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Form 990

Return of Organization Exempt From Income Tax

OMB No 1545-0047

2017

Open to Public Inspection

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

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

Information about Form 990 and its instructions is at [www.irs.gov/form990](#)

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

B Check if applicable

☐ Address change

☐ Name change

☐ Initial return

☐ Final return/terminated

☐ Amended return

☐ Application pending

C Name of organization

TAKOMA REGIONAL HOSPITAL INC

Doing business as

Number and street (or P O box if mail is not delivered to street address) Room/suite

1905 AMERICAN WAY

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

KINGSPORT, TN 37660

F Name and address of principal officer

TAMMY ALBRIGHT

1905 AMERICAN WAY

KINGSPORT, TN 37660

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 ▶

D Employer identification number

51-0603966

E Telephone number

(423) 302-3374

G Gross receipts \$ 60,785,959

I Tax-exempt status

☒ 501(c)(3) ☐ 501(c) () ◀(insert no) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ BALLADHEALTH.ORG

K Form of organization

☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation 2006

M State of legal domicile TN

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities

MISSION HONOR THOSE WE SERVE BY DELIVERING THE BEST POSSIBLE CARE VISION TO BUILD A LEGACY OF SUPERIOR HEALTH BY LISTENING TO AND CARING FOR THOSE WE SERVE

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)

4 Number of independent voting members of the governing body (Part VI, line 1b)

5 Total number of individuals employed in calendar year 2017 (Part V, line 2a)

6 Total number of volunteers (estimate if necessary)

7a Total unrelated business revenue from Part VIII, column (C), line 12

7b Net unrelated business taxable income from Form 990-T, line 34

Revenue

8 Contributions and grants (Part VIII, line 1h)

9 Program service revenue (Part VIII, line 2g)

10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)

11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)

12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)

Expenses

13 Grants and similar amounts paid (Part IX, column (A), lines 1–3)

14 Benefits paid to or for members (Part IX, column (A), line 4)

15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)

16a Professional fundraising fees (Part IX, column (A), line 11e)

b Total fundraising expenses (Part IX, column (D), line 25) ▶0

17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)

18 Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)

19 Revenue less expenses Subtract line 18 from line 12

Net Assets or Fund Balances

20 Total assets (Part X, line 16)

21 Total liabilities (Part X, line 26)

22 Net assets or fund balances Subtract line 21 from line 20

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

TAMMY ALBRIGHT, PRESIDENT-TRH

2019-05-13

Date

Paid Preparer Use Only

Print/Type preparer's name

Preparer's signature

Date

Check ☐ if self-employed

PTIN

Firm's name ▶

Firm's EIN ▶

Firm's address ▶

Phone no

May the IRS discuss this return with the preparer shown above? (see instructions)

☐ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate instructions.

Cat No 11282Y

Form 990 (2017)

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

HONOR THOSE WE SERVE BY DELIVERING THE BEST POSSIBLE CARE

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 \$ 54,982,539	including grants of \$ 2,100	(Revenue \$ 60,370,730)
See Additional Data				

4b	(Code)	(Expenses \$	including grants of \$	(Revenue \$)
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4c	(Code)	(Expenses \$	including grants of \$	(Revenue \$)
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4d	Other program services (Describe in Schedule O)	(Expenses \$	including grants of \$	(Revenue \$)
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4e	Total program service expenses ▶	54,982,539
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Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

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

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

		Yes	No
1a	Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable	1a	36
b	Enter the number of Forms W-2G included in line 1a Enter -0- if not applicable	1b	0
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c	Yes
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	726
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	2b	Yes
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?	3a	Yes
b	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O	3b	Yes
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a	No
b	If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)		
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a	No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b	No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	5c	
6a	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	6a	No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b	
7	Organizations that may receive deductible contributions under section 170(c).		
a	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?	7a	No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c	No
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d	
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e	No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f	No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g	
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h	
8	Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	8	
9a	Did the sponsoring organization make any taxable distributions under section 4966?	9a	
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	9b	
10	Section 501(c)(7) organizations. Enter		
a	Initiation fees and capital contributions included on Part VIII, line 12	10a	
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b	
11	Section 501(c)(12) organizations. Enter		
a	Gross income from members or shareholders	11a	
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)	11b	
12a	Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?	12a	
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b	
13	Section 501(c)(29) qualified nonprofit health insurance issuers.		
a	Is the organization licensed to issue qualified health plans in more than one state? Note. See the instructions for additional information the organization must report on Schedule O	13a	
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b	
c	Enter the amount of reserves on hand	13c	
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a	No
b	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O	14b	

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

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

Section A. Governing Body and Management

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

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

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

Section C. Disclosure

17 List the States with which a copy of this Form 990 is required to be filed: TN, VA

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 ☒ 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.
 ▶ LYNN KRUTAK 303 MED TECH PARKWAY SUITE 300 JOHNSON CITY, TN 37604 (423) 302-3374

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent ContractorsCheck if Schedule O contains a response or note to any line in this Part VII ☐**Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees****1a** Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
(1) BARTON HOVE RETIRED 1312018 CHAIR/PRES/C	0 10 31 90	X		X				0	1,219,926	49,559
(2) ERIC DEATON SR VP MARKET	0 10 49 90	X						0	604,699	33,581
(3) GARY MILLER TREAS/SR VP	0 10 49 90	X		X				0	520,874	27,097
(4) TODD DOUGAN END 4302018 SEC/FIN INTE	0 10 44 90	X		X				0	488,418	36,727
(5) TAMMY ALBRIGHT PRESIDENT-TR	45 00			X				202,646	0	26,052
(6) JUDITH CLARK CONTROLLER	40 00			X				94,853	0	3,548
(7) JOSEPH KRETSCHMAR MD PHYSICIAN	40 00					X		667,237	0	37,939
(8) TODD CHRISTENSEN MD PHYSICIAN	40 00					X		615,352	0	40,621
(9) WILLIAM BRIDGES MD PHYSICIAN	40 00					X		431,298	0	33,744
(10) JAMI GOODWIN MD PHYSICIAN	40 00					X		409,579	0	30,769
(11) HOWARD HERRELL MD PHYSICIAN	40 00					X		408,595	0	23,696

[illegible]

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization ▶ 45

Section B. Independent Contractors

(A)	(B)	(C)
Name and business address	Description of services	Compensation
PT SOLUTIONS, P O BOX 441146 KENNESAW, GA 30160	PHYS THRPY SVCS	1,865,577
MEDICAL SERVICES BILLING, P O BOX 22266 CHATTANOOGA, TN 37422	BILLING SVCS	767,651
ARUP LABORATORIES, P O BOX 27964 SALT LAKE CITY, UT 84127	LAB SERVICES	501,080
ARAMARK, 1101 MARKET STREET DRIVE PHILADELPHIA, PA 19101	CLINIC ENG SVCS	260,786
TELE-PHYSICIAN PC, 1768 BUSINESS CENTER DRIVE SUITE 10 RESTON, VA 20190	CONSULTING FEES	149,458

Form 990 (2017)

Part VIII Statement of RevenueCheck if Schedule O contains a response or note to any line in this Part VIII ☐

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns . . .	1a				
	b Membership dues . . .	1b				
	c Fundraising events . . .	1c				
	d Related organizations	1d	346,073			
	e Government grants (contributions)	1e				
	f All other contributions, gifts, grants, and similar amounts not included above	1f				
	g Noncash contributions included in lines 1a-1f \$ _____					
	h Total. Add lines 1a-1f ▶		346,073			
Program Service Revenue			Business Code			
	2a NET PATIENT REVENUE		621990	56,411,192	56,411,192	
	b TMA OCC MED REVENUE		621990	480,926	480,926	
	c LAB REVENUE		621990	56,007	56,007	
	d TRH ADMINISTRATIVE REVENUE		621990	47,403	47,403	
	e TMA BEHAVIORAL HEALTH REVENUE		622110	27,571	27,571	
	f All other program service revenue			12,922	12,922	
	g Total. Add lines 2a-2f ▶		57,036,021			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts) ▶					
	4 Income from investment of tax-exempt bond proceeds ▶					
	5 Royalties ▶					
	6a Gross rents	(i) Real (ii) Personal				
		2,736				
	b Less rental expenses					
	c Rental income or (loss)	2,736				
	d Net rental income or (loss) ▶		2,736	2,736		
	7a Gross amount from sales of assets other than inventory	(i) Securities (ii) Other				
		92,873				
	b Less cost or other basis and sales expenses	46,433				
	c Gain or (loss)	46,440				
	d Net gain or (loss) ▶		46,440	46,440		
	8a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18 a					
	b Less direct expenses b					
	c Net income or (loss) from fundraising events . . . ▶					
	9a Gross income from gaming activities See Part IV, line 19 a					
	b Less direct expenses b					
c Net income or (loss) from gaming activities . . . ▶						
10a Gross sales of inventory, less returns and allowances . . . a						
b Less cost of goods sold . . . b						
c Net income or (loss) from sales of inventory . . . ▶						
Miscellaneous Revenue		Business Code				
11a 340B REVENUE		900099	3,046,531	3,046,531		
b CAFETERIA SALES		900099	148,469	148,469		
c EMPLOYER PROVIDED PARKING		900099	22,723		22,723	
d All other revenue			90,533	90,533		
e Total. Add lines 11a-11d ▶			3,308,256			
12 Total revenue. See Instructions ▶			60,739,526	60,370,730	22,723	

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.	2,100	2,100		
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.	536,292		536,292	
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.	28,206,867	27,566,752	640,115	
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).	718,539	711,914	6,625	
9 Other employee benefits.	3,622,953	3,477,055	145,898	
10 Payroll taxes.	1,828,095	1,744,253	83,842	
11 Fees for services (non-employees):				
a Management.	595,295	5,836	589,459	
b Legal.	11,847		11,847	
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).	3,509,817	1,597,894	1,911,923	
12 Advertising and promotion.	3,349	1,011	2,338	
13 Office expenses.	1,256,507	933,362	323,145	
14 Information technology.				
15 Royalties.				
16 Occupancy.	2,223,017	2,203,779	19,238	
17 Travel.	35,133	27,667	7,466	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials.				
19 Conferences, conventions, and meetings.				
20 Interest.	20,788		20,788	
21 Payments to affiliates.				
22 Depreciation, depletion, and amortization.	1,047,439	1,047,439		
23 Insurance.	124,932		124,932	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O):				
a PURCHASED SERVICES	7,981,538	7,557,534	424,004	
b MEDICAL SUPPLIES & DRUGS	6,667,839	6,667,839		
c MANAGEMENT FEES TO PARENT	4,501,515		4,501,515	
d REPAIRS & MAINTENANCE	773,825	495,012	278,813	
e All other expenses	1,054,428	943,092	111,336	
25 Total functional expenses. Add lines 1 through 24e.	64,722,115	54,982,539	9,739,576	0
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

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

				(A) Beginning of year		(B) End of year
Assets	1	Cash—non-interest-bearing		7,753,853	1	3,662,160
	2	Savings and temporary cash investments			2	
	3	Pledges and grants receivable, net			3	
	4	Accounts receivable, net		-19,045,653	4	10,166,678
	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	799,101
	8	Inventories for sale or use		1,447,363	8	1,269,767
	9	Prepaid expenses and deferred charges		119,361	9	124,468
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D.	10a	15,590,251		
	b	Less: accumulated depreciation	10b	1,625,690		
				11,527,175	10c	13,964,561
	11	Investments—publicly traded securities			11	
	12	Investments—other securities. See Part IV, line 11			12	
	13	Investments—program-related. See Part IV, line 11			13	
	14	Intangible assets		2,460,679	14	2,507,964
15	Other assets. See Part IV, line 11			15		
16	Total assets. Add lines 1 through 15 (must equal line 34)		4,262,778	16	32,494,699	
Liabilities	17	Accounts payable and accrued expenses		4,383,198	17	3,043,192
	18	Grants payable			18	
	19	Deferred revenue			19	
	20	Tax-exempt bond liabilities			20	
	21	Escrow or custodial account liability. Complete Part IV of Schedule D			21	
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L			22	
	23	Secured mortgages and notes payable to unrelated third parties			23	
	24	Unsecured notes and loans payable to unrelated third parties			24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D		715,406	25	613,247
	26	Total liabilities. Add lines 17 through 25		5,098,604	26	3,656,439
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.					
	27	Unrestricted net assets		-835,826	27	28,838,260
	28	Temporarily restricted net assets			28	
	29	Permanently restricted net assets			29	
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.					
	30	Capital stock or trust principal, or current funds			30	
	31	Paid-in or capital surplus, or land, building or equipment fund			31	
	32	Retained earnings, endowment, accumulated income, or other funds			32	
33	Total net assets or fund balances		-835,826	33	28,838,260	
34	Total liabilities and net assets/fund balances		4,262,778	34	32,494,699	

