

Form **990**
Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

OMB No 1545-0047
2017
Open to Public Inspection

A For the 2017 calendar year, or tax year beginning 01-01-2017, and ending 12-31-2017

- B** Check if applicable:
 Address change
 Name change
 Initial return
 Final return/terminated
 Amended return
 Application pending

C Name of organization
WESTFIELDS HOSPITAL INC

Doing business as

Number and street (or P O box if mail is not delivered to street address) Room/suite
8170 33RD AVENUE SOUTH PO BOX 1309

City or town, state or province, country, and ZIP or foreign postal code
MINNEAPOLIS, MN 554401309

F Name and address of principal officer
STEVEN M MASSEY
8170 33RD AVENUE SOUTH PO BOX 1309
MINNEAPOLIS, MN 554401309

D Employer identification number
39-0808442

E Telephone number
(952) 883-6584

G Gross receipts \$ 59,051,787

H(a) Is this a group return for subordinates? Yes No
H(b) Are all subordinates included? Yes No
If "No," attach a list (see instructions)
H(c) Group exemption number ▶

- I** Tax-exempt status 501(c)(3) 501(c) () ◀ (insert no) 4947(a)(1) or 527
- J** Website: ▶ WWW.HEALTHPARTNERS.COM
- K** Form of organization Corporation Trust Association Other ▶

L Year of formation 1950 **M** State of legal domicile WI

Part I Summary

1 Briefly describe the organization's mission or most significant activities
SEE SCHEDULE O - PRIMARY EXEMPT PURPOSE AND ACHIEVEMENTS

2 Check this box if the organization discontinued its operations or disposed of more than 25% of its net assets

| | |
|--|-----|
| 3 Number of voting members of the governing body (Part VI, line 1a) | 17 |
| 4 Number of independent voting members of the governing body (Part VI, line 1b) | 8 |
| 5 Total number of individuals employed in calendar year 2017 (Part V, line 2a) | 443 |
| 6 Total number of volunteers (estimate if necessary) | 68 |
| 7a Total unrelated business revenue from Part VIII, column (C), line 12 | 0 |
| 7b Net unrelated business taxable income from Form 990-T, line 34 | 0 |

| | Prior Year | Current Year |
|---|------------|--------------|
| 8 Contributions and grants (Part VIII, line 1h) | 186,145 | 87,257 |
| 9 Program service revenue (Part VIII, line 2g) | 55,965,489 | 58,089,695 |
| 10 Investment income (Part VIII, column (A), lines 3, 4, and 7d) | 175,556 | 222,480 |
| 11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) | 398,901 | 375,304 |
| 12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12) | 56,726,091 | 58,774,736 |
| 13 Grants and similar amounts paid (Part IX, column (A), lines 1-3) | 82,480 | 66,070 |
| 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) | 32,538,573 | 36,159,979 |
| 16a Professional fundraising fees (Part IX, column (A), line 11e) | 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) | 20,186,554 | 21,831,922 |
| 18 Total expenses Add lines 13-17 (must equal Part IX, column (A), line 25) | 52,807,607 | 58,057,971 |
| 19 Revenue less expenses Subtract line 18 from line 12 | 3,918,484 | 716,765 |

| | Beginning of Current Year | End of Year |
|---|---------------------------|-------------|
| 20 Total assets (Part X, line 16) | 53,052,499 | 53,934,794 |
| 21 Total liabilities (Part X, line 26) | 19,303,996 | 19,086,803 |
| 22 Net assets or fund balances Subtract line 21 from line 20 | 33,748,503 | 34,847,991 |

Part II Signature Block

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

Sign Here
Signature of officer _____ Date 2018-11-13
DAVE A DZIUK TREASURER
Type or print name and title

Paid Preparer Use Only
Print/Type preparer's name MONROE JORDAN GIERL Preparer's signature MONROE JORDAN GIERL Date _____
Check if self-employed PTIN P01413237
Firm's name ▶ KPMG LLP Firm's EIN ▶ 13-5565207
Firm's address ▶ 4200 WELLS FARGO CTR 90 S7TH STREET Phone no (612) 305-5000
MINNEAPOLIS, MN 55402

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

WESTFIELDS HOSPITAL, IN PARTNERSHIP WITH OTHERS, WILL IMPROVE THE HEALTH OF OUR PATIENTS AND COMMUNITY BY PROVIDING HIGH QUALITY HEALTH CARE WHICH MEETS THE NEEDS OF ALL PEOPLE

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? Yes No

If "Yes," describe these new services on Schedule O

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? Yes No

If "Yes," describe these changes on Schedule O

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

4a (Code) (Expenses \$ 50,632,125 including grants of \$ 66,070) (Revenue \$ 57,990,390)
See Additional Data

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

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

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

4e Total program service expenses ▶ 50,632,125

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Table with columns for question ID, question text, and Yes/No response boxes. Includes sections for backup withholding, employee reporting, foreign accounts, prohibited tax shelter transactions, deductible contributions, and 501(c)(7), (12), and (29) organizations.

Part VI Governance, Management, and Disclosure For each "Yes" response to lines 2 through 7b below, and for a "No" response to lines 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O See instructions

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

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a Enter the number of voting members of the governing body at the end of the tax year (17); 1b Enter the number of voting members included in line 1a, above, who are independent (8); 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? (No); 3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? (No); 4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? (No); 5 Did the organization become aware during the year of a significant diversion of the organization's assets? (No); 6 Did the organization have members or stockholders? (Yes); 7a Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? (Yes); 7b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? (Yes); 8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: 8a The governing body? (Yes); 8b Each committee with authority to act on behalf of the governing body? (Yes); 9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O (No)

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

Table with 3 columns: Question, Yes, No. Rows include: 10a Did the organization have local chapters, branches, or affiliates? (No); 10b 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? (Yes); 11b 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 (Yes); 12b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? (Yes); 12c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done (Yes); 13 Did the organization have a written whistleblower policy? (Yes); 14 Did the organization have a written document retention and destruction policy? (Yes); 15 Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision? 15a The organization's CEO, Executive Director, or top management official (Yes); 15b Other officers or key employees of the organization (Yes); If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions); 16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year? (No); 16b If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?

Section C. Disclosure

Table with 3 columns: Question, Yes, No. Rows include: 17 List the States with which a copy of this Form 990 is required to be filed (WI); 18 Section 6104 requires an organization to make its Form 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply: [] Own website, [] Another's website, [X] 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: JASON J LUHRS CHIEF FINANCIAL OFFICER 535 HOSPITAL ROAD NEW RICHMOND, WI 54017 (715) 243-2852

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, or highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations

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

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

| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W- 2/1099-MISC) | (E) Reportable compensation from related organizations (W- 2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|---|--|---|-----------------------|---------|--------------|------------------------------|--------|---|--|---|
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| (1) ANGELA BRANDES MD DIRECTOR | 0 50 54 50 | X | | | | | | 0 | 292,365 | 38,966 |
| (2) GREG CHRISTENSON DIRECTOR | 0 25 | X | | | | | | 0 | 0 | 0 |
| (3) HEATHER MCABEE DIRECTOR | 0 25 | X | | | | | | 0 | 0 | 0 |
| (4) TOM MEWS CHAIR & DIRECTOR | 0 25 | X | | | | | | 0 | 0 | 0 |
| (5) ANNE MIKE DIRECTOR | 0 25 | X | | | | | | 0 | 0 | 0 |
| (6) JEFF MOBERG DIRECTOR | 0 25 | X | | | | | | 0 | 0 | 0 |
| (7) PATRICK OLSON DIRECTOR | 0 25 | X | | | | | | 0 | 0 | 0 |
| (8) JEFF REDMON DIRECTOR | 0 25 | X | | | | | | 0 | 0 | 0 |
| (9) JILL STEENIS DIRECTOR | 0 25 | X | | | | | | 0 | 0 | 0 |
| (10) AMY DEWANE DIRECTOR | 0 50 49 50 | X | | | | | | 0 | 352,955 | 51,172 |
| (11) ANDREW E DORWART MD DIRECTOR | 0 50 49 50 | X | | | | | | 0 | 481,126 | 36,065 |
| (12) DAVE A DZIUK DIRECTOR & TREASURER | 0 50 54 50 | X | | | | | | 0 | 654,806 | 223,250 |
| (13) ANTHONY C HECHT MD DIRECTOR | 0 50 54 50 | X | | | | | | 0 | 501,072 | 42,098 |
| (14) TYLER R SCHMIDTZ DIRECTOR | 0 50 39 50 | X | | | | | | 0 | 299,053 | 68,338 |
| (15) JASON LUHRS DIRECTOR & CFO | 0 50 49 50 | X | | X | | | | 0 | 209,275 | 61,093 |
| (16) STEVEN MASSEY DIRECTOR, PRESIDENT & CEO | 0 50 49 50 | X | | X | | | | 0 | 312,501 | 68,428 |
| (17) VINI MANCHANDA DIRECTOR | 0 50 49 50 | X | | | | | | 0 | 275,708 | 69,649 |

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

| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W-2/1099-MISC) | (E) Reportable compensation from related organizations (W-2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|---|--|---|-----------------------|---------|--------------|------------------------------|---------|--|---|---|
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| (18) DAVID DEGEAR MD VP - MEDICAL AFFAIRS | 0 50 64 50 | | | X | | | | 0 | 502,455 | 52,397 |
| (19) STEVE MUELLERLEILE VP - OPERATIONS & BUSINESS | 0 50 39 50 | | | X | | | | 0 | 161,143 | 32,111 |
| (20) HELEN A SATHRE VP - PATIENT SERVICES | 50 00 | | | X | | | | 200,335 | 0 | 25,076 |
| (21) MICHELE K RIEDEL PHARMACIST | 40 00 | | | | | X | | 143,772 | 0 | 0 |
| (22) CYNTHIA BLADER PHYSICIAN ASSISTANT | 40 00 | | | | | X | | 134,949 | 0 | 15,195 |
| (23) NICOLE M TROSEN PHARMACY MANAGER | 40 00 | | | | | X | | 138,745 | 0 | 16,157 |
| (24) JACQUELINE M NELSON PHARMACIST | 40 00 | | | | | X | | 133,806 | 0 | 36,743 |
| (25) KAY HANSON PHARMACIST | 40 00 | | | | | X | | 119,775 | 0 | 32,574 |
| 1b Sub-Total | | | | | | | | | | |
| 1c Total from continuation sheets to Part VII, Section A | | | | | | | | | | |
| 1d Total (add lines 1b and 1c) | | | | | | | 871,382 | 4,042,459 | | 869,312 |

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 ▶ 31

| | Yes | No |
|---|-----|----|
| 3 Did the organization list any former officer, director or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual | | No |
| 4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? If "Yes," complete Schedule J for such individual | Yes | |
| 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 | | No |

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 |
|---|--------------------------------|---------------------|
| DERRICK BUILDING SOLUTIONS LLC PO BOX 445 NEW RICHMOND, WI 54017 | CONSTRUCTION SERVICES | 3,998,907 |
| RIVER VALLEY ANESTHESIA INC PO BOX 118 NEW RICHMOND, WI 540170118 | ANESTHESIA SERVICES | 1,378,463 |
| CANCER CENTER OF WESTERN WISCONSIN 501 HOSPITAL RD NEW RICHMOND, WI 54017 | MEDICAL SERVICE | 532,039 |
| REGIONS HOSPITAL 640 JACKSON ST ST PAUL, MN 551012595 | MEDICAL SERVICE | 328,923 |
| SHARED MEDICAL TECHNOLOGY INC 202 W NEWTON ST RICE LAKE, WI 54868 | RADIOLOGY SERVICES | 281,086 |

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 ▶ 11

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 | 1a Federated campaigns | 1a | | | | | |
| | b Membership dues | 1b | | | | | |
| | c Fundraising events | 1c | | | | | |
| | d Related organizations | 1d | 53,980 | | | | |
| | e Government grants (contributions) | 1e | 4,960 | | | | |
| | f All other contributions, gifts, grants, and similar amounts not included above | 1f | 28,317 | | | | |
| | g Noncash contributions included in lines 1a-1f \$ _____ | | | | | | |
| | h Total. Add lines 1a-1f | | | 87,257 | | | |
| Program Service Revenue | | Business Code | | | | | |
| | 2a PATIENT SERVICES | 623000 | 57,990,390 | 57,990,390 | | | |
| | b DIETARY SERVICES | 900099 | 99,305 | | | 99,305 | |
| | c _____ | | | | | | |
| | d _____ | | | | | | |
| | e _____ | | | | | | |
| | f All other program service revenue | | | | | | |
| g Total. Add lines 2a-2f | | | 58,089,695 | | | | |
| Other Revenue | 3 Investment income (including dividends, interest, and other similar amounts) | | 222,480 | | | 222,480 | |
| | 4 Income from investment of tax-exempt bond proceeds | | | | | | |
| | 5 Royalties | | | | | | |
| | 6a Gross rents | (i) Real | (ii) Personal | | | | |
| | | 609,447 | | | | | |
| | | b Less rental expenses | 277,051 | | | | |
| | | c Rental income or (loss) | 332,396 | | | | |
| | d Net rental income or (loss) | | | 332,396 | | 332,396 | |
| | 7a Gross amount from sales of assets other than inventory | (i) Securities | (ii) Other | | | | |
| | | | | | | | |
| | | b Less cost or other basis and sales expenses | | | | | |
| | | c Gain or (loss) | | | | | |
| | d Net gain or (loss) | | | | | | |
| | 8a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18 | a | | | | | |
| | | b Less direct expenses | b | | | | |
| c Net income or (loss) from fundraising events | | | | | | | |
| 9a Gross income from gaming activities See Part IV, line 19 | a | | | | | | |
| | b Less direct expenses | b | | | | | |
| | c Net income or (loss) from gaming activities | | | | | | |
| 10a Gross sales of inventory, less returns and allowances | a | | | | | | |
| | b Less cost of goods sold | b | | | | | |
| | c Net income or (loss) from sales of inventory | | | | | | |
| Miscellaneous Revenue | Business Code | | | | | | |
| 11a GIFT SHOP | 453220 | 36,870 | | | 36,870 | | |
| b OTHER INCOME | 900099 | 6,038 | | | 6,038 | | |
| c _____ | | | | | | | |
| d All other revenue | | | | | | | |
| e Total. Add lines 11a-11d | | | 42,908 | | | | |
| 12 Total revenue. See Instructions | | | 58,774,736 | 57,990,390 | 0 | 697,089 | |

