

946-586

EXTENDED TO AUGUST 15, 2018

## Return of Organization Exempt From Income Tax

OMB No. 1545-0047

Form 990

Department of the Treasury  
Internal Revenue Service

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

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

► Information about Form 990 and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990)2016  
Open to Public  
Inspection

A For the 2016 calendar year, or tax year beginning OCT 1, 2016 and ending SEP 30, 2017

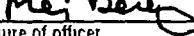
B Check if applicable  Address change Name change Initial return Final return/terminated Amended return <input checked="" type="checkbox"/> Application pending	C Name of organization  TJ HEALTH COLUMBIA, INC.  Doing business as		D Employer identification number  81-0893103	
	Number and street (or P.O. box if mail is not delivered to street address) <b>1301 N RACE STREET</b>	Room/suite	E Telephone number <b>270-651-4157</b>	
	City or town, state or province, country, and ZIP or foreign postal code <b>GLASGOW, KY 42141</b>		F Gross receipts \$ <b>8,500,325.</b>	
	F Name and address of principal officer <b>MEI DENG 1301 NORTH RACE STREET, GLASGOW, KY 42141</b>		G Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	1 Tax-exempt status <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c)(1) (insert no.) 4947(a)(1) or 527		H(b) Are all subordinates included? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Website: ► <a href="http://WWW.HEALTHIERCOLUMBIA.ORG">WWW.HEALTHIERCOLUMBIA.ORG</a>		H(c) Group exemption number ►	
	K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ►		L Year of formation: <b>2015</b> M State of legal domicile: <b>KY</b>	

## Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities <b>T.J. HEALTH COLUMBIA WILL PROMOTE AND PROVIDE FOR THE HEALTH AND WELLNESS OF THE COMMUNITIES</b>			
	2 Check this box ► <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.			
	3 Number of voting members of the governing body (Part VI, line 1a)	3	13	
	4 Number of independent voting members of the governing body (Part VI, line 1b)	4	9	
	5 Total number of individuals employed in calendar year 2016 (Part V, line 2a)	5	139	
	6 Total number of volunteers (estimate if necessary)	6	0	
	7 a Total unrelated business revenue from Part VIII, column (C), line 12	7a	0.	
b Net unrelated business taxable income from Form 990-T line 34	7b	0.		
Revenue	8 Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year	
	9 Program service revenue (Part VIII, line 2g)	0.	0.	
	10 Investment income (Part VIII, column (A), lines 3-4 and 7d)	4,665,436.	8,465,016.	
	11 Other revenue (Part VIII, column (A), lines 5, 6a, 6c, 9c, 10c, and 11e)	0.	7,310.	
	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	5,907.	27,864.	
		4,671,343.	8,500,190.	
	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0.	0.	
	14 Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.	
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	2,808,118.	5,870,159.	
	16a Professional fundraising fees (Part IX, column (A), line 11a)	0.	0.	
	b Total fundraising expenses (Part IX, column (D), line 25)	0.		
	17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	2,588,090.	5,110,970.	
18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	5,396,208.	10,981,129.		
19 Revenue less expenses. Subtract line 18 from line 12	-724,865.	-2,480,939.		
Net Assets or Fund Balances	20 Total assets (Part X, line 16)	Beginning of Current Year	End of Year	
	21 Total liabilities (Part X, line 26)	7,311,721.	6,792,014.	
	22 Net assets or fund balances Subtract line 21 from line 20	8,036,586.	9,997,818.	
	-724,865.	-3,205,804.		

## Part II Signature Block

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

Sign Here		Date			
	<b>MEI DENG, CFO</b>	8/15/18			
	Type or print name and title				
Paid Preparer	Print/Type preparer's name <b>CARRIE A. MERRILL, CPA</b>	Preparer's signature <b>CARRIE A. MERRILL, CPA</b>	Date <b>08/15/18</b>	Check <input type="checkbox"/> if self-employed	PTIN <b>P00832283</b>
Use Only	Firm's name <b>BLUE &amp; CO., LLC</b>	Firm's EIN <b>35-1178661</b>			
	Firm's address <b>2650 EASTPOINT PKWY, SUITE 300 LOUISVILLE, KY 40223</b>			Phone no. <b>502-992-3500</b>	

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

632001 11-11-16 LHA For Paperwork Reduction Act Notice, see the separate instructions.

SEE SCHEDULE O FOR ORGANIZATION MISSION STATEMENT CONTINUATION

Form 990 (2016)

Schedule H

g-53

29493251012038

ENVELOPE WORK DATE AUG 15 2018

SCANNED OCT 12 2018

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

**T.J. HEALTH COLUMBIA WILL PROMOTE AND PROVIDE FOR THE HEALTH AND WELLNESS OF THE COMMUNITIES WE SERVE AND THE HEALTHCARE PROFESSIONALS WHO SERVE THEM. THE PAST, PRESENT, AND FUTURE ACTIVITIES OF T. J. HEALTH COLUMBIA INCLUDE ESTABLISHING AND OPERATING A MEDICAL CENTER TO**

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 reported4a (Code \_\_\_\_\_) (Expenses \$ 10,135,312. including grants of \$ \_\_\_\_\_) (Revenue \$ 8,470,992.)

**T.J. HEALTH COLUMBIA PROVIDES HEALTHCARE SERVICES TO ADAIR AND SURROUNDING COUNTIES IN KENTUCKY. 2,090 ACUTE HOSPITAL AND EMERGENCY ROOM CARE PATIENT DAYS AND 8,231 ER VISITS IN FYE 9/30/17.**

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 ► 10,135,312.

## 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 X	
2 Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> ?	2 X	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I</i>	3 X	
4 <b>Section 501(c)(3) organizations.</b> Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? <i>If "Yes," complete Schedule C, Part II</i>	4 X	
5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? <i>If "Yes," complete Schedule C, Part III</i>	5 X	
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 X	
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? <i>If "Yes," complete Schedule D, Part II</i>	7 X	
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 X	
9 Did the organization report an amount in Part X, line 21, for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? <i>If "Yes," complete Schedule D, Part IV</i>	9 X	
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 X	
11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable. <ul style="list-style-type: none"> <li>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></li> <li>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></li> <li>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></li> <li>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></li> <li>e Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i></li> <li>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></li> </ul>	11a X	
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 X	
12b 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 X	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i>	13 X	
14a Did the organization maintain an office, employees, or agents outside of the United States? <ul style="list-style-type: none"> <li>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></li> </ul>	14a X	
15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? <i>If "Yes," complete Schedule F, Parts II and IV</i>	14b X	
16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? <i>If "Yes," complete Schedule F, Parts III and IV</i>	15 X	
17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? <i>If "Yes," complete Schedule G, Part I</i>	16 X	
18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? <i>If "Yes," complete Schedule G, Part II</i>	17 X	
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>	18 X	
	19 X	

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

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

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

	Yes	No
1a Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	15
1b Enter the number of Forms W-2G included in line 1a Enter -0- if not applicable	1b	0
c Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c	<input checked="" type="checkbox"/>
2a Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	139
b If at least one is reported on line 2a, did the organization file all required federal employment tax returns? <i>Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)</i>	2b	<input checked="" type="checkbox"/>
3a Did the organization have unrelated business gross income of \$1,000 or more during the year?	3a	<input checked="" type="checkbox"/>
b If "Yes," has it filed a Form 990-T for this year? If "No," to line 3b, provide an explanation in Schedule O	3b	
4a At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a	<input checked="" type="checkbox"/>
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	<input checked="" type="checkbox"/>
5a Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5b	<input checked="" type="checkbox"/>
b Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5c	
c If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	6a	<input checked="" type="checkbox"/>
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?	6b	
b If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	7a	<input checked="" type="checkbox"/>
<b>7 Organizations that may receive deductible contributions under section 170(c).</b>	7b	
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?	7c	<input checked="" type="checkbox"/>
b If "Yes," did the organization notify the donor of the value of the goods or services provided?	7d	
c Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7e	
d If "Yes," indicate the number of Forms 8282 filed during the year	7f	
e Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7g	
f Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7h	
g If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	8	
h If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	9a	
<b>8 Sponsoring organizations maintaining donor advised funds.</b> Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	9b	
<b>9 Sponsoring organizations maintaining donor advised funds.</b>		
a Did the sponsoring organization make any taxable distributions under section 4966?	10a	
b Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	10b	
<b>10 Section 501(c)(7) organizations.</b> Enter	11a	
a Initiation fees and capital contributions included on Part VIII, line 12	11b	
b Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	12a	
<b>11 Section 501(c)(12) organizations.</b> Enter	12b	
a Gross income from members or shareholders	13a	
b Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)	13b	
<b>12a Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?	13c	
b If "Yes," enter the amount of tax-exempt interest received or accrued during the year	14a	<input checked="" type="checkbox"/>
<b>13 Section 501(c)(29) qualified nonprofit health insurance issuers.</b>	14b	
a Is the organization licensed to issue qualified health plans in more than one state?  <i>Note. See the instructions for additional information the organization must report on Schedule O</i>		
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		
<b>14a Did the organization receive any payments for indoor tanning services during the tax year?</b>		
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 line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.
Check if Schedule O contains a response or note to any line in this Part VI **Section A. Governing Body and Management**

