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Form 990

Department of the Treasury  
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No 1545-0047

2018

Open to Public Inspection

A For the 2019 calendar year, or tax year beginning 01-01-2018 , and ending 12-31-2018

B Check if applicable

☐ Address change

☐ Name change

☐ Initial return

☐ Final return/terminated

☐ Amended return

☐ Application pending

C Name of organization

FORSYTH MEMORIAL HOSPITAL INC

Doing business as

NOVANT HEALTH FORSYTH MEDICAL CENTER

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

2085 FRONTIS PLAZA BLVD

Room/suite

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

WINSTON SALEM, NC 27103

F Name and address of principal officer

CARL ARMATO

2085 FRONTIS PLAZA BLVD

WINSTON SALEM, NC 27103

D Employer identification number

56-0928089

E Telephone number

(336) 718-2803

G Gross receipts \$ 1,417,283,176

I Tax-exempt status

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

J Website: ▶ WWW.NOVANTHEALTH.ORG

K Form of organization

☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation 1968

M State of legal domicile NC

Part I

Summary

Activities & Governance

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

SEE SCHEDULE O

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 2018 (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)

16b 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

Prior Year

5,895,007

1,307,553,317

698,869

12,224,669

1,326,371,862

Current Year

2,758,815

1,404,103,334

377,048

9,796,685

1,417,035,882

Beginning of Current Year

1,544,644,500

82,153,583

1,462,490,917

End of Year

1,692,009,282

95,643,703

1,596,365,579

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

FRED HARGETT EVP & CFO

Type or print name and title

2019-11-11

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 (2018)

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

SEE SCHEDULE O

**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

<b>4a</b>	(Code )	(Expenses \$ 1,071,982,101	including grants of \$ 1,180,904	(Revenue \$ 1,407,512,229 )
See Additional Data				

<b>4b</b>	(Code )	(Expenses \$	including grants of \$	(Revenue \$ )
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<b>4c</b>	(Code )	(Expenses \$	including grants of \$	(Revenue \$ )
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<b>4d</b>	Other program services (Describe in Schedule O )	(Expenses \$	including grants of \$	(Revenue \$ )
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<b>4e</b>	<b>Total program service expenses</b> ▶	1,071,982,101
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**Part IV Checklist of Required Schedules**

	Yes	No
<b>1</b> Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A	<b>1</b> Yes	
<b>2</b> Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?	<b>2</b> Yes	
<b>3</b> 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	<b>3</b>	No
<b>4 Section 501(c)(3) organizations.</b> Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II	<b>4</b> Yes	
<b>5</b> 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	<b>5</b>	No
<b>6</b> 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	<b>6</b>	No
<b>7</b> 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	<b>7</b>	No
<b>8</b> Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III	<b>8</b>	No
<b>9</b> 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	<b>9</b>	No
<b>10</b> 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	<b>10</b> Yes	
<b>11</b> 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		
<b>a</b> Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI	<b>11a</b> Yes	
<b>b</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	<b>11b</b>	No
<b>c</b> 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	<b>11c</b>	No
<b>d</b> 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	<b>11d</b> Yes	
<b>e</b> Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	<b>11e</b> Yes	
<b>f</b> 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	<b>11f</b> Yes	
<b>12a</b> Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII	<b>12a</b>	No
<b>b</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	<b>12b</b> Yes	
<b>13</b> Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	<b>13</b>	No
<b>14a</b> Did the organization maintain an office, employees, or agents outside of the United States?	<b>14a</b>	No
<b>b</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	<b>14b</b>	No
<b>15</b> 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	<b>15</b>	No
<b>16</b> 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	<b>16</b>	No
<b>17</b> 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)	<b>17</b>	No
<b>18</b> 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	<b>18</b>	No
<b>19</b> 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	<b>19</b>	No
<b>20a</b> Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H	<b>20a</b> Yes	
<b>b</b> If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	<b>20b</b> Yes	
<b>21</b> Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? If "Yes," complete Schedule I, Parts I and II	<b>21</b> Yes	
<b>22</b> Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? If "Yes," complete Schedule I, Parts I and III	<b>22</b> Yes	

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

		Yes	No	
<b>23</b>	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	
<b>24a</b>	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>b</b>	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? . . . .	24b		
<b>c</b>	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		
<b>d</b>	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? . . . .	24d		
<b>25a</b>	<b>Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.</b> Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i> . . . . .	25a		No
<b>b</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
<b>26</b>	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
<b>27</b>	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
<b>28</b>	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)			
<b>a</b>	A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> . . . . .	28a		No
<b>b</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
<b>c</b>	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
<b>29</b>	Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i> . . . . .	29		No
<b>30</b>	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
<b>31</b>	Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i> . . . . .	31		No
<b>32</b>	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
<b>33</b>	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	Yes	
<b>34</b>	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	
<b>35a</b>	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	Yes	
<b>b</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	Yes	
<b>36</b>	<b>Section 501(c)(3) organizations.</b> 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
<b>37</b>	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
<b>38</b>	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? <b>Note.</b> All Form 990 filers are required to complete Schedule O . . . . .	38	Yes	

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

		Yes	No	
<b>1a</b>	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable . . . . .	1a	0	
<b>b</b>	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable . . . . .	1b	0	
<b>c</b>	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? . . . . .	1c		

<b>2a</b> 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 . . . . .		<b>2a</b>	7,907			
<b>b</b> If at least one is reported on line 2a, did the organization file all required federal employment tax returns? <b>Note.</b> If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)				<b>2b</b>	Yes	
<b>3a</b> Did the organization have unrelated business gross income of \$1,000 or more during the year? . . . . .				<b>3a</b>	Yes	
<b>b</b> If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O . . . . .				<b>3b</b>	Yes	
<b>4a</b> 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)? . . . . .				<b>4a</b>		No
<b>b</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)						
<b>5a</b> Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . . . . .				<b>5a</b>		No
<b>b</b> Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?				<b>5b</b>		No
<b>c</b> If "Yes," to line 5a or 5b, did the organization file Form 8886-T? . . . . .				<b>5c</b>		
<b>6a</b> 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? . . . . .				<b>6a</b>		No
<b>b</b> If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? . . . . .				<b>6b</b>		
<b>7 Organizations that may receive deductible contributions under section 170(c).</b>						
<b>a</b> 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? . . . . .				<b>7a</b>		No
<b>b</b> If "Yes," did the organization notify the donor of the value of the goods or services provided? . . . . .				<b>7b</b>		
<b>c</b> Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? . . . . .				<b>7c</b>		No
<b>d</b> If "Yes," indicate the number of Forms 8282 filed during the year . . . . .				<b>7d</b>		
<b>e</b> Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?				<b>7e</b>		No
<b>f</b> Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . . . . .				<b>7f</b>		No
<b>g</b> If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? . . . . .				<b>7g</b>		
<b>h</b> If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? . . . . .				<b>7h</b>		
<b>8 Sponsoring organizations maintaining donor advised funds.</b> Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? . . . . .						
				<b>8</b>		
<b>9a</b> Did the sponsoring organization make any taxable distributions under section 4966? . . . . .				<b>9a</b>		
<b>b</b> Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . . . .				<b>9b</b>		
<b>10 Section 501(c)(7) organizations.</b> Enter						
<b>a</b> Initiation fees and capital contributions included on Part VIII, line 12 . . . . .				<b>10a</b>		
<b>b</b> Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities				<b>10b</b>		
<b>11 Section 501(c)(12) organizations.</b> Enter						
<b>a</b> Gross income from members or shareholders . . . . .				<b>11a</b>		
<b>b</b> Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them ) . . . . .				<b>11b</b>		
<b>12a Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?						
<b>b</b> If "Yes," enter the amount of tax-exempt interest received or accrued during the year				<b>12b</b>		
<b>13 Section 501(c)(29) qualified nonprofit health insurance issuers.</b>						
<b>a</b> Is the organization licensed to issue qualified health plans in more than one state? <b>Note.</b> See the instructions for additional information the organization must report on Schedule O				<b>13a</b>		
<b>b</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 . . . . .				<b>13b</b>		
<b>c</b> Enter the amount of reserves on hand . . . . .				<b>13c</b>		
<b>14a</b> Did the organization receive any payments for indoor tanning services during the tax year? . . . . .				<b>14a</b>		No
<b>b</b> If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O . . . . .				<b>14b</b>		
<b>15</b> Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see instructions and file Form 4720, Schedule N . . . . .				<b>15</b>		No
<b>16</b> Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O . . . . .				<b>16</b>		No

**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
<b>1a</b>	Enter the number of voting members of the governing body at the end of the tax year		
	1a 15		
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>b</b>	Enter the number of voting members included in line 1a, above, who are independent		
	1b 13		
<b>2</b>	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?		No
<b>3</b>	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?		No
<b>4</b>	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?		No
<b>5</b>	Did the organization become aware during the year of a significant diversion of the organization's assets?		No
<b>6</b>	Did the organization have members or stockholders?	Yes	
<b>7a</b>	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	Yes	
<b>7b</b>	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	Yes	
<b>8</b>	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following		
<b>a</b>	The governing body?	Yes	
<b>b</b>	Each committee with authority to act on behalf of the governing body?	Yes	
<b>9</b>	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O		No

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

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

### Section C. Disclosure

**17** List the States with which a copy of this Form 990 is required to be filed: NC

**18** Section 6104 requires an organization to make its Form 1023 (or 1024-A 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.  
 KAREN DAUGHERTY 2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 (336) 718-2803

## Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

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

☒

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

[illegible]

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

[illegible]

<b>1b Sub-Total</b>			
<b>c Total from continuation sheets to Part VII, Section A</b>			
<b>d Total (add lines 1b and 1c)</b>	7,395,377	6,381,653	1,167,936

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 ▶ 625

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

## Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
LABORATORY CORPORATION OF AMERICA HOLDIN  PO BOX 12140 BURLINGTON, NC 27216	LAB SERVICES	14,362,411
CROSS COUNTRY STAFFING  PO BOX 404674 ATLANTA, GA 30384	STAFFING SERVICES	13,119,382
MORRISON HEALTHCARE  PO BOX 102289 ATLANTA, GA 30368	FOOD MANAGEMENT SERVICES	11,238,945
CROTHALL HEALTH CARE INC  1500 LIBERTY RIDGE DR STE 210 WAYNE, PA 19087	FACILITY SERVICES	11,236,179
SPECTRUM MEDICAL GROUP PA  3001 LYNTHURST AVE WINSTON SALEM, NC 27103	HEALTH SERVICES	5,969,990

<p><b>2</b> Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization ► 98</p>	
---	--



Part VIII		Statement of Revenue					
Check if Schedule O contains a response or note to any line in this Part VIII . . . . . <input type="checkbox"/>							
		(A)	(B)	(C)	(D)		
		Total revenue	Related or exempt function revenue	Unrelated business revenue	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	2,521,373				
	e Government grants (contributions) . . . . .	1e					
	f All other contributions, gifts, grants, and similar amounts not included above . . . . .	1f	237,442				
	g Noncash contributions included in lines 1a - 1f \$ . . . . .						
	h Total. Add lines 1a-1f . . . . . ▶		2,758,815				
Program Service Revenue			Business Code				
	2a NET PATIENT REVENUE . . . . .		622110	1,356,252,739	1,356,252,739		
	b PHARMACY . . . . .		446110	46,995,099	46,995,099		
	c MOBILE MRI SERVICES . . . . .		621512	2,902,974	2,902,974		
	d LAB SERVICES . . . . .		621511	938,695	938,695		
	e VALUE BASED INCENTIVE . . . . .		900099	912,860	912,860		
	f All other program service revenue . . . . .			-3,899,033	-3,899,033		
	g Total. Add lines 2a-2f . . . . . ▶		1,404,103,334				
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts) . . . . . ▶		230,691			230,691	
	4 Income from investment of tax-exempt bond proceeds . . . . . ▶						
	5 Royalties . . . . . ▶						
	6a Gross rents . . . . .		(i) Real	(ii) Personal			
	b Less rental expenses . . . . .		261,661	0			
	c Rental income or (loss) . . . . .		261,661				
	d Net rental income or (loss) . . . . . ▶		261,661				261,661
	7a Gross amount from sales of assets other than inventory . . . . .		(i) Securities	(ii) Other			
	b Less cost or other basis and sales expenses . . . . .			316,264			
	c Gain or (loss) . . . . .			169,907			
	d Net gain or (loss) . . . . . ▶		146,357				146,357
	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		87,799				
	b Less cost of goods sold . . . . . b		77,387				
	c Net income or (loss) from sales of inventory . . . . . ▶		10,412				10,412
Miscellaneous Revenue . . . . .		Business Code					
11a CAFETERIA MEALS . . . . .		722514	3,636,259			3,636,259	
b DIALYSIS SERVICES . . . . .		621492	2,066,090	2,066,090			
c CHILD DEVELOPMENT CENTER . . . . .		624410	1,684,492		254,048	1,430,444	
d All other revenue . . . . .			2,137,771	1,342,805		794,966	
e Total. Add lines 11a-11d . . . . . ▶		9,524,612					
12 Total revenue. See Instructions . . . . . ▶		1,417,035,882		1,407,512,229	254,048	6,510,790	

**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
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21.	1,076,131	1,076,131		
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22.	104,773	104,773		
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.				
<b>4</b> Benefits paid to or for members.				
<b>5</b> Compensation of current officers, directors, trustees, and key employees.	3,863,572		3,863,572	
<b>6</b> Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B).				
<b>7</b> Other salaries and wages.	432,761,617	419,043,074	13,718,543	
<b>8</b> Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).	20,670,228	20,014,982	655,246	
<b>9</b> Other employee benefits.	63,026,636	61,028,692	1,997,944	
<b>10</b> Payroll taxes.	27,916,536	27,031,582	884,954	
<b>11</b> Fees for services (non-employees):				
<b>a</b> Management.				
<b>b</b> Legal.	8,050		8,050	
<b>c</b> Accounting.	1,487		1,487	
<b>d</b> Lobbying.				
<b>e</b> Professional fundraising services. See Part IV, line 17.				
<b>f</b> Investment management fees.				
<b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	111,059,849	106,071,431	4,988,418	
<b>12</b> Advertising and promotion.	1,015,276	1,015,276		
<b>13</b> Office expenses.	5,666,625	5,267,192	399,433	
<b>14</b> Information technology.	8,693,526	8,693,526		
<b>15</b> Royalties.				
<b>16</b> Occupancy.	26,903,154	26,903,154		
<b>17</b> Travel.	1,582,134	886,937	695,197	
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials.				
<b>19</b> Conferences, conventions, and meetings.	243,847		243,847	
<b>20</b> Interest.	13,904,168	13,904,168		
<b>21</b> Payments to affiliates.				
<b>22</b> Depreciation, depletion, and amortization.	25,925,258	25,925,258		
<b>23</b> Insurance.	2,049,175	1,852,862	196,313	
<b>24</b> 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):				
<b>a</b> CORPORATE SUPPORT	183,906,642		183,906,642	
<b>b</b> MEDICAL SUPPLIES	133,572,306	133,572,306		
<b>c</b> DRUGS	119,593,919	119,593,919		
<b>d</b> ACCRUED UBIT	-40,438		-40,438	
<b>e</b> All other expenses	113,199,742	99,996,838	13,202,904	
<b>25</b> Total functional expenses. Add lines 1 through 24e.	1,296,704,213	1,071,982,101	224,722,112	0
<b>26</b> Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

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

		(A) Beginning of year		(B) End of year
<b>Assets</b>	<b>1</b> Cash—non-interest-bearing . . . . .	-35,834	<b>1</b>	37,164
	<b>2</b> Savings and temporary cash investments . . . . .		<b>2</b>	
	<b>3</b> Pledges and grants receivable, net . . . . .		<b>3</b>	
	<b>4</b> Accounts receivable, net . . . . .	152,939,255	<b>4</b>	160,863,070
	<b>5</b> Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L . . . . .		<b>5</b>	
	<b>6</b> 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 . . . . .		<b>6</b>	
	<b>7</b> Notes and loans receivable, net . . . . .	11,777,628	<b>7</b>	13,452,882
	<b>8</b> Inventories for sale or use . . . . .	22,911,348	<b>8</b>	23,191,358
	<b>9</b> Prepaid expenses and deferred charges . . . . .	602,988	<b>9</b>	799,157
	<b>10a</b> Land, buildings, and equipment—cost or other basis. Complete Part VI of Schedule D	<b>10a</b> 566,597,406		
	<b>b</b> Less: accumulated depreciation	<b>10b</b> 332,882,934	227,353,001	<b>10c</b> 233,714,472
	<b>11</b> Investments—publicly traded securities . . . . .		<b>11</b>	
	<b>12</b> Investments—other securities. See Part IV, line 11 . . . . .	436,444	<b>12</b>	13,275,998
	<b>13</b> Investments—program-related. See Part IV, line 11 . . . . .		<b>13</b>	
	<b>14</b> Intangible assets . . . . .	31,015,047	<b>14</b>	31,015,047
	<b>15</b> Other assets. See Part IV, line 11 . . . . .	1,097,644,623	<b>15</b>	1,215,660,134
<b>16</b> <b>Total assets.</b> Add lines 1 through 15 (must equal line 34) . . . . .	1,544,644,500	<b>16</b>	1,692,009,282	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses . . . . .	54,688,468	<b>17</b>	65,310,957
	<b>18</b> Grants payable . . . . .		<b>18</b>	
	<b>19</b> Deferred revenue . . . . .	149,755	<b>19</b>	98,891
	<b>20</b> Tax-exempt bond liabilities . . . . .		<b>20</b>	
	<b>21</b> Escrow or custodial account liability. Complete Part IV of Schedule D . . . . .		<b>21</b>	
	<b>22</b> 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 . . . . .		<b>22</b>	
	<b>23</b> Secured mortgages and notes payable to unrelated third parties . . . . .		<b>23</b>	
	<b>24</b> Unsecured notes and loans payable to unrelated third parties . . . . .		<b>24</b>	
	<b>25</b> 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 . . . . .	27,315,360	<b>25</b>	30,233,855
	<b>26</b> <b>Total liabilities.</b> Add lines 17 through 25 . . . . .	82,153,583	<b>26</b>	95,643,703
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.</b>			
	<b>27</b> Unrestricted net assets	1,462,490,917	<b>27</b>	1,596,365,216
	<b>28</b> Temporarily restricted net assets . . . . .		<b>28</b>	0
	<b>29</b> Permanently restricted net assets		<b>29</b>	363
	<b>Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.</b>			
	<b>30</b> Capital stock or trust principal, or current funds . . . . .		<b>30</b>	
	<b>31</b> Paid-in or capital surplus, or land, building or equipment fund . . . . .		<b>31</b>	
	<b>32</b> Retained earnings, endowment, accumulated income, or other funds		<b>32</b>	
<b>33</b> <b>Total net assets or fund balances</b> . . . . .	1,462,490,917	<b>33</b>	1,596,365,579	
<b>34</b> <b>Total liabilities and net assets/fund balances</b> . . . . .	1,544,644,500	<b>34</b>	1,692,009,282	

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

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	1,417,035,882
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	1,296,704,213
<b>3</b>	Revenue less expenses Subtract line 2 from line 1	<b>3</b>	120,331,669
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	1,462,490,917
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	-1,469
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	13,544,462
<b>10</b>	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	<b>10</b>	1,596,365,579

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

- 1** Accounting method used to prepare the Form 990 ☐ Cash ☒ Accrual ☐ 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  
☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis
- 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  
☐ Separate basis ☒ Consolidated basis ☐ Both consolidated and separate basis
- 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
- 3a** As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?
- b** If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits

	Yes	No
<b>2a</b>		No
<b>2b</b>	Yes	
<b>2c</b>	Yes	
<b>3a</b>		No
<b>3b</b>		

# Additional Data

**Software ID:**  
**Software Version:**  
**EIN:** 56-0928089  
**Name:** FORSYTH MEMORIAL HOSPITAL INC

Form 990 (2018)

**Form 990, Part III, Line 4a:**

FORSYTH MEMORIAL HOSPITAL, INC (FMH), KERNERSVILLE MEDICAL CENTER (KMC), AND CLEMMONS MEDICAL CENTER (CMC) CARRY OUT THE PURPOSE OF THE FORSYTH COUNTY BOARD OF COMMISSIONERS BY ADVANCING AND SUPPORTING THE PROMOTION OF THE HEALTH OF THE INHABITANTS OF FORSYTH COUNTY AND THE KERNERSVILLE AREA OF NC FMH, KMC, AND CMC MAINTAIN AN OPEN DOOR POLICY, ACCEPTING ALL PATIENTS REGARDLESS OF THEIR ABILITY TO PAY FMH HAS 859 LICENSED BEDS DURING 2018 THERE WERE 235,639 PATIENT DAYS WITH AN AVERAGE LENGTH OF STAY OF 6 DAYS, AN AVERAGE DAILY CENSUS OF 646, AND 39,834 DISCHARGES THERE WERE 25,835 INPATIENT AND OUTPATIENT SURGERIES, A TOTAL OF 1,154,748 OUTPATIENT ENCOUNTERS AND 84,972 EMERGENCY DEPARTMENT VISITS (CONTINUED ON SCHEDULE O)

