

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

For Paperwork Reduction Act Notice, see the separate instructions. Cat No 11282Y Form **990** (2016)

Part III Statement of Program Service AccomplishmentsCheck if Schedule O contains a response or note to any line in this Part III ☒**1** Briefly describe the organization's mission

WE DELIVER SUPERIOR HEALTH CARE WITH COMPASSION

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 \$ 64,125,023 including grants of \$ 63,429) (Revenue \$ 66,402,629)
See Additional Data

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 ▶ 64,125,023

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)? <i>If "Yes," complete Schedule A</i>	1 Yes	
2 Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> (see instructions)?	2	No
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I</i>	3	No
4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? <i>If "Yes," complete Schedule C, Part II</i>	4 Yes	
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? <i>If "Yes," complete Schedule C, Part III</i>	5	No
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? <i>If "Yes," complete Schedule D, Part I</i>	6	No
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? <i>If "Yes," complete Schedule D, Part II</i>	7	No
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III</i>	8	No
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? <i>If "Yes," complete Schedule D, Part IV</i>	9	No
10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? <i>If "Yes," complete Schedule D, Part V</i>	10	No
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? <i>If "Yes," complete Schedule D, Part VI</i>	11a Yes	
b Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VII</i>	11b	No
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? <i>If "Yes," complete Schedule D, Part VIII</i>	11c	No
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? <i>If "Yes," complete Schedule D, Part IX</i>	11d	No
e Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i>	11e Yes	
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)? <i>If "Yes," complete Schedule D, Part X</i>	11f	No
12a Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI and XII</i>	12a	No
b Was the organization included in consolidated, independent audited financial statements for the tax year? <i>If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional</i>	12b	No
13 Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i>	13	No
14a Did the organization maintain an office, employees, or agents outside of the United States?	14a	No
b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? <i>If "Yes," complete Schedule F, Parts I and IV</i>	14b	No
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? <i>If "Yes," complete Schedule F, Parts II and IV</i>	15	No
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? <i>If "Yes," complete Schedule F, Parts III and IV</i>	16	No
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? <i>If "Yes," complete Schedule G, Part I</i> (see instructions)	17	No
18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? <i>If "Yes," complete Schedule G, Part II</i>	18	No
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III</i>	19	No

Part IV Checklist of Required Schedules (continued)

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

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.	85	
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable.	0	
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	Yes	
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.	743	
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions).	Yes	
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?		No
b	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)?		No
b	If "Yes," enter the name of the foreign country: _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).		
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		No
c	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?		No
b	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).		
a	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?		No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		No
d	If "Yes," indicate the number of Forms 8282 filed during the year.		
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		
h	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?		
9a	Did the sponsoring organization make any taxable distributions under section 4966?		
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?		
10	Section 501(c)(7) organizations. Enter		
a	Initiation fees and capital contributions included on Part VIII, line 12.		
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities.		
11	Section 501(c)(12) organizations. Enter		
a	Gross income from members or shareholders.		
b	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?		
b	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.		
a	Is the organization licensed to issue qualified health plans in more than one state? Note. See the instructions for additional information the organization must report on Schedule O.		
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans.		
c	Enter the amount of reserves on hand.		
14a	Did the organization receive any payments for indoor tanning services during the tax year?		No
b	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 lines 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.Check if Schedule O contains a response or note to any line in this Part VI. ☒**Section A. Governing Body and Management**

		Yes	No
1a Enter the number of voting members of the governing body at the end of the tax year	1a 4		
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	1b 0		
2 Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2		No
3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?	3		No
4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4		No
5 Did the organization become aware during the year of a significant diversion of the organization's assets?	5		No
6 Did the organization have members or stockholders?	6	Yes	
7a Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a	Yes	
b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b	Yes	
8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
a The governing body?	8a	Yes	
b Each committee with authority to act on behalf of the governing body?	8b	Yes	
9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O.	9	Yes	

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

Section C. Disclosure

17 List the States with which a copy of this Form 990 is required to be filed▶	
18 Section 6104 requires an organization to make its Form 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply. <input type="checkbox"/> Own website <input type="checkbox"/> Another's website <input checked="" type="checkbox"/> Upon request <input type="checkbox"/> 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. ▶TAMMY ALBRIGHT 1905 AMERICAN WAY KINGSPORT, TN 37660 (423) 230-8200	

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 ☐**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, or 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) BART HOVE CHAIR/CEO-WH	1 00 39 00	X		X				0	1,205,697	37,323
(2) ERIC DEATON EVP & COO-WH	1 00 39 00	X						0	584,676	28,425
(3) GARY MILLER EVP/CHIEF GE	1 00 39 00	X						0	495,239	20,368
(4) TODD J DOUGAN SEC/TREAS/CF	1 00 39 00	X		X				0	368,432	22,028
(5) DENNIS KILEY TERMED 12/31/2016 CEO-TRH	40 00 0 00	X		X				0	292,764	40,549
(6) DANIEL LEWIS CMO-TRH	40 00 0 00	X		X				0	287,720	14,388
(7) TAMMY ALBRIGHT CNO/PRESIDENT	40 00 0 00	X		X				0	183,945	33,862
(8) MICHAEL BLAIR TERMED 12/31/2016 INTERIM CFO-	40 00 0 00	X		X				0	142,947	13
(9) ROBIN ROBERTS CNO-TRH	40 00 0 00	X		X				0	97,049	4,436
(10) TODD CHRISTENSEN MD PHYSICIAN	40 00					X		641,407	0	0
(11) JOSEPH KRETSCHMAR MD PHYSICIAN	40 00					X		625,858	0	0
(12) GORDON MARSA MD PHYSICIAN	40 00					X		424,367	0	0
(13) JAMI GOODWIN MD PHYSICIAN	40 00					X		414,268	0	0
(14) WILLIAM BRIDGES PHYSICIAN	40 00					X		374,430	0	0

[illegible]

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 ▶ 21

Section B. Independent Contractors

(A)	(B)	(C)
Name and business address	Description of services	Compensation
PT SOLUTIONS, P O BOX 441146 KENNESAW, GA 30160	PHYS THER SVCS	1,974,664
MEDICAL SERVICES BILLING, P O BOX 22266 CHATTANOOGA, TN 37422	BILLING SVCS	753,754
ARUP LABORATORIES, P O BOX 27964 SALT LAKE CITY, UT 84127	LAB SERVICES	632,450
UNICOM RADIOLOGY SERVICES, P O BOX 32364 KNOXVILLE, TN 379302364	RADIOLOGY SVCS	331,558
EQUISCRIPT LLC, 1360 TRUXTON AVE NORTH CHARLESTON, SC 29405	PROCESSING	211,113

Form 990 (2016)

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	1,129			
	g Noncash contributions included in lines 1a-1f \$ _____					
	h Total. Add lines 1a-1f ▶		1,129			
Program Service Revenue			Business Code			
	2a NET PATIENT REVENUE		621990	66,111,063	66,111,063	
	b MEDICAL OFFICE REVENUE		621990	291,566	291,566	
	c _____					
	d _____					
	e _____					
	f All other program service revenue					
	g Total. Add lines 2a-2f ▶		66,402,629			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts) ▶					
	4 Income from investment of tax-exempt bond proceeds ▶					
	5 Royalties ▶					
	6a Gross rents	(i) Real (ii) Personal				
		975				
	b Less rental expenses					
	c Rental income or (loss)	975				
	d Net rental income or (loss) ▶		975	975		
	7a Gross amount from sales of assets other than inventory	(i) Securities (ii) Other				
	b Less cost or other basis and sales expenses					
	c Gain or (loss)					
	d Net gain or (loss) ▶					
	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 . . . ▶					
	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 . . . ▶					
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 . . . ▶						
Miscellaneous Revenue		Business Code				
11a 340B REVENUE	900099	1,967,580	1,967,580			
b MISCELLANEOUS REVENUE	900099	510,044	510,044			
c CAFETERIA	900099	102,732	102,732			
d All other revenue		47,272	47,272			
e Total. Add lines 11a-11d ▶		2,627,628				
12 Total revenue. See Instructions ▶		69,032,361	69,031,232			

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

	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21.	63,429	63,429		
2 Grants and other assistance to domestic individuals. See Part IV, line 22.				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.				
4 Benefits paid to or for members.				
5 Compensation of current officers, directors, trustees, and key employees.	538,555		538,555	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B).				
7 Other salaries and wages.	32,294,508	31,514,011	780,497	
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).	961,276	417,359	543,917	
9 Other employee benefits.	4,541,515	1,906,789	2,634,726	
10 Payroll taxes.	2,996,479	2,924,780	71,699	
11 Fees for services (non-employees):				
a Management.	535,278		535,278	
b Legal.	100,253		100,253	
c Accounting.	42,743		42,743	
d Lobbying.				
e Professional fundraising services. See Part IV, line 17.				
f Investment management fees.				
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	3,030,839	2,947,465	83,374	
12 Advertising and promotion.	230,847	99,685	131,162	
13 Office expenses.	1,823,710	1,775,023	48,687	
14 Information technology.	1,221,696		1,221,696	
15 Royalties.				
16 Occupancy.	2,858,812	2,505,413	353,399	
17 Travel.	155,548	119,696	35,852	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials.				
19 Conferences, conventions, and meetings.				
20 Interest.	48,170		48,170	
21 Payments to affiliates.				
22 Depreciation, depletion, and amortization.	1,151,343	1,151,343		
23 Insurance.	556,823	255,434	301,389	
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 PURCHASED SERVICES	6,750,615	6,512,584	238,031	
b MEDICAL SUPPLIES	6,686,312	6,686,312		
c PROVISION FOR BAD DEBT	3,319,514	3,319,514		
d TENNESSEE COVERAGE FEES	1,371,886	1,371,886		
e All other expenses	632,868	554,300	78,568	
25 Total functional expenses. Add lines 1 through 24e.	71,913,019	64,125,023	7,787,996	0
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

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

				(A) Beginning of year		(B) End of year
Assets	1	Cash—non-interest-bearing		3,556	1	7,753,853
	2	Savings and temporary cash investments		3,195,993	2	
	3	Pledges and grants receivable, net		105	3	
	4	Accounts receivable, net		7,777,519	4	-19,045,653
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L.			5	
	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.			6	
	7	Notes and loans receivable, net			7	
	8	Inventories for sale or use		1,337,129	8	1,447,363
	9	Prepaid expenses and deferred charges		77,378	9	119,361
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D.	10a	12,051,401		
	b	Less: accumulated depreciation	10b	524,226		
				14,106,781	10c	11,527,175
	11	Investments—publicly traded securities			11	
	12	Investments—other securities. See Part IV, line 11			12	
	13	Investments—program-related. See Part IV, line 11			13	
	14	Intangible assets			14	2,460,679
15	Other assets. See Part IV, line 11		1,196,253	15		
16	Total assets. Add lines 1 through 15 (must equal line 34)		27,694,714	16	4,262,778	
Liabilities	17	Accounts payable and accrued expenses		4,616,099	17	4,383,198
	18	Grants payable			18	
	19	Deferred revenue			19	
	20	Tax-exempt bond liabilities			20	
	21	Escrow or custodial account liability. Complete Part IV of Schedule D.			21	
	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			22	
	23	Secured mortgages and notes payable to unrelated third parties			23	
	24	Unsecured notes and loans payable to unrelated third parties			24	
	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.		7,270,998	25	715,406
	26	Total liabilities. Add lines 17 through 25		11,887,097	26	5,098,604
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.					
	27	Unrestricted net assets		15,807,617	27	-835,826
	28	Temporarily restricted net assets			28	
	29	Permanently restricted net assets			29	
	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		15,807,617	33	-835,826
34	Total liabilities and net assets/fund balances		27,694,714	34	4,262,778	

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	69,032,361
2	Total expenses (must equal Part IX, column (A), line 25)	2	71,913,019
3	Revenue less expenses Subtract line 2 from line 1	3	-2,880,658
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	15,807,617
5	Net unrealized gains (losses) on investments	5	
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-13,762,785
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	-835,826

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		No
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	Yes	
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	Yes	
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?		No
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		

Software ID:**Software Version:****EIN:** 51-0603966**Name:** TAKOMA REGIONAL HOSPITAL INC

Form 990 (2016)

Form 990, Part III, Line 4a:

WELLMONT HEALTH SYSTEM PREPARES A CONSOLIDATED COMMUNITY BENEFIT REPORT, WHICH INCLUDES THE ACTIVITIES OF ALL ITS OPERATIONS AND AFFILIATES. IN CONTRAST, AN INTERNAL REVENUE SERVICE (IRS) FORM 990 IS FILED FOR EACH TAX-EXEMPT CORPORATION (7 SEPARATE FORM 990S), AND THERE IS NO SUCH IRS FORM FOR THE TAXABLE CORPORATIONS. IN ADDITION, THE IRS INSTRUCTIONS TO FORM 990 HAVE SPECIFIC DEFINITIONS, METHODS AND WORKSHEETS TO CALCULATE THE COMMUNITY BENEFITS TO BE INCLUDED ON THE FORM 990. AS A RESULT, THERE ARE SIGNIFICANT DIFFERENCES BETWEEN THE COMMUNITY BENEFITS REPORTED IN THE CONSOLIDATED COMMUNITY BENEFIT REPORT AND THE VARIOUS FORM 990S. THERE ARE ALSO FUNDS AND SERVICES THAT ARE PROVIDED THAT DO NOT MEET THE SPECIFIC DEFINITIONS OF THE IRS INSTRUCTIONS, SUCH AS (CON'T ON SCHEDULE O) CONTRIBUTIONS TO COMMUNITY ORGANIZATIONS THAT DO NOT MEET THE DEFINITION OF "RESTRICTED TO ONE OR MORE OF THE ACTIVITIES DESCRIBED IN THE TABLE IN PART I, LINE 7 OF SCHEDULE H-HOSPITALS. TAKOMA REGIONAL HOSPITAL IS AN ACUTE CARE FACILITY IN GREENEVILLE, TENNESSEE. LIKE THE OTHER WELLMONT HEALTH SYSTEM FACILITIES OF WHICH IT IS A MEMBER, IT IS OUR MISSION TO DELIVER SUPERIOR HEALTH CARE WITH COMPASSION TO THE PEOPLE WE SERVE, AND IT IS OUR VISION TO DELIVER THE BEST HEALTH CARE ANYWHERE. CONSISTENT WITH THIS MISSION, WE HAVE WORKED TOWARD IMPROVING OUR COMMUNITY'S ACCESS TO QUALITY, AFFORDABLE HEALTH CARE, EDUCATING OUR REGION'S CAREGIVERS, IMPROVING THE HEALTH STATUS OF OUR COMMUNITIES AND CONTRIBUTING TO THE OVERALL QUALITY OF LIFE IN THE AREAS WE SERVE. TAKOMA REGIONAL HOSPITAL, INC. HAS BEEN A LEADER IN PATIENT SAFETY AND HEALTHCARE QUALITY FOR FIVE YEARS AND, IN 2016, CONCLUDED A ONE YEAR PERIOD WITH ZERO REPORTABLE, HOSPITAL-ACQUIRED INFECTIONS. WE BELIEVE OUR PATIENTS SHOULD BE ABLE TO ACCESS WORLD CLASS HEALTH CARE CLOSE TO HOME. OVERALL, WE RETURNED MORE THAN 8,218,734 IN BENEFITS TO OUR COMMUNITY IN FISCAL YEAR 2017, INCLUDING 7,950,200 OF UNREIMBURSED COSTS FOR INDIGENT AND MEDICAID PATIENTS AND 268,534 FOR OTHER COMMUNITY ACTIVITIES. TO FURTHER THE COMMUNITY'S HEALTH STATUS, TAKOMA REGIONAL TEACHES OR HAS AVAILABLE A VARIETY OF HEALTH PROGRAMS THAT INCLUDE -THE BIGGEST LOSER LIFESTYLE AND WEIGHT-LOSS PROGRAM -CREATION HEALTH TOTAL LIFESTYLE PROGRAM -CREATION HEALTH NATURE TRAIL, WHICH IS 1.1 MILE IN LENGTH -A VARIETY OF HEALTH PROGRAMS, AVAILABLE FOR EVERYONE IN THE GREENE COUNTY SERVICE AREA, INCLUDING THE UNDERSERVED AND UNDERPRIVILEGED AT NO OR A NOMINAL FEE. TAKOMA REGIONAL HAS ALSO COLLABORATED WITH LAUGHLIN MEMORIAL HOSPITAL, THE GREENE COUNTY HEALTH DEPARTMENT, AND THE UNIVERSITY OF TENNESSEE EXTENSION IN PROVIDING THE WESLEY HEIGHT'S COMMUNITY, AN UNDERSERVED COMMUNITY, WITH HEALTH PROGRAMING AIMED AT REDUCING DIABETES AND CANCER. THE WESLEY HEIGHTS AREA IS NOT DEFINED BY ZIP CODE(S), BUT RATHER BY GEOGRAPHICAL LOCATION DETERMINED BY LOCAL CITY STREETS. THE WESLEY HEIGHTS PROJECT IS AN ONGOING MULTI-YEAR INITIATIVE. PROGRAMMING INCLUDES HEALTHY MEALS, PHYSICIAN, DIETITIAN AND HEALTH PROFESSIONAL HEALTH LECTURES AND OTHER ACTIVITIES. TAKOMA REGIONAL HOSPITAL, INC. IS A 100-BED FACILITY IN GREENEVILLE, TENNESSEE. WE PROVIDE A WIDE VARIETY OF SERVICES, INCLUDING EMERGENCY CARE, PHYSICAL, STROKE AND OCCUPATIONAL THERAPIES, SURGERY, INTERMEDIATE MEDICAL CARE, OUTPATIENT SPECIALTY CLINICS, LABORATORY SERVICES, AUDIOLOGY SERVICES, CARDIOVASCULAR SERVICES, RESPIRATORY THERAPY, SLEEP EVALUATIONS AND TREATMENT, INFUSION, SPINE REHABILITATION SERVICES AND DIAGNOSTIC IMAGING. IN FISCAL YEAR 2017, WE PROVIDED SERVICES TO 2,348 INPATIENTS, HAD 1,682 INPATIENT AND OUTPATIENT SURGICAL CASES, AND HAD 18,320 EMERGENCY ROOM VISITS. IT IS OUR COMMITMENT - INDEED, IT IS IMPLICIT IN OUR MISSION - TO SUPPORT THE CAUSES AND DEVELOP THE INITIATIVES THAT WILL PROPEL OUR COMMUNITY TOWARD A BETTER, BRIGHTER, HEALTHIER AND MORE VIBRANT FUTURE. REGARDLESS OF RACE, RELIGION, ETHNICITY OR ABILITY TO PAY, TAKOMA REGIONAL HOSPITAL TREATS ALL PATIENTS FOR MEDICALLY NECESSARY CONDITIONS. RECOGNIZING SOME PATIENTS CANNOT AFFORD ESSENTIAL MEDICAL SERVICES, WE PROVIDED CARE FOR INDIGENT PATIENTS, WRITING OFF 3,319,514 OF CHARGES AND INCURRING COSTS OF 888,820. FOREWARNED IS FOREARMED. THE BEST WAY TO KEEP OUR COMMUNITIES HEALTHY IS TO PROVIDE THEM WITH THE LATEST INFORMATION ABOUT THEIR HEALTH. WE STRIVE TO PROVIDE INFORMATION ABOUT EVERYTHING FROM DISEASE AND INJURY PREVENTION TO THE LATEST TREATMENTS AND TECHNOLOGIES AVAILABLE TO COPING WITH DISEASE AND ITS SYMPTOMS. OUR TOTAL COMMUNITY BENEFIT FOR COMMUNITY HEALTH IMPROVEMENT SERVICES HAD A DIRECT COST OF 132,853. TAKOMA REGIONAL HOSPITAL, INC. WILL NOT SUCCEED IN OUR MISSION WITHOUT CONTINUALLY REINVESTING IN OUR MOST PRECIOUS RESOURCE - OUR PEOPLE. TO THAT END, WE SUPPORTED THE EDUCATION AND TRAINING OF HEALTH CARE PROFESSIONALS AT A DIRECT COST OF 105,796. TAKOMA REGIONAL HOSPITAL, INC. PROVIDED CASH AND IN-KIND CONTRIBUTIONS AT A DIRECT COST OF 29,885. IN-KIND SERVICES INCLUDED CONFERENCE ROOM SPACE DONATED TO NON-PROFIT COMMUNITY GROUPS SUCH AS GREENE COUNTY MINISTERIAL ASSOCIATION, HOPE CHEST, UNITED WAY AND OTHER VARIOUS SUPPORT GROUPS SUCH AS DIABETES, PRENATAL, STROKE, AND TOBACCO CESSATION GROUPS.

SCHEDULE A (Form 990 or 990-EZ)	Public Charity Status and Public Support Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust. ▶ Attach to Form 990 or Form 990-EZ. ▶ Information about Schedule A (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990 .	OMB No 1545-0047 2016 Open to Public Inspection
	Department of the Treasury Internal Revenue Service Name of the organization TAKOMA REGIONAL HOSPITAL INC	Employer identification number 51-0603966

Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.
The organization is not a private foundation because it is (For lines 1 through 12, check only one box)

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

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

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, 8, or 9 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support						
Calendar year (or fiscal year beginning in) ▶	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 Public support. Subtract line 5 from line 4						

Section B. Total Support						
Calendar year (or fiscal year beginning in) ▶	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here ▶						

Section C. Computation of Public Support Percentage						
14	Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f))	<table border="1"><tr><td>14</td><td></td></tr><tr><td>15</td><td></td></tr></table>	14		15	
14						
15						
15	Public support percentage for 2015 Schedule A, Part II, line 14					
16a	33 1/3% support test—2016. 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—2015. 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—2016. 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—2015. 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 10 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(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)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15 Public support percentage for 2016 (line 8, column (f) divided by line 13, column (f))	15	
16 Public support percentage from 2015 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2016 (line 10c, column (f) divided by line 13, column (f))	17	
18 Investment income percentage from 2015 Schedule A, Part III, line 17	18	

19a 33 1/3% support tests—2016. 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—2015. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ☐

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

	Yes	No
1 Are all of the organization's supported organizations listed by name in the organization's governing documents? <i>If "No," describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.</i>	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)? <i>If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).</i>	2	
3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? <i>If "Yes," answer (b) and (c) below.</i>	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)? <i>If "Yes," describe in Part VI when and how the organization made the determination.</i>	3b	
c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? <i>If "Yes," explain in Part VI what controls the organization put in place to ensure such use.</i>	3c	
4a Was any supported organization not organized in the United States ("foreign supported organization")? <i>If "Yes" and if you checked 12a or 12b in Part I, answer (b) and (c) below.</i>	4a	
b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? <i>If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.</i>	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)? <i>If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.</i>	4c	
5a Did the organization add, substitute, or remove any supported organizations during the tax year? <i>If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in Part VI, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed, (ii) the reasons for each such action, (iii) the authority under the organization's organizing document authorizing such action, and (iv) how the action was accomplished (such as by amendment to the organizing document).</i>	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? <i>If "Yes," provide detail in Part VI.</i>	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? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>	7	
8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>	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))? <i>If "Yes," provide detail in Part VI.</i>	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? <i>If "Yes," provide detail in Part VI.</i>	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? <i>If "Yes," provide detail in Part VI.</i>	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)? <i>If "Yes," answer line 10b below.</i>	10a	
b Did the organization have any excess business holdings in the tax year? <i>(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)</i>	10b	

Part IV Supporting Organizations (continued)

	Yes	No
11 Has the organization accepted a gift or contribution from any of the following persons?		
a A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization?		
b A family member of a person described in (a) above?		
c A 35% controlled entity of a person described in (a) or (b) above? <i>If "Yes" to a, b, or c, provide detail in Part VI</i>		
11a		
11b		
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? <i>If "No," describe in Part VI how the supported organization(s) effectively operated, supervised, or controlled the organization's activities. If the organization had more than one supported organization, describe how the powers to appoint and/or remove directors or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year.</i>		
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? <i>If "Yes," explain in Part VI how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised or controlled the supporting organization.</i>		
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)? <i>If "No," describe in Part VI how control or management of the supporting organization was vested in the same persons that controlled or managed the supported organization(s).</i>		
1		

Section D. All Type III Supporting Organizations

	Yes	No
1 Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?		
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? <i>If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s).</i>		
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? <i>If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.</i>		
3		

Section E. Type III Functionally-Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions)		
a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.		
b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).		
2 Activities Test Answer (a) and (b) below.		
a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <i>If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.</i>		
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? <i>If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.</i>		
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? <i>Provide details in Part VI.</i>		
3a		
b Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i>		
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)	1	
a Average monthly value of securities	1a	
b Average monthly cash balances	1b	
c Fair market value of other non-exempt-use assets	1c	
d Total (add lines 1a, 1b, and 1c)	1d	
e Discount claimed for blockage or other factors (explain in detail in Part VI)		
2 Acquisition indebtedness applicable to non-exempt use assets	2	
3 Subtract line 2 from line 1d	3	
4 Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions)	4	
5 Net value of non-exempt-use assets (subtract line 4 from line 3)	5	
6 Multiply line 5 by .035	6	
7 Recoveries of prior-year distributions	7	
8 Minimum Asset Amount (add line 7 to line 6)	8	

Section C - Distributable Amount

		Current Year
1 Adjusted net income for prior year (from Section A, line 8, Column A)	1	
2 Enter 85% of line 1	2	
3 Minimum asset amount for prior year (from Section B, line 8, Column A)	3	
4 Enter greater of line 2 or line 3	4	
5 Income tax imposed in prior year	5	
6 Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	
7 <input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)		

Part V

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

Section D - Distributions	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI) See instructions	
7 Total annual distributions. Add lines 1 through 6	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI) See instructions	
9 Distributable amount for 2016 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-2016	(iii) Distributable Amount for 2016
1 Distributable amount for 2016 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2016 (reasonable cause required--see instructions)			
3 Excess distributions carryover, if any, to 2016			
a			
b			
c From 2013.			
d From 2014.			
e From 2015.			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2016 distributable amount			
i Carryover from 2011 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2016 from Section D, line 7 \$			
a Applied to underdistributions of prior years			
b Applied to 2016 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2016, if any Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions)			
6 Remaining underdistributions for 2016 Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions)			
7 Excess distributions carryover to 2017. Add lines 3j and 4c			
8 Breakdown of line 7			
a			
b Excess from 2013.			
c Excess from 2014.			
d Excess from 2015.			
e Excess from 2016.			

