVICES.

THE SYSTEM INCLUDES A RESIDENTIAL FACILITY ON THE KENNESTONE HOSPITAL CAMPUS, CALLED ATHERTON PLACE. ATHERTON PLACE ALSO HOUSES AN ASSISTED LIVING UNIT AS AN ADDITIONAL LEVEL OF CARE.

Name of the organization WEST GEORGIA MEDICAL CENTER, INC.	Employer identification number 20-5497506
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PAULDING MEDICAL CENTER IS HOME TO A FULL CARE NURSING HOME, PAULDING NURSING CENTER AND WEST GEORGIA MEDICAL CENTER IS ALSO HOME TO TWO FULL CARE NURSING HOMES.

VERNON WOODS RETIREMENT COMMUNITY IS AN ASSISTED LIVING FACILITY.

COBB HOSPITAL IS HOME TO A HOME HEALTH AGENCY AND A RESIDENTIAL HOSPICE FACILITY CALLED TRANQUILITY FOR THOSE PATIENTS IN THE END STAGES OF LIFE.

KENNESTONE HOSPITAL ALSO OPENED A RESIDENTIAL HOSPICE FACILITY NOT FAR FROM ITS MAIN CAMPUS.

THE SYSTEM IS COMPLIMENTED WITH APPROXIMATELY 275 PHYSICIAN PRACTICES AND SEVERAL URGENT CARE CENTERS. THE SYSTEM IS THUS ABLE TO PROVIDE A COMPLETE CONTINUUM OF CARE FOR THE COMMUNITY IT SERVES. THE FOLLOWING STATEMENTS OF COMMUNITY BENEFIT AND PROGRAM SERVICE ACCOMPLISHMENTS REPRESENT SYSTEM-WIDE ACTIVITY FOR WELLSTAR HEALTH SYSTEM, INC. (THE "SYSTEM") - EIN 58-1649541.

ALL AFFILIATED ENTITIES OF THE SYSTEM EXCEPT THE PHYSICIAN HOSPITAL ORGANIZATION (EIN 58-2116179) OPERATE AS CHARITABLE ORGANIZATIONS CONSISTENT WITH THE REQUIREMENTS OF INTERNAL REVENUE CODE SECTION 501(C)(3) AND THE "COMMUNITY BENEFIT STANDARD" OF IRS REVENUE RULING 69-545. THE FOLLOWING EXCERPT FROM THE AUDITED FINANCIAL STATEMENTS

Name of the organization WEST GEORGIA MEDICAL CENTER, INC.	Employer identification number 20-5497506
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IDENTIFIES A BROAD OVERVIEW OF THE CHARITABLE PURPOSE FOR THE SYSTEM.

"THE SYSTEM MAINTAINS RECORDS TO IDENTIFY AND MONITOR THE LEVEL OF CHARITY CARE IT PROVIDES THROUGH ITS AFFILIATES. THESE RECORDS INCLUDE THE AMOUNT OF CHARGES FOREGONE FOR SERVICES AND SUPPLIES FURNISHED UNDER ITS COMMUNITY FINANCIAL AID POLICY."

IN FISCAL YEAR 2018 AND 2017, WELLSTAR AFFILIATE HOSPITALS MADE \$255.6 MILLION AND \$251.9 MILLION, RESPECTIVELY, IN PROVIDER PAYMENTS AND RECOGNIZED SUCH PAYMENTS AS A REDUCTION IN NET PATIENT SERVICE REVENUE IN THE ACCOMPANYING COMBINED FINANCIAL STATEMENTS. THE SYSTEM ALSO PARTICIPATES IN CERTAIN GOVERNMENTAL INSURANCE PROGRAMS, INCLUDING MEDICARE AND MEDICAID. UNDER THESE PROGRAMS, THE SYSTEM PROVIDES CARE TO PATIENTS AT PAYMENT RATES WHICH ARE DETERMINED BY THE FEDERAL AND STATE GOVERNMENTS, REGARDLESS OF THE SYSTEM'S ACTUAL CHARGES. IN MOST CASES, THESE PROGRAMS PAY THE SYSTEM AT AMOUNTS WHICH ARE LESS THAN ITS COST OF PROVIDING SERVICES. THE SYSTEM OFFERS MANY WELLNESS AND EDUCATIONAL SERVICES AT LITTLE OR NO COST TO THE COMMUNITY. THE HEALTH FAIRS ARE HELD THROUGHOUT THE YEAR AT CONVENIENT LOCATIONS, PROVIDING VARIOUS HEALTH SCREENINGS, SUCH AS MAMMOGRAMS, BONE DENSITY, BLOOD PRESSURE AND CHOLESTEROL CHECKS. A LARGE NUMBER OF EDUCATIONAL PROGRAMS ARE OFFERED FOR ALL AGES. THESE PROGRAMS INCLUDE BICYCLE SAFETY, CAR SEAT SAFETY, DEFENSIVE DRIVING, CPR AND FIRST-AID CLASSES. FLU SHOTS ARE AVAILABLE TO THE COMMUNITY DURING FLU SEASON AND HEALTH SCREENINGS, MEDICAL SUPPLIES, AND IMMUNIZATIONS ARE PROVIDED TO CHILDREN THROUGH LOCAL HEALTH

Name of the organization WEST GEORGIA MEDICAL CENTER, INC.	Employer identification number 20-5497506
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DEPARTMENTS AND HEALTH FAIRS. THE COSTS OF THESE SERVICES ARE INCLUDED IN UNRESTRICTED REVENUE, GAINS AND OTHER SUPPORT IN EXCESS OF EXPENSES AND LOSSES IN THE FINANCIAL STATEMENTS. THE PHYSICIANS OF THE SYSTEM MAKE SIGNIFICANT CONTRIBUTIONS TO IMPROVE THE HEALTH STATUS OF THE COMMUNITY, INCLUDING INVOLVEMENT IN MANY COMMUNITY ACTIVITIES PROMOTING HEALTH AWARENESS AND IMPROVEMENT, EMERGENCY ROOM CARE, AND DELIVERY OF CARE TO THE INDIGENT POPULATION OF THE SYSTEM'S SERVICE AREA. THE SYSTEM ALSO MADE SIGNIFICANT CONTRIBUTIONS TO THE NURSING PROGRAM AT A LOCAL UNIVERSITY. THIS FINANCIAL SUPPORT HAS HELPED TO GROW THE PROGRAM, WHICH BENEFITS THE SYSTEM AS WELL AS THE COMMUNITY. THE SYSTEM AND ALL BUT ONE OF ITS AFFILIATES HAVE BEEN RECOGNIZED AS ORGANIZATIONS EXEMPT FROM FEDERAL INCOME TAX UNDER INTERNAL REVENUE CODE SECTION 501(A) AS ORGANIZATIONS DESCRIBED IN SECTION 501(C)(3) AND, THEREFORE, RELATED INCOME IS GENERALLY NOT SUBJECT TO FEDERAL OR STATE INCOME TAXES. ONE OF THE SYSTEM'S AFFILIATES IS A CONTROLLED FOREIGN CORPORATION NOT SUBJECT TO FEDERAL INCOME TAX. THE PHYSICIAN HOSPITAL ORGANIZATION (EIN 58-2116179) IS A TAXABLE AFFILIATE OF THE SYSTEM AND FILES IRS FORM 1120 US CORPORATION INCOME TAX RETURN."