1a Enter the number of voting members of the governing body at the end of the tax year  
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.

1b Enter the number of voting members included in line 1a, above, who are independent

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?

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?

4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?

5 Did the organization become aware during the year of a significant diversion of the organization's assets?

6 Did the organization have members or stockholders?

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?

b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?

8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:

a The governing body?

b Each committee with authority to act on behalf of the governing body?

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

	Yes	No
1a	13	
1b	9	
2		X
3	X	
4	X	
5	X	
6	X	
7a	X	
7b	X	
8a	X	
8b	X	
9		X

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

10a Did the organization have local chapters, branches, or affiliates?

b If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?

11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?

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

b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?

c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done

13 Did the organization have a written whistleblower policy?

14 Did the organization have a written document retention and destruction policy?

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

b Other officers or key employees of the organization  
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?

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?

	Yes	No
10a	X	
10b		
11a	X	
12a	X	
12b	X	
12c	X	
13	X	
14	X	
15a	X	
15b	X	
16a		X
16b		

**Section C. Disclosure**

17 List the states with which a copy of this Form 990 is required to be filed ► **KY**

18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

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

19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.

20 State the name, address, and telephone number of the person who possesses the organization's books and records ►

**THE ORGANIZATION - 270-651-4157**  
**1301 N. RACE STREET, GLASGOW, KY 42141**

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

 Check if Schedule O contains a response or note to any line in this Part VII 
**Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees**

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

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, and highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below 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			
(1) MIKE BRYANT CHAIRMAN	1.00 3.00	X					0.	0.	78.
(2) JOEY BOTTS VICE CHAIRMAN	1.00 3.00	X					0.	14,766.	0.
(3) BUDDY UNDERWOOD SECRETARY	1.00 3.00	X					0.	0.	78.
(4) HENRY ROYSE TREASURER	1.00 3.00	X					0.	9,614.	0.
(5) DAN FOUTCH CHAIRMAN	1.00 3.00	X					0.	9,523.	0.
(6) KAREN SMALL, MD DIRECTOR	1.00 40.00	X					0.	45,537.	35,836.
(7) WALTER DAVIS EMERITUS STATUS	1.00 3.00	X					0.	0.	0.
(8) SCOTT YOUNG DIRECTOR	1.00 3.00	X					0.	0.	78.
(9) RICH ALEXANDER DIRECTOR	1.00 3.00	X					0.	0.	78.
(10) BRENT BILLINGSLEY DIRECTOR	1.00 3.00	X					0.	0.	26.
(11) DR JAMES THURMAN DIRECTOR	1.00 3.00	X					0.	0.	26.
(12) ALLISON CAMPBELL, M.D. DIRECTOR/CHIEF OF STAFF	1.00 40.00	X					0.	244,971.	19,437.
(13) WILLIAM KLPHEKE, M.D. DIRECTOR/VICE CHIEF OF STA	1.00 3.00	X					0.	507,176.	27,415.
(14) BUD WETHINGTON CHIEF EXECUTIVE OFFICER	5.00 40.00		X				0.	460,190.	22,412.
(15) NEIL THORNBURY CHIEF OPERATING OFFICER	5.00 40.00		X				0.	253,665.	29,076.
(16) MEI DENG CFO (10/31/16 - 9/30/17)	5.00 40.00		X				0.	32,550.	2,141.
(17) CLINTON KITECK PHYSICAN	40.00 0.00			X			237,724.	0.	20,127.

(A) Name and title	(B) Average hours per week (list any hours for related organizations below 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			
(18) NAIR HARIKRISHNAN PHYSICAN	0.00 40.00				X		0.	1,151,301.	25,608.
(19) VENKATA REDDY PHYSICAN	0.00 40.00				X		0.	982,493.	21,703.
(20) CARLOS KUMMERFELDT PHYSICAN	0.00 40.00				X		0.	787,539.	21,213.
(21) DONALD GOODIN PHYSICAN	0.00 40.00				X		0.	670,424.	23,084.
<b>1b Sub-total</b>							<b>237,724.</b>	<b>5,169,749.</b>	<b>248,416.</b>
c Total from continuation sheets to Part VII, Section A							<b>0.</b>	<b>0.</b>	<b>0.</b>
<b>d Total (add lines 1b and 1c)</b>							<b>237,724.</b>	<b>5,169,749.</b>	<b>248,416.</b>

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization ► 1

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

#### Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than \$100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year

(A) Name and business address	(B) Description of services	(C) Compensation
INSPIRE MEDICAL 2323 LIME KILN LANE, LOUISVILLE, KY 40222	ER MD COVERAGE	1,278,814.
HORIZON MENTAL HEALTH MGMT P O BOX 840839, DALLAS, TX 75284-0839	BHU MD COVERAGE	577,615.
MAX KINNAMAN JR DO 463 LEONATUS COURT, BOWLING GREEN, KY 42104	BHU MD	217,020.
PEDIATRIC PSYCH CONSULTANTS 303 N MAPLE AVENUE, DANVILLE, KY 40422	BHU MD	102,324.

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization ► 4

## Part VIII Statement of Revenue

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514	
Contributions, Gifts, Grants and Other Similar Amounts	1 a Federated campaigns	1a					
	b Membership dues	1b					
	c Fundraising events	1c					
	d Related organizations	1d					
	e Government grants (contributions)	1e					
	f All other contributions, gifts, grants, and similar amounts not included above	1f					
	g Noncash contributions included in lines 1a-1f \$						
	h Total. Add lines 1a-1f		►				
Program Service Revenue	2 a NET PATIENT REVENUE	Business Code 621990	8,465,016.	8,465,016.			
	b						
	c						
	d						
	e						
	f All other program service revenue			►	8,465,016.		
	g Total. Add lines 2a-2f			►	8,465,016.		
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		►	7,310.		7,310.	
	4 Income from investment of tax-exempt bond proceeds		►				
	5 Royalties		►				
	6 a Gross rents	(i) Real 6,111.	(ii) Personal				
	b Less rental expenses	135.					
	c Rental income or (loss)	5,976.					
	d Net rental income or (loss)		►	5,976.	5,976.		
	7 a 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)		►					
8 a 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		►					
9 a Gross income from gaming activities See Part IV, line 19	a						
b Less direct expenses	b						
c Net income or (loss) from gaming activities		►					
10 a 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						
11 a OTHER	900099	21,888.				21,888.	
b							
c							
d All other revenue							
e Total. Add lines 11a-11d		►	21,888.				
12 Total revenue. See instructions.		►	8,500,190.	8,470,992.	0.	29,198.	