Part IX Statement of Functional Expenses

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

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

| Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII. | (A) Total expenses | (B) Program service expenses | (C) Management and general expenses | (D) Fundraising expenses |
|--|-----------------------|---------------------------------|--|-----------------------------|
| 1 Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21 | 66,070 | 66,070 | | |
| 2 Grants and other assistance to domestic individuals See Part IV, line 22 | | | | |
| 3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, line 15 and 16 | | | | |
| 4 Benefits paid to or for members | | | | |
| 5 Compensation of current officers, directors, trustees, and key employees | 225,411 | 225,411 | | |
| 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 | 31,806,562 | 27,957,782 | 3,848,780 | |
| 8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions) | 621,756 | 552,510 | 69,246 | |
| 9 Other employee benefits | 2,139,485 | 1,895,354 | 244,131 | |
| 10 Payroll taxes | 1,366,765 | 1,214,545 | 152,220 | |
| 11 Fees for services (non-employees) | | | | |
| a Management | | | | |
| b Legal | 35,531 | | 35,531 | |
| c Accounting | | | | |
| d Lobbying | | | | |
| e Professional fundraising services See Part IV, line 17 | | | | |
| f Investment management fees | | | | |
| g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O) | 4,304,335 | 3,918,953 | 385,382 | |
| 12 Advertising and promotion | 265,487 | 10,672 | 254,815 | |
| 13 Office expenses | 507,063 | 366,122 | 140,941 | |
| 14 Information technology | 317,744 | 159,201 | 158,543 | |
| 15 Royalties | | | | |
| 16 Occupancy | 976,038 | 829,574 | 146,464 | |
| 17 Travel | 73,899 | 48,972 | 24,927 | |
| 18 Payments of travel or entertainment expenses for any federal, state, or local public officials | | | | |
| 19 Conferences, conventions, and meetings | 34,787 | 16,692 | 18,095 | |
| 20 Interest | 403,802 | 403,802 | | |
| 21 Payments to affiliates | | | | |
| 22 Depreciation, depletion, and amortization | 3,185,100 | 2,338,081 | 847,019 | |
| 23 Insurance | 185,087 | 185,087 | | |
| 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 | 5,989,270 | 5,984,780 | 4,490 | |
| b MEDICAL SUPPLIES | 2,885,822 | 2,877,426 | 8,396 | |
| c EQUIPMENT RENT/LEASE | 1,584,386 | 741,781 | 842,605 | |
| d MISCELLANEOUS | 505,758 | 428,349 | 77,409 | |
| e All other expenses | 577,813 | 410,961 | 166,852 | |
| 25 Total functional expenses. Add lines 1 through 24e | 58,057,971 | 50,632,125 | 7,425,846 | 0 |
| 26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720) | | | | |

Part X Balance Sheet

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

| | | (A) Beginning of year | | (B) End of year |
|---|---|--------------------------|------------|--------------------|
| Assets | 1 Cash—non-interest-bearing | 2,079,313 | 1 | 634,537 |
| | 2 Savings and temporary cash investments | 8,296,648 | 2 | 10,399,376 |
| | 3 Pledges and grants receivable, net | | 3 | |
| | 4 Accounts receivable, net | 7,001,879 | 4 | 6,615,836 |
| | 5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L | | 5 | |
| | 6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L | | 6 | |
| | 7 Notes and loans receivable, net | | 7 | |
| | 8 Inventories for sale or use | 724,218 | 8 | 707,597 |
| | 9 Prepaid expenses and deferred charges | 243,077 | 9 | 183,592 |
| | 10a Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D | 10a 45,057,450 | | |
| | b Less accumulated depreciation | 10b 21,263,192 | | |
| | | 21,597,539 | 10c | 23,794,258 |
| | 11 Investments—publicly traded securities | 7,772,993 | 11 | 8,135,910 |
| | 12 Investments—other securities See Part IV, line 11 | | 12 | |
| | 13 Investments—program-related See Part IV, line 11 | 385,000 | 13 | 395,235 |
| | 14 Intangible assets | 1,412,608 | 14 | 1,412,608 |
| 15 Other assets See Part IV, line 11 | 3,539,224 | 15 | 1,655,845 | |
| 16 Total assets. Add lines 1 through 15 (must equal line 34) | 53,052,499 | 16 | 53,934,794 | |
| Liabilities | 17 Accounts payable and accrued expenses | 9,538,672 | 17 | 9,537,728 |
| | 18 Grants payable | | 18 | |
| | 19 Deferred revenue | | 19 | |
| | 20 Tax-exempt bond liabilities | 9,765,324 | 20 | 9,549,075 |
| | 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 | | 25 | |
| | 26 Total liabilities. Add lines 17 through 25 | 19,303,996 | 26 | 19,086,803 |
| Net Assets or Fund Balances | 27 Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34. Unrestricted net assets | 33,748,503 | 27 | 34,847,991 |
| | 28 Temporarily restricted net assets | | 28 | |
| | 29 Permanently restricted net assets | | 29 | |
| | 30 Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34. Capital stock or trust principal, or current funds | | 30 | |
| | 31 Paid-in or capital surplus, or land, building or equipment fund | | 31 | |
| | 32 Retained earnings, endowment, accumulated income, or other funds | | 32 | |
| | 33 Total net assets or fund balances | 33,748,503 | 33 | 34,847,991 |
| | 34 Total liabilities and net assets/fund balances | 53,052,499 | 34 | 53,934,794 |

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 | 58,774,736 |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 58,057,971 |
| 3 | Revenue less expenses Subtract line 2 from line 1 | 3 | 716,765 |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | 33,748,503 |
| 5 | Net unrealized gains (losses) on investments | 5 | 382,723 |
| 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 | 34,847,991 |

Part XII Financial Statements and Reporting

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

| | Yes | No |
|---|-----|----|
| <p>1 Accounting method used to prepare the Form 990 <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____</p> <p>If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O</p> | | |
| <p>2a Were the organization's financial statements compiled or reviewed by an independent accountant?</p> <p>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</p> <p><input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis</p> | | No |
| <p>b Were the organization's financial statements audited by an independent accountant?</p> <p>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</p> <p><input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis</p> | Yes | |
| <p>c If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?</p> <p>If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O</p> | Yes | |
| <p>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?</p> | | No |
| <p>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</p> | | |

Additional Data

Software ID:

Software Version:

EIN: 39-0808442

Name: WESTFIELDS HOSPITAL INC

Form 990 (2017)

Form 990, Part III, Line 4a:

SEE SCHEDULE O - PRIMARY EXEMPT PURPOSE AND ACHIEVEMENTS FOR A DESCRIPTION OF PROGRAM SERVICE ACCOMPLISHMENTS

SCHEDULE A
(Form 990 or 990-EZ)

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.
▶ Attach to Form 990 or Form 990-EZ.

2017

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

Name of the organization
WESTFIELDS HOSPITAL INC

Employer identification number

39-0808442

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

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

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

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

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

(Complete only if you checked the box on line 5, 7, 8, or 9 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

| Calendar year (or fiscal year beginning in) ► | | (a) 2013 | (b) 2014 | (c) 2015 | (d) 2016 | (e) 2017 | (f) Total |
|--|---|----------|----------|----------|----------|----------|-----------|
| 1 | Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant") | | | | | | |
| 2 | Tax revenues levied for the organization's benefit and either paid to or expended on its behalf | | | | | | |
| 3 | The value of services or facilities furnished by a governmental unit to the organization without charge | | | | | | |
| 4 | Total. Add lines 1 through 3 | | | | | | |
| 5 | The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f) | | | | | | |
| 6 | Public support. Subtract line 5 from line 4 | | | | | | |

Section B. Total Support

| Calendar year (or fiscal year beginning in) ► | | (a) 2013 | (b) 2014 | (c) 2015 | (d) 2016 | (e) 2017 | (f) Total |
|--|--|----------|----------|----------|----------|-----------|-----------|
| 7 | Amounts from line 4 | | | | | | |
| 8 | Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources | | | | | | |
| 9 | Net income from unrelated business activities, whether or not the business is regularly carried on | | | | | | |
| 10 | Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI) | | | | | | |
| 11 | Total support. Add lines 7 through 10 | | | | | | |
| 12 | Gross receipts from related activities, etc (see instructions) | | | | | 12 | |

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

Section C. Computation of Public Support Percentage

| | | | |
|-----------|--|-----------|--|
| 14 | Public support percentage for 2017 (line 6, column (f) divided by line 11, column (f)) | 14 | |
| 15 | Public support percentage for 2016 Schedule A, Part II, line 14 | 15 | |

- 16a 33 1/3% support test—2017.** 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—2016.** 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—2017.** 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—2016.** 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) ► | | (a) 2013 | (b) 2014 | (c) 2015 | (d) 2016 | (e) 2017 | (f) Total |
|--|--|----------|----------|----------|----------|----------|-----------|
| 1 | Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.") | | | | | | |
| 2 | Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose | | | | | | |
| 3 | Gross receipts from activities that are not an unrelated trade or business under section 513 | | | | | | |
| 4 | Tax revenues levied for the organization's benefit and either paid to or expended on its behalf | | | | | | |
| 5 | The value of services or facilities furnished by a governmental unit to the organization without charge | | | | | | |
| 6 | Total. Add lines 1 through 5 | | | | | | |
| 7a | Amounts included on lines 1, 2, and 3 received from disqualified persons | | | | | | |
| b | Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year | | | | | | |
| c | Add lines 7a and 7b | | | | | | |
| 8 | Public support. (Subtract line 7c from line 6) | | | | | | |

Section B. Total Support

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

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

Section C. Computation of Public Support Percentage

| | | | |
|-----------|--|-----------|--|
| 15 | Public support percentage for 2017 (line 8, column (f) divided by line 13, column (f)) | 15 | |
| 16 | Public support percentage from 2016 Schedule A, Part III, line 15 | 16 | |

Section D. Computation of Investment Income Percentage

| | | | |
|-----------|--|-----------|--|
| 17 | Investment income percentage for 2017 (line 10c, column (f) divided by line 13, column (f)) | 17 | |
| 18 | Investment income percentage from 2016 Schedule A, Part III, line 17 | 18 | |

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

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

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

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? | | |
| 2 | Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization (s) or (ii) serving on the governing body of a supported organization? <i>If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s).</i> | | |
| 3 | By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? <i>If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.</i> | | |

Section E. Type III Functionally-Integrated Supporting Organizations

| | | | |
|----------|--|--|--|
| 1 | Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions) | | |
| a | <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below. | | |
| b | <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below. | | |
| c | <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions). | | |
| 2 | Activities Test Answer (a) and (b) below. | | |
| a | Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <i>If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.</i> | | |
| b | Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? <i>If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.</i> | | |
| 3 | Parent of Supported Organizations Answer (a) and (b) below. | | |
| a | Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>Provide details in Part VI.</i> | | |
| b | Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i> | | |

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

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

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

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

Additional Data

Software ID:

Software Version:

EIN: 39-0808442

Name: WESTFIELDS HOSPITAL INC

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

Facts And Circumstances Test

SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities
For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶Complete if the organization is described below. ▶Attach to Form 990 or Form 990-EZ.
▶Information about Schedule C (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

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2017
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If the organization answered "Yes" on Form 990, Part IV, Line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then
 ● Section 501(c)(3) organizations Complete Parts I-A and B Do not complete Part I-C
 ● Section 501(c) (other than section 501(c)(3)) organizations Complete Parts I-A and C below Do not complete Part I-B
 ● Section 527 organizations Complete Part I-A only
If the organization answered "Yes" on Form 990, Part IV, Line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then
 ● Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)) Complete Part II-A Do not complete Part II-B
 ● Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)) Complete Part II-B Do not complete Part II-A
If the organization answered "Yes" on Form 990, Part IV, Line 5 (Proxy Tax) (see separate instructions) or Form 990-EZ, Part V, line 35c (Proxy Tax) (see separate instructions), then
 ● Section 501(c)(4), (5), or (6) organizations Complete Part III

| | |
|---|--|
| Name of the organization WESTFIELDS HOSPITAL INC | Employer identification number 39-0808442 |
|---|--|

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

- 1 Provide a description of the organization's direct and indirect political campaign activities in Part IV (see instructions for definition of "political campaign activities")
- 2 Political campaign activity expenditures (see instructions) ▶ \$ _____
- 3 Volunteer hours for political campaign activities (see instructions) _____

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

- 1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ \$ _____
- 2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ \$ _____
- 3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? Yes No
- 4a Was a correction made? Yes No
- b If "Yes," describe in Part IV

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

- 1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ \$ _____
- 2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ \$ _____
- 3 Total exempt function expenditures Add lines 1 and 2 Enter here and on Form 1120-POL, line 17b ▶ \$ _____
- 4 Did the filing organization file **Form 1120-POL** for this year? Yes No
- 5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments For each organization listed, enter the amount paid from the filing organization's funds Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC) If additional space is needed, provide information in Part IV

| (a) Name | (b) Address | (c) EIN | (d) Amount paid from filing organization's funds If none, enter -0- | (e) Amount of political contributions received and promptly and directly delivered to a separate political organization If none, enter -0- |
|----------|-------------|---------|---|--|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |

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

- A** Check if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures)
- B** Check if the filing organization checked box A and "limited control" provisions apply

Limits on Lobbying Expenditures
(The term "expenditures" means amounts paid or incurred.)

| (a) Filing organization's totals | (b) Affiliated group totals |
|----------------------------------|-----------------------------|
|----------------------------------|-----------------------------|

- 1a** Total lobbying expenditures to influence public opinion (grass roots lobbying)
- b** Total lobbying expenditures to influence a legislative body (direct lobbying)
- c** Total lobbying expenditures (add lines 1a and 1b)
- d** Other exempt purpose expenditures
- e** Total exempt purpose expenditures (add lines 1c and 1d)
- f** Lobbying nontaxable amount Enter the amount from the following table in both columns

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

- g** Grassroots nontaxable amount (enter 25% of line 1f)
- h** Subtract line 1g from line 1a If zero or less, enter -0-
- i** Subtract line 1f from line 1c If zero or less, enter -0-
- j** If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?

| | |
|--|--|
| | |
| | |
| | |

Yes No

4-Year Averaging Period Under section 501(h)

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

Lobbying Expenditures During 4-Year Averaging Period

| Calendar year (or fiscal year beginning in) | (a) 2014 | (b) 2015 | (c) 2016 | (d) 2017 | (e) Total |
|--|----------|----------|----------|----------|-----------|
| 2a Lobbying nontaxable amount | | | | | |
| b Lobbying ceiling amount (150% of line 2a, column(e)) | | | | | |
| c Total lobbying expenditures | | | | | |
| d Grassroots nontaxable amount | | | | | |
| e Grassroots ceiling amount (150% of line 2d, column (e)) | | | | | |
| f Grassroots lobbying expenditures | | | | | |

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

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

| | (a) | | (b) |
|---|-----|----|--------|
| | Yes | No | Amount |
| 1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of | | | |
| a Volunteers? | | No | |
| b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)? | | No | |
| c Media advertisements? | | No | |
| d Mailings to members, legislators, or the public? | | No | |
| e Publications, or published or broadcast statements? | | No | |
| f Grants to other organizations for lobbying purposes? | | No | |
| g Direct contact with legislators, their staffs, government officials, or a legislative body? | | No | |
| h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means? | | No | |
| i Other activities? | Yes | | |
| j Total Add lines 1c through 1i | | | 0 |
| 2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)? | | No | |
| b If "Yes," enter the amount of any tax incurred under section 4912 | | | |
| c If "Yes," enter the amount of any tax incurred by organization managers under section 4912 | | | |
| d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year? | | | |

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

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

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

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

Part IV Supplemental Information

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

| Return Reference | Explanation |
|-------------------|--|
| PART II-B, LINE 1 | WESTFIELDS HOSPITAL, INC PAYS FOR CERTAIN CORPORATE AND EMPLOYEE PROFESSIONAL ASSOCIATION MEMBERSHIPS A PORTION OF SUCH MEMBERSHIP DUES POTENTIALLY COULD BE USED BY THE PROFESSIONAL ASSOCIATIONS FOR LOBBYING ACTIVITIES |

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.

