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Form **990****Return of Organization Exempt From Income Tax**

OMB No 1545-0047

2015Open to Public
InspectionDepartment of the Treasury
Internal Revenue Service

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

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

▶ Information about Form 990 and its instructions is at www.irs.gov/form990.**A** For the 2015 calendar year, or tax year beginning

12/14, 2015, and ending

06/30, 2016

B Check if applicable

- ☐ Address change
- ☐ Name change
- ☒ Initial return
- ☐ Final return/terminated
- ☐ Amended return
- ☐ Application pending

C Name of organization

WELLSTAR SPALDING REGIONAL HOSPITAL, INC.

Doing business as

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

F Name and address of principal officer

CANDICE L. SAUNDERS

793 SAWYER ROAD MARIETTA, GA 30062-2222

D Employer identification number

81-0864789

E Telephone number

(770) 956-7827

G Gross receipts \$ 32,039,911.**H(a)** Is this a group return for subordinates? ☐ Yes ☒ No**H(b)** Are all subordinates included? ☐ Yes ☐ No

If "No," attach a list (see instructions)

H(c) Group exemption number ▶**I** Tax-exempt status ☒ 501(c)(3) ☐ 501(c) () ◀ (insert no) ☐ 4947(a)(1) or ☐ 527**J** Website ▶ WWW.WELLSTAR.ORG**K** Form of organization ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶ **L** Year of formation 2015 **M** State of legal domicile GA**Part I Summary****1** Briefly describe the organization's mission or most significant activities TO PROVIDE WORLD-CLASS CHARITABLE HEALTHCARE TO THE COMMUNITY.**2** Check this box ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets

| | | |
|--|-----------|------|
| 3 Number of voting members of the governing body (Part VI, line 1a) | 3 | 20. |
| 4 Number of independent voting members of the governing body (Part VI, line 1b) | 4 | 12. |
| 5 Total number of individuals employed in calendar year 2015 (Part V, line 2a) | 5 | 0. |
| 6 Total number of volunteers (estimate if necessary) | 6 | 108. |
| 7a Total unrelated business revenue from Part VIII, column (C), line 12 | 7a | 0. |
| 7b Net unrelated business taxable income from Form 990-T, line 34 | 7b | 0. |

| | | Prior Year | Current Year |
|--|---------------------------|------------|--------------|
| 8 Contributions and grants (Part VIII, line 1h) | | 0. | 0. |
| 9 Program service revenue (Part VIII, line 2d) | | 0. | 31,901,558. |
| 10 Investment income (Part VIII, column (A), lines 3, 4, and 7d) | | 0. | 108,994. |
| 11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) | | 0. | 29,359. |
| 12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12) | | 0. | 32,039,911. |
| 13 Grants and similar amounts paid (Part IX, column (A), lines 1-3) | | 0. | 5,472. |
| 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) | | 0. | 12,318,290. |
| 16a Professional fundraising fees (Part IX, column (A), line 11e) | | 0. | 0. |
| 16b Total fundraising expenses (Part IX, column (D), line 25) ▶ | | 0. | 0. |
| 17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e) | | 0. | 14,808,821. |
| 18 Total expenses - Add lines 13-17 (must equal Part IX, column (A), line 25) | | 0. | 27,132,583. |
| 19 Revenue less expenses - Subtract line 18 from line 12 | | 0. | 4,907,328. |
| 20 Total assets (Part X, line 16) | Beginning of Current Year | 0. | 246,258,956. |
| 21 Total liabilities (Part X, line 26) | End of Year | 0. | 228,572,641. |
| 22 Net assets or fund balances - Subtract line 21 from line 20 | | 0. | 17,686,315. |

Part II Signature Block

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

Sign Here Signature of officer James M. Swartz Date 05-15-2017

JAMES M. SWARTZ VP, ACCOUNTING

Type or print name and title

Paid Preparer Use Only Print/Type preparer's name JOANNE KRUEGER Preparer's signature Joanne Krueger Date 05/10/2017 Check ☐ if self-employed PTIN P01235586

Firm's name ▶ PRICEWATERHOUSECOOPERS LLP Firm's EIN ▶ 13-4008324

Firm's address ▶ 2001 MARKET ST, SUITE 1800 PHILADELPHIA, PA 19103 Phone no 267-330-3000

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** (2015)

Part III Statement of Program Service AccomplishmentsCheck 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 \$ 19,350,539 including grants of \$ 5,472) (Revenue \$ 31,901,558)
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 **▶** 19,350,539.

Part IV Checklist of Required Schedules

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

Form **990** (2015)

Part IV Checklist of Required Schedules (continued)

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

Form 990 (2015)

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

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

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

| | Yes | No |
|---|-----|----|
| 1a Enter the number of voting members of the governing body at the end of the tax year | 20 | |
| If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O | | |
| b Enter the number of voting members included in line 1a, above, who are independent | 12 | |
| 2 Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee? | | X |
| 3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person? . . | | X |
| 4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? | | X |
| 5 Did the organization become aware during the year of a significant diversion of the organization's assets? . . . | | X |
| 6 Did the organization have members or stockholders? | X | |
| 7a Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? | X | |
| b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? | X | |
| 8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following | | |
| a The governing body? | X | |
| b Each committee with authority to act on behalf of the governing body? | X | |
| 9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O | | X |

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

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

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.
☐ Own website ☐ Another's website ☒ Upon request ☐ Other (explain in Schedule O)

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 ►
 JAMES M SWARTZ 793 SAWYER ROAD MARIETTA, GA 30062-2222 770-956-7827

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent ContractorsCheck 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) AVRIL P. BECKFORD, MD TRUSTEE & CHIEF PEDIATRIC OFF. | 2.00 48.00 | X | | X | | | | 0. | 553,416. | 30,618. |
| (2) CHARLES J. JONES TRUSTEE | 1.00 9.00 | X | | | | | | 0. | 4,079. | 0. |
| (3) DAVID H. HAFNER, MD TRUSTEE | 1.00 9.00 | X | | | | | | 0. | 23,923. | 0. |
| (4) FRANK ROS TRUSTEE | 1.00 9.00 | X | | | | | | 0. | 3,478. | 0. |
| (5) GARY A. MILLER TRUSTEE - CHAIR | 1.00 9.00 | X | | | | | | 0. | 4,120. | 0. |
| (6) GREG MORGAN, MD TRUSTEE | 1.00 9.00 | X | | | | | | 0. | 2,324. | 0. |
| (7) H. SPEER BURDETTE, III TRUSTEE | 1.00 9.00 | X | | | | | | 0. | 0. | 0. |
| (8) JANIE MADDOX TRUSTEE | 1.00 9.00 | X | | | | | | 0. | 7,842. | 0. |
| (9) JEFFREY L. THARP, MD, MPH TRUSTEE & CHIEF MEDICINE SRVS | 2.00 48.00 | X | | X | | | | 0. | 593,302. | 79,458. |
| (10) MICHAEL B. PATTON TRUSTEE | 1.00 9.00 | X | | | | | | 0. | 0. | 0. |
| (11) MITZI MOORE TRUSTEE | 1.00 9.00 | X | | | | | | 0. | 3,074. | 0. |
| (12) O. SCOTT SWAYZE, MD TRUSTEE | 1.00 9.00 | X | | | | | | 0. | 4,304. | 0. |
| (13) OTIS A. BRUMBY, III TRUSTEE | 1.00 9.00 | X | | | | | | 0. | 16,930. | 0. |
| (14) RANDALL BENTLEY, SR TRUSTEE | 1.00 9.00 | X | | | | | | 0. | 20,441. | 0. |

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) ROBERT N. CROSS, MD TRUSTEE | 1.00 9.00 | X | | | | | | 0. | 14,803. | 0. |
| (16) T. FITZ JOHNSON TRUSTEE | 1.00 11.00 | X | | | | | | 0. | 17,999. | 0. |
| (17) THOMAS E. GEARHARD, MD TRUSTEE | 1.00 9.00 | X | | | | | | 0. | 2,070. | 0. |
| (18) THOMAS M. PHILLIPS TRUSTEE | 1.00 9.00 | X | | | | | | 0. | 2,638. | 0. |
| (19) W. CHARLES BROCK TRUSTEE | 1.00 9.00 | X | | | | | | 0. | 21,470. | 0. |
| (20) WALTER G. ROBINSON TRUSTEE | 1.00 9.00 | X | | | | | | 0. | 4,348. | 0. |
| (21) ANTHONY J. BUDZINSKI EVP & CFO | 2.00 50.00 | | | X | | | | 0. | 793,732. | 76,107. |
| (22) ANTHONY M. TRUPIANO SVP SUPPLY CHAIN | 2.00 48.00 | | | X | | | | 0. | 377,102. | 49,343. |
| (23) BARBARA B. COREY SVP MANAGED CARE | 2.00 48.00 | | | X | | | | 0. | 416,030. | 47,665. |
| (24) BETH KOST VP COMPLIANCE CHF PRIVACY OFCR | 2.00 48.00 | | | X | | | | 0. | 331,271. | 34,355. |
| (25) BETHANY ROBERTSON VP & CHIEF LEARNING OFFICER | 2.00 48.00 | | | X | | | | 0. | 300,438. | 46,673. |
| 1b Sub-total | | | | | | | | 0. | 1,237,233. | 110,076. |
| c Total from continuation sheets to Part VII, Section A | | | | | | | | 0. | 13,831,387. | 1,854,006. |
| d Total (add lines 1b and 1c) | | | | | | | | 0. | 15,068,620. | 1,964,082. |

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization **0.**

- 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
- 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
- 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

| | Yes | No |
|---|-----|----|
| 3 | | X |
| 4 | X | |
| 5 | | 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 **0.**

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) BRADFORD B. NEWTON VP INFO. TECHNOLOGY ADMIN. | 2.00 48.00 | | | X | | | | 0. | 251,598. | 50,475. |
| (27) BRUCE A. DEAN VP REAL ESTATE DEPUTY GEN CNSL | 2.00 48.00 | | | X | | | | 0. | 304,967. | 72,423. |
| (28) CANDICE L. SAUNDERS PRESIDENT & CEO | 2.00 50.00 | | | X | | | | 0. | 1,180,672. | 77,248. |
| (29) CARRIE O. PLIETZ EVP & COO HOSP. (BEGIN. 2/16) | 2.00 48.00 | | | X | | | | 0. | 0. | 0. |
| (30) DANIEL J. STYF SVP PW HEALTH PLAN | 2.00 48.00 | | | X | | | | 0. | 401,787. | 30,738. |
| (31) DAVID W. ANDERSON EVP/HR/OL/CCO | 2.00 48.00 | | | X | | | | 0. | 636,243. | 73,566. |
| (32) DOUGLAS ARVIN, CPA, MBA SVP FINANCE (BEGIN. 3/2016) | 2.00 48.00 | | | X | | | | 0. | 0. | 0. |
| (33) DOUGLAS S. FOSTER VP FINANCIAL PLAN. (BEG. 3/16) | 2.00 48.00 | | | X | | | | 0. | 0. | 0. |
| (34) EHI OSEHOBO VP HOSPITAL CHIEF MED OFFICER | 50.00 0. | | | X | | | | 0. | 0. | 0. |
| (35) ELIZABETH H. LOUDERMILK VP ENT INTELLIGENCE & INTGRN | 2.00 48.00 | | | X | | | | 0. | 293,860. | 42,566. |
| (36) ELLEN LANGFORD SVP & COO WELLSTAR MED GROUP | 2.00 48.00 | | | X | | | | 0. | 330,231. | 71,209. |
| 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 **0.**

- 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
- 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
- 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

| | Yes | No |
|----------|-----|----|
| 3 | | X |
| 4 | X | |
| 5 | | 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 **0.**

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) FRED A LYON VP SYSTEM EMERGENCY & TRAUMA | 2.00 48.00 | | | X | | | | 0. | 148,720. | 21,078. |
| (38) JAMES M. SWARTZ VP ACCOUNTING | 2.00 48.00 | | | X | | | | 0. | 265,746. | 44,824. |
| (39) JILL M. CASE-WIRTH SVP & CHIEF NURSE EXECUTIVE | 2.00 48.00 | | | X | | | | 0. | 424,761. | 56,220. |
| (40) JIMMY E. FRANCIS VP INFO TECHNOLOGY OPERATIONS | 2.00 48.00 | | | X | | | | 0. | 266,152. | 49,549. |
| (41) JOEL W. HELMKE VP ONCOLOGY | 2.00 48.00 | | | X | | | | 0. | 319,000. | 70,175. |
| (42) JOHN A. BRENNAN EVP CHIEF CLNC.OFF (BEG. 4/16) | 2.00 48.00 | | | X | | | | 0. | 0. | 0. |
| (43) JONATHAN B. MORRIS, MD SVP CHIEF INFO OFFICER | 2.00 48.00 | | | X | | | | 0. | 511,024. | 53,680. |
| (44) JOSEPH L. BRYWCZYNSKI SVP HEALTH PARKS DEVELOPMENT | 2.00 48.00 | | | X | | | | 0. | 375,861. | 72,424. |
| (45) KEM M. MULLINS EVP COO AMBULATORY & BUS DEV | 2.00 48.00 | | | X | | | | 0. | 596,655. | 52,732. |
| (46) KIMBERLY W. MENEFFEE SVP STRATEGIC COMMUNITY DEV | 2.00 48.00 | | | X | | | | 0. | 385,571. | 50,772. |
| (47) KRISTEN S. TRICE VP DIAG. OUTREACH (BEG. 1/16) | 2.00 48.00 | | | X | | | | 0. | 0. | 0. |
| 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 **0.**