#### FINANCIAL & DATA STATISTICS

##### SERVICES PROVIDED SYSTEM-WIDE:

LICENSED BEDS - 2,775

ADULT DISCHARGES - 114,306

NEWBORN DISCHARGES - 14,959

EMERGENCY ROOM VISITS - 658,118

SURGERIES - 68950 CATH LAB/PACEMAKERS/EP - 18,029

Name of the organization WEST GEORGIA MEDICAL CENTER, INC.	Employer identification number 20-5497506
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NON-ED O/P RADIOLOGY PROCEDURES - 459,418

MED/SURG. SHORT STAY CASES - 1,462

GI LAB PROCEDURES - 10,628

RADIOLOGY ONCOLOGY PROCEDURES - 31,718

COMMUNITY BENEFITS -

WELLSTAR'S COMMUNITY EDUCATION & OUTREACH DEPARTMENT PROVIDES FREE BROCHURES ON A VARIETY OF HEALTH-RELATED ISSUES. WELLSTAR PROVIDES SUPPORT GROUPS AND EDUCATIONAL OPPORTUNITIES TO THE COMMUNITY ON A VARIETY OF TOPICS INCLUDING MEN'S AND WOMEN'S HEALTH ISSUES, CARDIAC HEALTH, NUTRITION, CANCER, AND DIABETES. SOME OF THESE OPPORTUNITIES ARE PROVIDED FREE OF CHARGE OR AT A MINIMAL FEE. WELLSTAR ALSO PROVIDES FREE HEALTH SCREENINGS SUCH AS BLOOD PRESSURE, CHOLESTEROL, GLUCOSE, BONE DENSITY AND WEIGHT ASSESSMENT. COMMUNITY EDUCATION & OUTREACH PROVIDES HEALTH AND WELLNESS PROGRAMS AND SERVICES ACROSS ALL WELLSTAR MARKETS REACHING OVER 450,000 PEOPLE ANNUALLY. SOME OF THE MORE SPECIFIC PROGRAM/DEPARTMENTS ARE DOCUMENTED AS FOLLOWS:

CLINICS:

WELLSTAR IS AFFILIATED WITH SEVERAL CLINICS WHICH PROVIDE FREE OR SLIDING SCALE HEALTH SERVICES TO PERSONS WHO CANNOT AFFORD TO PAY OR THOSE WHO ARE NOT EXPECTED TO PAY.

SCHOOL HEALTH PROGRAM:

THIS PROGRAM TEACHES CHILDREN ABOUT HEALTH AND SAFETY TOPICS TO INCLUDE

Name of the organization WEST GEORGIA MEDICAL CENTER, INC.	Employer identification number 20-5497506
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NUTRITION, PHYSICAL ACTIVITY, HYGIENE, BIKE AND PEDESTRIAN SAFETY AND MORE. THE PROGRAMS ARE CURRENTLY TAUGHT IN ELEMENTARY SCHOOLS (GRADES K-5) AND MIDDLE SCHOOLS (GRADES 6-8) IN CHEROKEE, COBB, DOUGLAS AND PAULDING COUNTIES.

**SAFE KIDS:**

WELLSTAR IS A CO-LEAD AGENCY FOR SAFE KIDS COBB COUNTY ALONG WITH COBB AND DOUGLAS PUBLIC HEALTH. SAFE KIDS COBB COUNTY IS COMMITTED TO REDUCING AND PREVENTING ACCIDENTAL INJURIES TO CHILDREN AGES 19 AND UNDER IN COBB COUNTY BY HOSTING SAFETY EDUCATION EVENTS AND DISTRIBUTING SAFETY EDUCATION MATERIALS AND EQUIPMENT THROUGHOUT THE COUNTY TO FAMILIES IN NEED. SAFETY AREAS OF FOCUS INCLUDE: CHILD PASSENGER, PEDESTRIAN, WHEEL, HOME, POISON PREVENTION AND WATER. EQUIPMENT DISTRIBUTION INCLUDES: CAR AND BOOSTER SEATS, BICYCLE HELMETS AND REFLECTORS, SMOKE/CARBON MONOXIDE ALARMS, HOME SAFETY KITS AND LIFEJACKETS. MOST OF THE EVENTS ARE FREE AND OPEN TO THE PUBLIC. THE IMPORTANT MESSAGE TAUGHT AT THESE EVENTS IS THAT SAFETY BEGINS WITH THE PARENTS AND CAREGIVERS. ANNUALLY, NEARLY 800 CAR SEATS ARE PRESENTED TO FAMILIES IN NEED, AND NEARLY 2,500 INFANT CAR SEATS ARE CHECKED AT OVER 130 CAR SEAT EVENTS.

**WOMEN & CHILDREN RESOURCE CENTERS:**

THE WOMEN'S AND CHILDREN'S RESOURCE CENTER AT COBB, DOUGLAS, AND KENNESTONE HOSPITALS PROVIDE MUCH NEEDED SUPPORT FOR MOTHERS AND THEIR NEWBORN BABIES THROUGH INPATIENT AND OUTPATIENT CONSULTATIONS, WARM LINE PHONE CALLS, CHILDBIRTH, NEWBORN CARE AND BREASTFEEDING CLASSES, AN

Name of the organization WEST GEORGIA MEDICAL CENTER, INC.	Employer identification number 20-5497506
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ANNUAL MATERNITY AND BABY FAIR, AS WELL AS OTHER EDUCATIONAL OPPORTUNITIES. THESE PROGRAMS DEMONSTRATE WELLSTAR'S COMMITMENT TO THE HEALTH AND WELL-BEING OF THE NEW MOTHERS AND THEIR BABIES IN OUR COMMUNITY. IN FY2018 THE UNREIMBURSED COSTS ASSOCIATED WITH THE PROGRAM TOTALED APPROXIMATELY \$400,000 AND MORE THAN 7,000 PARENTS PARTICIPATED IN PRENATAL AND CHILDBIRTH PROGRAMS.

THE GOOD LIFE CLUB:

WELLSTAR PROVIDES A SPECIAL PROGRAM FOR AREA RESIDENTS AGE 50 AND OLDER CALLED THE GOOD LIFE CLUB. THIS PROGRAM PROVIDES HEALTHY AGING RESOURCES AND PROMOTES HEALTH, WELLNESS, AND AN ACTIVE LIFESTYLE THROUGH CLASSES, HEALTH SCREENINGS AND OTHER OPPORTUNITIES. A SMALL ONE-TIME FEE COVERS A LIFETIME MEMBERSHIP AND INCLUDES:

- HEALTH AND WELLNESS EDUCATION AND PROGRAMS
- A QUARTERLY NEWSLETTER
- FREE HEALTH SCREENINGS
- DISCOUNTED PARKING AT HOSPITALS AND OTHER RETAIL DISCOUNTS
- TRAVEL DISCOUNTS

THE GOOD LIFE CLUB CURRENTLY HAS MORE THAN 2,000 MEMBERS.