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	60,739,526
2	Total expenses (must equal Part IX, column (A), line 25)	2	64,722,115
3	Revenue less expenses Subtract line 2 from line 1	3	-3,982,589
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	-835,826
5	Net unrealized gains (losses) on investments	5	
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	33,656,675
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	28,838,260

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

	Yes	No
1 Accounting method used to prepare the Form 990 <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O		
2a Were the organization's financial statements compiled or reviewed by an independent accountant? If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		No
b Were the organization's financial statements audited by an independent accountant? If 'Yes,' check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	Yes	
c If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O	Yes	
3a As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?		No
b If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits		

Additional Data

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

Form 990 (2017)

Form 990, Part III, Line 4a:

TAKOMA REGIONAL HOSPITAL, INC., IS A 100-BED ACUTE CARE FACILITY LOCATED IN GREENEVILLE, TENNESSEE. TAKOMA REGIONAL HOSPITAL FOUNDATION IS A SUPPORTING ORGANIZATION FOR THE HOSPITAL. WE PROVIDE A WIDE VARIETY OF SERVICES, INCLUDING EMERGENCY CARE, PHYSICAL, STROKE AND OCCUPATIONAL THERAPIES, SURGERY, ACUTE MEDICAL CARE SERVICES INCLUDING ICU, PROGRESSIVE CARE, AND GENERAL MED SURG, INPATIENT REHABILITATION UNIT, GERO-PSYCH SERVICES, LABORATORY SERVICES, RESPIRATORY THERAPY, SLEEP EVALUATIONS AND TREATMENT, INPATIENT AND OUTPATIENT (CONTINUED ON SCHEDULE O) (CONT'D) REHABILITATION SERVICES, PRIMARY AND SPECIALTY PHYSICIAN CLINICS AND DIAGNOSTIC IMAGING. IN FISCAL YEAR 2018, WE PROVIDED SERVICES TO 2,443 INPATIENTS, HAD 1,793 SURGICAL CASES AND 17,705 EMERGENCY ROOM VISITS. CONSISTENT WITH OUR MISSION, WE HAVE WORKED TOWARD IMPROVING OUR COMMUNITY'S ACCESS TO QUALITY, AFFORDABLE HEALTHCARE, IMPROVING THE HEALTH STATUS OF OUR COMMUNITIES AND CONTRIBUTING TO THE OVERALL QUALITY OF LIFE IN THE AREAS WE SERVE. THE HOSPITAL AND ITS EMPLOYED PHYSICIAN PRACTICES WENT LIVE ON WELLMONT HEALTH SYSTEM'S EPIC ELECTRONIC HEALTH RECORD SYSTEM IN NOVEMBER 2017. THE EPIC SYSTEM IS THE PREMIER SUCH SYSTEM AND ENABLES A PATIENT AND THEIR HEALTHCARE PROVIDERS TO SEE ALL OF THE PATIENT'S HEALTH INFORMATION ACROSS, NOT ONLY TAKOMA'S SITES, BUT ALSO WELLMONT HEALTH SYSTEM AND ALL EPIC SITES IN THE COUNTRY. THIS RESULTS IN BETTER, QUICKER AND MORE EFFICIENT CARE OF THE PATIENT. TO FURTHER THE COMMUNITY'S HEALTH STATUS, TAKOMA REGIONAL TEACHES OR HAS AVAILABLE A VARIETY OF HEALTH PROGRAMS THAT INCLUDE - A NATURE TRAIL, WHICH IS A LITTLE MORE THAN A MILE IN LENGTH - THE "BIGGEST LOSER" LIFESTYLE AND WEIGHT-LOSS PROGRAM - TOTAL LIFESTYLE PROGRAM - STROKE SUPPORT GROUP - DIABETES TREATMENT CENTER (SENIOR ADULT CENTER) - LECTURES AT THE LOCAL YMCA - A VARIETY OF HEALTH PROGRAMS, AVAILABLE FOR EVERYONE IN THE GREENE COUNTY SERVICE AREA, INCLUDING THE UNDERSERVED AND UNDERPRIVILEGED FOR FREE OR A NOMINAL FEE - ALONG WITH OTHER LOCAL AGENCIES, TRH TEAM MEMBERS VISITED FIVE HIGH SCHOOLS TO DEMONSTRATE THE DANGERS OF DISTRACTED DRIVING, CHARITY AND OTHER UNREIMBURSED COSTS. CHARITY CARE WHILE REIMBURSEMENT FOR HEALTHCARE SERVICES RENDERED IS CRITICAL TO THE OPERATION AND SUSTAINABILITY OF THE ORGANIZATION, TRH RECOGNIZES ITS OBLIGATION TO PROVIDE CARE TO INDIVIDUALS WHO CANNOT AFFORD ESSENTIAL MEDICAL SERVICES, INCLUDING EMERGENCY CARE. TRH ACCEPTS ALL PATIENTS REGARDLESS OF THEIR ABILITY TO PAY. A PATIENT IS CLASSIFIED AS A CHARITY PATIENT WHEN THEY MEET THE ESTABLISHED POLICIES OF TRH AND GUIDELINES OUTLINED BY THE FEDERAL GOVERNMENT. HOWEVER, FINANCIAL ASSISTANCE DECISIONS ARE NOT SOLELY BASED ON INCOME. UNIQUE FINANCIAL CIRCUMSTANCES ARE WEIGHED WITH VERIFIED PATIENT ASSETS WHICH CAN DETERMINE FINANCIAL ASSISTANCE ELIGIBILITY. IT IS NOT UNTIL AFTER VERIFICATION OF INCOME AND ASSETS THAT A DECISION REGARDING THE AMOUNT OF FINANCIAL ASSISTANCE CAN BE MADE. IN FISCAL YEAR 2018, TRH INCURRED A LOSS OF 972,691 ATTRIBUTABLE TO THE PROVISION OF CHARITY CARE, AN INCREASE OF MORE THAN 9.4% FROM FISCAL YEAR 2017. THIS AMOUNT DOES NOT INCLUDE THE COSTS ASSOCIATED WITH BAD DEBT ACCOUNTS. TENN CARE/MEDICAID. TRH PROVIDES CARE TO PERSONS COVERED BY GOVERNMENTAL PROGRAMS, SUCH AS TENN CARE (TENNESSEE RESIDENTS) AND MEDICAID. TRH INCURRED A LOSS OF 2,327,851 PROVIDING CARE TO THIS POPULATION OF PATIENTS DURING THE YEAR. UNINSURED DISCOUNT. UNINSURED PATIENTS RECEIVED A 74 PERCENT DISCOUNT THROUGHOUT FY2018. THE UNINSURED DISCOUNT IS APPLIED TO ALL UNINSURED PATIENTS AT WHS HOSPITALS. ALSO, CERTAIN ELECTIVE PROCEDURES ARE NOT ELIGIBLE FOR THE UNINSURED DISCOUNT. THE UNINSURED DISCOUNT IS CALCULATED EACH YEAR IN ACCORDANCE WITH TENNESSEE REGULATIONS AND WITHOUT REGARD TO A PATIENT'S INCOME OR ASSETS. THE APPROXIMATE COST OF THIS DISCOUNT IN FY2018, USING OUR COST TO CHARGE RATIO, WAS 1,862,165. THE BEST WAY TO KEEP OUR COMMUNITIES HEALTHY IS TO PROVIDE THEM WITH THE LATEST INFORMATION ABOUT THEIR HEALTH. WE STRIVE TO PROVIDE INFORMATION ABOUT EVERYTHING FROM DISEASE AND INJURY PREVENTION TO THE LATEST TREATMENTS AND TECHNOLOGIES AVAILABLE TO COPING WITH DISEASE AND ITS SYMPTOMS. SOME OF OUR PROGRAMS DURING FY2018 INCLUDE -WE OFFERED DIABETES EDUCATION CLASSES THROUGHOUT THE YEAR, THE CLASS IS TWO-PARTS, WITH FOUR-HOUR SESSIONS OVER TWO DAYS -NUTRITION PRESENTATIONS WERE PROVIDED BY OUR DIETITIAN ON TOPICS SUCH AS TIPS FOR HEALTHY EATING, HOW TO READ FOOD LABELS, WITH INFORMATION PAMPHLETS PROVIDED TO PARTICIPANTS, AND HEALTHY SNACKS -WE OFFERED MONTHLY PRENATAL CLASSES, WHICH WERE OPEN TO THE PUBLIC -OUR INFECTION CONTROL NURSE VISITED A LOCAL ELEMENTARY SCHOOL TO EXPLAIN THE IMPORTANCE OF HANDWASHING TO THE STUDENTS -NUMEROUS PRESENTATIONS WERE PROVIDED AT THE ADULT CENTER FOR AGING, DISCUSSIONS INCLUDED SUPERFOOD NUTRITION AND OTHER NUTRITION LEARNING SESSIONS FROM OUR DIETITIAN, GENERAL HEALTH, DIABETES CARE MANAGEMENT, HEPATITIS C, WOUND CARE, AND OTHERS WE PARTICIPATED IN HEALTH FAIRS, SUCH AS -DIABETES HOLIDAY HEALTH FAIR -A GENERAL HOLIDAY HEALTH FAIR -TWO WORKPLACE HEALTH FAIRS -A HEALTH FAIR AT THE YMCA -GREENE COUNTY FAIR WORKING A FIRST AID STATION AND DISTRIBUTING WATER. HOSPITAL TEAM MEMBERS ARE ENGAGED IN A MYRIAD OF COMMUNITY ACTIVITIES. SOME EXAMPLES DURING FY2018 -TRH STAFF WORKED AT THE I-40 WELCOME CENTER THE DAY OF THE SOLAR ECLIPSE TO KEEP PEOPLE'S EYESIGHT SAFE. THE WELCOME CENTER PROVIDED SOLAR GLASSES -HOSPITAL STAFF WORKED AT THREE BLOOD DRIVES -OUR WELLNESS COORDINATOR ORGANIZED A 5K RUN FOR THE TOWN OF GREENEVILLE POLICE DEPARTMENT -THE HOSPITAL IS INVOLVED IN THE GREENE COUNTY ANTI-DRUG COALITION -TWO TEAM MEMBERS REPRESENT THE HOSPITAL ON THE HEALTHIER TENNESSEE COMMITTEE FOR OUR AREA -TEAM MEMBERS SERVE ON THE GREENE COUNTY HEALTH COUNCIL. HOSPITAL MEETING SPACE IS OPEN TO LOCAL ORGANIZATIONS THAT SUPPORT COMMUNITY HEALTH AND WELLNESS. SOME EXAMPLES INCLUDE CITY SCHOOL MEETINGS, SPORTS MEDICINE DISCUSSIONS FOR HIGH SCHOOLS AND A LOCAL COLLEGE, GREENE COUNTY PARTNERSHIP ADULT LEADERSHIP, A DIABETES SUPPORT GROUP, GREENE COUNTY MINISTERIAL ASSOCIATION, A STROKE SUPPORT GROUP, A BREAST CANCER SUPPORT GROUP, AND A CANCER SUPPORT GROUP. SOME OF THE HEALTHIER TENNESSEE COMMITTEE MEETINGS WERE ALSO HELD AT TRH. TAKOMA REGIONAL HOSPITAL SERVES AS A CLINICAL TRAINING SITE FOR HEALTH PROFESSIONAL EDUCATION STUDENTS. WE DEDICATE STAFF TO WORK WITH REGIONAL COLLEGES AND UNIVERSITIES TO COORDINATE PLACEMENT OF HEALTHCARE PROFESSIONAL STUDENTS AS PART OF THEIR EDUCATIONAL CURRICULUM. IN ADDITION TO CLINICAL TRAINING, THE HEALTH CARE STUDENTS ENTERING OUR SYSTEM ARE REQUIRED TO HAVE ORIENTATION AND COMPUTER TRAINING. INCLUDED IN THE NUMBER OF PARTICIPANTS RECEIVING CLINICAL EXPERIENCE AT TRH WERE 28 NURSING STUDENTS. THIS CLINICAL NURSING EXPERIENCE REQUIRED EXTENSIVE TRH NURSING STAFF INVOLVEMENT. THE CLINICAL SETTING AND HANDS-ON INSTRUCTION COST THE HOSPITAL 42,908. TRH PROVIDED CLINICAL TRAINING FOR ANOTHER 11 STUDENTS TRAINING IN OTHER ALLIED HEALTH DISCIPLINES. THE HOSPITAL INCURRED EXPENSE OF 9,411 TO PROVIDE THIS TRAINING.