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

| | Yes | No |
|----------|-----|----|
| 3 | | X |
| 4 | X | |
| 5 | | 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

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

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 **0.**

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) KRISTYN M. GREIFER VP POPULATION MANAGEMENT | 2.00 48.00 | | | X | | | | 0. | 397,576. | 18,767. |
| (49) LEO E. REICHERT EVP & GENERAL COUNSEL | 2.00 48.00 | | | X | | | | 0. | 717,317. | 63,211. |
| (50) MARY L. TAVERNARO VP HUMAN RESOURCES OPERATIONS | 2.00 48.00 | | | X | | | | 0. | 283,376. | 51,130. |
| (51) MICHAEL G. PAUL VP FACILITIES ENG SUPPORT SVCS | 2.00 48.00 | | | X | | | | 0. | 233,220. | 24,754. |
| (52) MICHELLE M. ROBINSON VP MKTNG/PR/INTERNAL COMM | 2.00 48.00 | | | X | | | | 0. | 253,969. | 42,237. |
| (53) NICOLE V. ASHE VP FINANCE & CFO WMG | 2.00 48.00 | | | X | | | | 0. | 284,586. | 49,175. |
| (54) PETER R. JUNGBLUT, MD, MBA SVP & MEDICAL DIR WMG | 2.00 48.00 | | | X | | | | 0. | 422,089. | 71,361. |
| (55) REBECCA L. RUHL VP FACILITY CMPL. (BEG. 4/16) | 2.00 48.00 | | | X | | | | 0. | 0. | 0. |
| (56) RICHARD S. SIEGEL VP CARDIOLOGY & CVM ADMIN | 2.00 48.00 | | | X | | | | 0. | 353,273. | 76,096. |
| (57) ROBERT J. DECOUX VP CORPORATE MED STAFF SVCS | 2.00 48.00 | | | X | | | | 0. | 195,690. | 45,418. |
| (58) ROBERT MANDLER VP DIAGNOSTIC OUTREACH | 2.00 48.00 | | | X | | | | 0. | 274,022. | 63,575. |

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 **0.**

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

| | Yes | No |
|----------|-----|----|
| 3 | | X |
| 4 | X | |
| 5 | | 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

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

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) ROBIN G. BOEHRINGER VP TOTAL REWARDS (BEG. 11/15) | 2.00 48.00 | | | X | | | | 0. | 0. | 0. |
| (60) SANDRA LUCIUS VP INFO TECHNOLOGY APPS | 2.00 48.00 | | | X | | | | 0. | 262,637. | 49,160. |
| (61) SEAN P. TURNER VP REVENUE CYCLE MANAGEMENT | 2.00 48.00 | | | X | | | | 0. | 317,142. | 51,201. |
| (62) SNEHAL H. DOSHI VP SYSTEM PHARMACIST | 2.00 48.00 | | | X | | | | 0. | 175,084. | 26,331. |
| (63) STACEY J. HANCOCK VP HUMAN RESOURCES | 50.00 0. | | | X | | | | 0. | 0. | 0. |
| (64) STEPHEN L. BADGER CHIEF ADMIN. OFF. (BEG. 2/16) | 2.00 48.00 | | | X | | | | 0. | 0. | 0. |
| (65) TAMARA D. ISON SVP HOSP. PRES. (BEGIN. 4/16) | 48.00 2.00 | | | X | | | | 0. | 0. | 0. |
| (66) VALERY A. AKOPOV, MD VP & CHIEF OF HOSPITALIST SVCS | 2.00 48.00 | | | X | | | | 0. | 460,432. | 54,453. |
| (67) WADRA G. MCCULLOUGH VP CNO | 50.00 0. | | | X | | | | 0. | 0. | 0. |
| (68) WANDA Y. ROBINSON VP COMPLIANCE PWHP | 2.00 48.00 | | | X | | | | 0. | 226,225. | 23,315. |

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 **0.****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

Yes No

3 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**4** 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**5** 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 RevenueCheck if Schedule O contains a response or note to any line in this Part VIII. ☐

| | | | | (A) Total revenue | (B) Related or exempt function revenue | (C) Unrelated business revenue | (D) Revenue excluded from tax under sections 512-514 |
|---|--|--|----------------|----------------------|--|---|--|
| Contributions, Gifts, Grants and Other Similar Amounts | 1a | Federated campaigns | 1a | | | | |
| | b | Membership dues | 1b | | | | |
| | c | Fundraising events | 1c | | | | |
| | d | Related organizations | 1d | | | | |
| | e | Government grants (contributions) | 1e | | | | |
| | f | All other contributions, gifts, grants, and similar amounts not included above | 1f | | | | |
| | g | Noncash contributions included in lines 1a-1f \$ | | | | | |
| | h | Total. Add lines 1a-1f | | | 0 | | |
| Program Service Revenue | Business Code | | | | | | |
| | 2a | PATIENT REVENUE | 621990 | 31,901,558 | 31,901,558 | | |
| | b | | | | | | |
| | c | | | | | | |
| | d | | | | | | |
| | e | | | | | | |
| | f | All other program service revenue | | | | | |
| | g | Total. Add lines 2a-2f | | | 31,901,558 | | |
| Other Revenue | 3 | Investment income (including dividends, interest, and other similar amounts) | | | 0 | | |
| | 4 | Income from investment of tax-exempt bond proceeds | | | 0 | | |
| | 5 | Royalties | | | 0 | | |
| | | | (i) Real | (ii) Personal | | | |
| | 6a | Gross rents | 12,407 | | | | |
| | b | Less rental expenses | | | | | |
| | c | Rental income or (loss) | 12,407 | | | | |
| | d | Net rental income or (loss) | | 12,407 | | | 12,407 |
| | 7a | Gross amount from sales of assets other than inventory | (i) Securities | (ii) Other | | | |
| | b | Less cost or other basis and sales expenses | | 108,994 | | | |
| | c | Gain or (loss) | | 108,994 | | | |
| | d | Net gain or (loss) | | 108,994 | | | 108,994 |
| | 8a | Gross income from fundraising events (not including \$ of contributions reported on line 1c) See Part IV, line 18 | a | | | | |
| | b | Less direct expenses | b | | | | |
| | c | Net income or (loss) from fundraising events | | 0 | | | |
| | 9a | Gross income from gaming activities See Part IV, line 19 | a | | | | |
| | b | Less direct expenses | b | | | | |
| | c | Net income or (loss) from gaming activities | | 0 | | | |
| 10a | Gross sales of inventory, less returns and allowances | a | | | | | |
| b | Less cost of goods sold | b | | | | | |
| c | Net income or (loss) from sales of inventory | | 0 | | | | |
| Miscellaneous Revenue | | | Business Code | | | | |
| 11a | ALL OTHER REVENUE | 621990 | 16,952 | | | 16,952 | |
| b | | | | | | | |
| c | | | | | | | |
| d | All other revenue | | | | | | |
| e | Total. Add lines 11a-11d | | 16,952 | | | | |
| 12 | Total revenue. See instructions | | | 32,039,911 | 31,901,558 | | 138,353 |

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

| | (A) Total expenses | (B) Program service expenses | (C) Management and general expenses | (D) Fundraising expenses |
|--|-----------------------|------------------------------------|---|--------------------------------|
| Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII. | | | | |
| 1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 | 0. | | | |
| 2 Grants and other assistance to domestic individuals. See Part IV, line 22 | 5,472. | 5,472. | | |
| 3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16 | 0. | | | |
| 4 Benefits paid to or for members | 0. | | | |
| 5 Compensation of current officers, directors, trustees, and key employees | 249,162. | 227,327. | 21,835. | |
| 6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) | 0. | | | |
| 7 Other salaries and wages | 9,746,453. | 8,892,312. | 854,141. | |
| 8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions) | 91,999. | 83,937. | 8,062. | |
| 9 Other employee benefits | 1,195,661. | 1,090,878. | 104,783. | |
| 10 Payroll taxes | 1,035,015. | 944,310. | 90,705. | |
| 11 Fees for services (non-employees) | | | | |
| a Management | 0. | | | |
| b Legal | 0. | | | |
| c Accounting | 0. | | | |
| d Lobbying | 0. | | | |
| e Professional fundraising services. See Part IV, line 17. | 0. | | | |
| f Investment management fees | 0. | | | |
| g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O). <u>ATCH 1.</u> | 5,284,945. | 1,684,072. | 3,600,873. | |
| 12 Advertising and promotion | 74,480. | 1,458. | 73,022. | |
| 13 Office expenses | 1,910,328. | 1,822,133. | 88,195. | |
| 14 Information technology | 0. | | | |
| 15 Royalties | 0. | | | |
| 16 Occupancy | 662,456. | 198,943. | 463,513. | |
| 17 Travel | 4,689. | 884. | 3,805. | |
| 18 Payments of travel or entertainment expenses for any federal, state, or local public officials | 0. | | | |
| 19 Conferences, conventions, and meetings | 303. | 58. | 245. | |
| 20 Interest | 262,303. | | 262,303. | |
| 21 Payments to affiliates | 854,081. | 779,233. | 74,848. | |
| 22 Depreciation, depletion, and amortization | 1,587,794. | 12,804. | 1,574,990. | |
| 23 Insurance | 413,135. | | 413,135. | |
| 24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O). | | | | |
| a <u>REPAIRS AND MAINTENANCE</u> | 226,399. | 169,600. | 56,799. | |
| b <u>MEDICAL SUPPLIES</u> | 3,524,273. | 3,435,536. | 88,737. | |
| c <u>OTHER EXPENSES</u> | 3,635. | 1,582. | 2,053. | |
| d | | | | |
| e All other expenses | | | | |
| 25 Total functional expenses. Add lines 1 through 24e | 27,132,583. | 19,350,539. | 7,782,044. | |
| 26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720) | 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 |
|--|---|--------------------------|--------------|------------------------|
| Assets | 1 Cash - non-interest-bearing | 0. | 1 | 19,811. |
| | 2 Savings and temporary cash investments | 0. | 2 | 0. |
| | 3 Pledges and grants receivable, net | 0. | 3 | 0. |
| | 4 Accounts receivable, net | 0. | 4 | 25,983,963. |
| | 5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L | 0. | 5 | 0. |
| | 6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L | 0. | 6 | 0. |
| | 7 Notes and loans receivable, net | 0. | 7 | 0. |
| | 8 Inventories for sale or use | 0. | 8 | 1,922,269. |
| | 9 Prepaid expenses and deferred charges | 0. | 9 | 197,961. |
| | 10a Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D | 10a 75,303,780. | | |
| | b Less accumulated depreciation | 10b 1,587,794. | 0. | 10c 73,715,986. |
| | 11 Investments - publicly traded securities | 0. | 11 | 0. |
| | 12 Investments - other securities See Part IV, line 11 | 0. | 12 | 0. |
| | 13 Investments - program-related See Part IV, line 11 | 0. | 13 | 0. |
| | 14 Intangible assets | 0. | 14 | 0. |
| | 15 Other assets See Part IV, line 11 | 0. | 15 | 144,418,966. |
| 16 Total assets. Add lines 1 through 15 (must equal line 34) | 0. | 16 | 246,258,956. | |
| Liabilities | 17 Accounts payable and accrued expenses | 0. | 17 | 5,080,363. |
| | 18 Grants payable | 0. | 18 | 0. |
| | 19 Deferred revenue | 0. | 19 | 0. |
| | 20 Tax-exempt bond liabilities | 0. | 20 | 0. |
| | 21 Escrow or custodial account liability Complete Part IV of Schedule D | 0. | 21 | 0. |
| | 22 Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L | 0. | 22 | 0. |
| | 23 Secured mortgages and notes payable to unrelated third parties | 0. | 23 | 0. |
| | 24 Unsecured notes and loans payable to unrelated third parties | 0. | 24 | 0. |
| | 25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24) Complete Part X of Schedule D | 0. | 25 | 223,492,278. |
| | 26 Total liabilities. Add lines 17 through 25 | 0. | 26 | 228,572,641. |
| Net Assets or Fund Balances | Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> X and complete lines 27 through 29, and lines 33 and 34. | | | |
| | 27 Unrestricted net assets | 0. | 27 | 17,686,315. |
| | 28 Temporarily restricted net assets | 0. | 28 | 0. |
| | 29 Permanently restricted net assets | 0. | 29 | 0. |
| | Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34. | | | |
| | 30 Capital stock or trust principal, or current funds | | 30 | |
| | 31 Paid-in or capital surplus, or land, building, or equipment fund | | 31 | |
| | 32 Retained earnings, endowment, accumulated income, or other funds | | 32 | |
| | 33 Total net assets or fund balances | 0. | 33 | 17,686,315. |
| | 34 Total liabilities and net assets/fund balances. | 0. | 34 | 246,258,956. |

Form **990** (2015)

Part XI Reconciliation of Net AssetsCheck if Schedule O contains a response or note to any line in this Part XI ☒

| | | | |
|-----------|---|-----------|-------------|
| 1 | Total revenue (must equal Part VIII, column (A), line 12) | 1 | 32,039,911. |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 27,132,583. |
| 3 | Revenue less expenses Subtract line 2 from line 1 | 3 | 4,907,328. |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | 0. |
| 5 | Net unrealized gains (losses) on investments | 5 | 0. |
| 6 | Donated services and use of facilities | 6 | 0. |
| 7 | Investment expenses | 7 | 0. |
| 8 | Prior period adjustments | 8 | 0. |
| 9 | Other changes in net assets or fund balances (explain in Schedule O) | 9 | 12,778,987. |
| 10 | Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 17,686,315. |

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

| | Yes | No |
|--|-----------|----|
| 1 Accounting method used to prepare the Form 990 <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O | | |
| 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 <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis | 2a | X |
| b Were the organization's financial statements audited by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis | 2b | X |
| 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 | 2c | X |
| 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? | 3a | X |
| 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 | 3b | |

Form **990** (2015)

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.

