

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	<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> </div> <div style="width: 20%; text-align: right;">2020-11-11</div> </div>			Date	
	<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;">JIM BONGIORNO CFO</div> <div style="width: 20%;"></div> </div>				
Type or print name and title					

Paid Preparer Use Only	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
	Firm's name ▶			Firm's EIN ▶	
	Firm's address ▶			Phone no.	

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

W.A. FOOTE MEMORIAL HOSPITAL IS AN AFFILIATE OF HENRY FORD HEALTH SYSTEM SERVING COMMUNITIES IN THE SOUTH- CENTRAL REGION OF MICHIGAN FOR OVER 100 YEARS. AS AN INTEGRATED COMPONENT OF ONE OF THE NATION'S LEADING COMPREHENSIVE, INTEGRATED HEALTH SYSTEMS, IT IS THE MISSION OF W.A. FOOTE MEMORIAL HOSPITAL TO LEAD THE COMMUNITY WE SERVE TO BETTER HEALTH AND WELL-BEING AT EVERY STAGE OF LIFE.

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

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

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

If "Yes," describe these changes on Schedule O.

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

4a	(Code:) (Expenses \$ 587,604,347 including grants of \$ 405,072) (Revenue \$ 683,825,089)
	See Additional Data

4b	(Code:) (Expenses \$ including grants of \$) (Revenue \$)
	See Additional Data

4c	(Code:) (Expenses \$ including grants of \$) (Revenue \$)
	See Additional Data

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

4e	Total program service expenses ▶	587,604,347
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Part IV Checklist of Required Schedules

	Yes	No
1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A	1 Yes	
2 Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?	2 Yes	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I	3	No
4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II	4 Yes	
5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? If "Yes," complete Schedule C, Part III	5	No
6 Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes," complete Schedule D, Part I	6	No
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II	7	No
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III	8	No
9 Did the organization report an amount in Part X, line 21 for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? If "Yes," complete Schedule D, Part IV	9	No
10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi endowments? If "Yes," complete Schedule D, Part V	10 Yes	
11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.		
a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI	11a Yes	
b Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII	11b	No
c Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII	11c	No
d Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part IX	11d	No
e Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	11e Yes	
f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part X	11f Yes	
12a Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII	12a	No
b Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional	12b Yes	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	13	No
14a Did the organization maintain an office, employees, or agents outside of the United States?	14a	No
b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV	14b Yes	
15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? If "Yes," complete Schedule F, Parts II and IV	15	No
16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? If "Yes," complete Schedule F, Parts III and IV	16	No
17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I (see instructions)	17	No
18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II	18	No
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III	19	No
20a Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H	20a Yes	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b Yes	
21 Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? If "Yes," complete Schedule I, Parts I and II	21 Yes	

Part IV Checklist of Required Schedules (continued)

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

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

		Yes	No	
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	466	
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0	
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c	Yes	

Part V **Statements Regarding Other IRS Filings and Tax Compliance** *(continued)*

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Part VI

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

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

Section A. Governing Body and Management

		Yes	No
1a Enter the number of voting members of the governing body at the end of the tax year	1a 17		
If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.			
b Enter the number of voting members included in line 1a, above, who are independent	1b 9		
2 Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2		No
3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?	3		No
4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4		No
5 Did the organization become aware during the year of a significant diversion of the organization's assets?	5		No
6 Did the organization have members or stockholders?	6	Yes	
7a Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a	Yes	
b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b	Yes	
8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
a The governing body?	8a	Yes	
b Each committee with authority to act on behalf of the governing body?	8b	Yes	
9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O	9		No

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

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

Section C. Disclosure

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

18 Section 6104 requires an organization to make its Form 1023 (or 1024-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:
 ROBIN DAMSCHRODER ONE FORD PLACE DETROIT, MI 48202 (313) 876-8714

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 ☐

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

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

See instructions for the order in which to list the persons above.

☐ 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)

(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			
See Additional Data Table										
1b Sub-Total										
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)								12,245,305	5,148,709	565,758

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 ▶ 380

	Yes	No
3 Did the organization list any former 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
INDEPENDENT HOSPITALIST PHYSICIANS PLLC PO BOX 100 ROYAL OAK, MI 48068	HEALTHCARE SERVICES	11,154,881
ST JOSEPH MERCY HEALTH SYSTEM PO BOX 992 ANN ARBOR, MI 48106	HEALTHCARE SERVICES	6,548,083
PULMONARY CLINICS OF SOUTHERN MI PC 900 E MICHIGAN AVENUE STE 105 JACKSON, MI 49201	HEALTHCARE SERVICES	5,056,632
CHRISTMAN COMPANY 208 N CAPITAL AVENUE LANSING, MI 489331357	GENERAL CONTRACTOR	4,648,876
OBHG MICHIGAN PC 777 LOWNDES HILLS RD BLDG 1 GREENVILLE, SC 29607	HEALTHCARE SERVICES	1,652,662

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization ▶ 72

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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										
	e Government grants (contributions)		1e										
	f All other contributions, gifts, grants, and similar amounts not included above		1f	1,800,000									
	g Noncash contributions included in lines 1a - 1f:\$		1g										
	h Total. Add lines 1a-1f ▶		1,800,000										
Program Service Revenue			Business Code										
	2a PATIENT SERVICES		621990	642,135,532		640,472,677		1,662,855					
	b												
	c												
	d												
	e												
	f All other program service revenue.												
	g Total. Add lines 2a-2f. ▶		642,135,532										
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts) ▶			29,077,253						29,077,253			
	4 Income from investment of tax-exempt bond proceeds ▶												
	5 Royalties ▶												
			(i) Real	(ii) Personal									
	6a Gross rents		6a	546,848									
	b Less: rental expenses		6b	0									
	c Rental income or (loss)		6c	546,848									
	d Net rental income or (loss) ▶			546,848						546,848			
			(i) Securities	(ii) Other									
	7a Gross amount from sales of assets other than inventory		7a	3,261,890	21,307								
	b Less: cost or other basis and sales expenses		7b	0	86,935								
	c Gain or (loss)		7c	3,261,890	-65,628								
	d Net gain or (loss) ▶			3,196,262		3,261,890				-65,628			
	8a Gross income from fundraising events (not including \$ of contributions reported on line 1c). See Part IV, line 18		8a										
	b Less: direct expenses		8b										
	c Net income or (loss) from fundraising events . . ▶												
	9a Gross income from gaming activities. See Part IV, line 19		9a										
	b Less: direct expenses		9b										
	c Net income or (loss) from gaming activities . . ▶												
	10a Gross sales of inventory, less returns and allowances		10a										
b Less: cost of goods sold		10b											
c Net income or (loss) from sales of inventory . . ▶													
Miscellaneous Revenue			Business Code										
11a CONTRACTED PHARMACY REVENUE			621110	30,523,899		30,523,899							
b JHN			621990	3,025,967		3,025,967							
c CAFETERIA			900099	2,117,900		2,117,900							
d All other revenue				4,879,474		4,422,756		456,718					
e Total. Add lines 11a-11d ▶					40,547,240								
12 Total revenue. See instructions ▶					717,303,135		683,825,089		2,119,573		29,558,473		

Form 990 (2019)

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	303,438	303,438		
2 Grants and other assistance to domestic individuals. See Part IV, line 22	101,634	101,634		
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16.				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	5,546,720	3,298,703	2,066,203	181,814
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	225,104		225,104	
7 Other salaries and wages	269,820,458	238,449,071	31,371,387	
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	3,057,683	2,682,319	373,348	2,016
9 Other employee benefits	41,201,147	36,143,246	5,030,730	27,171
10 Payroll taxes	17,838,321	15,648,468	2,178,089	11,764
11 Fees for services (non-employees):				
a Management				
b Legal	560,294	176,605	383,689	
c Accounting				
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	53,748,106	47,182,107	6,565,999	
12 Advertising and promotion	2,412,474	155,495	2,256,979	
13 Office expenses	16,481,006	10,169,565	6,311,441	
14 Information technology	2,460,277	2,019,662	440,615	
15 Royalties				
16 Occupancy	7,743,794	4,318,571	3,425,223	
17 Travel	826,319	402,115	424,204	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	545,336	378,016	167,320	
20 Interest	5,597,185	4,319,793	1,277,392	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	29,033,157	19,810,389	9,222,768	
23 Insurance	5,078,716	5,078,716		
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLIES	59,573,822	59,573,822		
b CORP OFFICE ALLOCATION	55,888,910	55,888,910		
c PHARMACEUTICAL SUPPLIES	50,588,365	50,588,365		
d QAAP TAX	16,410,079	16,410,079		
e All other expenses	21,908,914	14,505,258	7,403,656	
25 Total functional expenses. Add lines 1 through 24e	666,951,259	587,604,347	79,124,147	222,765
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

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

				(A) Beginning of year		(B) End of year	
Assets	1	Cash—non-interest-bearing		6,015,197	1	9,568,453	
	2	Savings and temporary cash investments		16,846,891	2	58,050,121	
	3	Pledges and grants receivable, net		911,234	3	442,436	
	4	Accounts receivable, net		78,705,782	4	87,045,385	
	5	Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons			5		
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)		115,000	6	115,000	
	7	Notes and loans receivable, net			7		
	8	Inventories for sale or use		8,453,746	8	11,757,105	
	9	Prepaid expenses and deferred charges		4,035,255	9	3,666,395	
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a	337,963,438			
	b	Less: accumulated depreciation	10b	91,273,732	241,875,965	10c	246,689,706
	11	Investments—publicly traded securities		143,221,026	11	236,114,712	
	12	Investments—other securities. See Part IV, line 11			12		
	13	Investments—program-related. See Part IV, line 11		4,684,605	13	5,784,169	
	14	Intangible assets			14		
	15	Other assets. See Part IV, line 11		4,132,633	15	8,027,124	
16	Total assets. Add lines 1 through 15 (must equal line 34)		508,997,334	16	667,260,606		
Liabilities	17	Accounts payable and accrued expenses		53,597,922	17	80,057,162	
	18	Grants payable			18		
	19	Deferred revenue			19		
	20	Tax-exempt bond liabilities		155,513,098	20	153,959,618	
	21	Escrow or custodial account liability. Complete Part IV of Schedule D			21		
	22	Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons			22		
	23	Secured mortgages and notes payable to unrelated third parties		135,457	23		
	24	Unsecured notes and loans payable to unrelated third parties			24		
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24). Complete Part X of Schedule D		62,592,150	25	69,050,225	
26	Total liabilities. Add lines 17 through 25		271,838,627	26	303,067,005		
Net Assets or Fund Balances	Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33.						
	27	Net assets without donor restrictions		233,975,313	27	361,329,063	
	28	Net assets with donor restrictions		3,183,394	28	2,864,538	
	Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> and complete lines 29 through 33.						
	29	Capital stock or trust principal, or current funds			29		
	30	Paid-in or capital surplus, or land, building or equipment fund			30		
	31	Retained earnings, endowment, accumulated income, or other funds			31		
	32	Total net assets or fund balances		237,158,707	32	364,193,601	
33	Total liabilities and net assets/fund balances		508,997,334	33	667,260,606		