Part VI **Supplemental Information.**

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

Facts And Circumstances Test

SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527
▶Complete if the organization is described below. ▶Attach to Form 990 or Form 990-EZ.
▶Information about Schedule C (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2016

Open to Public Inspection

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

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

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

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

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

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

Name of the organization TAKOMA REGIONAL HOSPITAL INC	Employer identification number 51-0603966
--	--

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

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV

2 Political expenditures ▶ \$

3 Volunteer hours

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

1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ \$

2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ \$

3 If the organization incurred a section 4955 tax, did it file Form 7202 for this year? ☐ Yes ☐ No

4a Was a correction made? ☐ Yes ☐ No

b If "Yes," describe in Part IV

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

1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ \$

2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ \$

3 Total exempt function expenditures Add lines 1 and 2 Enter here and on Form 1120-POL, line 17b ▶ \$

4 Did the filing organization fileForm 1120-POL for this year? ☐ Yes ☐ No

5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments For each organization listed, enter the amount paid from the filing organization's funds Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC) If additional space is needed, provide information in Part IV

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

Part II-A Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).

A Check ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures)

B Check ☐ if the filing organization checked box A and "limited control" provisions apply

Limits on Lobbying Expenditures
(The term "expenditures" means amounts paid or incurred.)**(a)** Filing
organization's
totals**(b)** Affiliated
group totals

1a Total lobbying expenditures to influence public opinion (grass roots lobbying)

b Total lobbying expenditures to influence a legislative body (direct lobbying)

c Total lobbying expenditures (add lines 1a and 1b)

d Other exempt purpose expenditures

e Total exempt purpose expenditures (add lines 1c and 1d)

f Lobbying nontaxable amount Enter the amount from the following table in both columns

If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:
Not over \$500,000	20% of the amount on line 1e
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000
Over \$17,000,000	\$1,000,000

g Grassroots nontaxable amount (enter 25% of line 1f)

h Subtract line 1g from line 1a If zero or less, enter -0-

i Subtract line 1f from line 1c If zero or less, enter -0-

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?

☐ Yes ☐ No**4-Year Averaging Period Under section 501(h)**

(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the separate instructions for lines 2a through 2f.)

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

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

		(a)		(b)
		Yes	No	Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
a	Volunteers?		No	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
c	Media advertisements?		No	
d	Mailings to members, legislators, or the public?		No	
e	Publications, or published or broadcast statements?		No	
f	Grants to other organizations for lobbying purposes?		No	
g	Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?	Yes		745
j	Total. Add lines 1c through 1i			745
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

Part IV Supplemental Information

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

Return Reference	Explanation
SCHEDULE C, PART II-B, LINE 1	REPRESENTS PERCENTAGE OF TOTAL DUES PAID TO TENNESSEE HOSPITAL ASSOCIATION THAT IS COMPRISED OF LOBBYING EXPENDITURES

efile GRAPHIC print - DO NOT PROCESS		As Filed Data -		DLN: 93493135040088	
<div>SCHEDULE D (Form 990)</div> <div>Department of the Treasury Internal Revenue Service</div>		<div>Supplemental Financial Statements</div> <div>► 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.</div> <div>Information about Schedule D (Form 990) and its instructions is at www.irs.gov/form990.</div>			<div>OMB No 1545-0047</div> <div>2016</div> <div>Open to Public Inspection</div>
Name of the organization TAKOMA REGIONAL HOSPITAL INC				Employer identification number 51-0603966	
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 an 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	Held at the End of the Year			
b	Total acreage restricted by conservation easements	2a			
c	Number of conservation easements on a certified historic structure included in (a)	2b			
d	Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2c			
		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 on Form 990, Part VIII, line 1		► \$			
(ii) Assets included in Form 990, Part X		► \$			
2	If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items				
a	Revenue included on Form 990, Part VIII, line 1				► \$
b	Assets included in Form 990, Part X				► \$
For Paperwork Reduction Act Notice, see the Instructions for Form 990.					
			Cat No 52283D	Schedule D (Form 990) 2016	

Part III

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

3

Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply)

a

☐ Public exhibition

b

☐ Scholarly research

c

☐ Preservation for future generations

d

☐ Loan or exchange programs

e

☐ Other

4

Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII

5

During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection?

☐ Yes

☐ No

Part IV

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

1a

Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?

☐ Yes

☐ No

b

If "Yes," explain the arrangement in Part XIII and complete the following table

c

Beginning balance

d

Additions during the year

e

Distributions during the year

f

Ending balance

	Amount
1c	
1d	
1e	
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 in Part XIII

☐

Part V

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

	(a)Current year	(b)Prior year	(c)Two years back	(d)Three years back	(e)Four years back
1a Beginning of year balance					
b Contributions					
c Net investment earnings, gains, and losses					
d Grants or scholarships					
e Other expenditures for facilities and programs					
f Administrative expenses					
g End of year balance					

2

Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as

a

Board designated or quasi-endowment

b

Permanent endowment

c

Temporarily restricted endowment

The percentages on lines 2a, 2b, and 2c should equal 100%

3a

Are there endowment funds not in the possession of the organization that are held and administered for the organization by

(i) unrelated organizations

(ii) related organizations

b

If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R?

	Yes	No
3a(i)		
3a(ii)		
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		2,604,550		2,604,550
b Buildings		6,137,248	144,231	5,993,017
c Leasehold improvements				
d Equipment		2,989,327	364,469	2,624,858
e Other		320,276	15,526	304,750
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c))				11,527,175

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

Part X

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
LEASES PAYABLE	410,065
RESERVE THIRD PARTIES	305,341
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 25) ▶	715,406

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

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

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

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

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

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

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

Part XIII Supplemental Information

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

Return Reference	Explanation	
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Part XIII	Supplemental Information <i>(continued)</i>
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Return Reference	Explanation
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SCHEDULE H
(Form 990)

Department of the Treasury

Internal Revenue Service

Hospitals

► 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.

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
TAKOMA REGIONAL HOSPITAL INC

Employer identification number
51-0603966

Part I

Financial Assistance and Certain Other Community Benefits at Cost

	Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a Yes	
b If "Yes," was it a written policy?	1b Yes	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the 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	3a Yes	
<input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other %		
b Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care	3b	No
<input type="checkbox"/> 200% <input type="checkbox"/> 250% <input 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"?	4 Yes	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a Yes	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	No
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c	
6a Did the organization prepare a community benefit report during the tax year?	6a Yes	
b If "Yes," did the organization make it available to the public?	6b Yes	
Complete the following table using the worksheets provided in the Schedule H instructions Do not submit these worksheets with the Schedule H		

7

Financial Assistance and Certain Other Community Benefits at Cost

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)			888,820		888,820	1 240 %
b Medicaid (from Worksheet 3, column a)			10,793,537	3,732,157	7,061,380	9 820 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			11,682,357	3,732,157	7,950,200	11 060 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	87	2,614	741,583	608,730	132,853	0 180 %
f Health professions education (from Worksheet 5)	63	105	106,202	406	105,796	0 150 %
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)	60	500	29,885		29,885	0 040 %
j Total. Other Benefits	210	3,219	877,670	609,136	268,534	0 370 %
k Total. Add lines 7d and 7j	210	3,219	12,560,027	4,341,293	8,218,734	11 430 %

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	3	1,100	2,515		2,515	
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building	1	25	144		144	
7 Community health improvement advocacy	25	120	1,347		1,347	
8 Workforce development						
9 Other						
10 Total	29	1,245	4,006		4,006	0.010 %

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?	1		No
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	2		
	888,305		
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3		
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME).	5	8,722,353
6 Enter Medicare allowable costs of care relating to payments on line 5.	6	8,841,335
7 Subtract line 6 from line 5. This is the surplus (or shortfall).	7	-118,982
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used.		
<input type="checkbox"/> Cost accounting system	<input checked="" type="checkbox"/> Cost to charge ratio	<input type="checkbox"/> Other

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures

(owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

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

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

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

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

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

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

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)
TAKOMA REGIONAL HOSPITAL INC**Name of hospital facility or letter of facility reporting group****Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):**

1

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?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the 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)	3	Yes
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input checked="" type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA 20 <u>15</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	No
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>BALLADHEALTH ORG/LOCATIONS HOSPITALS</u>		
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 checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>13</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) <u>BALLADHEALTH ORG/LOCATIONS HOSPITALS</u>	10	Yes
a		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	No
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V

Facility Information (continued)

Financial Assistance Policy (FAP)

TAKOMA REGIONAL HOSPITAL INC																																																																																								
Name of hospital facility or letter of facility reporting group																																																																																								
	<table><tr><td></td><td>Yes</td><td>No</td></tr><tr><td>Did the hospital facility have in place during the tax year a written financial assistance policy that</td><td></td><td></td></tr><tr><td>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</td><td>13 Yes</td><td></td></tr><tr><td>a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 000000000000 % and FPG family income limit for eligibility for discounted care of %</td><td></td><td></td></tr><tr><td>b <input type="checkbox"/> Income level other than FPG (describe in Section C)</td><td></td><td></td></tr><tr><td>c <input checked="" type="checkbox"/> Asset level</td><td></td><td></td></tr><tr><td>d <input checked="" type="checkbox"/> Medical indigency</td><td></td><td></td></tr><tr><td>e <input checked="" type="checkbox"/> Insurance status</td><td></td><td></td></tr><tr><td>f <input checked="" type="checkbox"/> Underinsurance discount</td><td></td><td></td></tr><tr><td>g <input checked="" type="checkbox"/> Residency</td><td></td><td></td></tr><tr><td>h <input type="checkbox"/> Other (describe in Section C)</td><td></td><td></td></tr><tr><td>14 Explained the basis for calculating amounts charged to patients?</td><td>14 Yes</td><td></td></tr><tr><td>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)</td><td>15 Yes</td><td></td></tr><tr><td>a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application</td><td></td><td></td></tr><tr><td>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</td><td></td><td></td></tr><tr><td>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</td><td></td><td></td></tr><tr><td>d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications</td><td></td><td></td></tr><tr><td>e <input type="checkbox"/> Other (describe in Section C)</td><td></td><td></td></tr><tr><td>16 Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)</td><td>16 Yes</td><td></td></tr><tr><td>a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) WWW BALLADHEALTH ORG</td><td></td><td></td></tr><tr><td>b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) WWW BALLADHEALTH ORG</td><td></td><td></td></tr><tr><td>c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) WWW BALLADHEALTH ORG</td><td></td><td></td></tr><tr><td>d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)</td><td></td><td></td></tr><tr><td>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)</td><td></td><td></td></tr><tr><td>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)</td><td></td><td></td></tr><tr><td>g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention</td><td></td><td></td></tr><tr><td>h <input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP</td><td></td><td></td></tr><tr><td>i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations</td><td></td><td></td></tr><tr><td>j <input type="checkbox"/> Other (describe in Section C)</td><td></td><td></td></tr></table>		Yes	No	Did the hospital facility have in place during the tax year a written financial assistance policy that			13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13 Yes		a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 000000000000 % and FPG family income limit for eligibility for discounted care of %			b <input 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 discount			g <input checked="" type="checkbox"/> Residency			h <input type="checkbox"/> Other (describe in Section C)			14 Explained the basis for calculating amounts charged to patients?	14 Yes		15 Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	15 Yes		a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			e <input type="checkbox"/> Other (describe in Section C)			16 Was widely publicized within the community served by the hospital facility? 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Part V Facility Information (continued)**Billing and Collections**