OMB No 1545-0047
2017
Open to Public Inspection

Name of the organization
WESTFIELDS HOSPITAL INC

Employer identification number
39-0808442

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)

Preservation of land for public use (e g , recreation or education) Preservation of an historically important land area

Protection of natural habitat Preservation of a certified historic structure

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

| | Held at the End of the Year | |
|---|-----------------------------|--|
| 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? Yes 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)? Yes No

9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.
Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

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

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items

(i) Revenue included on Form 990, Part VIII, line 1 ▶ \$ _____

(ii) Assets included in Form 990, Part X ▶ \$ _____

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items

a Revenue included on Form 990, Part VIII, line 1 ▶ \$ _____

b Assets included in Form 990, Part X ▶ \$ _____

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

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

Part IV Escrow and Custodial Arrangements.

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

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

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

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

- 2** Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as
- a** Board designated or quasi-endowment ▶
 - b** Permanent endowment ▶
 - c** Temporarily restricted endowment ▶
- The percentages on lines 2a, 2b, and 2c should equal 100%
- 3a** Are there endowment funds not in the possession of the organization that are held and administered for the organization by
- | | | |
|--|------------|-----------|
| (i) unrelated organizations | Yes | No |
| 3a(i) | | |
| (ii) related organizations | | |
| 3a(ii) | | |
| b If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R? | | |
| 3b | | |
- 4** Describe in Part XIII the intended uses of the organization's endowment funds

Part VI Land, Buildings, and Equipment.

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

| Description of property | (a) Cost or other basis (investment) | (b) Cost or other basis (other) | (c) Accumulated depreciation | (d) Book value |
|---|--------------------------------------|---------------------------------|------------------------------|----------------|
| 1a Land | | 48,587 | | 48,587 |
| b Buildings | | 26,669,779 | 8,027,472 | 18,642,307 |
| c Leasehold improvements | | 75,957 | 36,107 | 39,850 |
| d Equipment | | 17,939,253 | 12,956,947 | 4,982,306 |
| e Other | | 323,874 | 242,666 | 81,208 |
| Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c)) . . . ▶ | | | | 23,794,258 |

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

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

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

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

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

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

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

| 1. (a) Description of liability | (b) Book value |
|--|----------------|
| (1) Federal income taxes | |
| (2) | |
| (3) | |
| (4) | |
| (5) | |
| (6) | |
| (7) | |
| (8) | |
| (9) | |
| Total. (Column (b) must equal Form 990, Part X, col (B) line 25) | ▶ |

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

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

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

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

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

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

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

Part XIII Supplemental Information

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

| Return Reference | Explanation |
|---------------------------|-------------|
| See Additional Data Table | |
| | |
| | |
| | |
| | |
| | |
| | |

Additional Data

Software ID:

Software Version:

EIN: 39-0808442

Name: WESTFIELDS HOSPITAL INC

Supplemental Information

| Return Reference | Explanation |
|------------------|---|
| PART X, LINE 2 | WESTFIELDS HOSPITAL, INC IS INCLUDED IN THE HEALTHPARTNERS, INC (HP) CONSOLIDATED AUDITED FINANCIAL STATEMENT HP'S ACCOUNTING POLICY PROVIDES THAT A TAX BENEFIT FROM AN UNCERTAIN TAX POSITION MAY BE RECOGNIZED WHEN IT IS MORE LIKELY THAN NOT THAT THE POSITION WILL BE SUSTAINED UPON EXAMINATION, INCLUDING RESOLUTIONS OF ANY RELATED APPEALS OR LITIGATION PROCESSES, BASED ON THE TECHNICAL MERITS HP RECORDED NO LIABILITIES AT DECEMBER 31, 2017 OR 2016 FOR UNRECOGNIZED TAX BENEFITS |

SCHEDULE H (Form 990)
 Department of the Treasury
 Internal Revenue Service

Hospitals

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, question 20.**
 ▶ **Attach to Form 990.**
 ▶ **Information about Schedule H (Form 990) and its instructions is at www.irs.gov/form990.**

OMB No 1545-0047
2017
Open to Public Inspection

Name of the organization
 WESTFIELDS HOSPITAL INC

Employer identification number
 39-0808442

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

7 Financial Assistance and Certain Other Community Benefits at Cost

| | (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 |
|--|---|-------------------------------|-------------------------------------|-------------------------------|-----------------------------------|------------------------------|
| Financial Assistance and Means-Tested Government Programs | | | | | | |
| a Financial Assistance at cost (from Worksheet 1) | | 202 | 375,067 | | 375,067 | 0 650 % |
| b Medicaid (from Worksheet 3, column a) | | 2,660 | 6,667,593 | 3,921,992 | 2,745,601 | 4 730 % |
| c Costs of other means-tested government programs (from Worksheet 3, column b) | | | | | | |
| d Total Financial Assistance and Means-Tested Government Programs | | 2,862 | 7,042,660 | 3,921,992 | 3,120,668 | 5 380 % |
| Other Benefits | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4) | | 1,571 | 242,304 | 2,939 | 239,365 | 0 410 % |
| f Health professions education (from Worksheet 5) | | | 156,075 | | 156,075 | 0 270 % |
| g Subsidized health services (from Worksheet 6) | | 23,520 | 3,118,058 | | 3,118,058 | 5 370 % |
| h Research (from Worksheet 7) | | | 40,549 | | 40,549 | 0 070 % |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | | | | | | |
| j Total. Other Benefits | | 25,091 | 3,556,986 | 2,939 | 3,554,047 | 6 120 % |
| k Total. Add lines 7d and 7j | | 27,953 | 10,599,646 | 3,924,931 | 6,674,715 | 11 500 % |

Part III Community Building Activities Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

| | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community building expense | (d) Direct offsetting revenue | (e) Net community building expense | (f) Percent of total expense |
|---|---|-------------------------------|--------------------------------------|-------------------------------|------------------------------------|------------------------------|
| 1 Physical improvements and housing | | | | | | |
| 2 Economic development | | | | | | |
| 3 Community support | 1 | | 1,115 | | 1,115 | 0 % |
| 4 Environmental improvements | 1 | | 977 | | 977 | 0 % |
| 5 Leadership development and training for community members | | | | | | |
| 6 Coalition building | | | | | | |
| 7 Community health improvement advocacy | | | | | | |
| 8 Workforce development | | | | | | |
| 9 Other | | | | | | |
| 10 Total | 2 | | 2,092 | | 2,092 | 0 % |

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

| | Yes | No |
|---|-------------|----|
| 1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? | 1 Yes | |
| 2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount. | 2 1,186,865 | |
| 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. | 3 375,067 | |
| 4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements. | | |

Section B. Medicare

| | |
|---|--------------|
| 5 Enter total revenue received from Medicare (including DSH and IME). | 5 17,161,075 |
| 6 Enter Medicare allowable costs of care relating to payments on line 5. | 6 17,161,075 |
| 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: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other | |

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures

| (a) Name of entity (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions) | (b) Description of primary activity of entity | (c) Organization's profit % or stock ownership % | (d) Officers, directors, trustees, or key employees' profit % or stock ownership % | (e) Physicians' profit % or stock ownership % |
|---|---|--|--|---|
| 1 1 CANCER CENTER OF WESTERN WISCONSIN | ONCOLOGY SERVICES | 23.680 % | 0 % | 0 % |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |
| 11 | | | | |
| 12 | | | | |
| 13 | | | | |

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

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

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

1

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

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

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group _____

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

| | | Yes | No |
|--|---|-----|----|
| Community Health Needs Assessment | | | |
| 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? | | No |
| 2 | Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C | | No |
| 3 | During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply) | Yes | |
| a | <input checked="" type="checkbox"/> A definition of the community served by the hospital facility | | |
| b | <input checked="" type="checkbox"/> Demographics of the community | | |
| c | <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | |
| d | <input checked="" type="checkbox"/> How data was obtained | | |
| e | <input checked="" type="checkbox"/> The significant health needs of the community | | |
| f | <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | |
| g | <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs | | |
| h | <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests | | |
| i | <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s) | | |
| j | <input type="checkbox"/> Other (describe in Section C) | | |
| 4 | Indicate the tax year the hospital facility last conducted a CHNA 20 <u>15</u> | | |
| 5 | In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge 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 | Yes | |
| 6 a | Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | Yes | |
| b | Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C | | No |
| 7 | Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply) | Yes | |
| a | <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>HTTP /LWWW WESTFIELDSHOSPITAL COM/HEALTH-WELLNESS-PROGRAMS/PROGRAMS/HEALTHI</u> | | |
| b | <input type="checkbox"/> Other website (list url) _____ | | |
| c | <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility | | |
| d | <input type="checkbox"/> Other (describe in Section C) | | |
| 8 | Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 | Yes | |
| 9 | Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>15</u> | | |
| 10 | Is the hospital facility's most recently adopted implementation strategy posted on a website? | Yes | |
| a | If "Yes" (list url) <u>HTTP /LWWW WESTFIELDSHOSPITAL COM/HEALTH-WELLNESS-PROGRAMS/PROGRAMS/HEALTHI</u> | | |
| b | If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? | | |
| 11 | Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed | | |
| 12a | Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? | | No |
| b | If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? | | |
| c | If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____ | | |

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

WESTFIELDS HOSPITAL INC

Name of hospital facility or letter of facility reporting group _____

| | | Yes | No |
|-----------|---|---------------|----|
| | Did the hospital facility have in place during the tax year a written financial assistance policy that | | |
| 13 | Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP | 13 Yes | |
| a | <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200 000000000000</u> % and FPG family income limit for eligibility for discounted care of <u>250 000000000000</u> % | | |
| b | <input type="checkbox"/> Income level other than FPG (describe in Section C) | | |
| c | <input checked="" type="checkbox"/> Asset level | | |
| d | <input checked="" type="checkbox"/> Medical indigency | | |
| e | <input checked="" type="checkbox"/> Insurance status | | |
| f | <input type="checkbox"/> Underinsurance discount | | |
| g | <input type="checkbox"/> Residency | | |
| h | <input type="checkbox"/> Other (describe in Section C) | | |
| 14 | Explained the basis for calculating amounts charged to patients? | 14 Yes | |
| 15 | Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply) | 15 Yes | |
| a | <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application | | |
| b | <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | |
| c | <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | |
| d | <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | |
| e | <input type="checkbox"/> Other (describe in Section C) | | |
| 16 | Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply) | 16 Yes | |
| a | <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>WWW WESTFIELDSHOSPITAL COM</u> | | |
| b | <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>WWW WESTFIELDSHOSPITAL COM</u> | | |
| c | <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>WWW WESTFIELDSHOSPITAL COM</u> | | |
| d | <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| e | <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| f | <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| g | <input checked="" type="checkbox"/> 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 checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations | | |
| j | <input type="checkbox"/> Other (describe in Section C) | | |

Part V Facility Information (continued)**Billing and Collections**

WESTFIELDS HOSPITAL INC

Name of hospital facility or letter of facility reporting group _____

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

WESTFIELDS HOSPITAL INC

Name of hospital facility or letter of facility reporting group _____

- 22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care
- a** The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
 - b** The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
 - c** The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
 - d** The hospital facility used a prospective Medicare or Medicaid method

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

| | Yes | No |
|-----------|-----|----|
| 23 | | No |
| 24 | | No |

Part V Facility Information *(continued)***Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

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

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

Part VI Supplemental Information

Provide the following information

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

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|-------------------------|--|
| PART I, LINE 7 | ACTUAL COSTS ESTIMATED USING COST-TO-CHARGE RATIO WORKSHEETS PROVIDED IN SCHEDULE H |
| PART I, LINE 7G | WESTFIELDS HOSPITAL, INC , (WESTFIELDS) IS COMMITTED TO PROVIDING NEEDED SERVICES EVEN AT A FINANCIAL LOSS IN 2017, LOSS ON SERVICES FOR HOSPITAL OUTPATIENT SERVICES INCLUDING EMERGENCY, RESPIRATORY THERAPY, PHYSICAL THERAPY, ONCOLOGY, SPECIALTY CLINIC, AND PRIMARY CLINIC TOTALED \$2,108,588 |