**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 

<i>Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII</i>	(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				
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, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees				
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	5,007,404.	4,606,812.	400,592.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	71,890.	66,139.	5,751.	
9 Other employee benefits	451,906.	415,754.	36,152.	
10 Payroll taxes	338,959.	311,842.	27,117.	
11 Fees for services (non-employees)				
a Management				
b Legal	513.		513.	
c Accounting	3,855.		3,855.	
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 Sch O.)	2,345,767.	2,158,106.	187,661.	
12 Advertising and promotion				
13 Office expenses	216,145.	198,853.	17,292.	
14 Information technology	37,803.	34,779.	3,024.	
15 Royalties				
16 Occupancy	398,556.	366,672.	31,884.	
17 Travel	28,144.	25,892.	2,252.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings				
20 Interest	3,784.	3,481.	303.	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	692,942.	637,507.	55,435.	
23 Insurance	23,187.	21,332.	1,855.	
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 DRUGS	458,631.	458,631.		
b SUPPLIES	391,636.	360,305.	31,331.	
c TAXES & LICENSES	266,956.	245,600.	21,356.	
d REPAIRS & MAINT	127,396.	117,204.	10,192.	
e All other expenses	115,655.	106,403.	9,252.	
25 Total functional expenses. Add lines 1 through 24e	10,981,129.	10,135,312.	845,817.	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 ►  if following SOP 98-2 (ASC 958-720)

## Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	83,221.	1	111,636.
	2 Savings and temporary cash investments	51,461.	2	1,414,080.
	3 Pledges and grants receivable, net		3	
	4 Accounts receivable, net	3,584,838.	4	1,865,207.
	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 instr) Complete Part II of Sch L		6	
	7 Notes and loans receivable, net	0.	7	1,950.
	8 Inventories for sale or use	165,666.	8	170,168.
	9 Prepaid expenses and deferred charges	319,303.	9	38,248.
	10a Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	3,422,425.		
	b Less accumulated depreciation	10b 673,372.	10c 2,714,245.	10c 2,749,053.
	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	392,987.	14	441,672.
	15 Other assets. See Part IV, line 11		15	
	16 Total assets. Add lines 1 through 15 (must equal line 34)	7,311,721.	16	6,792,014.
Liabilities	17 Accounts payable and accrued expenses	564,285.	17	661,221.
	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	7,472,301.	25	9,336,597.
	26 Total liabilities. Add lines 17 through 25	8,036,586.	26	9,997,818.
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here ► <input type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.			
	27 Unrestricted net assets		27	
	28 Temporarily restricted net assets		28	
	29 Permanently restricted net assets		29	
	Organizations that do not follow SFAS 117 (ASC 958), check here ► <input checked="" type="checkbox"/> and complete lines 30 through 34.			
	30 Capital stock or trust principal, or current funds	0.	30	0.
	31 Paid-in or capital surplus, or land, building, or equipment fund	0.	31	0.
	32 Retained earnings, endowment, accumulated income, or other funds	-724,865.	32	-3,205,804.
	33 Total net assets or fund balances	-724,865.	33	-3,205,804.
	34 Total liabilities and net assets/fund balances	7,311,721.	34	6,792,014.

**Part XI Reconciliation of Net Assets**Check 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	8,500,190.
2 Total expenses (must equal Part IX, column (A), line 25)	2	10,981,129.
3 Revenue less expenses. Subtract line 2 from line 1	3	-2,480,939.
4 Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	-724,865.
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	0.
10 Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	-3,205,804.

**Part XII Financial Statements and Reporting**Check if Schedule O contains a response or note to any line in this Part XII 

	Yes	No
1 Accounting method used to prepare the Form 990 <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O		
2a Were the organization's financial statements compiled or reviewed by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	2a	X
2b Were the organization's financial statements audited by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	2b	X
2c If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O	2c	X
3a As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133? 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	3a	X
	3b	

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

## Public Charity Status and Public Support

OMB No 1545-0047

2016

**Open to Public  
Inspection**

Department of the Treasury  
Internal Revenue Service

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

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](http://www.irs.gov/form990).**

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**Name of the organization**

**Employer identification number**

81-0893103

TJ HEALTH COLUMBIA, INC.

**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.)

f Enter the number of supported organizations

g Provide the following information about the supported organization(s)

**Part II Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)**

(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ►

- 1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants")
- 2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf
- 3 The value of services or facilities furnished by a governmental unit to the organization without charge
- 4 **Total.** Add lines 1 through 3
- 5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)

6 **Public support.** Subtract line 5 from line 4

	(a) 2012	(b) 2013	(c) 2014	(d) 2015	(e) 2016	(f) Total
1						
2						
3						
4						
5						
6						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►

- 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

	(a) 2012	(b) 2013	(c) 2014	(d) 2015	(e) 2016	(f) Total
7						
8						
9						
10						
11						

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))
- 15 Public support percentage from 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 ►
- 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 ►
- 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 ►
- 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 ►
- 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 ►

**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) ►

- 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)

	(a) 2012	(b) 2013	(c) 2014	(d) 2015	(e) 2016	(f) Total
1						
2						
3						
4						
5						
6						
7a						
b						
c						
8						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►

- 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)

	(a) 2012	(b) 2013	(c) 2014	(d) 2015	(e) 2016	(f) Total
9						
10a						
b						
c						
11						
12						
13						

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

**Section A. All Supporting Organizations**

	Yes	No
1		
2		
3a		
3b		
3c		
4a		
4b		
4c		
5a		
5b		
5c		
6		
7		
8		
9a		
9b		
9c		
10a		
10b		

**Part IV Supporting Organizations (continued)**

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

**Section B. Type I Supporting Organizations**

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

**Section C. Type II Supporting Organizations**

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

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

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

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

	Yes	No
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? If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities	2a	
b Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement	2b	
3 Parent of Supported Organizations. Answer (a) and (b) below.		
a Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? Provide details in Part VI	3a	
b Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? If "Yes," describe in Part VI the role played by the organization in this regard	3b	

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

1  Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970 (explain in Part VI) **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		
<b>8 Adjusted Net Income</b> (subtract lines 5, 6, and 7 from line 4)	<b>8</b>		
Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1 Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year)			
a Average monthly value of securities	1a		
b Average monthly cash balances	1b		
c Fair market value of other non-exempt-use assets	1c		
d Total (add lines 1a, 1b, and 1c)	1d		
e Discount claimed for blockage or other factors (explain in detail in Part VI)			
2 Acquisition indebtedness applicable to non-exempt-use assets	2		
3 Subtract line 2 from line 1d	3		
4 Cash deemed held for exempt use Enter 1-1/2% of line 3 (for greater amount, see instructions)	4		
5 Net value of non-exempt-use assets (subtract line 4 from line 3)	5		
6 Multiply line 5 by 035	6		
7 Recoveries of prior-year distributions	7		
<b>8 Minimum Asset Amount</b> (add line 7 to line 6)	<b>8</b>		
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		
<b>6 Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	<b>6</b>		
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)**

<b>Section D - Distributions</b>		<b>Current Year</b>
1	Amounts paid to supported organizations to accomplish exempt purposes	
2	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3	Administrative expenses paid to accomplish exempt purposes of supported organizations	
4	Amounts paid to acquire exempt-use assets	
5	Qualified set-aside amounts (prior IRS approval required)	
6	Other distributions (describe in Part VI) See instructions	
7	<b>Total annual distributions.</b> Add lines 1 through 6	
8	Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI) See instructions	
9	Distributable amount for 2016 from Section C, line 6	
10	Line 8 amount divided by Line 9 amount	
<b>Section E - Distribution Allocations (see instructions)</b>		<b>(i) Excess Distributions</b>
		<b>(ii) Underdistributions Pre-2016</b>
		<b>(iii) Distributable Amount for 2016</b>
1	Distributable amount for 2016 from Section C, line 6	
2	Underdistributions, if any, for years prior to 2016 (reasonable cause required- explain in Part VI) See instructions	
3	Excess distributions carryover, if any, to 2016	
a		
b		
c	From 2013	
d	From 2014	
e	From 2015	
f	<b>Total of lines 3a through e</b>	
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 For result greater than zero, explain in Part VI See instructions	
6	Remaining underdistributions for 2016 Subtract lines 3h and 4b from line 1. For result greater than zero, explain in Part VI See instructions	
7	<b>Excess distributions carryover to 2017.</b> 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 )

**SCHEDULE D**  
(Form 990)Department of the Treasury  
Internal Revenue Service**Supplemental Financial Statements**

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

► Attach to Form 990.