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

OMB No 1545-0047

2015

Open to Public
Inspection

Name of the organization

WELLSTAR SPALDING REGIONAL HOSPITAL, INC.

Employer identification number

81-0864789

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 11, 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 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.)
- 10 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4)**.
- 11 ☐ 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 11a through 11d that describes the type of supporting organization and complete lines 11e, 11f, and 11g.
- a ☐ **Type I** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. You must complete **Part IV, Sections A and B**.
- b ☐ **Type II** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). You must complete **Part IV, Sections A and C**.
- c ☐ **Type III functionally integrated** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). You must complete **Part IV, Sections A, D, and E**.
- d ☐ **Type III non-functionally integrated** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). You must complete **Part IV, Sections A and D, and Part V**.
- e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.
- f Enter the number of supported organizations: _____
- g Provide the following information about the supported organization(s):

| (i) Name of supported organization | (ii) EIN | (iii) Type of organization (described on lines 1-9 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) | | | | | | |
| Total | | | | | | |

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

Schedule A (Form 990 or 990-EZ) 2015

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

| Calendar year (or fiscal year beginning in) ► | (a) 2011 | (b) 2012 | (c) 2013 | (d) 2014 | (e) 2015 | (f) Total |
|--|----------|----------|----------|----------|----------|-----------|
| 1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants") | | | | | | |
| 2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf | | | | | | |
| 3 The value of services or facilities furnished by a governmental unit to the organization without charge | | | | | | |
| 4 Total. Add lines 1 through 3 | | | | | | |
| 5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f). | | | | | | |
| 6 Public support. Subtract line 5 from line 4 | | | | | | |

Section B. Total Support

| Calendar year (or fiscal year beginning in) ► | (a) 2011 | (b) 2012 | (c) 2013 | (d) 2014 | (e) 2015 | (f) Total |
|--|----------|----------|----------|----------|----------|--------------------------|
| 7 Amounts from line 4 | | | | | | |
| 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources | | | | | | |
| 9 Net income from unrelated business activities, whether or not the business is regularly carried on | | | | | | |
| 10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI) | | | | | | |
| 11 Total support. Add lines 7 through 10 | | | | | | |
| 12 Gross receipts from related activities, etc. (see instructions) | | | | | 12 | |
| 13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here | | | | | | <input type="checkbox"/> |

Section C. Computation of Public Support Percentage

| | | |
|--|----|--------------------------|
| 14 Public support percentage for 2015 (line 6, column (f) divided by line 11, column (f)) | 14 | % |
| 15 Public support percentage from 2014 Schedule A, Part II, line 14 | 15 | % |
| 16a 33 1/3% support test - 2015. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization | | <input type="checkbox"/> |
| b 33 1/3% support test - 2014. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization | | <input type="checkbox"/> |
| 17a 10%-facts-and-circumstances test - 2015. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization | | <input type="checkbox"/> |
| b 10%-facts-and-circumstances test - 2014. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization | | <input type="checkbox"/> |
| 18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions | | <input type="checkbox"/> |

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

(Complete only if you checked the box on line 9 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) 2011 | (b) 2012 | (c) 2013 | (d) 2014 | (e) 2015 | (f) Total |
|--|----------|----------|----------|----------|----------|-----------|
| 1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.") | | | | | | |
| 2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose | | | | | | |
| 3 Gross receipts from activities that are not an unrelated trade or business under section 513 | | | | | | |
| 4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf | | | | | | |
| 5 The value of services or facilities furnished by a governmental unit to the organization without charge | | | | | | |
| 6 Total. Add lines 1 through 5 | | | | | | |
| 7a Amounts included on lines 1, 2, and 3 received from disqualified persons | | | | | | |
| b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year | | | | | | |
| c Add lines 7a and 7b. | | | | | | |
| 8 Public support. (Subtract line 7c from line 6) | | | | | | |

Section B. Total Support

| Calendar year (or fiscal year beginning in) ► | (a) 2011 | (b) 2012 | (c) 2013 | (d) 2014 | (e) 2015 | (f) Total |
|--|----------|----------|----------|----------|----------|-----------|
| 9 Amounts from line 6. | | | | | | |
| 10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources | | | | | | |
| b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975 | | | | | | |
| c Add lines 10a and 10b | | | | | | |
| 11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on | | | | | | |
| 12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI) | | | | | | |
| 13 Total support. (Add lines 9, 10c, 11, and 12) | | | | | | |
| 14 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here. <input type="checkbox"/> | | | | | | |

Section C. Computation of Public Support Percentage

| | | |
|---|----|---|
| 15 Public support percentage for 2015 (line 8, column (f) divided by line 13, column (f)) | 15 | % |
| 16 Public support percentage from 2014 Schedule A, Part III, line 15 | 16 | % |

Section D. Computation of Investment Income Percentage

| | | |
|--|----|---|
| 17 Investment income percentage for 2015 (line 10c, column (f) divided by line 13, column (f)) | 17 | % |
| 18 Investment income percentage from 2014 Schedule A, Part III, line 17 | 18 | % |

- 19a **33 1/3% support tests - 2015.** 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 - 2014.** 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 11 of Part I. If you checked 11a of Part I, complete Sections A and B. If you checked 11b of Part I, complete Sections A and C. If you checked 11c of Part I, complete Sections A, D, and E. If you checked 11d of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

| | Yes | No |
|--|-----|----|
| 1 Are all of the organization's supported organizations listed by name in the organization's governing documents? If "No," describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain. | 1 | |
| 2 Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2). | 2 | |
| 3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? If "Yes," answer (b) and (c) below. | 3a | |
| b Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? If "Yes," describe in Part VI when and how the organization made the determination. | 3b | |
| c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? If "Yes," explain in Part VI what controls the organization put in place to ensure such use. | 3c | |
| 4a Was any supported organization not organized in the United States ("foreign supported organization")? If "Yes," and if you checked 11a or 11b in Part I, answer (b) and (c) below. | 4a | |
| b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations. | 4b | |
| c Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes. | 4c | |
| 5a Did the organization add, substitute, or remove any supported organizations during the tax year? If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in Part VI , including (i) the names and EIN numbers of the supported organizations added, substituted, or removed, (ii) the reasons for each such action, (iii) the authority under the organization's organizing document authorizing such action, and (iv) how the action was accomplished (such as by amendment to the organizing document). | 5a | |
| b Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document? | 5b | |
| c Substitutions only. Was the substitution the result of an event beyond the organization's control? | 5c | |
| 6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? If "Yes," provide detail in Part VI . | 6 | |
| 7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ). | 7 | |
| 8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ). | 8 | |
| 9a Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? If "Yes," provide detail in Part VI . | 9a | |
| b Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? If "Yes," provide detail in Part VI . | 9b | |
| c Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? If "Yes," provide detail in Part VI . | 9c | |
| 10a Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? If "Yes," answer 10b below. | 10a | |
| b Did the organization have any excess business holdings in the tax year? (Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.) | 10b | |

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

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. See instructions. All other Type III non-functionally integrated supporting organizations must complete Sections A through E.

| Section A - Adjusted Net Income | | (A) Prior Year | (B) Current Year (optional) |
|--|---|----------------|-----------------------------|
| 1 Net short-term capital gain | 1 | | |
| 2 Recoveries of prior-year distributions | 2 | | |
| 3 Other gross income (see instructions) | 3 | | |
| 4 Add lines 1 through 3 | 4 | | |
| 5 Depreciation and depletion | 5 | | |
| 6 Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions) | 6 | | |
| 7 Other expenses (see instructions) | 7 | | |
| 8 Adjusted Net Income (subtract lines 5, 6 and 7 from line 4) | 8 | | |

| Section B - Minimum Asset Amount | | (A) Prior Year | (B) Current Year (optional) |
|--|----|----------------|-----------------------------|
| 1 Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year) | | | |
| a Average monthly value of securities | 1a | | |
| b Average monthly cash balances | 1b | | |
| c Fair market value of other non-exempt-use assets | 1c | | |
| d Total (add lines 1a, 1b, and 1c) | 1d | | |
| e Discount claimed for blockage or other factors (explain in detail in Part VI) | | | |
| 2 Acquisition indebtedness applicable to non-exempt-use assets | 2 | | |
| 3 Subtract line 2 from line 1d | 3 | | |
| 4 Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions) | 4 | | |
| 5 Net value of non-exempt-use assets (subtract line 4 from line 3) | 5 | | |
| 6 Multiply line 5 by .035 | 6 | | |
| 7 Recoveries of prior-year distributions | 7 | | |
| 8 Minimum Asset Amount (add line 7 to line 6) | 8 | | |

| Section C - Distributable Amount | | | Current Year |
|---|---|--|--------------|
| 1 Adjusted net income for prior year (from Section A, line 8, Column A) | 1 | | |
| 2 Enter 85% of line 1 | 2 | | |
| 3 Minimum asset amount for prior year (from Section B, line 8, Column A) | 3 | | |
| 4 Enter greater of line 2 or line 3 | 4 | | |
| 5 Income tax imposed in prior year | 5 | | |
| 6 Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions) | 6 | | |

7 ☐ 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) 2015

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

| Section D - Distributions | | Current Year | |
|---------------------------|--|--------------|--|
| 1 | Amounts paid to supported organizations to accomplish exempt purposes | | |
| 2 | Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity | | |
| 3 | Administrative expenses paid to accomplish exempt purposes of supported organizations | | |
| 4 | Amounts paid to acquire exempt-use assets | | |
| 5 | Qualified set-aside amounts (prior IRS approval required) | | |
| 6 | Other distributions (describe in Part VI) See instructions | | |
| 7 | Total annual distributions. Add lines 1 through 6 | | |
| 8 | Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI) See instructions | | |
| 9 | Distributable amount for 2015 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-2015 | (iii) Distributable Amount for 2015 |
|---|-----------------------------|--|---|
| 1 Distributable amount for 2015 from Section C, line 6 | | | |
| 2 Underdistributions, if any, for years prior to 2015 (reasonable cause required-see instructions) | | | |
| 3 Excess distributions carryover, if any, to 2015 | | | |
| a | | | |
| b | | | |
| c | | | |
| d From 2013 | | | |
| e From 2014 | | | |
| f Total of lines 3a through e | | | |
| g Applied to underdistributions of prior years | | | |
| h Applied to 2015 distributable amount | | | |
| i Carryover from 2010 not applied (see instructions) | | | |
| j Remainder Subtract lines 3g, 3h, and 3i from 3f | | | |
| 4 Distributions for 2015 from Section D, line 7 \$ | | | |
| a Applied to underdistributions of prior years | | | |
| b Applied to 2015 distributable amount | | | |
| c Remainder Subtract lines 4a and 4b from 4 | | | |
| 5 Remaining underdistributions for years prior to 2015, if any Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions) | | | |
| 6 Remaining underdistributions for 2015 Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions) | | | |
| 7 Excess distributions carryover to 2016 Add lines 3j and 4c | | | |
| 8 Breakdown of line 7 | | | |
| a | | | |
| b | | | |
| c Excess from 2013 | | | |
| d Excess from 2014 | | | |
| e Excess from 2015 | | | |

Schedule A (Form 990 or 990-EZ) 2015

Part VI **Supplemental Information.** Provide the explanations required by Part II, line 10, Part II, line 17a or 17b, and Part III, line 12. Also complete this part for any additional information. (See instructions)

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Name of the organization

WELLSTAR SPALDING REGIONAL HOSPITAL, INC.

Supplemental Financial Statements

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

▶ Attach to Form 990

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

OMB No 1545-0047

2015

Open to Public
Inspection

Employer identification number

81-0864789

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

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

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

Part II Conservation Easements.