SCHEDULE A
(Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.
▶ Attach to Form 990 or Form 990-EZ.
▶ Information about Schedule A (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
TAKOMA REGIONAL HOSPITAL INC

Employer identification number
51-0603966

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

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

- 1

☐

A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i)**.
- 2

☐

A school described in **section 170(b)(1)(A)(ii)**. (Attach Schedule E (Form 990 or 990-EZ))
- 3

☒

A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii)**.
- 4

☐

A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii)**. Enter the hospital's name, city, and state _____
- 5

☐

An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv)**. (Complete Part II)
- 6

☐

A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v)**.
- 7

☐

An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi)**. (Complete Part II)
- 8

☐

A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II)
- 9

☐

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

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

- 1** ☐ Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970 (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: 51-0603966
Name: TAKOMA REGIONAL 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

efile GRAPHIC print - DO NOT PROCESS

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DLN: 93493133032239

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
TAKOMA REGIONAL HOSPITAL INC

Employer identification number
51-0603966

Part I

Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.
Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

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?

☐ Yes ☐ 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?

☐ Yes ☐ 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

2a

2b

2c

2d

Held at the End of the Year

3

Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ►

4

Number of states where property subject to conservation easement is located ►

5

Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?

☐ 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

► \$

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

Cat No 52283D

Schedule D (Form 990) 2017

Part III

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

3

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

a

☐ Public exhibition

b

☐ Scholarly research

c

☐ Preservation for future generations

d

☐ Loan or exchange programs

e

☐ Other

4

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

5

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

☐ Yes

☐ No

Part IV

Escrow and Custodial Arrangements.

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

1a

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

☐ Yes

☐ No

b

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

c

Beginning balance

d

Additions during the year

e

Distributions during the year

f

Ending balance

	Amount
1c	
1d	
1e	
1f	

2a

Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability?

☐ Yes

☐ No

b

If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII

☐

Part V

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

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

2

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

a

Board designated or quasi-endowment ▶

b

Permanent endowment ▶

c

Temporarily restricted endowment ▶

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

3a

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

(i) unrelated organizations

(ii) related organizations

b

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

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

4

Describe in Part XIII the intended uses of the organization's endowment funds

Part VI

Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		2,558,118		2,558,118
b Buildings		6,700,419	450,077	6,250,342
c Leasehold improvements				
d Equipment		6,189,622	1,140,167	5,049,455
e Other		142,092	35,446	106,646
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c)) . . . ▶				13,964,561

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.

(a) Description of liability	(b) Book value
(1) Federal income taxes	
OBLIGATIONS CAPITAL LEASES	226,773
CAPITAL LEASE	191,541
DUE TO THIRD-PARTY PAYERS	188,984
DUE TO RELATED PARTIES	5,949
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 25)	613,247

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	

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

Return Reference	Explanation

Additional Data

Software ID:

Software Version:

EIN: 51-0603966

Name: TAKOMA REGIONAL HOSPITAL INC

Supplemental Information

Return Reference	Explanation
SCHEDULE D, PAGE 3, PART X	TAKOMA REGIONAL HOSPITAL, INC IS INCLUDED IN THE AUDITED CONSOLIDATED FINANCIAL STATEMENT S OF BALLAD HEALTH THE FOOTNOTE EXPLANATION RELATIVE TO INCOME TAXES READS "BALLAD IS CL ASSIFIED AS AN ORGANIZATION EXEMPT FROM FEDERAL INCOME TAXES UNDER SECTION 501(C)(3) OF TH E INTERNAL REVENUE CODE AS SUCH, NO PROVISION FOR FEDERAL INCOME TAXES HAS BEEN MADE IN T HE ACCOMPANYING CONSOLIDATED FINANCIAL STATEMENTS FOR BALLAD AND ITS TAX- EXEMPT SUBSIDIAR IES BALLAD'S TAXABLE SUBSIDIARIES ARE DISCUSSED IN NOTE L BALLAD HAS NO SIGNIFICANT UNCE RTAIN TAX POSITIONS AT JUNE 30, 2018 AT JUNE 30, 2018, TAX RETURNS FOR MSHA AND WHS FOR 2 015 THROUGH 2017 ARE SUBJECT TO EXAMINATION BY THE INTERNAL REVENUE SERVICE "

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
TAKOMA REGIONAL HOSPITAL INC

Employer identification number
51-0603966

Part I

Financial Assistance and Certain Other Community Benefits at Cost

	Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a Yes	
b If "Yes," was it a written policy?	1b Yes	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year		
<input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities		
<input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year		
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care	3a Yes	
<input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other 225 0000000000 %		
b Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care	3b Yes	
<input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other 450 0000000000 %		
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care		
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4 Yes	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a Yes	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	No
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c	
6a Did the organization prepare a community benefit report during the tax year?	6a Yes	
b If "Yes," did the organization make it available to the public?	6b Yes	
Complete the following table using the worksheets provided in the Schedule H instructions Do not submit these worksheets with the Schedule H		

7

Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			972,691		972,691	1 500 %
b Medicaid (from Worksheet 3, column a)			5,754,326	3,426,475	2,327,851	3 600 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			6,727,017	3,426,475	3,300,542	5 100 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			215,289	2,347	212,942	0 330 %
f Health professions education (from Worksheet 5)			52,318		52,318	0 080 %
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			2,005		2,005	
j Total. Other Benefits			269,612	2,347	267,265	0 410 %
k Total. Add lines 7d and 7j			6,996,629	3,428,822	3,567,807	5 510 %

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

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

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

		Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	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	4,086,782	
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3		
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME).	5	11,291,112	
6 Enter Medicare allowable costs of care relating to payments on line 5.	6	11,510,948	
7 Subtract line 6 from line 5. This is the surplus (or shortfall).	7	-219,836	
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				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

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

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

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

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

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

Part V Facility Information (continued)**Section B. Facility Policies and Practices**(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)
TAKOMA REGIONAL HOSPITAL INC**Name of hospital facility or letter of facility reporting group** _____**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** _____

1

Community Health Needs Assessment

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

Part V Facility Information (continued)**Financial Assistance Policy (FAP)**

TAKOMA REGIONAL HOSPITAL INC

Name of hospital facility or letter of facility reporting group _____

		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>225 000000000000</u> % and FPG family income limit for eligibility for discounted care of <u>450 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 type="checkbox"/> Insurance status			
f <input type="checkbox"/> Underinsurance discount			
g <input type="checkbox"/> Residency			
h <input checked="" type="checkbox"/> Other (describe in Section C)			
14 Explained the basis for calculating amounts charged to patients?	14	Yes	
15 Explained the method for applying for financial assistance?	15	Yes	
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)			
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?	16	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>BALLADHEALTH ORG</u>			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>BALLADHEALTH ORG</u>			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>BALLADHEALTH ORG</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**

TAKOMA REGIONAL HOSPITAL INC

Name of hospital facility or letter of facility reporting group

	Yes	No
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon 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)**

TAKOMA REGIONAL HOSPITAL INC

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

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
22		
23		No
24		No

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

[illegible]

Part V Facility Information (continued)**Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**
(list in order of size, from largest to smallest)How many non-hospital health care facilities did the organization operate during the tax year? 9