► Information about Schedule D (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047

**2016**  
Open to Public  
Inspection

Name of the organization

TJ HEALTH COLUMBIA, INC.

Employer identification number  
81-0893103**Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.** Complete if the organization answered "Yes" on Form 990, Part IV, line 6

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

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

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

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

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

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

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

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 on Part XIII

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

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a					
b					
c					
d					
e					
f					
g					

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

	Yes	No
3a(i)		
3a(ii)		

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

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		167,576.		167,576.
b Buildings		2,382,714.	396,558.	1,986,156.
c Leasehold improvements				
d Equipment		867,885.	276,743.	591,142.
e Other		4,250.	71.	4,179.
<b>Total.</b> Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10c.)			►	2,749,053.

**Part VII Investments - Other Securities.**

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

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

**Part VIII Investments - Program Related.**

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

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

**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

(a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) DUE TO RELATED ENTITIES	9,313,765.
(3) MISCELLANEOUS	22,832.
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
<b>Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ►</b>	9,336,597.

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

**SCHEDULE H**  
(Form 990)

Department of the Treasury  
Internal Revenue Service

**Hospitals**

OMB No 1545-0047

**2016**

Open to Public  
Inspection

► 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](http://www.irs.gov/form990).

Name of the organization

**TJ HEALTH COLUMBIA, INC.**

Employer identification number  
**81-0893103**

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

1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a

b If "Yes," was it a written policy?  
If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year

Applied uniformly to all hospital facilities       Applied uniformly to most hospital facilities

Generally tailored to individual hospital facilities

2

3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year

a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care?  
If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care

100%       150%       200%       Other \_\_\_\_\_ %

b Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care

200%       250%       300%       350%       400%       Other \_\_\_\_\_ %

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"?

5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?

b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?

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?

6a Did the organization prepare a community benefit report during the tax year?

b If "Yes," did the organization make it available to the public?

	Yes	No
1a	X	
1b	X	
3a	X	
3b	X	
4	X	
5a	X	
5b	X	
5c		X
6a	X	
6b	X	

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

**7 Financial Assistance and Certain Other Community Benefits at Cost**

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			261,984.	764,856.	0.	.00%
b Medicaid (from Worksheet 3, column a)			4901829.	3807417.	1094412.	9.97%
c Costs of other means-tested government programs (from Worksheet 3, column b)						
<b>d Total Financial Assistance and Means-Tested Government Programs</b>			<b>5163813.</b>	<b>4572273.</b>	<b>1094412.</b>	<b>9.97%</b>
<b>Other Benefits</b>						
e Community health improvement services and community benefit operations (from Worksheet 4)						
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
<b>j Total, Other Benefits</b>			<b>5163813.</b>	<b>4572273.</b>	<b>1094412.</b>	<b>9.97%</b>
<b>k Total, Add lines 7d and 7j</b>			<b>5163813.</b>	<b>4572273.</b>	<b>1094412.</b>	<b>9.97%</b>

**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.

Community building activities promoted the health of the communities it served						
	(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
<b>1 Physical improvements and housing</b>						
<b>2 Economic development</b>						
<b>3 Community support</b>						
<b>4 Environmental improvements</b>						
<b>5 Leadership development and training for community members</b>						
<b>6 Coalition building</b>	10	150	2,274.		2,274.	.02%
<b>7 Community health improvement advocacy</b>						
<b>8 Workforce development</b>						
<b>9 Other</b>						
<b>10 Total</b>	10	150	2,274.		2,274.	.02%

Part III Bad Debt, Medicare, & Collection Practices

### **Section A. Bad Debt Expense**

1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2
3	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	

	Yes	No
ment Association	1	X
2	2,952,604.	
3		

## Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5
6	Enter Medicare allowable costs of care relating to payments on line 5	6
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7
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	8

Cost to charge ratio  Cost accounting system  Other

ed on line

## **Section C. Collection Practices**

**9a** Did the organization have a written debt collection policy during the tax year?  
**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

5	977,033.
6	1,017,710.
7	-40,677.
Community benefit ated on line 6.	
<i>J</i>	
9a	X
9b	X

## Part IV Management Companies and Joint Ventures

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

**Part V Facility Information**

## Section A Hospital Facilities

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

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

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

1. T.A.L. HEALTH COLUMBIA

1.5. READING COLORED  
901 WESTLAKE DRIVE

501 WESTBARE DRIVE  
COLUMBIA KY 42728

**WWW. HEALTHIERCOLUMBIA.ORG**

www.h  
10001

**Other (describe)**

Facility reporting group

**Part V Facility Information (continued)**

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

T.J. HEALTH COLUMBIA:

PART V, SECTION B, LINE 2: T.J. REGIONAL HEALTH, INC. PURCHASED THE ASSETS OF WESTLAKE REGIONAL HOSPITAL IN COLUMBIA, KY. T.J. REGIONAL HEALTH, INC. HAS FORMED T.J. HEALTH COLUMBIA, INC., A SEPERATE LEGAL ENTITY AND THIS NEW ENTITY BEGAN OPERATIONS IN FEBRUARY OF 2016.

T.J. HEALTH COLUMBIA

PART V, LINE 16A, FAP WEBSITE:

HTTPS://WWW.TJSAMSON.ORG/CHARITYFINANCIAL ASSISTANCE.ASPX

T.J. HEALTH COLUMBIA

PART V, LINE 16B, FAP APPLICATION WEBSITE:

HTTPS://WWW.TJSAMSON.ORG/CHARITYFINANCIAL ASSISTANCE.ASPX

T.J. HEALTH COLUMBIA

PART V, LINE 16C, FAP PLAIN LANGUAGE SUMMARY WEBSITE:

HTTPS://WWW.TJSAMSON.ORG/CHARITYFINANCIAL ASSISTANCE.ASPX

**Part V Facility Information (continued)**

**Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

How many non-hospital health care facilities did the organization operate during the tax year? **5**

Name and address	Type of Facility (describe)
1 T.J. HEALTH COLUMBIA CLINIC	PHYSICIAN CLINIC
902 WESTLAKE DRIVE	
COLUMBIA, KY 42728	
2 T.J. HEALTH COLUMBIA -PRIMARY CARE	PRIMARY CARE
810 JAMESTOWN STREET	
COLUMBIA, KY 42728	
3 T.J. HEALTH EDMONTON	PHYSICIAN CLINIC
112 SARTIN DRIVE, LOT 1	
EDMONTON, KY 42129	
4 T.J. HEALTH RUSSELL SPRINGS	PHYSICIAN CLINIC
LAKEWAY DRIVE	
RUSSELL SPRINGS, KY 42642	
5 T.J. HEALTH GREENSBURG	PHYSICIAN CLINIC
603 COLUMBIA HIGHWAY	
GREENSBURG, KY 42743	

**Part V Facility Information (continued)****Section B. Facility Policies and Practices**

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

**Name of hospital facility or letter of facility reporting group** T. J. HEALTH COLUMBIA**Line number of hospital facility, or line numbers of hospital****facilities in a facility reporting group (from Part V, Section A):** 1

	<b>Yes</b>	<b>No</b>
<b>Community Health Needs Assessment</b>		
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	<input checked="" type="checkbox"/> X
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	<input checked="" type="checkbox"/> X
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3	<input checked="" type="checkbox"/> X
a <input type="checkbox"/> A definition of the community served by the hospital facility		
b <input type="checkbox"/> Demographics of the community		
c <input type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input type="checkbox"/> How data was obtained		
e <input type="checkbox"/> The significant health needs of the community		
f <input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA	20	
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	
a <input type="checkbox"/> Hospital facility's website (list url) _____		
b <input type="checkbox"/> Other website (list url) _____		
c <input type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	
9 Indicate the tax year the hospital facility last adopted an implementation strategy	20	
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? a If "Yes," (list url) _____ b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10	
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	10b	
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	<input checked="" type="checkbox"/> X
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

**Part V Facility Information (continued)**Financial Assistance Policy (FAP)Name of hospital facility or letter of facility reporting group T.J. HEALTH COLUMBIA

	Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that		
<b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13	X
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>100</u> % and FPG family income limit for eligibility for discounted care of <u>200</u> %		
b <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
c <input checked="" type="checkbox"/> Asset level		
d <input checked="" type="checkbox"/> Medical indigency		
e <input checked="" type="checkbox"/> Insurance status		
f <input checked="" type="checkbox"/> Underinsurance status		
g <input type="checkbox"/> Residency		
h <input type="checkbox"/> Other (describe in Section C)		
<b>14</b> Explained the basis for calculating amounts charged to patients?	14	X
<b>15</b> Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	15	X
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e <input type="checkbox"/> Other (describe in Section C)		
<b>16</b> Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	16	X
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>SEE PART V, PAGE 8</u>		
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>SEE PART V, PAGE 8</u>		
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>SEE PART V, PAGE 8</u>		
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g <input 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		
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i <input 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		
j <input type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information (continued)****Billing and Collections**Name of hospital facility or letter of facility reporting group T.J. HEALTH COLUMBIA

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 nonpayment?