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

| | |
|---|---|
| 1 Purpose(s) of conservation easements held by the organization (check all that apply) | |
| <input type="checkbox"/> Preservation of land for public use (e g , recreation or education) | <input type="checkbox"/> Preservation of a historically important land area |
| <input type="checkbox"/> Protection of natural habitat | <input type="checkbox"/> Preservation of a certified historic structure |
| <input type="checkbox"/> Preservation of open space | |
| 2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year | |
| a Total number of conservation easements | 2a Held at the End of the Tax Year |
| b Total acreage restricted by conservation easements | 2b |
| c Number of conservation easements on a certified historic structure included in (a) | 2c |
| d Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register | 2d |
| 3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶ | |
| 4 Number of states where property subject to conservation easement is located ▶ | |
| 5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ▶ | |
| 7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ▶ \$ | |
| 8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements | |

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

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

| | |
|---|------|
| 1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items | |
| b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items | |
| (i) Revenue included in 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 in 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) 2015

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 d ☐ Loan or exchange programs
- b ☐ Scholarly research e ☐ Other _____
- c ☐ Preservation for future generations
- 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 |
|---|--------|
| c Beginning balance | 1c |
| d Additions during the year | 1d |
| e Distributions during the year | 1e |
| f Ending balance | 1f |
- 2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? ☐ Yes ☐ No
- b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided on Part XIII ☐ Yes ☐ No

Part V Endowment Funds.

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

- | | (a) Current year | (b) Prior year | (c) Two years back | (d) Three years back | (e) Four years back |
|--|------------------|----------------|--------------------|----------------------|---------------------|
| 1a Beginning of year balance | | | | | |
| b Contributions | | | | | |
| c Net investment earnings, gains, and losses | | | | | |
| d Grants or scholarships | | | | | |
| e Other expenditures for facilities and programs | | | | | |
| f Administrative expenses | | | | | |
| g End of year balance | | | | | |
- 2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as
- a Board designated or quasi-endowment ▶ _____ %
- b Permanent endowment ▶ _____ %
- c Temporarily restricted endowment ▶ _____ %
- The percentages on lines 2a, 2b, and 2c should equal 100%
- 3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by
- | | Yes | No |
|--|--------|----|
| (i) unrelated organizations | 3a(i) | |
| (ii) related organizations | 3a(ii) | |
| b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R? | 3b | |
- 4 Describe in Part XIII the intended uses of the organization's endowment funds

Part VI Land, Buildings, and Equipment.

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

- | Description of property | (a) Cost or other basis (investment) | (b) Cost or other basis (other) | (c) Accumulated depreciation | (d) Book value |
|--|--------------------------------------|---------------------------------|------------------------------|----------------|
| 1a Land | | 2,835,000. | | 2,835,000. |
| b Buildings | | 57,133,000. | | 57,133,000. |
| c Leasehold improvements | | 1,515,000. | | 1,515,000. |
| d Equipment | | 13,562,861. | 1,574,990. | 11,987,871. |
| e Other | | 257,919. | 12,804. | 245,115. |
| Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10c) | | | | 73,715,986. |

Schedule D (Form 990) 2015

Part VII Investments - Other Securities.

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

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

Part VIII Investments - Program Related.

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

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

Part IX Other Assets.

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

| (a) Description | (b) Book value |
|--|----------------|
| (1) OTHER ASSETS | 144,418,966. |
| (2) _____ | |
| (3) _____ | |
| (4) _____ | |
| (5) _____ | |
| (6) _____ | |
| (7) _____ | |
| (8) _____ | |
| (9) _____ | |
| Total. (Column (b) must equal Form 990, Part X, col (B) line 15.) ► | 144,418,966. |

Part X Other Liabilities.

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

| (a) Description of liability | (b) Book value |
|--|----------------|
| (1) Federal income taxes | |
| (2) LONG TERM DEBT & CLO | 223,492,278. |
| (3) _____ | |
| (4) _____ | |
| (5) _____ | |
| (6) _____ | |
| (7) _____ | |
| (8) _____ | |
| (9) _____ | |
| Total. (Column (b) must equal Form 990, Part X, col (B) line 25.) ► | 223,492,278. |

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

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

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

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

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

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

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

Part XIII Supplemental Information.

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

SEE PAGE 5

Part XIII Supplemental Information (continued)

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, A TAXABLE NOT-FOR-PROFIT.

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

2015

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

▶ Attach to Form 990.

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

Name of the organization

WELLSTAR SPALDING REGIONAL HOSPITAL, INC.

Employer identification number

81-0864789

Part I Financial Assistance and Certain Other Community Benefits at Cost

| | Yes | No |
|---|-----|----|
| 1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a | X | |
| 1b If "Yes," was it a written policy? | X | |
| 2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year | | |
| <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 | | |
| 3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year | | |
| a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care | X | |
| <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input type="checkbox"/> Other <u>125.0000</u> % | | |
| 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 | X | |
| <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 _____ % | | |
| c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care | | |
| 4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"? | X | |
| 5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? | X | |
| b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? | X | |
| c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care? | | X |
| 6a Did the organization prepare a community benefit report during the tax year? | X | |
| b If "Yes," did the organization make it available to the public? | X | |
| Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H. | | |

| 7 Financial Assistance and Certain Other Community Benefits at Cost | | | | | | |
|--|---|-------------------------------|-------------------------------------|-------------------------------|-----------------------------------|------------------------------|
| Financial Assistance and Means-Tested Government Programs | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community benefit expense | (d) Direct offsetting revenue | (e) Net community benefit expense | (f) Percent of total expense |
| a Financial Assistance at cost (from Worksheet 1) | | | 4,300,646. | | 4,300,646. | 15.85 |
| b Medicaid (from Worksheet 3, column a) | | | 2,376,973. | 2,400,654. | | |
| c Costs of other means-tested government programs (from Worksheet 3, column b) | | | | | | |
| d Total Financial Assistance and Means-Tested Government Programs | | | 6,677,619. | 2,400,654. | 4,300,646. | 15.85 |
| Other Benefits | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4) | | | 29,150. | | 29,150. | .11 |
| f Health professions education (from Worksheet 5) | | | | | | |
| g Subsidized health services (from Worksheet 6) | | | | | | |
| h Research (from Worksheet 7) | | | | | | |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | | | | | | |
| j Total Other Benefits | | | 29,150. | | 29,150. | .11 |
| k Total. Add lines 7d and 7j. | | | 6,706,769. | 2,400,654. | 4,329,796. | 15.96 |

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

Schedule H (Form 990) 2015

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. | 418,408. | |
| 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) | 7,540,896. |
| 6 Enter Medicare allowable costs of care relating to payments on line 5 | 6,721,233. |
| 7 Subtract line 6 from line 5. This is the surplus (or shortfall) | 819,663. |
| 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 % |
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Section A Hospital Facilities

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 WELLSTAR SPALDING REGIONAL HOSPITAL | | | | | | | |
| 601 SOUTH 8TH STREET | | | | | | | |
| GRIFFIN | | | | GA 30224-4213 | | | |
| WWW.WELLSTAR.ORG | | | | | | | |
| 126-712 | | | | | | | |
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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 WELLSTAR SPALDING REGIONAL HOSPITAL

Line number of hospital facility, or line numbers of hospital

facilities in a facility reporting group (from Part V, Section A): 1**Community Health Needs Assessment**

| | 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 type="checkbox"/> A definition of the community served by the hospital facility | | |
| b <input type="checkbox"/> Demographics of the community | | |
| c <input 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 type="checkbox"/> How data was obtained | | |
| e <input type="checkbox"/> The significant health needs of the community | | |
| f <input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | |
| g <input type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs | | |
| h <input type="checkbox"/> The process for consulting with persons representing the community's interests | | |
| i <input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs | | |
| j <input type="checkbox"/> Other (describe in Section C) | | |
| 4 Indicate the tax year the hospital facility last conducted a CHNA 20 ____ | | |
| 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 | | |
| 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 | | |
| b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C | | |
| 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) | | |
| a <input type="checkbox"/> Hospital facility's website (list url) _____ | | |
| b <input type="checkbox"/> Other website (list url) _____ | | |
| c <input 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 | | |
| 9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 ____ | | |
| 10 Is the hospital facility's most recently adopted implementation strategy posted on a website? | | |
| a If "Yes," (list url) _____ | | |
| 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)? | | |
| 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 WELLSTAR SPALDING REGIONAL HOSPITAL

| | Yes | No |
|--|-------------|----|
| Did the hospital facility have in place during the tax year a written financial assistance policy that | | |
| 13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP | 13 X | |
| a <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 <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C) | | |
| c <input checked="" type="checkbox"/> Asset level | | |
| d <input checked="" type="checkbox"/> Medical indigency | | |
| e <input checked="" type="checkbox"/> Insurance status | | |
| f <input checked="" type="checkbox"/> Underinsurance status | | |
| g <input type="checkbox"/> Residency | | |
| h <input checked="" type="checkbox"/> Other (describe in Section C) | | |
| 14 Explained the basis for calculating amounts charged to patients? | 14 X | |
| 15 Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply) | 15 X | |
| a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application | | |
| b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | |
| c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | |
| d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | |
| e <input checked="" type="checkbox"/> Other (describe in Section C) | | |
| 16 Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply) | 16 X | |
| a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>SEE PART V, SECTION C</u> | | |
| b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>SEE PART V, SECTION C</u> | | |
| c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>SEE PART V, SECTION C</u> | | |
| d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| g <input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility | | |
| h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP | | |
| i <input checked="" type="checkbox"/> Other (describe in Section C) | | |
| Billing and Collections | | |
| 17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment? | 17 X | |
| 18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP | | |
| a <input type="checkbox"/> Reporting to credit agency(ies) | | |
| b <input type="checkbox"/> Selling an individual's debt to another party | | |
| c <input type="checkbox"/> Actions that require a legal or judicial process | | |
| d <input type="checkbox"/> Other similar actions (describe in Section C) | | |
| e <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted | | |

Part V Facility Information (continued)Name of hospital facility or letter of facility reporting group WELLSTAR SPALDING REGIONAL HOSPITAL

| | Yes | No |
|---|-----|----|
| 19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged | 19 | X |
| a <input type="checkbox"/> Reporting to credit agency(ies) | | |
| b <input type="checkbox"/> Selling an individual's debt to another party | | |
| c <input type="checkbox"/> Actions that require a legal or judicial process | | |
| d <input type="checkbox"/> Other similar actions (describe in Section C) | | |
| 20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply) | | |
| a <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission | | |
| b <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge | | |
| c <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills | | |
| d <input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy | | |
| e <input checked="" type="checkbox"/> Other (describe in Section C) | | |
| f <input type="checkbox"/> None of these efforts were made | | |

Policy Relating to Emergency Medical Care

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

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

| | | |
|---|----|---|
| 22 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care | | |
| a <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged | | |
| b <input checked="" type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged | | |
| c <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged | | |
| d <input type="checkbox"/> Other (describe in Section C) | | |
| 23 During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C | 23 | X |
| 24 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C | 24 | X |

Schedule H (Form 990) 2015

Part V Facility Information (continued)

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

SCHEDULE H, PART V, SECTION B, LINE 2

HOSPITAL FACILITY RECENTLY PLACED INTO SERVICE AS A TAX-EXEMPT HOSPITAL:

ON APRIL 1, 2016 WELLSTAR HEALTH SYSTEM, INC. ACQUIRED FIVE NEW HOSPITALS AND FINALIZED A PARTNERSHIP WITH WEST GEORGIA HEALTH. THE NEWEST MEMBERS OF OUR FAMILY INCLUDE: WELLSTAR ATLANTA MEDICAL CENTER; WELLSTAR ATLANTA MEDICAL CENTER SOUTH; WELLSTAR NORTH FULTON HOSPITAL; WELLSTAR SPALDING REGIONAL HOSPITAL; WELLSTAR SYLVAN GROVE HOSPITAL; AND WELLSTAR WEST GEORGIA MEDICAL CENTER. THE ADDITION EXTENDS THE COMMUNITIES WE SERVE TO BUTTS, FULTON, JACKSON, SPALDING AND TROUP COUNTIES, MAKING WELLSTAR THE LARGEST HEALTH SYSTEM IN GEORGIA AND ONE OF THE LARGEST NOT-FOR-PROFIT HEALTH SYSTEMS IN THE COUNTRY.

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 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.

Part V Facility Information (continued)

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

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 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

Part V Facility Information (continued)

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

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.

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-](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

ITS WEBSITE:

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

[NCIAL-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

Part V Facility Information (continued)

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

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

THE 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/](https://www.wellstar.org/about-us/policies-procedures/)

DOCUMENTS/FAP-PLAINLANGUAGE-SUMMARY-WGH.PDF.

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

PUBLICATION OF THE FINANCIAL ASSISTANCE POLICY (FAP):

IN ADDITION TO THE OTHER METHODS OF POSTING THE FINANCIAL ASSISTANCE

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? _____

| Name and address | Type of Facility (describe) |
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Schedule H (Form 990) 2015

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

WELLSTAR SPALDING REGIONAL HOSPITAL 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 WELLSTAR SPALDING REGIONAL HOSPITAL) 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 CALCULATED COST TO CHARGE RATIO TO ARRIVE AT THE ESTIMATED BAD DEBT

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

EXPENSE.