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(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			
BAREFOOT SAMUEL ..... TRUSTEE	2 00 .....	X						0	0	0
BROWN CANDICE ..... TRUSTEE	2 00 .....	X						0	0	0
CARROLL JOE ..... TRUSTEE	2 00 .....	X						0	0	0
EDWARDS JOEL MD ..... TRUSTEE	2 00 .....	X						548,967	0	36,480
ELY JOSEPH ..... CHAIR	2 00 .....	X		X				0	0	0
FORIEST BRYANT ..... TRUSTEE	2 00 .....	X						0	0	0
HARDING LARI ..... TRUSTEE	2 00 .....	X						0	0	0
HAUSER CHARLES ..... TRUSTEE	2 00 .....	X						0	0	0
JOHNSON JOIA ..... VICE CHAIR	2 00 .....	X		X				0	0	0
LAMBE CLARENCE ..... SEC/TREAS	2 00 .....	X		X				0	0	0

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(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			
LATHAM LINDA ..... TRUSTEE	2 00 .....	X						0	0	0
LEON CHRISTOPHER ..... TRUSTEE	2 00 .....	X						0	0	0
LOBO LUIS ..... TRUSTEE	2 00 .....	X						0	0	0
THOMASON JASON MD ..... TRUSTEE	2 00 .....	X						0	0	0
WOLFE III JOHN ..... TRUSTEE	2 00 .....	X						0	0	0
MORRIS JOHN ..... ASST SEC	2 00 .....			X				0	393,030	47,612
SANZ SEAN ..... FMR PRES & COO	60 00 .....			X				427,205	0	24,159
SETLIFF MICHAEL ..... PRES & COO FMH INCL KMC	60 00 .....			X				529,052	0	73,480
SMITH HARRY ..... SVP HOSPITAL OPERATIONS	60 00 .....			X				0	1,131,009	154,164
BRIGHT JANET ..... CNO	60 00 .....				X			246,687	0	18,101

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(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			
MOTEW STEPHEN ..... SVP	60 00 .....				X			867,372	0	126,435
NYCUM LAWRENCE ..... SVP	60 00 .....				X			791,442	0	124,147
ROYSTER KIRSTEN ..... PRES & COO KMC	60 00 .....				X			27,635	409,049	32,954
BRAVO JULIO ..... RHEUMATOLOGIST	40 00 .....					X		775,154	0	61,567
MCDONALD COLIN ..... NEUROLOGIST	40 00 .....					X		726,529	0	58,534
NOUREDDINE NIZAR ..... CARDIOLOGIST	40 00 .....					X		719,011	0	58,909
PRELI ROBERT ..... CARDIOLOGIST	40 00 .....					X		728,277	0	60,397
ZEYLIKMAN YURIY ..... NEUROLOGIST	40 00 .....					X		1,008,046	0	58,811
LINDSAY JEFFERY ..... FMR PRES - FMH/COO WS MKT	0 00 .....						X	0	1,905,834	54,246
MIHAL DENISE ..... FMR PRES - FMH/COO WS MKT	0 00 .....						X	0	1,457,418	43,808



**Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors**

(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			
GREGORY CHERE ..... FMR SVP	0 00 .....						X	0	743,181	110,198
JARRETT-PULLIAM KIMBERLY ..... FMR CNO	0 00 .....						X	0	342,132	23,934

<b>SCHEDULE A</b> (Form 990 or 990-EZ)	<b>Public Charity Status and Public Support</b> 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. ▶ Go to <a href="http://www.irs.gov/Form990">www.irs.gov/Form990</a> for the latest information.	OMB No 1545-0047
		<b>2018</b>
		<b>Open to Public Inspection</b>
Department of the Treasury Internal Revenue Service	<b>Name of the organization</b> FORSYTH MEMORIAL HOSPITAL INC	<b>Employer identification number</b> 56-0928089

**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.)

- ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
- ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ) )
- ☒ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- ☐ 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
- ☐ 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 )
- ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- ☐ 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 )
- ☐ A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II )
- ☐ An agricultural research organization described in **section 170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture See instructions Enter the name, city, and state of the college or university
- ☐ 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 )
- ☐ An organization organized and operated exclusively to test for public safety See **section 509(a)(4).**
- ☐ 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
  - ☐ **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.**
  - ☐ **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.**
  - ☐ **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.**
  - ☐ **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.**
  - ☐ 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
- Enter the number of supported organizations
- 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		
<b>Total</b>						

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) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(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	<b>Total.</b> 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	<b>Public support.</b> Subtract line 5 from line 4						

Section B. Total Support							
Calendar year (or fiscal year beginning in) ►		(a)2014	(b)2015	(c)2016	(d)2017	(e)2018	(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	<b>Total support.</b> Add lines 7 through 10						
12	Gross receipts from related activities, etc (see instructions)					<b>12</b>	
13	<b>First five years.</b> 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 <b>stop here</b> . . . . . ► <input type="checkbox"/>						

Section C. Computation of Public Support Percentage		
<b>14</b>	Public support percentage for 2018 (line 6, column (f) divided by line 11, column (f))	<b>14</b>
<b>15</b>	Public support percentage for 2017 Schedule A, Part II, line 14	<b>15</b>
<b>16a</b>	<b>33 1/3% support test—2018.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization <span>► <input type="checkbox"/></span>	
<b>b</b>	<b>33 1/3% support test—2017.</b> 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 <b>stop here.</b> The organization qualifies as a publicly supported organization <span>► <input type="checkbox"/></span>	
<b>17a</b>	<b>10%-facts-and-circumstances test—2018.</b> 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 <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization <span>► <input type="checkbox"/></span>	
<b>b</b>	<b>10%-facts-and-circumstances test—2017.</b> 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 <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization <span>► <input type="checkbox"/></span>	
<b>18</b>	<b>Private foundation.</b> If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions <span>► <input type="checkbox"/></span>	

**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) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
<b>2</b> 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						
<b>3</b> Gross receipts from activities that are not an unrelated trade or business under section 513						
<b>4</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
<b>5</b> The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>6 Total.</b> Add lines 1 through 5						
<b>7a</b> Amounts included on lines 1, 2, and 3 received from disqualified persons						
<b>b</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						
<b>c</b> Add lines 7a and 7b						
<b>8 Public support.</b> (Subtract line 7c from line 6.)						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
<b>9</b> Amounts from line 6						
<b>10a</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
<b>b</b> Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
<b>c</b> Add lines 10a and 10b						
<b>11</b> Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
<b>12</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
<b>13 Total support.</b> (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**

<b>15</b> Public support percentage for 2018 (line 8, column (f) divided by line 13, column (f))	<b>15</b>	
<b>16</b> Public support percentage from 2017 Schedule A, Part III, line 15	<b>16</b>	

**Section D. Computation of Investment Income Percentage**

<b>17</b> Investment income percentage for <b>2018</b> (line 10c, column (f) divided by line 13, column (f))	<b>17</b>	
<b>18</b> Investment income percentage from <b>2017</b> Schedule A, Part III, line 17	<b>18</b>	

**19a 33 1/3% support tests—2018.** 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—2017.** 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
<b>1</b> Are all of the organization's supported organizations listed by name in the organization's governing documents? <i>If "No," describe in <b>Part VI</b> how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.</i>	<b>1</b>	
<b>2</b> 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 <b>Part VI</b> how the organization determined that the supported organization was described in section 509(a)(1) or (2).</i>	<b>2</b>	
<b>3a</b> 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>	<b>3a</b>	
<b>b</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 <b>Part VI</b> when and how the organization made the determination.</i>	<b>3b</b>	
<b>c</b> 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 <b>Part VI</b> what controls the organization put in place to ensure such use.</i>	<b>3c</b>	
<b>4a</b> 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>	<b>4a</b>	
<b>b</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 <b>Part VI</b> how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.</i>	<b>4b</b>	
<b>c</b> 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 <b>Part VI</b> 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>	<b>4c</b>	
<b>5a</b> 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 <b>Part VI</b>, 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>	<b>5a</b>	
<b>b</b> <b>Type I or Type II only.</b> Was any added or substituted supported organization part of a class already designated in the organization's organizing document?	<b>5b</b>	
<b>c</b> <b>Substitutions only.</b> Was the substitution the result of an event beyond the organization's control?	<b>5c</b>	
<b>6</b> 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 <b>Part VI</b>.</i>	<b>6</b>	
<b>7</b> 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>	<b>7</b>	
<b>8</b> 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>	<b>8</b>	
<b>9a</b> 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 <b>Part VI</b>.</i>	<b>9a</b>	
<b>b</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 <b>Part VI</b>.</i>	<b>9b</b>	
<b>c</b> 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 <b>Part VI</b>.</i>	<b>9c</b>	
<b>10a</b> 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>	<b>10a</b>	
<b>b</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>	<b>10b</b>	

**Part IV Supporting Organizations** (continued)

	Yes	No
<b>11</b> Has the organization accepted a gift or contribution from any of the following persons?		
<b>a</b> 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>b</b> A family member of a person described in (a) above?		
<b>c</b> 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>		
	<b>11a</b>	
	<b>11b</b>	
	<b>11c</b>	

**Section B. Type I Supporting Organizations**

	Yes	No
<b>1</b> 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>		
	<b>1</b>	
<b>2</b> 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>		
	<b>2</b>	

**Section C. Type II Supporting Organizations**

	Yes	No
<b>1</b> 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>		
	<b>1</b>	

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

	Yes	No
<b>1</b> 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?		
	<b>1</b>	
<b>2</b> 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>		
	<b>2</b>	
<b>3</b> 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>		
	<b>3</b>	

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

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

**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

<b>Section A - Adjusted Net Income</b>		(A) Prior Year	(B) Current Year (optional)
<b>1</b> Net short-term capital gain	<b>1</b>		
<b>2</b> Recoveries of prior-year distributions	<b>2</b>		
<b>3</b> Other gross income (see instructions)	<b>3</b>		
<b>4</b> Add lines 1 through 3	<b>4</b>		
<b>5</b> Depreciation and depletion	<b>5</b>		
<b>6</b> 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)	<b>6</b>		
<b>7</b> Other expenses (see instructions)	<b>7</b>		
<b>8 Adjusted Net Income</b> (subtract lines 5, 6 and 7 from line 4)	<b>8</b>		
<b>Section B - Minimum Asset Amount</b>		(A) Prior Year	(B) Current Year (optional)
<b>1</b> Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year)	<b>1</b>		
<b>a</b> Average monthly value of securities	<b>1a</b>		
<b>b</b> Average monthly cash balances	<b>1b</b>		
<b>c</b> Fair market value of other non-exempt-use assets	<b>1c</b>		
<b>d Total</b> (add lines 1a, 1b, and 1c)	<b>1d</b>		
<b>e Discount</b> claimed for blockage or other factors (explain in detail in Part VI)			
<b>2</b> Acquisition indebtedness applicable to non-exempt use assets	<b>2</b>		
<b>3</b> Subtract line 2 from line 1d	<b>3</b>		
<b>4</b> Cash deemed held for exempt use Enter 1-1/2% of line 3 (for greater amount, see instructions)	<b>4</b>		
<b>5</b> Net value of non-exempt-use assets (subtract line 4 from line 3)	<b>5</b>		
<b>6</b> Multiply line 5 by .035	<b>6</b>		
<b>7</b> Recoveries of prior-year distributions	<b>7</b>		
<b>8 Minimum Asset Amount</b> (add line 7 to line 6)	<b>8</b>		
<b>Section C - Distributable Amount</b>			Current Year
<b>1</b> Adjusted net income for prior year (from Section A, line 8, Column A)	<b>1</b>		
<b>2</b> Enter 85% of line 1	<b>2</b>		
<b>3</b> Minimum asset amount for prior year (from Section B, line 8, Column A)	<b>3</b>		
<b>4</b> Enter greater of line 2 or line 3	<b>4</b>		
<b>5</b> Income tax imposed in prior year	<b>5</b>		
<b>6 Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	<b>6</b>		
<b>7</b> <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 2018 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-2018	(iii) Distributable Amount for 2018
1 Distributable amount for 2018 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2018 (reasonable cause required-- explain in Part VI) See instructions			
3 Excess distributions carryover, if any, to 2018			
a From 2013. . . . .			
b From 2014. . . . .			
c From 2015. . . . .			
d From 2016. . . . .			
e From 2017. . . . .			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2018 distributable amount			
i Carryover from 2013 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2018 from Section D, line 7 \$			
a Applied to underdistributions of prior years			
b Applied to 2018 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2018, 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 2018 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 2019. Add lines 3j and 4c			
8 Breakdown of line 7			
a Excess from 2014. . . . .			
b Excess from 2015. . . . .			
c Excess from 2016. . . . .			
d Excess from 2017. . . . .			
e Excess from 2018. . . . .			



Additional Data

Software ID:  
Software Version:  
EIN: 56-0928089  
Name: FORSYTH MEMORIAL HOSPITAL INC

Part VI

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

Facts And Circumstances Test

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

Department of the Treasury  
Internal Revenue Service

**Political Campaign and Lobbying Activities**

For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶Complete if the organization is described below. ▶Attach to Form 990 or Form 990-EZ.  
▶Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No 1545-0047

**2018**

**Open to Public Inspection**

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

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

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

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

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

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

Name of the organization FORSYTH MEMORIAL HOSPITAL INC	Employer identification number 56-0928089
---	--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**d** Other exempt purpose expenditures

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

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

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

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

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

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

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

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

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

**Lobbying Expenditures During 4-Year Averaging Period**

Calendar year (or fiscal year beginning in)	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) Total
<b>2a</b> Lobbying nontaxable amount					
<b>b</b> Lobbying ceiling amount (150% of line 2a, column(e))					
<b>c</b> Total lobbying expenditures					
<b>d</b> Grassroots nontaxable amount					
<b>e</b> Grassroots ceiling amount (150% of line 2d, column (e))					
<b>f</b> Grassroots lobbying expenditures					

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

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

		(a)		(b)
		Yes	No	Amount
<b>1</b>	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
<b>a</b>	Volunteers?		No	
<b>b</b>	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
<b>c</b>	Media advertisements?		No	
<b>d</b>	Mailings to members, legislators, or the public?		No	
<b>e</b>	Publications, or published or broadcast statements?		No	
<b>f</b>	Grants to other organizations for lobbying purposes?		No	
<b>g</b>	Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
<b>h</b>	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
<b>i</b>	Other activities?	Yes		59,660
<b>j</b>	Total. Add lines 1c through 1i			59,660
<b>2a</b>	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
<b>b</b>	If "Yes," enter the amount of any tax incurred under section 4912			
<b>c</b>	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
<b>d</b>	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

**Part IV** Supplemental Information

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

Return Reference	Explanation
LINE 1I	DUES PAID TO CERTAIN ORGANIZATIONS WHICH INCLUDE A PORTION RELATED TO LOBBYING ACTIVITIES

efile GRAPHIC print - DO NOT PROCESS

As Filed Data -

DLN: 93493319014829

SCHEDULE D

(Form 990)

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.

► Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No 1545-0047

2018

Open to Public Inspection

Department of the Treasury  
Internal Revenue Service

Name of the organization

FORSYTH MEMORIAL HOSPITAL INC

Employer identification number

56-0928089

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

(a) Donor advised funds

(b) Funds and other accounts

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)

☐ Protection of natural habitat

☐ Preservation of open space

☐ Preservation of an historically important land area

☐ Preservation of a certified historic structure

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 on a certified historic structure included in (a)

4

Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register

5

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

6

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

7

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

8

Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ►

9

Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ► \$

10

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

11

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

Part III

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

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

1a

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

1b

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

(i) Revenue included on Form 990, Part VIII, line 1

► \$

(ii) Assets included in Form 990, Part X

► \$

2

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

a

Revenue included on Form 990, Part VIII, line 1

► \$

b

Assets included in Form 990, Part X

► \$

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

Cat No 52283D

Schedule D (Form 990) 2018

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	0				
b Contributions	363				
c Net investment earnings, gains, and losses	0				
d Grants or scholarships	0				
e Other expenditures for facilities and programs	0				
f Administrative expenses	0				
g End of year balance	363				

2

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

a

Board designated or quasi-endowment

0 %

b

Permanent endowment

100 000 %

c

Temporarily restricted endowment

0 %

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)		No
3a(ii)		No
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		10,727,897		10,727,897
b Buildings		158,569,260	34,187,077	124,382,183
c Leasehold improvements		14,091,040	10,602,121	3,488,919
d Equipment		341,647,490	269,273,182	72,374,308
e Other		41,561,719	18,820,554	22,741,165
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c))				233,714,472

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) DUE FROM AFFILIATE	1,215,636,632
(2) FEDERAL INCOME TAX RECEIVABLE	23,502
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 15 ) . . . . . ▶	1,215,660,134

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	0
THIRD PARTY PAYMENT PAYABLE	9,300,551
NOTES PAYABLE	16,052,025
PATIENT REFUNDS	4,881,279
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 25 ) ▶	30,233,855

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.