TAKOMA REGIONAL HOSPITAL INC

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

TAKOMA REGIONAL HOSPITAL INC

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

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
22		
23		No
24		No

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

[illegible]

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? 9

Name and address	Type of Facility (describe)
1 TAKOMA MEDICAL ASSOCIATES 438 E VANN ROAD GREENEVILLE, TN 37743	PHYSICIAN SERVICES
2 WOMENS CENTER OF GREENEVILLE 1021 COOLIDGE STREET SUITE 2 GREENEVILLE, TN 37743	OUTPATIENT CLINIC
3 GREENEVILLE URGENT CARE & OCCUPATIO 1021 COOLIDGE STREET SUITE 4 GREENEVILLE, TN 37743	OUTPATIENT CLINIC
4 KIDSFIRST PEDIATRICS 5000 MONARCH POINTE GREENEVILLE, TN 37745	OUTPATIENT CLINIC
5 KIDSFIRST PEDIATRICS 600 BOONES CREEK ROAD JONESBOROUGH, TN 37659	OUTPATIENT CLINIC
6 TAKOMA CENTER FOR SLEEP DISORDERS 1024 COOLIDGE STREET GREENEVILLE, TN 37743	OUTPATIENT CLINIC
7 TAKOMA OUTPATIENT REHABILITATION 108 W SUMMERS STREET GREENEVILLE, TN 37743	REHABILITATION SERVICES
8 TAKOMA OUTPATIENT REHABILITATION 1321 TUSCULUM BOULEVARD GREENEVILLE, TN 37743	REHABILITATION SERVICES
9 TAKOMA OUTPATIENT REHABILITATION 3135 PEOPLES STREET JOHNSON CITY, TN 37604	REHABILITATION SERVICES
10	

Part VI Supplemental Information

Provide the following information

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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7, COLUMN (F) - EXCLUSIONS FROM PERCENT OF TOTAL EXPENSE	BAD DEBT EXPENSE OF 3,319,514 WAS INCLUDED ON FORM 990, PART IX, LINE 25, COLUMN A, BUT WAS SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGES IN THIS COLUMN PART I, LINE 7 - FINANCIAL ASSISTANCE AND CERTAIN OTHER COMMUNITY BENEFITS AT COST FOR WORKSHEET 2, THE RATIO OF PATIENT CARE COST-TO-CHARGES WAS USED TO DETERMINE THE COSTS FOR AMOUNTS IN LINES 7A AND 7B, COLUMN C THE COSTS INCLUDED IN THE COST-TO-CHARGE RATIO INCLUDED THE COSTS FROM ALL PATIENT SEGMENTS ACTUAL COSTS FROM THE GENERAL LEDGER WERE USED FOR AMOUNTS IN LINES 7F AND 7I, COLUMN C
PART II - COMMUNITY BUILDING ACTIVITIES	COMMUNITY SUPPORT TAKOMA REGIONAL HOSPITAL, INC LEADERSHIP TEAM AND DIRECTORS (SIXTEEN VOLUNTEERS) TOOK SHIFTS RINGING THE SALVATION ARMY BELLS AT A LOCAL GROCERY TO RAISE FUNDS FOR THE COMMUNITY FOOD BANK THE CHAPLAIN OF TAKOMA REGIONAL HOSPITAL, INC ASSISTED WITH THE COMMUNITY CHRISTMAS PARADE COALITION BUILDING GREENE COUNTY COMMUNITY MEMBERS CAME TOGETHER TO DEVELOP A HEALTHY TENNESSEE COMMITTEE COMMUNITY HEALTH IMPROVEMENT ADVOCACY SEVERAL TAKOMA REGIONAL HOSPITAL, INC EMPLOYEES SERVED ON THE GREENE COUNTY HEALTH COUNCIL AND SUB-COMMITTEES THE PATIENT EXPERIENCE DIRECTOR FOR TAKOMA REGIONAL HOSPITAL, INC ATTENDED THE EMERGENCY FOOD AND SHELTER PROGRAM (EFSP) TO VOTE ON WHERE TO DISPERSE FUNDS FOR FOOD AND SHELTER IN THE COMMUNITY

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 2 - BAD DEBT EXPENSE METHODOLOGY	<p>THE COST REPORTED ON LINE 2 IS CALCULATED AS THE BAD DEBT EXPENSE FROM THE GENERAL LEDGER TIMES THE RATIO OF COST TO CHARGES AS CALCULATED ON WORKSHEET 2. THERE ARE NO AMOUNTS REPORTED ON LINE 3. DISCOUNTS ON PATIENT ACCOUNTS ARE NOT INCLUDED IN BAD DEBT EXPENSE. PAYMENTS ON PATIENT ACCOUNTS THAT HAVE PREVIOUSLY BEEN WRITTEN OFF AS BAD DEBT ARE USED TO REDUCE BAD DEBT EXPENSE. A THIRD PARTY VENDOR IS USED TO HELP DETERMINE THE AMOUNT THAT REASONABLY COULD BE ATTRIBUTABLE TO PATIENTS WHO LIKELY WOULD QUALIFY FOR FINANCIAL ASSISTANCE UNDER THE CHARITY CARE POLICY. TEXT OF NOTE TO FINANCIAL STATEMENTS THAT DESCRIBES BAD DEBT EXPENSE. NET PATIENT SERVICE REVENUE IS REPORTED ON THE ACCRUAL BASIS IN THE PERIOD IN WHICH SERVICES ARE PROVIDED AT THE ESTIMATED NET REALIZABLE AMOUNTS EXPECTED TO BE COLLECTED. NET PATIENT SERVICE REVENUE INCLUDES AMOUNTS ESTIMATED BY MANAGEMENT TO BE REIMBURSABLE BY PATIENTS AND VARIOUS THIRD-PARTY PAYORS UNDER PROVISIONS OF REIMBURSEMENT FORMULAS IN EFFECT, INCLUDING RETROACTIVE ADJUSTMENTS UNDER REIMBURSEMENT AGREEMENTS. ESTIMATED RETROACTIVE ADJUSTMENTS ARE ACCRUED IN THE PERIOD RELATED SERVICES ARE RENDERED AND ADJUSTED IN FUTURE PERIODS AS FINAL AND OTHER SETTLEMENTS ARE DETERMINED. WELLMONT PROVIDES CARE TO PATIENTS WHO MEET CRITERIA UNDER ITS CHARITY CARE POLICY WITHOUT CHARGE OR AT AMOUNTS LESS THAN ITS ESTABLISHED RATES. BECAUSE WELLMONT DOES NOT PURSUE COLLECTION OF AMOUNTS DETERMINED TO QUALIFY AS CHARITY CARE, THEY ARE NOT INCLUDED IN NET PATIENT SERVICE REVENUE. PATIENT ACCOUNTS RECEIVABLE ARE REPORTED NET OF BOTH AN ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS AND AN ALLOWANCE FOR CONTRACTUAL ADJUSTMENTS. THE CONTRACTUAL ALLOWANCE REPRESENTS THE DIFFERENCE BETWEEN ESTABLISHED BILLING RATES AND ESTIMATED REIMBURSEMENT FROM MEDICARE, TENNCARE, MEDICAID, AND OTHER THIRD-PARTY PAYMENT PROGRAMS. WELLMONT'S POLICY DOES NOT REQUIRE COLLATERAL OR OTHER SECURITY FOR PATIENT ACCOUNTS RECEIVABLE. WELLMONT ROUTINELY OBTAINS ASSIGNMENT OF, OR IS OTHERWISE ENTITLED TO RECEIVE, PATIENT BENEFITS PAYABLE UNDER HEALTH INSURANCE PROGRAMS, PLANS, OR POLICIES.</p>
PART VI, LINE 2 - NEEDS ASSESSMENT	<p>AS REPORTED IN SCHEDULE H, PART V, SECTION B, TAKOMA REGIONAL HOSPITAL, INC. (THE HOSPITAL) CONDUCTED COMMUNITY HEALTH NEEDS ASSESSMENTS (CHNA'S) IN 2012 AND 2015. THE HOSPITAL'S 2012 AND 2015 CHNA'S COMPLIED WITH THE GUIDANCE SET FORTH BY THE IRS IN PROPOSED REGULATION SECTION 1.501(R)-(1)-(3). IN ADDITION TO THE CHNA'S DISCUSSED ABOVE, A VARIETY OF PRACTICES AND PROCESSES ARE IN PLACE TO ENSURE THAT THE FILING ORGANIZATION IS RESPONSIVE TO THE HEALTH NEEDS OF ITS COMMUNITY. SUCH PRACTICES AND PROCESSES INVOLVE THE FOLLOWING: 1. A HOSPITAL OPERATING/COMMUNITY BOARD COMPOSED OF INDIVIDUALS BROADLY REPRESENTATIVE OF THE COMMUNITY, COMMUNITY LEADERS, AND THOSE WITH SPECIALIZED MEDICAL TRAINING AND EXPERTISE; 2. POST-DISCHARGE PATIENT FOLLOW-UP RELATED TO THE ON-GOING CARE AND TREATMENT OF PATIENTS WHO SUFFER FROM CHRONIC DISEASES; 3. SPONSORSHIP AND PARTICIPATION IN COMMUNITY HEALTH AND WELLNESS ACTIVITIES THAT REACH A BROAD SPECTRUM OF THE FILING ORGANIZATION'S COMMUNITY, AND 4. COLLABORATION WITH OTHER LOCAL COMMUNITY GROUPS TO ADDRESS THE HEALTH CARE NEEDS OF THE FILING ORGANIZATION'S COMMUNITY.</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 3 - PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE	LINE NUMBER 1, PART VI, LINE 3 TAKOMA REGIONAL HOSPITAL, INC PROACTIVELY INFORMS PATIENTS OF THE FINANCIAL ASSISTANCE POLICY BY POSTING THE POLICY ON ITS WEBSITE AS WELL AS POSTING THE POLICY AT POINTS OF REGISTRATION IN THE HOSPITAL TAKOMA REGIONAL HOSPITAL, INC USES PROGRAM ELIGIBILITY SPECIALISTS WHO CONTACT THE UNINSURED PATIENT POPULATION THESE SPECIALISTS DISCUSS THE VARIOUS GOVERNMENTAL ASSISTANCE PROGRAMS THAT ARE AVAILABLE TO PATIENTS IN ORDER TO DETERMINE IF THE PATIENT WOULD QUALIFY FOR ANY OF THESE PROGRAMS THE SPECIALISTS WILL WORK WITH THE PATIENTS TO COMPLETE ANY NECESSARY APPLICATIONS AND WILL HELP THEM THROUGH THE QUALIFICATION PROCESS
PART VI, LINE 4 - COMMUNITY INFORMATION	LINE NUMBER 1, PART VI, LINE 4 TAKOMA REGIONAL HOSPITAL, INC 'S PRIMARY SERVICE AREA IS GREENE COUNTY OF TENNESSEE THE DEMOGRAPHICS OF THESE COUNTIES ARE AS FOLLOWS GREENE - POPULATION 68,615, MEDIAN HOUSEHOLD INCOME 36,711 APPROXIMATELY 14 57% OF OUR PATIENTS ARE MEDICAID RECIPIENTS AND 3 71% ARE UNINSURED, AND GREENE COUNTY IS DESIGNATED AS A MEDICALLY UNDERSERVED AREA