SCHEDULE H, PART III, SECTION A, LINE 3

METHODOLOGY & RATIONALE USED TO DETERMINE BAD DEBT ATTRIBUTABLE TO

PATIENT'S ELIGIBLE UNDER ORGANIZATION'S FAP:

THE BAD DEBT ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE PROGRAM IS DETERMINED USING A WEEKLY BAD DEBT CONVERSION REPORT FOR A PERIOD OF TWELVE MONTHS. THE CONVERSION RATE FOR THIS PERIOD IS USED TO DETERMINE THIS BAD DEBT CATEGORY. THE TOTAL REPORTED CONVERSION CHARGES IS MULTIPLIED BY A CALCULATED COST TO CHARGE RATIO TO ARRIVE AT THE COST OF BAD DEBT ATTRIBUTABLE TO PATIENT'S ELIGIBLE UNDER THE HOSPITAL'S FAP.

SCHEDULE H, PART III, SECTION B, LINE 8

MEDICARE SURPLUS:

WELLSTAR SPALDING REGIONAL HOSPITAL IS A PROVIDER OF INPATIENT AND OUTPATIENT SERVICES TO MEDICARE PROGRAM BENEFICIARIES AT DETERMINED RATES. WITHOUT THE PARTICIPATION IN THE MEDICARE PROGRAM THESE PATIENTS

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

MAY NOT HAVE HAD CONVENIENT ACCESS TO THOSE SERVICES. THE MEDICARE SURPLUS 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 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.

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

SCHEDULE H, PART VI, LINE 2

NEEDS ASSESSMENT:

TO ASSESS THE CURRENT HEALTH AND WELL-BEING OF THE COMMUNITY SERVED, WELLSTAR HEALTH SYSTEM, INC. CONDUCTED A JOINT COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) FOR ITS FIVE LEGACY HOSPITAL COMMUNITY. THE CHNA WAS A COLLABORATIVE EFFORT INVOLVING WELLSTAR EXECUTIVE LEADERSHIP, HOSPITAL LEADERSHIP, PUBLIC HEALTH AGENCIES, AND A MULTI-SECTOR COALITION OF COMMUNITY STAKEHOLDERS. COLLABORATORS REPRESENTED A BROAD KNOWLEDGE BASE OF THE HOSPITAL'S PRIMARY SERVICE AREA COMPRISING BARTOW, CHEROKEE, COBB, DOUGLAS, AND PAULDING COUNTIES AND SOME OUTLYING ZIP CODES DETERMINED BY UTILIZATION.

TO ASSESS THE CURRENT COMMUNITY HEALTH STATUS AND CAPTURE A BROAD BASE OF INPUT, WELLSTAR USED THE FOLLOWING QUESTIONS TO GUIDE THE CHNA PROCESS AND RESEARCH:

1. WHAT IS THE CURRENT HEALTH STATUS OF THE COMMUNITY WELLSTAR SERVES?
2. WHAT ARE THE MAJOR RISK FACTORS AND CAUSES OF POOR HEALTH IN OUR COMMUNITY?
3. WHAT ACTIONS BY WELLSTAR AND ITS PARTNERS ARE NEEDED TO ADDRESS 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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- 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

RISK FACTORS AND CAUSES?

4. WHAT ARE THE EXISTING WELLSTAR AND COMMUNITY ASSETS, PROGRAMS AND SERVICES THAT CAN HELP ADDRESS THE NEEDS?

5. WHO ARE THE PARTNERS OR POTENTIAL PARTNERS WITH THE EXPERTISE AND RESOURCES TO HELP EXPEDITE A CONNECTION TO HEALTHCARE, EDUCATION AND RESOURCES?

THE ADDITION OF WELLSTAR SPALDING REGIONAL HOSPITAL AND OTHER NEWLY ACQUIRED DESCRIBED EARLIER EXTENDS THE COMMUNITIES SERVED TO BUTTS, FULTON, JACKSON, SPALDING AND TROUP COUNTIES, MAKING WELLSTAR THE LARGEST HEALTH SYSTEM IN GEORGIA AND ONE OF THE LARGEST NOT-FOR-PROFIT HEALTH SYSTEMS IN THE COUNTRY.

WELLSTAR SPALDING REGIONAL HOSPITAL WILL CONDUCT A COMMUNITY HEALTH NEEDS ASSESSMENT AS REQUIRED BY JUNE 30, 2018.

SCHEDULE H, PART VI, LINE 3

THE HOSPITAL PROVIDES NOTICE OF THE AVAILABILITY OF COMMUNITY FINANCIAL ASSISTANCE THROUGH THE FINANCIAL ASSISTANCE POLICY (FAP) VIA:

- SIGNAGE

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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- PATIENT BROCHURE

- BILLING STATEMENT

- COLLECTION ACTION LETTER

- ONLINE AT:

[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)

WELLSTAR SPALDING REGIONAL HOSPITAL PROVIDES ITS PATIENTS WITH HOSPITAL PERSONNEL OR CONTRACTED PERSONNEL WHO ARE TRAINED IN ALL ASPECTS OF GOVERNMENTAL PROGRAMS, PAYMENTS PLANS, CHARITY DISCOUNTS, AND OTHER 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

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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PAY IMMEDIATELY OR OVER TIME. ALL PATIENTS ARE AFFORDED THESE OPPORTUNITIES.

SCHEDULE H, PART VI, LINE 4

COMMUNITY INFORMATION:

WELLSTAR SPALDING REGIONAL HOSPITAL IS A 160-BED FACILITY SERVING THE RESIDENTS OF SPALDING, PIKE, LAMAR, BUTTS, UPSON AND HENRY COUNTIES, PROVIDING COMPREHENSIVE CARE. WELLSTAR SPALDING REGIONAL HOSPITAL WAS RECOGNIZED NATIONALLY AS A "TOP PERFORMER" IN 2014.

SCHEDULE H, PART VI, LINE 5

PROMOTION OF COMMUNITY HEALTH:

WELLSTAR SPALDING REGIONAL HOSPITAL (AN AFFILIATE OF WELLSTAR HEALTH SYSTEM, INC.) OPERATE 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

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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HOSPITAL ARE AVAILABLE TO ALL QUALIFIED PHYSICIANS IN THE AREA CONSISTENT WITH THE SIZE AND NATURE OF THE FACILITY; AND THE HOSPITAL 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.

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 INPATIENT HOSPITALS: WELLSTAR ATLANTA MEDICAL CENTER, WELLSTAR ATLANTA MEDICAL CENTER SOUTH, WELLSTAR KENNESTONE REGIONAL MEDICAL CENTER

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

(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 WELLSTAR.ORG.

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

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

Department of the Treasury
Internal Revenue Service
Name of the organization

WELLSTAR SPALDING REGIONAL HOSPITAL, INC.

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 non-cash assistance | (h) Purpose of grant or assistance |
|---|---------|-------------------------------|--------------------------|-----------------------------------|---|--|------------------------------------|
| (1) | | | | | | | |
| (2) | | | | | | | |
| (3) | | | | | | | |
| (4) | | | | | | | |
| (5) | | | | | | | |
| (6) | | | | | | | |
| (7) | | | | | | | |
| (8) | | | | | | | |
| (9) | | | | | | | |
| (10) | | | | | | | |
| (11) | | | | | | | |
| (12) | | | | | | | |
| 2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table | | | | | | | |
| 3 Enter total number of other organizations listed in the line 1 table | | | | | | | |

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

Schedule I (Form 990) (2015)

Part III Grants and Other Assistance to Individuals in the United States. 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 | SCHOLARSHIPS | | 5,472 | | FMV | N/A |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |

Part IV Supplemental Information. Complete this part to 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 GRANT/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

Name of the organization

WELLSTAR SPALDING REGIONAL HOSPITAL, INC.

Compensation Information

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

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23.

▶ Attach to Form 990.

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

OMB No 1545-0047

2015

**Open to Public
Inspection**

Employer identification number

81-0864789

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 type="checkbox"/> Housing allowance or residence for personal use |
| <input type="checkbox"/> Travel for companions | <input type="checkbox"/> Payments for business use of personal residence |
| <input type="checkbox"/> Tax indemnification and gross-up payments | <input type="checkbox"/> Health or social club dues or initiation fees |
| <input type="checkbox"/> Discretionary spending account | <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef) |

b If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain.

2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked in line 1a?

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 type="checkbox"/> Compensation committee | <input type="checkbox"/> Written employment contract |
| <input type="checkbox"/> Independent compensation consultant | <input type="checkbox"/> Compensation survey or study |
| <input type="checkbox"/> Form 990 of other organizations | <input 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" to 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 non-fixed 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" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?

| | Yes | No |
|----|-----|----|
| 1a | | |
| 1b | | |
| 2 | | |
| 3 | | |
| 4a | | X |
| 4b | X | |
| 4c | | X |
| 5a | | X |
| 5b | | X |
| 6a | | X |
| 6b | | X |
| 7 | X | |
| 8 | | X |
| 9 | | |

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

Schedule J (Form 990) 2015

Schedule J (Form 990) 2015

Page 2

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

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

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

| (A) Name and Title | (B) Breakdown of W-2 and/or 1099-MISC compensation | | | (C) Retirement and other deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation in column (B) reported as deferred on prior Form 990 |
|---|--|-------------------------------------|-------------------------------------|--|-------------------------|---------------------------------|---|
| | (i) Base compensation | (ii) Bonus & incentive compensation | (iii) Other reportable compensation | | | | |
| 1 ANTHONY J. BUDZINSKI EVP & CFO | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| 2 ANTHONY M. TRUPIANO SVP SUPPLY CHAIN | 606,611. | 162,569. | 24,552. | 47,300. | 28,807. | 869,839. | 0. |
| 3 AVRIL P. BECKFORD, MD TRUSTEE & CHIEF PEDIATRIC OFF | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| 4 BARBARA B. COREY SVP MANAGED CARE | 288,371. | 73,361. | 15,370. | 47,300. | 2,043. | 426,445. | 0. |
| 5 BETH KOST SVP COMPLIANCE CHF PRIVACY OFFCR | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| 6 BETHANY ROBERTSON VP & CHIEF LEARNING OFFICER | 492,548. | 58,415. | 2,453. | 28,660. | 1,958. | 584,034. | 0. |
| 7 BRADFORD B. NEWTON VP INFO TECHNOLOGY ADMIN | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| 8 BRUCE A. DEAN VP REAL ESTATE DEPUTY GEN CNSL | 321,048. | 81,823. | 13,159. | 21,392. | 26,273. | 463,695. | 0. |
| 9 CANDICE L. SAUNDERS PRESIDENT & CEO | 271,419. | 49,750. | 10,102. | 22,418. | 11,937. | 365,626. | 0. |
| 10 DANIEL J. STYF SVP PW HEALTH PLAN | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| 11 DAVID W. ANDERSON EVP/HR/OL/CCO | 203,392. | 87,926. | 9,120. | 17,301. | 29,372. | 347,111. | 0. |
| 12 ELIZABETH H. LOUDERMILK VP ENT INTELLIGENCE & INTGRN | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| 13 ELLEN LANGFORD SVP & COO WELLSTAR MED GROUP | 202,322. | 40,120. | 9,156. | 22,555. | 27,920. | 302,073. | 0. |
| 14 FRED A. LYON VP SYSTEM EMERGENCY & TRAUMA | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| 15 JAMES M. SWARTZ VP ACCOUNTING | 242,590. | 48,105. | 14,272. | 47,300. | 25,123. | 377,390. | 0. |
| 16 JEFFREY L. THARP, MD, M TRUSTEE & CHIEF MEDICINE SVCS | 929,590. | 231,348. | 19,734. | 46,319. | 30,929. | 1,257,920. | 889,660. |
| | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| | 290,368. | 96,256. | 15,163. | 21,353. | 9,385. | 432,525. | 0. |
| | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| | 460,491. | 152,440. | 23,312. | 47,185. | 26,381. | 709,809. | 92,098. |
| | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| | 239,990. | 43,990. | 9,880. | 23,251. | 19,315. | 336,426. | 0. |
| | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| | 253,469. | 64,482. | 12,280. | 41,525. | 29,684. | 401,440. | 0. |
| | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| | 117,693. | 25,000. | 6,027. | 8,903. | 12,175. | 169,798. | 0. |
| | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| | 215,613. | 41,138. | 8,995. | 18,573. | 26,251. | 310,570. | 0. |
| | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| | 512,199. | 78,598. | 2,505. | 47,185. | 32,273. | 672,760. | 0. |