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

**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.

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

**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:** 56-0928089  
**Name:** FORSYTH MEMORIAL HOSPITAL INC

**Supplemental Information**

Return Reference	Explanation
PART V, LINE 4	THE ENDOWMENT FUNDS ARE HELD FOR COMMUNITY ENGAGEMENT

## Supplemental Information

Return Reference	Explanation
PART X, LINE 2	PART X, LINE 2 LIABILITY UNDER FIN 48 (ASC 740) FOOTNOTE THE AUDIT FOR NOVANT HEALTH AND ITS AFFILIATES IS PREPARED ON A CONSOLIDATED BASIS THE COMPANY IS REQUIRED TO EVALUATE UN CERTAIN TAX POSITIONS THIS EVALUATION INCLUDES A QUANTIFICATION OF TAX RISK IN AREAS SUCH AS UNRELATED BUSINESS TAXABLE INCOME AND THE TAXATION OF OUR FOR-PROFIT SUBSIDIARIES THI S EVALUATION DID NOT HAVE A MATERIAL EFFECT ON THE COMPANY'S CONSOLIDATED STATEMENTS OF OP ERATIONS AND CHANGES IN NET ASSETS FOR THE YEARS ENDED DECEMBER 31, 2018 AND 2017

<b>SCHEDULE H</b> <b>(Form 990)</b>  Department of the Treasury Internal Revenue Service	<h1 style="margin:0;">Hospitals</h1> <p>► <b>Complete if the organization answered "Yes" on Form 990, Part IV, question 20.</b>                  ► <b>Attach to Form 990.</b>                  ► <b>Go to <a href="http://www.irs.gov/Form990EZ">www.irs.gov/Form990EZ</a> for instructions and the latest information.</b></p>	OMB No 1545-0047  <div style="font-size: 2em; font-weight: bold; text-align: center;">2018</div> Open to Public Inspection
Name of the organization FORSYTH MEMORIAL HOSPITAL INC		Employer identification number 56-0928089

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

		Yes	No
<b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	<b>1a</b>	Yes	
<b>b</b> If "Yes," was it a written policy? . . . . .	<b>1b</b>	Yes	
<b>2</b> 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			
<b>3</b> 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			
<b>a</b> Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other <u>30000 0000000000</u> %	<b>3a</b>	Yes	
<b>b</b> Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %	<b>3b</b>		No
<b>c</b> 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			
<b>4</b> 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"?	<b>4</b>		No
<b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	<b>5a</b>	Yes	
<b>b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	<b>5b</b>	Yes	
<b>c</b> 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?	<b>5c</b>		No
<b>6a</b> Did the organization prepare a community benefit report during the tax year?	<b>6a</b>	Yes	
<b>b</b> If "Yes," did the organization make it available to the public?	<b>6b</b>	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
<b>a</b> Financial Assistance at cost (from Worksheet 1)			48,008,023		48,008,023	3 900 %
<b>b</b> Medicaid (from Worksheet 3, column a)			166,250,005	112,176,299	54,073,706	4 400 %
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b)			2,500,181	2,271,678	228,503	0 020 %
<b>d Total</b> Financial Assistance and Means-Tested Government Programs			216,758,209	114,447,977	102,310,232	8 320 %
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4)			976,909	83,329	893,580	0 070 %
<b>f</b> Health professions education (from Worksheet 5)			12,965,472	2,984,616	9,980,856	0 810 %
<b>g</b> Subsidized health services (from Worksheet 6)			36,676,511	26,276,107	10,400,404	0 850 %
<b>h</b> Research (from Worksheet 7)			1,170,719	460	1,170,259	0 100 %
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8)			428,550	0	428,550	0 030 %
<b>j Total.</b> Other Benefits			52,218,161	29,344,512	22,873,649	1 860 %
<b>k Total.</b> Add lines 7d and 7j			268,976,370	143,792,489	125,183,881	10 180 %

**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
<b>1</b> Physical improvements and housing			15,000		15,000	0 %
<b>2</b> Economic development			166,799		166,799	0 010 %
<b>3</b> Community support			237,386		237,386	0 020 %
<b>4</b> Environmental improvements			2,670		2,670	0 %
<b>5</b> Leadership development and training for community members			8,500		8,500	0 %
<b>6</b> Coalition building						
<b>7</b> Community health improvement advocacy			456		456	0 %
<b>8</b> Workforce development			116,090		116,090	0 010 %
<b>9</b> Other						
<b>10 Total</b>			546,901		546,901	0 040 %

**Part III Bad Debt, Medicare, & Collection Practices**

**Section A. Bad Debt Expense**

<b>1</b> Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	<b>1</b>	Yes	No
<b>2</b> Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	<b>2</b>	66,870,056	
<b>3</b> 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.	<b>3</b>	0	
<b>4</b> 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**

<b>5</b> Enter total revenue received from Medicare (including DSH and IME).	<b>5</b>	216,420,737
<b>6</b> Enter Medicare allowable costs of care relating to payments on line 5.	<b>6</b>	215,211,037
<b>7</b> Subtract line 6 from line 5. This is the surplus (or shortfall).	<b>7</b>	1,209,700
<b>8</b> 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**

<b>9a</b> Did the organization have a written debt collection policy during the tax year?	<b>9a</b>	Yes	No
<b>b</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.	<b>9b</b>		No

**Part IV Management Companies and Joint Ventures** (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

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

**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?

3

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)

		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
	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)  
FORSYTH MEMORIAL 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):** \_\_\_\_\_

		Yes	No
<b>Community Health Needs Assessment</b>			
<b>1</b>	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? . . . . .	<b>1</b>	No
<b>2</b>	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 . . . . .	<b>2</b>	No
<b>3</b>	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)	<b>3</b>	Yes
<b>a</b>	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b>	<input checked="" type="checkbox"/> Demographics of the community		
<b>c</b>	<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		
<b>d</b>	<input checked="" type="checkbox"/> How data was obtained		
<b>e</b>	<input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b>	<input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b>	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b>	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b>	<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)		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>4</b>	Indicate the tax year the hospital facility last conducted a CHNA <u>20 16</u>		
<b>5</b>	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 . . . . .	<b>5</b>	Yes
<b>6 a</b>	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b>	No
<b>b</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 . . . . .	<b>6b</b>	No
<b>7</b>	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)	<b>7</b>	Yes
<b>a</b>	<input type="checkbox"/> Hospital facility's website (list url) _____		
<b>b</b>	<input checked="" type="checkbox"/> Other website (list url) <u>WWW.NOVANTHEALTH.ORG</u>		
<b>c</b>	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>8</b>	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 . . . . .	<b>8</b>	Yes
<b>9</b>	Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 16</u>		
<b>10</b>	Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . .	<b>10</b>	Yes
<b>a</b>	If "Yes" (list url) <u>WWW.NOVANTHEALTH.ORG</u>		
<b>b</b>	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b>	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		
<b>12a</b>	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .	<b>12a</b>	No
<b>b</b>	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b>	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)

FORSYTH MEMORIAL 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 300 000000000000 % and FPG family income limit for eligibility for discounted care of 0 000000000000 %		
b <input type="checkbox"/> Income level other than FPG (describe in Section C)		
c <input checked="" type="checkbox"/> Asset level		
d <input type="checkbox"/> Medical indigency		
e <input checked="" type="checkbox"/> Insurance status		
f <input type="checkbox"/> Underinsurance discount		
g <input checked="" type="checkbox"/> Residency		
h <input checked="" type="checkbox"/> Other (describe in Section C)		
14 Explained the basis for calculating amounts charged to patients?	14	No
15 Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	15 Yes	
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e <input type="checkbox"/> Other (describe in Section C)		
16 Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	16 Yes	
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) SEE SECTION C		
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) SEE SECTION C		
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) SEE SECTION C		
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**

FORSYTH MEMORIAL HOSPITAL INC

**Name of hospital facility or letter of facility reporting group**

**17** Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment? . . . . .

	Yes	No
<b>17</b>	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** ☐ Reporting to credit agency(ies)
- b** ☐ Selling an individual's debt to another party
- c** ☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP
- d** ☐ Actions that require a legal or judicial process
- e** ☐ Other similar actions (describe in Section C)
- f** ☒ None of these actions or other similar actions were permitted

**19** Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? . . . . .

<b>19</b>		No
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If "Yes," check all actions in which the hospital facility or a third party engaged

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

**20** Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply)

- a** ☒ Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs
- b** ☒ Made a reasonable effort to orally notify individuals about the FAP and FAP application process
- c** ☒ Processed incomplete and complete FAP applications
- d** ☒ Made presumptive eligibility determinations
- e** ☐ Other (describe in Section C)
- f** ☐ None of these efforts were made

**Policy Relating to Emergency Medical Care**

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

<b>21</b>	Yes	
-----------	-----	--

If "No," indicate why

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

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

FORSYTH MEMORIAL 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
<b>22</b>		
<b>23</b>		No
<b>24</b>	Yes	

**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? **57**

Name and address	Type of Facility (describe)
<b>1</b> See Additional Data Table	
<b>2</b>	
<b>3</b>	
<b>4</b>	
<b>5</b>	
<b>6</b>	
<b>7</b>	
<b>8</b>	
<b>9</b>	
<b>10</b>	

**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 CRITERIA BESIDES INCOME AND FPG USED IN DETERMINING ELIGIBILITY FOR FREE CARE INCLUDE (1) RESIDENCY - PATIENTS MUST RESIDE WITHIN THE SERVICE AREA OF THE HOSPITAL, (2) THE KIND OF SERVICE PROVIDED - ONLY MEDICALLY NECESSARY SERVICES ARE COVERED, (3) PATIENT STATUS - IN PROVIDER BASED PHYSICIAN CLINICS, PATIENTS MUST HAVE BEEN TREATED BY AN AFFILIATED MEDICAL GROUP PRIMARY CARE PHYSICIAN WITHIN THE PREVIOUS THREE YEARS, AND (4) ACCESS TO HEALTH CARE COVERAGE - PATIENTS MUST BE UNABLE TO ACCESS EMPLOYER SPONSORED HEALTH PLANS OR ENTITLEMENT PROGRAMS LASTLY, THE PATIENT MUST BE WITHOUT SUBSTANTIAL LIQUID ASSETS (I E CASH-ON-HAND) ASSETS SUCH AS HOUSES, CARS, PENALIZED RETIREMENT SAVINGS FUNDS, ETC ARE NOT CONSIDERED LIQUID ASSETS SUBSTANTIAL ASSETS ARE DEFINED AS ENOUGH CASH-ON-HAND TO COVER THE MEDICAL EXPENSES WITHOUT PLACING A HARDSHIP ON THE PATIENT PATIENTS WITH SPECIAL CIRCUMSTANCES SUCH AS BANKRUPTCY MAY ALSO BE ELIGIBLE FOR CHARITY CARE, DETERMINATION IS MADE ON A CASE BY CASE BASIS UNDER THESE CIRCUMSTANCES
PART I, LINE 6A	PART I, LINE 6A THE ORGANIZATION IS A PART OF NOVANT HEALTH, AN INTEGRATED NOT-FOR-PROFIT HEALTH SYSTEM THE COMMUNITY BENEFIT REPORT, REFERRED TO AS A COMMUNITY IMPACT REPORT, IS PREPARED BY A RELATED ORGANIZATION NOVANT HEALTH, INC IS THE PARENT COMPANY AND PRODUCES A COMMUNITY BENEFIT REPORT REPRESENTING THE HEALTH SYSTEM AS A WHOLE THE REPORT CAN BE FOUND AT <a href="https://www.novanthealth.org/home/about-us/community-involvement/community-benefit.aspx">HTTPS //WWW NOVANTHEALTH ORG/HOME/ABOUT-US/COMMUNITY-INVOLVEMENT/COMMUNITY-BENEFIT ASPX</a> PLEASE NOTE THAT THE NUMERIC DATA IN THIS REPORT IS NOT BASED UPON THE FORM 990, SCHEDULE H CRITERIA, BUT RATHER IT HAS BEEN PREPARED IN ACCORDANCE WITH THE NORTH CAROLINA HOSPITAL ASSOCIATION REPORTING GUIDELINES IT SHOULD NOT BE RELIED UPON AS THE ORGANIZATION'S FORM 990, SCHEDULE H COMMUNITY BENEFIT REPORT, ITS COMMUNITY HEALTH NEEDS ASSESSMENT OR COMMUNITY BENEFIT IMPLEMENTATION STRATEGY

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7	COSTS REPORTED IN THE TABLE FOR CHARITY CARE AND CERTAIN OTHER COMMUNITY BENEFITS AMOUNTS ARE CALCULATED USING AN ENTITY SPECIFIC COST TO CHARGE RATIO BASED ON WORKSHEET 2 (CCR)
PART I, LN 7 COL(F)	PART I, LN 7 COL(F) THE AMOUNT OF BAD DEBT REMOVED FROM TOTAL EXPENSES (DENOMINATOR) WAS \$66,870,056

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART II, COMMUNITY BUILDING ACTIVITIES	THE ORGANIZATION'S COMMUNITY BUILDING ACTIVITIES ADDRESSES THE UNDERLYING CAUSES OF HEALTH PROBLEMS AND IMPACTS THE HEALTH OF OUR COMMUNITY THROUGH PARTNERSHIPS WITH LOCAL AGENCIES DEDICATED TO IMPROVING THE LIVES OF ALL INDIVIDUALS OUTREACH INCLUDES PROVIDING SUPPORT TO ORGANIZATIONS SUCH AS LOCAL YMCA'S, UNITED WAY PARTNER AGENCIES, CHAMBERS OF COMMERCE AND OTHER LOCAL COMMUNITY ORGANIZATIONS, ASSISTING WITH COMMUNITY AND COUNTY COALITIONS, AND PROVIDING EDUCATION SEMINARS AND TRAINING FOR COMMUNITY WORKFORCES
PART III, LINE 2	IMPLICIT PRICE CONCESSIONS (ANALOGOUS TO BAD DEBT EXPENSE) ARE DETERMINED BASED ON MANAGEMENT'S ASSESSMENT OF CONTRACTUAL AGREEMENTS, DISCOUNT POLICIES, AND HISTORICAL EXPERIENCE

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART III, LINE 4	THE ORGANIZATION'S IMPLICIT PRICE CONCESSIONS (ANALOGOUS TO BAD DEBT EXPENSE) ON LINE 2 IS CALCULATED USING THE SAME METHODOLOGY AS CHARITY CARE AND OTHER COMMUNITY BENEFITS USING AN ENTITY SPECIFIC COST TO CHARGE RATIO (CCR) FOOTNOTE 2 (ACCOUNTS RECEIVABLE) ON PAGE 7 OF THE AUDITED FINANCIAL STATEMENTS DESCRIBES PRICE CONCESSIONS
PART III, LINE 8	THE METHODOLOGY USED TO DETERMINE THE MEDICARE ALLOWABLE COSTS REPORTED IN THE ORGANIZATION'S MEDICARE COST REPORT AS REFLECTED IN THE AMOUNT REPORTED IN PART III, LINE 6 IS DETERMINED BY FOLLOWING THE MEDICARE PRINCIPLES OF ALLOWABLE COSTS COST FOR THE OVERHEAD DEPARTMENTS ARE STEPPED DOWN TO THE REMAINING COST CENTERS BASED ON STATISTICS FOR EACH OVERHEAD COST CENTER ONCE THE STEP-DOWN PROCESS IS COMPLETE, A COST TO CHARGE RATIO ("CCR") IS DEVELOPED FOR EACH COST CENTER THE CCR IS THEN APPLIED TO THE MEDICARE REVENUE BY COST CENTER AND TOTALED IT SHOULD BE NOTED THAT THE MEDICARE COST REPORTS DO NOT ADDRESS ANY MANAGED CARE MEDICARE REVENUES, COSTS, OR RELATED SHORTFALL THE TOTAL REVENUES REPORTED AS RECEIVED FROM MEDICARE IN LINE 5 OF SECTION B ARE ONLY REPRESENTATIVE OF MEDICARE FEE FOR SERVICE PAYMENTS RECEIVED THE ALLOWABLE COSTS ON LINE 6 ARE SIGNIFICANTLY LOWER THAN THE ACTUAL EXPENDITURES AS SUCH, THE SHORTFALL IS UNDERESTIMATED EVERY HOSPITAL TREATS MEDICARE PATIENTS SOME HOSPITALS ARE LOCATED IN HIGH MEDICARE POPULATION AREAS, OTHERS PROVIDE SERVICES DISPROPORTIONATELY USED BY MEDICARE PATIENTS MEDICARE RATES AND NUMBERS OF MEDICARE PATIENTS ARE NOT NEGOTIATED AS REIMBURSEMENT RATES DECLINE RELATIVE TO COSTS OF CARE, HOSPITALS CONTINUE TO SERVE THE MEDICARE POPULATION WITHOUT THIS SERVICE THESE PATIENTS WOULD BECOME AN OBLIGATION ON THE GOVERNMENT ANY UNREIMBURSED COSTS OF THIS CARE ARE A COMMUNITY BENEFIT PROVIDED BY THE HOSPITAL TO THE COMMUNITY AND GOVERNMENT



**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART III, LINE 9B	THE ORGANIZATION'S BILLING AND COLLECTIONS POLICY DOES EXPLAIN ACTIONS AGAINST PATIENTS WHO HAVE OUTSTANDING DELINQUENT AMOUNTS, BUT THE POLICY DOES NOT CONTAIN PROVISIONS FOR COLLECTION PRACTICES AGAINST PATIENTS WHO ARE ELIGIBLE UNDER THE FINANCIAL ASSISTANCE POLICY (FAP) BECAUSE FAP ELIGIBLE PATIENTS RECEIVE 100% FREE CARE AND THEREFORE DO NOT RECEIVE BILLS ONCE FAP ELIGIBILITY HAS BEEN ESTABLISHED
PART VI, LINE 2	PART VI, LINE 2 NEEDS ASSESSMENTTHE ORGANIZATION IS PART OF NOVANT HEALTH, AN INTEGRATED NOT-FOR-PROFIT HEALTH SYSTEM, WHICH HAS A COMMUNITY BENEFIT DEPARTMENT ("CB DEPARTMENT") COMPRISED OF COMMUNITY BENEFIT PROFESSIONALS AND AN ASSOCIATED ADVISORY WORKING GROUP ("THE COMMUNITY BENEFIT GROUP") THAT INCLUDES REPRESENTATIVES FROM INTERNAL AUDIT, LEGAL, AND TAX THE CB DEPARTMENT IS RESPONSIBLE FOR COORDINATING THE PREPARATION OF THE COMMUNITY HEALTH NEEDS ASSESSMENTS (CHNA) FOR EACH HOSPITAL WITHIN THE SYSTEM, INCLUDING THE CHNAS REPORTED IN PART V, SECTION B EACH HOSPITAL AND THE COMMUNITY BENEFIT GROUP WORK TOGETHER TO IDENTIFY ORGANIZATIONS AND RESOURCES WITHIN ITS COMMUNITY THAT CONTRIBUTE TO THE PROCESS THESE ORGANIZATIONS AND RESOURCES INCLUDE PUBLIC HEALTH DEPARTMENTS, LOCAL COMMUNITY COALITIONS REPRESENTING THE MEDICALLY UNDERSERVED, UNITED WAY, LOCAL UNIVERSITIES, ETC COMMUNITY HEALTH ASSESSMENTS PREPARED BY OTHER ORGANIZATIONS IN THE COMMUNITY ARE USED IN COMBINATION WITH INTERNAL HOSPITAL DATA AND INFORMATION COLLECTED FROM LOCAL AGENCIES TO PREPARE THE HOSPITAL'S CHNA IN ADDITION TO ADDRESSING NEEDS IDENTIFIED THROUGH THE CHNA, EACH HOSPITAL MAY RESPOND TO REQUESTS FOR SPECIFIC COMMUNITY BENEFIT ACTIVITIES OR PROGRAMS FROM PUBLIC AGENCIES OR COMMUNITY GROUPS

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Form and Line Reference	Explanation
PART VI, LINE 3	<p>PART VI, LINE 3 PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE THE ORGANIZATION IS COMMITTED TO PROVIDING OUTSTANDING HEALTHCARE TO ALL MEMBERS OF OUR COMMUNITIES, REGARDLESS OF THEIR ABILITY TO PAY OUR FINANCIAL COUNSELING TEAMS ARE CONSTANTLY WORKING WITH THE PATIENTS WITHIN OUR COMMUNITIES TO UNDERSTAND THEIR NEEDS AND ENSURE THAT OUR POLICIES AND PROCESSES ADDRESS THESE NEEDS WE ALSO MAINTAIN CONTRACTS WITH MEDICAID ELIGIBILITY VENDORS AND THESE TEAMS OFFER ADDITIONAL SUPPORT IN PROCESSING AND ASSESSING HOW WE SERVE THE FINANCIAL NEEDS OF OUR PATIENTS BASED ON THE ASSESSMENTS OF OUR COMMUNITIES, THE ORGANIZATION HAS DEVELOPED FINANCIAL ASSISTANCE POLICIES AND PROGRAMS THAT ADDRESS THE FINANCIAL NEEDS OF OUR PATIENTS WE PRIDE OURSELVES ON THE TRANSPARENCY OF OUR PROGRAMS AND THE EDUCATION WE OFFER OUR PATIENTS AROUND OUR FINANCIAL ASSISTANCE POLICIES OUR PROGRAMS ARE DOCUMENTED ON OUR WEBSITE, ALONG WITH CONTACT INFORMATION FOR OUR FINANCIAL COUNSELORS ADDITIONALLY, OUR PROGRAMS ARE DOCUMENTED ON PATIENT FLYERS THROUGHOUT THE ORGANIZATION'S FACILITIES AND PHYSICIAN OFFICES OUR PATIENT ACCESS SPECIALISTS, FINANCIAL COUNSELORS AND BUSINESS OFFICE TEAMS WORK WITH ALL ELIGIBLE PATIENTS TO EDUCATE THEM ON THE VARIOUS OPTIONS AVAILABLE VIA OUR FINANCIAL ASSISTANCE PROGRAMS OR GOVERNMENT SPONSORED CARE THEY ALSO REFERENCE OUR FINANCIAL ASSISTANCE POLICY IN ALL CONVERSATIONS RELATED TO PATIENTS BILLS FINALLY, WE WORK WITH LOCAL AREA FREE HEALTH CLINICS AND OTHER CHARITABLE ORGANIZATIONS TO PROVIDE CONTINUATION OF CARE FOR THEIR PATIENTS IN ADDITION TO OUR FINANCIAL COUNSELING PROCESSES USED TO IDENTIFY CHARITY CARE PATIENTS, OUR COLLECTIONS PROCESSES WITHIN OUR BUSINESS OFFICES ALSO HELP IDENTIFY PATIENTS WHO ARE ALREADY ELIGIBLE FOR CHARITY OR WHO MAY BE ELIGIBLE BASED ON THEIR STATUS WITHIN THE FEDERAL POVERTY GUIDELINES ("FPG") WE UTILIZE PREVIOUSLY SUBMITTED PATIENT DOCUMENTATION AND CREDIT AGENCY REPORTED FPG FOR DETERMINATION SUPPORTING DOCUMENTS ARE VALID 6 MONTHS FROM THE DATE OF SUBMISSION OUR POLICIES ARE CONSIDERED FLUID AND ARE UPDATED FREQUENTLY BASED ON LOCAL AND NATIONAL MARKET STANDARDS AND NATIONAL ECONOMIC CONDITIONS ANY UPDATES TO OUR POLICIES REQUIRE MULTI-LEVEL LEADERSHIP APPROVAL AND ARE ULTIMATELY APPROVED BY THE ORGANIZATION'S BOARD</p>
PART VI, LINE 4	<p>PART VI, LINE 4 COMMUNITY INFORMATION THE FORSYTH MEMORIAL HOSPITAL, INC FORM 990 INCLUDES THE OPERATIONS OF ONE LICENSED HOSPITAL WITH FACILITIES IN THREE LOCATIONS FORSYTH MEMORIAL HOSPITAL, INC DBA NOVANT HEALTH FORSYTH MEDICAL CENTER, AS NOVANT HEALTH KERNERSVILLE MEDICAL CENTER, AND AS NOVANT HEALTH CLEMMONS MEDICAL CENTER THE ORGANIZATION DEFINES ITS COMMUNITY BY ITS PRIMARY SERVICE AREA THE PRIMARY SERVICE AREAS OF THE FACILITIES LISTED ABOVE INCLUDE THE CITY OF WINSTON-SALEM, THE TOWNS OF BETHANIA, KERNERSVILLE, LEWISVILLE, RURAL HALL, WALKERTOWN, AND THE VILLAGE OF CLEMMONS, ALL OF WHICH ARE LOCATED IN FORSYTH COUNTY, NORTH CAROLINA THE SECONDARY SERVICE AREA COVERS A SEVEN COUNTY RADIUS INCLUDING DAVIDSON, DAVIE, GUILFORD, STOKES, SURRY, WILKES, AND YADKIN COUNTIES FORSYTH COUNTY IS MORE URBAN IN NATURE THE COUNTY CONSISTS OF A LARGE URBAN CENTER SURROUNDED BY SMALLER, MORE RURAL COMMUNITIES ACCORDING TO THE US CENSUS BUREAU DATA, THE MEDIAN HOUSEHOLD INCOME LEVEL WAS \$49,402 ACCORDING TO SG2 DATA, THE SPECIFIC POPULATION GROUPS (ETHNIC AND CULTURAL) FOR THE PRIMARY AND SECONDARY SERVICE AREAS ARE AS FOLLOWS PRIMARY SERVICE AREA ETHNICITY POPULATION % OF POPULATION WHITE 233,910 58.76% BLACK/AFRICAN AMERICAN 94,848 23.83% HISPANIC/LATINO 50,160 12.60% ASIAN/PACIFIC ISLANDERS 9,946 2.50% OTHER 9,203 2.31% TOTAL POPULATION 398,067 100% SECONDARY SERVICE AREA ETHNICITY POPULATION % OF POPULATION WHITE 560,152 65.90% BLACK/AFRICAN AMERICAN 171,235 20.15% HISPANIC/LATINO 70,425 8.29% ASIAN/PACIFIC ISLANDERS 28,614 3.37% OTHER 19,586 2.30% TOTAL POPULATION 850,012 100% ACCORDING TO SG2 DATA, THE AGE BREAKDOWN FOR THE PRIMARY AND SECONDARY SERVICE AREAS IS AS FOLLOWS PRIMARY SERVICE AREA ETHNICITY POPULATION % OF POPULATION 0-17 92,161 23.15% 18-64 242,138 60.83% 65+ 63,768 16.02% TOTAL POPULATION 398,067 100.00% SECONDARY SERVICE AREA ETHNICITY POPULATION % OF POPULATION 0-17 186,347 21.92% 18-64 514,730 60.56% 65+ 148,935 17.52% TOTAL POPULATION 850,012 100.00% THERE ARE FIVE NONPROFIT ACUTE CARE HOSPITAL FACILITIES IN THE COMMUNITY, FOUR OF WHICH ARE PART OF THE NOVANT HEALTH SYSTEM THERE IS ALSO ONE ACADEMIC TEACHING HOSPITAL</p>