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	717,303,135
2	Total expenses (must equal Part IX, column (A), line 25)	2	666,951,259
3	Revenue less expenses. Subtract line 2 from line 1	3	50,351,876
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	237,158,707
5	Net unrealized gains (losses) on investments	5	
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	76,683,018
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	364,193,601

Part XII Financial Statements and ReportingCheck 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
2a		No
2b	Yes	
2c	Yes	
3a		No
3b		

Additional Data

Software ID:
Software Version:
EIN: 38-2027689
Name: WA FOOTE MEMORIAL HOSPITAL

Form 990 (2019)

Form 990, Part III, Line 4a:

FOR MORE THAN 100 YEARS W.A. FOOTE MEMORIAL HOSPITAL HAS SERVED THE JACKSON COUNTY COMMUNITY OF SOUTH-CENTRAL MICHIGAN WITH A COMMITMENT TO CHARITABLE GIVING, OUTREACH AND BUILDING STRONGER, HEALTHIER INDIVIDUALS AND FAMILIES. THE 475-BED ACUTE CARE HOSPITAL OFFERS A FULL RANGE OF CLINICAL SERVICES, INCLUDING GENERAL MEDICINE, SURGERY, BIRTHING CENTER AND 24-HOUR EMERGENCY CARE. W.A. FOOTE MEMORIAL HOSPITAL ALSO PROVIDES PHYSICAL MEDICINE AND REHAB, CARDIAC, CANCER AND NEUROSURGICAL SERVICES. DURING 2019 W.A. FOOTE MEMORIAL HOSPITAL HAD 18,463 DISCHARGES.WITH A SENSE OF HUMAN COMPASSION, WE GIVE, ORGANIZE, LEAD, PARTNER AND EMBRACE THE WIDE-RANGING COMMUNITY PROGRAMS AND SERVICES. IN GIVING BACK TO THE CULTURE AND PEOPLE THAT SURROUND US, WE GAIN FULFILLMENT IN KNOWING WE HAVE INVESTED IN THE HEALTH AND WELL-BEING OF THE COMMUNITY WHICH WE SERVE. ESTABLISHED IN 1918, OUR MISSION IS TO LEAD THE COMMUNITY WE SERVE TO BETTER HEALTH AND WELL-BEING AT EVERY STAGE OF LIFE. SERVING THE JACKSON COUNTY REGION OF SOUTH-CENTRAL MICHIGAN, W.A. FOOTE MEMORIAL HOSPITAL IS ONE OF THE MAJOR EMPLOYERS IN THE AREA. A GRADUATE MEDICAL EDUCATION PROGRAM OFFERS ROTATIONS TO RESIDENTS, INTERNS AND MEDICAL STUDENTS. A NATIONAL LEADER IN FORMING COMMUNITY PARTNERSHIPS, W.A. FOOTE MEMORIAL HOSPITAL PROMOTES WELLNESS AND PREVENTION THROUGH OUR HEALTH IMPROVEMENT ORGANIZATION.

Form 990, Part III, Line 4b:

W.A. FOOTE MEMORIAL HOSPITAL PROVIDES OUTPATIENT SERVICES AT APPROXIMATELY 40 LOCATIONS THROUGHOUT THE JACKSON COUNTY COMMUNITY OF SOUTH-CENTRAL MICHIGAN. IN TOTAL THIS REPRESENTED 1,309,673 OUTPATIENT VISITS DURING 2019.

Form 990, Part III, Line 4c:

W. A. FOOTE MEMORIAL HOSPITAL OPERATES A 24 HOUR EMERGENCY FACILITY. EMERGENCY SERVICES REPRESENTED 74,614 PATIENT VISITS DURING 2019.

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			
FRANK LAMARCA MD PHYSICIAN	60.00 0.00					X		2,454,189	0	32,032
ROBERT G RINEY TRUSTEE	1.00 64.00	X						0	2,083,776	51,953
AZAM BASHEER MD PHYSICIAN	60.00 0.00					X		2,043,788	0	28,889
AMRITRAJ G LOGANATHAN MD PHYSICIAN	60.00 0.00					X		1,601,579	0	30,786
VISHAL GUPTA MD PHYSICIAN	60.00 0.00					X		1,584,115	0	24,145
GEORGIA R FOJTASEK RN EDD TRUSTEE-PRESIDENT & CEO (THRU 7/19)	58.00 7.00	X		X				0	1,246,674	41,376
ADNAN R MUNKARAH MD PHYSICIAN TRUSTEE	1.00 63.00	X						0	1,180,579	62,113
TUDOR TIEN MD PHYSICIAN	60.00 0.00					X		1,121,129	0	44,093
MOHAN G KULKARNI MD PHYSICIAN TRUSTEE	60.00 1.00	X						1,124,381	0	40,228
ONDREA L BATES RN SVP PATIENT CARE	60.00 5.00				X			556,831	0	35,463

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			
MARK A SMITH MD CMO/CEO HFAHMG	55.00 5.00				X			530,318	0	35,479
KEVIN P LEONARD VP FINANCE/ CFO (THRU 7/19)	55.00 5.00				X			392,818	0	10,408
MICHAEL GRISDELA CFO (THRU 7/19)	55.00 5.00				X			0	346,872	31,233
KENNETH W EMPEY GENERAL COUNSEL	55.00 5.00				X			347,838	74,836	33,858
PAULA AUTRY TRUSTEE-PRESIDENT & CEO (START 8/19)	58.00 7.00	X		X				317,089	0	12,884
JIM BONGIORNO CFO (START 7/19)	55.00 5.00				X			0	215,972	38,433
SANDRA KILIAN MD TRUSTEE	60.00 1.00	X						134,430	0	12,385
DAVID L HALSEY MD TRUSTEE	1.00 1.00	X						36,800	0	0
KEVIN E OXLEY TRUSTEE	1.00 1.00	X						0	0	0
TIMOTHY K LEVY TRUSTEE- CHAIR	2.00 2.00	X		X				0	0	0

SCHEDULE A
(Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.
▶ Attach to Form 990 or Form 990-EZ.
▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
WA FOOTE MEMORIAL HOSPITAL

Employer identification number
38-2027689

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

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

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

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

Part II

Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)
(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III.
If the organization failed to qualify under the tests listed below, please complete Part III.)

Section A. Public Support							
	Calendar year (or fiscal year beginning in) ►	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
1	Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grant.") . . .						
2	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . . .						
3	The value of services or facilities furnished by a governmental unit to the organization without charge..						
4	Total. Add lines 1 through 3						
5	The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f). . .						
6	Public support. Subtract line 5 from line 4.						

Section B. Total Support							
Calendar year (or fiscal year beginning in) ►		(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
7	Amounts from line 4. . .						
8	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . . .						
9	Net income from unrelated business activities, whether or not the business is regularly carried on. . .						
10	Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.). . .						
11	Total support. Add lines 7 through 10						
12	Gross receipts from related activities, etc. (see instructions)					12	
13	First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here ► <input type="checkbox"/>						

Section C. Computation of Public Support Percentage		
14	Public support percentage for 2019 (line 6, column (f) divided by line 11, column (f))	14
15	Public support percentage for 2018 Schedule A, Part II, line 14	15
16a	33 1/3% support test—2019. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization ► <input type="checkbox"/>	
b	33 1/3% support test—2018. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization ► <input type="checkbox"/>	
17a	10%-facts-and-circumstances test—2019. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ► <input type="checkbox"/>	
b	10%-facts-and-circumstances test—2018. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ► <input type="checkbox"/>	
18	Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ► <input type="checkbox"/>	

Part III Support Schedule for Organizations Described in Section 509(a)(2)

(Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . .						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year.						
c Add lines 7a and 7b. .						
8 Public support. (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
9 Amounts from line 6. . .						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. .						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975.						
c Add lines 10a and 10b.						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on.						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) . .						
13 Total support. (Add lines 9, 10c, 11, and 12.) . .						
14 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here. <input type="checkbox"/>						

Section C. Computation of Public Support Percentage

15 Public support percentage for 2019 (line 8, column (f) divided by line 13, column (f))	15	
16 Public support percentage from 2018 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2019 (line 10c, column (f) divided by line 13, column (f))	17	
18 Investment income percentage from 2018 Schedule A, Part III, line 17	18	
19a 33 1/3% support tests—2019. 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 <input type="checkbox"/>		
b 33 1/3% support tests—2018. 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 <input type="checkbox"/>		
20 Private foundation. If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions <input type="checkbox"/>		

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

Part V

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

1		<input type="checkbox"/> Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970 (explain in Part VI). See instructions. All other Type III non-functionally integrated supporting organizations must complete Sections A through E.	
Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1	Net short-term capital gain	1	
2	Recoveries of prior-year distributions	2	
3	Other gross income (see instructions)	3	
4	Add lines 1 through 3	4	
5	Depreciation and depletion	5	
6	Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6	
7	Other expenses (see instructions)	7	
8	Adjusted Net Income (subtract lines 5, 6 and 7 from line 4)	8	
Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):	1	
a	Average monthly value of securities	1a	
b	Average monthly cash balances	1b	
c	Fair market value of other non-exempt-use assets	1c	
d	Total (add lines 1a, 1b, and 1c)	1d	
e	Discount claimed for blockage or other factors (explain in detail in Part VI):		
2	Acquisition indebtedness applicable to non-exempt use assets	2	
3	Subtract line 2 from line 1d	3	
4	Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions).	4	
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5	
6	Multiply line 5 by .035	6	
7	Recoveries of prior-year distributions	7	
8	Minimum Asset Amount (add line 7 to line 6)	8	
Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1	
2	Enter 85% of line 1	2	
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3	
4	Enter greater of line 2 or line 3	4	
5	Income tax imposed in prior year	5	
6	Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	
7	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)		

Part V

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

Section D - Distributions			Current Year
1			Amounts paid to supported organizations to accomplish exempt purposes
2			Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity
3			Administrative expenses paid to accomplish exempt purposes of supported organizations
4			Amounts paid to acquire exempt-use assets
5			Qualified set-aside amounts (prior IRS approval required)
6			Other distributions (describe in Part VI). See instructions
7			Total annual distributions. Add lines 1 through 6.
8			Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions
9			Distributable amount for 2019 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-2019	(iii) Distributable Amount for 2019
1			Distributable amount for 2019 from Section C, line 6
2			Underdistributions, if any, for years prior to 2019 (reasonable cause required-- explain in Part VI). See instructions.
3			Excess distributions carryover, if any, to 2019:
a			From 2014.
b			From 2015.
c			From 2016.
d			From 2017.
e			From 2018.
f			Total of lines 3a through e
g			Applied to underdistributions of prior years
h			Applied to 2019 distributable amount
i			Carryover from 2014 not applied (see instructions)
j			Remainder. Subtract lines 3g, 3h, and 3i from 3f.
4			Distributions for 2019 from Section D, line 7:
			\$
a			Applied to underdistributions of prior years
b			Applied to 2019 distributable amount
c			Remainder. Subtract lines 4a and 4b from 4.
5			Remaining underdistributions for years prior to 2019, 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 2019. 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 2020. Add lines 3j and 4c.
8			Breakdown of line 7:
a			Excess from 2015.
b			Excess from 2016.
c			Excess from 2017.
d			Excess from 2018.
e			Excess from 2019.