990 Schedule H, Information

| Form and Line Reference | Explanation |
|---|---|
| <p>PART II, COMMUNITY BUILDING ACTIVITIES</p> | <p>WESTFIELDS SUPPORTS INDIVIDUALS, ORGANIZATIONS, EVENTS AND PROGRAMS, IT LIVES OUT ITS COMMITMENT TO IMPROVE THE HEALTH OF THE COMMUNITY KNOWING MUCH MORE CAN BE ACCOMPLISHED TOGETHER, WESTFIELDS COMMUNITY BENEFIT PROGRAM STRIVES TO MAKE VALUABLE CONNECTIONS WITH INDIVIDUALS AND ORGANIZATIONS FROM PUBLIC, PRIVATE AND NONPROFIT SECTORS TO SHARE SKILLS AND ASSETS WESTFIELDS PARTICIPATED IN COMMUNITY-BUILDING ACTIVITIES THAT SUPPORTED ECONOMIC DEVELOPMENT TO IMPROVE THE BUSINESS CLIMATE IN THE REGION THESE ACTIVITIES INCLUDED EMERGENCY PREPAREDNESS AND YOUTH ASSET DEVELOPMENT INCLUDING DRUG AND SAFETY PREVENTION, LEADERSHIP DEVELOPMENT/CONFLICT RESOLUTION, HEALTH IMPROVEMENT ADVOCACY, WORKFORCE DEVELOPMENT AND COALITION BUILDING TO PROVIDE LEADERSHIP AND IN-KIND SUPPORT FOR HEALTHIER TOGETHER - PIERCE & ST CROIX COUNTIES AND THE CENTRE WELLNESS FACILITY AND LOCAL COMMUNITY HEALTH TO PROMOTE POSITIVE BEHAVIOR TO REDUCE OBESITY, WESTFIELDS HAS IMPLEMENTED POWERUP, A COMMUNITY-WIDE YOUTH HEALTH INITIATIVE TO MAKE BETTER EATING AND ACTIVE LIVING EASY, FUN, AND POPULAR, SO THAT OUR YOUTH CAN REACH THEIR FULL POTENTIAL ADDITIONAL PROGRAMS/ACTIVITIES INCLUDED NEW RICHMOND CHAMBER OF COMMERCE & THE CENTRE PARTNERSHIPS, VISION 2020 COMMUNITY GROUP, AND THE LEADERSHIP TRUST INITIATIVE - A PROGRAM DEDICATED TO PROMOTING AND DEVELOPING DYNAMIC BUSINESS AND COMMUNITY LEADERS IN SUPPORT OF "HEALTHY FOOD IN HEALTH CARE", LOCAL FARMS AND PROCUREMENT OF LOCAL FOOD, WESTFIELDS PARTICIPATED IN COMMUNITY SUPPORTED AGRICULTURE AND HOSTED WEEKLY FARMER'S MARKET EVENTS</p> |
| <p>SCHEDULE H, PART VI LINE 5 - PROMOTION OF COMMUNITY HEALTH</p> | <p>AS A NOT-FOR-PROFIT COMMUNITY HOSPITAL SERVING THE NEW RICHMOND AREA SINCE 1950, WESTFIELDS CONTINUES TO PLAY AN IMPORTANT ROLE AND IS POSITIONED WELL TO MEET THE HEALTH CARE NEEDS OF THE AREA WESTFIELDS IS A FULL-SERVICE MEDICAL CAMPUS OFFERING EMERGENCY SERVICES, SPECIALTY CLINICS, PHARMACY, AS WELL AS INPATIENT, OUTPATIENT AND MATERNITY SERVICES WESTFIELDS IS GOVERNED BY A BOARD OF DIRECTORS WITH REPRESENTATION FROM COMMUNITY MEMBERS WORKING IN PARTNERSHIP WITH EACH OTHER, WESTFIELDS, THE HEALTHPARTNERS FAMILY OF ORGANIZATIONS, AND THE COMMUNITY ACCOMPLISHED A GREAT DEAL IN 2017 ADVANCEMENTS WERE MADE IN SUPPORT OF THE TRIPLE AIM TO ENSURE BETTER HEALTH FOR ALL, IMPROVED PATIENT EXPERIENCE AND AFFORDABLE HEALTH CARE DEDICATED STAFF PROMOTE COMMUNITY HEALTH IN THE FOLLOWING WAYS FREE ON-GOING SUPPORT AND EDUCATION GROUPS IN BEREAVEMENT/ GRIEF, BREASTFEEDING, CANCER, DIABETES, NUTRITION AND WEIGHT MANAGEMENT AND CAREGIVERS, SCHOOL-BASED EDUCATION FOR ELEMENTARY AND SECONDARY SCHOOLS, TRAININGS FOR HEALTH CARE PROFESSIONALS AND NURSING STUDENTS, SELF-HELP PROGRAMMING FOLLOWING CARDIAC REHAB AND PHYSICAL THERAPY TO COMMUNITY MEMBERS WESTFIELDS ENCOURAGES PATIENTS AND THEIR FAMILIES - THEIR PARTNERS IN HEALTH - TO BE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR OWN HEALTH CARE RESEARCH SHOWS THAT PATIENTS AND THEIR FAMILIES WHO ARE MORE INVOLVED WITH THEIR CARE FEEL THEY GET BETTER RESULTS AND ARE MORE SATISFIED SAFETY AND SATISFACTION ARE PRIORITIES AT WESTFIELDS WESTFIELDS IS MORE THAN JUST A HOSPITAL TAKING CARE OF PATIENTS WHEN THEY ARE SICK OR HURT THE GOAL IS TO BE A LEADING PARTNER IN HEALTH EDUCATION, OUTREACH AND IMPROVEMENT WESTFIELDS IS CONTINUALLY MAKING IMPROVEMENTS TO REACH THAT GOAL BENEFITS TO PATIENTS AND THE COMMUNITY IN 2017WESTFIELDS' DEVOTION TO THE HEALTH OF THE COMMUNITY STARTS WITH PROVIDING EXCEPTIONAL MEDICAL CARE TO EACH PATIENT AND EXTENDS TO FAMILIES AND ORGANIZATIONS THROUGHOUT THE REGION THROUGH ITS COMMUNITY BENEFIT PROGRAM, WESTFIELDS OFFERED SPECIAL HELP AND SUPPORT - FOR INDIVIDUALS OR FAMILIES EXPERIENCING FINANCIAL HARDSHIP TO EFFORTS OR ORGANIZATIONS STRIVING TO IMPROVE THE QUALITY OF LIFE FOR ALL TOTAL 2017 COMMUNITY BENEFIT CONTRIBUTION EQUALED \$6,684,715, WHICH REPRESENTS 11.5% OF NET REVENUE THIS FIGURE IS REPORTED AT COST PER THE CATHOLIC HEALTH ASSOCIATION (CHA) COMMUNITY BENEFIT REPORTING 2017 ACCOMPLISHMENTS INCLUDE CLINIC GROWTH INCLUDED NEW OR EXPANDED SERVICES THAT INCLUDED BEHAVIORAL HEALTH, FAMILY MEDICINE, NEUROLOGY, CARDIOLOGY, AND ONCOLOGY THE ADDITIONS CREATED CONVENIENT ACCESS TO SPECIALIZED CARE THAT IS CLOSE TO HOME AND PHYSICIAN AVAILABILITY PRIMARY CARE CLINIC CONTINUED PROVIDING ALL CHILDREN 6 MONTHS TO 5 YEARS WITH A BOOK AT EVERY WELL-CHILD VISIT THROUGH THE REACH OUT AND READ PROGRAM PRIMARY CARE PROVIDERS HANDED OUT HUNDREDS OF PRESCRIPTIONS - GOOD FOR FREE FRESH FRUITS AND VEGETABLES FROM LOCAL GROCERY STORES - TO CHILDREN DURING THEIR WELL-CHILD VISIT TO PROMOTE EATING FIVE FRUITS AND VEGETABLES A DAY AND REDUCE THE RISK OF OBESITY RECOGNIZED BY PRACTICE GREENHEALTH, WITH AN AWARD FOR CONTINUED ADVANCEMENT FOR SUSTAINABLE PRACTICES AND THE GREENING THE OR AWARD FOR ENVIRONMENTALLY PREFERRED PRACTICES OUR SOLAR PANEL POWER INITIATIVE GENERATED ENOUGH ENERGY TO POWER THREE HOMES FOR A FULL YEAR APPROXIMATELY 350 PEOPLE ATTENDED OUR COMMUNITY HEALTH FAIR WHICH OFFERED HEARING, SKIN AND BLOOD PRESSURE SCREENINGS AND HEALTH INFORMATION THE ST CROIX VALLEY UNITED WAY SUCCESS BY 6 INITIATIVE AWARDED WESTFIELDS WITH GOLD-LEVEL CERTIFICATION FOR HAVING A WORK ENVIRONMENT THAT SUPPORTS EMPLOYEES AND THEIR FAMILIES FOR INPATIENTS, WESTFIELDS FOR THE THIRD TIME IN FOUR YEARS, WESTFIELDS WAS NAMED AS A TOP 100 CRITICAL ACCESS HOSPITAL BY IVANTAGE WHICH MEASURES 70 DIFFERENT PERFORMANCE METRICS, INCLUDING QUALITY, OUTCOMES, PATIENT PERSPECTIVE AFFORDABILITY, POPULATION RISK AND EFFICIENCY CONTINUED A VOLUNTEER-SUPPORTED PROGRAM - WESTFIELD'S ELDER LIFE PROGRAM OR HELP TO ASSIST IN PREVENTING DELIRIUM IN OLDER INPATIENTS SURGERY NURSES DEVELOPED AN EDUCATIONAL BOOK FOR CHILDREN TO HELP THEM PREPARE FOR SURGERY FOR OUTPATIENTS, WESTFIELDS IN 2017 MANY DEPARTMENTS HIT RECORD VOLUMES, 1800 MAMMOGRAMS, 7300 EMERGENCY DEPARTMENT VISITS, 7400 HEALTHSTATION VISITS, 6700 SPECIALTY CLINIC VISITS, AND 42,200 PRIMARY CARE CLINIC VISITS CONTINUED AN \$8.8 MILLION CAMPUS RENOVATION PROJECT WHICH ACCOMMODATES CAMPUS GROWTH AND ALLOWS FOR EXPANDED PATIENT ACCESS AND ADDITION OF NEW SERVICES IN REHABILITATION SERVICES, CARDIOPULMONARY SERVICES, SLEEP HEALTH, OUTPATIENT SURGICAL SERVICES AND EMERGENCY MEDICINE MOST AREAS WERE COMPLETED DURING 2017, WITH THE FINAL PHASE OF THE EMERGENCY DEPARTMENT PROJECT SET TO CONCLUDE IN EARLY IN 2018 PRENATAL PATIENTS NOW SEE BIRTH CENTER NURSES AT THEIR FIRST CLINIC APPOINTMENT, THE PRACTICE REDUCES WAIT TIMES WESTFIELDS WAS AWARDED THE CONTRACT TO PROVIDE ATHLETIC TRAINING AT NEW RICHMOND HIGH SCHOOL</p> |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|-------------------------|--|
| PART III, LINE 4 | BAD DEBT EXPENSE REPRESENTS THE UNPAID OBLIGATION FOR CARE PROVIDED TO PATIENTS WHO HAVE BEEN DETERMINED TO BE ABLE TO PAY, BUT HAVE NOT DEMONSTRATED A WILLINGNESS TO DO SO BAD DEBT INCLUDES ANY UNPAID PATIENT RESPONSIBILITY THAT MAY INCLUDE, BUT IS NOT LIMITED TO, DEDUCTIBLES, CO-INSURANCE, CO-PAYMENTS AND NON-COVERED SERVICES BAD DEBT EXPENSE IS CALCULATED USING THE COST TO CHARGE RATIO FROM THE WORKSHEETS PROVIDED IN SCHEDULE H INSTRUCTIONS BAD DEBT EXPENSE IS CURRENTLY EXCLUDED FROM THE COMMUNITY BENEFIT CALCULATION PER THE WISCONSIN HOSPITAL ASSOCIATION (WHA) |
| PART III, LINE 8 | MEDICARE SURPLUS (SHORTFALL) IN LINE 7 REPRESENTS THE ADDITIONAL 1% OF ALLOWABLE COST THAT CRITICAL ACCESS HOSPITALS RECEIVE MEDICARE SHORTFALL IS CURRENTLY EXCLUDED FROM THE COMMUNITY BENEFIT CALCULATION PER THE WHA, BUT CAN BE INCLUDED IN OTHER FINANCIAL REPORTS WESTFIELDS BASES ITS MEDICARE COSTING METHODOLOGY ON THE CMS MEDICARE COST REPORT METHODOLOGY, COST TO CHARGE RATIO |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|-------------------------|--|
| PART III, LINE 9B | WESTFIELDS' DEBT COLLECTION POLICY CONTAINS PROVISIONS ON COLLECTION PRACTICES TO BE FOLLOWED FOR PATIENTS WHO ARE KNOWN TO BE ELIGIBLE FOR FINANCIAL ASSISTANCE WESTFIELDS WILL NOT REFER ANY ACCOUNT TO A THIRD PARTY DEBT COLLECTION AGENCY UNLESS IT HAS CONFIRMED THAT THERE IS REASONABLE BASIS TO BELIEVE THAT THE PATIENT OWES THE DEBT, ALL KNOWN THIRD-PARTY PAYERS HAVE BEEN PROPERLY BILLED, AND THE PATIENT IS RESPONSIBLE FOR THE REMAINING DEBT |
| PART VI, LINE 2 | IN 2015, A COMPREHENSIVE, SIX-STEP COMMUNITY HEALTH NEEDS ASSESSMENT ("CHNA") COLLABORATION WAS CONDUCTED FOR HEALTHPARTNERS AND ITS HOSPITALS (REGIONS HOSPITAL, LAKEVIEW MEMORIAL HOSPITAL ASSOCIATION, HUDSON HOSPITAL, WESTFIELDS HOSPITAL, AMERY REGIONAL MEDICAL CENTER, AND PARK NICOLLET METHODIST HOSPITAL) BY COMMUNITY HOSPITAL CONSULTING TO DETERMINE THE GREATEST HEALTH NEEDS IN THE COMMUNITIES THEY SERVE THESE HOSPITALS SERVE SIMILAR COMMUNITIES AND HAVE OVERLAPPING STUDY AREAS THE SYSTEM'S STUDY AREA IS DEFINED AS DAKOTA, HENNEPIN, RAMSEY, SCOTT, AND WASHINGTON COUNTIES IN MINNESOTA AND POLK AND ST CROIX COUNTIES IN WISCONSIN WESTFIELDS' SPECIFIC STUDY AREA IS DEFINED AS - ST CROIX COUNTY DATA ELEMENTS REGARDING ALL SEVEN COUNTIES IN THE SYSTEM'S STUDY AREA ARE INCLUDED IN THIS REPORT FOR COMPARISON, AND ARE ALSO PROVIDED AS AN OPPORTUNITY FOR THE HOSPITALS TO WORK TOGETHER TO MEET THE NEEDS IDENTIFIED IN THE OVERLAPPING COUNTIES - DEMOGRAPHICS CHC CONSULTING ANALYZED THE MOST CURRENT DEMOGRAPHICS OF RESIDENTS IN ST CROIX COUNTY, INCLUDING OVERALL POPULATION, POPULATION BY RACE AND ETHNICITY, MEDIAN AGE, MEDIAN HOUSEHOLD INCOME, POVERTY LEVELS, FOOD INSECURITY, AND EDUCATIONAL ATTAINMENT - HEALTH DATA COLLECTION WESTFIELDS HOSPITAL PARTICIPATED IN A COUNTY-WIDE INITIATIVE TO ANALYZE THE HEALTH OF RESIDENTS IN THE COMMUNITY, THE ST CROIX COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPROVEMENT PLAN 2014-2016 - COMMUNITY INPUT AS A PART OF THE COUNTY-WIDE ASSESSMENT, COMMUNITY INPUT WAS ANALYZED THROUGH THE FOLLOWING METHODS COMMUNITY HEALTH ASSESSMENT AND GROUP EVALUATION (CHANGE) ASSESSMENT, TRANSFORM WISCONSIN PUBLIC OPINION POLL, AND THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) SURVEY FINAL PRIORITIZED NEEDS- MENTAL AND BEHAVIORAL HEALTH- ACCESS AND AFFORDABILITY- CHRONIC DISEASE AND ILLNESS PREVENTION- EQUITABLE CARE- A FULL REPORT OF WESTFIELDS' CHNA AND IMPLEMENTATION PLAN IS POSTED ON WESTFIELDS' WEBPAGE AT HTTP //WWW WESTFIELDSHOSPITAL COM/HEALTH-WELLNESS-PROGRAMS/PROGRAMS/HEALTHIER-TOGETHER/ |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|-------------------------|---|
| PART VI, LINE 3 | WESTFIELDS IS COMMITTED TO PROVIDING QUALITY MEDICAL CARE TO OUR PATIENTS, INCLUDING THOSE IN NEED OF FINANCIAL ASSISTANCE AS A RESULT, OUR FINANCIAL ASSISTANCE POLICY (REFERRED TO HEREIN AS "FAP OR "POLICY") IS AVAILABLE TO UNINSURED OR UNDERINSURED PATIENTS BASED ON THE PATIENT'S ABILITY TO PAY FOR EMERGENCY AND OTHER MEDICALLY NECESSARY CARE OUR POLICY IS AVAILABLE TO PROVIDE EPISODIC HELP, IT IS NOT MEANT TO PROVIDE LONG-TERM, FREE OR DISCOUNTED CARE OUR POLICY SETS FORTH AND DESCRIBES ELIGIBILITY CRITERIA, HOW WE CALCULATE DISCOUNTS, HOW TO APPLY FOR FINANCIAL ASSISTANCE, THE PROVIDERS DELIVERING CARE IN OUR HOSPITAL AND OUR EMERGENCY MEDICAL CARE POLICY PATIENTS CAN OBTAIN FREE COPIES OF THIS POLICY AT ALL PATIENT REGISTRATION LOCATIONS AT WESTFIELDS FOR ADDITIONAL INFORMATION OR QUESTIONS ABOUT THE APPLICATION PROCESS, OR TO REQUEST COPIES BY MAIL, PATIENTS CAN CONTACT OUR PATIENT FINANCIAL SERVICES DEPARTMENT AT 1-715-243-2600 FREE COPIES OF THIS POLICY AND THE FINANCIAL ASSISTANCE APPLICATION FORM ARE ALSO AVAILABLE AT HTTP //WWW WESTFIELDSHOSPITAL COM |
| PART VI, LINE 4 | WESTFIELDS SERVES RESIDENTS FROM ST CROIX COUNTY, WISCONSIN AND SURROUNDING COUNTIES OF POLK, DUNN AND PIERCE 2014 CENSUS LISTS THE POPULATION OF ST CROIX COUNTY AT 86,759, A 2.8% POPULATION GROWTH SINCE 2010 RAPID GROWTH CONTINUES WITHIN ST CROIX COUNTY, MUCH IN PART DUE TO ITS CLOSE PROXIMITY TO THE TWIN CITIES (MINNEAPOLIS/ST PAUL) WHERE MANY RESIDENTS COMMUTE TO WORK ST CROIX COUNTY'S POPULATION IS COMPRISED OF 28% UNDER 19, 12% 65 YEARS AND OVER THE POPULATION IS 95.6% WHITE, 1.0% BLACK, 1.0% AMERICAN INDIAN, 1.0% ASIAN AND 1.4% HISPANIC OR LATINO ST CROIX COUNTY HAS A HIGH MEDIAN INCOME COMPARATIVELY WITHIN THE STATE - \$69,641 AND A POVERTY RATE APPROXIMATELY HALF THAT OF THE REST OF THE STATE - 6.3% ACCORDING TO THE 2015 COUNTY HEALTH RANKINGS REPORT, ST CROIX COUNTY RANKED AS THE NINTH HEALTHIEST COUNTY OVERALL IN THE STATE (OUT OF 72 COUNTIES) |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|--|--|
| PART VI, LINE 6 | PLEASE SEE WESTFIELD' SCHEDULE O DISCUSSION OF EXEMPT PURPOSE AND ACHIEVEMENTS - "I CORPORATE STRUCTURE, PURPOSE, GOVERNANCE " |
| PART VI, LINE 7, REPORTS FILED WITH STATES | WI |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|---|---|
| SCHEDULE H - PART I, LINE 7F -HEALTH PROFESSIONS EDUCATION | WESTFIELDS STAFF PROVIDED CLINICAL TRAINING 75 HEALTH PROFESSIONALS FROM 22 INSTITUTIONS AT A COST OF \$156,075 |