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 5 - PROMOTION OF COMMUNITY HEALTH	LINE NUMBER 1, PART VI, LINE 5 THE MEDICAL STAFF OF TAKOMA REGIONAL HOSPITAL, INC , LIKE ALL WELLMONT HEALTH SYSTEM HOSPITALS, IS OPEN TO ALL QUALIFIED PHYSICIANS, EXCEPT FOR SOME OF ITS HOSPITAL BASED DEPARTMENTS, SUCH AS ANESTHESIOLOGY, EMERGENCY MEDICINE, PATHOLOGY, AND RADIOLOGY ANY SURPLUS OF REVENUES AND GAINS IN EXCESS OF EXPENSES AND LOSSES FOR TAKOMA REGIONAL HOSPITAL, INC , LIKE ALL WELLMONT HEALTH SYSTEM HOSPITALS, IS USED TO FURTHER THE WELLMONT HEALTH SYSTEM MISSION AND VISION, WHICH ARE "WE DELIVER SUPERIOR HEALTH CARE WITH COMPASSION- AND "WE WILL DELIVER THE BEST HEALTH CARE ANYWHERE" THIS WOULD INCLUDE IMPROVEMENTS IN FACILITIES AS WELL AS OPERATIONS FOR PATIENT CARE
PART VI, LINE 6 - AFFILIATED HEALTH CARE SYSTEM	LINE NUMBER 1, PART VI, LINE 6 TAKOMA REGIONAL HOSPITAL IS AN AFFILIATE OF WELLMONT HEALTH SYSTEM WELLMONT HEALTH SYSTEM ("WELLMONT") IS A TENNESSEE NON-PROFIT CORPORATION BASED IN KINGSFORT, TENNESSEE AND A PREMIER PROVIDER OF HEALTHCARE SERVICES IN NORTHEAST TENNESSEE AND SOUTHWEST VIRGINIA WELLMONT WAS FORMED IN JULY 1996 WITH THE MERGER OF BRISTOL MEMORIAL HOSPITAL IN BRISTOL, TENNESSEE AND HOLSTON VALLEY MEDICAL CENTER IN KINGSFORT, TENNESSEE WELLMONT HAS GROWN TO INCLUDE FIVE ADDITIONAL HOSPITALS, AN INTEGRATED PHYSICIAN NETWORK AND SEVERAL AMBULATORY SITES WELLMONT HOSPITALS OFFER A BROAD SCOPE OF SERVICES RANGING FROM COMMUNITY-BASED ACUTE CARE TO HIGHLY SPECIALIZED TERTIARY SERVICES INCLUDING TWO TRAUMA CENTERS, COMPREHENSIVE HEART CARE AND CANCER CARE CENTERS WELLMONT OWNS AND OPERATES AN INTEGRATED HEALTH CARE DELIVERY SYSTEM PROVIDING INPATIENT, OUTPATIENT AND OTHER HEALTH CARE SERVICES AT MULTIPLE LOCATIONS IN NORTHEAST TENNESSEE AND SOUTHWEST VIRGINIA CURRENTLY, WELLMONT OWNS AND OPERATES FIVE ACUTE CARE HOSPITAL FACILITIES AND ONE CRITICAL ACCESS HOSPITAL WITH A TOTAL OF 1,091 LICENSED BEDS AND, THROUGH A JOINT VENTURE, PARTNERS TO OPERATE AN ADDITIONAL ACUTE CARE HOSPITAL FACILITY WITH 100 LICENSED BEDS THE ACUTE CARE FACILITIES OWNED BY WELLMONT INCLUDE HOLSTON VALLEY MEDICAL CENTER, BRISTOL REGIONAL MEDICAL CENTER, MOUNTAIN VIEW REGIONAL MEDICAL CENTER IN NORTON, VIRGINIA, LONESOME PINE HOSPITAL IN BIG STONE GAP, VIRGINIA, WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL IN ROGERSVILLE, TENNESSEE AND THE CRITICAL ACCESS HOSPITAL, HANCOCK COUNTY HOSPITAL IN SNEEDVILLE, TENNESSEE WELLMONT ALSO, DIRECTLY OR INDIRECTLY, CONTROLS, OWNS OR IS AFFILIATED WITH VARIOUS NONPROFIT AND FOR-PROFIT CORPORATIONS AND OTHER ORGANIZATIONS THAT CURRENTLY PROVIDE HEALTH CARE AND HEALTH CARE-RELATED SERVICES THROUGHOUT THE SERVICE AREA IN ADDITION TO THE HOSPITAL CAMPUSES AND AMBULATORY CARE CENTERS DESCRIBED ABOVE, WELLMONT ALSO OPERATES MEDICAL CLINICS, AMBULATORY SURGERY CENTERS, COMPREHENSIVE CANCER CARE CENTERS, AND IMAGING FACILITIES

Additional Data

Software ID:
Software Version:
EIN: 51-0603966
Name: TAKOMA REGIONAL HOSPITAL INC

Form 990 Schedule H, Part V Section A. Hospital Facilities

Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? 1		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER—24 hours	ER—other	Other (Describe)	Facility reporting group
1	TAKOMA REGIONAL HOSPITAL INC 401 TAKOMA AVENUE GREENEVILLE, TN 37743 BALLADHEALTH.ORG/LOCATIONS/HOSPITALS	X	X					X			

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

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

Form and Line Reference	Explanation
FACILITY 1, TAKOMA REGIONAL HOSPITAL, INC - PART V, LINE 5	IN CONJUNCTION WITH CONDUCTING THEIR 2015 COMMUNITY HEALTH NEEDS ASSESSMENT, TAKOMA REGIONAL HOSPITAL, INC (TRH OR THE HOSPITAL) CREATED A COMMUNITY HEALTH NEEDS ASSESSMENT COMMITTEE (CHNAC) TO PROVIDE INPUT AND GUIDE THE HEALTH NEEDS ASSESSMENT PROCESS ORGANIZATIONS AND INDIVIDUALS SERVING ON THE CHNAC INCLUDED REPRESENTATIVES FROM COUNTY AND CITY GOVERNMENT, THE GREENE COUNTY PUBLIC HEALTH DEPARTMENT, AND GREENE COUNTY PUBLIC SCHOOL HEALTH COORDINATORS THE SPECIFIC ORGANIZATIONS AND INDIVIDUALS PARTICIPATING IN THE CHNAC AND REPRESENTING THE MEDICALLY UNDERSERVED, LOW-INCOME, MINORITY POPULATIONS, AND POPULATIONS WITH CHRONIC DISEASE INCLUDED REPRESENTATIVES FROM FRONTIER HEALTH, A PROVIDER OF BEHAVIORAL HEALTH SERVICES, FOOD BANK OF GREENEVILLE, TABERNACLE SOUP KITCHEN, RURAL RESOURCES, AN ORGANIZATION SERVING AS A RESOURCE AND EDUCATOR WITH RESPECT TO SUSTAINABLE AGRICULTURAL PRACTICES, AND WESLEY HEIGHTS, A LOWER-INCOME UNDERSERVED NEIGHBORHOOD LOCATED WITHIN THE HOSPITAL'S COMMUNITY THE LISTING BELOW REFLECTS ALL OF THE ORGANIZATIONS/COMMUNITY AREAS REPRESENTED ON THE HOSPITAL'S CHNAC -TRH REPRESENTATIVES -GREENE COUNTY MAYOR'S OFFICE -RURAL RESOURCES -GREENE COUNTY HEALTH DEPARTMENT -CITY OF GREENEVILLE MAYOR'S OFFICE -THE HOPE CENTER -LAUGHLIN MEMORIAL HOSPITAL REPRESENTATIVES -FRONTIER HEALTH -WESLEY HEIGHTS -FOOD BANK OF GREENEVILLE -TABERNACLE SOUP KITCHEN -GREENE COUNTY PUBLIC SCHOOLS -GREENEVILLE CITY SCHOOLS PRIMARY AND SECONDARY DATA WERE COLLECTED FOR THE PURPOSE OF THE COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS IN ADDITION TO THE INPUT RECEIVED FROM INDIVIDUALS/ORGANIZATIONS SERVING ON THE CHNAC, PRIMARY DATA WAS COLLECTED PRIMARY DATA CONSISTED OF FOCUS GROUPS, GROUP INTERVIEWS, AN ONLINE COMMUNITY HEALTH NEEDS ASSESSMENT SURVEY AND A HARD COPY QUESTIONNAIRE THE INTERVIEWS INCLUDED A CROSS SECTION OF INDIVIDUALS WHO WERE ASSOCIATED WITH ORGANIZATIONS THAT SERVED THE MEDICALLY UNDERSERVED, LOW INCOME, MINORITY, AND CHRONICALLY DISEASED POPULATIONS THE QUESTIONNAIRE WAS COMPLETED BY 652 RESPONDENTS APPROXIMATELY 12% OF THE RESPONDENTS HAD HOUSEHOLD INCOMES BELOW 25,000
FACILITY 1, TAKOMA REGIONAL HOSPITAL, INC - PART V, LINE 6A	THE COMMUNITY HEALTH NEEDS ASSESSMENT CONDUCTED BY TAKOMA REGIONAL HOSPITAL, INC (THE HOSPITAL) WAS BASED UPON THE HOSPITAL'S INVOLVEMENT AND ENRICHMENT OF THOSE WHO LIVE WITHIN GREENE COUNTY, TENNESSEE THE PRIMARY SERVICE AREA IS SHARED BY LAUGHLIN MEMORIAL HOSPITAL AND THUS THE COMMUNITY HEALTH NEEDS ASSESSMENT WAS COMPLETED IN COOPERATION WITH BOTH LOCAL HOSPITALS

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

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

Form and Line Reference	Explanation
FACILITY 1, TAKOMA REGIONAL HOSPITAL, INC - PART V, LINE 7D	TAKOMA REGIONAL HOSPITAL, INC (THE HOSPITAL) ADOPTED A POLICY THAT ADDRESSES THE PUBLIC POSTING REQUIREMENTS OF THE COMMUNITY HEALTH NEEDS ASSESSMENT UNDER THIS POLICY, THE COMMUNITY HEALTH NEEDS ASSESSMENT REPORT WAS REQUIRED TO BE POSTED ON THE HOSPITAL'S WEBSITE BY THE END OF THE YEAR IN WHICH IT WAS CONDUCTED THE HOSPITAL MAKES A COPY OF ITS COMMUNITY HEALTH NEEDS ASSESSMENT REPORT AVAILABLE UPON REQUEST THE HOSPITAL ALSO MAKES A PAPER COPY OF THE COMMUNITY HEALTH NEEDS ASSESSMENT REPORT AVAILABLE FOR PUBLIC INSPECTIONS AT THE HOSPITAL FACILITY
FACILITY 1, TAKOMA REGIONAL HOSPITAL, INC - PART V, LINE 11	KEY FINDINGS NOTED DURING THE CHNA WERE THE LOW RANKINGS OF THE COUNTIES WE SERVE IN SEVERAL CATEGORIES RELATED TO HEALTH AND WELLNESS, INCLUDING PREVALENCE OF CHRONIC DISEASE MANAGEMENT, TOBACCO USE, DIET AND EXERCISE, AS WELL AS A NEED FOR EXPANDED AND ENHANCED MENTAL SERVICES THEY ALSO EMPHASIZED THE VULNERABILITY OF OUR UNDERINSURED AND UNINSURED POPULATIONS, AND THAT IF OUR COMMUNITIES ARE TO THRIVE, WE MUST FOCUS ON ENCOURAGING HEALTHY CHILDREN AND FAMILIES TO HELP MEET THESE NEEDS, TAKOMA REGIONAL HOSPITAL, INC WILL CONTINUE TO STRENGTHEN OUR PARTNERSHIPS AND CONTINUUM OF CARE OPPORTUNITIES WITH AREA HEALTH DEPARTMENTS, FEDERALLY QUALIFIED HEALTH CENTERS, AND FRONTIER HEALTH, THE REGION'S LEADING PROVIDER OF BEHAVIORAL HEALTH SERVICES

Schedule I
(Form 990)

Department of the Treasury
Internal Revenue Service

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

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

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

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
TAKOMA REGIONAL HOSPITAL INC

Employer identification number
51-0603966

Part I

General Information on Grants and Assistance

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

Part II

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance

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

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

Part III **Grants and Other Assistance to Domestic Individuals.** Complete if the organization answered "Yes" on Form 990, Part IV, line 22

Part III can be duplicated if additional space is needed

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

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

Return Reference	Explanation
SCHEDULE I, PAGE 1, PART I, LINE 2	ALL REQUESTS FOR CHARITABLE ASSISTANCE ARE REVIEWED BY THE SENIOR VICE PRESIDENT OF SYSTEM ADVANCEMENT THE REQUEST FOR GRANT FUNDS IS EVALUATED ON THE BASIS OF THE FOLLOWING ITEMS THE DEGREE TO WHICH THE REQUEST SUPPORTS WELLMONT HEALTH SYSTEM'S MISSION, REPRESENTATION OF WELLMONT HEALTH SYSTEM AS A GOOD CORPORATE CITIZEN, AND THE ANNUAL BUDGET THE SENIOR VICE PRESIDENT THEN MAKES A DETERMINATION OF APPROVAL FOR ALL REQUESTS AND THE REQUEST IS SENT DIRECTLY TO ACCOUNTS PAYABLE FOR PAYMENT WELLMONT HEALTH SYSTEM MAKES MINIMAL GRANTS (LESS THAN 5,000 PER ENTITY) THROUGHOUT THE YEAR THE USE OF THESE GRANT FUNDS IS NOT MONITORED BY WELLMONT HEALTH SYSTEM AS THESE GRANTS ARE MADE IN GENERAL SUPPORT OF THE GRANT RECIPIENT

Additional Data

Software ID:
Software Version:
EIN: 51-0603966
Name: TAKOMA REGIONAL HOSPITAL INC

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
BOYS AND GIRLS CLUB OF GREENE COUNT 740 W CHURCH STREET GREENEVILLE, TN 37745	62-1706248	501(C)	6,850				SPONSORSHIP
GREENE COUNTY PARTNERSHIP 115 ACADEMY STREET GREENEVILLE, TN 37743	62-1552105	501(C)	10,185				SPONSORSHIP

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
GREENE COUNTY LOCAL EDUCATIONAL ADV P O BOX 22 AFTON, TN 37616	45-4418460	501(C)	6,250				SPONSORSHIP

Schedule J
(Form 990)

Department of the Treasury
Internal Revenue Service

OMB No 1545-0047

2015

Open to Public Inspection

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.