Additional Data

Software ID:
Software Version:
EIN: 38-2027689
Name: WA FOOTE MEMORIAL HOSPITAL

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 for instructions and the latest information.

OMB No. 1545-0047

2019

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 WA FOOTE MEMORIAL HOSPITAL	Employer identification number 38-2027689
--	--

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4a	Was a correction made?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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) 2016	(b) 2017	(c) 2018	(d) 2019	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

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

		(a)		(b)
		Yes	No	Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a	Volunteers?		No	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?	Yes		
c	Media advertisements?		No	
d	Mailings to members, legislators, or the public?		No	
e	Publications, or published or broadcast statements?		No	
f	Grants to other organizations for lobbying purposes?		No	
g	Direct contact with legislators, their staffs, government officials, or a legislative body?	Yes		50,455
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?		No	
j	Total. Add lines 1c through 1i			50,455
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

Part IV Supplemental Information

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

Return Reference	Explanation
PART II-B, LINE 1:	HEALTH CARE IS A HIGHLY-REGULATED FIELD, REQUIRING FREQUENT AND HIGH-LEVEL COMMUNICATION WITH REGULATORS AND ELECTED OFFICIALS. A SMALL INVESTMENT IN LOBBYING ENABLES US TO REMAIN IN CONTACT WITH LEGISLATORS AND GOVERNMENT AGENCIES, MAXIMIZE THE RESOURCES WITH WHICH WE ARE ENTRUSTED AND ASSURE THAT WE PROVIDE THE BEST CARE TO OUR COMMUNITY. W.A. FOOTE MEMORIAL HOSPITAL DBA HENRY FORD ALLEGIANCE HEALTH ENLISTS THE SERVICES OF SEVERAL LOBBYING CONSULTANTS, ATTORNEYS AND HEALTHCARE TRADE ASSOCIATIONS. IN ADDITION, THE HOSPITAL EMPLOYS A CORPORATE ACCOUNTS SPECIALIST. THE SPECIALIST SPENDS A PORTION OF HIS TIME CONTACTING LEGISLATORS, PARTICIPATING IN GRASS ROOTS ADVOCACY, AND OTHER ACTIVITIES CLOSELY RELATED TO LOBBYING.

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

► Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
► Attach to Form 990.
► Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
WA FOOTE MEMORIAL HOSPITAL

Employer identification number
38-2027689

Part I

Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.

Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

	(a) Donor advised funds	(b) Funds and other accounts
1 Total number at end of year		
2 Aggregate value of contributions to (during year)		
3 Aggregate value of grants from (during year)		
4 Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?

☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?

☐ Yes ☐ No

Part II

Conservation Easements.

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

1 Purpose(s) of conservation easements held by the organization (check all that apply).

☐ Preservation of land for public use (e.g., recreation or education)

☐ Preservation of an historically important land area

☐ Protection of natural habitat

☐ Preservation of a certified historic structure

☐ Preservation of open space

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year.

	Held at the End of the Year
a Total number of conservation easements	2a
b Total acreage restricted by conservation easements	2b
c Number of conservation easements on a certified historic structure included in (a)	2c
d Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register	2d

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

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

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

☐ Yes ☐ No

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

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

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?

☐ Yes ☐ No

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

Part III

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

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

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

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

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

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

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

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

b Assets included in Form 990, Part X ► \$

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

Cat. No. 52283D

Schedule D (Form 990) 2019

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	3,183,393	2,713,012	2,037,753	1,614,108	1,451,944
b Contributions	1,800,000	2,074,346	1,513,373	471,995	463,114
c Net investment earnings, gains, and losses	192,950	-50,758	93,086	19,074	12,856
d Grants or scholarships					
e Other expenditures for facilities and programs	2,311,804	1,553,207	931,200	67,424	313,806
f Administrative expenses					
g End of year balance	2,864,539	3,183,393	2,713,012	2,037,753	1,614,108

2

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

a

Board designated or quasi-endowment ▶

b

Permanent endowment ▶ 30.860 %

c

Temporarily restricted endowment ▶ 69.140 %

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

3a(i)

Yes

No

(ii) related organizations

3a(ii)

Yes

b

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

3b

Yes

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		9,540,626		9,540,626
b Buildings		168,346,414	28,134,185	140,212,229
c Leasehold improvements		210,800	123,908	86,892
d Equipment		146,385,739	63,015,639	83,370,100
e Other		13,479,859		13,479,859
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).) . . . ▶				246,689,706

Schedule D (Form 990) 2019

Part VII

Investments—Other Securities.

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

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

Part VIII

Investments—Program Related.

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

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

Part IX

Other Assets.

Complete if the organization answered 'Yes' on Form 990, Part IV, line 11d. See Form 990, Part X, line 15.

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

Part X

Other Liabilities.

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

(a) Description of liability	(b) Book value
1. Federal income taxes	
Total. (Column (b) must equal Form 990, Part X, col.(B) line 25.) ▶	69,050,225

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

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

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

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

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

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

Part XIII Supplemental Information

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

Return Reference	Explanation
See Additional Data Table	

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

Additional Data

Software ID:
Software Version:
EIN: 38-2027689
Name: WA FOOTE MEMORIAL HOSPITAL

Supplemental Information

Return Reference	Explanation
PART V, LINE 4:	THE ORGANIZATION'S ENDOWMENT FUNDS ARE USED FOR VARIOUS CHARITABLE HOSPITAL PROGRAMS INCLU DING TREATMENT OF UNINSURED PATIENTS, COMMUNITY PREVENTATIVE HEALTH EDUCATION, PROGRAM DEV ELOPMENT AND CAPITAL IMPROVEMENTS.

Supplemental Information	
Return Reference	Explanation
PART X, LINE 2:	THE SYSTEM DOES NOT HAVE ANY MATERIAL UNCERTAIN TAX POSITIONS AS OF DECEMBER 31, 2019 AND 2018.

SCHEDULE F
(Form 990)

Department of the Treasury
Internal Revenue Service

Statement of Activities Outside the United States

► Complete if the organization answered "Yes" to Form 990, Part IV, line 14b, 15, or 16.
► Attach to Form 990.
► Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
WA FOOTE MEMORIAL HOSPITAL

Employer identification number
38-2027689

Part I

General Information on Activities Outside the United States. Complete if the organization answered "Yes" on Form 990, Part IV, line 14b.

- 1 For grantmakers. Does the organization maintain records to substantiate the amount of its grants and other assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? ☐ Yes ☐ No
- 2 For grantmakers. Describe in Part V the organization's procedures for monitoring the use of its grants and other assistance outside the United States.
- 3 Activities per Region. (The following Part I, line 3 table can be duplicated if additional space is needed.)

(a) Region	(b) Number of offices in the region	(c) Number of employees, agents, and independent contractors in the region	(d) Activities conducted in region (by type) (such as, fundraising, program services, investments, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in the region	(f) Total expenditures for and investments in the region
CENTRAL AMERICA AND CARRIBEAN			INVESTMENTS		27,243,556
3a Sub-total	0	0			27,243,556
b Total from continuation sheets to Part I	0	0			0
c Totals (add lines 3a and 3b)	0	0			27,243,556

Part II **Grants and Other Assistance to Organizations or Entities Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 15, for any recipient who received more than \$5,000. Part II can be duplicated if additional space is needed.

1	(a) Name of organization	(b) IRS code section and EIN (if applicable)	(c) Region	(d) Purpose of grant	(e) Amount of cash grant	(f) Manner of cash disbursement	(g) Amount of noncash assistance	(h) Description of noncash assistance	(i) Method of valuation (book, FMV, appraisal, other)

- 2 Enter total number of recipient organizations listed above that are recognized as charities by the foreign country, recognized as tax-exempt by the IRS, or for which the grantee or counsel has provided a section 501(c)(3) equivalency letter ► _____
- 3 Enter total number of other organizations or entities ► _____

Part III	Grants and Other Assistance to Individuals Outside the United States. Complete if the organization answered "Yes" on Form 990, Part IV, line 16.
-----------------	---

Part III can be duplicated if additional space is needed.

[illegible]

Part IV Foreign Forms

- 1 Was the organization a U.S. transferor of property to a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 926, Return by a U.S. Transferor of Property to a Foreign Corporation (see Instructions for Form 926)* ☐ Yes ☒ No
- 2 Did the organization have an interest in a foreign trust during the tax year? *If "Yes," the organization may be required to separately file Form 3520, Annual Return to Report Transactions with Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U.S. Owner (see Instructions for Forms 3520 and 3520-A; don't file with Form 990)* ☐ Yes ☒ No
- 3 Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U.S. Persons with Respect to Certain Foreign Corporations. (see Instructions for Form 5471)* ☐ Yes ☒ No
- 4 Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? *If "Yes," the organization may be required to file Form 8621, Information Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund. (see Instructions for Form 8621)* . ☐ Yes ☒ No
- 5 Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U.S. Persons with Respect to Certain Foreign Partnerships (see Instructions for Form 8865)* ☒ Yes ☐ No
- 6 Did the organization have any operations in or related to any boycotting countries during the tax year? *If "Yes," the organization may be required to separately file Form 5713, International Boycott Report (see Instructions for Form 5713; don't file with Form 990).* ☒ Yes ☐ No

Part V

Supplemental Information

Provide the information required by Part I, line 2 (monitoring of funds); Part I, line 3, column (f) (accounting method; amounts of investments vs. expenditures per region); Part II, line 1 (accounting method); Part III (accounting method); and Part III, column (c) (estimated number of recipients), as applicable. Also complete this part to provide any additional information. See instructions.