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Form and Line Reference	Explanation
PART VI, LINE 5	<p>PART VI, LINE 5 PROMOTION OF COMMUNITY HEALTHTHE ORGANIZATION FURTHERS ITS EXEMPT PURPOSES BY DOING THE FOLLOWING 1 ADOPTING A FINANCIAL ASSISTANCE POLICY,2 REMAINING CERTIFIED BY THE U S DEPARTMENT OF HEALTH AND HUMAN SERVICES TO PROVIDE SERVICES TO ALL BENEFICIARIES OF MEDICARE, MEDICAID, AND OTHER GOVERNMENT PAYMENT PROGRAMS, AND PROVIDING SERVICES IN A NONDISCRIMINATORY MANNER TO SUCH BENEFICIARIES,3 OPERATING A FULL-TIME EMERGENCY ROOM WHICH IS OPEN TO AND ACCEPTS ALL PERSONS, REGARDLESS OF THEIR ABILITY TO PAY,4 MAINTAINING AN OPEN MEDICAL STAFF, SUBJECT TO EXCLUSIVE CONTRACTS FOR HOSPITAL-BASED SERVICES SUCH AS ANESTHESIOLOGY, RADIOLOGY, PATHOLOGY, HOSPITALIST, AND EMERGENCY DEPARTMENT SERVICES, TO THE EXTENT AN EXCLUSIVE CONTRACT FOR THOSE SERVICES IS REQUIRED TO OBTAIN PROPER STAFFING COVERAGE OR TO PERMIT A MORE EFFICIENT DELIVERY OF THOSE SERVICES WITHIN THE HOSPITAL FACILITY,5 MAINTAINING A GOVERNING BOARD CONSISTING PRIMARILY OF A BROAD CROSS-SECTION OF LEADERS IN THE COMMUNITY,6 ADOPTING AND APPLYING A CONFLICT OF INTEREST POLICY, WHICH APPLIES TO THE GOVERNING BOARD AND ORGANIZATION OFFICERS,7 PROVIDING HEALTH EDUCATION LECTURES AND WORKSHOPS,8 PROVIDING HEALTH FAIRS, EDUCATION ON SPECIFIC DISEASES OR CONDITIONS, AND HEALTH PROMOTION AND WELLNESS PROGRAMS TO THE COMMUNITIES IT SERVES,9 PROVIDING SUPPORT GROUPS AND SELF HELP PROGRAMS TO THE COMMUNITIES IT SERVES,10 PROVIDING COMMUNITY-BASED CLINICAL SERVICES, INCLUDING WITHOUT LIMITATION, HEALTH SCREENINGS AND CLINICS FOR UNINSURED OR UNDERINSURED PERSONS TO THE COMMUNITIES IT SERVES,11 PROVIDING HEALTHCARE SUPPORT SERVICES, INCLUDING WITHOUT LIMITATION, INFORMATION AND REFERRAL TO COMMUNITY SERVICES, CASE MANAGEMENT OF UNDERINSURED AND UNINSURED PERSONS, TELEPHONE INFORMATION SERVICES AND ASSISTANCE TO ENROLL IN PUBLIC PROGRAMS, SUCH AS STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) AND MEDICAID TO THE COMMUNITIES IT SERVES,12 PROVIDING SUBSIDIZED HEALTH SERVICES AND CLINICAL PROGRAMS TO THE COMMUNITIES IT SERVES,13 PROVIDING CASH AND IN-KIND CONTRIBUTIONS TO NONPROFIT COMMUNITY HEALTHCARE ORGANIZATIONS IN THE COMMUNITIES IT SERVES, AND14 GENERALLY PROMOTING THE HEALTH, WELLNESS, AND WELFARE OF THE COMMUNITIES IT SERVES BY PROVIDING QUALITY HEALTHCARE SERVICES AT REASONABLE COST PLEASE SEE THE NOVANT HEALTH COMMUNITY BENEFIT REPORT, LOCATED AT <a href="http://www.novanthealth.org/home/about-us/company-information/financial-profile/community-benefit-report.aspx">HTTP //WWW NOVANTHEALTH ORG/HOME/ABOUT-US/COMPANY-INFORMATION/FINANCIAL-PROFILE/COMMUNITY-BENEFIT-REPORT ASPX</a> PLEASE NOTE THAT THE NUMERIC INFORMATION IN THIS REPORT IS NOT BASED UPON THE FORM 990, SCHEDULE H CRITERIA, BUT RATHER IT HAS BEEN PREPARED IN ACCORDANCE WITH THE NORTH CAROLINA HOSPITAL ASSOCIATION REPORTING GUIDELINES</p>
PART VI, LINE 6	<p>PART VI, LINE 6 AFFILIATED HEALTH CARE SYSTEMTHE ORGANIZATION IS AN INTEGRAL PART OF NOVANT HEALTH, A NOT-FOR-PROFIT INTEGRATED GROUP OF HOSPITALS, PHYSICIAN CLINICS, OUTPATIENT CENTERS AND OTHER HEALTHCARE SERVICE PROVIDERS NOVANT HEALTH IS RANKED AS ONE OF OUR NATION'S TOP 20 INTEGRATED HEALTHCARE SYSTEMS - CARING FOR PATIENTS AND COMMUNITIES IN NORTH CAROLINA, SOUTH CAROLINA, AND VIRGINIA EACH HOSPITAL PROVIDES SUBSTANTIAL COMMUNITY BENEFIT TO THE COMMUNITY IT SERVES, AS REPORTED INDIVIDUALLY ON EACH HOSPITAL'S FORM 990, SCHEDULE H THE COMMUNITY BENEFIT OF THE SYSTEM AS A WHOLE IS DOCUMENTED IN A SYSTEM-WIDE COMMUNITY BENEFIT REPORT, LOCATED AT <a href="https://www.novanthealth.org/home/about-us/community-involvement/community-benefit.aspx">HTTPS //WWW NOVANTHEALTH ORG/HOME/ABOUT-US/COMMUNITY-INVOLVEMENT/COMMUNITY-BENEFIT ASPX</a> PLEASE NOTE THAT THE NUMERIC INFORMATION IN THIS REPORT IS NOT BASED UPON THE FORM 990, SCHEDULE H CRITERIA, BUT RATHER IT HAS BEEN PREPARED IN ACCORDANCE WITH THE NORTH CAROLINA HOSPITAL ASSOCIATION REPORTING GUIDELINES IT SHOULD NOT BE RELIED UPON AS THE ORGANIZATION'S FORM 990, SCHEDULE H COMMUNITY BENEFIT REPORT, ITS COMMUNITY HEALTH NEEDS ASSESSMENT OR COMMUNITY BENEFIT IMPLEMENTATION STRATEGY THERE ARE SIGNIFICANT COMMUNITY BENEFIT ACTIVITIES WITHIN NOVANT HEALTH WHICH MAY NOT BE REPORTABLE ON A SCHEDULE H BECAUSE THEY ARE NOT CONDUCTED BY AN ENTITY WHICH OWNS OR OPERATES A HOSPITAL IN ADDITION TO HOSPITALS, NOVANT HEALTH INCLUDES A PHYSICIAN ORGANIZATION WITH PRACTICES IN NORTH CAROLINA, SOUTH CAROLINA, AND VIRGINIA AND FIVE HOSPITAL FOUNDATIONS WHICH SUPPORT AND ENHANCE THE ACTIVITIES IN THOSE HOSPITALS' COMMUNITIES FURTHER, NOVANT HEALTH INCLUDES AMBULATORY SURGERY CENTERS, IMAGING CENTERS, REHABILITATION CENTERS, AND OTHER OUTPATIENT FACILITIES, ALL DEDICATED TO PROMOTING THE HEALTH OF THEIR RESPECTIVE COMMUNITIES</p>

# 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 7 STATE FILING OF COMMUNITY BENEFIT REPORT	NOVANT HEALTH, INC FILES A SYSTEM-WIDE COMMUNITY BENEFIT REPORT PREPARED IN ACCORDANCE WITH THE NORTH CAROLINA HOSPITAL ASSOCIATION REPORTING GUIDELINES WITH THE NORTH CAROLINA MEDICAL CARE COMMISSION AS PART OF THE DOCUMENTATION REQUIRED FOR THE ISSUANCE OF TAX EXEMPT BOND FINANCING

Additional Data

Software ID:  
Software Version:  
EIN: 56-0928089  
Name: FORSYTH MEMORIAL HOSPITAL INC

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

Section A. Hospital Facilities		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER—24 hours	ER—other	Other (Describe)	Facility reporting group
(list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? 3											
Name, address, primary website address, and state license number											
1	FMH DBA NOVANT HEALTH FORSYTH MEDICAL CENTER 3333 SILAS CREEK PARKWAY WINSTONSALEM, NC 27103 WWW.NOVANTHEALTH.ORG	X	X					X			A
2	FMH DBA NOVANT HEALTH KERNERSVILLE MED CENTER 1750 KERNERSVILLE MEDICAL PARKWAY KERNERSVILLE, NC 27284 WWW.NOVANTHEALTH.ORG	X	X					X			A
3	FMH DBA NOVANT HEALTH CLEMMONS MEDICAL CENTER 6915 VILLAGE MEDICAL CIRCLE CLEMMONS, NC 27012 WWW.NOVANTHEALTH.ORG	X	X					X			A

**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
PART V, SECTION B	FACILITY REPORTING GROUP A
FACILITY REPORTING GROUP A CONSISTS OF	- FACILITY 1 FMH DBA NOVANT HEALTH FORSYTH MEDICAL CENTER, - FACILITY 2 FMH DBA NOVANT HEALTH KERNERSVILLE MED CENTER, - FACILITY 3 FMH DBA NOVANT HEALTH CLEMMONS MEDICAL CENTER

**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
FORSYTH MEMORIAL HOSPITAL, INC PART V, SECTION B, LINE 3J	FORSYTH MEMORIAL HOSPITAL, INC PART V, SECTION B, LINE 3E SEVERAL SOCIAL, BEHAVIORAL, AND CLINICAL HEALTH NEEDS WERE IDENTIFIED IN THE NEEDS ASSESSMENT ONCE THE HEALTH NEEDS WERE IDENTIFIED, SURVEYS AND COMMUNITY MEETINGS WERE CONDUCTED IN WHICH THE VARIOUS COMMUNITY STAKEHOLDERS RANKED THE HEALTH ISSUES ACCORDING TO THE YEARS OF POTENTIAL LIFE LOST AND MAGNITUDE OF IMPACT THE INFORMATION GATHERED WAS THEN MATRIXED AND SCORED IN ORDER TO RANK THE FOCUS AREAS AND PRIORITIZE THE IDENTIFIED HEALTH NEEDS FURTHER PRIORITIZATION OCCURRED WITH THE REVIEW BY THE ORGANIZATION'S BOARD
FORSYTH MEMORIAL HOSPITAL, INC PART V, SECTION B, LINE 5	WHILE CONDUCTING THE CHNA, THE HOSPITAL FACILITY(IES) SOLICITED INPUT FROM, AND CONSULTED WITH, A VARIETY OF COMMUNITY REPRESENTATIVES INCLUDING, BUT NOT LIMITED TO, REPRESENTATIVES OF CITY AND COUNTY GOVERNMENT INCLUDING HEALTH DEPARTMENTS, COMMUNITY-BASED ORGANIZATIONS, FOUNDATIONS, CHURCHES, COLLEGES/UNIVERSITIES, COMMUNITY COALITIONS AND OTHER SOCIAL SERVICE AGENCIES INPUT WAS GATHERED THROUGH COMMUNITY MEETINGS, STAKEHOLDERS INTERVIEWS, AND SOLICITED THROUGH WRITTEN COMMENTS THROUGHOUT THE SURVEY PERIOD UNTIL THE FINAL COMMUNITY PRIORITY SETTING MEETING(S) AND SURVEY THE SCOPE OF EXPERTISE WAS BROAD AND INCLUDED SUCH AREAS AS PUBLIC HEALTH, MINORITY POPULATIONS, HEALTH DISPARITIES, AND SOCIAL 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
<p>FORSYTH MEMORIAL HOSPITAL, INC PART V, SECTION B, LINE 11</p>	<p>THE HOSPITAL FACILITY(IES) IS/ARE A PART OF NOVANT HEALTH, AN INTEGRATED NOT-FOR-PROFIT HEALTH SYSTEM AS SUCH, NOVANT HEALTH INCLUDES MULTIPLE HOSPITAL FACILITIES AND HAS ENGAGED IN CHNAs FOR ALL OF THE COMMUNITIES BEING SERVED THE FACILITY'S CHNA IDENTIFIED MULTIPLE NEEDS FOR THE COMMUNITY SERVED THE NEEDS IDENTIFIED WERE REVIEWED AND PRIORITIZED BY THE CHNA RESOURCE GROUP AND SUBSEQUENTLY BY EACH FACILITY'S BOARD THEY EVALUATED EACH DOCUMENTED NEED AND ITS INTERSECTION WITH THE ORGANIZATION'S VISION, COMMITMENTS, AND KEY STRENGTHS BEFORE FURTHER PRIORITIZING THE HEALTH NEEDS AND AGREEING UPON THE TOP HEALTH PRIORITIES TO BE ADDRESSED WHERE POSSIBLE, WE HAVE LEVERAGED THE SYSTEM'S STRENGTHS AND RESOURCES TO BEST ADDRESS THOSE NEEDS THAT ARE HIGHEST IN PRIORITY AND CONSISTENT ACROSS COMMUNITIES NOVANT HEALTH AND EACH OF ITS HOSPITAL FACILITIES HAVE ADOPTED AND EXECUTED AN IMPLEMENTATION STRATEGY THAT ADDRESSES THE PRIORITIZED COMMUNITY HEALTH NEEDS FROM THE CHNAs THE IMPLEMENTATION STRATEGIES OUTLINE THE PLAN THAT THE HOSPITAL FACILITY(IES) WILL UNDERTAKE TO MEET THOSE HEALTH NEEDS IN EACH OF ITS COMMUNITIES CERTAIN NEEDS THAT WERE IDENTIFIED BY THE CHNA HAVE NOT BEEN ADDRESSED IT WAS DETERMINED THAT THERE ARE OTHER RESOURCES IN THE COMMUNITY THAT CAN MORE APPROPRIATELY ADDRESS THESE NEEDS BASED ON SCOPE OF SERVICES AND SKILL SET FOR MORE DETAILED INFORMATION, REFER TO THE PUBLICLY AVAILABLE IMPLEMENTATION PLAN AVAILABLE ON THE WEBSITE, REFER TO THE URL GIVEN PREVIOUSLY FOR THE POSTING OF THE PLAN</p>
<p>FORSYTH MEMORIAL HOSPITAL, INC PART V, SECTION B, LINE 13H</p>	<p>OTHER ELIGIBILITY CRITERIA EXPLAINED IN THE FAP INCLUDE THE FOLLOWING FREE CARE IS ONLY APPLICABLE TO MEDICALLY NECESSARY SERVICES, PROVIDER BASED PHYSICIAN CLINICS REQUIRE THAT PATIENTS MUST HAVE BEEN TREATED BY AN AFFILIATED MEDICAL GROUP PRIMARY CARE PHYSICIAN WITHIN THE PREVIOUS THREE YEARS, PATIENTS MUST BE UNABLE TO ACCESS ENTITLEMENT PROGRAMS, PATIENTS WITH SPECIAL CIRCUMSTANCES SUCH AS BANKRUPTCY MAY ALSO BE ELIGIBLE FOR CHARITY CARE SCHEDULE H, PART V, SECTION B FACILITY REPORTING GROUP APART V, LINE 16A, FAP WEBSITE <a href="https://www.novanthealth.org/home/patients--visitors/your-healthcare-costs/financial-assistance-for-the-uninsured.aspx">HTTPS://WWW.NOVANTHEALTH.ORG/HOME/PATIENTS--VISITORS/YOUR-HEALTHCARE-COSTS/FINANCIAL-ASSISTANCE-FOR-THE-UNINSURED ASPX</a> SCHEDULE H, PART V, SECTION B FACILITY REPORTING GROUP APART V, LINE 16B, FAP APPLICATION WEBSITE <a href="https://www.novanthealth.org/home/patients--visitors/your-healthcare-costs/financial-assistance-for-the-uninsured.aspx">HTTPS://WWW.NOVANTHEALTH.ORG/HOME/PATIENTS--VISITORS/YOUR-HEALTHCARE-COSTS/FINANCIAL-ASSISTANCE-FOR-THE-UNINSURED ASPX</a> SCHEDULE H, PART V, SECTION B FACILITY REPORTING GROUP APART V, LINE 16C, FAP PLAIN LANGUAGE SUMMARY WEBSITE <a href="https://www.novanthealth.org/home/patients--visitors/your-healthcare-costs/financial-assistance-for-the-uninsured.aspx">HTTPS://WWW.NOVANTHEALTH.ORG/HOME/PATIENTS--VISITORS/YOUR-HEALTHCARE-COSTS/FINANCIAL-ASSISTANCE-FOR-THE-UNINSURED ASPX</a></p>