Name of the organization
TAKOMA REGIONAL HOSPITAL INC

Employer identification number
51-0603966

Part I

Questions Regarding Compensation

	Yes	No
<div>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.</div> <div><div><input type="checkbox"/> First-class or charter travel</div><div><input type="checkbox"/> Travel for companions</div><div><input type="checkbox"/> Tax indemnification and gross-up payments</div><div><input type="checkbox"/> Discretionary spending account</div><div><input type="checkbox"/> Housing allowance or residence for personal use</div><div><input type="checkbox"/> Payments for business use of personal residence</div><div><input type="checkbox"/> Health or social club dues or initiation fees</div><div><input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)</div></div>		
<div>b If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain.</div>	Yes	
<div>2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?</div>	Yes	
<div>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.</div> <div><div><input type="checkbox"/> Compensation committee</div><div><input type="checkbox"/> Independent compensation consultant</div><div><input type="checkbox"/> Form 990 of other organizations</div><div><input type="checkbox"/> Written employment contract</div><div><input type="checkbox"/> Compensation survey or study</div><div><input type="checkbox"/> Approval by the board or compensation committee</div></div>		
<div>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:</div> <div><div>a Receive a severance payment or change-of-control payment?</div><div>b Participate in, or receive payment from, a supplemental nonqualified retirement plan?</div><div>c Participate in, or receive payment from, an equity-based compensation arrangement?</div></div> <div>If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.</div>	Yes	
<div>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</div>		
<div>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:</div> <div><div>a The organization?</div><div>b Any related organization?</div></div> <div>If "Yes," on line 5a or 5b, describe in Part III.</div>		No
<div>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:</div> <div><div>a The organization?</div><div>b Any related organization?</div></div> <div>If "Yes," on line 6a or 6b, describe in Part III.</div>	Yes	No
<div>7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III.</div>		No
<div>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.</div>		No
<div>9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?</div>		

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

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

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

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

Part III **Supplemental Information**

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

Return Reference	Explanation
See Additional Data	

Additional Data

Software ID:
Software Version:
EIN: 51-0603966
Name: TAKOMA REGIONAL HOSPITAL INC

Part III, Supplemental Information

Return Reference	Explanation
SCHEDULE J, PAGE 1, PART I, LINE 1A	THE FILING ORGANIZATION WAS PART OF THE SYSTEM OF HEALTHCARE ORGANIZATIONS KNOWN AS ADVENTIST HEALTH SYSTEM (AHS) UNTIL 12/31/2016 ON JANUARY 1, 2017, WELLMONT HEALTH SYSTEM PURCHASED 100% OF THE MEMBERSHIP INTERESTS OF TAKOMA REGIONAL HOSPITAL, INC MEMBERS OF THE FILING ORGANIZATION'S EXECUTIVE MANAGEMENT TEAM THAT HELD THE POSITION OF VICE-PRESIDENT OR ABOVE WERE COMPENSATED BY AND ON THE PAYROLL OF ADVENTIST HEALTH SYSTEM SUNBELT HEALTHCARE CORPORATION (AHSSHC), THE PARENT ORGANIZATION OF AHS AHSSHC IS EXEMPT FROM FEDERAL INCOME TAX UNDER IRC SECTION 501 (C)(3) THE FILING ORGANIZATION REIMBURSED AHSSHC FOR THE SALARY AND BENEFIT COST OF THOSE EXECUTIVES ON THE PAYROLL OF AHSSHC THAT PROVIDED SERVICES AND WERE ON THE MANAGEMENT TEAM OF THE FILING ORGANIZATION TRAVEL FOR COMPANIONS AHSSHC HAS A CORPORATE EXECUTIVE POLICY THAT PROVIDES A BENEFIT TO ALLOW FOR A TRAVELING AHSSHC EXECUTIVE TO HAVE HIS OR HER SPOUSE ACCOMPANY THE EXECUTIVE ON TWO BUSINESS TRIPS EACH YEAR TYPICALLY, REIMBURSEMENT IS ONLY PROVIDED TO VICE-PRESIDENTS AND ABOVE AND IS USUALLY LIMITED TO ONE BUSINESS TRIP PER YEAR BEYOND THE ANNUAL AHS PRESIDENT'S COUNCIL BUSINESS MEETING AND OTHER MEETINGS WHERE THE SPOUSE IS SPECIFICALLY INVITED THE AHSSHS CORPORATE EXECUTIVE SPOUSAL TRAVEL POLICY WAS ORIGINALLY APPROVED AND REVIEWED BY THE AHSSHC BOARD COMPENSATION COMMITTEE, AN INDEPENDENT BODY OF THE AHSSHC BOARD OF DIRECTORS ALL SPOUSAL TRAVEL COSTS REIMBURSED TO THE EXECUTIVE ARE CONSIDERED TAXABLE COMPENSATION TO THE EXECUTIVE TAX INDEMNIFICATION AND GROSS-UP PAYMENTS AHS HAS A SYSTEM-WIDE POLICY ADDRESSING GROSS-UP PAYMENTS PROVIDED IN CONNECTION WITH EMPLOYER-PROVIDED BENEFITS/OTHER TAXABLE ITEMS UNDER THE POLICY, CERTAIN TAXABLE BUSINESS-RELATED REIMBURSEMENTS (IE TAXABLE BUSINESS-RELATED MOVING EXPENSES, TAXABLE ITEMS PROVIDED IN CONNECTION WITH EMPLOYMENT) PROVIDED TO ANY EMPLOYEE MAY BE GROSSED-UP AT A 25% RATE UPON APPROVAL OF THE FILING ORGANIZATION'S CEO AND CFO ADDITIONALLY, EMPLOYEES AT THE DIRECTOR LEVEL AND ABOVE ARE ELIGIBLE FOR GROSS-UP PAYMENTS ON GIFTS RECEIVED FOR BOARD OF DIRECTOR SERVICES DISCRETIONARY SPENDING ACCOUNT A NOMINAL DISCRETIONARY SPENDING AMOUNT WAS PROVIDED IN THE CURRENT YEAR TO ALL ELIGIBLE EXECUTIVES WHO ATTEND THE ANNUAL AHS PRESIDENT'S COUNCIL BUSINESS MEETING (500 PER EXECUTIVE) OR THE ANNUAL AHS CFO CONFERENCE, OR CMO/CNO BUSINESS MEETING (300 PER EXECUTIVE) OTHER DISCRETIONARY SPENDING ACCOUNTS MAY BE PROVIDED IN CONNECTION WITH OTHER AHS SPONSORED CONFERENCES BUT TYPICALLY DO NOT EXCEED 200 PER PARTICIPANT WITH RESPECT TO THE AHS PRESIDENT'S COUNCIL MEETING, ELIGIBLE EXECUTIVES MAY INCLUDE AHSSHC VICE PRESIDENTS AND ABOVE AND ALL AHSSHC SUBSIDIARY ORGANIZATION CEO'S AND REGIONAL CFO'S THE PAYMENT PROVIDED TO EACH EXECUTIVE WAS CONSIDERED TAXABLE COMPENSATION TO THE EXECUTIVE HEALTH OR SOCIAL CLUB DUES DURING THE FISCAL YEAR ENDED JUNE 30, 2017, WELLMONT HEALTH SYSTEM PROVIDED A COUNTRY CLUB MEMBERSHIP TO BARTON A HOVE THESE AMOUNTS ARE INCLUDED IN TAXABLE COMPENSATION TAKOMA REGIONAL HOSPITAL, INC PROVIDED A COUNTRY CLUB MEMBERSHIP TO ELIGIBLE EXECUTIVES DURING THE FISCAL YEAR ENDED JUNE 30, 2017

Part III, Supplemental Information

Return Reference	Explanation
SCHEDULE J, PAGE 1, PART I, LINE 4	DENNIS KILEY (TERMED 12/31/2016) 264,711 0 0

Part III, Supplemental Information

Return Reference	Explanation
SCHEDULE J, PAGE 1, PART I, LINE 6B	INCENTIVE COMPENSATION IS BASED ON MEETING BUDGETED OPERATING MARGIN GOALS

Part III, Supplemental Information

Return Reference	Explanation
SCHEDULE J, PART III	DURING THE YEAR ENDING JUNE 30, 2017, DENNIS KILEY RECEIVED SEVERANCE PAYMENTS IN THE AMOUNT OF 264,711 PURSUANT TO THE AHSSHC CORPORATE EXECUTIVE POLICY GOVERNING EXECUTIVE SEVERANCE, SEVERANCE AGREEMENTS FOR EXECUTIVES OPERATING AT THE VICE PRESIDENT LEVEL AND ABOVE ARE ENTERED INTO UPON ELIGIBILITY TO FACILITATE THE TRANSITION TO SUBSEQUENT EMPLOYMENT FOLLOWING AN INVOLUNTARY SEPARATION FROM EMPLOYMENT WITH AHS

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1BART HOVE CHAIR/CEO-WHS	(i)	-----	-----	-----	-----	-----	-----	-----
	(ii)	789,605	404,004	12,088	27,331	- 9,992	- 1,243,020	
1ERIC DEATON EVP & COO-WHS	(i)	-----	-----	-----	-----	-----	-----	-----
	(ii)	388,994	186,579	9,103	18,433	- 9,992	- 613,101	
2GARY MILLER EVP/CHIEF GEN CNSEL	(i)	-----	-----	-----	-----	-----	-----	-----
	(ii)	334,622	158,905	1,712	16,116	- 4,252	- 515,607	
3TODD J DOUGAN SEC/TREAS/CFO-WHS	(i)	-----	-----	-----	-----	-----	-----	-----
	(ii)	260,491	107,769	172	12,036	- 9,992	- 390,460	
DENNIS KILEY TERMED 412312016 CEO-TRH	(i)	-----	-----	-----	-----	-----	-----	-----
	(ii)			292,764	14,388	- 26,161	- 333,313	
5DANIEL LEWISCMO-TRH	(i)	-----	-----	-----	-----	-----	-----	-----
	(ii)	236,794	50,342	584	14,388	- 302,108	- 302,108	
6TAMMY ALBRIGHT CNO/PRESIDENT-TRH	(i)	-----	-----	-----	-----	-----	-----	-----
	(ii)	153,497	26,448	4,000	9,405	- 24,457	- 217,807	
7TODD CHRISTENSEN MD PHYSICIAN	(i)	641,407 -----	-----	-----	-----	-----	641,407 -----	-----
	(ii)					-	-	
8JOSEPH KRETSCHMAR MD PHYSICIAN	(i)	625,858 -----	-----	-----	-----	-----	625,858 -----	-----
	(ii)					-	-	
9GORDON MARSA MD PHYSICIAN	(i)	424,367 -----	-----	-----	-----	-----	424,367 -----	-----
	(ii)					-	-	
10JAMI GOODWIN MD PHYSICIAN	(i)	414,268 -----	-----	-----	-----	-----	414,268 -----	-----
	(ii)					-	-	
11WILLIAM BRIDGES PHYSICIAN	(i)	374,430 -----	-----	-----	-----	-----	374,430 -----	-----
	(ii)					-	-	

efile GRAPHIC print - DO NOT PROCESS		As Filed Data -	DLN: 93493135040088
SCHEDULE O (Form 990 or 990-EZ) <div>Department of the Treasury Internal Revenue Service Name of the organization TAKOMA REGIONAL HOSPITAL INC</div>	Supplemental Information to Form 990 or 990-EZ Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information. ▶ Attach to Form 990 or 990-EZ. ▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990 .		OMB No 1545-0047
			2016 Open to Public Inspection
		Employer identification number 51-0603966	