990 Schedule F, Supplemental Information

Return Reference	Explanation
PART III ACCOUNTING METHOD:	

SCHEDULE H
(Form 990)

Department of the Treasury
Internal Revenue Service

Name of the organization
WA FOOTE MEMORIAL HOSPITAL

Hospitals

► Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
► Attach to Form 990.
► Go to www.irs.gov/Form990EZ for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Employer identification number
38-2027689

Part I Financial Assistance and Certain Other Community Benefits at Cost

		Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	Yes
b	If "Yes," was it a written policy?	1b	Yes
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year. a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other <u>25000.0000000000 %</u> 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 _____ % c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care. 4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"? 5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care? 6a Did the organization prepare a community benefit report during the tax year? b If "Yes," did the organization make it available to the public? Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.	3a	Yes
		3b	No
		4	Yes
		5a	Yes
		5b	No
		5c	
		6a	Yes
		6b	Yes

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			6,964,933		6,964,933	1.050 %
b Medicaid (from Worksheet 3, column a)			190,521,903	134,454,054	56,067,849	8.480 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			197,486,836	134,454,054	63,032,782	9.530 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4).			14,662,456	12,115,188	2,547,268	0.390 %
f Health professions education (from Worksheet 5)			16,901,234	6,778,376	10,122,858	1.530 %
g Subsidized health services (from Worksheet 6)			22,234,054	17,136,955	5,097,099	0.770 %
h Research (from Worksheet 7)			160,926	0	160,926	0.020 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)			489,819	0	489,819	0.070 %
j Total. Other Benefits			54,448,489	36,030,519	18,417,970	2.780 %
k Total. Add lines 7d and 7j			251,935,325	170,484,573	81,450,752	12.310 %

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support			14,352		14,352	0 %
4 Environmental improvements						
5 Leadership development and training for community members			5,979		5,979	0 %
6 Coalition building			353,885	120	353,765	0.050 %
7 Community health improvement advocacy						
8 Workforce development						
9 Other						
10 Total			374,216	120	374,096	0.050 %

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

		Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1		No
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	2		
	5,716,588		
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3		
	1,429,147		
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME)	5	198,492,061
6 Enter Medicare allowable costs of care relating to payments on line 5	6	226,328,164
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-27,836,103
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:		
<input type="checkbox"/> Cost accounting system	<input checked="" type="checkbox"/> Cost to charge ratio	<input type="checkbox"/> Other

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1 1 FOOTE HEALTH CENTER ASSOCIATES	ENTITY LEASES MEDICAL OFFICE SPACE.	62.000 %	0 %	38.000 %
2 2 GRASS LAKE REAL ESTATE LLC	TO BUILD AND MANAGE OUTPATIENT SURGICAL CENTER	46.000 %	0 %	46.000 %
3 3 GRASS LAKE SURGERY CENTER LLC	TO OPERATE OUTPATIENT SURGICAL CENTER	46.000 %	0 %	46.000 %
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

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

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

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

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

	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)
WA FOOTE MEMORIAL HOSPITAL**Name of hospital facility or letter of facility reporting group** _____**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** _____**1****Community Health Needs Assessment**

	Yes	No
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C.	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12. If "Yes," indicate what the CHNA report describes (check all that apply):	3	Yes
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>19</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C.	6b	No
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply):	7	Yes
a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>SEE LINE 10A BELOW</u>		
b <input type="checkbox"/> Other website (list url): _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11.	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>19</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? HTTPS://WWW.HENRYFORD.COM/ABOUT/COMMUNITY-HEALTH/NEEDS-	10	Yes
a If "Yes" (list url): <u>ASSESSMENT</u>		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

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

WA FOOTE MEMORIAL HOSPITAL

Name of hospital facility or letter of facility reporting group _____

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	13 Yes	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>250.000000000000</u> % and FPG family income limit for eligibility for discounted care of _____ %		
b	<input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input checked="" type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance discount		
g	<input checked="" type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	14 Yes	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	15 Yes	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	16 Yes	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>HTTPS://WWW.HENRYFORD.COM/VISITORS/BILLING/FINANCIAL-ASSISTANCE</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>HTTPS://WWW.HENRYFORD.COM/VISITORS/BILLING/FINANCIAL-ASSISTANCE</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>HTTPS://WWW.HENRYFORD.COM/VISITORS/BILLING/FINANCIAL-ASSISTANCE</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input type="checkbox"/> Other (describe in Section C)		

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

WA FOOTE MEMORIAL HOSPITAL

Name of hospital facility or letter of facility reporting group _____

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

Policy Relating to Emergency Medical Care

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

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

WA FOOTE MEMORIAL HOSPITAL

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

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

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

If "Yes," explain in Section C.

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

If "Yes," explain in Section C.

	Yes	No
23		No
24		No

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, 20a, 20b, 20c, 20d, 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? 72

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

Part VI Supplemental Information

Provide the following information.

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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7G:	SUBSIDIZED SERVICES CONSIST OF FACILITY COSTS OF WOMEN'S AND BEHAVIORAL HEALTH SERVICES.
PART I, LN 7 COL(F):	THE BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25(A), BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGE IN THIS COLUMN IS \$5,716,588