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

Part VI Supplemental Information

Provide the following information

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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 3C - OTHER INCOME BASED CRITERIA FOR FREE OR DISCOUNTED CARE	FINANCIAL ASSISTANCE APPROVAL CAN APPLY TO AN ASSORTMENT OF PATIENTS SUCH AS THOSE WHO HAVE EXHAUSTED THEIR TENNCARE/MEDICAID BENEFITS, THOSE WHO QUALIFIED FOR TENNCARE/MEDICAID AFTER THE DATE OF SERVICE, DECEASED PATIENTS WITH NO ESTATE OR ASSETS, UNINSURED PATIENTS, AND UNDERINSURED PATIENTS WHILE BALLAD HEALTH'S QUALIFICATIONS FOR FINANCIAL ASSISTANCE IS BASED ON FEDERAL POVERTY GUIDELINES, ASSET VALUES MAY ALSO BE USED TO DETERMINE ELIGIBILITY UNIQUE CIRCUMSTANCES MAY BE ASSESSED ON A CASE-BY- CASE BASIS CHARITY APPROVAL COVERS ALL DATES OF SERVICE FOR THE PATIENT WHEN THEY ARE APPROVED AND THERE IS NO LIMITATION OR CAP ON THE AMOUNT OF CHARITY THAT A PATIENT MAY RECEIVE BALLAD HEALTH HOSPITALS DO NOT STOP APPROVING FINANCIAL ASSISTANCE FOR PATIENT ACCOUNTS IF A HOSPITAL'S CHARITY WRITE-OFFS EXCEED THE HOSPITAL'S CHARITY BUDGET ALL BALLAD HEALTH HOSPITALS PROVIDE AN UNINSURED DISCOUNT THE CURRENT UNINSURED DISCOUNT IS 74% FOR TAKOMA REGIONAL HOSPITAL, INC IN ADDITION TO THE UNINSURED DISCOUNT, MANY PATIENTS WILL FURTHER QUALIFY FOR ADDITIONAL FINANCIAL ASSISTANCE ALL PATIENTS SEEKING FINANCIAL ASSISTANCE MUST SUBMIT AN APPLICATION FOR FINANCIAL ASSISTANCE AND SUBMIT DOCUMENTS IN SUPPORT OF THE INFORMATION ON THE APPLICATION, UNLESS SPECIFICALLY EXCLUDED PER OUR POLICY GUIDELINES MEDICAID ELIGIBLE PATIENTS WILL QUALIFY FOR 100% FINANCIAL ASSISTANCE AND NOT BE REQUIRED TO COMPLETE THE REQUIRED DOCUMENTATION WHEN A) MEDICAID ELIGIBILITY REQUIREMENTS ARE MET AFTER THE SERVICE IS PROVIDED, B) NON-COVERED CHARGES OCCUR ON A MEDICAID ELIGIBLE ENCOUNTER, OR C) BENEFITS HAVE BEEN EXHAUSTED DECEASED PATIENTS WITH NO ESTATE ALSO QUALIFY FOR 100% FINANCIAL ASSISTANCE FINANCIAL ASSISTANCE DETERMINATIONS MAY BE RETROACTIVE FOR ALL OUTSTANDING BALANCES IN ADDITION, WE HAVE A NUMBER OF PROGRAMS WITH SPECIAL DISCOUNTS SUCH AS LACTATION CONSULTATION SERVICES, ONCOLOGY TREATMENT REGIMENS, ENROLLMENT IN VARIOUS COMMUNITY PROGRAMS, AND PRESCRIPTION DRUGS FILLED POST-DISCHARGE
PART I, LINE 7 - COSTING METHODOLOGY EXPLANATION	THE COST TO CHARGE RATIO (WORKSHEET 2 "RATIO OF PATIENT CARE COST TO CHARGES") WAS USED TO COMPUTE THE COST RELATED TO FINANCIAL ASSISTANCE (LINE 7A) AND TENNCARE/MEDICAID LOSSES (LINE 7B) LINE 7E COMMUNITY HEALTH IMPROVEMENT INCLUDES COSTS TAKEN DIRECTLY FROM DEPARTMENTAL OPERATING REPORTS OR SPECIFIC GENERAL LEDGER EXPENSE ACCOUNTS, WITH NO ADDITIONAL OVERHEAD INCLUDED LINE 7F HEALTH PROFESSIONS EDUCATION IS COMPRISED OF COSTS ASSOCIATED WITH HOSPITAL STAFF INVOLVED WITH TRAINING STUDENTS FROM COLLEGES, UNIVERSITIES AND PROGRAMS STUDENTS RECEIVE HANDS-ON TRAINING AT OUR HOSPITAL AS PART OF THEIR HEALTH PROFESSIONS CURRICULUM LINE 7I REPORTS CASH CONTRIBUTIONS MADE TO LOCAL NONPROFITS THAT PROVIDE HEALTH AND WELLNESS SERVICES TO COMMUNITY RESIDENTS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART II - COMMUNITY BUILDING ACTIVITIES	<p>BALLAD HEALTH LEADERS SUPPORT AND ENCOURAGE ALL TEAM MEMBERS TO VOLUNTEER TIME, MONEY AND SKILLS TO COMMUNITY SERVICE PROJECTS AND CHARITABLE ORGANIZATIONS. SENIOR LEADERS AND BOARD MEMBERS SET A POSITIVE EXAMPLE FOR BALLAD TEAM MEMBERS, SERVING VOLUNTARILY ON COMMITTEES AND BOARDS OF LOCAL SERVICE AND NONPROFIT ORGANIZATIONS. SOME ALSO SERVE AS MEMBERS AND CONSULTANTS ON PROFESSIONAL COMMITTEES AND TASK FORCES THAT AFFECT REGIONAL DEVELOPMENT IN HEALTHCARE AND EDUCATION. EXAMPLES OF TRH PROFESSIONAL COMMITTEE AND TASK FORCE INVOLVEMENT INCLUDE - GREENE COUNTY ANTI-DRUG COALITION - GREEN COUNTY HEALTH COUNCIL - GREENE COUNTY PARTNERSHIP LEADERSHIP PROGRAM - HEALTHY TN COMMUNITY COMMITTEE THE HOSPITAL, IN COLLABORATION WITH AREA HEALTH AGENCIES AND PROVIDERS, MAY OFFER ASSISTANCE WITH COORDINATION, ADVOCACY, PROVIDE SPACE, OR CONTRIBUTE SUPPLIES TO SUPPORT GROUPS FOR THEIR PROGRAM ACTIVITIES THAT SERVE TO ASSIST SPECIAL POPULATIONS WITHIN OUR AREA. MOST OF THESE ORGANIZATIONS WORK TO IMPROVE THE LIVES OF COMMUNITY MEMBERS THAT HAVE LIMITED, OR NO, FINANCIAL RESOURCES. EXAMPLES INCLUDE - OUR DIABETES EDUCATOR PROVIDED CORE EDUCATION CLASSES ON HOW TO MANAGE DIABETES AND READ FOOD LABELS, PRESENTED A HEALTHCARE LECTURE TO THE TOWN OF GREENEVILLE PUBLIC WORKS AND PROVIDED SEVERAL LECTURES ON NUTRITION TIPS AND TRENDS TO THE ADULT CENTER FOR AGING - AN INFECTION PREVENTION RN SPOKE TO 6TH GRADERS ON THE PROPER WAY OF HANDWASHING - A PHARMACIST AND PHYSICAL THERAPIST PRESENTED LECTURES TO THE HOPE CHEST CANCER SUPPORT GROUP ON LYMPHEDEMA MANAGEMENT AND THE SHORT AND LONG- TERM EFFECTS OF CHEMOTHERAPY - OUR ACTIVITY ROOM WAS PROVIDED TO THE STROKE SUPPORT GROUP TO CONDUCT THEIR GROUP MEETINGS SEVERAL TAKOMA REGIONAL HOSPITAL, INC EMPLOYEES SERVED ON THE GREENE COUNTY HEALTH COUNCIL AND SUB-COMMITTEES</p>
PART III, LINE 2 - BAD DEBT EXPENSE METHODOLOGY	<p>SELF-PAY BALANCES INCLUDE ACCOUNTS AFTER PAYMENTS AND CONTRACTUAL ADJUSTMENTS (DISCOUNTS) HAVE BEEN APPLIED FROM ALL THIRD-PARTY PAYERS SUCH AS MEDICARE, TENNCARE, COMMERCIAL INSURERS, AND OTHERS - GENERALLY LEAVING THE PATIENT RESPONSIBLE FOR ANY REMAINING DEDUCTIBLE AND/OR CO-PAYMENT. OTHER SELF-PAY ACCOUNTS ARE FROM PATIENTS WITH NO INSURANCE OR OTHER THIRD-PARTY COVERAGE. UNDER OUR SELF-PAY POLICY, ANY PATIENT WHO HAS NO INSURANCE AND IS INELIGIBLE FOR ANY GOVERNMENT ASSISTANCE PROGRAM RECEIVED A 76% DISCOUNT THROUGH FEBRUARY 1, 2018, AT WHICH TIME THE UNINSURED DISCOUNT WAS ADJUSTED TO 74%. MANY SELF-PAY PATIENTS WILL FURTHER QUALIFY FOR FINANCIAL ASSISTANCE (SOMETIMES REFERRED TO AS CHARITY CARE) IF THEY PROVIDE THE FINANCIAL INFORMATION WE NEED TO DEEM THEM ELIGIBLE. AFTER THE NORMAL COLLECTION PROCESS HAS INDICATED AN ACCOUNT IS UNCOLLECTIBLE, TAKOMA REGIONAL HOSPITAL, INC. WRITES THE ACCOUNT OFF TO BAD DEBT. THE HOSPITAL'S OVERALL SELF-PAY ACCOUNTS RECEIVABLE BALANCE IS EVALUATED ON AN ONGOING BASIS TO EVALUATE THE AGE OF ACCOUNTS RECEIVABLE, HISTORICAL WRITE-OFFS AND RECOVERIES AND ANY UNUSUAL INSTANCES (SUCH AS LOCAL, REGIONAL OR NATIONAL ECONOMIC CONDITIONS) WHICH AFFECT THE COLLECTIVITY OF RECEIVABLES.</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
BAD DEBT EXPENSE FOOTNOTE TO FINANCIAL STATEMENTS	BALLAD HEALTH'S AUDITED FINANCIAL STATEMENTS INCLUDE A FOOTNOTE ON PAGES 13-14 THAT DESCRIBES BAD DEBT TAKOMA REGIONAL HOSPITAL, INC IS INCLUDED IN THE JUNE 30, 2018 AUDITED FINANCIAL STATEMENTS OF BALLAD HEALTH THE AUDITED FINANCIAL STATEMENTS ARE FOR THE FIVE MONTHS ENDING AFTER THE FEBRUARY 1, 2018 MERGER OF WELLMONT HEALTH SYSTEM AND MOUNTAIN STATES HEALTH ALLIANCE (ATTACHED)
PART VI, LINE 2 - NEEDS ASSESSMENT	AS REPORTED IN SCHEDULE H, PART V, SECTION B, TAKOMA REGIONAL HOSPITAL, INC CONDUCTED COMMUNITY HEALTH NEEDS ASSESSMENTS (CHNA'S) IN 2012 AND 2015 IN ADDITION TO THE CHNA, A VARIETY OF PRACTICES AND PROCESSES ARE IN PLACE TO ENSURE THAT THE FILING ORGANIZATION IS RESPONSIVE TO THE HEALTH NEEDS OF ITS COMMUNITY SUCH PRACTICES AND PROCESSES INVOLVE THE FOLLOWING 1 A HOSPITAL OPERATING/COMMUNITY BOARD COMPOSED OF INDIVIDUALS BROADLY REPRESENTATIVE OF THE COMMUNITY, COMMUNITY LEADERS, AND THOSE WITH SPECIALIZED MEDICAL TRAINING AND EXPERTISE, 2 POST-DISCHARGE PATIENT FOLLOW-UP RELATED TO THE ON-GOING CARE AND TREATMENT OF PATIENTS WHO SUFFER FROM CHRONIC DISEASES, 3 SPONSORSHIP AND PARTICIPATION IN COMMUNITY HEALTH AND WELLNESS ACTIVITIES THAT REACH A BROAD SPECTRUM OF THE FILING ORGANIZATION'S COMMUNITY, AND 4 COLLABORATION WITH OTHER LOCAL COMMUNITY GROUPS TO ADDRESS THE HEALTH CARE NEEDS OF THE FILING ORGANIZATION'S COMMUNITY