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

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

Form and Line Reference	Explanation
FORSYTH MEMORIAL HOSPITAL, INC PART V, SECTION B, LINE 24	IT IS POSSIBLE FOR A FINANCIAL ASSISTANCE POLICY (FAP) ELIGIBLE PATIENT TO BE CHARGED AN AMOUNT EQUAL TO THE GROSS CHARGE FOR A NON-EMERGENCY OR NON-MEDICALLY NECESSARY SERVICE HOWEVER, IF THE SERVICE IS DEEMED AN EMERGENCY OR A MEDICAL NECESSITY, THEN THE FAP ELIGIBLE PATIENT WOULD NOT BE CHARGED FOR CARE AND WOULD NOT RECEIVE A BILL ONCE FAP ELIGIBILITY HAD BEEN ESTABLISHED

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

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

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

Name and address	Type of Facility (describe)
<b>1</b> 2 - NH ARCADIA FAMILY MEDICINE 12208 NC HWY 150 NORTH WINSTONSALEM, NC 27127	PHYSICIAN CLINIC
<b>1</b> 3 - NH BREAST CENTER 2025 FRONTIS PLAZA BLVD SUITE 123 WINSTONSALEM, NC 27103	IMAGING CENTER
<b>2</b> 4 - NH CARDIOLOGY CLEMMONS 7114 VILLAGE MEDICAL CIRCLE CLEMMONS, NC 27012	PHYSICIAN CLINIC
<b>3</b> 5 - NH CARDIOLOGY KERNERSVILLE 1710 KVILLE MEDICAL PKWY STE 205 KERNERSVILLE, NC 27284	PHYSICIAN CLINIC
<b>4</b> 6 - NH CARDIOLOGY MT AIRY 694 RIVERSIDE DR MOUNT AIRY, NC 27030	PHYSICIAN CLINIC
<b>5</b> 7 - NH CARDIOLOGY WINSTON-SALEM 186 KIMEL PARK DRIVE WINSTONSALEM, NC 27103	PHYSICIAN CLINIC
<b>6</b> 8 - NH CHAIR CITY FAMILY MEDICINE 903 RANDOLPH ST THOMASVILLE, NC 27360	PHYSICIAN CLINIC
<b>7</b> 9 - NH CLEMMONS FAMILY MEDICINE 6301 STADIUM DRIVE CLEMMONS, NC 27012	PHYSICIAN CLINIC
<b>8</b> 10 - NH DAVIE MEDICAL ASSOCIATES 485 VALLEY ROAD MOCKSVILLE, NC 27028	PHYSICIAN CLINIC
<b>9</b> 11 - NH FORSYTH ENDOCRINE CONSULTANTS 755 HIGHLAND OAKS DRIVE SUITE 201 WINSTONSALEM, NC 27103	PHYSICIAN CLINIC
<b>10</b> 12 - NH FORSYTH FAMILY MEDICINE 400 JONESTOWN ROAD WINSTONSALEM, NC 27104	PHYSICIAN CLINIC
<b>11</b> 13 - NH FORSYTH INTERNAL MEDICINE 1381 WESTGATE CENTER DRIVE WINSTONSALEM, NC 27103	PHYSICIAN CLINIC
<b>12</b> 14 - NH GATEWAY FAMILY MEDICINE 390 SALEM AVENUE WINSTONSALEM, NC 27101	PHYSICIAN CLINIC
<b>13</b> 15 - NH HAWTHORNE OUTPATIENT SURGERY 1999 S HAWTHORNE ROAD WINSTONSALEM, NC 27103	AMBULATORY SURGERY CENTER
<b>14</b> 16 - NH HILLSDALE MEDICAL ASSOCIATES 121 MEDICAL DRIVE ADVANCE, NC 27006	PHYSICIAN CLINIC

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

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

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

Name and address	Type of Facility (describe)
<b>16</b> 17 - NH IMAGING KERNERSVILLE 445 PINEVIEW DRIVE SUITE 100 KERNERSVILLE, NC 27284	IMAGING CENTER
<b>1</b> 18 - NH IMAGING MAPLEWOOD 3155 MAPLEWOOD AVENUE WINSTONSALEM, NC 27103	IMAGING CENTER
<b>2</b> 19 - NH INFECTIOUS DISEASE SPECIALISTS 1381 WESTGATE CENTER DRIVE WINSTONSALEM, NC 27103	PHYSICIAN CLINIC
<b>3</b> 20 - NH INPATIENT CARE SPECIALISTS KVILLE 1750 KERNERSVILLE MEDICAL PKWY KERNERSVILLE, NC 27284	PHYSICIAN CLINIC
<b>4</b> 21 - NH KERNERSVILLE FAMILY MEDICINE 291 BROAD STREET WINSTONSALEM, NC 27284	PHYSICIAN CLINIC
<b>5</b> 22 - NH KERNERSVILLE OUTPATIENT SURGERY 1730 KVILLE MEDICAL PKWY STE 304 KERNERSVILLE, NC 27284	AMBULATORY SURGERY CENTER
<b>6</b> 23 - NH LEWISVILLE FAMILY MEDICINE 1225 LEWISVILLE-CLEMMONS ROAD LEWISVILLE, NC 27023	PHYSICIAN CLINIC
<b>7</b> 24 - NH LEXINGTON PRIMARY CARE 110 WEST MEDICAL PARK DRIVE LEXINGTON, NC 27292	PHYSICIAN CLINIC
<b>8</b> 25 - NH MAPLEWOOD FAMILY MEDICINE ROBINHOOD MEDICAL PLAZA BLDG 100 WINSTONSALEM, NC 27106	PHYSICIAN CLINIC
<b>9</b> 26 - NH METCALF RHEUMATOLOGY 1551 WESTBROOK PLAZA DR SUITE 200 WINSTONSALEM, NC 27103	PHYSICIAN CLINIC
<b>10</b> 27 - NH MOUNTAINVIEW MEDICAL 216 MOORE ROAD KING, NC 27021	PHYSICIAN CLINIC
<b>11</b> 28 - NH NEW GARDEN MEDICAL ASSOCIATES 1941 NEW GARDEN RD SUITES 212 216 GREENSBORO, NC 27410	PHYSICIAN CLINIC
<b>12</b> 29 - NH NORTH POINT MEDICAL ASSOCIATES 1995 BETHABARA ROAD WINSTONSALEM, NC 27106	PHYSICIAN CLINIC
<b>13</b> 30 - NH NORTHWEST FAMILY MEDICINE 7607 NC HIGHWAY 68 N STE B OAK RIDGE, NC 27310	PHYSICIAN CLINIC
<b>14</b> 31 - NH ONCOLOGY SPECIALISTS 1213 LEXINGTON AVENUE STE B LEXINGTON, NC 27360	PHYSICIAN CLINIC

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

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

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

Name and address	Type of Facility (describe)
<b>31</b> 32 - NH ONCOLOGY SPECIALISTS 1710 KVILLE MEDICAL PKWY STE 116 KERNERSVILLE, NC 27284	PHYSICIAN CLINIC
<b>1</b> 33 - NH ONCOLOGY SPECIALISTS 276 OLD MOCKSVILLE ROAD SUITE 800 STATESVILLE, NC 28625	PHYSICIAN CLINIC
<b>2</b> 34 - NH ONCOLOGY SPECIALISTS 865 WESTLAKE DRIVE MOUNT AIRY, NC 27030	PHYSICIAN CLINIC
<b>3</b> 35 - NH ORTHOPEDICS & SPORTS MEDICINE 211 OLD LEXINGTON RD THOMASVILLE, NC 27360	PHYSICIAN CLINIC
<b>4</b> 36 - NH PFAFFTOWN FAMILY MEDICINE 4611 YADKINVILLE ROAD PFAFFTOWN, NC 27040	PHYSICIAN CLINIC
<b>5</b> 37 - NH PILOT MOUNTAIN MEDICAL CARE 207 MEDICAL STREET PILOT MOUNTAIN, NC 27041	PHYSICIAN CLINIC
<b>6</b> 38 - NH PREMIER MEDICAL ASSOCIATES 3333 BROOKVIEW HILLS BLVD STE 202-204 WINSTONSALEM, NC 27103	PHYSICIAN CLINIC
<b>7</b> 39 - NH PSYCHIATRIC MEDICINE 175 KIMEL PARK DRIVE SUITE 100 WINSTONSALEM, NC 27103	PHYSICIAN CLINIC
<b>8</b> 40 - NH PSYCHIATRIC MEDICINE 309 PINEYWOOD ROAD THOMASVILLE, NC 27360	PHYSICIAN CLINIC
<b>9</b> 41 - NH RHEUMATOLOGY AND ARTHRITIS 1551 WESTBROOK PLAZA DR SUITE 200 WINSTONSALEM, NC 27106	PHYSICIAN CLINIC
<b>10</b> 42 - NH SALEM FAMILY MEDICINE 105 VEST MILL CIRCLE WINSTONSALEM, NC 27103	PHYSICIAN CLINIC
<b>11</b> 43 - NH SPINE SPECIALISTS 5380 US HIGHWAY 158 SUITE 110 ADVANCE, NC 27006	PHYSICIAN CLINIC
<b>12</b> 44 - NH SPORTS MEDICINE 2337 WINTERHAVEN LANE WINSTONSALEM, NC 27103	PHYSICIAN CLINIC
<b>13</b> 45 - NH SURRY MEDICAL ASSOCIATES 2133 ROCKFORD ST SUITE 1400 MOUNT AIRY, NC 27030	PHYSICIAN CLINIC
<b>14</b> 46 - NH SURRY MEDICAL ASSOCIATES 865 WESTLAKE DRIVE MOUNT AIRY, NC 27030	PHYSICIAN CLINIC

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

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

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

Name and address	Type of Facility (describe)
<b>46</b> 47 - NH THOMASVILLE MEDICAL ASSOCIATES 309 PINEYWOOD ROAD THOMASVILLE, NC 27360	PHYSICIAN CLINIC
<b>1</b> 48 - NH TRIAD ENDOCRINE 500 PINEVIEW DR SUITE 101 KERNERSVILLE, NC 27284	PHYSICIAN CLINIC
<b>2</b> 49 - NH UROLOGY 140 KIMEL PARK DR SUITE 100 WINSTONSALEM, NC 27103	PHYSICIAN CLINIC
<b>3</b> 50 - NH UROLOGY PARTNERS 1710 KVILLE MEDICAL PKWY STE 201 KERNERSVILLE, NC 27284	PHYSICIAN CLINIC
<b>4</b> 51 - NH UROLOGY PARTNERS 2010 BALDWIN LANE WINSTONSALEM, NC 27103	PHYSICIAN CLINIC
<b>5</b> 52 - NH VILLAGE POINT FAMILY MEDICINE 7130 VILLAGE MEDICAL CIRCLE CLEMMONS, NC 27012	PHYSICIAN CLINIC
<b>6</b> 53 - NH WEST FORSYTH INTERNAL MED & PED 105 STADIUM OAKS DRIVE CLEMMONS, NC 27012	PHYSICIAN CLINIC
<b>7</b> 54 - NH WINSTON-SALEM CARDIOLOGY 445 PINEVIEW DRIVE SUITE 220 WINSTONSALEM, NC 27284	PHYSICIAN CLINIC
<b>8</b> 55 - NH WINSTON-SALEM HEALTH CARE 175 KIMEL PARK DRIVE SUITE 250 WINSTONSALEM, NC 27103	PHYSICIAN CLINIC
<b>9</b> 56 - NH WINSTON-SALEM HEALTH CARE 250 CHARLOIS BLVD WINSTONSALEM, NC 27103	PHYSICIAN CLINIC
<b>10</b> 57 - NH WOUND CARE & HYPERBARIC MEDICINE 1901 S HAWTHORNE ROAD SUITE 220 WINSTONSALEM, NC 27103	PHYSICIAN CLINIC
<b>11</b> 58 - NH YADKIN MEDICAL ASSOCIATES 305 EAST LEE AVENUE YADKINVILLE, NC 27055	PHYSICIAN CLINIC

Note: To capture the full content of this document, please select landscape mode (11" x 8.5") when printing.

Schedule I  
(Form 990)

Department of the Treasury  
Internal Revenue Service

Name of the organization  
FORSYTH MEMORIAL HOSPITAL INC

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

Complete if the organization answered "Yes," on Form 990, Part IV, line 21 or 22.  
▶ Attach to Form 990.  
▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No 1545-0047

2018

Open to Public Inspection

Employer identification number  
56-0928089

Part I

General Information on Grants and Assistance

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

Part II

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

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

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table . . . . . 36

3 Enter total number of other organizations listed in the line 1 table . . . . . 2

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

Part III can be duplicated if additional space is needed

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of noncash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of noncash assistance
(1) PATIENT ASSISTANCE	22	20,840			
(2) MEDICATION FOR INDIGENT PATIENTS	551		36,231	FMV	MEDICATION FOR INDIGENT PATIENTS
(3) PATIENT TRANSPORTATION	3085		47,702	FMV	CAB FARES FOR INDIGENT PATIENTS
(3)					
(4)					
(5)					
(6)					
(7)					

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

Return Reference	Explanation
PART I, LINE 2 PROCEDURES FOR MONITORING THE USE OF THE GRANT FUNDS	THE FILING ORGANIZATION IS PART OF THE INTEGRATED HEALTHCARE SYSTEM OPERATED BY NOVANT HEALTH, INC ("NOVANT HEALTH"), THE PARENT ORGANIZATION NOVANT HEALTH'S BYLAWS AUTHORIZE IT TO ESTABLISH CERTAIN POLICIES FOR ALL OF ITS SUBSIDIARIES WITHIN THE SYSTEM NOVANT HEALTH HAS ESTABLISHED A SYSTEM-WIDE CORPORATE POLICY WITH STANDARDIZED GUIDELINES THAT ARE TO BE USED IN REVIEWING THE ELIGIBILITY AND SELECTION OF GRANTEEES RECEIVING CERTAIN EXEMPT PURPOSE FUNDS THE FILING ORGANIZATION MAINTAINS DOCUMENTATION OF THE ELIGIBILITY AND SELECTION CRITERIA AND RECORDS OF THE AMOUNTS ARE MAINTAINED VIA THE GENERAL LEDGER FUNDS ARE GENERALLY NOT TRACKED AFTER BEING GRANTED, AS THE ORIGINAL ELIGIBILITY AND SELECTION CRITERIA HAVE ALREADY BEEN MET

Additional Data

Software ID:  
Software Version:  
EIN: 56-0928089  
Name: FORSYTH MEMORIAL HOSPITAL INC

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
ABC OF NC FOUNDATION 905 FRIEDBERG CHURCH ROAD WINSTONSALEM, NC 27127	91-1963813	501(C)(3)	15,000	0			COMMUNITY OUTREACH
AMERICAN HEART ASSOCIATION INC 7272 GREENVILLE AVENUE DALLAS, TX 75231	13-5613797	501(C)(3)	105,000	0			COMMUNITY OUTREACH



Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CANCER SERVICES INC 3175 MAPLEWOOD AVENUE WINSTONSALEM, NC 27103	56-0656375	501(C)(3)	10,000	0			COMMUNITY OUTREACH
COMMUNITY CARE CENTER FOR FORSYTH COUNTY 2135 NEW WALKERTOWN ROAD WINSTONSALEM, NC 27101	58-1403699	501(C)(3)	25,000	0			COMMUNITY OUTREACH

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CRISIS CONTROL MINISTRY INC 200 EAST TENTH STREET WINSTONSALEM, NC 27101	23-7348168	501(C)(3)	15,000	0			COMMUNITY OUTREACH
DAVIE COMMUNITY FOUNDATION INC 107 N SALISBURY STREET MOCKSVILLE, NC 27028	58-1850531	501(C)(3)	11,250	0			COMMUNITY OUTREACH

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
EXPERIMENT IN SELF-RELIANCE INC PO BOX 135 WINSTONSALEM, NC 27102	56-6060100	501(C)(3)	15,000	0			COMMUNITY OUTREACH
FAMILY SERVICES INC 1200 SOUTH BROAD STREET WINSTONSALEM, NC 27101	56-0689235	501(C)(3)	25,000	0			COMMUNITY OUTREACH

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
FORSYTH TECHNICAL COMMUNITY COLLEGE 2100 SILAS CREEK PARKWAY WINSTONSALEM, NC 27103	56-1070364	501(C)(3)	100,000	0			COMMUNITY OUTREACH
GREENSBORO AREA CHAMBER OF COMMERCE 111 W FEBRUARY ONE PLACE GREENSBORO, NC 27401	56-0245040	501(C)(6)	50,000	0			COMMUNITY OUTREACH

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
HANDS ON NORTHWEST NORTH CAROLINA 751 WEST FOURTH STREET SUITE 200 WINSTONSALEM, NC 27101	26-0824793	501(C)(3)	26,000	0			COMMUNITY OUTREACH
HOSPICE & PALLIATIVE CARECENTER 101 HOSPICE LANE WINSTONSALEM, NC 27103	58-1343313	501(C)(3)	12,500	0			COMMUNITY OUTREACH

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
HOSPITAL HOSPITALITY HOUSE OF WINSTON-SALEM 1970 BALDWIN LANE WINSTONSALEM, NC 27103	20-3604576	501(C)(3)	10,000	0			COMMUNITY OUTREACH
INSIGHT HUMAN SERVICES INC 665 WEST FOURTH STREET WINSTONSALEM, NC 27101	56-0951129	501(C)(3)	20,000	0			COMMUNITY OUTREACH

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
JDRF INTERNATIONAL 26 BROADWAY 15TH FL NEW YORK, NY 10004	23-1907729	501(C)(3)	15,000	0			COMMUNITY OUTREACH
LEADERSHIP WINSTON-SALEM 624 W SIXTH STREET SUITE 110 WINSTONSALEM, NC 27101	58-1574887	501(C)(3)	6,456	0			COMMUNITY OUTREACH

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MARCH OF DIMES FOUNDATION 1275 MAMARONECK AVENUE WHITE PLAINS, NY 10605	13-1846366	501(C)(3)	13,000	0			COMMUNITY OUTREACH
MEDASSIST OF MECKLENBURG DBA NC MEDASSIST 4428 TAGGART CREEK ROAD CHARLOTTE, NC 28208	56-2018957	501(C)(3)	7,500	0			COMMUNITY OUTREACH



Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
NATIONAL CYCLING CENTER INC 145 KIMEL PARK DR WINSTONSALEM, NC 27103	47-2950622	501(C)(3)	10,000	0			COMMUNITY OUTREACH
OLD HICKORY COUNCIL INC 6600 SILAS CREEK PKWY WINSTONSALEM, NC 27106	56-0529985	501(C)(3)	14,360	0			COMMUNITY OUTREACH

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
PIEDMONT TRIAD PARTNERSHIP PO BOX 2672 HIGH POINT, NC 27261	56-1750279	501(C)(3)	25,000	0			COMMUNITY OUTREACH
RONALD MCDONALD HOUSE OF WINSTON-SALEM 419 S HAWTHORNE ROAD WINSTONSALEM, NC 27103	58-1454715	501(C)(3)	10,000	0			COMMUNITY OUTREACH

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
SAMARITAN MINISTRIES 414 E NORTHWEST BLVD WINSTONSALEM, NC 27105	56-1490019	501(C)(3)	10,000	0			COMMUNITY OUTREACH
SECOND HARVEST FOOD BANK OF NORTHWEST NC INC 3655 REED STREET WINSTNSALEM, NC 27107	58-1457912	501(C)(3)	20,000	0			COMMUNITY OUTREACH

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
SENIOR SERVICES INC 2895 SHOREFAIR DRIVE WINSTONSALEM, NC 27105	56-1085968	501(C)(3)	45,000	0			COMMUNITY OUTREACH
SUSAN G KOMEN NORTHWEST NC 1106 BURKE STREET WINSTONSALEM, NC 27101	75-2891104	501(C)(3)	10,000	0			COMMUNITY OUTREACH

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
THE SCIENCE CENTER AND ENVIRONMENTAL PARK OF FORSYTH COUNTY DBA SCIWORKS 400 W HANES MILL ROAD WINSTONSALEM, NC 27105	56-0815746	501(C)(3)	9,100	0			COMMUNITY OUTREACH
THE SHALOM PROJECT INC 639 SOUTH GREEN STREET WINSTONSALEM, NC 27101	20-2136431	501(C)(3)	12,000	0			COMMUNITY OUTREACH