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART II, COMMUNITY BUILDING ACTIVITIES:	HFAH BELIEVES THAT THE STRENGTH AND VITALITY OF A COMMUNITY HAS A SIGNIFICANT IMPACT ON THE BEHAVIORS OF ITS RESIDENTS AND THAT THERE IS DIRECT CORRELATION BETWEEN THE VIABILITY OF A COMMUNITY AND THE ATTITUDE OF ITS RESIDENTS TOWARD HEALTHIER BEHAVIORS. THEREFORE, HFAH INCLUDES IN ITS COMMITMENT TO COMMUNITY BENEFIT A FOCUS ON DIRECT INVOLVEMENT IN THE COMMUNITY TO BOTH IMPROVE THE ENVIRONMENT AND ENSURE THAT CRITICAL MESSAGES ON THE BENEFITS OF HEALTHIER BEHAVIORS ARE HEARD. HFAH LEADERS COLLABORATE WITH COMMUNITY TASK FORCES AND COALITIONS IN ADDRESSING THE NEEDS OF OUR SERVICE AREA.
PART III, LINE 2:	THE ORGANIZATION'S BAD DEBT EXPENSE IS STATED IN PATIENT GROSS CHARGES.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 4:	<p>IN EVALUATING THE COLLECTABILITY OF ACCOUNTS RECEIVABLE, THE ORGANIZATION ANALYZES ITS PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYOR SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR DOUBTFUL ACCOUNTS AND PROVISION FOR BAD DEBTS. MANAGEMENT REGULARLY REVIEWS DATA ABOUT THESE MAJOR PAYOR SOURCES OF REVENUE IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS. FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, THE ORGANIZATION ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND A PROVISION FOR BAD DEBTS. FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS (WHICH INCLUDE BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND CO-PAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR A PORTION OF THE BILL), THE ORGANIZATION RECORDS A PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE. AT SUCH POINT IN TIME THAT A BILLED SERVICE IS BELIEVED TO BE UNCOLLECTIBLE, THE RELATED RECEIVABLE IS WRITTEN OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS. ESTIMATES OF RETROACTIVE ADJUSTMENTS UNDER REIMBURSEMENT AGREEMENTS WITH THIRD-PARTY PAYORS ARE ACCRUED IN THE PERIOD THE RELATED SERVICES ARE RENDERED AND ADJUSTED IN FUTURE PERIODS AS FINAL SETTLEMENTS ARE RECEIVED. FOR UNINSURED PATIENTS THAT DO NOT QUALIFY FOR FINANCIAL ASSISTANCE, THE ORGANIZATION OFFERS A DISCOUNT OFF STANDARD RATES FOR SERVICES PROVIDED THAT RESULT IN NET CHARGES THAT DO NOT EXCEED 115% OF MEDICARE RATES. FOR UNINSURED PATIENTS WHO MEET THE QUALIFICATIONS STIPULATED IN THE ORGANIZATION'S PATIENT FINANCIAL ASSISTANCE POLICY, EMERGENCY AND OTHER MEDICALLY NECESSARY INPATIENT AND OUTPATIENT SERVICES ARE PROVIDED AT NO COST. THE ORGANIZATION DETERMINES THE COSTS OF SUCH UNPAID SERVICES BY APPLYING A COST-TO-CHARGE RATIO TO THE BILLED CHARGES</p>
PART III, LINE 9B:	<p>SHOULD A PATIENT BE DEEMED ELIGIBLE FOR ASSISTANCE ANY COLLECTION EFFORTS ASSOCIATED WITH THE QUALIFYING SERVICE ARE SUSPENDED. IF THE PATIENT IS DETERMINED TO QUALIFY UNDER THE ORGANIZATION'S PATIENT FINANCIAL ASSISTANCE POLICY PRIOR TO BILLING, NO BILL IS EVER GENERATED AND THEREFORE THE ELEMENTS OF THE COLLECTION POLICY ARE NEVER INVOKED. WHEN THE DETERMINATION IS NOT MADE PRIOR TO THE BILLING, THE ORGANIZATION'S COLLECTION POLICY WOULD APPLY. THIS POLICY READS IN PART:- "PATIENTS WILL BE EVALUATED FOR THE SYSTEM'S PATIENT FINANCIAL ASSISTANCE PROGRAM"- "UNINSURED PATIENTS WILL BE GIVEN A DISCOUNT"- "UNDERINSURED PATIENTS MAY QUALIFY FOR DISCOUNTED SERVICES BASED UPON THEIR AGGREGATE HOUSEHOLD INCOME" - "THE ORGANIZATION WILL REVIEW THE PATIENTS'S RECORD TO DETERMINE IF REASONABLE EFFORTS WERE UNDERTAKEN TO ENSURE THAT FINANCIAL ASSISTANCE WAS OFFERED AND/OR IF FINANCIAL ASSISTANCE IS REQUESTED"- "LEGAL ACTION...MAY BE TAKEN...WHEN THERE IS EVIDENCE THAT THE PATIENT OR RESPONSIBLE PARTY HAS INCOME AND/OR ASSETS TO MEET HIS OR HER OBLIGATION"- "THE ORGANIZATION WILL NOT FORCE THE SALE OF FORECLOSURE OF ANY PATIENT OR GUARANTOR'S PRIMARY RESIDENCE TO PAY AN OUTSTANDING MEDICAL BILL"- "THE ORGANIZATION WILL NOT...REQUIRE THE PATIENT OR RESPONSIBLE PARTY TO APPEAR IN COURT"- "THE ORGANIZATION WILL DIRECT THEIR COLLECTION AGENCIES TO FOLLOW THESE GUIDELINES"</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 2:	<p>HENRY FORD HEALTH SYSTEM (HFHS) CONSIDERS THE ONGOING ASSESSMENT OF COMMUNITY HEALTH NEEDS AS AN ESSENTIAL FUNCTION. HENRY FORD ALLEGIANCE HOSPITAL WAS ENCOMPASSED IN THE HFHS COMMUNITY HEALTH NEEDS ASSESSMENT. IT PROVIDES KEY INFORMATION REGARDING THE DEMOGRAPHICS AND MAJOR NEEDS OF THE COMMUNITIES SERVED, IT SUPPORTS THE PRIORITIZATION OF THE SERVICES MADE AVAILABLE, AND IT HELPS TARGET POPULATIONS WITH THE MOST VULNERABILITY TO HEALTH NEEDS SUCH AS THE POOR, UNINSURED, AS WELL AS VARIOUS OTHER POPULATIONS THAT MAY HAVE BEEN OVERLOOKED. THE COMMUNITY HEALTH NEEDS ASSESSMENT ALSO PROVIDES VALUABLE INFORMATION REGARDING OTHER ORGANIZATIONS SUPPORTING THE NEEDS WITHIN THE COMMUNITY SO PROGRAMS CAN BE COORDINATED AND LEVERAGED TO ENSURE THAT EVERY DOLLAR IS INVESTED WISELY. INTERNALLY THE COMMUNITY HEALTH ANCHOR COUNCIL ENTERPRISE (CHANCE) PROVIDES EXECUTIVE OVERSIGHT OF THE COMMUNITY HEALTH NEEDS ASSESSMENT FOR HENRY FORD HEALTH SYSTEM. THE CHNA WAS COMPLETED IN SEVERAL PHASES. THE FIRST PHASE INCLUDED DATA COLLECTION FROM A VARIETY OF PUBLIC AND PROPRIETARY SOURCES THAT PROVIDED INFORMATION AROUND POPULATION DEMOGRAPHICS, SOCIOECONOMIC DATA, HEALTH STATUS INDICATORS AS WELL AS SEVERAL OTHER DATA ELEMENTS. THE SECOND PHASE INVOLVED DEVELOPING AND DISTRIBUTING A KEY STAKEHOLDER SURVEY TO CAPTURE COMMUNITY ORGANIZATION AND COALITION INPUT AS TO MAJOR HEALTH NEEDS THEY BELIEVE THAT SHOULD PRIORITIZED AND ADDRESSED IN THE FOUR-COUNTY AREA. THE THIRD PHASE INCORPORATED QUANTITATIVE AND QUALITATIVE DATA COLLECTED IN THE FIRST TWO PHASES AND BASED ON THIS INFORMATION IDENTIFIED PRIORITIES FOR HENRY FORD HEALTH SYSTEM TO ADDRESS WITHIN THE COMMUNITIES IT SERVES. THIS ASSESSMENT WAS PREPARED JOINTLY BY THE HFHS BUSINESS INTEGRITY SERVICES AND CORPORATE STRATEGIC PLANNING DEPARTMENTS, ALONG WITH THE OFFICE OF COMMUNITY HEALTH, EQUITY AND WELLNESS. RESULTS ARE BEING USED AS A FOUNDATION FOR PLANNING, DEVELOPING, AND REFINING HFHS'S FUTURE COMMUNITY SERVICES IN THE FOUR-COUNTY AREAS. RESULTS OF THIS ASSESSMENT HAVE BEEN REVIEWED WITH SEVERAL HENRY FORD HEALTH SYSTEM LEADERS, LEADING TO STRATEGIC AND IMPLEMENTATION PLAN MODIFICATIONS TO ALIGN STRATEGY WITH IDENTIFIED NEEDS.</p>
PART VI, LINE 3:	<p>HFAH HAS VARIOUS APPROACHES TO TARGET AND INFORM RESIDENTS OF ITS COMMUNITIES ABOUT THE PROGRAMS AND SERVICES IT OFFERS. PROGRAMS WHERE WE PARTNER WITH ORGANIZATIONS WITH ESTABLISHED RELATIONSHIPS WITH THE INDIVIDUALS SUCH AS THROUGH COMMUNITY HEALTH CENTERS, THE PUBLIC SCHOOLS AND FAITH-BASED ORGANIZATIONS HAVE BEEN PARTICULARLY SUCCESSFUL. HFAH FOLLOWS THE HFHS PATIENT FINANCIAL ASSISTANCE POLICY. HFHS HAS A SINGULAR PATIENT FINANCIAL ASSISTANCE POLICY (PFAP). INDIVIDUALS WITHOUT ADEQUATE HEALTH INSURANCE COVERAGE MOST FREQUENTLY APPEAR IN OUR EMERGENCY ROOM FOR SERVICES, ALL PATIENTS ARE SEEN WITHOUT REGARD TO ABILITY TO PAY. INTAKE STAFF IS TRAINED HOW TO APPROACH AND ENGAGE AN INDIVIDUAL WHEN THERE IS AN APPARENT LACK OF ADEQUATE HEALTH COVERAGE. THIS INCLUDES INFORMING THEM OF THE PROGRAMS OFFERED BY HFAH AS WELL AS OTHER COMMUNITY, LOCAL, STATE AND FEDERAL PROGRAMS OFFERING POTENTIAL SUPPORT. HFAH HAS DEDICATED STAFF RESPONSIBLE TO IDENTIFY PATIENTS WHO MAY QUALIFY FOR SUPPORTIVE PROGRAMS AND ASSIST THEM WITH THE ENROLLMENT PROCESS. THERE ARE MANY REASONS WHY A PATIENT IN NEED OF FINANCIAL ASSISTANCE WITH THEIR MEDICAL CARE MAY NOT HAVE BEEN IDENTIFIED AT THE TIME OF THE CARE DELIVERY. PATIENT FINANCIAL SERVICE AND COLLECTION STAFFS ARE TRAINED TO RECOGNIZE THESE INDIVIDUALS AND PROVIDE THEM WITH ADVICE REGARDING THE VARIOUS OPTIONS AVAILABLE TO SUPPORT THEIR CARE NEEDS.</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 4:	<p>THE FOUR-COUNTY AREA INCLUDES THE COUNTIES OF WAYNE, OAKLAND, MACOMB, AND JACKSON WHICH ARE LOCATED IN SOUTHEASTERN AND SOUTHCENTRAL MICHIGAN AND ACCOUNT FOR 41% OF THE MICHIGAN POPULATION. WAYNE, OAKLAND, AND MACOMB (IN THAT ORDER) ARE THE MOST POPULATED COUNTIES IN MICHIGAN. JACKSON COUNTY IS MUCH SMALLER. OF THE NEARLY 4 MILLION RESIDENTS, APPROXIMATELY 51% OF THE POPULATION IS FEMALE. WITH REGARD TO RACE/ETHNICITY, THE FOUR-COUNTY AREA IS 64% WHITE, COMPARED TO A NATIONAL AVERAGE OF 60%. OF NOTE, THE FOUR-COUNTY AREA IS 24% BLACK, WHICH IS TWICE THE NATIONAL PERCENTAGE OF 12%. CONVERSELY, THE HISPANIC POPULATION (5.0%) IS A LITTLE UNDER ONE THIRD THE NATIONAL PERCENTAGE OF 18%.THE NUMBER OF FOUR-COUNTY RESIDENTS IS EXPECTED TO REMAIN FLAT OVER THE NEXT SEVERAL YEARS. WHEN EXAMINING AGE DISTRIBUTION, THE FOUR-COUNTY AREA HAS A COMPARABLE POPULATION TO THAT OF THE COUNTRY WITH 17% OF THE POPULATION ABOVE THE AGE OF 65. OF PARTICULAR INTEREST TO HEALTHCARE PROVIDERS IS THE AGING POPULATION OF THE FOUR-COUNTY AREA WITH THE 65-YEARS-OLD AND ABOVE POPULATION EXPECTED TO RISE BY 15% FROM 2019 TO 2024.WITH REGARDS TO EDUCATION, THE FOUR-COUNTY AREA HAS APPROXIMATELY 11% OF RESIDENTS WHO HAVE SOME HIGH SCHOOL EDUCATION OR LESS COMPARED TO THE NATIONAL AVERAGE OF 13%. FURTHER, 29% OF RESIDENTS HAVE A BACHELOR'S DEGREE OR GREATER, WHICH IS COMPARABLE TO THE NATIONAL AVERAGE. THE FOUR-COUNTY AREA IS DIVERSE IN POPULATION, RACE/ETHNICITY, ECONOMIC GROWTH AND DEVELOPMENT. THE AUTOMOTIVE INDUSTRY REMAINS THE LARGEST EMPLOYER IN THE REGION, BUT THE HEALTH CARE SECTOR IS REPRESENTED AMONG THE TOP EMPLOYERS IN THE REGION AS WELL. THE AVERAGE MEDIAN HOUSEHOLD INCOME WITHIN THE FOUR-COUNTY AREA (\$56,240) IS SLIGHTLY LESS THAN THE NATIONAL AVERAGE (\$57,652). WITHIN THE FOUR-COUNTY AREA, THE MEDIAN HOUSEHOLD INCOME IN OAKLAND COUNTY (\$73,369) IS SIGNIFICANTLY HIGHER THAN WAYNE COUNTY (\$43,702), JACKSON COUNTY (\$49,715) AND MACOMB COUNTY (\$58,175). AT THE ZIP CODE LEVEL, AVERAGE HOUSEHOLD INCOMES VARY SIGNIFICANTLY.LOWER HOUSEHOLD INCOMES NEGATIVELY IMPACT PURCHASING POWER, HEALTH INSURANCE COVERAGE, AND COSTS OF BASIC NECESSITIES. AS A RESULT, THE FOUR-COUNTY AREA'S SAFETY NETS, INCLUDING HEALTHCARE SYSTEMS, ARE BEING STRETCHED TO THE LIMIT. MICHIGAN RANKS 33RD IN THE COUNTRY FOR CHILDREN UNDER 18 IN FAMILIES BELOW THE POVERTY LEVEL, AT 19.3%, A 3% IMPROVEMENT FROM 2016. UNEMPLOYMENT IN MICHIGAN HAS DROPPED TO 4.6% IN 2018, WHICH IS SIMILAR TO THE NATIONAL AVERAGE AND A DECLINE OF 0.8% SINCE 2016 IN MICHIGAN. CONVERSELY, WITHIN THE FOUR-COUNTY AREA THE UNEMPLOYMENT RATE MATCHES THE NATIONAL AVERAGE OF 4% AND RANGES FROM 3.2% IN OAKLAND COUNTY TO 5.0% IN WAYNE COUNTY.THERE ARE KEY DEMOGRAPHIC DIFFERENCES BETWEEN THE RESIDENTS OF EACH COUNTY WITHIN THE FOUR-COUNTY AREA. FOR EXAMPLE, AGE, SEX, EDUCATION, AND INCOME DISTRIBUTION DIFFER FROM COUNTY TO COUNTY. IN ORDER TO INCREASE THE UTILITY OF THE COMMUNITY HEALTH NEEDS ASSESSMENT, IT IS IMPORTANT TO ANALYZE THE PROFILE(S) OF EACH OF THESE COUNTIES AT A MORE DETAILED LEVEL, SUCH AS ZIP CODES, SO THAT CERTAIN DIFFERENCES WITHIN THE AREA BECOME EVIDENT.ONE COMMUNITY IN PARTICULAR NEED OF ATTENTION IS THE CITY OF DETROIT. WHEN EXAMINING THE CITY OF DETROIT THE AVERAGE HOUSEHOLD INCOME IS \$40,314, WHICH IS SIGNIFICANTLY LESS THAN AVERAGE HOUSEHOLD INCOME OF THE OVERALL FOUR-COUNTY AREA (\$68,064). REGARDING EDUCATION, 23% OF RESIDENTS HAVE LESS THAN A HIGH SCHOOL EDUCATION AND ONLY 14% HAVE A BACHELOR'S DEGREE OR HIGHER. IN TERMS OF RACE/ETHNICITY, APPROXIMATELY 91% OF DETROIT IS COMPOSED OF A MINORITY POPULATION VERSUS 37% FOR THE FOUR-COUNTY AREA AS A WHOLE. THE DETROIT UNEMPLOYMENT RATE IS 7.9% (NOVEMBER 2018), DOWN FROM 11.5% IN SEPTEMBER 2015.WHEN LOOKING OUTSIDE OF THE CITY OF DETROIT, VARIOUS OTHER ZIP CODES IN THE FOUR-COUNTY AREA INDICATE SECTIONS OF THE REGION THAT HAVE LOWER INCOMES, LESS EDUCATION, AND ARE MORE RACIALLY AND ETHNICALLY DIVERSE. THE AVERAGE HOUSEHOLD INCOME OF THESE ZIP CODES RANGES FROM \$29,486-\$54,251, LOWER THAN THE FOUR-COUNTY SERVICE AREA. OVERALL, 17% OF RESIDENTS IN THESE ZIP CODES HAVE LESS THAN A HIGH SCHOOL EDUCATION COMPARED TO 11% FOR THE FOUR-COUNTY AREA. THESE TWENTY ZIP CODES HAVE A SLIGHTLY DIFFERENT PERCENTAGE OF RACIAL/ETHNIC MINORITIES AS COMPARED TO THE REST OF THE FOUR-COUNTY AREA. AS A WHOLE THESE ZIP CODES ARE COMPOSED OF 40% MINORITIES COMPARED TO 36% FOR THE FOUR-COUNTY AREA.AS A RESULT, THE CITY OF DETROIT AND ABOVE TWENTY ZIP CODES ARE OF PARTICULAR INTEREST IN PLANNING COMMUNITY NEEDS INITIATIVES WITHIN THE FOUR-COUNTY AREA.</p>
PART VI, LINE 5:	<p>HENRY FORD ALLEGIANCE HOSPITAL (HFAH) IS PART OF HENRY FORD HEALTH SYSTEM, ONE OF THE NATION'S LARGEST INTEGRATED HEALTH DELIVERY SYSTEMS SERVING SOUTHEASTERN MICHIGAN. THIS TAX RETURN REFLECTS ACTIVITIES OF HFAH, WHICH INCLUDES APPROXIMATELY 365 INPATIENT BEDS WITH AN INTEGRATED MEDICAL STAFF SERVING MORE THAN 40 FACILITIES IN THE JACKSON COUNTY AREA OF MICHIGAN. HFAH IS GOVERNED BY A DEDICATED VOLUNTEER COMMUNITY BOARD AND IT PROVIDES ITS COMMUNITIES WITH A FULL RANGE OF CLINICAL SERVICES INCLUDING GENERAL MEDICINE, SURGERY, OBSTETRICS, PEDIATRICS, CARDIAC CARE, PHYSICAL AND REHABILITATION MEDICINE, AMBULATORY SURGERY, INPATIENT AND OUTPATIENT BEHAVIORAL SERVICES, AND 24 HOUR EMERGENCY CARE.</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 6:	THE SYSTEM DEMONSTRATES ITS EXEMPT PURPOSE TO BENEFIT THE COMMUNITY BY OPERATING EMERGENCY ROOMS OPEN TO THE PUBLIC 24 HOURS A DAY, 7 DAYS A WEEK; PROVIDING FACILITIES FOR THE EDUCATION AND TRAINING OF HEALTH CARE PROFESSIONALS; AND MAINTAINING RESEARCH FACILITIES FOR THE STUDY OF NEW DRUGS AND MEDICAL DEVICES THAT OFFER THE PROMISE OF IMPROVING HEALTH CARE. THE SYSTEM ALSO PROVIDES COMMUNITY HEALTH SERVICES, SUCH AS COMMUNITY EDUCATION AND OUTREACH IN THE FORM OF FREE OR LOW-COST CLINICS; HEALTH EDUCATION TELEVISION PROGRAMMING; DONATIONS FOR THE COMMUNITY; MULTIPLE HEALTH PROMOTION AND WELLNESS PROGRAMS, SUCH AS HEALTH SCREENING; AND VARIOUS COMMUNITY PROJECTS AND SUPPORT GROUPS.