	Yes	No
17	X	
19	X	

18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP

- a  Reporting to credit agency(ies)
- b  Selling an individual's debt to another party
- c  Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP
- d  Actions that require a legal or judicial process
- e  Other similar actions (describe in Section C)
- f  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?

If "Yes," check all actions in which the hospital facility or a third party engaged

- a  Reporting to credit agency(ies)
- b  Selling an individual's debt to another party
- c  Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP
- d  Actions that require a legal or judicial process
- e  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  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  Made a reasonable effort to orally notify individuals about the FAP and FAP application process
- c  Processed incomplete and complete FAP applications
- d  Made presumptive eligibility determinations
- e  Other (describe in Section C)
- f  None of these efforts were made

**Policy Relating to Emergency Medical Care**

21 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?

If "No," indicate why

- a  The hospital facility did not provide care for any emergency medical conditions
- b  The hospital facility's policy was not in writing
- c  The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- d  Other (describe in Section C)

21	X	

**Part V Facility Information (continued)****Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**Name of hospital facility or letter of facility reporting group T.J. HEALTH COLUMBIA

		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care		
a	<input checked="" type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b	<input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
c	<input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
d	<input type="checkbox"/> 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?	23	<input checked="" type="checkbox"/>
	If "Yes," explain in Section C.		
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?	24	<input checked="" type="checkbox"/>
	If "Yes," explain in Section C		

**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

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**PART III, LINE 2:**

PATIENT ACCOUNTS RECEIVABLE ARE STATED AT NET REALIZABLE VALUE. THE HOSPITAL MAINTAINS ALLOWANCES FOR UNCOLLECTIBLE ACCOUNTS AND FOR ESTIMATED LOSSES RESULTING FROM A PAYOR'S INABILITY TO PAY. MANAGEMENT ESTIMATES THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS BASED ON THEIR ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS CONSIDERING HISTORICAL AND CURRENT BUSINESS AND ECONOMIC FACTORS, TRENDS IN HEALTHCARE COVERAGE, AND OTHER COLLECTION INDICATORS. ACCOUNTS RECEIVABLE ARE CHARGED TO THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS WHEN THEY ARE DEEMED UNCOLLECTIBLE.

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**PART III, LINE 9B:**

THE HOSPITAL PROVIDES ASSISTANCE TO PATIENTS THAT QUALIFY UNDER THE GUIDELINES.

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**PART VI, LINE 2:**

NEEDS ASSESSMENT- T.J. HEALTH COLUMBIA (TJHC) HAS AN ORGANIZATIONAL COMMITMENT TO IMPROVE THE OVERALL HEALTH OF THE COMMUNITIES THAT WE SERVE. THE HEALTH NEEDS OF OUR COMMUNITY ARE ASSESSED IN A NUMBER OF WAYS.

**Part VI Supplemental Information**

Provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7, Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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QUARTERLY MARKET SHARE REPORTS ARE UTILIZED TO IDENTIFY INPATIENT AND OUTPATIENT TRENDS AND MIGRATION OF PATIENTS. THIS METHOD IS USED TO IDENTIFY SERVICES THAT ARE CURRENTLY NEEDED OR IN HIGH DEMAND FOR EXPANSION. IN ADDITION, BY STUDYING COMMUNITY HEALTH REPORTING CONDUCTED BY IOWA DEPARTMENT OF PUBLIC HEALTH, WE ARE ABLE TO IDENTIFY AREAS THAT NEED TO BE ADDRESSED WITHIN OUR COMMUNITY. CURRENTLY, PLANS ARE DEVELOPED UTILIZING HOSPITAL COMMUNITY HEALTH EDUCATORS TO SCREEN AND EDUCATE THE COMMUNITY AND TARGET THOSE SPECIFIC DEMOGRAPHICS IN NEEDS. A DEDICATED LOCATION IN THE COMMUNITY HAS BEEN DESIGNATED TO HOUSE THE EDUCATORS. IT WAS DETERMINED THAT A SEPARATE LOCATION AWAY FROM THE HOSPITAL WAS APPEALING TO OUR CONSUMERS AND ALLOWED THE COMMUNITY EDUCATORS PLENTY OF SPACE TO PROVIDE SERVICES. OUR COMMUNITY HEALTH EDUCATORS PARTNER WITH LOCAL BUSINESSES AND INDUSTRIES TO CONDUCT HEALTH EVENTS. SOME EXAMPLES OF SERVICES PROVIDED TO THE COMMUNITY ARE; HEALTH FAIRS, PROSTATE SCREENINGS, GLUCOSE CHECKS, CPR, CHOLESTEROL TESTS, BLOOD PRESSURE SCREENINGS, BMI CHECK, CANCER SUPPORT, DIABETIC SUPPORT, BEREAVEMENT SUPPORT, CHILD BIRTH CLASSES, CHILD SAFETY SEAT TRAINING, AND COMMUNITY SUPPORT GROUPS. TJHC PROUDLY SPONSORS EVENTS CONDUCTED BY AREA SCHOOL SYSTEMS. OUR VISION IS TO

**Part VI Supplemental Information**

Provide the following information

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INVEST IN THE YOUTH BY PROVIDING INFORMATION AND EDUCATION AT AN EARLY AGE  
CAUSING STUDENTS TO BE PROACTIVE ABOUT THEIR HEALTH. EXAMPLES OF EVENTS  
INCLUDE SPORTS BOWLS, CAREER FAIRS, AND SCHOOL HEALTH EVENTS. THE  
HOSPITAL ALSO UTILIZES COMMUNITY MEMBERS TO FORM THE PATIENT ADVISORY  
COUNCIL TO WORK AS A SOUNDING BOARD FOR NEW AND EXPANDING SERVICES AS WELL  
AS TO IDENTIFY PATIENT EXPERIENCES THAT NEED IMPROVEMENT. ANNUALLY, T.J.  
HEALTH COLUMBIA WORKS THROUGH STRATEGIC PLANNING AND CONSUMER PREFERENCE  
DATA (AN ONLINE SERVICING TOOL) TO HELP IDENTIFY AND PRIORITIZE SERVICES  
THAT NEED TO BE IMPROVED OR CREATED IN ORDER TO BETTER MEET THE HEALTH  
NEEDS OF THE COMMUNITY.

PART VI, LINE 3:

PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE: T.J. HEALTH COLUMBIA  
INFORMS EACH PERSON BILLED FOR SERVICES ON THEIR ELIGIBILITY FOR  
ASSISTANCE UNDER FEDERAL, STATE, AND LOCAL GOVERNMENT. UPON ADMISSION EACH  
PATIENT IS PROVIDED WITH A PACKET THAT INCLUDES A BROCHURE THAT IS A GUIDE  
TO THEIR HOSPITAL BILL. THIS GUIDE EDUCATES THAT PATIENT ON INSURANCE  
BILLING INFORMATION AS WELL AS PAYMENT ARRANGEMENTS OFFERED BY THE

**Part VI Supplemental Information**

Provide the following information

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7, Part II and Part III, lines 2, 3, 4, 8 and 9b
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report

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HOSPITAL. OPTIONS INCLUDE A DISPROPORTIONATE SHARE HOSPITAL PROGRAM (DSH), FIRST SOURCE WHICH PROVIDES INFORMATION AND EDUCATION ON FEDERAL ASSISTANCE PROGRAMS, CHARITY AND FINANCIAL AID ASSISTANCE APPLICATIONS, AND PAYMENT SCHEDULE ARRANGEMENTS.