Schedule H (Form 990) 2017

Additional Data**Software ID:****Software Version:****EIN:** 39-0808442**Name:** WESTFIELDS HOSPITAL INC**Form 990 Schedule H, Part V Section A. Hospital Facilities**

| Section A. Hospital Facilities | | Licensed hospital | General medical & surgical | Children's hospital | Teaching hospital | Critical access hospital | Research facility | ER-24 hours | ER-other | Other (Describe) | Facility reporting group |
|---|--|-------------------|----------------------------|---------------------|-------------------|--------------------------|-------------------|-------------|----------|------------------|--------------------------|
| (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? <u>1</u> | | | | | | | | | | | |
| Name, address, primary website address, and state license number | | | | | | | | | | | |
| 1 | WESTFIELDS HOSPITAL INC 535 HOSPITAL ROAD NEW RICHMOND, WI 54017 WWW.WESTFIELDSHOSPITAL.COM WISCONSIN LICENSE # 1050 | X | X | | | X | | X | | | |

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

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

| Form and Line Reference | Explanation |
|--------------------------|---|
| WESTFIELDS HOSPITAL, INC | <p>PART V, SECTION B, LINE 5 WESTFIELDS HOSPITAL (WESTFIELDS) IS AN INTEGRAL PART OF HEALTHIER TOGETHER - PIERCE & ST CROIX COUNTIES, AND SERVES AS ONE OF THE SIX PARTNERS IN THE COALITION AS PART OF THE DATA COLLECTION PROCESS FOR THE MOST RECENT CHNA THAT WAS CONDUCTED IN 2015, WESTFIELDS COLLABORATED EXTENSIVELY WITH THE COALITION TO CONDUCT - THE COMMUNITY HEALTH ASSESSMENT AND GROUP EVALUATION (CHANGE) TOOL, DEVELOPED BY CDC'S HEALTHY COMMUNITIES PROGRAM TO HELP ORGANIZE INFORMATION ON INDICATORS RELATED TO ENVIRONMENTS AND POLIES SUPPORTING HEALTH EATING, ACTIVE LIVING, AND CHRONIC DISEASE MANAGEMENT INTERVIEWS WERE CONDUCTED IN THE COMMUNITY AT LARGE, HEALTHCARE, AND SCHOOL SECTORS WITH OVER 25 KEY INFORMANTS - A PUBLIC OPINION POLL WITH THE HELP OF PUBLIC OPINION STRATEGIES THE PURPOSE OF THE POLL WAS TO EVALUATE PUBLIC SUPPORT FOR HEALTHIER TOGETHER'S EFFORTS TO PROMOTE HEALTHIER PLACES TO LIVE, WORK AND PLAY PUBLIC OPINION STRATEGIES COMPLETED THE SURVEY WITH 300 RANDOM ST CROIX ADULTS - A COMMUNITY HEALTH NEEDS ASSESSMENT ONLINE AND PAPER SURVEY, HEAVILY PROMOTED WITH PUBLIC HEALTH PROGRAM PARTICIPANTS FEEDBACK WAS RECEIVED BETWEEN JULY AND DECEMBER 2013 FROM - STATE, LOCAL, TRIBAL, OR REGIONAL GOVERNMENTAL PUBLIC HEALTH DEPARTMENT (OR EQUIVALENT DEPARTMENT OR AGENCY) WITH KNOWLEDGE, INFORMATION, OR EXPERTISE RELEVANT TO THE HEALTH NEEDS OF THE COMMUNITY - MEMBERS OF MEDICALLY UNDERSERVED, LOW-INCOME, AND MINORITY POPULATIONS IN THE COMMUNITY, OR INDIVIDUALS OR ORGANIZATIONS SERVING OR REPRESENTING THE INTERESTS OF SUCH POPULATIONS FOR A FULL DETAILED LIST OF INSTITUTIONS AND PERSONS, PLEASE SEE OUR WEBSITE HTTP //WWW WESTFIELDSHOSPITAL COM/HEALTH-WELLNESS-PROGRAMS/PROGRAMS/HEALTHIER-TOGETHER/</p> |
| WESTFIELDS HOSPITAL, INC | <p>PART V, SECTION B, LINE 6A OTHER HOSPITAL FACILITIES INCLUDED IN THE 2015 HEALTHPARTNERS CHNA WERE - LAKEVIEW MEMORIAL HOSPITAL ASSOCIATION, STILLWATER, MN - PARK NICOLLET METHODIST HOSPITAL, MN - REGIONS HOSPITAL, MN - AMERY REGIONAL MEDICAL CENTER, WI - HUDSON HOSPITAL, HUDSON, WI</p> |

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

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

| Form and Line Reference | Explanation |
|--------------------------|---|
| WESTFIELDS HOSPITAL, INC | PART V, SECTION B, LINE 11 THE 2015 HEALTHPARTNERS CHNA CONDUCTED RESULTED IN THE FOLLOWING PRIORITIES PRIORITY 1 INCREASE ACCESS TO MENTAL HEALTH PRIORITY 2 PROMOTE POSITIVE BEHAVIORS TO REDUCE OBESITY (NUTRITION / PHYSICAL THERAPY) PRIORITY 3 INCREASE ACCESS TO PRIMARY AND PREVENTIVE CARE PRIORITY 4 IMPROVE SERVICE INTEGRATION PRIORITY 5 PROMOTE CHANGE IN UNHEALTHY LIFESTYLES (TOBACCO / ALCOHOL / SUBSTANCE ABUSE) A FULL REPORT OF WESTFIELDS 2015 CHNA AND ANNUAL IMPLEMENTATION PLAN UPDATE IS POSTED ON THEIR WEBPAGE AT HTTP //WWW WESTFIELD SHOSPITAL COM/HEALTH-WELLNESS-PROGRAMS/PROGRAMS/HEALTHIER-TOGETHER/ WHICH PROVIDES A DETAILED DESCRIPTION OF ALL THE ACTIVITIES |

**Schedule I
(Form 990)**

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

OMB No 1545-0047

2017

**Open to Public
Inspection**

Department of the
Treasury
Internal Revenue Service

Complete if the organization answered "Yes," on Form 990, Part IV, line 21 or 22.
▶ Attach to Form 990.
▶ Information about Schedule I (Form 990) and its instructions is at www.irs.gov/form990.

Name of the organization
WESTFIELDS HOSPITAL INC

Employer identification number
39-0808442

Part I General Information on Grants and Assistance

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

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC section (if applicable) | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of noncash assistance | (h) Purpose of grant or assistance |
|--|---------|---------------------------------|--------------------------|-----------------------------------|---|---------------------------------------|------------------------------------|
| (1) See Additional Data | | | | | | | |
| (2) | | | | | | | |
| (3) | | | | | | | |
| (4) | | | | | | | |
| (5) | | | | | | | |
| (6) | | | | | | | |
| (7) | | | | | | | |
| (8) | | | | | | | |
| (9) | | | | | | | |
| (10) | | | | | | | |
| (11) | | | | | | | |
| (12) | | | | | | | |

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

3 Enter total number of other organizations listed in the line 1 table ▶ 0

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

Part III can be duplicated if additional space is needed

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

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

| Return Reference | Explanation |
|------------------|---|
| PART I, LINE 2 | WESTFIELDS HOSPITAL, INC (WESTFIELDS) MANAGEMENT STAFF REVIEW THE MISSION AND PURPOSE OF POTENTIAL GRANTEE ORGANIZATIONS TO ASSURE CONSISTENCY WITH WESTFIELDS' MISSION AND PURPOSE AMOUNTS SUBSEQUENTLY GRANTED ARE SUBJECT TO THE WESTFIELDS' FORMAL SPENDING APPROVAL AND DOCUMENTATION PROCESS BASED ON AMOUNT OF THE EXPENDITURE |

Additional Data

Software ID:
Software Version:
EIN: 39-0808442
Name: WESTFIELDS HOSPITAL INC

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
|--|----------------|--------------------------------------|---------------------------------|--|--|---|---|
| WESTFIELDS HOSPITAL FOUNDATION INC 8170 33RD AVENUE SOUTH PO BOX 1309 MPLS, MN 554401309 | 39-1770913 | 501(C)(3) | 23,258 | | | | PROGRAM SUPPORT |
| CITY OF NEW RICHMOND 156 E 1ST STREET NEW RICHMOND, WI 54017 | | | 7,500 | | | | PROGRAM SUPPORT |

| Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments. | | | | | | | |
|---|----------------|--------------------------------------|---------------------------------|--|--|---|---|
| (a) Name and address of organization or government | (b) EIN | (c) IRC section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
| NEW RICHMOND AREA CENTRE LTD 428 S STARR AVE NEW RICHMOND, WI 54017 | 26-3891288 | 501(C)(3) | 8,333 | | | | PROGRAM SUPPORT |

Schedule J
(Form 990)

Compensation Information

OMB No 1545-0047

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees
▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 23.**
▶ **Attach to Form 990.**
▶ **Information about Schedule J (Form 990) and its instructions is at www.irs.gov/form990.**

2017

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
WESTFIELDS HOSPITAL INC

Employer identification number
39-0808442

Part I Questions Regarding Compensation

| | Yes | No | | | | | | | | |
|---|---|--|---|--|--|---|---|--|--|--|
| <p>1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a Complete Part III to provide any relevant information regarding these items</p> <table border="0"> <tr> <td><input type="checkbox"/> First-class or charter travel</td> <td><input type="checkbox"/> Housing allowance or residence for personal use</td> </tr> <tr> <td><input type="checkbox"/> Travel for companions</td> <td><input type="checkbox"/> Payments for business use of personal residence</td> </tr> <tr> <td><input type="checkbox"/> Tax indemnification and gross-up payments</td> <td><input type="checkbox"/> Health or social club dues or initiation fees</td> </tr> <tr> <td><input type="checkbox"/> Discretionary spending account</td> <td><input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)</td> </tr> </table> | <input type="checkbox"/> First-class or charter travel | <input type="checkbox"/> Housing allowance or residence for personal use | <input type="checkbox"/> Travel for companions | <input type="checkbox"/> Payments for business use of personal residence | <input type="checkbox"/> Tax indemnification and gross-up payments | <input type="checkbox"/> Health or social club dues or initiation fees | <input type="checkbox"/> Discretionary spending account | <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef) | | |
| <input type="checkbox"/> First-class or charter travel | <input type="checkbox"/> Housing allowance or residence for personal use | | | | | | | | | |
| <input type="checkbox"/> Travel for companions | <input type="checkbox"/> Payments for business use of personal residence | | | | | | | | | |
| <input type="checkbox"/> Tax indemnification and gross-up payments | <input type="checkbox"/> Health or social club dues or initiation fees | | | | | | | | | |
| <input type="checkbox"/> Discretionary spending account | <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef) | | | | | | | | | |
| <p>b If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain</p> | 1b | | | | | | | | | |
| <p>2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?</p> | 2 | | | | | | | | | |
| <p>3 Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director Check all that apply Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III</p> <table border="0"> <tr> <td><input type="checkbox"/> Compensation committee</td> <td><input type="checkbox"/> Written employment contract</td> </tr> <tr> <td><input checked="" type="checkbox"/> Independent compensation consultant</td> <td><input checked="" type="checkbox"/> Compensation survey or study</td> </tr> <tr> <td><input type="checkbox"/> Form 990 of other organizations</td> <td><input checked="" type="checkbox"/> Approval by the board or compensation committee</td> </tr> </table> | <input type="checkbox"/> Compensation committee | <input type="checkbox"/> Written employment contract | <input checked="" type="checkbox"/> Independent compensation consultant | <input checked="" type="checkbox"/> Compensation survey or study | <input type="checkbox"/> Form 990 of other organizations | <input checked="" type="checkbox"/> Approval by the board or compensation committee | | | | |
| <input type="checkbox"/> Compensation committee | <input type="checkbox"/> Written employment contract | | | | | | | | | |
| <input checked="" type="checkbox"/> Independent compensation consultant | <input checked="" type="checkbox"/> Compensation survey or study | | | | | | | | | |
| <input type="checkbox"/> Form 990 of other organizations | <input checked="" type="checkbox"/> Approval by the board or compensation committee | | | | | | | | | |
| <p>4 During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization</p> <p>a Receive a severance payment or change-of-control payment?</p> <p>b Participate in, or receive payment from, a supplemental nonqualified retirement plan?</p> <p>c Participate in, or receive payment from, an equity-based compensation arrangement?</p> <p>If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III</p> | 4a | No | | | | | | | | |
| | 4b | Yes | | | | | | | | |
| | 4c | No | | | | | | | | |
| <p>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</p> <p>5 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of</p> <p>a The organization?</p> <p>b Any related organization?</p> <p>If "Yes," on line 5a or 5b, describe in Part III</p> | 5a | No | | | | | | | | |
| | 5b | No | | | | | | | | |
| <p>6 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of</p> <p>a The organization?</p> <p>b Any related organization?</p> <p>If "Yes," on line 6a or 6b, describe in Part III</p> | 6a | No | | | | | | | | |
| | 6b | Yes | | | | | | | | |
| <p>7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III</p> | 7 | No | | | | | | | | |
| <p>8 Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III</p> | 8 | No | | | | | | | | |
| <p>9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?</p> | 9 | | | | | | | | | |