Additional Data

Software ID:
Software Version:
EIN: 38-2027689
Name: WA FOOTE MEMORIAL HOSPITAL

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

Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? 1		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (Describe)	Facility reporting group
1	WA FOOTE MEMORIAL HOSPITAL 205 N EAST AVENUE JACKSON, MI 49201 WWW.HENRYFORD.COM	X	X		X		X	X			

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

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

Form and Line Reference	Explanation
W.A. FOOTE MEMORIAL HOSPITAL	PART V, SECTION B, LINE 5: OUR METHODOLOGY FOR DATA COLLECTION INVOLVED REACHING OUT TO COMMUNITY EXPERTS AND OTHER MEMBERS OF COMMUNITY AGENCIES IN JACKSON COUNTY USING A WEB-BASED 5-QUESTION SURVEY. THE SURVEY WAS DISTRIBUTED TO HEALTH LEADERS AND OTHER RESPECTED INDIVIDUALS WITHIN THE COMMUNITY REPRESENTING PUBLIC AGENCIES AND PROGRAMS FROM MAY THROUGH JULY OF 2019. INDIVIDUALS SURVEYED INCLUDED LEADERS FROM AGENCIES SUCH AS JACKSON COUNTY HEALTH DEPARTMENT, LIFE MISSIONS CENTER, CATHOLIC CHARITIES OF JACKSON, LENAWEE AND HILLSDALE COUNTIES, COMMUNITY ACTION AGENCY, UNITED WAY OF JACKSON COUNTY AND MANY OTHERS. PARTICIPANTS HAD A WIDE RANGE OF EXPERTISE. FROM THEIR SURVEY RESPONSES WE GAINED INSIGHT INTO THE KINDS OF HEALTH ISSUES FACING OUR COMMUNITIES. OUR METHODOLOGY ALSO INCLUDED A WIDE VARIETY OF SECONDARY DATA SOURCES IN ADDITION TO RESULTS OBTAINED FROM BOTH SURVEY AND FOCUS GROUP PARTICIPANTS IN OAKLAND, MACOMB AND WAYNE COUNTIES. ADDITIONALLY, WE LOCATED STATE HEALTH NEEDS DATA FOR HFHS USING THE MICHIGAN BEHAVIORAL RISK FACTOR SURVEY AND MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES PROFILES AMONG OTHER SOURCES. DATA FROM THESE SOURCES CAN BE FOUND IN THE APPENDIX.
W.A. FOOTE MEMORIAL HOSPITAL	PART V, SECTION B, LINE 6A: HENRY FORD HOSPITALHENRY FORD KINGSWOOD HOSPITALHENRY FORD MACOMB HOSPITALSHENRY FORD WEST BLOOMFIELD HOSPITALHENRY FORD WYANDOTTE HOSPITALHENRY FORD COTTAGE HOSPITAL/MEDICAL CENTERHENRY FORD ALLEGIANCE SPECIALTY HOSPITAL

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
W.A. FOOTE MEMORIAL HOSPITAL	PART V, SECTION B, LINE 11: THE CHNA WAS CONDUCTED IN 2019 IN PARTNERSHIP WITH THE JACKSON COUNTY HEALTH DEPARTMENT AND THEIR COMMUNITY HEALTH ASSESSMENT AND IMPROVEMENT PLAN TEAMS. THE IMPLEMENTATION PLAN FOCUSES ON THE PROGRAMS IDENTIFIED WHICH WERE DEEMED TO BE THE AREAS OF MOST CRITICAL NEED, AND WITH THE GREATEST POTENTIAL FOR ACHIEVING A MEASURABLE IMPROVEMENT. SEVERAL SIGNIFICANT HEALTH NEEDS WITHIN THE SERVICE AREA OF HENRY FORD ALLEGIANCE HOSPITAL WERE IDENTIFIED. HEALTH NEEDS WERE PRIORITIZED BASED ON SEVERAL CRITERIA INCLUDING THE IMPORTANCE GIVEN TO PARTICULAR HEALTH ISSUES BY SURVEY AND FOCUS GROUP PARTICIPANTS, STATISTICAL DATA FROM THE STATE OF MICHIGAN, AS WELL AS INPUT FROM HFHS AND COMMUNITY LEADERS. HENRY FORD ALLEGIANCE HOSPITAL'S RESOURCES AND OVERALL ALIGNMENT WITH THE HENRY FORD HEALTH SYSTEM MISSION, VISION, GOALS AND STRATEGIC PRIORITIES WERE TAKEN INTO CONSIDERATION WHEN IDENTIFYING THE TOP THREE MOST SIGNIFICANT HEALTH ISSUES TO BE ADDRESSED: HEALTHY LIFESTYLES & DIABETES, SUBSTANCE ABUSE & MENTAL HEALTH INFANT MORTALITY. IN TERMS OF SIGNIFICANT HEALTH NEEDS THAT WILL NOT BE ADDRESSED, HENRY FORD ALLEGIANCE HOSPITAL ACKNOWLEDGES THE WIDE RANGE OF HEALTH CONCERNS WHICH EMERGED FROM THE CHNA PROCESS, AND DETERMINED IT COULD MOST EFFECTIVELY ADDRESS THOSE HEALTH NEEDS THAT WERE DETERMINED TO BE MOST URGENT AND ESSENTIAL TO THE HEALTH OF THE COMMUNITY AS WELL AS WITHIN ITS ABILITY TO INFLUENCE. WHILE MOST OF THESE ADDITIONAL HEALTH ISSUES ARE CURRENTLY BEING ADDRESSED THROUGH SUPPORTIVE CLINICAL SERVICES, HFHA WILL NOT TAKE NEW OR SPECIFIC, ADDITIONAL ACTIONS RELATED TO THE FOLLOWING HEALTH NEEDS: KIDNEY DISEASE, FAMILY PLANNING, ASTHMA AND ALZHEIMER'S DISEASE.
W.A. FOOTE MEMORIAL HOSPITAL	PART V, SECTION B, LINE 13B: PATIENT'S PERSONAL RESPONSIBILITIES FOR MEDICALLY NECESSARY SERVICES NOT COVERED BY INSURANCE ARE GENERALLY BASED ON THE AMOUNT GENERALLY BILLED FOR THE SERVICE, WHICH APPROXIMATES 115% OF PREVAILING MEDICARE RATES. UNINSURED PATIENTS WHO DO NOT OTHERWISE QUALIFY FOR INSURANCE WITH HOUSEHOLD INCOMES AT OR BELOW 250% OF THE FEDERAL POVERTY LEVEL MAY QUALIFY FOR MEDICALLY NECESSARY SERVICES TO BE PROVIDED AT NO COST. PATIENTS REGARDLESS OF INSURANCE STATUS WITH ANNUAL MEDICAL LIABILITIES TO HFHS IN EXCESS OF 30% OF THEIR HOUSEHOLD INCOME MAY QUALIFY FOR DISCOUNTS ON THEIR PERSONAL OBLIGATIONS.