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PART VI, LINE 4:

T.J. HEALTH COLUMBIA IS LOCATED IN ADAIR COUNTY, KY. AS OF THE 2010 CENSUS, THE POPULATION WAS 18,656. THE RACIAL MAKEUP OF THE COUNTY WAS 96% WHITE, 2.55% BLACK OR AFRICAN AMERICAN, 0.22% NATIVE AMERICAN, 0.26% ASIAN, 0.02% PACIFIC ISLANDER, 0.19% FROM OTHER RACES, AND 0.76% FROM TWO OR MORE RACES. 0.77% OF THE POPULATION WERE HISPANIC OR LATINO OF ANY RACE. THE MEDIAN INCOME FOR A HOUSEHOLD IN THE COUNTY WAS \$24,055, AND THE MEDIAN INCOME FOR A FAMILY WAS \$29,779. MALES HAD A MEDIAN INCOME OF \$23,183 VERSUS \$17,009 FOR FEMALES. THE PER CAPITA INCOME FOR THE COUNTY WAS \$14,931. ABOUT 18.20% OF FAMILIES AND 24.00% OF THE POPULATION WERE BELOW THE POVERTY LINE, INCLUDING 29.60% OF THOSE UNDER AGE 18 AND 21.70% OF THOSE AGE 65 OR OVER.

**Part VI Supplemental Information**

Provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7, Part II and Part III, lines 2, 3, 4, 8 and 9b
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B
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- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report

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**PART VI, LINE 5:**

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PROMOTION OF COMMUNITY HEALTH OUR MISSION: TJHC WILL PROMOTE AND PROVIDE FOR THE HEALTH AND WELL BEING OF THOSE WE SERVE. OUR VISION: AS A REGIONAL PROVIDER, TJHC TAKES PRIDE IN BEING GOOD STEWARDS OF OUR AVAILABLE RESOURCES AND UTILIZING THEM TO ANTICIPATE AND MEET THE HEALTH NEEDS OF THE REGION BY PROMOTING HEALTH IN OUR COMMUNITIES AND DELIVERING QUALITY, APPROPRIATE AND COMPASSIONATE CARE. OUR GOALS: \* CLINICAL QUALITY \* CUSTOMER SERVICE \* QUALITY WORK-LIFE \* FINANCIAL PERFORMANCE  
ORGANIZATIONAL VALUES: \* SERVICE \* EXCELLENCE \* RESOURCES \* VALUE \* INNOVATION \* COMPASSIONATE CARE \* ETHICS STATEMENT OF COMMUNITY  
COMMITMENT: TJHC IS A NONPROFIT, CHARITABLE CORPORATION OPERATED FOR THE SOLE PURPOSE OF PROMOTING AND PROVIDING FOR THE HEALTH OF THE PEOPLE IN ITS SERVICE AREA. IT DOES SO BY MAKING SURE THAT NECESSARY HOSPITAL AND HEALTH SERVICES, APPROPRIATE FOR THE SIZE OF THE COMMUNITY, ARE AVAILABLE TO ALL ON A COST-EFFECTIVE BASIS, WITHOUT REGARD TO THEIR ABILITY TO PAY. THESE INCLUDE SUCH ESSENTIAL SERVICES SUCH AS A 24-HOUR EMERGENCY ROOM, OBSTETRICS, CRITICAL CARE CAPABILITIES, AND DISASTER PREPAREDNESS. TO BE ABLE TO CONTINUE TO OFFER THESE SERVICES AT A LEVEL OF SAFETY THE

**Part VI Supplemental Information**

Provide the following information

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7, Part II and Part III, lines 2, 3, 4, 8 and 9b
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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COMMUNITY HAS A RIGHT TO EXPECT, THIS ORGANIZATION MUST BE ABLE TO  
GENERATE SUFFICIENT VOLUME AND SUFFICIENT REVENUE TO SUPPORT THOSE  
ESSENTIAL SERVICES WHICH, DUE TO INSUFFICIENT REIMBURSEMENT OR HIGH  
EXPENSES ASSOCIATED WITH THE TYPE OF SERVICE OR PATIENT INVOLVED, CANNOT  
SUSTAIN THEMSELVES. IT MUST ALSO RELY ON THE SUPPORT OF A HIGH QUALITY  
STAFF OF PHYSICIANS, NURSES AND OTHER PROFESSIONALS WHO NOT ONLY DELIVER  
CARE, BUT ALSO MONITOR AND WORK TO IMPROVE THE QUALITY AND EFFECTIVENESS  
OF THE SERVICES PROVIDED TO THE COMMUNITY. ALL POLICIES AND ACTIONS OF  
TJHC SHALL BE IN FURTHERANCE OF IDENTIFYING AND MEETING THE HEALTH NEEDS  
OF THOSE THAT WE SERVE. WITH DEDICATED STAFF POSITIONED LOCALLY, THE  
COMMUNITY CAN BE ASSURED ACCESS TO PRIMARY CARE. PHYSICIANS STRATEGICALLY  
ALIGNED WITH THE RURAL PROVIDER CAN SUCCESSFULLY MANAGE THEIR PRACTICE AND  
THE HEALTH OF THE LOCAL COMMUNITY. PAST STRATEGIES RECOMMENDED THAT RURAL  
HOSPITALS AFFILIATE WITH LARGER, URBAN HOSPITALS OR HEALTH SYSTEMS TO  
INCREASE THE FACILITY'S ACCESS TO CAPITAL, ADVANCED HEALTH CARE AND  
IMPROVED COMMUNITY HEALTH OPTIONS. TO DIRECTLY INFLUENCE ITS OWN  
OPERATIONS, THE DEVELOPMENT OF STRONG SPECIALTY CLINICS SHOULD INCREASE  
ANCILLARY UTILIZATION AND IMPROVE LOCAL CONFIDENCE IN THE HOSPITAL'S

**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

ABILITY TO MEET THE LOCAL COMMUNITY'S HEALTH DEMANDS. IN ORDER TO MEET INCREASED DEMAND FOR ANCILLARY SERVICES, RURAL HOSPITALS NEED TO EXPAND AND GROW OUTPATIENT BUSINESS. THIS IS DONE SO BY PURCHASING THE TECHNOLOGY AND LABORATORY EQUIPMENT TO KEEP TESTING IN- HOUSE. BY EXPANDING THE OUTPATIENT SERVICES OFFERED TO THE COMMUNITY AND INVESTING IN THE EQUIPMENT TO PROVIDE THOSE SERVICES, A RURAL HOSPITAL IS ABLE TO TAKE FULL ADVANTAGE OF THE BUSINESS DRIVEN BY THE SPECIALTY CLINICS. MARKETING A SITUATION WHERE YOUR CARE CAN BE MANAGED LOCALLY DRIVES FACILITY CONFIDENCE LOCALLY. THE COMMUNITY WILL BE AWARE OF THE MANY SERVICES AVAILABLE THROUGH THE HOSPITAL, ITS OUTPATIENT CENTERS AND ITS SPECIALTY CLINICS. THE AGING COMMUNITY OPENS THE DOOR TO INCREASED DEMAND FOR SUB-ACUTE HEALTHCARE. HOME HEALTH, SKILLED NURSING, AND REHABILITATION SERVICES PROVIDE AN INPATIENT HOSPITAL WITH A CONTINUUM OF CARE TO SERVE THE COMMUNITY BEYOND THE ACUTE ENVIRONMENT. EVEN IF A RESIDENT NEEDS TO SEEK SPECIALTY CARE OUT OF MARKET, EXTENSIVE SUB-ACUTE SERVICES WILL RETURN THE PATIENT TO THEIR COMMUNITY WHERE THEY ARE COMFORTABLE AND FAMILIAR TO THE SURROUNDINGS. TJHC IS VERY INVOLVED IN THE COMMUNITY. \*