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 3 - PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE	<p>CONSISTENT WITH THE BALLAD HEALTH FINANCIAL ASSISTANCE POLICY, TAKOMA REGIONAL HOSPITAL, INC (TRH) COMMUNICATES WITH AND PROVIDES EDUCATION TO OUR PATIENTS THROUGH VARIOUS AVENUES REGARDING GOVERNMENTAL ASSISTANCE PROGRAMS AND HOSPITAL FINANCIAL ASSISTANCE. VARIOUS EDUCATIONAL AND APPLICATION DOCUMENTS RELATED TO OBTAINING FINANCIAL ASSISTANCE ARE WIDELY AVAILABLE AT TRH AND ALL DOCUMENTS ARE AVAILABLE ON THE BALLAD HEALTH WEBSITE. PRINTED FINANCIAL ASSISTANCE EDUCATIONAL MATERIALS ARE PART OF EACH REGISTRATION PACKET AND POSTERS ARE DISPLAYED IN HIGHLY VISIBLE AREAS OF THE HOSPITAL. OUR FINANCIAL ASSISTANCE POLICY AND DOCUMENTS ARE AVAILABLE IN OUR EMERGENCY DEPARTMENT AND ADMITTING AREAS. WE ARE ALSO HAPPY TO MAIL ALL DOCUMENTS TO PATIENTS. WE OFFER A PLAIN LANGUAGE SUMMARY AND ALL OF OUR DOCUMENTS ARE AVAILABLE IN ENGLISH AND SPANISH. FINANCIAL ASSISTANCE INFORMATION IS AVAILABLE DURING PRE-REGISTRATION, REGISTRATION AND/OR DURING FINANCIAL COUNSELING. WE OFFER GOVERNMENTAL PROGRAM ELIGIBILITY REPRESENTATIVES TO ASSIST PATIENTS IN SECURING ELIGIBILITY FOR MEDICAID OR TENN CARE, FEDERAL DISABILITY AND OTHER GOVERNMENTAL ASSISTANCE PROGRAMS. ADDITIONALLY, IF A PATIENT OR COMMUNITY RESIDENT EXPRESSES AN INTEREST IN THE ACA-HEALTHCARE EXCHANGE, OUR REPRESENTATIVES HAVE THE QUALIFICATIONS AND EXPERIENCE TO ASSIST THEM THROUGH THE ENTIRE PROCESS. OUR FINANCIAL COUNSELORS OFFER FINANCIAL ASSISTANCE APPLICATIONS TO PATIENTS WHO DO NOT QUALIFY FOR GOVERNMENTAL ASSISTANCE PROGRAMS AND ARE UNABLE TO PAY FOR SOME OR ALL OF THEIR HEALTHCARE. ALL PATIENT BILLING STATEMENTS HAVE VERBIAGE DISCUSSING FINANCIAL ASSISTANCE ALONG WITH CONTACT INFORMATION. OUR LAST LETTER TO THE PATIENT DISPLAYS THE PLAIN LANGUAGE SUMMARY. IN ALL ORAL CORRESPONDENCES WITH A PATIENT, IF IT IS IDENTIFIED THE PATIENT CANNOT MEET PAYMENT REQUIREMENTS ON THEIR ACCOUNT, FINANCIAL ASSISTANCE IS DISCUSSED AS AN OPTION. APPLICANTS ARE NOTIFIED OF FINANCIAL ASSISTANCE DETERMINATION IN WRITING.</p>
PART VI, LINE 4 - COMMUNITY INFORMATION	<p>TAKOMA REGIONAL HOSPITAL, INC IS LOCATED IN GREENEVILLE, TENNESSEE (GREENE COUNTY) ON THE EASTERN BORDER OF THE STATE. THE COUNTY IS PRIMARILY RURAL AND THE POPULATION IS ESTIMATED BY UNITED STATES CENSUS BUREAU TO BE 68,808. THE LATEST CENSUS BUREAU DATA ESTIMATES THE MEDIAN AGE OF RESIDENTS OF GREENE COUNTY IS 44.3, WHICH IS OLDER THAN THE MEDIAN AGE OF 38.6 IN TENNESSEE. 20.3% OF THE COUNTY'S RESIDENTS ARE 65 OR OLDER COMPARED TO 15.4% FOR THE STATE. THE BUREAU ESTIMATES GREENE COUNTY'S MEDIAN HOUSEHOLD INCOME AT 38,266 (33,445 FOR THE TOWN OF GREENEVILLE) COMPARED TO 48,708 FOR THE STATE OF TENNESSEE. 23.9% OF THE COUNTY'S CHILDREN (UNDER 18 YEARS) LIVE IN POVERTY, WHILE 30.6% OF CHILDREN UNDER 5 YEARS LIVE BELOW THE POVERTY LEVEL. GREENE COUNTY IS 65.2% RURAL COMPARED WITH THE STATEWIDE RURAL RATE OF 33.6%. THIS IS A SIGNIFICANT CONTRIBUTING FACTOR IN INFLUENCING HEALTH OUTCOMES IN A POPULATION. MANY RURAL RESIDENTS MUST TRAVEL A GREATER DISTANCE TO ACCESS DIFFERENT POINTS OF THE HEALTH CARE DELIVERY SYSTEM. DUE TO GEOGRAPHIC DISTANCE, SOMETIMES EXTREME WEATHER CONDITIONS, LACK OF PUBLIC TRANSPORTATION AND CHALLENGING ROADS, RURAL RESIDENTS MAY BE LIMITED, AND IN SOME INSTANCES, EVEN PROHIBITED FROM ACCESSING HEALTH CARE SERVICES. ALTHOUGH 19% OF PEOPLE IN THE U.S. LIVE IN RURAL AREAS AND 30% OF THE VEHICLE MILES TRAVELED OCCUR IN RURAL AREAS, ALMOST HALF OF CRASH DEATHS OCCUR THERE.</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 5 - PROMOTION OF COMMUNITY HEALTH	TAKOMA REGIONAL HOSPITAL, INC (TRH) WAS GOVERNED BY WELLMONT HEALTH SYSTEM, ITS SOLE MEMBER, UNTIL FEBRUARY, 2018 WHEN WELLMONT HEALTH SYSTEM (WHS) MERGED WITH MOUNTAIN STATES HEALTH ALLIANCE (MSHA) IN FEBRUARY TO FORM THE BALLAD HEALTH HEALTHCARE SYSTEM, BALLAD HEALTH'S BOARD OF DIRECTORS ASSUMED BOARD RESPONSIBILITIES FOR BOTH WELLMONT HEALTH SYSTEM (INCLUDING TRH) AND MOUNTAIN STATES HEALTH ALLIANCE WELLMONT AND MOUNTAIN STATES STILL EXIST AS LEGAL ENTITIES AND CONTINUE TO OPERATE MULTIPLE HOSPITALS WHS REMAINS TRH'S SOLE MEMBER TRH ALSO HAS A COMMUNITY BOARD THAT HAS CO-APPROVAL VOTING RIGHTS FOR CERTAIN DECISIONS BOARD STRUCTURE AND RIGHTS ARE DISCUSSED IN MORE DETAIL IN SCHEDULE O (FORM 990, PART VI, LINES 6 & 7) THE TRH COMMUNITY BOARD IS COMPRISED PRIMARILY OF GREENE COUNTY RESIDENTS THE TRH BOARD DELEGATED CERTAIN RESPONSIBILITIES TO THE COMMUNITY BOARD SUCH AS ADMINISTER A QUALITY ASSURANCE PROGRAM, APPOINT MEDICAL STAFF AND ADMINISTER THE CREDENTIALING AND DISCIPLINARY PROCESS APPLICABLE TO THE TAKOMA MEDICAL STAFF TRH EXTENDS MEDICAL STAFF PRIVILEGES TO ALL QUALIFIED PHYSICIANS IN OUR COMMUNITY TRH IS DEDICATED TO OPERATING EFFICIENTLY SO THAT WASTE IS MINIMIZED VARIOUS CHECKS AND BALANCES ARE ESTABLISHED TO ENSURE THAT EXPENDITURES FOR OPERATING EXPENSES AND CAPITAL COSTS ARE REASONABLE AND NECESSARY
PART VI, LINE 6 - AFFILIATED HEALTH CARE SYSTEM	TAKOMA REGIONAL HOSPITAL IS A SUBSIDIARY OF WELLMONT HEALTH SYSTEM WELLMONT HEALTH SYSTEM ("WELLMONT") IS A TENNESSEE NON-PROFIT CORPORATION BASED IN KINGSFORT, TENNESSEE WELLMONT INCLUDES FIVE ADDITIONAL HOSPITALS, AN INTEGRATED PHYSICIAN NETWORK AND SEVERAL AMBULATORY SITES WELLMONT HOSPITALS OFFER A BROAD SCOPE OF SERVICES RANGING FROM COMMUNITY-BASED ACUTE CARE TO HIGHLY SPECIALIZED TERTIARY SERVICES INCLUDING TWO TRAUMA CENTERS, COMPREHENSIVE HEART CARE AND CANCER CARE CENTERS WELLMONT HEALTH SYSTEM (WHS) IS THE SOLE MEMBER OF TAKOMA REGIONAL HOSPITAL, INC (TRH) DURING FY2018, WELLMONT HEALTH SYSTEM (WHS) MERGED WITH MOUNTAIN STATES HEALTH ALLIANCE (MSHA) TO FORM BALLAD HEALTH BALLAD HEALTH IS THE SOLE MEMBER OF WHS AND MSHA AND SERVES AS THE PARENT COMPANY FOLLOWING MERGER, WHS AND MSHA CONTINUE TO EXIST AS SEPARATE LEGAL ENTITIES, EACH OPERATING MULTIPLE HOSPITALS TAKOMA REGIONAL HOSPITAL, INC (TRH) IS OWNED BY WHS WITH THE MERGER OF WHS AND MSHA, THE EXPECTATION IS THAT TRH AND LAUGHLIN MEMORIAL HOSPITAL WILL WORK TOGETHER SO THAT COMBINED SYNERGIES WILL RESULT IN BETTER UTILIZATION OF LIMITED RESOURCES TO IMPROVE OVERALL DELIVERY OF HEALTHCARE IN THE AREA BEING PART OF A 21-HOSPITAL HEALTHCARE SYSTEM BENEFITS PATIENTS WHERE THEY ARE ABLE TO BE MOVED EFFICIENTLY ALONG AN INTEGRATED, COMPREHENSIVE CONTINUUM OF CARE AS THEIR HEALTH STATUS DICTATES IF NEEDED, A TRH PATIENT MAY BE MOVED TO ONE OF BALLAD HEALTH'S TERTIARY REFERRAL CENTERS FOR COMPLEX PATIENTS FROM TRH AND ITS SERVICE AREA

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 7 - STATE FILING OF COMMUNITY BENEFIT REPORT	TENNESSEE, VIRGINIA
ADDITIONAL INFORMATION	BALLAD HEALTH IS REQUIRED TO REPORT COMMUNITY BENEFIT ESTIMATES ON A QUARTERLY BASIS WITH THE STATES OF TENNESSEE AND VIRGINIA THE REPORTING INCLUDES ALL OF BALLAD'S HOSPITAL ORGANIZATIONS AND IS REPORTED USING IRS FORM 990 SCHEDULE H COMMUNITY BENEFIT INSTRUCTIONS BALLAD OPERATES UNDER A CERTIFICATE OF PUBLIC ADVANTAGE (COPA) IN TENNESSEE AND COOPERATIVE AGREEMENT (CA) IN VIRGINIA AS OBLIGATED BY AGREEMENTS BETWEEN BALLAD AND THE TWO STATES TO ALLOW MOUNTAIN STATES HEALTH ALLIANCE AND WELLMONT HEALTH SYSTEM TO MERGE

Schedule H (Form 990) 2017

Additional Data

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

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

Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? 1		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER—24 hours	ER—other	Other (Describe)	Facility reporting group
1	TAKOMA REGIONAL HOSPITAL INC 401 TAKOMA AVENUE GREENEVILLE, TN 37743 BALLADHEALTH.ORG/LOCATIONS/HOSPITALS 0000000054	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
FACILITY 1, TAKOMA REGIONAL HOSPITAL, INC - PART V, LINE 3E	THE COMMUNITY HEALTH NEEDS ASSESSMENT FOR TAKOMA REGIONAL HOSPITAL, INC , CONDUCTED IN 2016, PROVIDED A BROAD OVERVIEW OF THE HEALTH STATUS OF THE COMMUNITY SERVED AS OUTLINED IN THE REPORT, REVEALING THAT THE REGION SUFFERS FROM HIGHER RATES OF DIABETES, CARDIOVASCULAR DISEASE, AND BEHAVIOR RELATED CANCERS (RELATED TO SMOKING, OBESITY, SEDENTARY LIFESTYLES, ETC) THAT ASSESSMENT WAS POSTED PUBLICLY AND HAS BEEN USED IN THE INTERVENING YEARS TO SHAPE THE PRIORITIZED COMMUNITY BENEFIT INVESTMENTS MADE BY THE SYSTEM TO PARTNER WITH COMMUNITY ORGANIZATIONS SUCH INVESTMENTS HAVE FUNDED PROGRAMS FOCUSED ON INCREASING PHYSICAL ACTIVITY AND REDUCING TOBACCO USE, TWO OF THE PRIMARY BEHAVIORS THAT DRIVE POOR HEALTH AND ADVERSE HEALTH OUTCOMES IN OUR REGION IN ADDITION, PARTNERSHIPS HAVE BEEN FORMED WITH A VARIETY OF OTHER ORGANIZATIONS, INCLUDING REGIONAL YMCAS TO ENACT AFTER SCHOOL PROGRAMS WITH THE SIMILAR GOAL TO REDUCE CHILDHOOD OBESITY AND PREVENT TOBACCO USE THE CHNA CONTINUES TO INFORM PROGRAMMATIC INVESTMENTS MADE BY THE HEALTH SYSTEM TO SUPPORT EFFORTS SUCH AS NURSE CONNECT THAT IS AVAILABLE THROUGHOUT OUR REGION NURSE CONNECT, A DEPARTMENT OF WELLMONT HEALTH SYSTEM, IS A 24/7 TOLL-FREE PHONE LINE AVAILABLE TO EAST TENNESSEE AND SOUTHWEST VIRGINIA RESIDENTS THAT CONNECTS CALLERS WITH EXPERIENCED NURSES AROUND THE CLOCK WHO PROVIDE MEDICAL ADVICE, MAKE REFERRALS TO PRIMARY CARE PROVIDERS OR PHYSICIAN SPECIALISTS, PROVIDE HEALTH INFORMATION AND RESOURCES INCLUDING HEALTH SCREENINGS AND IMMUNIZATIONS, AND PROVIDE INFORMATION ON URGENT CARE CLINIC LOCATIONS
FACILITY 1, TAKOMA REGIONAL HOSPITAL, INC - PART V, LINE 5	IN CONJUNCTION WITH CONDUCTING OUR COMMUNITY HEALTH NEEDS ASSESSMENT, TAKOMA REGIONAL HOSPITAL, INC (TRH) CREATED A COMMUNITY HEALTH NEEDS ASSESSMENT COMMITTEE (CHNAC) TO PROVIDE INPUT AND GUIDE THE HEALTH NEEDS ASSESSMENT PROCESS ORGANIZATIONS AND INDIVIDUALS SERVING ON THE CHNAC INCLUDED REPRESENTATIVES FROM COUNTY AND CITY GOVERNMENT, THE GREENE COUNTY PUBLIC HEALTH DEPARTMENT, GREENE COUNTY PUBLIC SCHOOL HEALTH COORDINATORS, AND LAUGHLIN MEMORIAL HOSPITAL THE SPECIFIC ORGANIZATIONS AND INDIVIDUALS PARTICIPATING IN THE CHNAC AND REPRESENTING THE MEDICALLY UNDERSERVED, LOW-INCOME, MINORITY POPULATIONS, AND POPULATIONS WITH CHRONIC DISEASE INCLUDED REPRESENTATIVES FROM FRONTIER HEALTH, A PROVIDER OF BEHAVIORAL HEALTH SERVICES, FOOD BANK OF GREENEVILLE, TABERNACLE SOUP KITCHEN, RURAL RESOURCES, AN ORGANIZATION SERVING AS A RESOURCE AND EDUCATOR WITH RESPECT TO SUSTAINABLE AGRICULTURAL PRACTICES, AND WESLEY HEIGHTS, A LOWER-INCOME UNDERSERVED NEIGHBORHOOD LOCATED WITHIN THE HOSPITAL'S COMMUNITY THE LISTING BELOW REFLECTS ALL OF THE ORGANIZATIONS/COMMUNITY AREAS REPRESENTED ON THE HOSPITAL'S CHNAC -TRH REPRESENTATIVES -GREENE COUNTY MAYOR'S OFFICE -RURAL RESOURCES -GREENE COUNTY HEALTH DEPARTMENT -CITY OF GREENEVILLE MAYOR'S OFFICE -THE HOPE CENTER -LAUGHLIN MEMORIAL HOSPITAL REPRESENTATIVES -FRONTIER HEALTH -WESLEY HEIGHTS -FOOD BANK OF GREENEVILLE -TABERNACLE SOUP KITCHEN -GREENE COUNTY PUBLIC SCHOOLS -GREENEVILLE CITY SCHOOLS PRIMARY AND SECONDARY DATA WERE COLLECTED FOR THE PURPOSE OF THE COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS IN ADDITION TO THE INPUT RECEIVED FROM INDIVIDUALS/ORGANIZATIONS SERVING ON THE CHNAC, PRIMARY DATA WAS COLLECTED PRIMARY DATA CONSISTED OF FOCUS GROUPS, GROUP INTERVIEWS, AN ONLINE COMMUNITY HEALTH NEEDS ASSESSMENT SURVEY AND A HARD COPY QUESTIONNAIRE THE INTERVIEWS INCLUDED A CROSS SECTION OF INDIVIDUALS WHO WERE ASSOCIATED WITH ORGANIZATIONS THAT SERVED THE MEDICALLY UNDERSERVED, LOW INCOME, MINORITY, AND CHRONICALLY DISEASED POPULATIONS THE QUESTIONNAIRE WAS COMPLETED BY 652 RESPONDENTS APPROXIMATELY 12% OF THE RESPONDENTS HAD HOUSEHOLD INCOMES BELOW 25,000