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
W.A. FOOTE MEMORIAL HOSPITAL	PART V, SECTION B, LINE 15E: PART V, SECTION B, LINE 22A: PATIENT'S PERSONAL RESPONSIBILITIES FOR MEDICALLY NECESSARY SERVICES NOT COVERED BY INSURANCE OR FAP ARE GENERALLY BASED ON THE AMOUNT GENERALLY BILLED FOR THE SERVICE, WHICH APPROXIMATES 115% OF PREVAILING MEDICARE RATES. UNINSURED PATIENTS WHO DO NOT OTHERWISE QUALIFY FOR INSURANCE WITH HOUSEHOLD INCOMES AT OR BELOW 250% OF THE FEDERAL POVERTY LEVEL MAY QUALIFY UNDER THE PATIENT FINANCIAL ASSISTANCE POLICY (FAP) FOR MEDICALLY NECESSARY SERVICES TO BE PROVIDED AT NO COST. IN ADDITION, PATIENTS REGARDLESS OF INSURANCE STATUS WITH ANNUAL MEDICAL LIABILITIES TO HFHS IN EXCESS OF 30% OF THEIR HOUSEHOLD INCOME MAY QUALIFY FOR DISCOUNTS ON THEIR PERSONAL OBLIGATIONS.

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

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

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

Name and address	Type of Facility (describe)
1 1 - HENRY FORD ALLEGIANCE OCCUPATIONAL HLTH 100 E MICHIGAN AVE STE 101 JACKSON, MI 49201	URGENT CARE, EMPLOYMENT SCREENING
1 2 - HENRY FORD ALLEGIANCE PHYSICAL REHAB-JAC 100 E MICHIGAN AVE STE 103 JACKSON, MI 49201	REHAB
2 3 - HENRY FORD ALLEGIANCE SUBSTANCE ABUSE SE 2424 W WASHINGTON AVE JACKSON, MI 49201	OUTPATIENT TREATMENT
3 4 - HENRY FORD ALLEGIANCE HOME CARE 100 E MICHIGAN AVE STE 400 JACKSON, MI 49201	VISITING NURSES
4 5 - HENRY FORD ALLEGIANCE PERSONAL CARE 100 E MICHIGAN AVE STE 400 JACKSON, MI 49201	PRIVATE DUTY NURSING
5 6 - HENRY FORD ALLEGIANCE TOBACCO TREATMENT 100 E MICHIGAN AVE STE 900 JACKSON, MI 49201	OUTPATIENT TREATMENT
6 7 - GAYLE M JACOB CANCER CENTER 1100 E MICHIGAN AVE STE 307 JACKSON, MI 49201	HEMATOLOGY ONCOLOGY PRACTICE AND INFUSION CENTER
7 8 - ALLEGIANCE WELLNESS CENTER 1100 E MICHIGAN AVE STE 100 JACKSON, MI 49201	WELLNESS CENTER
8 9 - HENRY FORD ALLEGIANCE CARDIAC REHAB 1100 E MICHIGAN AVE STE 102 JACKSON, MI 49201	POST-SURGICAL REHAB FACILITY
9 10 - HENRY FORD ALLEGIANCE PULMONARY REHAB 1100 E MICHIGAN AVE STE 102 JACKSON, MI 49201	POST-SURGICAL REHAB FACILITY
10 11 - HENRY FORD ALLEGIANCE DIAGNOSTIC CENTER- 1100 E MICHIGAN AVE STE 104 JACKSON, MI 49201	LAB AND IMAGING SERVICES
11 12 - HENRY FORD ALLEGIANCE OUTPATIENT TRAUMA 1100 E MICHIGAN AVE STE 201 JACKSON, MI 49201	PHYSICIAN SPECIALTY PRACTICE
12 13 - HENRY FORD ALLEGIANCE THORACIC SURGERY 1100 E MICHIGAN AVE STE 201 JACKSON, MI 49201	PHYSICIAN SPECIALTY PRACTICE
13 14 - HENRY FORD ALLEGIANCE PEDIATRIC CARDIOLO 1100 E MICHIGAN AVE STE 201 JACKSON, MI 49201	PHYSICIAN SPECIALTY PRACTICE
14 15 - HENRY FORD ALLEGIANCE CARDIAC SURGERY S 1100 E MICHIGAN AVE STE 201 JACKSON, MI 49201	PHYSICIAN SPECIALTY PRACTICE

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)
16 16 - HENRY FORD ALLEGIANCE GENERAL SURGERY 1100 E MICHIGAN AVE STE 300 JACKSON, MI 49201	PHYSICIAN SPECIALTY PRACTICE
1 17 - HENRY FORD ALLEGIANCE RADIATION ONCOLOGY 1102 E MICHIGAN AVE JACKSON, MI 49201	RADIATION THERAPY
2 18 - HENRY FORD ALLEGIANCE ENT 1111 TENEYCK ST STE 100 JACKSON, MI 49201	PHYSICIAN SPECIALTY PRACTICE
3 19 - HENRY FORD ALLEGIANCE HEARING CENTER 1111 TENEYCK ST STE 200 JACKSON, MI 49201	HEARING LOSS TREATMENT; HEARING AID SALES/SERVICE
4 20 - HENRY FORD ALLEGIANCE SURGERY CENTER 1125 E MICHIGAN AVENUE JACKSON, MI 49201	OUTPATIENT SURGERY CENTER
5 21 - HENRY FORD ALLEGIANCE SENIOR HEALTH CNTR 100 E MICHIGAN AVE STE 102 JACKSON, MI 49201	RETAIL SALES OF DURABLE MEDICAL EQUIPMENT
6 22 - HENRY FORD ALLEGIANCE DIAGNOSTIC ORTHOPED 1201 E MICHIGAN AVENUE JACKSON, MI 49201	OUTPATIENT CLINIC/DIAGNOSTIC CENTER
7 23 - HENRY FORD ALLEGIANCE DIAGNOSTIC CENTER- 1310 GREENWOOD AVE JACKSON, MI 49203	LABORATORY SERVICES
8 24 - HENRY FORD ALLEGIANCE NEUROPSYCHOLOGY 1400 E MICHIGAN AVE JACKSON, MI 49202	PHYSICIAN SPECIALTY PRACTICE
9 25 - HENRY FORD ALLEGIANCE DIAGNOSTIC CENTER- 1401 W NORTH STREET JACKSON, MI 49202	LAB AND IMAGING SERVICES
10 26 - HENRY FORD ALLEGIANCE FAMILY MEDICINE 1401 W NORTH STREET JACKSON, MI 49202	FAMILY MEDICINE AND EXTENDED HOURS CLINIC
11 27 - HENRY FORD ALLEGIANCE CRNA 205 N EAST AVE JACKSON, MI 49201	ANESTHESIOLOGY SERVICES
12 28 - HENRY FORD ALLEGIANCE EEG 205 N EAST AVE JACKSON, MI 49201	PATIENT TESTING
13 29 - HENRY FORD ALLEGIANCE EKG 205 N EAST AVE JACKSON, MI 49201	PATIENT TESTING
14 30 - HENRY FORD ALLEGIANCE EMERGENCY CARE 205 N EAST AVE JACKSON, MI 49201	EMERGENCY ROOM AND URGENT CARE

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)
31 31 - HENRY FORD ALLEGIANCE HEALTH PHARMACY 205 N EAST AVE JACKSON, MI 49201	OUTPATIENT PHARMACY
1 32 - HENRY FORD ALLEGIANCE SLEEP HEALTH CENT 205 N EAST AVE JACKSON, MI 49201	DIAGNOSTIC AND TESTING CENTER
2 33 - HENRY FORD ALLEGIANCE BEHAVIORAL HEALTH 205 N EAST AVE JACKSON, MI 49201	MENTAL HEALTH OUTPATIENT SERVICES
3 34 - HENRY FORD ALLEGIANCE DIGESTIVE HEALTH 205 S EAST AVE JACKSON, MI 49201	OUTPATIENT GI PROCEDURES
4 35 - HENRY FORD ALLEGIANCE HEALTH CENTER SPRING 2200 SPRINGPORT ROAD JACKSON, MI 49202	OUTPATIENT CLINIC/DIAGNOSTIC CENTER
5 36 - HENRY FORD ALLEGIANCE ADDICTION RECOVERY 2424 W WASHINGTON AVE JACKSON, MI 49203	OUTPATIENT TREATMENT CENTER
6 37 - ALLEGIANCE FAMILY MEDICINE - SUMMIT WOOD 2585 SPRING ARBOR ROAD JACKSON, MI 49203	FAMILY MEDICINE
7 38 - HENRY FORD ALLEGIANCE VASCULAR HEALTH 300 W WASHINGTON AVENUE STE 300 JACKSON, MI 49201	PHYSICIAN SPECIALTY PRACTICE
8 39 - HENRY FORD ALLEGIANCE VASCULAR LABORATOR 300 W WASHINGTON AVENUE STE 350 JACKSON, MI 49201	VASCULAR SYSTEM TESTING (ULTRASOUND)
9 40 - HENRY FORD ALLEGIANCE HEALTH CARDIOLOGY 309 PAGE AVENUE JACKSON, MI 49201	CARDIOVASCULAR CARE, DIAGNOSTIC TESTING
10 41 - HENRY FORD ALLEGIANCE FAMILY MEDICINE 3235 E MICHIGAN AVENUE STE 100 JACKSON, MI 49202	FAMILY MEDICINE
11 42 - HENRY FORD ALLEGIANCE INTERNAL MEDICINE 3235 E MICHIGAN AVENUE STE 150 JACKSON, MI 49202	INTERNAL MEDICINE
12 43 - HENRY FORD ALLEGIANCE DIAGNOSTIC CENTER 3305 SPRING ARBOR RD STE 100 JACKSON, MI 49203	LAB AND IMAGING SERVICES
13 44 - HENRY FORD ALLEGIANCE WOMEN'S HEALTH CNT 3305 SPRING ARBOR RD STE 500 JACKSON, MI 49203	CLINICAL EXAMS, MAMMOGRAMS, SPA SERVICES
14 45 - HENRY FORD ALLEGIANCE FAMILY MEDICINE 3333 SPRING ARBOR RD STE 100 JACKSON, MI 49203	FAMILY MEDICINE (PENDING, NOT CURRENTLY OPEN)