AMERICAN CANCER SOCIETY-RELAY FOR LIFE \* AMERICAN HEART ASSOCIATION-HEART

**Part VI Supplemental Information**

Provide the following information

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7, Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B
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WALK AND WEAR RED DAY \* HEALTH EDUCATION THEATRE \* MARCH OF DIMES WALK  
AMERICA \* SUSAN G. KOMEN \* UNITED WAY \* LINDSEY WILSON COLLEGE

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PART VI, LINE 6:

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AFFILIATED HEALTH CARE SYSTEM: TJ REGIONAL HEALTH INC. : AS OF DECEMBER  
2015, TJHC BECAME A SUBSIDIARY OF T. J. REGIONAL HEALTH, INC. THIS  
ORGANIZATION SERVES AS THE PARENT ORGANIZATION AND WAS FORMED TO HELP  
FACILITATE THE ORGANIZATIONS PLANS TO BECOME MORE REGIONALLY FOCUSED. TJHC  
ALONG WITH T.J. SAMSON COMMUNITY HOSPITAL AND T. J. HEALTH PARTNERS, LLC  
ARE ALL SUBSIDIARIES OF T. J. REGIONAL HEALTH, INC. T. J. HEALTH  
PARTNERS, LLC. OPERATES PHYSICIAN CLINICS THAT INCLUDE FAMILY MEDICINE,  
INTERNAL MEDICINE, CARDIOLOGY, UROLOGY, NEUROLOGY, GYNECOLOGY AND PAIN  
MANAGEMENT. T. J. HEALTH PARTNERS, LLC IS A PHYSICIAN MULTI-SPECIALTY  
CLINIC THAT OFFERS PATIENTS EASY ACCESS TO CARE. THE COMPREHENSIVE  
SERVICES ALLOW PATIENTS TO REMAIN IN THE COMMUNITY FOR THEIR HEALTHCARE  
NEEDS. T.J. SAMSON COMMUNITY HOSPITAL IS A 196-BED, ACUTE-CARE FACILITY  
PROVIDING HEALTHCARE SERVICES TO BARREN AND SURROUNDING COUNTIES. AS  
COMMUNITY NEEDS ARE IDENTIFIED, ONGOING EFFORTS WILL BE MADE TO EXPAND THE

**Part VI Supplemental Information**

Provide the following information

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7, Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B
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- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report

OFFERINGS. SPECIALTIES RANGE FROM PRIMARY CARE TO INVASIVE/INTERVENTIONAL CARDIOLOGY, UROLOGY, PULMONARY, ONCOLOGY, AND NEUROLOGY. EACH OFFICE IS DESIGNED TO MEET AS MANY OF THE PATIENT'S NEEDS IN THE OFFICE SETTING AS POSSIBLE. T.J. HEALTH PAVILION IS AN OUTPATIENT SERVICE FACILITY OWNED AND OPERATED BY T.J. SAMSON COMMUNITY HOSPITAL AND IS DESIGNED TO MEET THE DEMAND OF RISING OUTPATIENT VOLUMES. THE T.J. HEALTH PAVILION HOUSES THE PHYSICIAN GROUP OF T.J. HEALTH PARTNERS AND THE OUTPATIENT SERVICES OF T.J. SAMSON COMMUNITY HOSPITAL. THE FACILITY ALLOWS THE COMMUNITY ACCESS TO A WIDE ARRAY OF SERVICES AND TECHNOLOGY ALL LOCATED IN ONE CONVENIENT LOCATION. SERVICES AND SPECIALTIES INCLUDE; REHABILITATION, DIALYSIS, URGENT CARE SERVICES, LABORATORY, RADIOLOGY, PRIMARY CARE, ONCOLOGY, UROLOGY, PAIN MANAGEMENT, SURGERY PHYSICIANS, OBSTETRICS AND GYNECOLOGY, CARDIOLOGY, AND NEPHROLOGY. T.J. HEALTH COLUMBIA IS A 74-BED, (25 FOR BHU AND 49 FOR ACUTE-CARE) FACILITY PROVIDING HEALTHCARE SERVICES TO ADAIR AND SURROUNDING COUNTIES. THE BHU UNIT WAS CLOSED IN JULY OF 2018.

**SCHEDULE J**  
**(Form 990)**

## Compensation Information

OMB No 1545-0047

2016

**Open to Public  
Inspection**

Department of the Treasury  
Internal Revenue Service

**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.

Name of the organization

► **Information about Schedule J (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).**

**Employer identification number**

81-0893103

**TJ HEALTH COLUMBIA, INC.**

**Part I Questions Regarding Compensation**

	Yes	No
<b>1a</b> Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items		
<input type="checkbox"/> First-class or charter travel	<input type="checkbox"/> Housing allowance or residence for personal use	
<input type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence	
<input type="checkbox"/> Tax indemnification and gross-up payments	<input type="checkbox"/> Health or social club dues or initiation fees	
<input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (such as, maid, chauffeur, chef)	
<b>b</b> If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain		
<b>2</b> Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked on line 1a?		
<b>3</b> Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.		
<input type="checkbox"/> Compensation committee	<input type="checkbox"/> Written employment contract	
<input type="checkbox"/> Independent compensation consultant	<input type="checkbox"/> Compensation survey or study	
<input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Approval by the board or compensation committee	
<b>4</b> 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		
<b>a</b> Receive a severance payment or change-of-control payment?	4a	X
<b>b</b> Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b	X
<b>c</b> Participate in, or receive payment from, an equity-based compensation arrangement?	4c	X
If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III		
<b>Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</b>		
<b>5</b> 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		
<b>a</b> The organization?	5a	X
<b>b</b> Any related organization?	5b	X
If "Yes" on line 5a or 5b, describe in Part III		
<b>6</b> 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		
<b>a</b> The organization?	6a	X
<b>b</b> Any related organization?	6b	X
If "Yes" on line 6a or 6b, describe in Part III		
<b>7</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described on lines 5 and 6? If "Yes," describe in Part III	7	X
<b>8</b> Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	8	X
<b>9</b> If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9	X