Schedule J (Form 990) 2015

Schedule J (Form 990) 2015

Page 2

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

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

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

| (A) Name and Title | (B) Breakdown of W-2 and/or 1099-MISC compensation | | | (C) Retirement and other deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation in column (B) reported as deferred on prior Form 990 |
|--|--|-------------------------------------|-------------------------------------|--|-------------------------|---------------------------------|---|
| | (i) Base compensation | (ii) Bonus & incentive compensation | (iii) Other reportable compensation | | | | |
| JILL M. CASE-WIRTH 1 SVP & CHIEF NURSE, EXECUTIVE | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| JIMMY E. FRANCIS 2 VP INFO TECHNOLOGY OPERATIONS | 336,440. | 73,003. | 15,318. | 46,319. | 9,901. | 480,981. | 0. |
| JOEL W. HELMKE 3 VP ONCOLOGY | 215,259. | 41,071. | 9,822. | 46,420. | 3,129. | 315,701. | 0. |
| JONATHAN B. MORRIS, MD 4 SVP CHIEF INFO OFFICER | 260,000. | 49,580. | 9,420. | 41,300. | 28,875. | 389,175. | 0. |
| JOSEPH L. BRYWCZYNSKI 5 VP HEALTH PARKS DEVELOPMENT | 397,155. | 101,035. | 12,834. | 25,576. | 28,104. | 564,704. | 0. |
| KEM M. MULLINS 6 VP COO AMBULATORY & BUS DEV | 283,379. | 74,924. | 17,558. | 47,300. | 25,124. | 448,285. | 42,507. |
| KIMBERLY W. MENEFFEE 7 SVP STRATEGIC COMMUNITY DEV | 496,864. | 87,504. | 12,287. | 23,300. | 29,432. | 649,387. | 0. |
| KRISTYN M. GREIFER 8 VP POPULATION MANAGEMENT | 293,842. | 77,691. | 14,038. | 29,300. | 21,472. | 436,343. | 0. |
| LEO E. REICHERT 9 EVP & GENERAL COUNSEL | 333,466. | 54,496. | 9,614. | 9,013. | 9,754. | 416,343. | 0. |
| MARY L. TAVERNARO 10 VP HUMAN RESOURCES OPERATIONS | 531,190. | 168,916. | 17,211. | 29,300. | 33,911. | 780,528. | 27,209. |
| MICHAEL G. PAUL 11 VP FACILITIES ENG SUPPORT SVCS | 227,968. | 45,205. | 10,203. | 29,060. | 22,070. | 334,506. | 34,242. |
| MICHELLE M. ROBINSON 12 VP MKTG/PR/INTERNAL COMM | 186,846. | 34,053. | 12,321. | 0. | 24,754. | 257,974. | 0. |
| NICOLE V. ASHE 13 VP FINANCE & CFO WMG | 204,235. | 40,499. | 9,235. | 15,206. | 27,031. | 296,206. | 0. |
| PETER R. JUNGBLUT, MD, 14 SVP & MEDICAL DIR WMG | 234,187. | 41,156. | 9,243. | 23,487. | 25,688. | 333,761. | 0. |
| RICHARD S. SIEGEL 15 VP CARDIOLOGY & CVM ADMIN | 322,899. | 86,624. | 12,566. | 41,300. | 30,061. | 493,450. | 0. |
| ROBERT J. DECOUX 16 VP CORPORATE MED STAFF SVCS | 289,286. | 53,009. | 10,978. | 47,300. | 28,796. | 429,369. | 0. |
| | 167,823. | 23,013. | 4,854. | 20,316. | 25,102. | 241,108. | 0. |

Schedule J (Form 990) 2015

Schedule J (Form 990) 2015

Page 2

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

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

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

| (A) Name and Title | (B) Breakdown of W-2 and/or 1099-MISC compensation | | | (C) Retirement and other deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation in column (B) reported as deferred on prior Form 990 |
|----------------------------------|--|-------------------------------------|-------------------------------------|--|-------------------------|---------------------------------|---|
| | (i) Base compensation | (ii) Bonus & incentive compensation | (iii) Other reportable compensation | | | | |
| ROBERT MANDLER | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| 1 VP DIAGNOSTIC OUTREACH | 214,261. | 42,487. | 17,274. | 46,766. | 16,809. | 337,597. | 21,426. |
| SANDRA LUCIUS | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| 2 VP INFO TECHNOLOGY APPS | 209,269. | 41,497. | 11,871. | 46,691. | 2,469. | 311,797. | 0. |
| SEAN P. TURNER | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| 3 VP REVENUE CYCLE MANAGEMENT | 248,019. | 59,082. | 10,041. | 22,462. | 28,739. | 368,343. | 0. |
| SNEHAL H. DOSHI | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| 4 VP SYSTEM PHARMACIST | 102,312. | 68,000. | 4,772. | 14,909. | 11,422. | 201,415. | 0. |
| VALERY A. AKOPOV, MD | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| 5 VP & CHIEF OF HOSPITALIST SVCS | 364,063. | 78,508. | 17,861. | 28,177. | 26,276. | 514,885. | 0. |
| WANDA Y. ROBINSON | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| 6 VP COMPLIANCE P&HP | 207,043. | 7,312. | 11,870. | 6,692. | 16,623. | 249,540. | 0. |
| 7 | | | | | | | |
| 8 | | | | | | | |
| 9 | | | | | | | |
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| 16 | | | | | | | |

Schedule J (Form 990) 2015

Part III Supplemental Information

Complete this part to 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 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):

CANDICE L. SAUNDERS \$889,660

DAVID W. ANDERSON 92,098

JOSEPH L. BRYWCZYNSKI 42,507

MARY L. TAVERNARO 34,242

LEO E. REICHERT 27,209

ROBERT MANDLER 21,426

SCHEDULE J, PART I, LINE 7

NON-FIXED PAYMENTS TO OFFICERS:

AS PART OF THE WELLSTAR EXECUTIVE COMPENSATION PHILOSOPHY A PERFORMANCE

Part III Supplemental Information

Complete this part to 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.

PAY PLAN WAS INSTITUTED SEVERAL YEARS AGO WHEREBY THE WELLSTAR BOARD OF

TRUSTEES APPROVES AN ANNUAL INCENTIVE PLAN WHICH CONSISTS OF SEVERAL

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

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.

OMB No 1545-0047

2015

**Open to Public
Inspection**

Employer identification number

81-0864789

WELLSTAR SPALDING REGIONAL HOSPITAL, INC.

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 AND LONG TERM NURSING CARE. THE SYSTEM THROUGH ITS AFFILIATED BUSINESS ORGANIZATIONS OPERATES 11 HOSPITALS (KENNESTONE, COBB, PAULDING MEDICAL, 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 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-

| | |
|---|--------------------------------|
| Name of the organization | Employer identification number |
| WELLSTAR SPALDING REGIONAL HOSPITAL, INC. | 81-0864789 |

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

SUBORDINATE AFFILIATES:

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

SERVICES -

Name of the organization

Employer identification number

WELLSTAR SPALDING REGIONAL HOSPITAL, INC.

81-0864789

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

PAULDING MEDICAL CENTER IS HOME TO A FULL CARE NURSING HOME, PAULDING NURSING CENTER AND WEST GEORGIA MEDICAL CENTER ALSO HOME TO TWO FULL CARE NURSING HOMES.

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 100 PHYSICIAN PRACTICES AND

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|---|--------------------------------|
| Name of the organization | Employer identification number |
| WELLSTAR SPALDING REGIONAL HOSPITAL, INC. | 81-0864789 |

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 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 CHARITY CARE POLICY. IN FISCAL YEAR 2016 AND 2015, WELLSTAR AFFILIATE HOSPITALS MADE \$147.9 MILLION AND \$100.9 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

Name of the organization

Employer identification number

WELLSTAR SPALDING REGIONAL HOSPITAL, INC.

81-0864789

COMMUNITY. HEALTH FAIRS ARE HELD THROUGHOUT THE YEAR AT CONVENIENT LOCATIONS, PROVIDING VARIOUS HEALTH SCREENINGS, SUCH AS MAMMOGRAMS, 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. HEALTH SCREENINGS, MEDICAL SUPPLIES, AND IMMUNIZATIONS ARE PROVIDED TO CHILDREN THROUGH LOCAL HEALTH DEPARTMENTS AND HEALTH FAIRS WITH SYSTEM SPONSORSHIP IN MANY CASES. THE COSTS OF THESE SERVICES ARE INCLUDED IN OPERATING EXPENSES. THE SYSTEM PROMOTES HEALTH EDUCATION AND ACTIVITIES FOR STUDENTS, PARENTS, AND TEACHERS THROUGH ITS PARTNER-IN-EDUCATION PROGRAMS. 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

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|---|--------------------------------|
| Name of the organization | Employer identification number |
| WELLSTAR SPALDING REGIONAL HOSPITAL, INC. | 81-0864789 |

US CORPORATION INCOME TAX RETURN."

FINANCIAL DATA AND STATISTICS (SERVICES PROVIDED SYSTEM-WIDE):

LICENSED BEDS - 2,775

ADULT DISCHARGES - 80,835

NEWBORN DISCHARGES - 10,896

EMERGENCY ROOM VISITS - 453,429

SURGERIES - 52,301 CATH LAB/PACEMAKERS/EP - 11,238

NON-ED O/P RADIOLOGY PROCEDURES - 373,364

MED/SURG. SHORT STAY CASES - 355

GI LAB PROCEDURES - 6,790

RADIOLOGY ONCOLOGY PROCEDURES - 24,431

COMMUNITY BENEFITS -

WELLSTAR HEALTH SYSTEM PARTICIPATES AND COLLABORATES WITH PATIENTS AND RESIDENTS IN MEETING HEALTH NEEDS AND IMPROVING THE OVERALL QUALITY OF LIFE IN THE COMMUNITY. THIS IS ESPECIALLY IMPORTANT IN RESPONDING TO THE NEEDS OF THE UNDERSERVED REGARDLESS OF THE SYSTEM'S ABILITY TO GENERATE A POSITIVE MARGIN. SOME SERVICES WOULD POSSIBLY BE DISCONTINUED IF BASED ON A PURELY FINANCIAL BASIS. THE FOLLOWING ARE SOME EXAMPLES OF THE SYSTEM'S SERVICES THAT PROVIDE COMMUNITY BENEFITS (AND A MONETARY VALUE OF THOSE BENEFITS IF KNOWN).

CLINICS:

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

COMMUNITY HEALTH/EDUCATION:

Name of the organization

Employer identification number

WELLSTAR SPALDING REGIONAL HOSPITAL, INC.

81-0864789

WELLSTAR'S MARKETING AND PUBLIC RELATIONS DEPARTMENT PROVIDES FREE BROCHURES ON A VARIETY OF HEALTH-RELATED ISSUES. ON A QUARTERLY BASIS WELLSTAR SENDS OUT A WELLNESS MAGAZINE ENTITLED "HEALTH AND YOU" TO SIGNIFICANT NUMBER OF HOMES IN THE COMMUNITY/SERVICE AREA. THE MAGAZINE PROVIDES INFORMATION ON HEALTH ISSUES AND A SCHEDULE OF HEALTH RELATED CLASSES/SEMINARS AVAILABLE THROUGHOUT THE SYSTEM. WHILE THE MAGAZINE IS AN EXCELLENT REFERRAL SOURCE FOR WELLSTAR'S VARIED SERVICES, IT PROVIDES FREE MEDICAL INFORMATION TO THE HOUSEHOLDS RECEIVING THE PUBLICATION. WELLSTAR PROVIDES SUPPORT GROUPS AND EDUCATIONAL OPPORTUNITIES TO THE COMMUNITY ON A VARIETY OF TOPICS (EXAMPLES-- MEN'S AND WOMEN'S HEALTH ISSUES, PALLIATIVE CARE, MENTAL HEALTH, BIRTHING CLASSES, ETC.). SOME OF THESE OPPORTUNITIES ARE PROVIDED FREE OF CHARGE OR AT A MINIMAL FEE. WELLSTAR ALSO PROVIDES FREE OR LOW COST SCREENINGS ON HEALTH ISSUES SUCH AS BLOOD PRESSURE, CHOLESTEROL SCREENINGS, FLU SHOTS, DIABETES, AND MANY OTHERS. THESE SCREENINGS MAY TARGET SPECIFIC ETHNIC CLASSES, SCHOOL AGE KIDS, WOMEN'S GROUPS, AND OTHER GROUPS IN AN EFFORT TO MEET A VARIETY OF NEEDS FOR THE COMMUNITY. NOTE: THESE PROGRAMS WILL BE FANNED OUT TO THE NEWLY ACQUIRED HOSPITALS AND PHYSICIAN PRACTICES. APPROXIMATELY OVER 280,000 PEOPLE TOOK PART IN AT LEAST ONE OF THE HEALTH SCREENINGS OFFERED. SOME OF THE MORE SPECIFIC PROGRAM/DEPARTMENTS ARE DOCUMENTED AS FOLLOWS:

SCHOOL HEALTH PROGRAM:

THIS PROGRAM TEACHES SCHOOL CHILDREN ABOUT HEALTH AND SAFETY TOPICS TO INCLUDE NUTRITION, DENTAL HEALTH, WATER SAFETY, SEAT BELT SAFETY, INTERNET SAFETY, DIABETES, AND MORE. THE PROGRAMS ARE TAUGHT IN

Name of the organization

WELLSTAR SPALDING REGIONAL HOSPITAL, INC.

Employer identification number

81-0864789

ELEMENTARY SCHOOLS (GRADES K-5) IN COBB, CHEROKEE, PAULDING AND DOUGLAS COUNTIES AS WELL AS AFTER SCHOOL AND TO HOME SCHOOLED GROUPS.