COMMUNITY ACTIVITIES -

WELLSTAR HAS PARTNERED WITH A LOCAL COLLEGE, KENNESAW STATE UNIVERSITY ("KSU") TO DEVELOP EDUCATIONAL AND ON-SITE TRAINING PROGRAMS WHICH WILL HOPEFULLY IMPROVE THE CURRENT AND FUTURE HEALTH OF OUR COMMUNITY. MANY OF THE NURSES IN THE SYSTEM ARE TRAINED THROUGH THE NURSING PROGRAM OFFERED



Name of the organization WEST GEORGIA MEDICAL CENTER, INC.	Employer identification number 20-5497506
---	--

BY KSU. WELLSTAR IS ALSO AFFILIATED WITH THE CHATTAHOOCHEE TECHNICAL COLLEGE- NORTH METRO CAMPUS'S RADIOLOGIC TECHNOLOGY PROGRAM. WELLSTAR SERVES AS THE CLINICAL AFFILIATE FOR THE STUDENTS IN THIS TWO-YEAR PROGRAM. THE STUDENTS TRAIN AT WELLSTAR'S HOSPITALS AND OUTPATIENT FACILITIES. THE PROGRAM RECEIVED ACCREDITATION FROM THE JOINT REVIEW COMMITTEE ON EDUCATION IN RADIOLOGIC TECHNOLOGY. THE GOAL IS TO HAVE TRAINED STUDENTS WHO CAN SUBSEQUENTLY CONTRIBUTE TO THE HEALTH OF THE COMMUNITY WE SERVE.

COMMUNITY PARTNERSHIPS AND SPONSORSHIPS -

COMMUNITY EDUCATION & OUTREACH IS RESPONSIBLE FOR DEVELOPING AND CULTIVATING STRATEGIC COMMUNITY PARTNERSHIPS BY ALIGNING WELLSTAR'S STRATEGIC GOALS, COMMUNITY DEVELOPMENT OPPORTUNITIES AND THE PRIORITY HEALTH NEEDS OF OUR LOCAL COMMUNITIES. SPONSORSHIPS PROVIDE AN OPPORTUNITY TO SUPPORT WELLSTAR'S MISSION TO IMPROVE THE HEALTH AND WELL-BEING OF THE COMMUNITIES WE SERVE BY SUPPORTING ORGANIZATIONS AND EVENTS AS A SPONSOR. ORGANIZATIONS INCLUDE THE AMERICAN HEART ASSOCIATION, AMERICAN CANCER SOCIETY, AMERICAN LUNG ASSOCIATION, THE AMERICAN DIABETES ASSOCIATION, MARCH OF DIMES, AS WELL AS NUMEROUS LOCAL ORGANIZATIONS. MANY EMPLOYEES ALSO VOLUNTEER AND PARTICIPATE IN SOME OF THE EVENTS HELD BY THESE ORGANIZATIONS SUCH AS WALKS, FUNDRAISERS AND SCREENINGS.

IN FY2018 THE TOTAL UNCOMPENSATED CARE, OTHER COMMUNITY BENEFITS AND COMMUNITY INVESTMENTS PROVIDED BY WELLSTAR WAS OVER \$ 939 MILLION.

Name of the organization WEST GEORGIA MEDICAL CENTER, INC.	Employer identification number 20-5497506
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## COMMITMENT TO THE COMMUNITY BREAKDOWN:

CHARITY &amp; INDIGENT (UNCOMPENSATED CARE COSTS) - \$ 255,954,000

MEDICAID SHORTFALLS (UNCOMPENSATED CARE COSTS) - \$ 86,107,000

MEDICARE SHORTFALLS (UNCOMPENSATED CARE COSTS) - \$ 206,724,000

OTHER PATIENTS (UNCOMPENSATED CARE COSTS) - \$ 127,756,000

TOTAL UNCOMPENSATED CARE - \$ 676,541,000

OTHER COMMUNITY PROGRAMS (PARTICIPATION IN COALITIONS) - \$ 345,000

OTHER COMMUNITY PROGRAMS (COMMUNITY HEALTH EDUCATION) - \$ 249,000

OTHER COMMUNITY PROGRAMS (HEALTH CARE SUPPORT) - \$ 7,777,000

TOTAL OTHER COMMUNITY PROGRAMS - \$ 8,371,000

COMMUNITY INVESTMENTS (FUNDS BACK INTO INFRASTRUCTURE) - \$ 245,436,000

COMMUNITY INVESTMENTS (ALLIED HLTH/MEDICAL EDUCATION) - \$ 9,456,000

COMMUNITY INVESTMENTS (OPERATIONS - STAFF/SOFTWARE) - \$ 92,000

TOTAL COMMUNITY INVESTMENTS - \$ 254,984,000

WELLSTAR CONTINUES TO PARTICIPATE IN THE CENTER FOR MEDICARE AND MEDICAID SERVICES (CMS) MEDICARE SAVINGS PROGRAM AS AN ACCOUNTABLE CARE ORGANIZATION (ACO). WELLSTAR'S ACO IS THE LARGEST ACO IN GEORGIA INCLUDING 50,000 MEMBERS AND 1,400 PHYSICIANS. THE ACO HAS BEEN RECOGNIZED AS ONE OF THE TOP 100 ACO'S IN THE COUNTRY. THE PROGRAM HAS BEEN SUCCESSFUL THROUGH A FOCUS ON WELLNESS AND THE IMPROVED MANAGEMENT OF CHRONIC ILLNESSES AND THE RELATED COORDINATION OF CARE, TO ENSURE

Name of the organization WEST GEORGIA MEDICAL CENTER, INC.	Employer identification number 20-5497506
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PATIENTS, ESPECIALLY CHRONICALLY ILL, GET THE RIGHT CARE AT THE RIGHT TIME TO MAINTAIN THEIR OPTIMAL HEALTH, AND AVOID THE NEED FOR HIGH-COST EMERGENCY AND HOSPITAL CARE.

AWARDS, RECOGNITION AND ACCOMPLISHMENTS

WELLSTAR HEALTH SYSTEM (WELLSTAR) WAS RECOGNIZED FOR DIVERSITY IN THE WORKPLACE. DIVERSITY MAGAZINE LISTS WELLSTAR AS ONE OF ITS 50 BEST PLACES FOR WOMEN AND DIVERSE MANAGERS TO WORK. WELLSTAR WEST GEORGIA MEDICAL CENTER (WGMC) WAS NAMED TO BECKER HOSPITAL REVIEW'S 2016 LIST OF "100 GREAT COMMUNITY HOSPITALS." WGMC IS ONE OF ONLY THREE COMMUNITY HOSPITALS IN GEORGIA TO RECEIVE THIS HONOR.

WELLSTAR KENNESTONE REGIONAL MEDICAL CENTER RECEIVED THE PRESTIGIOUS AMERICAN ACADEMY OF MEDICAL SURGICAL NURSES PRISM AWARD. THIS HONOR RECOGNIZED EXCEPTIONAL NURSING PRACTICE, LEADERSHIP AND OUTCOMES IN HOSPITAL MEDICAL-SURGICAL UNITS ACROSS THE COUNTRY. KENNESTONE REGIONAL MEDICAL CENTER IS JUST ONE OF 14 HOSPITALS TO RECEIVE THIS HONOR IN 2016 AND THE ONLY ONE IN THE STATE OF GEORGIA. US NEWS AND WORLD REPORT NAMED WELLSTAR KENNESTONE REGIONAL MEDICAL CENTER TO ITS ANNUAL LISTING OF BEST REGIONAL HOSPITALS RANKING IT THIRD IN GEORGIA.