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

Schedule J (Form 990) 2016

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

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

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

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) ALLISON CAMPBELL, M.D. DIRECTOR/CHIEF OF STAFF	(i) 0. (ii) 244,971.	(ii) 0. (ii) 0.	(iii) 0. (iii) 9,262.	(C) 0. (C) 10,175.	(D) 0. (D) 0.	(E) 0. (E) 264,408.	(F) 0. (F) 0.
(2) WILLIAM KLAPEKE, M.D. DIRECTOR/VICE CHIEF OF STA	(i) 0. (ii) 383,671.	(ii) 0. (ii) 117,920.	(iii) 0. (iii) 5,585.	(C) 0. (C) 9,250.	(D) 0. (D) 18,165.	(E) 0. (E) 534,591.	(F) 0. (F) 0.
(3) BRIAN WETHINGTON CHIEF EXECUTIVE OFFICER	(i) 0. (ii) 394,813.	(ii) 0. (ii) 50,062.	(iii) 0. (iii) 15,315.	(C) 0. (C) 10,070.	(D) 0. (D) 12,342.	(E) 0. (E) 482,602.	(F) 0. (F) 0.
(4) NEIL THORNBURY CHIEF OPERATING OFFICER	(i) 0. (ii) 252,807.	(ii) 0. (ii) 0.	(iii) 0. (iii) 858.	(C) 0. (C) 18,843.	(D) 0. (D) 10,233.	(E) 0. (E) 282,741.	(F) 0. (F) 0.
(5) CLINTON KITECK PHYSICIAN	(i) 203,968. (ii) 0.	(ii) 26,235. (ii) 0.	(iii) 7,521. (iii) 0.	(C) 6,595. (C) 0.	(D) 0. (D) 13,532.	(E) 0. (E) 257,851.	(F) 0. (F) 0.
(6) NAIR HARIKRISHNAN PHYSICIAN	(i) 0. (ii) 595,971.	(ii) 0. (ii) 554,490.	(iii) 0. (iii) 840.	(C) 0. (C) 10,168.	(D) 0. (D) 15,440.	(E) 0. (E) 1,176,909.	(F) 0. (F) 0.
(7) VENKATA REDDY PHYSICIAN	(i) 0. (ii) 815,376.	(ii) 0. (ii) 163,205.	(iii) 0. (iii) 3,912.	(C) 0. (C) 10,600.	(D) 0. (D) 11,103.	(E) 0. (E) 1,004,196.	(F) 0. (F) 0.
(8) CARLOS KUMMERFELDT PHYSICIAN	(i) 0. (ii) 396,267.	(ii) 0. (ii) 390,600.	(iii) 0. (iii) 672.	(C) 0. (C) 8,013.	(D) 0. (D) 13,200.	(E) 0. (E) 808,752.	(F) 0. (F) 0.
(9) DONALD GOODIN PHYSICIAN	(i) 0. (ii) 491,726.	(ii) 0. (ii) 157,438.	(iii) 0. (iii) 21,260.	(C) 0. (C) 9,523.	(D) 0. (D) 13,561.	(E) 0. (E) 693,508.	(F) 0. (F) 0.
(10)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(11)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(12)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(13)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(14)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(15)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(16)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(17)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(18)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(19)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(20)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(21)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(22)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(23)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(24)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(25)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(26)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(27)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(28)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(29)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(30)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(31)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(32)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(33)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(34)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(35)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(36)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(37)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(38)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(39)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(40)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(41)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(42)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(43)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(44)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(45)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(46)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(47)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(48)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(49)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(50)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(51)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(52)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(53)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(54)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(55)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(56)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(57)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(58)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(59)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(60)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(61)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(62)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(63)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(64)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(65)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(66)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(67)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(68)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(69)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(70)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(71)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(72)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(73)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(74)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(75)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(76)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(77)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(78)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(79)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(80)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(81)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(82)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(83)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(84)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(85)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(86)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(87)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(88)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(89)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(90)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(91)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(92)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(93)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(94)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(95)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(96)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(97)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(98)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(99)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(100)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(101)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(102)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(103)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(104)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(105)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(106)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(107)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(108)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(109)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(110)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(111)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(112)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(113)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(114)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(115)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(116)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(117)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(118)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(119)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(120)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(121)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(122)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(123)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(124)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(125)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(126)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(127)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(128)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(129)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(130)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(131)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(132)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(133)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(134)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(135)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(136)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(137)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(138)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(139)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(140)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(141)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(142)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(143)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(144)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(145)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(146)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(147)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(148)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(149)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(150)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(151)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(152)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(153)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(154)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(155)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(156)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(157)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(158)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(159)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(160)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(161)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(162)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(163)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(164)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(165)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(166)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(167)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(168)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(169)	(i)	(ii)	(iii)	(C)	(D)	(E)	(F)
(170)	(i)	(ii)	(iii)	(C)			

**Part III** Supplemental Information

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

**PART I, LINE 3:**

THE ORGANIZATION'S OFFICERS ARE PAID BY A RELATED ORGANIZATION.

**PART I, LINE 7:**

PHYSICIANS ARE ELIGIBLE FOR INCENTIVE COMPENSATION. PHYSICIANS MAY EARN ADDITIONAL COMPENSATION THROUGH QUARTERLY PRODUCTIVITY BONUSES THAT ARE BASED ON THE CALCULATED DIFFERENCE OF ACTUAL WRVUS FOR THE QUARTER LESS A WRVU QUARTERLY TARGET.

## Supplemental Information to Form 990 or 990-EZ

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

► Attach to Form 990 or 990-EZ.

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

Name of the organization

TJ HEALTH COLUMBIA, INC.

Employer identification number  
81-0893103

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

WE SERVE AND THE HEALTHCARE PROFESSIONALS WHO SERVE THEM.

### FORM 990, PART III, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

PROVIDE INPATIENT AND OUTPATIENT HOSPITAL AND ANCILLARY HEALTH CARE  
SERVICES TO THE COMMUNITY OF COLUMBIA, KENTUCKY, ADAIR COUNTY AND THE  
SOUTH-CENTRAL REGION OF KENTUCKY, REGARDLESS OF ANY PATIENT'S ABILITY  
TO PAY.

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

THE 990 IS REVIEWED BY THE CEO AND CFO BEFORE FILED.

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

YEARLY THE BOARD REVIEWS THE POLICY AND ENSURES COMPLIANCE BY ALL MEMBERS.  
EACH MEMBER MUST ANNUALLY DISCLOSE COMPLIANCE.

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

THE HOSPITAL USES AN OUTSIDE THIRD PARTY AGENCY TO HELP DETERMINE  
COMPENSATION LEVELS

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

ALL DOCUMENTS ARE MADE AVAILABLE UPON REQUEST FROM THE ORGANIZATION.

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

PURCHASED SERVICES:

PROGRAM SERVICE EXPENSES

2,013,077.

Name of the organization <b>TJ HEALTH COLUMBIA, INC.</b>	Employer identification number <b>81-0893103</b>
<b>MANAGEMENT AND GENERAL EXPENSES</b>	<b>175,050.</b>
<b>FUNDRAISING EXPENSES</b>	<b>0.</b>
<b>TOTAL EXPENSES</b>	<b>2,188,127.</b>

## CONTRACT LABOR:

<u>PROGRAM SERVICE EXPENSES</u>	145,029.
<u>MANAGEMENT AND GENERAL EXPENSES</u>	12,611.
<u>FUNDRAISING EXPENSES</u>	0.
<u>TOTAL EXPENSES</u>	157,640.
TOTAL OTHER FEES ON FORM 990 PART IX LINE 11C COL A	2,345,767

FORM 990 - PART XII, LINE 2C. OVERSIGHT OF AUDIT:

THE BOARD OF DIRECTORS ASSUMES RESPONSIBILITY FOR OVERSIGHT OF THE  
AUDIT OF THE FINANCIAL STATEMENTS AND NO PROCESSES HAVE CHANGED FROM  
THE PRIOR YEAR.

**SCHEDULE R**  
**(Form 890)**

Department of the Treasury  
Internal Revenue Service

### **Related Organizations and Unrelated Partnerships**

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

OMB No 1545-0047

2016  
Open to Public

**Open to Public  
Inspection**

Name of the organization

TJ HEALTH COLUMBIA, INC.

Employer identification number  
81-0893103

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
TJ REGIONAL HEALTH INC - 27-3988336 1301 NORTH RACE STREET GLASGOW, KY 42141	PARENT ORGANIZATION OF HEALTHCARE FACILITY	KENTUCKY	501(C)(3)	LINE 12B, II			X
TJ HEALTH PARTNERS, LLC - 27-3988456 1301 NORTH RACE STREET GLASGOW, KY 42141	PHYSICIAN CLINICS	KENTUCKY	501(C)(3)	LINE 10	TJ REGIONAL HEALTH INC		X
TJ SAMSON COMMUNITY HOSPITAL - 61-0461767 1301 NORTH RACE STREET GLASGOW, KY 42141	HOSPITAL	KENTUCKY	501(C)(3)	LINE 3	TJ REGIONAL HEALTH INC		X
TJ COMMUNITY MISSION FOUNDATION - 47-2208322 1301 NORTH RACE STREET GLASGOW, KY 42141	FOUNDATION	KENTUCKY	501(C)(3)	LINE 10	TJ REGIONAL HEALTH INC		X

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

**Schedule R (Form 990) 2016**

**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

**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

## 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?

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

	Yes	No
1a	X	
1b	X	
1c	X	
1d	X	
1e	X	
1f	X	
1g	X	
1h	X	
1i	X	
1j	X	
1k	X	
1l	X	
1m	X	
1n	X	
1o	X	
1p	X	
1q	X	
1r	X	
1s	X	

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

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

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

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

## Part VII Supplemental Information.

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