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 2, PART III, LINE 4A	<p>CONTRIBUTIONS TO COMMUNITY ORGANIZATIONS THAT DO NOT MEET THE DEFINITION OF "RESTRICTED TO ONE OR MORE OF THE ACTIVITIES DESCRIBED IN THE TABLE IN PART I, LINE 7 OF SCHEDULE H-HOSPITALS TAKOMA REGIONAL HOSPITAL IS AN ACUTE CARE FACILITY IN GREENEVILLE, TENNESSEE LIKE THE OTHER WELLMONT HEALTH SYSTEM FACILITIES OF WHICH IT IS A MEMBER, IT IS OUR MISSION TO DELIVER SUPERIOR HEALTH CARE WITH COMPASSION TO THE PEOPLE WE SERVE, AND IT IS OUR VISION TO DELIVER THE BEST HEALTH CARE ANYWHERE CONSISTENT WITH THIS MISSION, WE HAVE WORKED TOWARD IMPROVING OUR COMMUNITY'S ACCESS TO QUALITY, AFFORDABLE HEALTH CARE, EDUCATING OUR REGION'S CAREGIVERS, IMPROVING THE HEALTH STATUS OF OUR COMMUNITIES AND CONTRIBUTING TO THE OVERALL QUALITY OF LIFE IN THE AREAS WE SERVE TAKOMA REGIONAL HOSPITAL, INC. HAS BEEN A LEADER IN PATIENT SAFETY AND HEALTHCARE QUALITY FOR FIVE YEARS AND, IN 2016, CONCLUDED A ONE YEAR PERIOD WITH ZERO REPORTABLE, HOSPITAL-ACQUIRED INFECTIONS WE BELIEVE OUR PATIENTS SHOULD BE ABLE TO ACCESS WORLD CLASS HEALTH CARE CLOSE TO HOME OVERALL, WE RETURNED MORE THAN 8,218,734 IN BENEFITS TO OUR COMMUNITY IN FISCAL YEAR 2017, INCLUDING 7,950,200 OF UNREIMBURSED COSTS FOR INDIGENT AND MEDICAID PATIENTS AND 268,534 FOR OTHER COMMUNITY ACTIVITIES TO FURTHER THE COMMUNITY'S HEALTH STATUS, TAKOMA REGIONAL TEACHES OR HAS AVAILABLE A VARIETY OF HEALTH PROGRAMS THAT INCLUDE -THE BIGGEST LOSER LIFESTYLE AND WEIGHT-LOSS PROGRAM -CREATION HEALTH TOTAL LIFESTYLE PROGRAM -CREATION HEALTH NATURE TRAIL, WHICH IS 1.1 MILE IN LENGTH -A VARIETY OF HEALTH PROGRAMS, AVAILABLE FOR EVERYONE IN THE GREENE COUNTY SERVICE AREA, INCLUDING THE UNDERSERVED AND UNDERPRIVILEGED AT NO OR A NOMINAL FEE TAKOMA REGIONAL HAS ALSO COLLABORATED WITH LAUGHLIN MEMORIAL HOSPITAL, THE GREENE COUNTY HEALTH DEPARTMENT, AND THE UNIVERSITY OF TENNESSEE EXTENSION IN PROVIDING THE WESLEY HEIGHTS COMMUNITY, AN UNDERSERVED COMMUNITY, WITH HEALTH PROGRAMMING AIMED AT REDUCING DIABETES AND CANCER THE WESLEY HEIGHTS AREA IS NOT DEFINED BY ZIP CODE(S), BUT RATHER BY GEOGRAPHICAL LOCATION DETERMINED BY LOCAL CITY STREETS THE WESLEY HEIGHTS PROJECT IS AN ONGOING MULTI-YEAR INITIATIVE PROGRAMMING INCLUDES HEALTHY MEALS, PHYSICIAN, DIETITIAN AND HEALTH PROFESSIONAL HEALTH LECTURES AND OTHER ACTIVITIES TAKOMA REGIONAL HOSPITAL, INC. IS A 100-BED FACILITY IN GREENEVILLE, TENNESSEE WE PROVIDE A WIDE VARIETY OF SERVICES, INCLUDING EMERGENCY CARE, PHYSICAL, STROKE AND OCCUPATIONAL THERAPIES, SURGERY, INTERMEDIATE MEDICAL CARE, OUTPATIENT SPECIALTY CLINICS, LABORATORY SERVICES, AUDIOLOGY SERVICES, CARDIOVASCULAR SERVICES, RESPIRATORY THERAPY, SLEEP EVALUATIONS AND TREATMENT, INFUSION, SPINE REHABILITATION SERVICES AND DIAGNOSTIC IMAGING IN FISCAL YEAR 2017, WE PROVIDED SERVICES TO 2,348 INPATIENTS, HAD 1,682 INPATIENT AND OUTPATIENT SURGICAL CASES, AND HAD 18,320 EMERGENCY ROOM VISITS IT IS OUR COMMITMENT - INDEED, IT IS IMPLICIT IN OUR MISSION - TO SUPPORT THE CAUSES AND DEVELOP THE INITIATIVES THAT</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 2, PART III, LINE 4A	T WILL PROPEL OUR COMMUNITY TOWARD A BETTER, BRIGHTER, HEALTHIER AND MORE VIBRANT FUTURE REGARDLESS OF RACE, RELIGION, ETHNICITY OR ABILITY TO PAY, TAKOMA REGIONAL HOSPITAL TREATS ALL PATIENTS FOR MEDICALLY NECESSARY CONDITIONS RECOGNIZING SOME PATIENTS CANNOT AFFORD ESSENTIAL MEDICAL SERVICES, WE PROVIDED CARE FOR INDIGENT PATIENTS, WRITING OFF 3,319,514 OF CHARGES AND INCURRING COSTS OF 888,820 FOREWARNED IS FOREARMED THE BEST WAY TO KEEP O UR COMMUNITIES HEALTHY IS TO PROVIDE THEM WITH THE LATEST INFORMATION ABOUT THEIR HEALTH WE STRIVE TO PROVIDE INFORMATION ABOUT EVERYTHING FROM DISEASE AND INJURY PREVENTION TO TH E LATEST TREATMENTS AND TECHNOLOGIES AVAILABLE TO COPING WITH DISEASE AND ITS SYMPTOMS OU R TOTAL COMMUNITY BENEFIT FOR COMMUNITY HEALTH IMPROVEMENT SERVICES HAD A DIRECT COST OF 1 32,853 TAKOMA REGIONAL HOSPITAL, INC WILL NOT SUCCEED IN OUR MISSION WITHOUT CONTINUALLY REINVESTING IN OUR MOST PRECIOUS RESOURCE - OUR PEOPLE TO THAT END, WE SUPPORTED THE EDU CATION AND TRAINING OF HEALTH CARE PROFESSIONALS AT A DIRECT COST OF 105,796 TAKOMA REGIO NAL HOSPITAL, INC PROVIDED CASH AND IN-KIND CONTRIBUTIONS AT A DIRECT COST OF 29,885 IN- KIND SERVICES INCLUDED CONFERENCE ROOM SPACE DONATED TO NON-PROFIT COMMUNITY GROUPS SUCH A S GREENE COUNTY MINISTERIAL ASSOCIATION, HOPE CHEST, UNITED WAY AND OTHER VARIOUS SUPPORT GROUPS SUCH AS DIABETES, PRENATAL, STROKE, AND TOBACCO CESSATION GROUPS

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 6	THE BUSINESS AND AFFAIRS OF TAKOMA REGIONAL HOSPITAL, INC (THE CORPORATION) SHALL BE GOVERNED EXCLUSIVELY BY THE BOARD OF DIRECTORS THE CORPORATION'S BOARD OF DIRECTORS IS DESIGNATED BY WELLMONT HEALTH SYSTEM, THE SOLE MEMBER OF THE CORPORATION IN ADDITION TO SUCH RIGHTS OF APPROVAL AND CONSENT AS MAY BE RESERVED TO THE SOLE MEMBER OF THE CORPORATION PURSUANT TO APPLICABLE LAW, TRANSACTIONS OF THE FOLLOWING MATTERS BY THE CORPORATION SHALL REQUIRE THE PRIOR APPROVAL OF WELLMONT HEALTH SYSTEM, THE SOLE MEMBER OF THE CORPORATION A) IMPLEMENTATION OF CORPORATION'S ANNUAL BUDGET, B) INCURRING ANY LOAN OR OTHER INDEBTEDNESS FOR BORROWED MONEY, C) ACQUISITION OF ANY EQUIPMENT OR PERSONAL PROPERTY FOR A PURCHASE PRICE IN EXCESS OF 50,000 OR THE ACQUISITION OF ANY REAL ESTATE, REGARDLESS OF PURCHASE PRICE, D) THE UNDERTAKING OF CERTAIN CONTRACTUAL COMMITMENTS, E) ENTERING INTO ANY PLAN OF MERGER OR CONSOLIDATION, F) ACQUISITION OF SUBSTANTIALLY ALL OF THE ASSETS OF ANY OTHER LEGAL ENTITY, AND G) INSTITUTION OF ANY LITIGATION BY OR ON BEHALF OF CORPORATION

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 7A	SEE FORM 990, PART VI, SECTION A, LINE 6 FOR EXPLANATION

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 7B	SEE FORM 990, PART VI, SECTION A, LINE 6 FOR EXPLANATION

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 9	DENNIS KILEY (TERMED 12/31/2016) 1905 AMERICAN WAY KINGSFORT, TN 37660 MICHAEL BLAIR (TERMED 12/31/2016) 1905 AMERICAN WAY KINGSFORT, TN 37660

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 11B	TAKOMA REGIONAL HOSPITAL, INC 'S FORM 990 IS REVIEWED BY THE CHIEF FINANCIAL OFFICER, THE CORPORATE CONTROLLER, AND THE MANAGER OF ACCOUNTING FOR WELLMONT HEALTH SYSTEM, AND THE BOARD OF DIRECTORS OF TAKOMA REGIONAL HOSPITAL, INC PRIOR TO FILING ANY QUESTIONS OR COMMENTS ARISING FROM THE INITIAL REVIEW ARE ADDRESSED TO ENSURE THE RETURN IS COMPLETE AND ACCURATE ANY CHANGES OR CORRECTIONS ARE IDENTIFIED, REVISED IN THE RETURN, AND REVIEWED BY THE INDIVIDUALS LISTED ABOVE PRIOR TO FILING WITH THE INTERNAL REVENUE SERVICE

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 12C	OFFICERS, DIRECTORS AND KEY EMPLOYEES ARE REQUIRED TO SIGN A CONFLICT OF INTEREST POLICY ACKNOWLEDGEMENT ANY POTENTIAL CONFLICTS ARE DISCUSSED WITH THE COMPLIANCE AND AUDIT SERVICES DEPARTMENT AS THEY ARISE TAKOMA REGIONAL HOSPITAL, INC 'S OFFICERS, DIRECTORS AND KEY EMPLOYEES ARE GOVERNED BY WELLMONT HEALTH SYSTEM'S CONFLICT OF INTEREST POLICY WELLMONT HEALTH SYSTEM ALSO HAS A POLICY ON BUSINESS PRACTICES THAT DISCUSSES CONFLICT OF INTEREST AND INFORMS THE WORKFORCE TO DISCLOSE ANY ISSUES TO THE COMPLIANCE AND AUDIT SERVICES DEPARTMENT, FOR RESOLUTION WELLMONT HEALTH SYSTEM ALSO USES A HOTLINE THAT ALLOWS ANONYMOUS REPORTING OF POSSIBLE CONFLICT OF INTEREST SITUATIONS FOR INVESTIGATION BY THE COMPLIANCE AND AUDIT SERVICES DEPARTMENT