WELLSTAR DOUGLAS HOSPITAL WAS DESIGNATED AS A REMOTE TREATMENT STROKE CENTER BY THE OFFICE OF EMS AND TRAUMA IN THE GEORGIA DEPARTMENT OF PUBLIC HEALTH BECOMING ONE OF THE FIRST HOSPITALS IN THE STATE TO GARNER THE RECOGNITION.

Name of the organization WEST GEORGIA MEDICAL CENTER, INC.	Employer identification number 20-5497506
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WELLSTAR EARNED A SPOT IN THE DAVE THOMAS FOUNDATION FOR ADOPTION'S 100 BEST ADOPTION-FRIENDLY WORKPLACES. THIS IS THE SYSTEM'S FIFTH TIME ON THE FOUNDATION'S TOP 100 LIST. WELLSTAR OFFERS FULL-TIME TEAM MEMBERS 120 HOURS AND ELIGIBLE PART-TIME TEAM MEMBERS 60 HOURS OF PAID LEAVE. IN ADDITION, WELLSTAR OFFERS TEAM MEMBERS A MAXIMUM OF \$19,000 PER FINALIZED ADOPTION (\$20,000 PER FAMILY LIFETIME AMOUNT.) EMPLOYEE RECRUITING AND COMMITMENT TO PROPER WORK-LIFE BALANCE OF PERSONAL AND PROFESSIONAL TIME ARE IMPORTANT TO THE DESIGNATION OF THIS AWARD. WELLSTAR WAS NAMED TO WORKING MOTHER 100 BEST COMPANIES LIST FOR THE 9TH TIME FOR ITS COMMITMENT TO PROGRESSIVE WORKPLACE PROGRAMS, INCLUDING ADVANCEMENT OF WOMEN, FLEXIBILITY, CHILD CARE AND PAID PARENTAL LEAVE. WELLSTAR WAS NAME TO THE 2016 BEST PLACES TO WORK FOR WOMEN LIST BY GREAT PLACES TO WORK. COBB HOSPITAL WAS DESIGNATED A BABY-FRIENDLY HOSPITAL BY BABY-FRIENDLY USA. ONLY 5 OTHER GEORGIA HOSPITALS HOLD THIS DESIGNATION.

GEORGIA TREND MAGAZINE NAMED WELLSTAR WGMC THE NUMBER 1 LARGE HOSPITAL IN THE STATE. FIVE OF WELLSTAR' HEALTH SYSTEM'S HOSPITALS HAVE BEEN GRANTED THREE-YEAR ACCREDITATION WITH THE GOLD COMMENDATION BY THE COMMISSION ON CANCER(COC), A QUALITY PROGRAM BY THE AMERICAN COLLEGE OF SURGEONS. THIS IS THE HIGHEST HONOR AWARDED TO A CANCER PROGRAM. TO EARN THIS ACCREDITATION THE PROGRAM MUST MEET OR EXCEED COC'S QUALITY CARE STANDARDS, BE EVALUATED EVERY THREE YEARS AND SHOW EXCELLENCE IN THE DELIVERY OF PATIENT CENTERED CARE.

WELLSTAR CANCER NETWORK ALSO RECEIVED NATIONAL DISTINCTION BY BEING

Name of the organization WEST GEORGIA MEDICAL CENTER, INC.	Employer identification number 20-5497506
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GRANTED A THREE-YEAR ACCREDITATION BY THE COC. THIS IS THE HIGHEST HONOR AWARDED TO A CANCER PROGRAM.

WELLSTAR KENNESTONE REGIONAL MEDICAL CENTER AND WELLSTAR ATLANTA MEDICAL CENTER RECEIVED THE PLATINUM HONOR BY THE US DEPARTMENT OF HEALTH AND HUMAN SERVICES' HEALTH RESOURCES AND SERVICES ADMINISTRATION FOR THEIR CONTINUED EFFORTS TO PROMOTE ORGAN DONOR REGISTRATION.

OTHER HOSPITALS HONORED INCLUDED WELLSTAR COBB, DOUGLAS, NORTH FULTON, WEST GEORGIA MEDICAL CENTER AND PAULDING HOSPITALS. THE PARTNERSHIP FOR HEALTH AND ACCOUNTABILITY(PHA) AN AFFILIATE OF THE GEORGIA HOSPITAL ASSOCIATION, RECENTLY PRESENTED ITS QUALITY AND PATIENT SAFETY AWARD TO SEVERAL WELLSTAR HOSPITALS AS WELL AS TO THE SYSTEM ITSELF. THESE AWARDS RECOGNIZE GEORGIA HEALTHCARE ORGANIZATIONS FOR ACHIEVEMENT IN REDUCING THE RISK OF MEDICAL ERRORS AND IMPROVING PATIENT SAFETY AND MEDICAL OUTCOMES.

WELLSTAR SPALDING REGIONAL HOSPITAL WON FIRST PLACE IN THE HOSPITALS WITH 100-299 BEDS CATEGORY FOR ITS HELP ME, DON'T HURT ME - REDUCING CAUTI'S PROJECT. WELLSTAR COBB HOSPITAL WON SECOND PLACE IN THE HOSPITALS WITH GREATER THAN 300 BEDS CATEGORY FOR ITS INTERDISCIPLINARY MODEL BEDSIDE MEDICATION DELIVERY TO REDUCE 30-DAY READMISSION RATES PROJECT. WELLSTAR DOUGLAS HOSPITAL WON THIRD PLACE IN THE HOSPITALS WITH 100-299 BEDS CATEGORY FOR ITS MISSION NOT IMPOSSIBLE: STRATEGIES TO DECREASE CLOSTRIDIUM DIFFICILE PROJECT. IN THE HOSPITALS/HEALTH SYSTEMS CATEGORY,

Name of the organization WEST GEORGIA MEDICAL CENTER, INC.	Employer identification number 20-5497506
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WELLSTAR HEALTH SYSTEM EARNED FIRST PLACE FOR ITS OUTPATIENT SURGERY CENTER PRE-OP THROUGHPUT PROJECT, WHICH IMPROVED THE SAFETY OF PATENTS UNDERGOING CT-SCANS. WELLSTAR COBB HOSPITAL WAS ALSO PRESENTED WITH A CIRCLE OF EXCELLENCE AWARD, AN HONOR GIVEN TO HOSPITALS AND HEALTH SYSTEMS THAT HAVE DEMONSTRATED A SUSTAINED COMMITMENT TO QUALITY AND PATIENT SAFETY.

EVERY YEAR THE ATLANTA BUSINESS CHRONICLE PUBLISHES ITS LIST OF THE 100 MOST INFLUENTIAL LEADERS IN GEORGIA'S HEALTHCARE INDUSTRY. SEVEN MEMBERS OF WELLSTAR HEALTH SYSTEMS SENIOR LEADERSHIP TEAM WERE INCLUDED IN THE 2017 LIST.