Part III Supplemental Information

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

| Return Reference | Explanation |
|--|--|
| PART I, LINE 4B | DEFERRED COMPENSATION IN COLUMN C OF SCHEDULE J, PART II INCLUDES AMOUNTS FROM A NONQUALIFIED 457(F) PLAN FOR THE FOLLOWING DIRECTOR DAVID A DZIUK \$42,301 |
| PART I, LINE 6 | WESTFIELDS HOSPITAL, INC (WESTFIELDS) DOES HAVE EMPLOYEES, HOWEVER, WESTFIELDS' CHIEF EXECUTIVE OFFICER AND CHIEF FINANCIAL OFFICER ARE EMPLOYEES OF RELATED ORGANIZATIONS REGIONS HOSPITAL (REGIONS) AND GROUP HEALTH PLAN, INC (GHI) RESPECTIVELY. COMPENSATION PAID TO THESE TWO OFFICERS BY REGIONS AND GHI IS REIMBURSED BY WESTFIELDS. BOTH REGIONS AND GHI HAVE MANAGEMENT INCENTIVE PROGRAMS THAT INCENT AND REWARD THE ORGANIZATIONS' BUSINESS LEADERS WHO HELP THE ORGANIZATION ACHIEVE STATED BUSINESS AND/OR HEALTH IMPROVEMENT GOALS FOR A SPECIFIC FISCAL YEAR. THE PROGRAM IS AN ELEMENT OF THE PARTICIPANT'S REGIONS OR GHI TOTAL COMPENSATION PACKAGE. REGIONS AND GHI MANAGEMENT INCENTIVE PROGRAMS' REWARDS ARE BASED ON POSITION IN THE ORGANIZATION AND THE ACHIEVEMENT OF BUSINESS AND HEALTH IMPROVEMENT GOALS ESTABLISHED IN A VARIETY OF AREAS. GOALS WILL BE RELATED TO THE ORGANIZATION'S STRATEGIC PLAN AND WILL BE BALANCED. THESE AREAS MAY INCLUDE BUT ARE NOT LIMITED TO PATIENT SATISFACTION, EMPLOYEE SATISFACTION, WORK ENVIRONMENT, EMPLOYEE AND/OR LEADERSHIP DEVELOPMENT, CARE DELIVERY, PATIENT EDUCATION, SIX AIMS, MARKET SHARE, STRATEGIC CAPABILITIES, FINANCIAL PERFORMANCE (NET MARGIN), ETC, AND WILL BE DEFINED ANNUALLY FOR EACH YEAR'S PROGRAM. A NET MARGIN THRESHOLD MUST BE MET FOR ANY PAYMENT TO BE MADE FROM THE PROGRAM AND THERE IS A CAP ON THE MAXIMUM INCENTIVE POTENTIALLY AVAILABLE TO EACH PARTICIPANT. |
| FORM 990, SCH J, PART II - PRIOR REPORTED COMPENSATION | COLUMN (F) INCLUDES AMOUNTS PAID TO PARTICIPANTS IN THE CURRENT YEAR, WHICH WERE PREVIOUSLY REPORTED IN COLUMN (C) OF PRIOR YEARS' 990'S, AS RETIREMENT AND DEFERRED COMPENSATION, FOR THE FOLLOWING DIRECTORS DAVID A DZIUK \$ 55,672. ANY ANALYSIS OF EARNINGS FOR THE CURRENT YEAR, FOR THESE PARTICIPANTS OF THE PLAN, SHOULD EXCLUDE THE AMOUNT IN COLUMN F AS PART OF THE ANALYSIS SINCE THOSE EARNINGS WERE ALREADY REPORTED IN COLUMN (C) OF PREVIOUS YEARS' 990'S. |

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Name of the organization
WESTFIELDS HOSPITAL INC