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
FACILITY 1, TAKOMA REGIONAL HOSPITAL, INC - PART V, LINE 6A	THE COMMUNITY HEALTH NEEDS ASSESSMENT CONDUCTED BY TAKOMA REGIONAL HOSPITAL, INC WAS BASED UPON THE HOSPITAL'S INVOLVEMENT AND ENRICHMENT OF THOSE WHO LIVE WITHIN GREENE COUNTY, TENNESSEE THE PRIMARY SERVICE AREA IS SHARED BY LAUGHLIN MEMORIAL HOSPITAL AND THUS THE COMMUNITY HEALTH NEEDS ASSESSMENT WAS COMPLETED IN COOPERATION WITH BOTH HOSPITALS
FACILITY 1, TAKOMA REGIONAL HOSPITAL, INC - PART V, LINE 11	KEY FINDINGS NOTED DURING THE CHNA WERE THE LOW RANKINGS OF THE COUNTIES WE SERVE IN SEVERAL CATEGORIES RELATED TO HEALTH AND WELLNESS, INCLUDING PREVALENCE OF CHRONIC DISEASE MANAGEMENT, TOBACCO USE, DIET AND EXERCISE, AS WELL AS A NEED FOR EXPANDED AND ENHANCED MENTAL HEALTH SERVICES THEY ALSO EMPHASIZED THE VULNERABILITY OF OUR UNDERINSURED AND UNINSURED POPULATIONS, AND THAT IF OUR COMMUNITIES ARE TO THRIVE, WE MUST FOCUS ON ENCOURAGING HEALTHY CHILDREN AND FAMILIES TAKOMA REGIONAL HOSPITAL OPERATES A DIABETES TREATMENT CENTER THE CENTER OFFERS DIABETES SERVICES AND FREE EDUCATIONAL PROGRAMS DIETITIANS, NURSES AND CERTIFIED DIABETES EDUCATORS TEACH ABOUT TOPICS SUCH AS PREPARING NUTRITIOUS MEALS, TRACKING BLOOD SUGAR, REDUCING DIABETES' LONG-TERM EFFECTS, AND OTHER DIABETES RELATED TOPICS TO HELP MEET THESE NEEDS, TAKOMA REGIONAL HOSPITAL, INC WILL CONTINUE TO STRENGTHEN OUR PARTNERSHIPS AND CONTINUUM OF CARE OPPORTUNITIES WITH AREA HEALTH DEPARTMENTS, FEDERALLY QUALIFIED HEALTH CENTERS, AND FRONTIER HEALTH, THE REGION'S LEADING PROVIDER OF BEHAVIORAL HEALTH SERVICES

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
FACILITY 1, TAKOMA REGIONAL HOSPITAL, INC - PART V, LINE 13H	BALLAD HEALTH'S FINANCIAL ASSISTANCE POLICY ALLOWS FOR SOME EXCEPTIONS TO STRICTLY ADHERING TO FEDERAL POVERTY GUIDELINES WHEN AWARDING FINANCIAL ASSISTANCE UNIQUE CIRCUMSTANCES MAY BE WEIGHED AND ASSESSED FOR FINANCIAL ASSISTANCE CONSIDERATION ON A CASE-BY-CASE BASIS ALSO, THERE ARE SOME SERVICES WHERE FINANCIAL ASSISTANCE MAY BE PROVIDED OUTSIDE OF FEDERAL POVERTY GUIDELINES THESE ARE NOTED IN BALLAD HEALTH'S FINANCIAL ASSISTANCE POLICY

Schedule J
(Form 990)

Compensation Information

OMB No 1545-0047

Department of the Treasury
Internal Revenue Service

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

2017

Open to Public Inspection

Name of the organization
TAKOMA REGIONAL HOSPITAL INC

Employer identification number
51-0603966

Part I Questions Regarding Compensation

	Yes	No
1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items. <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> First-class or charter travel <input type="checkbox"/> Travel for companions <input type="checkbox"/> Tax indemnification and gross-up payments <input type="checkbox"/> Discretionary spending account </div> <div> <input type="checkbox"/> Housing allowance or residence for personal use <input type="checkbox"/> Payments for business use of personal residence <input type="checkbox"/> Health or social club dues or initiation fees <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef) </div> </div>		
b If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain.	1b	
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?	2	
3 Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III. <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Compensation committee <input type="checkbox"/> Independent compensation consultant <input type="checkbox"/> Form 990 of other organizations </div> <div> <input type="checkbox"/> Written employment contract <input type="checkbox"/> Compensation survey or study <input type="checkbox"/> Approval by the board or compensation committee </div> </div>		
4 During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization: <div style="margin-left: 20px;"> a Receive a severance payment or change-of-control payment? b Participate in, or receive payment from, a supplemental nonqualified retirement plan? c Participate in, or receive payment from, an equity-based compensation arrangement? </div> If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.	4a 4b 4c	 No No No
Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.		
5 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of: <div style="margin-left: 20px;"> a The organization? b Any related organization? </div> If "Yes," on line 5a or 5b, describe in Part III.	5a 5b	 No No
6 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of: <div style="margin-left: 20px;"> a The organization? b Any related organization? </div> If "Yes," on line 6a or 6b, describe in Part III.	6a 6b	 No No
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.	7	No
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.	8	No
9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9	

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

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

See Additional Data Table

[illegible]

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
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efile GRAPHIC print - DO NOT PROCESS		As Filed Data -	DLN: 93493133032239
SCHEDULE O (Form 990 or 990-EZ) <small>Department of the Treasury Internal Revenue Service</small>	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
Name of the organization TAKOMA REGIONAL HOSPITAL INC		Employer identification number 51-0603966	