WELLSTAR KENNESTONE REGIONAL MEDICAL CENTER'S CARDIAC PROGRAM IS ONE OF ONLY TWO PROGRAMS IN THE UNITED STATES TO RECEIVE THE JOINT COMMISSION GOLD SEAL DISEASE-SPECIFIC CERTIFICATION FOR HEART-VALVE, CORONARY ARTERY BYPASS SURGERY (CABS) AND CONGESTIVE HEART FAILURE.

WELLSTAR WEST GEORGIA MEDICAL CENTER WAS NAMED ONE OF THE NATION'S 100 TOP HOSPITALS BY TRUVEN HEALTH ANALYTICS. TRUVEN IS A LEADING PROVIDER OF INFORMATION AND SOLUTIONS THAT SUPPORT HEALTHCARE COST AND QUALITY IMPROVEMENT.

WELLSTAR COBB HOSPITAL'S INTENSIVE CARE UNIT WAS HONORED WITH THE BEACON AWARD FOR EXCELLENCE BY THE AMERICAN ASSOCIATION OF CRITICAL CARE NURSES. THE BEACON AWARD HONORS INDIVIDUAL HOSPITAL UNITS THAT DISTINGUISH

Name of the organization WEST GEORGIA MEDICAL CENTER, INC.	Employer identification number 20-5497506
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THEMSELVES BY IMPROVING EVERY FACET OF PATIENT CARE.

WELLSTAR PAULDING MEDICAL CENTER RECEIVED TWO BRILLIANCE AWARDS FROM VIZIENT MIDSOUTH. THE HOSPITAL WAS RECOGNIZED FOR INNOVATION AND EXCELLENCE IN CLINICAL CARE FOR PATIENTS WITH COPD AND DIABETES.

TWO OF WELLSTAR KENNESTONE REGIONAL MEDICAL CENTER'S NURSES HAVE BEEN NAMED AS TWO OF THE TOP 10 NURSES IN GEORGIA BY THE ATLANTA JOURNAL CONSTITUTION.

WELLSTAR'S SUPPLY CHAIN SERVICES WAS RECOGNIZED AS A BEST PERFORMER BY THE ECRI INSTITUTE, A NONPROFIT ORGANIZATION THAT USES RESEARCH TO DISCOVER WHICH MEDICAL PROCEDURES, DRUGS AND PROCESSES ARE BEST TO ENABLE IMPROVED PATIENT CARE. THIS AWARD IS GIVEN FOR DEMONSTRATING EXCELLENCE IN OVERALL SPEND MANAGEMENT.

THE WOUND CARE CENTER AT WELLSTAR WEST GEORGIA MEDICAL CENTER HAS BEEN RECOGNIZED WITH A CENTER OF DISTINCTION AWARD FOR CLINICAL EXCELLENCE BY HEALOGICS, THE NATION'S LEADING AND LARGEST WOUND CARE MANAGEMENT COMPANY.

THE CENTER FOR COMPANIES THAT CARE RECENTLY NAMED WELLSTAR TO ITS HONOR ROLL FOR THE 10TH YEAR IN A ROW. THIS HONOR FOCUSES ON WELLSTAR'S EFFORT TO OFFERING WORKLIFE SERVICES THAT CREATE A CULTURE OF INCLUSION AND ASSISTANCE FOR TEAM MEMBERS UTILIZING SERVICES THAT PROVIDE A BALANCE

Name of the organization WEST GEORGIA MEDICAL CENTER, INC.	Employer identification number 20-5497506
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BETWEEN WORK AND HOME LIFE. THE PURPOSE OF THE AWARD IS TO RECOGNIZE MEMBER ORGANIZATIONS THAT HAVE ACHIEVED A CERTAIN LEVEL OF EXCELLENCE ACROSS THREE KEY FOCUS AREAS- FINANCIAL AND OPERATIONAL EXCELLENCE, CLINICAL QUALITY EXCELLENCE AND INNOVATION.

WELLSTAR WAS NAMED ONE OF BEST AND BRIGHTEST COMPANIES TO WORK FOR BY WSBTV2, BIZ 1190AM-WAFS, CORP! MAGAZINE, BAUDVILLE, BASIC AND THE ORSUS GROUP. THIS AWARD IS GIVEN TO COMPANIES THAT DISTINGUISH THEMSELVES AS HAVING THE MOST INNOVATIVE AND THOUGHTFUL APPROACH TO HUMAN RESOURCES. WELLSTAR HEALTH SYSTEM WAS A WINNER OF THE LEADERSHIP IN EXCELLENCE AWARD BY VIZIENT MIDSOUTH, A MEMBER ALLIANCE FOR NOT FOR PROFIT HEALTHCARE PROVIDERS.

THE PURPOSE OF THIS AWARD IS TO RECOGNIZE ORGANIZATIONS THAT HAVE ACHIEVED A CERTAIN LEVEL OF EXCELLENCE ACROSS THREE KEY FOCUS AREAS- FINANCIAL AND OPERATIONAL EXCELLENCE, CLINICAL QUALITY EXCELLENCE AND INNOVATION.

FORM 990, PART IV, LINE 12B  
AUDITED FINANCIAL STATEMENTS

WEST GEORGIA MEDICAL CENTER, INC. IS AUDITED ON AN ANNUAL BASIS BY AN OUTSIDE AUDITING FIRM, KPMG, AND AS PART OF THAT AUDIT A CONSOLIDATED FINANCIAL STATEMENT IS ISSUED FOR ALL OF WELLSTAR HEALTH SYSTEM, INC. AND ITS CONTROLLED AFFILIATES. THE INDEPENDENT AUDITORS REPORT INCLUDES THE ACCOUNTS OF WELLSTAR AND ITS CONTROLLED AFFILIATES, WELLSTAR KENNESTONE HOSPITAL, INC., WELLSTAR COBB HOSPITAL, INC., WELLSTAR DOUGLAS HOSPITAL,



Name of the organization WEST GEORGIA MEDICAL CENTER, INC.	Employer identification number 20-5497506
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INC., WELLSTAR PAULDING MEDICAL CENTER, INC., WELLSTAR ATLANTA MEDICAL CENTER, INC., WELLSTAR NORTH FULTON HOSPITAL, INC., WELLSTAR SPALDING REGIONAL HOSPITAL, INC., WELLSTAR SYLVAN GROVE HOSPITAL, INC., WELLSTAR WEST GEORGIA HEALTH SERVICES, INC., WELLSTAR WEST GEORGIA MEDICAL CENTER, INC., WELLSTAR FOUNDATION, INC., WELLSTAR WEST GEORGIA FOUNDATION, INC., VERNON WOODS RETIREMENT COMMUNITY, INC., CHS FOUNDATION, INC., COMMUNITY ASSURANCE COMPANY, LTD., VARIOUS WELLSTAR OWNED PHYSICIAN PRACTICES, A HOSPICE FACILITY, A NURSING FACILITY, HOME HEALTH BUSINESS, AND ENTITIES FOR INFUSION THERAPY AND DURABLE MEDICAL EQUIPMENT. ALL SIGNIFICANT INTERCOMPANY ACCOUNTS AND TRANSACTIONS HAVE BEEN ELIMINATED IN COMBINATION. THE BOARD OF TRUSTEES OF WELLSTAR HEALTH SYSTEM, INC. HAS THE AUTHORITY TO APPROVE APPOINTMENTS OF THE MEMBERS OF THE BOARD OF TRUSTEES OF ALL AFFILIATE CORPORATIONS.