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 15A	<p>THE COMPENSATION OF BARTON A HOVE, THE PRESIDENT AND CEO OF WELLMONT HEALTH SYSTEM, IS REVIEWED, APPROVED AND DOCUMENTED BY THE WELLMONT HEALTH SYSTEM HUMAN RESOURCES COMMITTEE AND THE BOARD OF DIRECTORS. THE LAST COMPENSATION DELIBERATION AND REVIEW PROCESS FOR BARTON A HOVE WAS COMPLETED AND APPROVED BY THE BOARD OF DIRECTORS OF WELLMONT HEALTH SYSTEM ON NOVEMBER 7, 2017. THE COMPENSATION OF TAMMY ALBRIGHT, PRESIDENT AND CEO OF TAKOMA REGIONAL HOSPITAL, INC. EFFECTIVE JANUARY 1, 2017, WAS BASED ON MARKET AND INTERNAL EQUITY REVIEWS. THE LAST COMPENSATION DELIBERATION AND REVIEW PROCESS FOR TAMMY ALBRIGHT WAS COMPLETED JANUARY 1, 2017. IN ADDITION, THESE BODIES USE COMPARABILITY DATA TO DETERMINE THE APPROPRIATE COMPENSATION. ALL COMPENSATION DELIBERATIONS AND REVIEWS ARE CONTEMPORANEOUSLY DOCUMENTED. THIS PROCESS IS COMPLETED ON AN ANNUAL BASIS. THE COMPENSATION FOR DENNIS KILEY, PRESIDENT AND CEO OF TAKOMA REGIONAL HOSPITAL, INC. UNTIL DECEMBER 31, 2016, WAS COMPENSATED BY ADVENTIST HEALTH SYSTEM SUNBELT HEALTHCARE CORPORATION (AHSSHC) FOR HIS ROLE SERVING AS CEO. COMPENSATION AND BENEFITS PROVIDED TO THIS INDIVIDUAL WERE DETERMINED PURSUANT TO POLICIES, PROCEDURES, AND PROCESSES OF AHSSHC THAT ARE DESIGNED TO ENSURE COMPLIANCE WITH THE INTERMEDIATE SANCTIONS LAWS AS SET FORTH IN IRC SECTION 4958. AHSSHC HAS TAKEN STEPS TO ENSURE THAT PROCESSES ARE IN PLACE TO SATISFY THE REBUTTABLE PRESUMPTION OF REASONABLENESS STANDARD AS SET FORTH IN TREASURY REGULATION 53.4958-6 WITH RESPECT TO ITS ACTIVE EXECUTIVE-LEVEL POSITIONS.</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 15B	<p>THE COMPENSATION OF THE OTHER OFFICERS AND KEY EMPLOYEES OF TAKOMA REGIONAL HOSPITAL, INC ARE REVIEWED, APPROVED AND DOCUMENTED BY THE WELLMONT HEALTH SYSTEM HUMAN RESOURCES COMMITTEE OF THE BOARD OF DIRECTORS OTHER OFFICERS AND KEY EMPLOYEES OF THE ORGANIZATION HAVE WRITTEN EMPLOYMENT CONTRACTS, AND COMPENSATION IS BASED ON SURVEYS/STUDIES AND THEN APPROVED BY THE WELLMONT HEALTH SYSTEM CEO IN ADDITION, THESE BODIES USE COMPARABILITY DATA TO DETERMINE THE APPROPRIATE COMPENSATION ALL COMPENSATION DELIBERATIONS AND REVIEWS ARE CONTEMPORANEOUSLY DOCUMENTED THIS PROCESS IS COMPLETED ON AN ANNUAL BASIS THE HUMAN RESOURCES COMMITTEE OF THE BOARD OF DIRECTORS REVIEWED THE SALARY AND MARKET COMPENSATION DATA FOR THE FOLLOWING OTHER OFFICERS AND KEY EMPLOYEES ON NOVEMBER 7, 2017 -WELLMONT HEALTH SYSTEM EXECUTIVE VP AND CHIEF OPERATING OFFICER - BUFORD E DEATON -WELLMONT HEALTH SYSTEM CHIEF FINANCIAL OFFICER - TODD DOUGAN, TODD DOUGAN ALSO IS THE SECRETARY/TREASURER OF TAKOMA REGIONAL HOSPITAL, INC WELLMONT HEALTH SYSTEM USES ONE OR MORE OF THE METHODS DESCRIBED TO ESTABLISH THE COMPENSATION OF THE FOLLOWING OTHER OFFICERS AND KEY EMPLOYEES -WELLMONT HEALTH SYSTEM EXECUTIVE VP GENERAL COUNSEL - GARY MILLER -TAKOMA REGIONAL HOSPITAL, INC CHIEF MEDICAL OFFICER - DANIEL LEWIS (BEGINS 1/1/2017) -TAKOMA REGIONAL HOSPITAL, INC CHIEF NURSING OFFICER - ROBIN ROBERTS (BEGINS 1/1/2017) THE COMPENSATION FOR MICHAEL BLAIR, INTERIM CHIEF FINANCIAL OFFICER OF TAKOMA REGIONAL HOSPITAL, INC UNTIL DECEMBER 31, 2016, WAS COMPENSATED BY ADVENTIST HEALTH SYSTEM SUNBELT HEALTHCARE CORPORATION (AHSSHC) THE COMPENSATION FOR TAMMY ALBRIGHT, CHIEF NURSING OFFICER OF TAKOMA REGIONAL HOSPITAL, INC UNTIL DECEMBER 31, 2016, WAS COMPENSATED BY ADVENTIST HEALTH SYSTEM SUNBELT HEALTHCARE CORPORATION (AHSSHC) COMPENSATION AND BENEFITS PROVIDED TO THESE INDIVIDUALS WERE DETERMINED PURSUANT TO POLICIES, PROCEDURES, AND PROCESSES OF AHSSHC THAT ARE DESIGNED TO ENSURE COMPLIANCE WITH THE INTERMEDIATE SANCTIONS LAWS AS SET FORTH IN IRC SECTION 4958 AHSSHC HAS TAKEN STEPS TO ENSURE THAT PROCESSES ARE IN PLACE TO SATISFY THE REBUTTABLE PRESUMPTION OF REASONABLENESS STANDARD AS SET FORTH IN TREASURY REGULATION 53 4958-6 WITH RESPECT TO ITS ACTIVE EXECUTIVE-LEVEL POSITIONS</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 19	TAKOMA REGIONAL HOSPITAL, INC 'S GOVERNING DOCUMENTS AND CONFLICT OF INTEREST POLICY ARE NOT AVAILABLE TO THE PUBLIC. WELLMONT HEALTH SYSTEM'S AUDITED FINANCIAL STATEMENTS AND QUARTERLY UNAUDITED FINANCIAL STATEMENTS ARE AVAILABLE THROUGH THE ELECTRONIC MUNICIPAL MARKET ACCESS WEBSITE.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9	BOOK / TAX DEPRECIATION DIFFERENCE 1,675,569 MEMBER ACQUISITION COST ADJUSTMENTS -15,438,354 TOTAL -13,762,785

SCHEDULE R
(Form 990)

Department of the Treasury
Internal Revenue Service

Name of the organization
TAKOMA REGIONAL HOSPITAL INC

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

2016

Open to Public Inspection

Employer identification number

51-0603966

Part I

Identification of Disregarded Entities

Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity

Part II

Identification of Related Tax-Exempt Organizations

Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.

See Additional Data Table

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No

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

(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) HOLSTON VALLEY IMAGING CENTER 103 WEST STONE DRIVE KINGSPORT, TN 37660 20-2043285	HEALTHCARE	TN	N/A					No			No	
(2) SAPLING GROVE AMBULATORY SURGERY 220 MEDICAL PARK BOULEVARD BRISTOL, TN 37620 20-4450153	HEALTHCARE	TN	N/A					No			No	
(3) HOLSTON VALLEY AMBULATORY SURGERY 103 WEST STONE DRIVE KINGSPORT, TN 37660 62-1816864	HEALTHCARE	TN	N/A					No			No	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of- year assets	(h) Percentage ownership	(i) Section 512(b) (13) controlled entity?	
								Yes	No
(1) WELLMONT INC 1905 AMERICAN WAY KINGSPORT, TN 37660 62-1320035	PHYS SVCS	TN	WHS						No
(2) MCOT INC 1905 AMERICAN WAY KINGSPORT, TN 37660 62-1325938	MED SVCS	TN	WELLMTINC						No
(3) MEDICAL MALL PHARMACY INC 1905 AMERICAN WAY KINGSPORT, TN 37660 62-1565006	MED SVCS	TN	WELLMTINC						No
(4) WELLMONT PHYSICIAN SERVICES INC 1905 AMERICAN WAY KINGSPORT, TN 37660 62-1567353	PHYS SVCS	TN	WELLMTINC						No
(5) WPS PROVIDERS INC 1905 AMERICAN WAY KINGSPORT, TN 37660 20-5564642	PHYS SVCS	TN	WELLMTINC						No
(6) WELLMONT HEALTH SERVICES INC 1905 AMERICAN WAY KINGSPORT, TN 37660 62-1254373	HEALTHCARE	TN	WELLMTINC						No

Part V Transactions With Related Organizations Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.**Note.** Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule**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		No
b Gift, grant, or capital contribution to related organization(s)		No
c Gift, grant, or capital contribution from related organization(s)	Yes	
d Loans or loan guarantees to or for related organization(s)		No
e Loans or loan guarantees by related organization(s)		No
f Dividends from related organization(s)		No
g Sale of assets to related organization(s)		No
h Purchase of assets from related organization(s)		No
i Exchange of assets with related organization(s)		No
j Lease of facilities, equipment, or other assets to related organization(s)		No
k Lease of facilities, equipment, or other assets from related organization(s)		No
l Performance of services or membership or fundraising solicitations for related organization(s)		No
m Performance of services or membership or fundraising solicitations by related organization(s)	Yes	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)		No
o Sharing of paid employees with related organization(s)		No
p Reimbursement paid to related organization(s) for expenses		No
q Reimbursement paid by related organization(s) for expenses		No
r Other transfer of cash or property to related organization(s)		No
s Other transfer of cash or property from related organization(s)		No

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)WELLMONT HEALTH SYSTEM	M	86,722	INVOICES

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.

[illegible]

Part VII **Supplemental Information**

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

Return Reference	Explanation
SCHEDULE R	PART V, LINE 2 RELATED ORGANIZATION TRANSACTIONS WITH WELLMONT FOUNDATION, DURING THE FISCAL YEAR ENDED JUNE 30, 2017, AND DID NOT MEET THE 50,000 THRESHOLD AMOUNT FOR SEPARATE DISCLOSURE ORGANIZATION TRANS TYPE AMOUNT METHOD DETERMINATION WELLMONT FOUNDATION C 1,442 NEED

Additional Data

Software ID:
Software Version:
EIN: 51-0603966
Name: TAKOMA REGIONAL HOSPITAL INC

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c) (3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
(1) 1905 AMERICAN WAY KINGSPORT, TN 37660 62-1636465	HEALTHCARE	TN	501C3	3	WHS		No
(1) 1905 AMERICAN WAY KINGSPORT, TN 37660 62-1816368	HEALTHCARE	TN	501C3	3	WHS		No
(2) 1905 AMERICAN WAY KINGSPORT, TN 37660 26-3557623	HEALTHCARE	TN	501C3	3	WHS		No
(3) 1905 AMERICAN WAY KINGSPORT, TN 37660 27-0898372	HEALTHCARE	TN	501C3	3	WHS		No
(4) 1905 AMERICAN WAY KINGSPORT, TN 37660 45-5443060	HEALTHCARE	TN	501C3	3	WHS		No
(5) 1905 AMERICAN WAY KINGSPORT, TN 37660 27-3777167	HEALTHCARE	TN	501C3	3	WHS		No
(6) 1905 AMERICAN WAY KINGSPORT, TN 37660 58-1594191	HEALTHCARE	TN	501C3	7	WHS		No
(7) 1905 AMERICAN WAY KINGSPORT, TN 37660 62-1308216	HEALTHCARE	TN	501C3	3	WHS		No
(8) 1905 AMERICAN WAY KINGSPORT, TN 37660 58-1589039	HEALTHCARE	TN	501C3	3	WHS		No
(9) 1905 AMERICAN WAY KINGSPORT, TN 37660 86-1103148	HEALTHCARE	TN	501C3	3	WHS		No