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
THE SHEPHERD'S CENTER OF KERNERSVILLE INC PO BOX 2044 KERNERSVILLE, NC 27285	56-1471510	501(C)(3)	7,500	0			COMMUNITY OUTREACH
UNITED WAY OF FORSYTH COUNTY INC 301 N MAIN STREET SUITE 1700 WINSTONSALEM, NC 27101	23-7357234	501(C)(3)	40,000	0			COMMUNITY OUTREACH

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
UNIVERSITY OF NORTH CAROLINA SCHOOL OF THE ARTS FOUNDATION INC 1533 SOUTH MAIN STREET WINSTONSALEM, NC 27127	56-6064850	501(C)(3)	8,300	0			COMMUNITY OUTREACH
WAKE FOREST UNIVERSITY HEALTH SCIENCES MEDICAL CENTER BLVD WINSTONSALEM, NC 27157	22-3849199	501(C)(3)	150,000	0			COMMUNITY OUTREACH

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
WINSTON-SALEM ALLIANCE 100 N MAIN STREET WINSTONSALEM, NC 27101	31-1726654	501(C)(6)	35,000	0			COMMUNITY OUTREACH
WINSTON-SALEM FOUNDATION 751 WEST FOURTH STREET SUITE 200 WINSTONSALEM, NC 27101	56-6037615	501(C)(3)	50,500	0			COMMUNITY OUTREACH



Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
WINSTON-SALEM POLICE FOUNDATION INC PO BOX 24011 WINSTONSALEM, NC 27114	47-5289473	501(C)(3)	25,000	0			COMMUNITY OUTREACH
WINSTON-SALEM SYMPHONY ASSOCIATION 201 NORTH BROAD STREET SUITE 200 WINSTONSALEM, NC 27101	56-0692826	501(C)(3)	15,000	0			COMMUNITY OUTREACH

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
YOUNG MEN'S CHRISTIAN ASSOCIATION OF NORTHWEST NORTH CAROLINA 301 N MAIN STREET SUITE 1900 WINSTONSALEM, NC 27101	56-0530015	501(C)(3)	16,000	0			COMMUNITY OUTREACH
MORAVIAN HOME INCORPORATED 1000 SALEM TOWNE DRIVE WINSTONSALEM, NC 27106	56-0963926	501(C)(3)	40,000				COMMUNITY OUTREACH

<b>Schedule J</b> (Form 990)	<b>Compensation Information</b>  <b>For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees</b> <b>▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23.</b> <b>▶ Attach to Form 990.</b> <b>▶ Go to <u>www.irs.gov/Form990</u> for instructions and the latest information.</b>	OMB No 1545-0047  <div style="font-size: 2em; font-weight: bold; text-align: center;">2018</div> <div style="background-color: black; color: white; text-align: center; padding: 5px;"> <b>Open to Public Inspection</b> </div>
	<div style="display: flex; justify-content: space-between;"> <div style="width: 65%;">           Name of the organization            FORSYTH MEMORIAL HOSPITAL INC         </div> <div style="width: 30%;">           Employer identification number             56-0928089         </div> </div>	
	<div style="display: flex; justify-content: space-between;"> <div style="width: 65%;"> <b>Part I</b>    <b>Questions Regarding Compensation</b> </div> </div>	

		Yes	No
<b>1a</b> Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a Complete Part III to provide any relevant information regarding these items			
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input checked="" type="checkbox"/> First-class or charter travel  <input checked="" type="checkbox"/> Travel for companions  <input type="checkbox"/> Tax indemnification and gross-up payments  <input checked="" type="checkbox"/> Discretionary spending account               </div> <div style="width: 45%;"> <input checked="" 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>b</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	<b>1b</b>	Yes	
<b>2</b> 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?	<b>2</b>	Yes	
<b>3</b> Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director Check all that apply Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III			
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> Compensation committee  <input type="checkbox"/> Independent compensation consultant  <input type="checkbox"/> Form 990 of other organizations               </div> <div style="width: 45%;"> <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>			
<b>4</b> During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization			
<b>a</b> Receive a severance payment or change-of-control payment?	<b>4a</b>		No
<b>b</b> Participate in, or receive payment from, a supplemental nonqualified retirement plan?	<b>4b</b>	Yes	
<b>c</b> Participate in, or receive payment from, an equity-based compensation arrangement? If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III	<b>4c</b>		No
<b>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</b>			
<b>5</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of			
<b>a</b> The organization?	<b>5a</b>		No
<b>b</b> Any related organization? If "Yes," on line 5a or 5b, describe in Part III	<b>5b</b>		No
<b>6</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of			
<b>a</b> The organization?	<b>6a</b>		No
<b>b</b> Any related organization? If "Yes," on line 6a or 6b, describe in Part III	<b>6b</b>		No
<b>7</b> 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	<b>7</b>		No
<b>8</b> Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	<b>8</b>		No
<b>9</b> If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	<b>9</b>		

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 TableSchedule J (Form 990) 2018

**Part III Supplemental Information**

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

Return Reference	Explanation
PART I, LINE 1A	FRINGE OR EXPENSE EXPLANATION FIRST-CLASS OR CHARTER TRAVEL. FIRST-CLASS OR CHARTER TRAVEL IS NOT A COVERED TRAVEL EXPENSE FOR EXECUTIVES, THEY ARE LIMITED TO BUSINESS OR COACH CLASS FARES FOR COMMERCIAL FLIGHTS. HOWEVER, CHARTER TRAVEL IS AVAILABLE TO CERTAIN EXECUTIVES, BOARD MEMBERS, AND APPROVED BUSINESS PERSONNEL MEETING APPLICABLE POLICY CRITERIA. TRAVEL FOR COMPANIONS. COMPANIONS ARE ALLOWED ON CERTAIN CHARTER FLIGHTS PAID FOR BY THE ORGANIZATION. IN THAT CASE, THE VALUE OF THE COMPANION'S FLIGHT IS CALCULATED UNDER APPLICABLE TAX LAWS AND THAT AMOUNT IS INCLUDED IN THE EXECUTIVE'S TAXABLE INCOME AS PRESCRIBED BY THE APPLICABLE TAX LAWS. DISCRETIONARY SPENDING ACCOUNT. CERTAIN EXECUTIVES RECEIVE A DISCRETIONARY SPENDING ACCOUNT. THE DOLLAR AMOUNT IN THE ACCOUNT IS PRE-APPROVED BY THE COMPENSATION AND LEADERSHIP COMMITTEE OF THE NOVANT HEALTH BOARD OF TRUSTEES. THE ACCOUNT CAN BE USED ONLY FOR AN APPROVED LIST OF EXPENDITURES. ALL OPTIONS OTHER THAN A DEFERRED, AT-RISK, COMPENSATION OPTION ARE CONSIDERED TAXABLE AND ARE INCLUDED IN THE EXECUTIVE'S TAXABLE INCOME AS PRESCRIBED BY THE APPLICABLE TAX LAWS. HOUSING ALLOWANCE OR RESIDENCE FOR PERSONAL USE. WE PROVIDE TEMPORARY HOUSING ALLOWANCES IN CERTAIN EXECUTIVE RECRUITMENT AND RELOCATION PACKAGES. THE VALUE IS CALCULATED UNDER APPLICABLE TAX LAWS AND THAT AMOUNT IS INCLUDED IN THE EXECUTIVE'S INCOME AS PRESCRIBED BY THE APPLICABLE TAX LAWS.

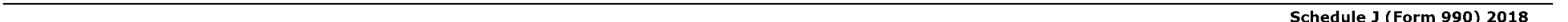
Return Reference	Explanation
PART I, LINE 3	THE FILING ORGANIZATION IS AN INTEGRAL PART OF NOVANT HEALTH, AN INTEGRATED HEALTHCARE SYSTEM AND RELIES UPON NOVANT HEALTH, INC , THE PARENT ORGANIZATION, TO USE THE PROCESS DESCRIBED IN PART VI, LINE 15A/15B OF THIS RETURN TO ESTABLISH COMPENSATION FOR CERTAIN EXECUTIVES THIS PROCESS ADHERES TO THE REQUIREMENTS SET FORTH TO SECURE THE REBUTTABLE PRESUMPTION OF REASONABLENESS AND INCLUDES A REVIEW AND APPROVAL BY INDEPENDENT AND DISINTERESTED MEMBERS OF A COMPENSATION COMMITTEE, CONSULTATION WITH INDEPENDENT COMPENSATION CONSULTANTS, THE UTILIZATION OF THIRD-PARTY COMPARABILITY DATA SUCH AS PUBLISHED COMPENSATION SURVEYS, AND CONTEMPORANEOUS SUBSTANTIATION OF THE DELIBERATION AND DECISION

Return Reference	Explanation
PART I, LINE 4B	PART I, LINES 4A-C SEVERANCE, NONQUALIFIED, AND EQUITY-BASED PAYMENTS SEVERANCE NONQUALIFIED EQUITY-BASED GREGORY, CHERE MD 52,500 MOTEW, STEPHEN 56,250 NYCUM, LAWRENCE 28,125 SANZ, SEAN 25,550 SMITH, HARRY 77,250

Return Reference	Explanation
PART I, LINE 4A - SEVERANCE PLAN	<p>ELIGIBLE EXECUTIVES MAY RECEIVE SEVERANCE PAY THAT IS BASED ON ANNUAL COMPENSATION FOR A SPECIFIED PERIOD OF TIME THE SEVERANCE PAY WOULD BE PAID ONLY IN THE EVENT OF CERTAIN TYPES OF EMPLOYMENT TERMINATION, AND IS FURTHER CONTINGENT ON THE SATISFACTION OF OTHER CONDITIONS SUCH AS COMPLIANCE WITH A NON-COMPETITION COVENANT ANY CURRENT YEAR PAYMENTS HAVE BEEN INCLUDED IN THE COMPENSATION AMOUNTS REPORTED IN PART VII AND IN COLUMN (B)(III) OF SCHEDULE J THE COMPENSATION AND LEADERSHIP COMMITTEE OF THE NOVANT HEALTH BOARD REVIEWS, APPROVES, AND OVERSEES ALL ASPECTS AND ALL ELEMENTS OF EXECUTIVE COMPENSATION AND BENEFITS, INCLUDING THE AMOUNTS AWARDED UNDER THIS SEVERANCE PLAN</p>



Return Reference	Explanation
PART I, LINE 4B - SUPPLEMENTAL NONQUALIFIED RETIREMENT PLANS	THE SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN ("SERP") IS INTENDED TO SUPPORT RETENTION OF KEY EXECUTIVES, AND TO OFFER COMPETITIVE TOTAL COMPENSATION. ELIGIBLE EXECUTIVES WILL BE NOMINATED BY THE CEO AND APPROVED BY THE NOVANT HEALTH COMPENSATION AND LEADERSHIP COMMITTEE ("THE COMMITTEE") TO PARTICIPATE. GENERALLY, ANNUAL CONTRIBUTIONS TO THE PLAN OR PAYMENTS TO PARTICIPANTS WILL BE BASED ON A PERCENTAGE OF THE PARTICIPANT'S BASE SALARY AS OF JANUARY 1ST OF THE PREVIOUS PLAN YEAR AND ARE REPORTED IN COLUMN (C) OF SCHEDULE J. PRIOR TO MAKING THE CONTRIBUTIONS OR PAYMENTS, THE COMMITTEE WILL APPROVE THE AMOUNTS AS TO REASONABLENESS, WHEN COMBINED WITH ALL OTHER ANNUAL COMPENSATION. A 3 YEAR CLASS-YEAR VESTING PERIOD WILL APPLY UP TO AGE 62, WHEN ALL MONEY WOULD BE VESTED AND PAID OUT TO THE PARTICIPANT. OTHERWISE, VESTING WILL OCCUR ON JANUARY 1ST OF EACH YEAR FOR THE APPROPRIATE CLASS-YEAR VESTING PERIOD. THE COMMITTEE REVIEWS, APPROVES, AND OVERSEES ALL ASPECTS AND ALL ELEMENTS OF EXECUTIVE COMPENSATION AND BENEFITS.



Additional Data

Software ID:  
Software Version:  
EIN: 56-0928089  
Name: FORSYTH MEMORIAL HOSPITAL INC

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
EDWARDS JOEL MD TRUSTEE	(i)	391,343	125,621	32,003	16,500	19,980	585,447	0
	(ii)	0	0	0	0	0	0	0
MORRIS JOHN ASST SEC	(i)	0	0	0	0	0	0	0
	(ii)	258,746	101,077	33,207	24,000	23,612	440,642	7,500
SANZ SEAN FMR PRES & COO	(i)	85,208	257,849	84,148	15,201	8,959	451,365	25,550
	(ii)	0	0	0	0	0	0	0
SETLIFF MICHAEL PRES & COO FMH INCL KMC	(i)	324,981	168,313	35,758	45,450	28,030	602,532	0
	(ii)	0	0	0	0	0	0	0
SMITH HARRY SVP HOSPITAL OPERATIONS	(i)	0	0	0	0	0	0	0
	(ii)	590,928	386,327	153,754	116,199	37,965	1,285,173	84,750
BRIGHT JANET CNO	(i)	185,469	36,075	25,143	7,446	10,655	264,788	0
	(ii)	0	0	0	0	0	0	0
MOTEW STEPHEN SVP	(i)	457,344	275,852	134,176	95,850	30,585	993,807	63,750
	(ii)	0	0	0	0	0	0	0
NYCUM LAWRENCE SVP	(i)	437,172	268,532	85,738	92,949	31,198	915,589	35,625
	(ii)	0	0	0	0	0	0	0
ROYSTER KIRSTEN PRES & COO KMC	(i)	7,398	0	20,237	21,591	817	50,043	0
	(ii)	260,633	131,192	17,224	0	10,546	419,595	0
BRAVO JULIO RHEUMATOLOGIST	(i)	450,437	296,199	28,518	23,688	37,880	836,722	7,500
	(ii)	0	0	0	0	0	0	0
MCDONALD COLIN NEUROLOGIST	(i)	390,729	17,205	318,595	16,500	42,034	785,063	0
	(ii)	0	0	0	0	0	0	0
NOUREDDINE NIZAR CARDIOLOGIST	(i)	461,490	225,200	32,321	22,533	36,375	777,919	7,500
	(ii)	0	0	0	0	0	0	0
PRELI ROBERT CARDIOLOGIST	(i)	478,472	219,466	30,339	24,000	36,397	788,674	7,500
	(ii)	0	0	0	0	0	0	0
ZEYLIKMAN YURIY NEUROLOGIST	(i)	358,868	14,320	634,858	24,000	34,811	1,066,857	0
	(ii)	0	0	0	0	0	0	0
LINDSAY JEFFERY FMR PRES - FMH/COO WS MKT	(i)	0	0	0	0	0	0	0
	(ii)	915,320	762,396	228,118	24,000	30,246	1,960,080	7,500
MIHAL DENISE FMR PRES - FMH/COO WS MKT	(i)	0	0	0	0	0	0	0
	(ii)	676,022	583,872	197,524	24,000	19,808	1,501,226	7,500
GREGORY CHERE FMR SVP	(i)	0	0	0	0	0	0	0
	(ii)	406,827	250,606	85,748	78,427	31,771	853,379	60,000
JARRETT-PULLIAM KIMBERLY FMR CNO	(i)	0	0	0	0	0	0	0
	(ii)	132,377	182,864	26,891	16,173	7,761	366,066	0

efile GRAPHIC print - DO NOT PROCESS		As Filed Data -	DLN: 93493319014829
<b>SCHEDULE O</b> (Form 990 or 990-EZ)	<b>Supplemental Information to Form 990 or 990-EZ</b> 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. ▶ Go to <u><a href="http://www.irs.gov/Form990">www.irs.gov/Form990</a></u> for the latest information.		OMB No 1545-0047
			<b>2018</b>
Department of the Treasury			<b>Open to Public Inspection</b>
Name of the organization FORSYTH MEMORIAL HOSPITAL INC	Employer identification number  56-0928089		