FORM 990, PART IV, LINE 24A

TAX EXEMPT BOND REPORTING

FOR PURPOSES OF THE FORM 990 REPORTING, WELLSTAR HEALTH SYSTEM, INC. (EIN 58-1649541) WILL LIST ALL TAX-EXEMPT BONDS ISSUED SINCE JANUARY 1, 2003 ON SCHEDULE K AS IT TYPICALLY ALLOCATES THE PROCEEDS OF THE BONDS TO MEMBERS OF THE OBLIGATED GROUP (INCLUDING THE HOSPITALS AND PHYSICIAN GROUP). WEST GEORGIA MEDICAL CENTER, INC. WILL REPORT THIS TAX EXEMPT BOND LIABILITY ON FORM 990, PART X, LINE 25 OTHER LIABILITIES DUE TO WHS, INC.

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

POWERS OF THE BOARD

Name of the organization WEST GEORGIA MEDICAL CENTER, INC.	Employer identification number 20-5497506
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AS PER THE ARTICLES OF INCORPORATION, THE ULTIMATE SOLE MEMBER OF WEST GEORGIA MEDICAL CENTER, INC. IS WELLSTAR HEALTH SYSTEM, INC., A GEORGIA NONPROFIT CORPORATION. AS SOLE MEMBER, WELLSTAR HEALTH SYSTEM, INC. HOLDS CERTAIN POWERS OF ELECTION AND APPROVAL IN CONNECTION WITH THE GOVERNING BODY OF THE ORGANIZATION. THESE POWERS ARE PRESENTED IN DETAIL IN THE GOVERNING DOCUMENTS WHICH THE COMPANY MAKES AVAILABLE TO THE PUBLIC UPON REQUEST.

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

BOARD REVIEW OF FORM 990

INTERNAL STAFF PREPARES THE ORGANIZATION'S FORM 990. BEFORE FILING THE RETURN WITH THE INTERNAL REVENUE SERVICE. AN EXTERNAL ACCOUNTING FIRM, PRICEWATERHOUSECOOPERS LLP, REVIEWS AND SIGN-OFFS ON THE COMPLETED RETURN OF EACH ORGANIZATION. GENERALLY, FORM 990 IS THEN REVIEWED BY THE FINANCE COMMITTEE ALONG WITH A QUESTION AND ANSWER SESSION. A MOTION IS THEN MADE BY THE FINANCE COMMITTEE TO APPROVE THE RETURNS AND PRESENT TO THE FULL BOARD COPIES OF THE FORMS IN AN ELECTRONIC (PDF. FORMAT) VERSION AS WELL AS A HARD COPY. THE ORGANIZATION'S CFO OR DESIGNEE SUBSEQUENTLY SIGNS THE RETURN FOR EITHER MANUAL OR ELECTRONIC FILING BY THE APPROPRIATE DUE DATE.

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

CONFLICT OF INTEREST POLICY

OUR CONFLICT OF INTEREST POLICY REQUIRES ALL COVERED PERSONS TO ANNUALLY REVIEW THE POLICY AND THEN COMPLETE, SIGN AND RETURN THE CONFLICTS OF

Name of the organization WEST GEORGIA MEDICAL CENTER, INC.	Employer identification number 20-5497506
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INTEREST SURVEY AND ATTESTATION TO THE COMPLIANCE OFFICE. THE POLICY REQUIRES AN ON-GOING DISCLOSURE OBLIGATION IN THE EVENT A CONFLICT ARISES DURING THE YEAR. THE FOLLOWING IS OUR PROCESS TO REGULARLY AND CONSISTENTLY MONITOR AND ENFORCE THE POLICY: COMPLIANCE IDENTIFIES ALL COVERED PERSONS WHO MUST COMPLETE THE SURVEY AND ATTESTATION. COMPLIANCE VERIFIES THAT THE SURVEY AND ATTESTATION IS DISTRIBUTED TO THESE PERSONS. COMPLIANCE VERIFIES THAT THESE PERSONS RETURN A FULLY COMPLETED AND SIGNED SURVEY AND ATTESTATION. COMPLIANCE REVIEWS EACH COMPLETED AND SIGNED SURVEY AND ATTESTATION TO IDENTIFY ALL CONFLICTS LISTED IN THE DOCUMENT. ALL CONFLICTS, POTENTIAL CONFLICTS AND INCIDENCES OF NON-COMPLIANCE ARE REFERRED TO THE CHIEF COMPLIANCE OFFICER. THE CCO TAKES APPROPRIATE ACTION TO COMPLETELY RESOLVE ALL IDENTIFIED CONFLICTS AND INCIDENCES OF NON-COMPLIANCE.

FORM 990, PART VI, SECTION B, LINES 15A & 15B

COMPENSATION OF OFFICERS

WELLSTAR HEALTH SYSTEM, INC. HAS ENGAGED SULLIVAN COTTER TO WORK WITH THE GOVERNING BOARD TO REVIEW AND RECOMMEND EXECUTIVE COMPENSATION. THE EXECUTIVE COMPENSATION PROCESS AT WELLSTAR IS OVERSEEN BY A COMMITTEE OF INDEPENDENT TRUSTEES, WHICH FOLLOWS A BOARD-APPROVED EXECUTIVE COMPENSATION PHILOSOPHY. THE COMPENSATION COMMITTEE CONSISTS OF FIVE TRUSTEES AS WELL AS THE CEO IN AN ADVISORY ROLE AND NOT A VOTING MEMBER. FURTHER IN COMMITTEE DISCUSSIONS ABOUT THE COMPENSATION FOR THE CHIEF EXECUTIVE OFFICER, THE CEO WILL RECUSE HIM/HERSELF FROM THAT PROCESS AND IS A NON-VOTING COMMITTEE MEMBER FOR DISCUSSIONS ON ALL OTHER OFFICERS.