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No 1545-0047

2017

Open to Public Inspection

Employer identification number

39-0808442

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|--|
| FORM 990, PART III, LINE 4A- PRIMARY EXEMPT PURPOSE AND ACHIEVEMENTS | <p>CORPORATE STRUCTURE, PURPOSE, GOVERNANCE WESTFIELDS HOSPITAL (WESTFIELDS), A STATE LICENSE D 25-BED, LEVEL IV CRITICAL ACCESS HOSPITAL (CAH), IS A WISCONSIN NON-STOCK CORPORATION RE COGNIZED AS EXEMPT FROM FEDERAL INCOME TAX UNDER INTERNAL REVENUE CODE ("IRC") SECTION 501 (C)(3) AND IS PART OF THE FAMILY OF HEALTHPARTNERS ORGANIZATIONS "HEALTHPARTNERS" FOUNDED IN 1957, HEALTHPARTNERS IS AN INTEGRATED SYSTEM OF HEALTH CARE DELIVERY AND HEALTH CARE FINANCING ORGANIZATIONS, AND IS ONE OF THE LARGEST CONSUMER-GOVERNED ORGANIZATIONS IN THE COUNTRY HEALTHPARTNERS' MISSION IS TO IMPROVE HEALTH AND WELL-BEING IN PARTNERSHIP WITH OUR MEMBERS, PATIENTS AND COMMUNITY HEALTHPARTNERS SEEKS TO TRANSFORM HEALTHCARE THROUGH A RELENTLESS FOCUS ON THE TRIPLE AIM - PROVIDING EXCEPTIONAL EXPERIENCE FOR THE INDIVIDUAL, IMPROVING THE HEALTH OF THE POPULATION, AND MAINTAINING AFFORDABILITY, ALL AT THE SAME TIME HEALTHPARTNERS INCLUDES AN ARRAY OF TAX-EXEMPT AND TAXABLE ORGANIZATIONS WITH HEALTH CARE ACTIVITIES PRIMARILY OPERATING IN MINNESOTA, WESTERN WISCONSIN AND EXPANDING TO SEVERAL OTHER MIDWESTERN STATES HEALTHPARTNERS PROVIDES A FULL RANGE OF HEALTH CARE DELIVERY AND HEALTH PLAN SERVICES INCLUDING INSURANCE, PATIENT CARE, ADMINISTRATION AND HEALTH AND WELL-BEING PROGRAMS HEALTHPARTNERS HEALTH PLANS SERVE MORE THAN 1.8 MILLION MEDICAL AND DENTAL MEMBERS NATIONWIDE HEALTHPARTNERS MEDICAL CARE SYSTEM INCLUDES MORE THAN 1,800 PHYSICIANS AND DENTISTS, SIX OWNED HOSPITALS WITH OVER 1,000 ACUTE CARE BEDS, OVER 100 OWNED AND LEASED PRIMARY AND SPECIALTY CARE MEDICAL FACILITIES AND 25 DENTAL FACILITIES WITH PRACTICES IN MINNESOTA AND WESTERN WISCONSIN HEALTHPARTNERS ALSO CONTRACTS WITH OTHER PRIMARY AND SPECIALTY MEDICAL FACILITIES AND DENTAL FACILITIES, PHYSICIAN GROUPS, HOSPITALS AND RELATED HEALTHCARE PROVIDERS LOCATED PRIMARILY IN MINNESOTA, WESTERN WISCONSIN AND EXPANDING TO OTHER MIDWESTERN STATES HEALTHPARTNERS ALSO PROVIDES MEDICAL EDUCATION AND TRAINING TO MEDICAL PROFESSIONALS AND CONDUCTS RESEARCH AND FUND RAISING ACTIVITIES THAT SUPPORT THE HEALTH CARE DELIVERY SYSTEM A COMPLETE LISTING OF ALL ORGANIZATIONS WITHIN THE HEALTHPARTNERS FAMILY, AND THE RELATIONSHIP BETWEEN THEM, CAN BE FOUND ON SCHEDULE R WITHIN THIS 990 RETURN DETAILED INFORMATION ABOUT THE COMMUNITY BENEFIT ACTIVITIES AND ACCOMPLISHMENTS OF EACH TAX-EXEMPT ORGANIZATION CAN BE FOUND IN THE INDIVIDUAL FORM 990 RETURN FOR THAT ORGANIZATION HEALTHPARTNERS IS DRIVING CHANGE THAT HELPS OUR MEMBERS AND PATIENTS LIVE HEALTHIER LIVES HEALTHPARTNERS COLLABORATE WITH OTHER PLANS, CARE PROVIDERS AND OTHER COMMUNITY AND BUSINESS ORGANIZATIONS IN THE REGION AND THROUGHOUT THE NATION TO INCREASE ACCESS, CREATE AND SHARE QUALITY MEASURES AND INITIATIVES, PARTICIPATE IN DEVELOPMENT OF PUBLIC POLICY, AND COLLABORATE IN IMPROVEMENTS THAT SUPPORT THE TRIPLE AIM AMONG HEALTHPARTNERS' SIGNATURE INITIATIVES CONTINUING IN 2017 ARE TOTAL COST OF CARE MEASUREMENTS (DEVELOPMENT OF A NATIONALLY RECOGNIZED METRIC</p> |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|--|
| FORM 990, PART III, LINE 4A- PRIMARY EXEMPT PURPOSE AND ACHIEVEMENTS | <p>, ENDORSED BY THE NATIONAL QUALITY FORUM, ENABLING MEASUREMENT AND INCENTIVES BASED ON COORDINATION AND EVIDENCE-BASED PRACTICES), MENTAL HEALTH (REDUCING STIGMA, AND ASSURING ACCESS TO HIGH QUALITY CARE IN THE MOST APPROPRIATE SETTINGS), CHILDREN'S HEALTH (IMPROVING CHILD HEALTH BY PROMOTING EARLY BRAIN DEVELOPMENT, PROVIDING FAMILY CENTERED CARE, AND STRENGTHENING COMMUNITIES), AND SUSTAINABILITY (ENERGY EFFICIENCY, WASTE REDUCTION, AND RESOURCE MANAGEMENT) HEALTHPARTNERS, INC (HPI) IS THE PARENT ENTITY OF HEALTHPARTNERS AND IS A MINNESOTA NON-PROFIT CORPORATION AND LICENSED HEALTH MAINTENANCE ORGANIZATION (HMO) RECOGNIZED AS EXEMPT FROM FEDERAL INCOME TAX UNDER IRC SECTION 501(C)(4) HPI IS THE SOLE CORPORATE MEMBER OF HPI-RAMSEY, A MINNESOTA NON-PROFIT CORPORATION RECOGNIZED AS EXEMPT FROM FEDERAL INCOME TAX UNDER IRC SECTION 501(C)(3) IN TURN, HPI-RAMSEY IS THE SOLE CORPORATE MEMBER OF REGIONS HOSPITAL, REGIONS HOSPITAL FOUNDATION, CAPITOL VIEW TRANSITIONAL CARE CENTER, STILLWATER HEALTH SYSTEM (LAKEVIEW HEALTH), RAMSEY INTEGRATED HEALTH SERVICES AND RH-WISCONSIN, INC , ALL OF WHICH ARE NON-PROFIT CORPORATIONS EXEMPT FROM FEDERAL INCOME TAX UNDER IRC SECTION 501(C)(3) RH-WISCONSIN, INC IS THE CLASS A CORPORATE MEMBER OF WESTFIELDS WESTFIELDS IS THE SOLE CORPORATE MEMBER OF WESTFIELDS HOSPITAL FOUNDATION COMMUNITY BENEFIT TO THE COMMUNITY 1 COMMUNITY HEALTH SERVICES COMMUNITY HEALTH IMPROVEMENT SERVICES NEARLY 3,000 PEOPLE BENEFITED FROM THE FOLLOWING PROGRAMS OR ACTIVITIES THAT WERE CARRIED OUT AND SUPPORTED BY WESTFIELDS IN 2017 FOR THE EXPRESS PURPOSE OF IMPROVING COMMUNITY HEALTH TOTALING A COST OF \$199,106 COMMUNITY HEALTH EDUCATION OVER 800 PEOPLE ATTENDED EDUCATIONAL PROGRAMS, CLASSES, SPECIAL EVENTS, HEALTH FAIRS OR SUPPORT GROUPS TAUGHT OR HOSTED BY MEDICAL AND CLINICS STAFF AND CAMPUS PARTNERS TOTAL COMMUNITY HEALTH EDUCATION EXPENSES TOTALLED \$99,619 CLASSES INCLUDED BREASTFEEDING, FAMILY/PARENTING/SIBLING EDUCATION, DIABETES, NUTRITION AND WEIGHT MANAGEMENT, SCHOOL BASED HEALTH EDUCATION, WORKSITE HEALTH EDUCATION, WOMEN'S HEALTH TOPICS, AND SENIOR CARE IN ADDITION, OVER 1,000 PEOPLE ATTENDED SUPPORT GROUPS HELD FOR THE BROADER COMMUNITY ON BREASTFEEDING, CANCER, DIABETES, NUTRITION AND WEIGHT MANAGEMENT, CAREGIVERS, AND SMOKING CESSATION COMMUNITY BASED CLINICAL SERVICES WESTFIELDS HOSTED A BLOOD DRIVE IN SUPPORT OF THE AMERICAN RED CROSS, OFFERED A FREE DIABETES SCREENING, AND BLOOD PRESSURE SCREENING AT A COST OF \$4,552 HEALTH CARE SUPPORT SERVICES IN 2017, ALMOST 300 PEOPLE REALIZED THE BENEFIT OF HEALTH CARE SUPPORT SERVICES AVAILABLE THESE SERVICES INCLUDED ENROLLMENT ASSISTANCE, INFORMATION AND REFERRAL SERVICES WHICH WERE PROVIDED TO HELP SECURE A PAYMENT SOURCE OR ACCESS SERVICES BEYOND MEDICAL CARE FOR UNINSURED AND UNDERINSURED PATIENTS, THE COST WAS \$91,882 2 HEALTH PROFESSIONAL EDUCATION WESTFIELDS' STAFF PROVIDED CLINICAL TRAINING FOR 75 HEALTH PROFESSIONALS FROM 22 INSTITUTIONS AT A COST OF \$156,0</p> |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| <p>FORM 990, PART III, LINE 4A- PRIMARY EXEMPT PURPOSE AND ACHIEVEMENTS</p> | <p>75 3 SUBSIDIZED HEALTH SERVICES WESTFIELDS IS COMMITTED TO PROVIDING NEEDED SERVICES EV EN AT A FINANCIAL LOSS IN 2017, LOSS ON SERVICES FOR OUTPATIENT HEALTH SERVICES INCLUDING EMERGENCY CARE, PRIMARY CLINIC, SPECIALTY CLINIC, ONCOLOGY, PHYSICAL THERAPY, AND RESPIRA TORY THERAPY TOTALED \$2,108,588 FINANCIAL ASSISTANCE AND HEALTHCARE ACCESS FOR LOW-INCOME INDIVIDUALS FINANCIAL ASSISTANCE IS DEFINED AS THE COST OF CARE DELIVERED TO PATIENTS WHO ARE WILLING, BUT UNABLE TO PAY FOR THE SERVICES THEY RECEIVE THIS INCLUDES PATIENTS WHOS E CHARGES ARE FORGIVEN OR REDUCED BECAUSE OF INABILITY TO PAY, PATIENTS WHO ARE UNABLE TO PAY THE BALANCE LEFT BY ANY PAYER, AND PATIENTS FOR WHOM UNUSUAL CIRCUMSTANCES OR SPECIAL FINANCIAL HARDSHIP WARRANT SPECIAL CONSIDERATION WESTFIELDS PROVIDED \$375,067 IN FINANCIA L ASSISTANCE TO 202 LOW INCOME AND/OR UNINSURED PATIENTS FINANCIAL ASSISTANCE REPRESENTS ABOUT 0 64% OF WESTFIELDS TOTAL OPERATING EXPENSES 4 FINANCIAL CONTRIBUTIONS CASH DONAT IONS & GRANTS WESTFIELDS DONATIONS AND GRANTS TO COMMUNITY ORGANIZATIONS IN SUPPORT OF HEA LTH CAREERS EDUCATION AND COMMUNITY BUILDING EFFORTS TO IMPROVE THE HEALTH AND WELL-BEING OF THE COMMUNITY AT LARGE TOTALED \$34,196 IN 2017 MAJOR CONTRIBUTIONS WERE MADE TO THE CE NTR E, RELAY FOR LIFE SPONSORSHIP, ALZHEIMER'S WALK, LOCAL SCHOOLS, AND MANY OTHERS IN-KIN D DONATIONS IN-KIND DONATIONS IN 2017 CONSISTED OF ADMINISTRATIVE SUPPORT FOR NOT-FOR-PROF IT GROUPS, EQUIPMENT AND SUPPLY DONATIONS PROVIDED TO PATIENT FAMILIES AND COMMUNITY MEMBE RS TOTALING \$6,353 AND OVER 140 ADMINISTRATIVE SUPPORT HOURS CONTRIBUTION 6 COMMUNITY BU ILDING ACTIVITIES WESTFIELDS LIVES OUT ITS COMMITMENT TO IMPROVE THE HEALTH OF THE COMMUN ITY BY SUPPORTING INDIVIDUALS, ORGANIZATIONS, EVENTS AND PROGRAMS KNOWING MUCH MORE CAN B E ACCOMPLISHED WHEN PEOPLE COME TOGETHER, WESTFIELDS COMMUNITY BENEFIT PROGRAM STRIVES TO MAKE VALUABLE CONNECTIONS WITH INDIVIDUALS AND ORGANIZATIONS FROM PUBLIC, PRIVATE AND NONP ROFIT SECTORS TO SHARE SKILLS AND ASSETS IN 2017, WESTFIELDS COMMUNITY-BUILDING ACTIVITIE S EQUALED \$2,132 WESTFIELDS PARTICIPATED IN COMMUNITY-BUILDING ACTIVITIES THAT SUPPORTED ECONOMIC DEVELOPMENT TO IMPROVE BUSINESS CLIMATE IN THE REGION, EMERGENCY PREPAREDNESS AND YOUTH ASSET DEVELOPMENT, HEALTH IMPROVEMENT ADVOCACY, AND COALITION BUILDING TO PROVIDE L EADERSHIP AND IN-KIND SUPPORT FOR HEALTHIER TOGETHER - ST CROIX COUNTY, THE CENTRE WELLNE SS FACILITY, AND LOCAL COMMUNITY HEALTH</p> |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|-----------------------------|--|
| FORM 990, PART III, LINE 4A | <p>7 COMMUNITY BENEFIT OPERATIONS COSTS ASSOCIATED WITH DEDICATED STAFF, PROGRAM OPERATIONS , RESOURCE EXPENSES, WHA SURVEY COMPLETION, HEALTHIER TOGETHER PARTICIPATION, NEEDS ASSESSMENT EXPENSES TOTALED \$40,259, AND A TOTAL OF 1,102 SUPPORT HOURS WERE CONTRIBUTED COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA), PLEASE REFER TO FORM 990 SCHEDULE H NARRATIVE TOTAL 2,017 COMMUNITY BENEFIT CONTRIBUTION EQUALED \$6,686,838, WHICH REPRESENTED 11.5% OF THE OVERALL NET REVENUE OF WESTFIELDS THIS FIGURE IS REPORTED AT COST PER THE CATHOLIC HEALTH ASSOCIATION (CHA) COMMUNITY BENEFIT REPORTING GUIDELINES AND IN ACCORDANCE WITH THE WISCONSIN HOSPITAL ASSOCIATION (WHA) REPORTING REQUIREMENTS 8 ORGANIZATION AWARDS AND ACHIEVEMENTS CLINIC GROWTH INCLUDED NEW OR EXPANDED SERVICES THAT INCLUDED BEHAVIORAL HEALTH, FAMILY MEDICINE, NEUROLOGY, CARDIOLOGY, AND ONCOLOGY THE ADDITIONS CREATED CONVENIENT ACCESS TO SPECIALIZED CARE THAT IS CLOSE TO HOME AND PHYSICIAN AVAILABILITY PRIMARY CARE CLINIC CONTINUED PROVIDING ALL CHILDREN 6 MONTHS TO 5 YEARS WITH A BOOK AT EVERY WELL-CHILD VISIT THROUGH THE REACH OUT AND READ PROGRAM PRIMARY CARE PROVIDERS HANDED OUT HUNDREDS OF RECIPIENTS - GOOD FOR FREE FRESH FRUITS AND VEGETABLES FROM LOCAL GROCERY STORES - TO CHILDREN DURING THEIR WELL-CHILD VISIT TO PROMOTE EATING FIVE FRUITS AND VEGETABLES A DAY AND REDUCE THE RISK OF OBESITY RECOGNIZED BY PRACTICE GREENHEALTH, WITH AN AWARD FOR CONTINUED ADVANCEMENT FOR SUSTAINABLE PRACTICES AND THE GREENING THE OR AWARD FOR ENVIRONMENTALLY PREFERRED PRACTICES OUR SOLAR PANEL POWER INITIATIVE GENERATED ENOUGH ENERGY TO POWER THREE HOMES FOR A FULL YEAR APPROXIMATELY 350 PEOPLE ATTENDED OUR COMMUNITY HEALTH FAIR WHICH OFFERED HEARING, SKIN AND BLOOD PRESSURE SCREENINGS AND HEALTH INFORMATION THE ST. CROIX VALLEY UNITED WAY SUCCESS BY 6 INITIATIVE AWARDED WESTFIELDS WITH GOLD-LEVEL CERTIFICATION FOR HAVING A WORK ENVIRONMENT THAT SUPPORTS EMPLOYEES AND THEIR FAMILIES FOR INPATIENTS, WESTFIELDS FOR THE THIRD TIME IN FOUR YEARS, WESTFIELDS WAS NAMED AS A TOP 100 CRITICAL ACCESS HOSPITAL BY IVANTAGE WHICH MEASURES 70 DIFFERENT PERFORMANCE METRICS, INCLUDING QUALITY, OUTCOMES, PATIENT PERSPECTIVE AFFORDABILITY, POPULATION RISK AND EFFICIENCY CONTINUED A VOLUNTEER-SUPPORTED PROGRAM - THE HOSPITAL ELDER LIFE PROGRAM OR HELP TO ASSIST IN PREVENTING DELIRIUM IN OLDER INPATIENTS SURGERY NURSES DEVELOPED AN EDUCATIONAL BOOK FOR CHILDREN TO HELP THEM PREPARE FOR SURGERY FOR OUTPATIENTS, WESTFIELDS IN 2017 MANY DEPARTMENTS HIT RECORD VOLUMES, 1800 MAMMOGRAMS, 7300 EMERGENCY DEPARTMENT VISITS, 7400 HEALTHSTATION VISITS, 6700 SPECIALTY CLINIC VISITS, AND 42,200 PRIMARY CARE CLINIC VISITS CONTINUED AN \$8.8 MILLION DOLLAR CAMPUS RENOVATION PROJECT WHICH ACCOMMODATES CAMPUS GROWTH AND ALLOWS FOR EXPANDED PATIENT ACCESS AND ADDITION OF NEW SERVICES IN REHABILITATION SERVICES, CARDIOPULMONARY SERVICES, SLEEP HEALTH, OUTPATIENT SURGICAL SERVICES AND EMERGENCY MEDICINE MOST AREAS WERE COMPLETED</p> |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|-----------------------------|---|
| FORM 990, PART III, LINE 4A | DURING 2017, WITH THE FINAL PHASE OF THE EMERGENCY DEPARTMENT PROJECT SET TO CONCLUDE IN E ARLY IN 2018 PRENATAL PATIENTS NOW SEE BIRTH CENTER NURSES AT THEIR FIRST CLINIC APPOINTM ENT, THE PRACTICE REDUCES WAIT TIMES WESTFIELDS WAS AWARDED THE CONTRACT TO PROVIDE ATHLE TIC TRAINING AT NEW RICHMOND HIGH SCHOOL |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|--|
| FORM 990, PART VI, SECTION A, LINE 6 | RH WISCONSIN, INC IS THE CLASS A MEMBER AND GROUP HEALTH PLAN, INC IS THE CLASS B MEMBER OF WESTFIELDS |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|---|
| FORM 990, PART VI, SECTION A, LINE 7A | THE CLASS A MEMBER (RH WISCONSIN, INC) APPOINTS THREE DIRECTORS TO REPRESENT THE CLASS A MEMBER THE CLASS B MEMBER (GROUP HEALTH PLAN, INC) APPOINTS TWO DIRECTORS TO REPRESENT THE CLASS B MEMBER TWO HEALTH CARE PROVIDERS ARE NOMINATED AS DIRECTORS BY AN UNRELATED MEDICAL GROUP AND APPOINTED BY MAJORITY VOTE OF THE FULL BOARD EIGHT COMMUNITY REPRESENTATIVES ARE APPOINTED AS DIRECTORS BY THE CLASS A MEMBER UPON RECOMMENDATION BY THE EXECUTIVE COMMITTEE OF THE BOARD OF DIRECTORS |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---------------------------------------|--|
| FORM 990, PART VI, SECTION A, LINE 7B | THE CLASS A AND CLASS B MEMBERS (RH WISCONSIN, INC AND GROUP HEALTH PLAN, INC RESPECTIVELY) BOTH MUST APPROVE THE DECISIONS OF THE BOARD OF DIRECTORS AS FOLLOWS - AMENDMENT OF ARTICLES OR BYLAWS IMPACTING MEMBERSHIP - RESIGNATION OF A MEMBER - DISSOLUTION - ANY CHANGE IN THE FUNDAMENTAL NATURE OR PURPOSE - MERGER OR CONSOLIDATION WITH ANOTHER CORPORATION - DISPOSITION OF SUBSTANTIALLY ALL ASSETS ONLY THE CLASS A MEMBER MUST APPROVE THE DECISIONS OF THE BOARD OF DIRECTORS AS FOLLOWS - AMENDMENT OF ARTICLES OR BYLAWS NOT IMPACTING MEMBERSHIP - ANNUAL OPERATING AND CAPITAL BUDGETS AND STRATEGIC PLANS - ESTABLISHMENT OF NEW ENTITIES OR SIGNIFICANT RELATIONSHIPS WITH OTHER ENTITIES - UNBUDGETED EXPENDITURES IN EXCESS OF AMOUNTS ESTABLISHED BY THE MEMBER - GUARANTEEING THE DEBT OF ANY OTHER PERSON OR ENTITY - A LOAN OR OTHER INDEBTEDNESS IN EXCESS OF AMOUNTS ESTABLISHED BY THE MEMBER - TRANSFER OF ASSETS TO ANOTHER ENTITY - APPOINTMENT OF AUDITORS - APPOINTMENT OF THE PRESIDENT AND THE BOARD CHAIR |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|---|
| FORM 990, PART VI, SECTION B, LINE 11B | WESTFIELDS' 990 RETURN HAS A COMPREHENSIVE REVIEW PROCESS THAT IS FOLLOWED BEFORE IT IS PRESENTED TO THE GOVERNING BODY OF WESTFIELDS. THE REVIEW PROCESS INCLUDES A LAYERED REVIEW BY THE TAX DEPARTMENT OF GROUP HEALTH PLAN, INC (GHI), THE MANAGEMENT TEAM OF WESTFIELDS, GHI'S INTERNAL LEGAL DEPARTMENT AND WESTFIELDS'S OUTSIDE INDEPENDENT ACCOUNTANTS. EACH ONE OF THOSE AREAS HAS AN OPPORTUNITY TO REVIEW, ASK QUESTIONS AND MAKE COMMENTS BACK TO THE TAX DEPARTMENT OF GHI BEFORE THE FORM 990 IS COMPLETED AND PRESENTED TO THE GOVERNING BODY OF WESTFIELDS. WESTFIELDS MAKES AVAILABLE TO THE GOVERNING BODY (BOARD OF DIRECTORS) A COPY OF THE 990 FOR REVIEW AND COMMENT PRIOR TO THE FILING OF THE 990 RETURN. THIS COPY IS PROVIDED IN A PRE-MEETING PACKET, AND IS AN AGENDA ITEM AT A MEETING OF THE FULL BOARD OF DIRECTORS. THIS PROCESS IS NOTED AND DOCUMENTED IN THE WRITTEN MINUTES OF THE MEETING. |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|---|
| FORM 990, PART VI, SECTION B, LINE 12C | WESTFIELDS BOARD MONITORS POTENTIAL CONFLICTS OF INTEREST ON THE PART OF ITS BOARD MEMBERS, PRINCIPAL OFFICERS, MEMBERS OF COMMITTEES WITH BOARD DELEGATED POWERS, AND KEY EMPLOYEES ("COVERED PERSONS") BY MAINTAINING A CONFLICT OF INTEREST POLICY UNDER THE POLICY, COVERED PERSONS ANNUALLY ARE PROVIDED WITH A COPY OF THE POLICY AND REQUESTED TO COMPLETE A QUESTIONNAIRE IDENTIFYING ANY POTENTIAL CONFLICTS OF INTERESTS THE LEGAL DEPARTMENT OF HEALTHPARTNERS REVIEWS THE QUESTIONNAIRE RESPONSES AND DEVELOPS A REPORT DETAILING ANY POTENTIALLY MATERIAL CONFLICTS FOR THE PRESIDENT AND CHAIR OF THE BOARD A VERBAL SUMMARY IS ALSO GIVEN TO THE FULL BOARD OR APPROPRIATE COMMITTEE, AND REINFORCES THE POLICY'S MANDATE THAT EACH PERSON IS OBLIGATED TO DISCLOSE ANY NEW POTENTIAL CONFLICTS AS THEY MAY ARISE THROUGHOUT THE YEAR BOARD AGENDAS AND EXECUTIVE DECISIONS ARE MONITORED IN RELATION TO THIS POLICY |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---------------------------------------|--|
| FORM 990, PART VI, SECTION B, LINE 15 | <p>WESTFIELDS' CEO AND ITS OFFICERS ARE EMPLOYED BY REGIONS HOSPITAL (REGIONS), GROUP HEALTH PLAN, INC , (GHI), OR HUDSON HOSPITAL, ALL OF WHICH ARE RELATED ORGANIZATIONS, OR BY WESTFIELDS GHI, REGIONS, HUDSON HOSPITAL AND WESTFIELDS HAVE AN ANNUAL PROCESS TO REVIEW THE MARKET COMPARABILITY OF THE TOTAL COMPENSATION OF WESTFIELDS CEO AND OTHER OFFICERS EVERY THREE YEARS. THE INDEPENDENT COMPENSATION COMMITTEE OF THE GHI BOARD OF DIRECTORS (THE "COMMITTEE"), RETAINS AN EXTERNAL COMPENSATION EXPERT TO CONDUCT AN EXTENSIVE MARKET COMPARABILITY REVIEW FOR ALL OFFICERS OF THE ORGANIZATION THE REVIEW INCLUDES ALL COMPONENTS OF TOTAL COMPENSATION BASE SALARY, ANNUAL INCENTIVES, BENEFITS AND PERQUISITES THE MARKET SURVEY RESULTS ARE PRESENTED TO, REVIEWED BY AND APPROVED BY THE APPROPRIATE COMMITTEE BASED ON THIS DATA, EITHER THE EXECUTIVE COMMITTEE OF HUDSON HOSPITAL, THE EXECUTIVE COMMITTEE OF REGIONS, THE COMPENSATION COMMITTEE OF GHI OR WESTFIELDS EXECUTIVE COMMITTEE (THE "COMMITTEES") DETERMINE MINIMUM AND MAXIMUM TOTAL COMPENSATION RANGES FOR EACH EMPLOYED OFFICER IN INTERIM YEARS, GHI'S HUMAN RESOURCES STAFF, UNDER THE COMMITTEES' DIRECTION, UPDATES CHANGES IN THE SALARY STRUCTURE BASED ON THE SAME INDEPENDENT STUDIES PERFORMED BY THE COMPENSATION CONSULTANT FOR THE COMMITTEE FOR CERTAIN POSITIONS FULL INDEPENDENT REVIEWS ARE PERFORMED TO SET SALARY RANGES BASED ON THE COMPETITIVE MARKET DATA SPECIFIC TO THOSE POSITIONS THE COMMITTEES REVIEW AND APPROVE EACH YEAR'S COMPENSATION RESULTS IN ALL CASES, THE COMMITTEES' MEMBERS COMPLETE AN ANNUAL CONFLICT OF INTEREST SURVEY TO ASSURE THE COMMITTEES MEMBERS' INDEPENDENCE AND THIS IS UPDATED AT ANY MEETING AT WHICH DECISIONS ARE BEING MADE STAFF (OTHER THAN THE SECRETARY TO THE BOARD) IS NOT IN THE ROOM DURING DELIBERATIONS OR VOTE INCLUDING EXECUTIVE SESSIONS, AND CONTEMPORANEOUS MINUTES ARE KEPT WITH WESTFIELDS' BOARD OF DIRECTORS INPUT, THE ST CROIX VALLEY EXECUTIVE LEADER CONDUCTS THE ANNUAL PERFORMANCE REVIEW AND, WITH WESTFIELDS'S BOARD APPROVAL, DETERMINES THE COMPENSATION OF THE WESTFIELDS CEO THE WESTFIELDS BOARD HAS DELEGATED TO THE CEO THE ACCOUNTABILITY TO CONDUCT ANNUAL PERFORMANCE REVIEWS AND DETERMINE THE COMPENSATION OF ALL WESTFIELDS-EMPLOYED OFFICERS WITHIN THE COMPENSATION RANGES DETERMINED BY THE COMMITTEE ANY EXCEPTIONS TO COMPENSATION IN EXCESS OF THE APPROVED RANGES ARE APPROVED BY WESTFIELDS EXECUTIVE COMMITTEE TOTAL COMPENSATION IS APPROPRIATELY DOCUMENTED ON THE FORM 990 AND ON THE EMPLOYEE'S W-2</p> |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|--|
| FORM 990, PART VI, SECTION C, LINE 19 | WESTFIELDS' FINANCIAL STATEMENTS AND 990 RETURNS ARE MADE AVAILABLE TO ANY PERSON WHO REQUESTS THE INFORMATION FROM WESTFIELDS OR HEALTHPARTNERS |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| 990, PART VII, SEC A, LN 1A, COL (B) - RELATED ORGANIZATION AVERAGE HOURS | DIRECTORS AND OFFICERS OF WESTFIELDS ARE EMPLOYED AND COMPENSATED BY GHI, INC , REGIONS HOSPITAL OR WESTFIELDS REPORTED AVERAGE HOURS WORKED ARE BASED ON THEIR TOTAL COMPENSATION FROM ALL RELATED ORGANIZATIONS |