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 2, PART III, LINE 4A	<p>(CONT'D) REHABILITATION SERVICES, PRIMARY AND SPECIALTY PHYSICIAN CLINICS AND DIAGNOSTIC IMAGING IN FISCAL YEAR 2018, WE PROVIDED SERVICES TO 2,443 INPATIENTS, HAD 1,793 SURGICAL CASES AND 17,705 EMERGENCY ROOM VISITS. CONSISTENT WITH OUR MISSION, WE HAVE WORKED TOWARD IMPROVING OUR COMMUNITY'S ACCESS TO QUALITY, AFFORDABLE HEALTHCARE, IMPROVING THE HEALTH STATUS OF OUR COMMUNITIES AND CONTRIBUTING TO THE OVERALL QUALITY OF LIFE IN THE AREAS WE SERVE. THE HOSPITAL AND ITS EMPLOYED PHYSICIAN PRACTICES WENT LIVE ON WELLMONT HEALTH SYSTEM'S EPIC ELECTRONIC HEALTH RECORD SYSTEM IN NOVEMBER 2017. THE EPIC SYSTEM IS THE PREMIER SUCH SYSTEM AND ENABLES A PATIENT AND THEIR HEALTHCARE PROVIDERS TO SEE ALL OF THE PATIENT'S HEALTH INFORMATION ACROSS, NOT ONLY TAKOMA'S SITES, BUT ALSO WELLMONT HEALTH SYSTEM AND ALL EPIC SITES IN THE COUNTRY. THIS RESULTS IN BETTER, QUICKER AND MORE EFFICIENT CARE OF THE PATIENT TO FURTHER THE COMMUNITY'S HEALTH STATUS. TAKOMA REGIONAL TEACHES OR HAS AVAILABLE A VARIETY OF HEALTH PROGRAMS THAT INCLUDE - A NATURE TRAIL, WHICH IS A LITTLE MORE THAN A MILE IN LENGTH - THE "BIGGEST LOSER" LIFESTYLE AND WEIGHT-LOSS PROGRAM - TOTAL LI FESTYLE PROGRAM - STROKE SUPPORT GROUP - DIABETES TREATMENT CENTER (SENIOR ADULT CENTER) - LECTURES AT THE LOCAL YMCA - A VARIETY OF HEALTH PROGRAMS, AVAILABLE FOR EVERYONE IN THE GREENE COUNTY SERVICE AREA, INCLUDING THE UNDERSERVED AND UNDERPRIVILEGED FOR FREE OR A NOMINAL FEE - ALONG WITH OTHER LOCAL AGENCIES, TRH TEAM MEMBERS VISITED FIVE HIGH SCHOOLS TO DEMONSTRATE THE DANGERS OF DISTRACTED DRIVING CHARITY AND OTHER UNREIMBURSED COSTS. CHARITY CARE WHILE REIMBURSEMENT FOR HEALTHCARE SERVICES RENDERED IS CRITICAL TO THE OPERATION AND SUSTAINABILITY OF THE ORGANIZATION, TRH RECOGNIZES ITS OBLIGATION TO PROVIDE CARE TO INDIVIDUALS WHO CANNOT AFFORD ESSENTIAL MEDICAL SERVICES, INCLUDING EMERGENCY CARE. TRH ACCEPTS ALL PATIENTS REGARDLESS OF THEIR ABILITY TO PAY. A PATIENT IS CLASSIFIED AS A CHARITY PATIENT WHEN THEY MEET THE ESTABLISHED POLICIES OF TRH AND GUIDELINES OUTLINED BY THE FEDERAL GOVERNMENT. HOWEVER, FINANCIAL ASSISTANCE DECISIONS ARE NOT SOLELY BASED ON INCOME. UNIQUE FINANCIAL CIRCUMSTANCES ARE WEIGHED WITH VERIFIED PATIENT ASSETS WHICH CAN DETERMINE FINANCIAL ASSISTANCE ELIGIBILITY. IT IS NOT UNTIL AFTER VERIFICATION OF INCOME AND ASSETS THAT A DECISION REGARDING THE AMOUNT OF FINANCIAL ASSISTANCE CAN BE MADE. IN FISCAL YEAR 2018, TRH INCURRED A LOSS OF 972,691 ATTRIBUTABLE TO THE PROVISION OF CHARITY CARE, AN INCREASE OF MORE THAN 9.4% FROM FISCAL YEAR 2017. THIS AMOUNT DOES NOT INCLUDE THE COSTS ASSOCIATED WITH BAD DEBT ACCOUNTS. TENNCARE/MEDICAID. TRH PROVIDES CARE TO PERSONS COVERED BY GOVERNMENTAL PROGRAMS, SUCH AS TENNCARE (TENNESSEE RESIDENTS) AND MEDICAID. TRH INCURRED A LOSS OF 2,327,851 PROVIDING CARE TO THIS POPULATION OF PATIENTS DURING THE YEAR. UNINSURED DISCOUNT. UNINSURED PATIENTS RECEIVED A 74 PERCENT DISCOUNT THROUGHOUT FY2018. THE UNINSURED DISCOUNT IS APPLIED TO A</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 2, PART III, LINE 4A	<p>LL UNINSURED PATIENTS AT WHS HOSPITALS ALSO, CERTAIN ELECTIVE PROCEDURES ARE NOT ELIGIBLE FOR THE UNINSURED DISCOUNT THE UNINSURED DISCOUNT IS CALCULATED EACH YEAR IN ACCORDANCE WITH TENNESSEE REGULATIONS AND WITHOUT REGARD TO A PATIENT'S INCOME OR ASSETS THE APPROXIMATE COST OF THIS DISCOUNT IN FY2018, USING OUR COST TO CHARGE RATIO, WAS 1,862,165 THE BEST WAY TO KEEP OUR COMMUNITIES HEALTHY IS TO PROVIDE THEM WITH THE LATEST INFORMATION ABOUT THEIR HEALTH WE STRIVE TO PROVIDE INFORMATION ABOUT EVERYTHING FROM DISEASE AND INJURY PREVENTION TO THE LATEST TREATMENTS AND TECHNOLOGIES AVAILABLE TO COPING WITH DISEASE AND ITS SYMPTOMS SOME OF OUR PROGRAMS DURING FY2018 INCLUDE -WE OFFERED DIABETES EDUCATION CLASSES THROUGHTOUT THE YEAR, THE CLASS IS TWO-PARTS, WITH FOUR-HOUR SESSIONS OVER TWO DAYS -NUTRITION PRESENTATIONS WERE PROVIDED BY OUR DIETITION ON TOPICS SUCH AS TIPS FOR HEALTHY EATING, HOW TO READ FOOD LABELS, WITH INFORMATION PAMPHLETS PROVIDED TO PARTICIPANTS, AND HEALTHY SNACKS -WE OFFERED MONTHLY PRENATAL CLASSES, WHICH WERE OPEN TO THE PUBLIC -OUR INFECTION CONTROL NURSE VISITED A LOCAL ELEMENTARY SCHOOL TO EXPLAIN THE IMPORTANCE OF HAND WASHING TO THE STUDENTS -NUMEROUS PRESENTATIONS WERE PROVIDED AT THE ADULT CENTER FOR AGING, DISCUSSIONS INCLUDED SUPERFOOD NUTRITION AND OTHER NUTRITION LEARNING SESSIONS FROM OUR DIETITION, GENERAL HEALTH, DIABETES CARE MANAGEMENT, HEPATITIS C, WOUND CARE, AND OTHERS WE PARTICIPATED IN HEALTH FAIRS, SUCH AS -DIABETES HOLIDAY HEALTH FAIR -A GENERAL HOLIDAY HEALTH FAIR -TWO WORKPLACE HEALTH FAIRS -A HEALTH FAIR AT THE YMCA -GREENE COUNTY FAIR WORKING A FIRST AID STATION AND DISTRIBUTING WATER HOSPITAL TEAM MEMBERS ARE ENGAGED IN A VARIETY OF COMMUNITY ACTIVITIES SOME EXAMPLES DURING FY2018 -TRH STAFF WORKED AT THE I-40 WELCOME CENTER THE DAY OF THE SOLAR ECLIPSE TO KEEP PEOPLE'S EYESIGHT SAFE THE WELCOME CENTER PROVIDED SOLAR GLASSES -HOSPITAL STAFF WORKED AT THREE BLOOD DRIVES -OUR WELLNESS COORDINATOR ORGANIZED A 5K RUN FOR THE TOWN OF GREENEVILLE POLICE DEPARTMENT -THE HOSPITAL IS INVOLVED IN THE GREENE COUNTY ANTI-DRUG COALITION -TWO TEAM MEMBERS REPRESENT THE HOSPITAL ON THE HEALTHIER TENNESSEE COMMITTEE FOR OUR AREA -TEAM MEMBERS SERVE ON THE GREENE COUNTY HEALTH COUNCIL HOSPITAL MEETING SPACE IS OPEN TO LOCAL ORGANIZATIONS THAT SUPPORT COMMUNITY HEALTH AND WELLNESS SOME EXAMPLES INCLUDE CITY SCHOOL MEETINGS, SPORTS MEDICINE DISCUSSIONS FOR HIGH SCHOOLS AND A LOCAL COLLEGE, GREENE COUNTY PARTNERSHIP ADULT LEADERSHIP, A DIABETES SUPPORT GROUP, GREENE COUNTY MINISTERIAL ASSOCIATION, A STROKE SUPPORT GROUP, A BREAST CANCER SUPPORT GROUP, AND A CANCER SUPPORT GROUP SOME OF THE HEALTHIER TENNESSEE COMMITTEE MEETINGS WERE ALSO HELD AT TRH TAKOMA REGIONAL HOSPITAL SERVES AS A CLINICAL TRAINING SITE FOR HEALTH PROFESSIONAL EDUCATION STUDENTS WE DEDICATE STAFF TO WORK WITH REGIONAL COLLEGES AND UNIVERSITIES TO COORDINATE PLACEMENT OF HEALTHCARE PROFESSIONAL STUDENTS AS PART OF THEIR EDUCATION</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 2, PART III, LINE 4A	NAL CURRICULUM IN ADDITION TO CLINICAL TRAINING, THE HEALTH CARE STUDENTS ENTERING OUR SY STEM ARE REQUIRED TO HAVE ORIENTATION AND COMPUTER TRAINING INCLUDED IN THE NUMBER OF PAR TICIPANTS RECEIVING CLINICAL EXPERIENCE AT TRH WERE 28 NURSING STUDENTS THIS CLINICAL NUR SING EXPERIENCE REQUIRED EXTENSIVE TRH NURSING STAFF INVOLVEMENT THE CLINICAL SETTING AND HANDS-ON INSTRUCTION COST THE HOSPITAL 42,908 TRH PROVIDED CLINICAL TRAINING FOR ANOTHER 11 STUDENTS TRAINING IN OTHER ALLIED HEALTH DISCIPLINES THE HOSPITAL INCURRED EXPENSE OF 9,411 TO PROVIDE THIS TRAINING

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 6	WELLMONT HEALTH SYSTEM IS TRH'S SOLE MEMBER THE BOARD OF DIRECTORS OF BALLAD HEALTH, WELLMONT'S PARENT ORGANIZATION, SERVES AS WELLMONT'S BOARD OF DIRECTORS AND IS RESPONSIBLE FOR APPOINTING THE DIRECTORS OF TRH'S BOARD TAKOMA REGIONAL HOSPITAL'S BOARD OF DIRECTORS ARE RESPONSIBLE FOR - DEVELOPMENT AND ESTABLISHMENT OF THE ORGANIZATION'S POLICIES AND STRATEGIC PLAN, - DEVELOPMENT AND APPROVAL OF THE ORGANIZATION'S ANNUAL CAPITAL AND OPERATING BUDGETS, - REGULAR REVIEW OF THE ORGANIZATION'S FINANCIAL PERFORMANCE, - ANNUAL REVIEW OF MEDICAL STAFF COMPETENCY STANDARDS, AND - REGULAR REVIEW OF THE ORGANIZATION'S CORPORATE COMPLIANCE PLAN

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 7A	FOLLOWING THE MERGER OF TRH'S SOLE MEMBER, WELLMONT HEALTH SYSTEM, AND MOUNTAIN STATES HEALTH ALLIANCE IN FEBRUARY 2018 TO FORM BALLAD HEALTH, THE NEWLY APPOINTED BALLAD HEALTH BOARD OF DIRECTORS ASSUMED BOARD RESPONSIBILITIES FOR WELLMONT AND MOUNTAIN STATES BOTH WELLMONT AND MOUNTAIN STATES REMAIN SEPARATE LEGAL ENTITIES

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 7B	CERTAIN DECISIONS OF THE BOARD ARE, PURSUANT TO CHARTER, SUBJECT TO APPROVAL OF THE MEMBER NO ORDINARY, DAY-TO-DAY DECISIONS ARE SUBJECT TO MEMBER APPROVAL

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 9	BARTON HOVE (RETIRED 1/31/2018)

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 11B	THE PRESIDENT OF TAKOMA REGIONAL HOSPITAL, INC REVIEWED THE TAKOMA REGIONAL HOSPITAL, INC 'S FORM 990 WITH THE BOARD OF DIRECTORS PRIOR TO FILING THE RETURN WAS MADE AVAILABLE TO EACH BOARD MEMBER IN AN ELECTRONIC FORMAT PRIOR TO THE REVIEW

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 12C	<p>TAKOMA REGIONAL HOSPITAL, INC IS PART OF THE NEWLY FORMED BALLAD HEALTH HEALTHCARE SYSTEM FORMED WHEN WELLMONT HEALTH SYSTEM AND MOUNTAIN STATES HEALTH ALLIANCE MERGED IN FEBRUARY 2018 BALLAD HEALTH HAS A CONFLICT OF INTEREST POLICY FOR ALL MEMBERS OF THE BOARD OF DIRECTORS, THE EXECUTIVE CHAIR/PRESIDENT, EXECUTIVE VICE PRESIDENTS, SENIOR VICE PRESIDENTS, AND VICE PRESIDENTS, AND APPLIES TO ALL BALLAD HEALTH ORGANIZATIONS ALL PERSONS COVERED BY THIS POLICY ARE REQUIRED TO COMPLETE A CONFLICT OF INTEREST DISCLOSURE FORM ON AN ANNUAL BASIS SHOULD A CONFLICT ARISE, IT IS THE RESPONSIBILITY OF THE CONFLICTED INDIVIDUAL TO UPDATE HIS OR HER DISCLOSURE IMMEDIATELY ALL MEETINGS OF THE BOARD OR BOARD COMMITTEES HAVE A STANDING AGENDA ITEM FIRST ON THE AGENDA TITLED "CONFLICTS OF INTEREST" IF A MEMBER OF THE BOARD OR BOARD COMMITTEE HAS A CONFLICT OF INTEREST INVOLVING ANY ISSUE ON THE BOARD AGENDA, HE OR SHE MUST DECLARE THE CONFLICT OF INTEREST DURING THE PERIOD ALLOTTED FOR DISCLOSURE IF ANY ISSUE ARISES DURING A MEETING IN WHICH THE BOARD MEMBER HAS A CONFLICT OF INTEREST, HE OR SHE MUST IMMEDIATELY DECLARE THE CONFLICT WHILE EACH MEMBER OF THE BOARD OR BOARD COMMITTEES ARE RESPONSIBLE FOR DISCLOSING CONFLICTS OF INTEREST, IT IS ALSO THE RESPONSIBILITY OF ANY BOARD MEMBER AWARE OF A CONFLICT WHICH HAS NOT BEEN DISCLOSED TO ENSURE THE BOARD IS MADE AWARE THE PRESIDING OFFICER OF A BOARD OR BOARD COMMITTEE MEETING MAY ASK A CONFLICTED MEMBER TO EXCUSE THEMSELVES FROM THE MEETING DURING THE DISCUSSION RELATED TO THE ISSUE WITH WHICH THE CONFLICT OF INTEREST APPLIES UNDER NO CIRCUMSTANCES SHALL A MEMBER VOTE ON A MATTER THAT GIVES RISE TO A POTENTIAL CONFLICT</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 15A	ON AN ANNUAL BASIS, BALLAD HEALTH'S HUMAN RESOURCES (HR) DEPARTMENT EVALUATES COMPENSATION FOR ALL EXECUTIVES AT A POSITION LEVEL OF ASSISTANT VICE PRESIDENT AND ABOVE THE REVIEW INCLUDES TRH'S BOARD PRESIDENT AND WELLMONT HEALTH SYSTEM CEO, MR HOVE, AND TRH'S PRESIDENT, MS ALBRIGHT HR'S EVALUATION IS BASED ON MARKET DATA OBTAINED FROM AN INDEPENDENT COMPENSATION CONSULTANT FOR POSITIONS WITH SIMILAR RESPONSIBILITIES AT SIMILARLY SITUATED ORGANIZATIONS BASED ON THIS COMPARABILITY DATA, BALLAD HEALTH'S PRESIDENT & CEO EVALUATES THE DATA AND SUBMITS HIS RECOMMENDATIONS TO BALLAD HEALTH'S BOARD OF DIRECTORS FOR THEIR FINAL REVIEW AND APPROVAL