SAFE KIDS:

COBB/DOUGLAS/CHEROKEE COUNTY SAFE KIDS-COBB COUNTY IS COMMITTED TO REDUCING AND PREVENTING ACCIDENTAL INJURIES TO CHILDREN IN COBB COUNTY. SAFE KIDS COBB WORKS TOWARD THIS GOAL THROUGH YOUTH AND ADULT EDUCATION AND THE DISTRIBUTION OF SAFETY EQUIPMENT TO FAMILIES IN NEED. WITH THE HELP OF SPONSORSHIP BY WELLSTAR AND COBB PUBLIC HEALTH, SAFE KIDS COBB HOSTS SAFETY EDUCATION EVENTS AND DISTRIBUTES SAFETY EDUCATION MATERIALS AND EQUIPMENT INCLUDING: CAR AND BOOSTER SEATS, BICYCLE/WHEEL SAFETY, POISON PREVENTION, HOME SAFETY, AND WATER SAFETY. 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. WITH THIS PROGRAM ABOUT 500 CAR SEATS WERE PRESENTED TO FAMILIES IN NEED, AND 1,500 INFANT CAR SEATS CHECKED AT 50 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 PHONE CALLS, BREASTFEEDING CLASSES, AND 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 FY2016 THE UNREIMBURSED COSTS ASSOCIATED WITH THE PROGRAM TOTALED APPROXIMATELY \$ 285,000 AND MORE THAN 2,000 PARENTS PARTICIPATED IN PRENATAL AND CHILDBIRTH PROGRAMS.

THE GOOD LIFE CLUB:

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|---|--------------------------------|
| Name of the organization | Employer identification number |
| WELLSTAR SPALDING REGIONAL HOSPITAL, INC. | 81-0864789 |

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

- A QUARTERLY NEWSLETTER,
- FREE SCREENINGS,
- FITNESS PROGRAMS,
- DISCOUNTED PARKING AT HOSPITALS, AND
- A DISCOUNTED PRESCRIPTION CARD.

GROUP ACTIVITIES AND TRIPS (WITH A GROUP DISCOUNT) ARE OFFERED AT COST TO MEMBERS. THE GOOD LIFE CLUB CURRENTLY HAS MORE THAN 6,000 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 BY KSU. WELLSTAR IS ALSO AFFILIATED WITH THE NORTH METRO TECHNICAL COLLEGE'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.

SPONSORSHIPS -

WELLSTAR PARTICIPATES AS A SPONSOR IN MANY EVENTS WITHIN THE COMMUNITY

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| Name of the organization WELLSTAR SPALDING REGIONAL HOSPITAL, INC. | Employer identification number 81-0864789 |
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RELATED TO THE HEALTH AND WELL-BEING OF ITS RESIDENTS. THE AMERICAN HEART ASSOCIATION, AMERICAN CANCER SOCIETY, AMERICAN LUNG ASSOCIATION, THE AMERICAN DIABETES ASSOCIATION, MARCH OF DIMES, AS WELL AS NUMEROUS LOCAL ORGANIZATIONS ARE JUST A FEW OF THE RECIPIENTS OF EVENTS SPONSORED BY WELLSTAR. MANY EMPLOYEES ALSO VOLUNTEER AND PARTICIPATE IN SOME OF THE EVENTS HELD BY THESE ORGANIZATIONS SUCH AS WALKS, FUNDRAISERS AND SCREENINGS. IN FY2016 THE TOTAL CONTRIBUTIONS AND SPONSORSHIPS PAID BY WELLSTAR WAS OVER \$ 497 MILLION.

COMMITMENT TO THE COMMUNITY:

PARTICIPATION IN COALITIONS - \$ 497,800

COMMUNITY HEALTH EDUCATION - \$ 373,000

UNIVERSITY & COLLEGE PARTNERSHIPS - \$ 664,000

HEALTH CARE SUPPORT - \$ 2,700,000

MEDICAID SHORTFALLS (UNCOMPENSATED COSTS) - \$ 48,000,000

UNREIMBURSED COMMUNITY FINANCIAL AID (CHARITY & INDIGENT):

GROSS CHARGES FOR THE YEAR - \$649,000,000

UNREIMBURSED SERVICES (AT COST) - \$ 147,000,000

INVESTMENTS OF EXCESS FUNDS BACK INTO INFRASTRUCTURE AND COMMUNITY:

WELLSTAR SYSTEM-WIDE FOR FY2016 - \$ 89,000,000

AWARDS, RECOGNITION AND ACCOMPLISHMENTS-

WELLSTAR CONTINUES TO PARTICIPATE IN THE CENTER FOR MEDICARE AND MEDICAID SERVICES (CMS) MEDICARE SAVINGS PROGRAM AS AN ACCOUNTABLE CARE ORGANIZATION (ACO). WELLSTAR IS ONE OF ONLY 89 ENTITIES SELECTED AND THE ONLY GEORGIA ORGANIZATION IN THE INITIAL COHORT. AS A MEMBER OF THIS GROUP OF ORGANIZATIONS WELLSTAR IS POSITIONED TO HELP CMS ACHIEVE ITS

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|---|--------------------------------|
| Name of the organization | Employer identification number |
| WELLSTAR SPALDING REGIONAL HOSPITAL, INC. | 81-0864789 |

GOAL OF IMPROVING QUALITY WHILE CONTAINING COSTS. WELLSTAR HEALTH NETWORK WILL INITIALLY HAVE APPROXIMATELY 36,000 MEDICARE BENEFICIARIES AS THE ORGANIZATION IS PROVIDED WITH AN EXCELLENT OPPORTUNITY TO GAIN POPULATION MANAGEMENT EXPERIENCE AND IMPACT THE QUALITY OF PATIENT CARE.

WELLSTAR ALSO RANKED THIRD IN THE HEALTHCARE INDUSTRY AND 44TH OVERALL ON THE 2015 BEST ADOPTION-FRIENDLY WORKPLACES LIST BY THE DAVE THOMAS FOUNDATION FOR ADOPTION. WELLSTAR OFFERS FULL-TIME TEAM MEMBERS 120 HOURS AND ELIGIBLE PART-TIME TEAM MEMBERS 60 HOURS OF PAID LEAVE, PER IN ADDITION WELLSTAR OFFERS TEAM MEMBERS A MAXIMUM OF \$10,000 PER FINALIZED ADOPTION (\$20,000 MAXIMUM 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 ENTERED INTO A NEW PARTNERSHIP WITH THE CENTER FOR FAMILY RESOURCES (CFR), A 55-YEAR-OLD, LOCAL ORGANIZATION THAT IS COMMITTED TO WORKING TO STABILIZE AND EMPOWER FAMILIES TO BECOME SELF-SUFFICIENT AND FINANCIALLY ESTABLISHED DURING CRISIS OR OTHERWISE. CFR ALSO MANAGES EMERGENCY ASSISTANCE FUNDS FOR OTHER ORGANIZATIONS AND WILL BEGIN TO MANAGE ALL PENDING AND NEW APPLICATIONS FOR WELLSTAR FOUNDATION'S TEAM MEMBER EMERGENCY ASSISTANCE FUND.

FOR THE THIRD YEAR IN A ROW WELLSTAR WAS NAMED ONE OF THE FORTUNE 100 BEST COMPANIES TO WORK FOR, WHICH RECOGNIZES COMPANIES ACROSS THE COUNTRY THAT HAVE EXCEPTIONAL WORKPLACE CULTURES. THE PRESTIGIOUS AWARD IS A REFLECTION OF THE HEALTH SYSTEM'S COMMITMENT TO TAKING CARE OF CAREGIVERS WHO TAKE CARE OF OTHERS AND A RECOGNITION FOR ITS EMPLOYER OF CHOICE STRATEGY.

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|---|--------------------------------|
| Name of the organization | Employer identification number |
| WELLSTAR SPALDING REGIONAL HOSPITAL, INC. | 81-0864789 |

WELLSTAR CONTINUES TO GAIN NATIONAL ATTENTION FOR ITS WORKPLACE CULTURE, WHICH ALLOWS TEAM MEMBERS TO FLOURISH AND PROVIDE PATIENTS WITH EXCEPTIONAL HEALTH CARE. THE HEALTH SYSTEM WAS AWARDED THE WORK-LIFE SEAL OF DISTINCTION AT THE WORLD AT WORK FUTURE OF WORK FORUM FOR THE THIRD YEAR; WAS NAMED TO BECKER'S HEALTHCARE 150 GREAT PLACES TO WORK IN HEALTHCARE LIST.

WELLSTAR KENNESTONE AND DOUGLAS HOSPITALS HAVE BEEN RANKED AS TWO OF THE BEST REGIONAL HOSPITALS IN 2015 BY US NEWS & WORLD REPORT. WELLSTAR KENNESTONE IS RANKED IN FOURTH PLACE FOR THE ENTIRE ATLANTA METRO AREA AND WELLSTAR DOUGLAS IS RANKED FIFTH. THE LIST OF FIVE BEST REGIONAL HOSPITALS RANKING WAS SELECTED FROM 54 HOSPITALS IN THE ATLANTA AREA. THE HOSPITALS WERE CONSIDERED ACCORDING TO THEIR PERFORMANCE IN MEDICAL SPECIALTIES, LIKE CANCER, AND IN COMMON PROCEDURES AND CONDITIONS SUCH AS KNEE REPLACEMENT AND HEARTH FAILURE.

WELLSTAR KENNESTONE HOSPITAL OPENED ITS PEDIATRIC UNIT IN ORDER TO OFFER PEDIATRIC CARE CLOSE TO HOME FOR CHILDREN AND PARENTS. THIS IS A 12-BED UNIT WHICH OCCUPIES 4,700 SQUARE FEET, PEDIATRIC FRIENDLY SPACE.

WELLSTAR COBB AND DOUGLAS HOSPITALS RECEIVED THE AMERICAN HEART ASSOCIATION/AMERICAN STROKE ASSOCIATION'S GET WITH THE GUIDELINES STROKE GOLD PLUS QUALITY ACHIEVEMENT AWARD WITH TARGET: HONOR ROLL. TO RECEIVE THE GOLD PLUS QUALITY ACHIEVEMENT AWARD, THE HOSPITALS MUST ACHIEVE INDICATORS FOR TWO OR MORE CONSECUTIVE 12-MONTH PERIODS AND 75 PERCENT OR HIGHER COMPLIANCE WITH FIVE OF EIGHT GET WITH THE GUIDELINES-STROKE QUALITY MEASURES. THIS IS THE SECOND TIME WELLSTAR COBB HAS RECEIVED THIS AWARD.

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| Name of the organization | Employer identification number |
| WELLSTAR SPALDING REGIONAL HOSPITAL, INC. | 81-0864789 |

ON DECEMBER 1, 2015 FOLLOWING APPROVAL BY THE WELLSTAR HEALTH SYSTEM BOARD OF TRUSTEES, WELLSTAR SIGNED A DEFINITIVE AGREEMENT TO PURCHASE DALLAS TEXAS-BASED TENET HEALTHCARE'S FIVE METRO ATLANTA HOSPITALS. THE FACILITIES INVOLVED IN THIS TRANSACTION ARE NORTH FULTON HOSPITAL, SPALDING HOSPITAL, SYLVAN GROVE HOSPITAL, ATLANTA MEDICAL CENTER AND ITS SOUTH CAMPUS, AS WELL AS TENET'S COMPLIMENTARY PHYSICIAN PRACTICES IN ATLANTA. IN ALL THE TENET FACILITIES INCLUDE 1,192 LICENSED HOSPITAL BEDS SUPPORTED BY ABOUT 4,300 TEAM MEMBERS AND A MEDICAL STAFF OF 1,390 PHYSICIANS AND ADVANCED PRACTICE PROFESSIONALS. THE HEALTH SYSTEM WILL EXPAND ITS PROVEN CLINICAL CARE MODELS AND PATIENT SAFETY PROGRAMS, WHICH HAVE RESULTED IN INCREASED QUALITY AND IMPROVED ACCESS TO HEALTHCARE, TO NEW COMMUNITIES. ADDITIONALLY, IN NOVEMBER 2015, THE WEST GEORGIA HEALTH'S BOARD OF TRUSTEES IN LAGRANGE, GA VOTED TO JOIN WELLSTAR. COUPLED WITH THE TENET ACQUISITION, WELLSTAR HAS GROWN TO 11 HOSPITALS. FOR THE EIGHTH CONSECUTIVE YEAR, WELLSTAR WAS NAMED ONE OF THE WORKING MOTHER 100 BEST COMPANIES AND FOR THE SIXTH YEAR WELLSTAR WAS AMONG THE COVETED TOP TEN COMPANIES IN THE NATION. WORKING MOTHER HONORS ORGANIZATIONS FOR THEIR WIDE ARRAY OF PROGRESSIVE WORKPLACE PROGRAMS, INCLUDING CHILD CARE, FLEXIBILITY, ADVANCEMENT AND PAID FAMILY LEAVE. WELLSTAR RECEIVED AWARD OF EXCELLENCE FOR FACILITIES' SAFETY FROM FM GLOBAL, WELLSTAR'S PROPERTY INSURANCE CARRIER FOR IMPLEMENTING VARIOUS RECOMMENDATIONS AIMED AT REDUCING SAFETY RISKS WITHIN ALL ENTITIES. WELLSTAR WAS AMONG VHA GEORGIA'S 2015 LEADERSHIP AWARD WINNERS. WELLSTAR RECEIVED SIX OF THE 13 AWARDS PRESENTED. THE AWARDS ARE A CULMINATION OF A SIX-MONTH PROCESS OF COLLECTING APPLICATIONS FROM MEMBER HOSPITALS AND

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|---|--------------------------------|
| Name of the organization | Employer identification number |
| WELLSTAR SPALDING REGIONAL HOSPITAL, INC. | 81-0864789 |

AN EXTENSIVE PEER REVIEW EVALUATION TO SELECT WINNERS.