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No 1545-0047

2017

**Open to Public
Inspection**

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.**
▶ **Attach to Form 990.**
▶ **Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.**

Department of the Treasury
Internal Revenue Service

Name of the organization
WESTFIELDS HOSPITAL INC

Employer identification number

39-0808442

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

| (a) Name, address, and EIN (if applicable) of disregarded entity | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Total income | (e) End-of-year assets | (f) Direct controlling entity |
|---|-------------------------|--|---------------------|---------------------------|----------------------------------|
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Part II Identification of Related Tax-Exempt Organizations Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.

See Additional Data Table

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512(b)(13) controlled entity? | |
|---|-------------------------|--|----------------------------|---|----------------------------------|--|----|
| | | | | | | Yes | No |
| | | | | | | | |
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Part III Identification of Related Organizations Taxable as a Partnership Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a partnership during the tax year.

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Predominant income(related, unrelated, excluded from tax under sections 512- 514) | (f) Share of total income | (g) Share of end-of-year assets | (h) Disproportionate allocations? | | (i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065) | (j) General or managing partner? | | (k) Percentage ownership |
|--|----------------------------|---|--|--|---------------------------------|--|---|----|--|---|----|--------------------------------|
| | | | | | | | Yes | No | | Yes | No | |
| | | | | | | | | | | | | |
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Part IV Identification of Related Organizations Taxable as a Corporation or Trust Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a corporation or trust during the tax year.

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income | (g) Share of end-of- year assets | (h) Percentage ownership | (i) Section 512(b) (13) controlled entity? | |
|--|---|---|---|---|---------------------------------|---|--------------------------------|---|----|
| | | | | | | | | Yes | No |
| (1) HEALTHPARTNERS ADMINISTRATORS INC 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 41-1629390 | THIRD PARTY ADMINISTRATOR | MN | HEALTHPARTNERS INC | C | | | | | No |
| (2) HEALTHPARTNERS ASSOCIATES INC 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 52-2365151 | MEDICAL CLINIC STAFFING AND ASSET MANAGEMENT | MN | HEALTHPARTNERS ADMINISTRATORS INC | C | | | | | No |
| (3) HEALTHPARTNERS SERVICES INC 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 41-1683568 | MEDICAL CLINIC STAFFING AND ASSET MANAGEMENT | MN | HEALTHPARTNERS ADMINISTRATORS INC | C | | | | | No |
| (4) HEALTHPARTNERS INSURANCE COMPANY 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 41-1683523 | MEDICAL AND DENTAL INSURANCE | MN | HEALTHPARTNERS ADMINISTRATORS INC | C | | | | | No |
| (5) DENTAL SPECIALTIES INC 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 45-1297583 | PROFESSIONAL DENTAL SERVICES | MN | HEALTHPARTNERS ADMINISTRATORS INC | C | | | | | No |
| (6) HEALTHPARTNERS CENTRAL MINNESOTA CLINICS INC 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 41-1236798 | MEDICAL CLINIC STAFFING | MN | HEALTHPARTNERS ADMINISTRATORS INC | C | | | | | No |
| (7) PARK NICOLLET ENTERPRISES 6500 EXCELSIOR BLVD ST LOUIS PARK, MN 55426 41-1656735 | REAL ESTATE FOR RELATED ORGANIZATIONS | MN | PARK NICOLLET HEALTH SERVICES | C | | | | | No |

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

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

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

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

| (a) Name of related organization | (b) Transaction type (a-s) | (c) Amount involved | (d) Method of determining amount involved |
|---|-------------------------------|------------------------|--|
| (1)HEALTHPARTNERS INC - CLAIMSHEALTHCARE SERVICES | L | 568,321 | CASH AMOUNT |
| (2)WESTFIELDS HOSPITAL FOUNDATION | C | 34,980 | CASH AMOUNT |
| | | | |
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Part VII **Supplemental Information**

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

Additional Data

Software ID:
Software Version:
EIN: 39-0808442
Name: WESTFIELDS HOSPITAL INC

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512 (b)(13) controlled entity? | |
|---|--|--|----------------------------|---|----------------------------------|---|----|
| | | | | | | Yes | No |
| 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 41-1693838 | HYBRID STAFF MODEL/NETWORK MODEL HEALTH MAINTENANCE ORGANIZATION | MN | 501(C)(4) | | N/A | | No |
| 8171 33RD AVE S PO BOX 1309 MPLS, MN 554401309 20-2287016 | CORPORATE PLANNING AND OVERSIGHT | WI | 501(C)(3) | 509(A)(3) TYPE I | HPI - RAMSEY | | No |
| 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 41-1793333 | CORPORATE PLANNING AND OVERSIGHT | MN | 501(C)(3) | 509(A)(3) TYPE I | HEALTHPARTNERS INC | | No |
| 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 41-0797853 | STAFF MODEL HEALTH MAINTENANCE ORGANIZATION | MN | 501(C)(3) | 170(B)(1) (A)(III) | HEALTHPARTNERS INC | | No |
| 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 41-1670163 | HEALTHCARE EDUCATION AND RESEARCH | MN | 501(C)(3) | 509(A)(3) TYPE I | HEALTHPARTNERS INC | | No |
| 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 41-2011453 | TRANSITIONAL CARE SERVICES, STEP DOWN FROM INPATIENT HOSPITAL | MN | 501(C)(3) | 170(B)(1) (A)(III) | HPI - RAMSEY | | No |
| 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 41-0956618 | HOSPITAL | MN | 501(C)(3) | 170(B)(1) (A)(III) | HPI - RAMSEY | | No |
| 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 41-1888902 | PROVIDE SUPPORT TO HOSPITAL AND IMPORVE COMMUNITY HEALTH | MN | 501(C)(3) | 170(B)(1) (A)(VI) | HPI - RAMSEY | | No |
| 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 41-1891928 | HEALTHCARE STAFFING AND INTENSE REHAB SERVICES | MN | 501(C)(3) | 509(A)(3) TYPE II | HPI - RAMSEY | | No |
| 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 27-0684883 | SPECIALTY PATIENT CARE | MN | 501(C)(3) | 509(A)(3) TYPE II | GROUP HEALTH PLAN INC | | No |
| 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 39-0804125 | HOSPITAL | WI | 501(C)(3) | 170(B)(1) (A)(III) | RH-WISCONSIN | | No |
| 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 39-1279567 | PROVIDE SUPPORT TO HOSPITAL AND IMPORVE COMMUNITY HEALTH | WI | 501(C)(3) | 170(B)(1) (A)(VI) | HUDSON HOSPITAL INC | | No |
| 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 41-1386635 | PROVIDE HOSPITAL PROGRAM FINANCIAL SUPPORT | MN | 501(C)(3) | 509(A)(3) TYPE II | STILLWATER HEALTH SYSTEM | | No |
| 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 41-0811697 | HOSPITAL | MN | 501(C)(3) | 170(B)(1) (A)(III) | STILLWATER HEALTH SYSTEM | | No |
| 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 83-0379473 | CLINIC STAFF AND FACILITIES | MN | 501(C)(3) | 509(A)(3) TYPE I | STILLWATER HEALTH SYSTEM | | No |
| 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 30-0221189 | CORPORATE PLANNING AND OVERSIGHT | MN | 501(C)(3) | 509(A)(3) TYPE II | HPI - RAMSEY | | No |
| 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 39-1770913 | PROVIDE HOSPITAL PROGRAM FINANCIAL SUPPORT | WI | 501(C)(3) | 509(A)(3) TYPE I | WESTFIELDS HOSPITAL INC | Yes | |
| 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 41-1503090 | HOME CARE AND HOSPICE | MN | 501(C)(3) | 509(A)(2) | HPI - RAMSEY | | No |
| 6500 EXCELSIOR BLVD ST LOUIS PARK, MN 55426 36-3465840 | CORPORATE PLANNING AND OVERSIGHT | MN | 501(C)(3) | 509(A)(2) | HEALTHPARTNERS INC | | No |
| 6500 EXCELSIOR BLVD ST LOUIS PARK, MN 55426 23-7346465 | SUPPORT TO RELATED ENTITIES AND COMMUNITY TO IMPROVE HEALTH | MN | 501(C)(3) | 170(B)(1) (A)(VI) | PARK NICOLLET HEALTH SERVICES | | No |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c) (3)) | (f) Direct controlling entity | (g) Section 512 (b)(13) controlled entity? | |
|---|---|--|-------------------------------|---|-------------------------------------|--|----|
| | | | | | | Yes | No |
| 6500 EXCELSIOR BLVD ST LOUIS PARK, MN 55426 41-0132080 | HOSPITAL | MN | 501(C)(3) | 170(B)(1) (A)(III) | PARK NICOLLET HEALTH SERVICES | | No |
| 6500 EXCELSIOR BLVD ST LOUIS PARK, MN 55426 01-0638901 | DURABLE MEDICAL EQUIPMENT , PHARMACY AND OTHER HEALTH CARE RETAIL SALES | MN | 501(C)(3) | 509(A)(3) TYPE I | PARK NICOLLET HEALTH SERVICES | | No |
| 6500 EXCELSIOR BLVD ST LOUIS PARK, MN 55426 41-0834920 | CLINIC SERVICES | MN | 501(C)(3) | 170(B)(1) (A)(III) | PARK NICOLLET HEALTH SERVICES | | No |
| 6500 EXCELSIOR BLVD ST LOUIS PARK, MN 55426 41-1741792 | HEALTHCARE REAL ESTATE | MN | 501(C)(3) | 509(A)(3) TYPE I | PARK NICOLLET HEALTH SERVICES | | No |
| 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 39-0908320 | HOSPITAL | WI | 501(C)(3) | 170(B)(1) (A)(III) | RH-WISCONSIN | | No |
| 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 39-1726539 | PROVIDE SUPPORT TO HOSPITAL AND IMPORVE COMMUNITY HEALTH | WI | 501(C)(3) | 170(B)(1) (A)(VI) | AMERY REGIONAL MEDICAL CENTER INC | | No |

Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income | (g) Share of end-of- year assets | (h) Percentage ownership | (i) Section 512 (b)(13) controlled entity? | |
|--|--|---|---|--|---------------------------------|---|--------------------------------|--|----|
| | | | | | | | | Yes | No |
| HEALTHPARTNERS ADMINISTRATORS INC 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 41-1629390 | THIRD PARTY ADMINISTRATOR | MN | HEALTHPARTNERS INC | C | | | | | No |
| HEALTHPARTNERS ASSOCIATES INC 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 52-2365151 | MEDICAL CLINIC STAFFING AND ASSET MANAGEMENT | MN | HEALTHPARTNERS ADMINISTRATORS INC | C | | | | | No |
| HEALTHPARTNERS SERVICES INC 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 41-1683568 | MEDICAL CLINIC STAFFING AND ASSET MANAGEMENT | MN | HEALTHPARTNERS ADMINISTRATORS INC | C | | | | | No |
| HEALTHPARTNERS INSURANCE COMPANY 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 41-1683523 | MEDICAL AND DENTAL INSURANCE | MN | HEALTHPARTNERS ADMINISTRATORS INC | C | | | | | No |
| DENTAL SPECIALTIES INC 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 45-1297583 | PROFESSIONAL DENTAL SERVICES | MN | HEALTHPARTNERS ADMINISTRATORS INC | C | | | | | No |
| HEALTHPARTNERS CENTRAL MINNESOTA CLINICS INC 8170 33RD AVE S PO BOX 1309 MPLS, MN 554401309 41-1236798 | MEDICAL CLINIC STAFFING | MN | HEALTHPARTNERS ADMINISTRATORS INC | C | | | | | No |
| PARK NICOLLET ENTERPRISES 6500 EXCELSIOR BLVD ST LOUIS PARK, MN 55426 41-1656735 | REAL ESTATE FOR RELATED ORGANIZATIONS | MN | PARK NICOLLET HEALTH SERVICES | C | | | | | No |