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 15B	THE COMPENSATION OF TRH'S OTHER OFFICERS, WITH THE EXCEPTION OF THE CONTROLLER, ARE EVALUATED EACH YEAR IN THE SAME MANNER AS TRH'S BOARD PRESIDENT AND TRH'S PRESIDENT THE CONTROLLER POSITION IS EVALUATED CONSISTENT WITH OTHER BALLAD HEALTH NON-EXECUTIVE POSITIONS BASED ON A MARKET PERCENTILE SPECIFIC TO HER POSITION

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 19	GOVERNING DOCUMENTS AND CONFLICT OF INTEREST POLICY ARE MADE AVAILABLE UPON REQUEST TO THE APPROPRIATE PARTIES REQUESTING THEM. FINANCIAL STATEMENTS ARE MADE AVAILABLE UPON REQUEST TO APPROPRIATE PARTIES REQUESTING THEM, AND THEY ARE MADE AVAILABLE TO THOSE PARTIES WHO OWN INDEBTEDNESS.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9	CAPITAL CONTRIBUTION FROM PARENT 33,679,398 EMPLOYER PROVIDED PARKING-NOT ON BOOKS -22,723 TOTAL 33,656,675

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 12, PART XII, LINE 2C	<p>BALLAD HEALTH (BALLAD) IS A TAX-EXEMPT ENTITY AND THE PARENT CORPORATION OF BOTH MOUNTAIN STATES HEALTH ALLIANCE (MSHA) AND WELLMONT HEALTH SYSTEM (WHS) THE TWO HEALTHCARE SYSTEMS CAME TOGETHER ON FEBRUARY 1, 2018 AS A RESULT OF A MERGER APPROVED BY BOTH TENNESSEE AND VIRGINIA DEPARTMENTS OF HEALTH THE INDIVIDUALS SERVING AS THE BOARD OF DIRECTORS OF BALLAD ALSO SERVE AS THE BOARD OF DIRECTORS OF MSHA AND WHS THE AUDITED CONSOLIDATED FINANCIAL STATEMENTS OF BALLAD INCLUDE MSHA, WHS AND THEIR SUBSIDIARIES AND AFFILIATES WHICH WERE PREVIOUSLY INCLUDED IN EITHER MSHA OR WHS AUDITED CONSOLIDATED FINANCIAL STATEMENTS BALLAD HAS AN AUDIT COMMITTEE WHICH ASSUMES RESPONSIBILITY FOR OVERSIGHT OF THE AUDIT OF ITS FINANCIAL STATEMENTS AND THE SELECTION OF AN INDEPENDENT AUDITOR FORM 990 - ADDITIONAL INFORMATION FY18 FORM 990 HAS NUMEROUS REPORTING CHANGES FROM PRIOR YEAR RETURNS WE BELIEVE THESE CHANGES ARE NECESSARY IN ORDER TO BETTER REFLECT THE ORGANIZATION'S ACTIVITY</p>

efile GRAPHIC print - DO NOT PROCESS		As Filed Data -		DLN: 93493133032239	
SCHEDULE R (Form 990)	Related Organizations and Unrelated Partnerships				OMB No 1545-0047
					2017
	▶ 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 .				Open to Public Inspection
Department of the Treasury Internal Revenue Service					
Name of the organization TAKOMA REGIONAL HOSPITAL INC				Employer identification number 51-0603966	

Part I Identification of Disregarded Entities Complete if the organization answered "Yes" on Form 990, Part IV, line 33.					
(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512- 514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) SAPLING GROVE AMBULATORY SURGERY 220 MEDICAL PARK BOULEVARD BRISTOL, TN 37620 20-4450153	MED SERV	TN	N/A					No			No	
(2) HOLSTON VALLEY AMBULATORY SURGERY 103 WEST STONE DRIVE KINGSPORT, TN 37660 62-1816864	MED SERV	TN	N/A					No			No	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of- year assets	(h) Percentage ownership	(i) Section 512(b) (13) controlled entity?	
								Yes	No
See Additional Data Table									

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

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

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

a Receipt of (i) interest, (ii)annuities, (iii) royalties, or(iv) rent from a controlled entity

b Gift, grant, or capital contribution to related organization(s)

c Gift, grant, or capital contribution from related organization(s)

d Loans or loan guarantees to or for related organization(s)

e Loans or loan guarantees by related organization(s)

f Dividends from related organization(s)

g Sale of assets to related organization(s)

h Purchase of assets from related organization(s)

i Exchange of assets with related organization(s)

j Lease of facilities, equipment, or other assets to related organization(s)

k Lease of facilities, equipment, or other assets from related organization(s)

l Performance of services or membership or fundraising solicitations for related organization(s)

m Performance of services or membership or fundraising solicitations by related organization(s)

n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)

o Sharing of paid employees with related organization(s)

p Reimbursement paid to related organization(s) for expenses

q Reimbursement paid by related organization(s) for expenses

r Other transfer of cash or property to related organization(s)

s Other transfer of cash or property from related organization(s)

Yes

No

1a

No

1b

No

1c

Yes

1d

No

1e

No

1f

No

1g

No

1h

No

1i

No

1j

No

1k

Yes

1l

No

1m

Yes

1n

No

1o

No

1p

Yes

1q

No

1r

No

1s

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

Schedule R (Form 990) 2017

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

[illegible]

Part VII **Supplemental Information**

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

Additional Data

Software ID:

Software Version:

EIN: 51-0603966

Name: TAKOMA REGIONAL HOSPITAL INC

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c) (3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
1905 AMERICAN WAY KINGSPORT, TN 37660 62-1636465	HOSP SYS	TN	501C3	3	BALLAD		No
851 LOCUST STREET ROGERSVILLE, TN 37857 62-1816368	HOSPITAL	TN	501C3	3	WHS		No
1905 AMERICAN WAY KINGSPORT, TN 37660 47-1334302	FUNDRAISER	TN	501C3	7	WHS		No
1905 AMERICAN WAY KINGSPORT, TN 37660 26-3557623	MED SERV	TN	501C3	10	WHS		No
1905 AMERICAN WAY KINGSPORT, TN 37660 27-0898372	MED SERV	TN	501C3	7	WHS		No
1905 AMERICAN WAY KINGSPORT, TN 37660 27-3777167	MED SERV	TN	501C3	3	WHS		No
1905 AMERICAN WAY KINGSPORT, TN 37660 58-1594191	FUNDRAISER	TN	501C3	7	WHS		No
1905 AMERICAN WAY KINGSPORT, TN 37660 62-1308216	ASST LIV	TN	501C3	10	WHS		No
1905 AMERICAN WAY KINGSPORT, TN 37660 58-1859039	NSG HOME	TN	501C3	10	WHS		No
1905 AMERICAN WAY KINGSPORT, TN 37660 86-1103148	HEALTHCARE	TN	501C3	12A	WHS		No
303 MED TECH PARKWAY SUITE 220 JOHNSON CITY, TN 37604 62-0476282	HOSP SYS	TN	501C3	3	BALLAD		No
2335 KNOB CREEK ROAD SUITE 101 JOHNSON CITY, TN 37604 58-1418862	FUNDRAISER	TN	501C3	12A	MSHA		No
400 N STATE OF FRANKLIN ROAD JOHNSON CITY, TN 37604 58-1418345	SUPP ORG	TN	501C3	12A	MSHA		No
245 MEDICAL PARK DRIVE MARION, VA 24354 54-0794913	HOSPITAL	VA	501C3	3	MSHA		No
100 15TH STREET NW NORTON, VA 24273 54-0566029	HOSPITAL	VA	501C3	3	NA		No
312 HOSPITAL DRIVE CLINTWOOD, VA 24228 77-0599553	HOSPITAL	VA	501C3	3	NCH		No
16000 JOHNSTON MEMORIAL DRIVE ABINGDON, VA 24211 54-0544705	HOSPITAL	VA	501C3	3	NA		No
16000 JOHNSTON MEMORIAL DRIVE ABINGDON, VA 24211 20-5485346	MED SERV	VA	501C3	12A	JMH		No
303 MED TECH PARKWAY SUITE 220 JOHNSON CITY, TN 37604 61-1771290	SUPP ORG	TN	501C3	12B	NA		No
203 GRAY COMMONS CIRCLE GRAY, TN 37615 81-5475903	OPIOID TRT	TN	501C3	3	MSHA		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
1420 TUSCULUM BOULEVARD GREENEVILLE, TN 37745 62-0701119	HOSPITAL	TN	501C3	3	MSHA		No
1420 TUSCULUM BOULEVARD GREENEVILLE, TN 37745 58-2105493	FUNDRAISER	TN	501C3	12A	MSHA		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
WELLMONT INC 1905 AMERICAN WAY KINGSPORT, TN 37660 62-1320035	MED SERV	TN	N/A						No
MCOT INC 1905 AMERICAN WAY KINGSPORT, TN 37660 62-1325938	BUS SERV	TN	N/A						No
MEDICAL MALL PHARMACY INC 1905 AMERICAN WAY KINGSPORT, TN 37660 62-1565006	MED SERV	TN	N/A						No
WELLMONT PHYSICIAN SERVICES INC 1905 AMERICAN WAY KINGSPORT, TN 37660 62-1567353	MED SERV	TN	N/A						No
WPS PROVIDERS INC 1905 AMERICAN WAY KINGSPORT, TN 37660 20-5564642	MED SERV	TN	N/A						No
WELLMONT HEALTH SERVICES INC 1905 AMERICAN WAY KINGSPORT, TN 37660 62-1254373	MED SERV	TN	N/A						No
WELLMONT INSURANCE CO SPC LTD 1905 AMERICAN WAY KINGSPORT, TN 37660 98-1195624	INSURANCE		N/A						No
BLUE RIDGE MEDICAL MANAGEMENT CORP 1905 AMERICAN WAY KINGSPORT, TN 37660 62-1490616	MED SERV	TN	N/A						No
MEDISERVE MEDICAL EQUIPMENT 1905 AMERICAN WAY KINGSPORT, TN 37660 62-1212286	DME	TN	N/A						No
MOUNTAIN STATES PROPERTIES 1905 AMERICAN WAY KINGSPORT, TN 37660 62-1845895	PROP MGMT	TN	N/A						No
MOUNTAIN STATES PHYSICIAN GROUP 1905 AMERICAN WAY KINGSPORT, TN 37660 62-1700412	MED SERV	TN	N/A						No
COMMUNITY HOME CARE INC 1490 PARK AVENUE NW SUITE B NORTON, VA 24273 54-1453810	DME	VA	N/A						No
WILSON PHARMACY INC PO BOX 5289 JOHNSON CITY, TN 37604 62-0329587	PHARMACY	TN	N/A						No
CRESTPOINT HEALTH INSURANCE COMPANY 509 MED TECH PARKWAY SUITE 100 JOHNSON CITY, TN 37604 62-0381170	INSURANCE	TN	N/A						No
INTEGRATED SOLUTIONS HEALTH NETWORK 509 MED TECH PARKWAY SUITE 100 JOHNSON CITY, TN 37604 62-1711997	HLTH NETWK	TN	N/A						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
NOLICHUCKEY MANAGEMENT SVCS INC 1420 TUSCULUM BOULEVARD GREENEVILLE, TN 37745 62-1776681	MED SERV	TN	N/A						No