WELLSTAR TEAMED UP WITH CASA FOR CHILDREN, INC. AND BRIGHT HORIZON'S FOUNDATION FOR CHILDREN TO CREATE A SAFE AND WARM HOME ENVIRONMENT FOR FOSTER CHILDREN IN CHEROKEE COUNTY TO REBUILT FAMILY BONDS. THE CHILDREN'S HAVEN WAS CREATED TO GIVE FOSTER KIDS THE OPPORTUNITY TO SUCCEED BY BRINGING A VARIETY OF SUPPORT PROGRAMS UNDER ONE ROOF. WELLSTAR PRESIDENT AND CEO WAS RECOGNIZED AS HEALTHCARE CHAMPION BY THE NATIONAL ASSOCIATION FOR FEMALE EXECUTIVES (NAFE). SHE WAS ONE OF ONLY 14 WOMEN RECOGNIZED BY NAFE WITH WOMEN EXCELLENCE AWARDS IN 2015 AND THE ONLY WOMAN IN HEALTHCARE.

WELLSTAR WAS AWARDED THE INAUGURAL PHOENIX HOSPITAL OF THE YEAR AWARD BY THE METRO ATLANTA CHAMBER OF COMMERCE DURING ITS RECENT HEALTH IT LEADERSHIP SUMMIT. WELLSTAR WAS HONORED FOR ITS USE OF ELECTRONIC HEALTH RECORDS AIMED AT PATIENT SAFETY WHEN ADMINISTERING MEDICATIONS.

FORM 990, PART I, LINES 7A & 7B

UNRELATED BUSINESS INCOME

WELLSTAR SPALDING REGIONAL HOSPITAL, INC. GENERATED NO UNRELATED BUSINESS INCOME ("UBI") FOR THE REPORTING PERIOD. AS A RESULT THE FILED 990-T SHOWS NO ACTIVITY. IF SUBSEQUENT REVIEW OF THE BOOKS REVEALS ANY UNREPORTED UBI WE WILL FILE AN AMENDED RETURN FOR TAX PERIOD ENDED JUNE 30, 2016.

FORM 990, PART IV, LINE 12B

AUDITED FINANCIAL STATEMENTS

WELLSTAR SPALDING REGIONAL HOSPITAL IS AUDITED ON AN ANNUAL BASIS BY AN

Name of the organization

Employer identification number

WELLSTAR SPALDING REGIONAL HOSPITAL, INC. -

81-0864789

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, 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., 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 VI, SECTION A, LINE 7B

POWERS OF THE BOARD

AS PER THE ARTICLES OF INCORPORATION, THE SOLE MEMBER OF THE ORGANIZATION 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

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|---|--------------------------------|
| Name of the organization | Employer identification number |
| WELLSTAR SPALDING REGIONAL HOSPITAL, INC. | 81-0864789 |

COMPANY MAKES AVAILABLE TO THE PUBLIC UPON REQUEST.

FROM 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. THE CURRENT YEAR 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 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

Name of the organization

Employer identification number

WELLSTAR SPALDING REGIONAL HOSPITAL, INC.

81-0864789

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. ENGAGES THE HAY GROUP 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. CURRENTLY THE EXECUTIVE COMPENSATION COMMITTEE CONSISTS OF FIVE MEMBERS OF THE BOARD OF TRUSTEES AS WELL AS THE CEO. 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. 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 TRUSTEE 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

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|---|--------------------------------|
| Name of the organization | Employer identification number |
| WELLSTAR SPALDING REGIONAL HOSPITAL, INC. | 81-0864789 |

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. WHEN PERFORMANCE IS AT A PREDETERMINED TARGETED LEVEL, THE COMPENSATION IS INTENDED TO BE AT OR AROUND THE MEDIAN OF COMPENSATION PAID TO SIMILAR POSITIONS AT SIMILAR ORGANIZATIONS (THE "MARKET"). 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 THE HAY GROUP 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 APPROVED AT THE FOLLOWING COMMITTEE MEETING.

FORM 990, PART VI, SECTION C, LINE 19
DOCUMENTS MADE AVAILABLE TO THE PUBLIC
THE ORGANIZATION AND ITS SUBSIDIARIES 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

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|---|--------------------------------|
| Name of the organization | Employer identification number |
| WELLSTAR SPALDING REGIONAL HOSPITAL, INC. | 81-0864789 |

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
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 SPALDING REGIONAL HOSPITAL HAD A CHANGE
IN NET ASSETS OF \$12,778,987 RELATED TO TRANSFERS TO AFFILIATES AS PART
OF THE ALLOCATION OF INCOME STATEMENT AND BALANCE SHEET TRANSACTIONS OVER

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| Name of the organization WELLSTAR SPALDING REGIONAL HOSPITAL, INC. | Employer identification number 81-0864789 |
|---|--|

THE YEAR.

ATTACHMENT 1FORM 990, PART IX - OTHER FEES

| DESCRIPTION | (A) TOTAL FEES | (B) PROGRAM SERVICE EXP. | (C) MANAGEMENT AND GENERAL | (D) FUNDRAISING EXPENSES |
|------------------------------|----------------------|--------------------------------|----------------------------------|--------------------------------|
| PURCHASES SERVICES/CONTRACTS | 2,534,799. | 1,106,949. | 1,427,850. | 0. |
| PROFESSIONAL FEES | 472,415. | 379,278. | 93,137. | 0. |
| TAXES, LICENSES | 301,030. | 78,889. | 222,141. | 0. |
| OTHER FEES | 1,976,701. | 118,956. | 1,857,745. | 0. |
| TOTALS | <u>5,284,945.</u> | <u>1,684,072.</u> | <u>3,600,873.</u> | <u>0.</u> |

**SCHEDULE R
(Form 990)**Department of the Treasury
Internal Revenue Service**Related Organizations and Unrelated Partnerships**

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

▶ Attach to Form 990.

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

OMB No 1545-0047

2015Open to Public
Inspection

Name of the organization

WELLSTAR SPALDING REGIONAL HOSPITAL, INC.

Employer identification number

81-0864789

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

| (1) | (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

| (1) | (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 30062-2222 | FOUNDATION | GA | 501(C)(3) | 11 TYPE 2 | WHS, INC. | X |
| (2) | DOUGLAS HOSPITAL, INC. 58-2026750 793 SAWYER ROAD MARIETTA, GA 30062-2222 | HEALTHCARE | GA | 501(C)(3) | 3 | WHS, INC. | X |
| (3) | KENNESTONE HOSPITAL, INC. 58-2032904 793 SAWYER ROAD MARIETTA, GA 30066-2222 | HEALTHCARE | GA | 501(C)(3) | 3 | WHS, INC. | X |
| (4) | PAULDING MEDICAL CENTER, INC 58-2095884 793 SAWYER ROAD MARIETTA, GA 30062-2222 | HEALTHCARE | GA | 501(C)(3) | 3 | WHS, INC. | X |
| (5) | WELLSTAR FOUNDATION, INC 58-1627413 793 SAWYER ROAD MARIETTA, GA 30062-2222 | FOUNDATION | GA | 501(C)(3) | 11 TYPE 2 | WHS, INC. | X |
| (6) | WELLSTAR HEALTH SYSTEM, INC. 58-1649541 793 SAWYER ROAD MARIETTA, GA 30062-2222 | HEALTHCARE | GA | 501(C)(3) | 11 TYPE 2 | N/A | X |
| (7) | WELLSTAR ATLANTA MEDICAL CENTER, INC 81-0837031 793 SAWYER ROAD MARIETTA, GA 30062-2222 | HEALTHCARE | GA | 501(C)(3) | 3 | WHS, INC. | X |

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Schedule R (Form 990) 2015

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**SCHEDULE R
(Form 990)****Related Organizations and Unrelated Partnerships**

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

▶ Attach to Form 990.

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

OMB No 1545-0047

2015Open to Public
InspectionDepartment of the Treasury
Internal Revenue Service

Name of the organization

WELLSTAR SPALDING REGIONAL HOSPITAL, INC.

Employer identification number

81-0864789

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

| (1) | (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.

| (1) | (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. 793 SAWYER ROAD MARIETTA, GA 30062-2222 | HEALTHCARE | GA | 501 (C) (3) | 3 | WHS, INC. | | X |
| (2) | WELLSTAR SYLVAN GROVE HOSPITAL, INC. 793 SAWYER ROAD MARIETTA, GA 30062-2222 | HEALTHCARE | GA | 501 (C) (3) | 3 | WHS, INC. | | X |
| (3) | WEST GEORGIA HEALTH SERVICES, INC. 793 SAWYER ROAD MARIETTA, GA 30062-2222 | HEALTHCARE | GA | 501 (C) (3) | 11 TYPE 3FI | WHS, INC. | | X |
| (4) | WEST GEORGIA MEDICAL CENTER, INC. 793 SAWYER ROAD MARIETTA, GA 30062-2222 | HEALTHCARE | GA | 501 (C) (3) | 3 | WHS, INC. | | X |
| (5) | VERNON WOODS RETIREMENT COMMUNITY, INC. 793 SAWYER ROAD MARIETTA, GA 30062-2222 | HEALTHCARE | GA | 501 (C) (3) | 9 | WHS, INC. | | X |
| (6) | WEST GEORGIA HEALTH FOUNDATION, INC. 793 SAWYER ROAD MARIETTA, GA 30062-2222 | FOUNDATION | GA | 501 (C) (3) | 7 | WHS, INC. | | X |
| (7) | COBB HOSPITAL, INC. 793 SAWYER ROAD MARIETTA, GA 30062-2222 | HEALTHCARE | GA | 501 (C) (3) | 3 | WHS, INC. | | X |

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Schedule R (Form 990) 2015

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5E1307 1 000

4852LB 1467

V 15-7.18

PAGE 80

SCHEDULE R
(Form 990)**Related Organizations and Unrelated Partnerships**

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

Department of the Treasury
Internal Revenue Service

Name of the organization

WELLSTAR SPALDING REGIONAL HOSPITAL, INC.

► Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990Open to Public
Inspection

Employer identification number

81-0864789

OMB No. 1545-0047

2015**Part I Identification of Disregarded Entities** Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

| (1) | (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 |
|-----|---|-------------------------|--|---------------------|---------------------------|----------------------------------|
| (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.

| (1) | (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? |
|-----|--|-------------------------|--|----------------------------|---|----------------------------------|--|
| (2) | (1) MEDICAL PARK FOUNDATION, INC 793 SAWYER ROAD MARIETTA, GA 30062-2222 | FOUNDATION | GA | 501 (C) (3) | 7 | WHS, INC. | Yes No X |
| (3) | | | | | | | |
| (4) | | | | | | | |
| (5) | | | | | | | |
| (6) | | | | | | | |
| (7) | | | | | | | |

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Schedule R (Form 990) 2015

JSA

5E1307 1 000

4852LB 1467

V 15-7.18

PAGE 81

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 | N/A | N/A | | | | | | | | |
| (3) GRIFFIN IMAGING, LLC 793 SAWYER ROAD | IMAGING | GA | WSRH, INC | EXCLUDED | 702,294 | 692,052 | | X | 0 | | X | 50 5000 |
| (4) TENET EMS/SPALDING 911, LLC 793 SAWYER ROAD | OFF BLDG/EMS CTR | GA | WSRH, INC | EXCLUDED | 0 | 0 | | X | 0 | | X | 64 1000 |
| (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? |
|--|-------------------------|--|-------------------------------------|--|---------------------------------|---------------------------------------|--------------------------------|---|
| (1) COMMUNITY ASSURANCE CO. 3RD FL, BARCLAYS HSE SHEDDEN GEORGE TOWN, CJ 58-1649541 | INSURANCE | CJ | WHS, INC | C CORP | | | | Yes No |
| (2) WEST GEORGIA HEALTH PHYSICIANS, INC 793 SAWYER ROAD MARIETTA, GA 30062-2222 27-5125341 | PHYSICIAN PRAC | GA | WHS, 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

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

| | Yes | No |
|--|--------------------------|-------------------------------------|
| a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| b Gift, grant, or capital contribution to related organization(s) | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| c Gift, grant, or capital contribution from related organization(s) | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| d Loans or loan guarantees to or for related organization(s) | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| e Loans or loan guarantees by related organization(s) | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| f Dividends from related organization(s) | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| g Sale of assets to related organization(s) | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| h Purchase of assets from related organization(s) | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| i Exchange of assets with related organization(s) | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| j Lease of facilities, equipment, or other assets to related organization(s) | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| k Lease of facilities, equipment, or other assets from related organization(s) | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| l Performance of services or membership or fundraising solicitations for related organization(s) | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| m Performance of services or membership or fundraising solicitations by related organization(s) | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| o Sharing of paid employees with related organization(s) | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| p Reimbursement paid to related organization(s) for expenses | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| q Reimbursement paid by related organization(s) for expenses | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| r Other transfer of cash or property to related organization(s) | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| s Other transfer of cash or property from related organization(s) | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

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) | | | | | | | | | | | | | |

Part VII **Supplemental Information**

Complete this part to provide additional information for responses to questions on Schedule R (see instructions)