Name of the organization WEST GEORGIA MEDICAL CENTER, INC.	Employer identification number 20-5497506
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THE EXECUTIVE COMPENSATION PHILOSOPHY EMPOWERS THE COMMITTEE TO OVERSEE THE EXECUTIVE COMPENSATION PROCESS AND ADMINISTER THE EXECUTIVE COMPENSATION PROGRAM ON BEHALF OF THE FULL BOARD OF TRUSTEES OF WELLSTAR; PROVIDED, HOWEVER, THE FULL BOARD OF TRUSTEES EVALUATES AND APPROVES THE COMPENSATION OF THE CHIEF EXECUTIVE OFFICER. THE PHILOSOPHY REQUIRES ANNUAL DISCLOSURE OF THE COMMITTEE'S ACTIONS AND DECISIONS TO THE FULL BOARD, WHICH IT HAS DONE. THE COMMITTEE IS GUIDED BY THE BOARD-APPROVED PHILOSOPHY. OVERALL, THE PHILOSOPHY IS INTENDED TO REWARD FOR ORGANIZATIONAL AND INDIVIDUAL PERFORMANCE. BASE COMPENSATION IS TARGETED AT THE MEDIAN BASE COMPENSATION PAID TO SIMILAR POSITIONS AT SIMILAR ORGANIZATIONS (THE MARKET). OFFICERS OF THE COMPANY ALSO RECEIVE VARIABLE COMPENSATION THAT IS DEPENDENT ON INDIVIDUAL AND ORGANIZATION PERFORMANCE. WHEN PERFORMANCE IS AT A PREDETERMINED TARGETED LEVEL, THE TOTAL COMPENSATION, BOTH BASE AND VARIABLE, IS INTENDED TO BE AT OR AROUND THE 75TH% OF COMPENSATION PAID TO SIMILAR POSITIONS AT SIMILAR ORGANIZATIONS. WELLSTAR'S EXECUTIVE COMPENSATION PHILOSOPHY DEFINES THE MARKET AS BEING COMPRISED OF COMPARABLE NOT-FOR-PROFIT HEALTH CARE DELIVERY SYSTEMS, I.E., NOT-FOR-PROFIT ORGANIZATIONS SIMILAR IN COMPLEXITY AND SCALE TO WELLSTAR. TO ASSIST THE COMMITTEE IN FULFILLING ITS DUTIES, THE COMMITTEE ENGAGED SULLIVAN COTTER TO PROVIDE MARKET COMPENSATION DATA TO COMPARE TO THE WELLSTAR POSITIONS WHOSE COMPENSATION THE COMMITTEE OVERSEES. THE COMMITTEE USES THIS DATA TO PROVIDE CONTEXT WHEN MAKING DECISIONS IN ADMINISTERING THE COMPENSATION PROGRAM. ACCURATE MINUTES OF THE COMMITTEE'S DISCUSSION AND DECISIONS ARE RECORDED DURING EACH COMMITTEE MEETING AND REVIEWED AND PROVIDED TO THE FULL BOARD OF

Name of the organization WEST GEORGIA MEDICAL CENTER, INC.	Employer identification number 20-5497506
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TRUSTEES FOR REVIEW.

FORM 990, PART VI, SECTION C, LINE 19

DOCUMENTS MADE AVAILABLE TO THE PUBLIC

THE ORGANIZATION AND ITS AFFILIATES ARE SUBJECT TO THE OPEN RECORDS LAW IN THE STATE OF GEORGIA. THEREFORE, BY LAW, CITIZENS ARE PERMITTED TO INSPECT AND COPY ITS GOVERNING DOCUMENTS, POLICIES AND FINANCIAL STATEMENTS AS MAY BE REQUESTED FROM TIME TO TIME. ADDITIONALLY, THE ORGANIZATION'S FORM 990 IS MADE READILY AVAILABLE ON THE GUIDESTAR WEBSITE. PERIODICALLY, THE ORGANIZATION PUBLISHES ITS FINANCIAL PERFORMANCE IN THE LOCAL NEWSPAPER FOR CITIZENS TO REVIEW, AND PUBLISHES A COMMUNITY BENEFIT REPORT ONCE A YEAR FOR DISTRIBUTION TO THE PUBLIC.

FORM 990, PART VII

OFFICERS HOURS WORKED

THE OFFICERS DEVOTE THEIR TIME TO ALL OF THE ORGANIZATIONS WITHIN WELLSTAR HEALTH SYSTEM THAT ARE LISTED IN SCHEDULE R, PART II. AS SUCH, THE TOTAL HOURS WORKED BY THE OFFICERS ACROSS ALL OF THE ORGANIZATIONS EXCEEDS 40 HOURS PER WEEK.

FORM 990, PART VII & FORM 990, SCHEDULE J

COMPENSATION

ALL COMPENSATION AMOUNTS REPORTED ON FORM 990, PART VII; PART IX, LINES 5-7; AND SCHEDULE J REPRESENT COMPENSATION PROVIDED TO INDIVIDUALS THAT PROVIDE SERVICES TO THE ORGANIZATION. LIKewise, THE NUMBER OF EMPLOYEES

Name of the organization WEST GEORGIA MEDICAL CENTER, INC.	Employer identification number 20-5497506
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REPORTED ON PART V, LINE 2A REPRESENTS THE NUMBER OF INDIVIDUALS PROVIDING SERVICES TO THE ORGANIZATION. ALL FEDERAL EMPLOYMENT TAX RESPONSIBILITIES FOR THESE INDIVIDUALS (INCLUDING FEDERAL EMPLOYMENT TAX REPORTING RESPONSIBILITIES) ARE HANDLED BY WELLSTAR HEALTH SYSTEM, INC. (EIN 58-1649541).

FORM 990, PART XI, LINE 9

OTHER CHANGES IN NET ASSETS

FOR THE REPORTING PERIOD WELLSTAR WEST GEORGIA MEDICAL CENTER, INC. HAD A CHANGE IN NET ASSETS OF \$(55,369,113) RELATED TO TRANSFERS TO AFFILIATES AS PART OF THE ALLOCATION OF INCOME STATEMENT AND BALANCE SHEET TRANSACTIONS OVER THE YEAR.

ATTACHMENT 1

990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
MARCUS L. WILLIAMS, MD 515 BRYANT LAKE BLVD. LAGRANGE, GA 30241	CALL PAY & DIRECTOR	185,725.
STEPHEN R. KARP 104 BROOKRIDGE DRIVE HOGANSVILLE, GA 30230	RADIATION PHYSICIST	176,928.
DAVID EUGENE MARTIN, MD 102 WOODCHASE DRIVE LAGRANGE, GA 30240	DIRECTOR PAY	140,000.
ANGAMPALLY G. RAJEEV, MD 313 NORTH LEE ST. LAGRANGE, GA 30240	CALL PAY	128,720.
G. RALSTON MAJOR II, MD 843 LAKEWOOD DRIVE LAGRANGE, GA 30240	CALL PAY	107,516.

Name of the organization WEST GEORGIA MEDICAL CENTER, INC.	Employer identification number 20-5497506
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ATTACHMENT 2FORM 990, PART IX - OTHER FEES

<u>DESCRIPTION</u>	(A) <u>TOTAL FEES</u>	(B) <u>PROGRAM SERVICE EXP.</u>	(C) <u>MANAGEMENT AND GENERAL</u>	(D) <u>FUNDRAISING EXPENSES</u>
CONTRACT LABOR	1,660,705.	1,650,407.	10,298.	0.
PURCHASED SERVICES	16,940,937.	7,022,288.	9,906,754.	11,895.
PROFESSIONAL FEES	307,330.	133,609.	173,721.	0.
BANKING FEES	191,061.	0.	191,061.	0.
LICENSE & TAXES	35,923.	22,982.	12,941.	0.
TOTALS	<u>19,135,956.</u>	<u>8,829,286.</u>	<u>10,294,775.</u>	<u>11,895.</u>

**SCHEDULE R  
(Form 990)**

**Related Organizations and Unrelated Partnerships**

OMB No. 1545-0047

**2017**

**Open to Public  
Inspection**

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

▶ Attach to Form 990.

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

WEST GEORGIA MEDICAL CENTER, INC.