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
<p>FORM 990, PI, L1 ORGANIZATION'S MISSION OR MOST SIGNIFICANT ACTIVITIES</p>	<p>FORSYTH MEMORIAL HOSPITAL, INC DOING BUSINESS AS NOVANT HEALTH FORSYTH MEDICAL CENTER ("N HFMC"), NOVANT HEALTH CLEMMONS MEDICAL CENTER ("NHCMC") AND NOVANT HEALTH KERNERSVILLE MEDICAL CENTER ("NHKMC") IS AN INTEGRAL PART OF THE NOVANT HEALTH SYSTEM (COLLECTIVELY KNOWN AS "NOVANT HEALTH"), A NOT-FOR-PROFIT INTEGRATED GROUP OF HOSPITALS, PHYSICIAN CLINICS, OUTPATIENT CENTERS AND OTHER HEALTHCARE SERVICE PROVIDERS. NOVANT HEALTH CONSISTS OF MORE THAN 1,600 PHYSICIANS AND OVER 28,000 EMPLOYEES WHO MAKE HEALTHCARE REMARKABLE AT OVER 640 LOCATIONS, INCLUDING 15 MEDICAL CENTERS AND HUNDREDS OF OUTPATIENT FACILITIES AND PHYSICIAN CLINICS HEADQUARTERED IN WINSTON-SALEM, NC. NOVANT HEALTH IS COMMITTED TO MAKING HEALTHCARE REMARKABLE FOR PATIENTS AND COMMUNITIES, SERVING MORE THAN FOUR MILLION PATIENTS ANNUALLY. NOVANT HEALTH IS RANKED AS ONE OF THE NATION'S TOP 25 INTEGRATED HEALTH SYSTEMS BY SK&amp;A. IN 2018, THE NOVANT HEALTH SYSTEM REPORTED \$5 BILLION IN REVENUES. GENERAL INFORMATION NOVANT HEALTH FORSYTH MEDICAL CENTER, NOVANT HEALTH CLEMMONS MEDICAL CENTER, AND NOVANT HEALTH KERNERSVILLE MEDICAL CENTER EXIST TO IMPROVE THE HEALTH OF THE COMMUNITIES THEY SERVE WITH A VISION OF PROVIDING A REMARKABLE PATIENT EXPERIENCE IN EVERY DIMENSION, EVERY TIME. THEY ACCOMPLISH THAT MISSION BY PROVIDING HEALTHCARE SERVICES TO ALL WHO ENTRUST THEIR CARE TO THEM AND BY SUPPORTING THE GREATER WINSTON SALEM, CLEMMONS AND KERNERSVILLE, NC COMMUNITIES THROUGH PARTNERSHIPS AND OUTREACH. THE HOSPITALS SUPPORT ORGANIZATIONS THAT PROVIDE HEALTH SERVICES, EDUCATION AND ASSISTANCE TO THE UNINSURED AND THE OVERALL COMMUNITY. IN ITS SEVENTH FULL YEAR OF OPERATION, NOVANT HEALTH FORSYTH MEDICAL CENTER AFFILIATE HOSPITAL, NOVANT HEALTH KERNERSVILLE MEDICAL CENTER IN KERNERSVILLE, NC FOCUSED ON PROVIDING A REMARKABLE PATIENT EXPERIENCE VIA A FAST-ACCESS EMERGENCY DEPARTMENT, GENERAL, ORTHOPEDIC AND EYE SURGICAL SERVICES, CONSISTENT QUALITY, AND EXCELLENT SERVICE TO RESIDENTS IN THE KERNERSVILLE AREA, WESTERN GUILFORD AND ROCKINGHAM COUNTIES OF NORTH CAROLINA, AS WELL AS EASTERN STOKES AND FORSYTH COUNTIES OF NORTH CAROLINA. NOVANT HEALTH FORSYTH MEDICAL CENTER'S AFFILIATE HOSPITAL, NOVANT HEALTH CLEMMONS MEDICAL CENTER IN CLEMMONS, NC FOCUSED ON PROVIDING A REMARKABLE PATIENT EXPERIENCE VIA A FAST-ACCESS EMERGENCY DEPARTMENT, GENERAL, ORTHOPEDIC, PODIATRIC, TRANSITIONAL/INFUSION SERVICES AND EAR, NOSE AND THROAT SURGICAL SERVICES, PROVIDING CONSISTENT QUALITY AND EXCELLENT SERVICE TO RESIDENTS IN WESTERN FORSYTH COUNTY, DAVIE COUNTY AND YADKIN COUNTY OF NORTH CAROLINA. IN ADDITION TO OUR QUALITY OF SERVICES AND COMPREHENSIVE CATEGORIES OF SERVICES, WE'RE VERY PROUD OF OUR PATIENT FINANCIAL ASSISTANCE PROGRAM. WE WORK WITH PATIENTS TO HELP QUALIFY THEM FOR PUBLIC ASSISTANCE, ESTABLISH A REASONABLE PAYMENT PLAN, DISCOUNT THEIR BILL, OR PROVIDE FREE CARE FOR THOSE THAT QUALIFY FOR FINANCIAL ASSISTANCE. COMMUNITY OUTREACH COMMUNITY OUTREACH IS A CRITICAL COMPONENT TO THE MISSION OF NOVANT HEALTH.</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PI, L1 ORGANIZATION'S MISSION OR MOST SIGNIFICANT ACTIVITIES	<p>NT HEALTH FORSYTH MEDICAL CENTER, NOVANT HEALTH KERNERSVILLE MEDICAL CENTER, AND NOVANT HEALTH CLEMMONS MEDICAL CENTER EACH YEAR, OUR PHYSICIANS, NURSES AND STAFF HOLD SCREENINGS, TEACH PROGRAMS, HOST SEMINARS AND VOLUNTEER COUNTLESS HOURS TO HELP IMPROVE THE LIVES OF THOSE IN THE TRIAD AND SURROUNDING COUNTIES IN MANY UNIQUE WAYS A FEW EXAMPLES OF THIS ARE AS FOLLOWS FREE COMMUNITY SCREENINGS - IN 2018, NOVANT HEALTH FORSYTH MEDICAL CENTER HELD 426 FREE SCREENING EVENTS THAT SERVED MORE THAN 4,300 SCREENING PARTICIPANTS LOCATIONS INCLUDE NOVANT HEALTH TRIAD CAMPUSES, LOCAL PUBLIC SCHOOLS, YMCA/YWCA, HOMELESS SHELTERS, CORPORATIONS, FAITH COMMUNITIES, AND SENIOR CENTERS THE VARIOUS EVENTS SCREENED FOR A1C, ABI, BONE DENSITY, BLOOD PRESSURE, BREAST CANCER AND HEART HEALTH COMMUNITY EDUCATION - AS ACTIVE COMMUNITY PARTNERS, NOVANT HEALTH FORSYTH MEDICAL CENTER, NOVANT HEALTH CLEMMONS MEDICAL CENTER, AND NOVANT HEALTH KERNERSVILLE MEDICAL CENTER REGULARLY HOST AND/OR DELIVER GENERAL HEALTH EDUCATION SESSIONS AND WELLNESS PROGRAMS THROUGHOUT THE YEAR IN 2018, 431 FREE EDUCATIONAL EVENTS SERVED MORE THAN 9,000 INDIVIDUALS LOCATIONS INCLUDE CAMPUS FACILITIES, PUBLIC SCHOOLS, YMCA/YWCA, RECREATION CENTERS, PUBLIC LIBRARIES, SENIOR CENTERS, CORPORATIONS, HOMELESS SHELTERS, FAITH COMMUNITIES, AND NEIGHBORHOOD EVENTS IN 2018, NEARLY 700 WELLNESS COACH SESSIONS WERE PROVIDED WITH A CERTIFIED COACH, EITHER IN 1:1 OR GROUP SETTINGS SUPPORT GROUPS - NOVANT HEALTH FORSYTH MEDICAL CENTER AND NOVANT HEALTH KERNERSVILLE MEDICAL CENTER HOST A FULL RANGE OF SUPPORT GROUPS THAT PROVIDE EMOTIONAL SUPPORT SERVICES TO THOSE IMPACTED BY A VARIETY OF CHRONIC DISEASES AND HEALTHCARE ISSUES FROM DIABETES AND WEIGHT MANAGEMENT, PROSTATE CANCER AND NURSING MOTHERS BREASTFEEDING, THE HOSPITALS OFFER OPPORTUNITIES FOR INDIVIDUALS TO MAKE CONNECTIONS WITH OTHERS FACING SIMILAR HEALTH ISSUES AND CHALLENGES ALL SUPPORT GROUPS ARE FREE AND OPEN TO ANYONE IN THE COMMUNITY IN 2018, 81 SUPPORT GROUPS WERE PROVIDED TO MORE THAN 2,000 ATTENDEES</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART I, LINE 1	<p>ARTS &amp; HEALING - NOVANT HEALTH FORSYTH MEDICAL CENTER OFFERS HEALING THROUGH MUSIC IN THE FORM OF PARTNERSHIPS WITH THE WINSTON-SALEM SYMPHONY AS WELL AS VOLUNTEER PERCUSSIONISTS AND PIANISTS. MUSIC IS AVAILABLE WEEKLY WHERE MUSICIANS ROTATE THROUGH LOBBY AND PATIENT CARE AREAS, INCLUDING PALLIATIVE SPACES. HEALING IS ALSO AVAILABLE IN THE FORM OF ART CLASSES, WHICH ARE HELD WEEKLY FOR EXPECTANT MOTHERS IN THE ANTE-PARTUM UNIT. SCHOOL PARTNERSHIPS - NOVANT HEALTH HAS PARTNERED WITH THE DAVIE, DAVIDSON AND ROWAN-SALISBURY SCHOOL SYSTEMS TO PROVIDE ATHLETIC TRAINERS AND RAPID PHYSICIAN ACCESS TO 14 SCHOOLS. THESE ATHLETIC TRAINERS PROVIDE ONGOING SPORTS PERFORMANCE, INJURY AND SAFETY MANAGEMENT THROUGH THE SCHOOL YEAR TO STUDENT ATHLETES AS PART OF THIS INITIATIVE. NOVANT HEALTH DONATED AUTOMATED EXTERNAL DEFIBRILLATORS TO PARTNER SCHOOLS SO THAT THEY ARE BETTER EQUIPPED TO MANAGE ON-CAMPUS MEDICAL EMERGENCIES. NOVANT HEALTH KERNERSVILLE MEDICAL CENTER, THE COMMUNITY'S FIRST HOSPITAL, OPENED IN MARCH 2011 AND IS A STATE-OF-THE-ART MEDICAL/SURGICAL FACILITY WITH 50 IN-PATIENT ROOMS, AN EMERGENCY DEPARTMENT WHICH IS OPEN 24/7, CRITICAL CARE BEDS AND SURGICAL SUITES. SOME KEY SERVICES INCLUDE INTERMEDIATE CARE UNIT - NEWLY EXPANDED IN 2018, KERNERSVILLE MEDICAL CENTER HAS AN INTERMEDIATE CARE UNIT TO BRIDGE THE GAP BETWEEN THE INTENSIVE CARE UNIT AND THE MEDICAL/SURGICAL FLOOR. THIS UNIT HAS 12 BEDS AND PROVIDES SPECIALTY CARE FOR PATIENTS IN THE KERNERSVILLE COMMUNITY TRANSITIONAL CARE &amp; INFUSION SERVICES - KERNERSVILLE MEDICAL CENTER HAS ALSO ADDED TRANSITIONAL CARE, WHICH IS A NEW HEALTHCARE DELIVERY MODEL THAT ALLOWS PATIENTS TO RECEIVE CARE AT THE MEDICAL CENTER DURING THE DAY AND GO HOME AT NIGHT. THIS MODEL LEADS TO SHORTER HOSPITAL STAYS AND LOWER HEALTHCARE COSTS. DURING A TRANSITIONAL CARE APPOINTMENT, PROVIDERS EVALUATE A PATIENT'S SYMPTOMS, PROVIDE MEDICATIONS IF NEEDED, ORDER ANY NECESSARY TESTS AND ANSWER ANY QUESTIONS A PATIENT MAY HAVE. RESPIRATORY AND PULMONARY SERVICES - KERNERSVILLE MEDICAL CENTER SPECIALISTS TREAT A WIDE RANGE OF RESPIRATORY AND PULMONARY DISEASES AND CONDITIONS INCLUDING ASTHMA, CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD), EMPHYSEMA, LUNG CANCER, PNEUMONIA, SLEEP APNEA, SNO RING AND MANY OTHERS. BREAST CENTER - NOVANT HEALTH BREAST CENTER OFFERS COMPREHENSIVE BREAST HEALTH CARE, INCLUDING MAMMOGRAPHY SCREENINGS, DIAGNOSTIC AND STEREOTACTIC PROCEDURES, BIOPSIES, CHEMOTHERAPY, RADIATION TREATMENT AND GENERAL AND PLASTIC SURGERY. NOVANT HEALTH KERNERSVILLE MEDICAL OFFICE BUILDING AND OUTPATIENT SURGERY CENTER - IN FALL 2016, NOVANT HEALTH BEGAN CONSTRUCTION ON A MEDICAL OFFICE BUILDING LOCATED ON THE CAMPUS OF NOVANT HEALTH KERNERSVILLE MEDICAL CENTER. THE NEW BUILDING, COMPLETED IN 2017, IS 60,000 SQUARE FEET AND HOUSES PHYSICIAN OFFICES AND SUITES, TWO OPERATING ROOMS AND A PROCEDURE ROOM. THE AMBULATORY SURGERY CENTER, LOCATED ON THE SECOND FLOOR OF THE MEDICAL OFFICE BUILDING WAS COMPLETED IN 2018. NOVANT HEALTH</p>

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART I, LINE 1	<p>LTH CLEMMONS MEDICAL CENTER BEGAN CONSTRUCTION ON A THREE-STORY, 60,000-SQUARE-FOOT MEDICAL OFFICE BUILDING THAT WILL SERVE AS A MULTI-SPECIALTY AMBULATORY SURGICAL CENTER FOR COMMUNITY MEMBERS. THE AMBULATORY SURGICAL CENTER MODEL LEADS TO SHORTER HOSPITAL STAYS AND LOWER HEALTHCARE COSTS FOR CLEMMONS PATIENTS. NEW TECHNOLOGY &amp; SERVICES A CONCURRENT ELECTRONIC HEALTH RECORD (EHR) INITIATIVE HAS BEEN IMPLEMENTED BY BOTH THE ACUTE AND AMBULATORY FACILITIES IN THE NOVANT HEALTH SYSTEM. CLINICIANS CAN SHARE PATIENTS' MEDICAL INFORMATION BETWEEN PHYSICIAN OFFICES, OUTPATIENT CENTERS AND HOSPITALS. THIS SHARING OF INFORMATION IMPROVES SAFETY AND COORDINATION OF CARE AND PROMOTES CONNECTIVITY AND COMMUNICATION BETWEEN HOSPITAL CAREGIVERS, SPECIALISTS AND PRIMARY CARE PROVIDERS. EMBARKING ON THE JOURNEY TO CREATE A SHARED EHR IS THE MOST SIGNIFICANT AND IMPORTANT INVESTMENT NOVANT HEALTH HAS EVER MADE FOR ITS PATIENTS, AND TEAM MEMBERS. AWARDS, RECOGNITIONS &amp; CERTIFICATIONS/RECERTIFICATIONS NATIONAL COMMITTEE FOR QUALITY ASSURANCE - THE HEART STROKE RECOGNITION PROGRAM (HSRP) ASSESSES KEY QUALITY PERFORMANCE MEASURES THAT ARE BASED ON NATIONAL EVIDENCE BASED GUIDELINES FOR SECONDARY PREVENTION OF CARDIOVASCULAR DISEASE AND STROKE. PROGRAM MEASURES INCLUDE BLOOD PRESSURE CONTROL, USE OF ASPIRIN, SMOKING AND TOBACCO USE CESSATION ASSISTANCE, BODY MASS INDEX SCREENING, AND MORE. NATIONAL COMMITTEE FOR QUALITY ASSURANCE - PATIENT-CENTERED MEDICAL HOME RECOGNITION NCQA'S PATIENT-CENTERED MEDICAL HOME PREVALIDATION PROGRAM EVALUATES ELECTRONIC HEALTH RECORD (EHR) SYSTEMS, ADVANCED REGISTRIES, POPULATION HEALTH MANAGEMENT TOOLS AND OTHER RELATED TECHNOLOGY SOLUTIONS TO IDENTIFY ALIGNMENT WITH PATIENT-CENTERED MEDICAL HOME RECOGNITION STANDARDS REQUIREMENT. AWARDS INCLUDE GET WITH THE GUIDELINES STROKE AWARDS NOVANT HEALTH FORSYTH MEDICAL CENTER GOLD PLUS WITH TARGET STROKE ELITE PLUS HONOR ROLL GET WITH THE GUIDELINES HEART FAILURE AWARDS NOVANT HEALTH FORSYTH MEDICAL CENTER GOLD PLUS WITH TARGET HEART FAILURE HONOR ROLL.</p>



**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART I, LINE 1	<p>HEALTH INFORMATION AND MANAGEMENT SYSTEMS SOCIETY (HIMSS) STAGE 7 ACUTE CARE AWARD - THIS RECOGNITION REPRESENTS NOVANT HEALTH KERNERSVILLE MEDICAL CENTER'S ACHIEVEMENT OF THE HIGH EST LEVEL ON THE ELECTRONIC MEDICAL RECORD ADOPTION MODEL (EMRAM), WHICH MEANS THAT WE ARE UTILIZING ELECTRONIC MEDICAL RECORD TECHNOLOGY TO ITS FULLEST POTENTIAL TO PROVIDE ACCESS AND CARE TO OUR PATIENTS LEADERS IN LGBTQ HEALTHCARE EQUALITY - NOVANT HEALTH FORSYTH MEDICAL CENTER AND NOVANT HEALTH KERNERSVILLE MEDICAL CENTER HAVE BEEN RECOGNIZED AS "LEADER IN LGBTQ HEALTHCARE EQUALITY" BY THE HUMAN RIGHTS CAMPAIGN FOUNDATION, THE EDUCATIONAL ARM OF THE COUNTRY'S LARGEST LESBIAN, GAY, BISEXUAL AND TRANSGENDER CIVIL RIGHTS ORGANIZATION FACILITIES AWARDED THIS TITLE MEET KEY CRITERIA, INCLUDING PATIENT AND EMPLOYEE NONDISCRIMINATION POLICIES, A GUARANTEE OF EQUAL VISITATION FOR SAME-SEX PARTNERS AND PARENTS, AND LGBTQ HEALTH EDUCATION FOR KEY STAFF MEMBERS ADDITIONAL CERTIFICATIONS FOR FORSYTH MEDICAL CENTER INCLUDE - AMERICAN ASSOCIATION FOR CARDIOVASCULAR AND PULMONARY REHABILITATION - AMERICAN DIABETES ASSOCIATION - SELF MANAGEMENT EDUCATION RECOGNITION - CENTER OF EXCELLENCE IN MINIMALLY INVASIVE GYNECOLOGY (AAGL) - INTERNATIONAL ASSOCIATION FOR HEALTHCARE SECURITY AND SAFETY - NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE - MEDICAID - ONCOLOGY REHAB PARTNERS STAR PROGRAM CERTIFICATION - THE JOINT COMMISSION - HIP FRACTURE CERTIFICATION - THE JOINT COMMISSION - TOTAL HIP JOINT REPLACEMENT CERTIFICATION - THE JOINT COMMISSION - ADVANCED PALLIATIVE CARE PROGRAM CERTIFICATION - THE JOINT COMMISSION - COMPREHENSIVE STROKE CENTER - THE JOINT COMMISSION - MINIMALLY INVASIVE COLORECTAL SURGERY CENTER ADDITIONAL CERTIFICATIONS FOR KERNERSVILLE MEDICAL CENTER INCLUDE - INTERNATIONAL ASSOCIATION FOR HEALTHCARE SECURITY AND SAFETY - NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE - MEDICAID ADDITIONAL CERTIFICATIONS FOR EACH HOSPITAL INCLUDE - COLLEGE OF AMERICAN PATHOLOGY - UNITED STATES DEPARTMENT OF HEALTH &amp; HUMAN SERVICES - CLIA - UNITED STATES DEPARTMENT OF HEALTH &amp; HUMAN SERVICES - MEDICARE ACCREDITATION THE JOINT COMMISSION - NOVANT HEALTH FORSYTH MEDICAL CENTER, NOVANT HEALTH KERNERSVILLE MEDICAL CENTER, AND NOVANT HEALTH CLEMMONS MEDICAL CENTER HAVE ALL BEEN ACCREDITED BY THE JOINT COMMISSION, AN INDEPENDENT ORGANIZATION THAT EVALUATES A HEALTHCARE ORGANIZATION'S PERFORMANCE IN AREAS THAT MOST AFFECT PATIENT HEALTH AND SAFETY THE AMERICAN NURSES CREDENTIALING CENTER (ANCC) - THE ANCC AWARDED THE NURSING PROGRAMS AT NOVANT HEALTH FORSYTH MEDICAL CENTER AND NOVANT HEALTH KERNERSVILLE MEDICAL CENTER FOR ITS EXCELLENCE AND QUALITY IN NURSING CARE BY NAMING IT WITH MAGNET RECOGNITION ONLY FIVE PERCENT OF ALL HOSPITALS NATIONWIDE HAVE EARNED THIS HIGH HONOR, WHICH RECOGNIZES FACILITIES THAT PROVIDE THE HIGHEST LEVEL OF NURSING CARE THE AMERICAN HEART ASSOCIATION/AMERICAN STROKE ASSOCIATION - NOVANT HEALTH FORSYTH MEDICAL CENTER IS RECOGNIZED AS AN ADVANCED COMPREHENSIVE</p>

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART I, LINE 1	<p>E STROKE CENTER, FOCUSING ON COMPREHENSIVE CARE OF THE COMPLEX STROKE PATIENT SOCIETY OF CHEST PAIN CENTERS - NOVANT HEALTH FORSYTH MEDICAL CENTER RECEIVED THE CHEST PAIN ACCREDITATION BY THE SOCIETY OF CHEST PAIN CENTERS THIS ACCREDITATION DEMONSTRATES A SEAMLESS AND STANDARDIZED PROCESS OF QUALITY CARE DELIVERY AT NOVANT HEALTH CHEST PAIN FACILITIES ADDITIONAL ACCREDITATIONS FOR NOVANT HEALTH FORSYTH MEDICAL CENTER INCLUDE - AMERICAN COLLEGE OF RADIOLOGY - AMERICAN COLLEGE OF RADIOLOGY - RADIATION ONCOLOGY - AMERICAN COLLEGE OF SURGEONS - CANCER CENTER - AMERICAN SOCIETY OF HEALTH SYSTEM PHARMACISTS - COMMISSION OF ACCREDITATION OF REHABILITATION FACILITIES - INTERSOCIETAL ACCREDITATION COMMISSION CAROTID STENTING - INTERSOCIETAL ACCREDITATION COMMISSION ECHOCARDIOGRAPHY LABORATORIES - NATIONAL ACCREDITATION PROGRAM FOR BREAST CENTERS - COLLEGE OF AMERICAN PATHOLOGY ADDITIONAL ACCREDITATIONS FOR KERNERSVILLE MEDICAL CENTER INCLUDE - AMERICAN COLLEGE OF RADIOLOGY - AMERICAN COLLEGE OF RADIOLOGY - MAMMOGRAPHY - INTERSOCIETAL ACCREDITATION COMMISSION ECHOCARDIOGRAPHY LABORATORIES - NATIONAL ACCREDITATION PROGRAM FOR BREAST CENTERS - COLLEGE OF AMERICAN PATHOLOGY COMMUNITY BENEFIT REPORT <a href="https://www.novanthealth.org/home/about-us/community-involvement/community-benefit.aspx">HTTPS://WWW.NOVANTHEALTH.ORG/HOME/ABOUT-US/COMMUNITY-INVOLVEMENT/COMMUNITY-BENEFIT.ASPX</a> THE COMMUNITY BENEFIT REPORT, REFERRED TO AS A COMMUNITY IMPACT REPORT, PREPARED BY NOVANT HEALTH IS A SYSTEM-WIDE REPORT THAT INCLUDES QUALITATIVE AND QUANTITATIVE INFORMATION PLEASE NOTE THAT THE NUMERIC DATA IN THIS REPORT IS NOT BASED UPON THE FORM 990, SCHEDULE H CRITERIA, BUT RATHER IT HAS BEEN PREPARED IN ACCORDANCE WITH THE NORTH CAROLINA HOSPITAL ASSOCIATION REPORTING GUIDELINES IT SHOULD NOT BE RELIED UPON AS THE ORGANIZATION'S FORM 990, SCHEDULE H COMMUNITY BENEFIT REPORT, ITS COMMUNITY HEALTH NEEDS ASSESSMENT OR COMMUNITY BENEFIT IMPLEMENTATION STRATEGY IN THIS REPORT, THE NOVANT HEALTH SYSTEM'S COMMUNITY BENEFIT WAS APPROXIMATELY \$884,000,000, INCLUDING \$15,500,000 IN FINANCIAL ASSISTANCE FOR 2018</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART III, LINE 1 MISSION, VISION, AND VALUES	<p>MISSION NOVANT HEALTH EXISTS TO IMPROVE THE HEALTH OF COMMUNITIES, ONE PERSON AT A TIME VISION WE, THE NOVANT HEALTH TEAM, WILL DELIVER THE MOST REMARKABLE PATIENT EXPERIENCE, IN EVERY DIMENSION, EVERY TIME VALUES -COMPASSION WE TREAT OUR CUSTOMERS AND THEIR FAMILIES, STAFF AND OTHER HEALTHCARE PROVIDERS AS FAMILY MEMBERS BY SHOWING THEM KINDNESS, PATIENCE, EMPATHY AND RESPECT -DIVERSITY AND INCLUSION WE RECOGNIZE THAT EVERY PERSON IS DIFFERENT, EACH SHAPED BY UNIQUE LIFE EXPERIENCES THIS ENABLES US TO BETTER UNDERSTAND ONE ANOTHER AND OUR CUSTOMERS BY ENGAGING THE STRENGTHS AND TALENTS OF EACH TEAM MEMBER, WE ENSURE A STRONG ORGANIZATION CAPABLE OF PROVIDING REMARKABLE HEALTHCARE TO OUR PATIENTS, FAMILIES AND COMMUNITIES -PERSONAL EXCELLENCE WE STRIVE TO GROW PERSONALLY AND PROFESSIONALLY, AND WE APPROACH EACH SERVICE OPPORTUNITY WITH A POSITIVE, FLEXIBLE ATTITUDE HONESTY AND PERSONAL INTEGRITY GUIDE ALL THAT WE DO -TEAMWORK THE NEEDS AND EXPECTATIONS OF ANY ONE CUSTOMER ARE GREATER THAN THAT WHICH ONE PERSON'S SERVICE EFFORTS CAN SATISFY WE SUPPORT EACH OTHER SO THAT TOGETHER AS A TEAM, WE CAN BE SUCCESSFUL IN THE EYE OF THE CUSTOMER AS A QUALITY SERVICE PROVIDER -COURAGE WE ACT BOLDLY IN MAKING THE CHANGES NECESSARY TO ACHIEVE OUR MISSION, VISION AND PROMISE OF DELIVERING REMARKABLE HEALTHCARE OUR PEOPLE WE ARE AN INCLUSIVE TEAM OF PURPOSE-DRIVEN PEOPLE INSPIRED AND UNITED BY OUR PASSION TO CARE FOR EACH OTHER, OUR PATIENTS AND OUR COMMUNITIES OUR PROMISE TO PATIENTS WE ARE MAKING YOUR HEALTHCARE EXPERIENCE REMARKABLE WE WILL BRING YOU WORLD-CLASS CLINICIANS, CARE AND TECHNOLOGY - WHEN AND WHERE YOU NEED THEM WE ARE REINVENTING THE HEALTHCARE EXPERIENCE TO BE SIMPLER, MORE CONVENIENT AND MORE AFFORDABLE, SO THAT YOU CAN FOCUS ON GETTING BETTER AND STAYING HEALTHY</p>