Employer identification number

20-5497506

**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)					

**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	No
(1) CHS FOUNDATION, INC. 58-1649540 793 SAWYER ROAD MARIETTA, GA 30062	FOUNDATION	GA	501(C)(3)	12 II	WHS, INC.	X	
(2) DOUGLAS HOSPITAL, INC. 58-2026750 793 SAWYER ROAD MARIETTA, GA 30062	HEALTHCARE	GA	501(C)(3)	3	WHS, INC.	X	
(3) KENNESTONE HOSPITAL, INC. 58-2032904 793 SAWYER ROAD MARIETTA, GA 30062	HEALTHCARE	GA	501(C)(3)	3	WHS, INC.	X	
(4) PAULDING MEDICAL CENTER, INC. 58-2095884 793 SAWYER ROAD MARIETTA, GA 30062	HEALTHCARE	GA	501(C)(3)	3	WHS, INC.	X	
(5) WELLSTAR FOUNDATION, INC. 58-1627413 793 SAWYER ROAD MARIETTA, GA 30062	FOUNDATION	GA	501(C)(3)	12 II	WHS, INC.	X	
(6) WELLSTAR HEALTH SYSTEM, INC. 58-1649541 793 SAWYER ROAD MARIETTA, GA 30062	HEALTHCARE	GA	501(C)(3)	12 II	N/A		X
(7) WELLSTAR ATLANTA MEDICAL CENTER, INC. 81-0837031 793 SAWYER ROAD MARIETTA, GA 30062	HEALTHCARE	GA	501(C)(3)	3	WHS, INC.	X	

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

Schedule R (Form 990) 2017



**SCHEDULE R  
(Form 990)**

**Related Organizations and Unrelated Partnerships**

OMB No. 1545-0047

**2017**

**Open to Public  
Inspection**

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Department of the Treasury  
Internal Revenue Service

Name of the organization

WEST GEORGIA MEDICAL CENTER, INC.

Employer identification number

20-5497506

**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)					

**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	No
(1) WELLSTAR NORTH FULTON HOSPITAL, INC. 81-0851756 793 SAWYER ROAD MARIETTA, GA 30062	HEALTHCARE	GA	501(C)(3)	3	WHS, INC.	X	
(2) WELLSTAR SPALDING REGIONAL HOSPITAL, INC. 81-0864789 793 SAWYER ROAD MARIETTA, GA 30062	HEALTHCARE	GA	501(C)(3)	3	WHS, INC.	X	
(3) WELLSTAR SYLVAN GROVE HOSPITAL, INC. 81-0875069 793 SAWYER ROAD MARIETTA, GA 30062	HEALTHCARE	GA	501(C)(3)	3	WHS, INC.	X	
(4) WEST GEORGIA HEALTH SERVICES, INC. 20-5497622 793 SAWYER ROAD MARIETTA, GA 30062	HEALTHCARE	GA	501(C)(3)	12 II	WHS, INC.	X	
(5) COBB HOSPITAL, INC. 58-0968382 793 SAWYER ROAD MARIETTA, GA 30062	HEALTHCARE	GA	501(C)(3)	3	WHS, INC.	X	
(6) VERNON WOODS RETIREMENT COMMUNITY, INC. 58-2575049 793 SAWYER ROAD MARIETTA, GA 30062	HEALTHCARE	GA	501(C)(3)	10	WGHS, INC.	X	
(7) WEST GEORGIA HEALTH FOUNDATION, INC. 20-0936376 793 SAWYER ROAD MARIETTA, GA 30062	FOUNDATION	GA	501(C)(3)	12 II	WGHS, INC.	X	

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

Schedule R (Form 990) 2017

**SCHEDULE R  
(Form 990)**

**Related Organizations and Unrelated Partnerships**

OMB No. 1545-0047

**2017**

**Open to Public  
Inspection**

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

▶ **Attach to Form 990.**

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

WEST GEORGIA MEDICAL CENTER, INC.

Employer identification number

20-5497506

**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)					

**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	No
(1) MEDICAL PARK FOUNDATION, INC. 1514 VERNON ROAD LAGRANGE, GA 30240 58-1303478	FOUNDATION	GA	501(C)(3)	7	WGHS, INC.	X	
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							

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

Schedule R (Form 990) 2017

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) COBB SOUTH PARKING DECK 793 SAWYER ROAD	PARKING	GA	N/A	N/A								
(2) KENNESTONE EAST PARKING DECK 793 SAWYER ROAD	PARKING	GA	WHS, INC.	N/A								
(3) GRIFFIN IMAGING, LLC 793 SAWYER ROAD	IMAGING CENTER	GA	N/A	N/A								
(4) TENET EMS/SPALDING 911, LLC 793 SAWYER ROAD	OFF. BLDG/EMS CTR	GA	N/A	N/A								
(5) NORTH FULTON PARKING DECK, LP 793 SAWYER ROAD	PARKING	GA	N/A	N/A								
(6)												
(7)												

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
(1) COMMUNITY ASSURANCE CO. 58-1649541 3RD FL BARCLAYS HSE, SHEDDEN RD GEORGE TOWN, GA	INSURANCE	CJ	WHS, INC.	C CORP					
(2) WEST GEORGIA HEALTH PHYSICIANS, INC. 27-5125341 793 SAWYER ROAD MARIETTA, GA 30062-2222	PHYSICIAN PRAC.	GA	WGHS, INC.	C CORP					
(3)									
(4)									
(5)									
(6)									
(7)									

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

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

	Yes	No
<b>1</b> During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?		
<b>a</b> Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity . . . . .		X
<b>b</b> Gift, grant, or capital contribution to related organization(s) . . . . .	X	
<b>c</b> Gift, grant, or capital contribution from related organization(s) . . . . .	X	
<b>d</b> Loans or loan guarantees to or for related organization(s) . . . . .		X
<b>e</b> Loans or loan guarantees by related organization(s) . . . . .		X
<b>f</b> Dividends from related organization(s) . . . . .		X
<b>g</b> Sale of assets to related organization(s) . . . . .		X
<b>h</b> Purchase of assets from related organization(s) . . . . .		X
<b>i</b> Exchange of assets with related organization(s) . . . . .		X
<b>j</b> Lease of facilities, equipment, or other assets to related organization(s) . . . . .		X
<b>k</b> Lease of facilities, equipment, or other assets from related organization(s) . . . . .	X	
<b>l</b> Performance of services or membership or fundraising solicitations for related organization(s) . . . . .		X
<b>m</b> Performance of services or membership or fundraising solicitations by related organization(s) . . . . .	X	
<b>n</b> Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) . . . . .		X
<b>o</b> Sharing of paid employees with related organization(s) . . . . .	X	
<b>p</b> Reimbursement paid to related organization(s) for expenses . . . . .	X	
<b>q</b> Reimbursement paid by related organization(s) for expenses . . . . .		X
<b>r</b> Other transfer of cash or property to related organization(s) . . . . .		X
<b>s</b> Other transfer of cash or property from related organization(s) . . . . .		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)				
(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 section 501(c)(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
				Yes	No			Yes	No		Yes	No	
(1)													
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
(9)													
(10)													
(11)													
(12)													
(13)													
(14)													
(15)													
(16)													

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

Provide additional information for responses to questions on Schedule R. See instructions.

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