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III, LINE 4A PROGRAM SERVICE ACCOMPLISHMENTS	KMC HAS 50 LICENSED BEDS DURING 2018 THERE WERE 10,955 PATIENT DAYS WITH AN AVERAGE LENGTH OF STAY OF 3 DAYS, AN AVERAGE DAILY CENSUS OF 30, AND 3,251 DISCHARGES THERE WERE 4,368 INPATIENT AND OUTPATIENT SURGERIES, A TOTAL OF 51,849 OUTPATIENT ENCOUNTERS AND 35,997 EMERGENCY DEPARTMENT VISITS CMC HAS 36 LICENSED BEDS DURING 2018 THERE WERE 4,219 PATIENT DAYS WITH AN AVERAGE LENGTH OF STAY OF 2 DAYS, AN AVERAGE DAILY CENSUS OF 12, AND 2,118 DISCHARGES THERE WERE 3,298 INPATIENT AND OUTPATIENT SURGERIES, A TOTAL OF 27,739 OUTPATIENT ENCOUNTERS AND 20,062 EMERGENCY DEPARTMENT VISITS

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 6	FORM 990, PART VI, SECTION A, LINE 6 CLASSES OF MEMBERS OR STOCKHOLDERS THE CORPORATION IS A NONPROFIT CORPORATION WITH MEMBERS (OR A MEMBER)

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7A	FORM 990, PART VI, SECTION A, LINE 7A ELECTION OF MEMBERS AND THEIR RIGHTS NOVANT HEALTH, INC ELECTS ALL MEMBERS OF THE GOVERNING BODY OF FORSYTH MEMORIAL HOSPITAL,INC

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B	FORM 990, PART VI, SECTION A, LINE 7B DECISIONS SUBJECT TO APPROVAL OF MEMBERS NOVANT HEALTH, INC HAS CERTAIN RESERVED POWERS, SUCH AS APPROVAL OF AMENDMENTS TO THE ARTICLES AND BYLAWS OF THE CORPORATION, AND TO ADOPT CERTAIN POLICIES WHICH SHALL BE IMPLEMENTED BY THE CORPORATION BOARD

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	FORM 990, PART VI, SECTION B, LINE 11 ORGANIZATION'S PROCESS TO REVIEW FORM 990 THE BOARD HAS DELEGATED REVIEW OF THE FORM 990 TO NOVANT HEALTH'S BOARD OF TRUSTEES' AUDIT AND COMPLIANCE COMMITTEE ("THE COMMITTEE"), WHICH OVERSEES TAX MATTERS FOR ENTITIES IN THE NOVANT HEALTH SYSTEM THE COMMITTEE IS THE REVIEW BODY FOR ALL OF THE FORM 990S FILED FOR ORGANIZATIONS WITHIN THE NOVANT HEALTH SYSTEM THE COMMITTEE MEETS BEFORE THE FORM 990S ARE FILED WITH THE IRS AND AFTER ALL BOARD MEMBERS HAVE BEEN PROVIDED A PAPER OR ELECTRONIC COPY OF THE FORM 990 AND A SUMMARY OF ITS CONTENTS THE VICE PRESIDENT OF TAX AND LEGAL COUNSEL FOR NOVANT HEALTH ATTEND THE MEETING TO ANSWER ANY QUESTIONS AND ADDRESS ANY SIGNIFICANT DISCLOSURES WITHIN THE FORM 990



**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	FORM 990, PART VI, SECTION B, LINE 12C MONITORING AND ENFORCEMENT OF COI THE ORGANIZATION'S TRUSTEE CONFLICT OF INTEREST POLICY APPLIES TO ALL TRUSTEES, PRINCIPAL OFFICERS OR MEMBERS OF A COMMITTEE WITH BOARD DELEGATED POWERS INCLUDING ANY APPLICABLE DISREGARDED ENTITIES ALL TRUSTEES ARE SENT AN ANNUAL DISCLOSURE QUESTIONNAIRE THE TRUSTEE ANNUAL DISCLOSURE QUESTIONNAIRES ARE REVIEWED BY THE COMPLIANCE DEPARTMENT WITH RESPECT TO PARTICULAR TRANSACTIONS THAT COME BEFORE THE BOARD, THE CONFLICT OF INTEREST POLICY WOULD BE FOLLOWED THE POTENTIAL CONFLICT OF INTEREST WOULD BE DISCLOSED BY THE BOARD MEMBER BEFORE A VOTE ON THE TRANSACTION AND THE REST OF THE BOARD WOULD DETERMINE WHETHER A CONFLICT OF INTEREST EXISTS IF THE REST OF THE BOARD DETERMINED THAT A CONFLICT OF INTEREST EXISTED THEN THE BOARD MEMBER WITH THE CONFLICT OF INTEREST WOULD NOT PARTICIPATE IN THE DELIBERATIONS AND VOTE

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15	FORM 990, PART VI, SECTION B, LINE 15A/15B THE FILING ORGANIZATION IS AN INTEGRAL PART OF NOVANT HEALTH, AN INTEGRATED HEALTHCARE SYSTEM COLLECTIVELY REFERRED TO AS "NOVANT HEALTH " NOVANT HEALTH, INC IS THE PARENT ORGANIZATION AND INDEPENDENT AND DISINTERESTED MEMBERS OF THE NOVANT HEALTH, INC BOARD OF TRUSTEES (WHO COMPRISE THE COMPENSATION AND LEADERSHIP COMMITTEE OF THE BOARD) REVIEW, APPROVE, AND OVERSEE ALL ASPECTS OF COMPENSATION AND BENEFITS FOR CERTAIN LEADERS AND EXECUTIVES ("EXECUTIVES") SERVING AS OFFICERS, INCLUDING THE TOP MANAGEMENT OFFICIAL, OR KEY EMPLOYEES FOR NOVANT HEALTH ENTITIES THE COMMITTEE WORKS WITH AN INDEPENDENT COMPENSATION CONSULTANT AND USES THIRD PARTY COMPARABILITY DATA FOR FUNCTIONALLY SIMILAR POSITIONS AT SIMILARLY SITUATED ORGANIZATIONS TO ENSURE THAT TOTAL COMPENSATION AND BENEFITS FOR EACH EXECUTIVE IS REASONABLE FOR THAT EXECUTIVE'S POSITION THE COMMITTEE REVIEWS AND APPROVES EXECUTIVE COMPENSATION AND BENEFITS ANNUALLY, CONSISTENT WITH THE WRITTEN EXECUTIVE COMPENSATION PHILOSOPHY OF NOVANT HEALTH, AND IN A MANNER THAT QUALIFIES FOR THE REBUTTABLE PRESUMPTION OF REASONABLENESS, THEREBY ASSURING THAT TOTAL COMPENSATION AND BENEFITS PROVIDED TO EACH EXECUTIVE IS REASONABLE

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	FORM 990, PART VI, SECTION C, LINE 19 GOVERNING DOCUMENTS DISCLOSURE THE AUDITED CONSOLIDATED FINANCIAL STATEMENTS CONTAINING ALL ORGANIZATIONS IN THE NOVANT HEALTH SYSTEM ARE POSTED TO THE NOVANT HEALTH WEBSITE THE GOVERNING DOCUMENTS AND CONFLICT OF INTEREST POLICY ARE NOT AVAILABLE TO THE PUBLIC

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VII, SECTION A, COLUMN B RELATED ORGANIZATIONS	THE ORGANIZATION EMPLOYS CERTAIN EXECUTIVES WHOSE ROLES ARE SUCH THAT THEY PROVIDE SERVICES TO NOT ONLY THE ORGANIZATION, BUT ALSO TO SOME OR ALL OF THE OTHER TAX-EXEMPT ORGANIZATIONS WITHIN THE HEALTHCARE SYSTEM. FOR EXAMPLE, MANY OF THESE EXECUTIVES' ROLES FOCUS ON PARTICULAR SERVICE LINES WHICH CROSS THE VARIOUS GEOGRAPHIC MARKETS OUR ORGANIZATIONS SERVE, THUS THE SERVICES PROVIDED BY THESE EXECUTIVES MAY BENEFIT AND BE RECEIVED BY MULTIPLE ORGANIZATIONS WITHIN THE SYSTEM. THE EXECUTIVES DO NOT ALLOCATE THEIR HOURS BETWEEN THE VARIOUS ORGANIZATIONS, BUT RATHER THEIR TIME SPENT ON SERVICES TO THE ORGANIZATION IS INCLUSIVE OF SERVICES TO ALL OF THE ORGANIZATIONS THEY SERVE WITHIN THE SYSTEM.

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VII, SECTION B INDEPENDENT CONTRACTORS	THE FILING ENTITY IS PART OF THE NOT-FOR-PROFIT INTEGRATED HEALTHCARE SYSTEM KNOWN AS NOVANT HEALTH. NOVANT HEALTH, INC., THE PARENT ORGANIZATION, IS RESPONSIBLE FOR CERTAIN CORPORATE SUPPORT FUNCTIONS INCLUDING ACCOUNTS PAYABLE AND ISSUES FORMS 1099 FOR CERTAIN ENTITIES IN THE SYSTEM INCLUDING THE FILING ENTITY. INFORMATION REPORTED IN PART VII, SECTION B REPRESENTS THE EXPENSES PAID ON BEHALF OF THE FILING ENTITY TO INDEPENDENT CONTRACTORS OVER \$100,000.

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART IX, LINE 6 COMPENSATION OF DISQUALIFIED PERSONS	THE AMOUNTS REPORTED HERE INCLUDE AMOUNTS ATTRIBUTABLE TO DISQUALIFIED PERSONS (DQP) AS DEFINED IN THE INSTRUCTIONS, BUT NOW ALSO INCLUDES AMOUNTS ATTRIBUTABLE TO INDIVIDUALS THAT MAY NOT DEFINITELY BE CONSIDERED DQPS UNDER THE 4958 RULES WE HAVE OPTED TO TAKE A MORE EXPANSIVE APPROACH AS TO WHO MAY BE CONSIDERED A DQP AND REPORT THEM HERE AS WELL

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9	CONTRIBUTIONS -1,401,008 MALPRACTICE INSURANCE -390,232 AFFILIATE TRANSFERS -1,510,878 PARTNERSHIP ADJUSTMENT 16,846,580

SCHEDULE R  
(Form 990)

Department of the Treasury  
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.  
▶ Attach to Form 990.  
▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization  
FORSYTH MEMORIAL HOSPITAL INC

Employer identification number  
56-0928089

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
(1) EXCEL IMAGING LLC 2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 20-4253946	INACTIVE	NC			FORSYTH MEMORIAL HOSPITAL INC
(2) NOVANT HEALTH CLEMMONS OUTPATIENT SURGERY LLC 2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 82-5250651	HEALTHCARE	NC	136,043	87,404	FORSYTH MEMORIAL HOSPITAL INC
(3) NOVANT HEALTH KERNERSVILLE OUTPATIENT SURGERY LLC 2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 82-1651821	HEALTHCARE	NC	896,924	3,673,484	FORSYTH MEMORIAL HOSPITAL INC

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	

**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.

See Additional Data Table

(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

**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 . . . . .

1a

No

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

1b

No

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

1c

Yes

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

1d

No

e Loans or loan guarantees by related organization(s) . . . . .

1e

No

f Dividends from related organization(s) . . . . .

1f

No

g Sale of assets to related organization(s) . . . . .

1g

No

h Purchase of assets from related organization(s) . . . . .

1h

No

i Exchange of assets with related organization(s) . . . . .

1i

No

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

1j

Yes

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

1k

Yes

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

1l

No

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

1m

Yes

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

1n

No

o Sharing of paid employees with related organization(s) . . . . .

1o

Yes

p Reimbursement paid to related organization(s) for expenses . . . . .

1p

Yes

q Reimbursement paid by related organization(s) for expenses . . . . .

1q

No

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

1r

Yes

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

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
(1)FORSYTH MEDICAL CENTER FOUNDATION	C	2,470,495	CASH
(2)AUXILIARY OF FORSYTH MEMORIAL HOSPITAL INC	C	50,878	CASH
(3)FORSYTH MEDICAL CENTER FOUNDATION	R	1,510,878	CASH

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

[illegible]

**Part VII**   **Supplemental Information**

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

Return Reference	Explanation

Additional Data

Software ID:

Software Version:

EIN: 56-0928089

Name: FORSYTH MEMORIAL 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
2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 56-0862112	HEALTHCARE	NC	501(C)(3)	LINE 10	FORSYTH MEMORIAL HOSPITAL INC	Yes	
2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 27-4616751	HEALTHCARE	NC	501(C)(3)	LINE 7	BRUNSWICK COMMUNITY HOSPITAL LLC		No
2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 58-1466368	HEALTHCARE	NC	501(C)(3)	LINE 12B, II	NOVANT MEDICAL GROUP INC		No
2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 56-0636250	HEALTHCARE	NC	501(C)(3)	LINE 3	NOVANT HEALTH TRIAD REGION LLC		No
2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 56-1828629	HEALTHCARE	NC	501(C)(3)	LINE 7	COMMUNITY GENERAL HEALTH PARTNERS INC		No
2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 56-2120959	HEALTHCARE	NC	501(C)(3)	LINE 7	FORSYTH MEMORIAL HOSPITAL INC	Yes	
2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 56-1373175	HEALTHCARE	NC	501(C)(3)	LINE 10	NOVANT HEALTH INC		No
2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 56-1340424	HEALTHCARE	NC	501(C)(3)	LINE 3	NOVANT HEALTH TRIAD REGION LLC		No
2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 56-2098809	HEALTHCARE	NC	501(C)(3)	LINE 10	NOVANT HEALTH INC		No
2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 56-1376950	HEALTHCARE	NC	501(C)(3)	LINE 12C, III-FI	N/A		No
2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 58-1728803	HEALTHCARE	NC	501(C)(3)	LINE 3	NMG SERVICES INC		No
2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 54-1291284	HEALTHCARE	VA	501(C)(3)	LINE 10	PRINCE WILLIAM HEALTH SYSTEM		No
2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 58-1413074	HEALTHCARE	NC	501(C)(3)	LINE 7	NOVANT HEALTH SOUTHERN PIEDMONT REGION LLC		No
2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 56-1376368	HEALTHCARE	NC	501(C)(3)	LINE 3	NOVANT HEALTH SOUTHERN PIEDMONT REGION LLC		No
2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 54-1278944	HEALTHCARE	VA	501(C)(3)	LINE 12C, III-FI	NOVANT HEALTH UVA HEALTH SYSTEM		No
2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 54-0696355	HEALTHCARE	VA	501(C)(3)	LINE 3	PRINCE WILLIAM HEALTH SYSTEM		No
2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 54-1307595	HEALTHCARE	VA	501(C)(3)	LINE 7	PRINCE WILLIAM HEALTH SYSTEM		No
2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 56-1424814	HEALTHCARE	NC	501(C)(3)	LINE 12C, III-FI	NOVANT HEALTH INC		No
2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 23-7022472	HEALTHCARE	NC	501(C)(3)	LINE 10	ROWAN REGIONAL MEDICAL CENTER INC		No
2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 56-1424818	HEALTHCARE	NC	501(C)(3)	LINE 7	ROWAN REGIONAL MEDICAL CENTER INC		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
2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 56-0547479	HEALTHCARE	NC	501(C)(3)	LINE 3	ROWAN HEALTH SERVICES CORPORATION		No
2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 58-1867242	HEALTHCARE	NC	501(C)(3)	LINE 12C, III-FI	NOVANT HEALTH INC		No
2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 56-0554230	HEALTHCARE	NC	501(C)(3)	LINE 3	NOVANT HEALTH SOUTHERN PIEDMONT REGION LLC		No
2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 54-0622371	HEALTHCARE	VA	501(C)(3)	LINE 3	NOVANT HEALTH UVA HEALTH SYSTEM		No
2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 81-0868533	HEALTHCARE	VA	501(C)(3)	LINE 12A, I	NOVANT HEALTH INC		No

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of- year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity?	
								Yes	No
(1) ADEPT HEALTH INC 2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 56-2226937	ADMIN SERVICES	NC	N/A	C					No
(1) CHOICEHEALTH INC 2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 56-1896065	MANAGED CARE	NC	N/A	C					No
(2) COMMUNICARE INC 2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 56-1952950	RENTAL REAL ESTATE	NC	N/A	C					No
(3) KERNERSVILLE MEDICAL CENTER PARK OWNERS' ASSOCIATION 2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 47-1511401	RENTAL REAL ESTATE	NC	N/A	C					No
(4) MEDQUEST INC & SUBSIDIARIES 3480 PRESTON RIDGE RD STE 600 ALPHARETTA, GA 30005 22-3860764	DIAGNOSTIC IMAGING	DE	N/A	C					No
(5) NOVANT HEALTH TRINOVA INSURANCE PROTECTED CELL INC 2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 81-2963143	INSURANCE	NC	N/A	C					No
(6) ROWAN MEDICAL FACILITIES INC 2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 56-1424672	MEDICAL SUPPLIES	NC	N/A	C					No
(7) SALEM DIAGNOSTICS INC 2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 56-1513621	HEALTH RELATED	NC	N/A	C					No
(8) SALEM HEALTH SERVICES INC 2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 56-1342654	HEALTH RELATED	NC	N/A	C					No
(9) THE PARK AT MONROE PROPERTY OWNERS ASSOCIATION INC 2085 FRONTIS PLAZA BLVD WINSTON SALEM, NC 27103 46-3910256	RENTAL REAL ESTATE	NC	N/A	C					No