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)
46 46 - HENRY FORD ALLEGIANCE FAMILY MEDICINE 400 HINCKLEY BLVD STE 100 JACKSON, MI 49203	FAMILY MEDICINE
1 47 - HENRY FORD ALLEGIANCE DIAGNOSTIC CENTER 400 HINCKLEY BLVD STE 200 JACKSON, MI 49203	LAB AND IMAGING SERVICES
2 48 - HENRY FORD ALLEGIANCE ENDOCRINOLOGY 4304 PAGE AVE MICHIGAN CENTER, MI 49254	FAMILY MEDICINE (PENDING, NOT CURRENTLY OPEN)
3 49 - HENRY FORD ALLEGIANCE DIAGNOSTIC CENTER 4304 PAGE AVE MICHIGAN CENTER, MI 49254	LAB AND IMAGING SERVICES
4 50 - HENRY FORD ALLEGIANCE PHYSICAL REHABILIT 4304 PAGE AVE STE 100 MICHIGAN CENTER, MI 49254	REHABILITATION SERVICES
5 51 - HENRY FORD ALLEGIANCE DIAGNOSTIC CENTER 505 N JACKSON ST STE 178 JACKSON, MI 49201	LAB AND IMAGING SERVICES
6 52 - HENRY FORD ALLEGIANCE HOME MEDICAL EQUIP 700 E MICHIGAN AVE JACKSON, MI 49201	RETAIL SALES OF DURABLE MEDICAL EQUIPMENT
7 53 - PHLEBOTOMY - DR LYND 724 W FRANKLIN JACKSON, MI 49203	PHLEBOTOMY OFFICE (INDEPENDENT PHYSICIAN PRACTICE)
8 54 - HENRY FORD ALLEGIANCE BARIATRIC CENTER 744 W MICHIGAN AVE STE 101 JACKSON, MI 49201	PHYSICIAN SPECIALTY PRACTICE
9 55 - HENRY FORD ALLEGIANCE GENERAL SURGERY 744 W MICHIGAN AVE STE 200 JACKSON, MI 49201	PHYSICIAN SPECIALTY PRACTICE
10 56 - HENRY FORD ALLEGIANCE GASTROENTEROLOGY 744 W MICHIGAN AVE STE 201 JACKSON, MI 49201	PHYSICIAN SPECIALTY PRACTICE
11 57 - HENRY FORD ALLEGIANCE UROLOGY WEST MICHIG 744 W MICHIGAN AVE STE 300 JACKSON, MI 49201	PHYSICIAN SPECIALTY PRACTICE
12 58 - HENRY FORD ALLEGIANCE PEDIATRICS 760 W FRANKLIN JACKSON, MI 49203	PEDIATRIC MEDICINE
13 59 - HENRY FORD ALLEGIANCE DIAGNOSTIC CENTER 12369 E MICHIGAN AVE GRASS LAKE, MI 49240	LAB AND IMAGING SERVICES
14 60 - HENRY FORD ALLEGIANCE FAMILY MEDICINE 12369 E MICHIGAN AVE GRASS LAKE, MI 49240	FAMILY MEDICINE

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)
61 61 - HENRY FORD ALLEGIANCE FAMILY MEDICINE 130 N SHERMAN ST LESLIE, MI 49251	FAMILY MEDICINE
1 62 - HENRY FORD ALLEGIANCE FAMILY MEDICINE 810 HOGSBACK RD STE A MASON, MI 48854	FAMILY MEDICINE
2 63 - HENRY FORD ALLEGIANCE HEALTH DIAGNOSTIC 810 HOGSBACK RD STE B MASON, MI 48854	LAB AND IMAGING SERVICES
3 64 - HENRY FORD ALLEGIANCE PHYSICAL REHAB 810 HOGSBACK RD STE B MASON, MI 48854	REHABILITATION SERVICES
4 65 - HENRY FORD ALLEGIANCE DIAGNOSTIC CENTER 153 WAMPLERS LAKE RD BROOKLYN, MI 49230	LABORATORY SERVICES (JAN 2016 ADDING IMAGING SERVICES)
5 66 - HENRY FORD ALLEGIANCE FAMILY MEDICINE 8958 M-50 ONSTED, MI 49265	FAMILY MEDICINE
6 67 - HENRY FORD ALLEGIANCE FAMILY MEDICINE 27931 C DRIVE NORTH ALBION, MI 49224	FAMILY MEDICINE
7 68 - HENRY FORD ALLEGIANCE FAMILY MEDICINE 7845 SPRING ARBOR ROAD SPRING ARBOR, MI 49283	FAMILY MEDICINE
8 69 - HENRY FORD ALLEGIANCE PLASTIC SURGERY 3305 SPRING ARBOR RD STE 200 SPRING ARBOR, MI 49283	PLASTIC SURGERY
9 70 - HENRY FORD ALLEGIANCE DERMATOLOGY 3333 SPRING ARBOR RD STE 500 SPRING ARBOR, MI 49283	DERMATOLOGY
10 71 - HENRY FORD ALLEGIANCE PODIATRY 3333 SPRING ARBOR RD STE 200 SPRING ARBOR, MI 49283	PODIATRY
11 72 - HENRY FOD ALLEGIANCE UROLOGY SPRING ARBOR 2800 SPRING ARBOR RD JACKSON, MI 49201	UROLOGY

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
WA FOOTE MEMORIAL HOSPITAL

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 for the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Employer identification number
38-2027689

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 ▶ 9

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) STAFF ASSISTANCE FUND FOR EMERGENCIES	95	76,171			
(2) WE CARE PATIENT NEEDS FUND	100	7,942			
(3) WOMENS HEALTH CENTER ONCOLOGY AESTHETICS	10	2,000			
(4) CANCER PATIENT IMMEDIATE NEEDS FUNDS	31	15,521			
(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:	AWARDS ARE GRANTED BASED ON AN APPLICATION AND REVIEW PROCESS.THE ORGANIZATION SENDS OUT AN AWARD LETTER TO ALL GRANTEE RECIPENTS. THE LETTER OUTLINES WHAT THE FUNDING MAY BE USED FOR AND REQUESTS A FINAL REPORT DETAILING THE YEAR'S ACTIVITIES.

Additional Data

Software ID:
Software Version:
EIN: 38-2027689
Name: WA FOOTE MEMORIAL HOSPITAL

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
ARTS & CULTURAL ALLIANCE OF JACKSON COUNTY PO BOX 1463 JACKSON, MI 49204	77-0612012	501(C)(3)	10,000		N/A		ORGANIZATIONAL SUPPORT
JACKSON SYMPHONY ORCHESTRA 215 W MICHIGAN AVE JACKSON, MI 49201	38-2146747	501(C)(3)	15,000		N/A		ORGANIZATIONAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
ANCHOR INITIATIVE 141 S JACKSON ST JACKSON, MI 49201	47-2475316	501(C)(3)	50,000		N/A		ORGANIZATIONAL SUPPORT
ENTERPRISE GROUP 100 E MICHIGAN AVE 1100 JACKSON, MI 49201	38-3326101	501(C)(6)	25,000		N/A		ORGANIZATIONAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
JACKSON COMMUNITY FOUNDATION 100 S JACKSON ST SUITE 206B JACKSON, MI 49201	38-6070739	501(C)(3)	27,000		N/A		ORGANIZATIONAL SUPPORT
DAHLEM CONSERVANCY 7117 S JACKSON ROAD JACKSON, MI 49201	41-2155768	501(C)(3)	10,000		N/A		ORGANIZATIONAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
JACKSON AREA MANUFACTURERS ASSOCIATION 2545 SPRING ARBOR RD STE 201 JACKSON, MI 49203	38-2073593	501(C)(6)	11,500		N/A		ORGANIZATIONAL SUPPORT
JACKSON AREA COMMERCIAL CONTRACTORS PO BOX 143 JACKSON, MI 49204	38-0031187	501(C)(3)	10,000		N/A		ORGANIZATIONAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
JACKSON SCHOOL OF THE ARTS 634 N MECHANIC JACKSON, MI 49202	38-3581314	501(C)(3)	45,000		N/A		ORGANIZATIONAL SUPPORT
THE UNITED WAY OF JACKSON COUNTY 536 N JACKSON ST JACKSON, MI 49201	38-1368341	501(C)(3)	7,000		N/A		ORGANIZATIONAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MICHIGAN STATE UNIVERSITY 965 WILSON ROAD ROOM A308 EAST EAST LANSING, MI 48824	38-6005984	115 GOVERNMENT	10,000		N/A		ORGANIZATIONAL SUPPORT

Schedule J (Form 990)	Compensation Information	OMB No. 1545-0047
		2019
Department of the Treasury Internal Revenue Service	For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees ▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23. ▶ Attach to Form 990. ▶ Go to www.irs.gov/Form990 for instructions and the latest information.	
Name of the organization WA FOOTE MEMORIAL HOSPITAL		Employer identification number 38-2027689

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

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

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

[illegible]

Part III Supplemental Information

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

Return Reference	Explanation
PART I, LINE 1A	HENRY FORD ALLEGIANCE HEALTH PROVIDES A COUNTRY CLUB MEMBERSHIP TO THREE EXECUTIVES. THE EXECUTIVES REIMBURSE THE HOSPITAL FOR ANY PERSONAL USE OF THE CLUB. THESE BENEFITS DID NOT RESULT IN TAXABLE COMPENSATION DURING FY 19.
PART I, LINE 3	THE CHIEF EXECUTIVE OFFICER FOR W.A. FOOTE MEMORIAL HOSPITAL IS AN EMPLOYEE OF HENRY FORD HEALTH SYSTEM (THE SOLE MEMBER OF HENRY FORD ALLEGIANCE HEALTH GROUP). HENRY FORD HEALTH SYSTEM ("HFHS") HAS A COMPENSATION COMMITTEE OF THE BOARD OF TRUSTEES CONSISTING OF ALL INDEPENDENT TRUSTEES. THE COMMITTEE MEETS THROUGHOUT THE YEAR AND IS CHARGED WITH THE APPROVAL OF THE ORGANIZATION'S OVERALL COMPENSATION AND BENEFIT PROGRAMS AS WELL AS THE SPECIFIC REVIEW AND APPROVAL OF THE COMPENSATION OF CERTAIN EMPLOYEES INCLUDING THE CHIEF EXECUTIVE OFFICER OF W.A. FOOTE MEMORIAL HOSPITAL. THE COMMITTEE DIRECTLY ENGAGES AN INDEPENDENT COMPENSATION ADVISOR TO ASSIST WITH THIS PROCESS. THE PROCESS INCLUDES EVALUATION OF THE INDIVIDUAL'S PERFORMANCE, UTILIZATION OF COMPENSATION STUDIES OF SIMILARLY SITUATED POSITIONS AS WELL AS COMPARISONS TO COMPENSATION AS REPORTED BY OTHER HEALTH CARE ORGANIZATIONS. THE REASONABLENESS OF COMPENSATION IS EVALUATED BASED UPON THESE AND OTHER FACTORS. THE CEO IS ACCOUNTABLE FOR ENSURING THAT ALLEGIANCE HEALTH'S MISSION IS EFFICIENTLY CARRIED OUT WITH THE HIGHEST LEVELS OF QUALITY, SAFETY AND SERVICE, WHILE AT THE SAME TIME ENSURING THAT THE ORGANIZATION IS FINANCIALLY HEALTHY. EXECUTIVE COMPENSATION IS REVIEWED ANNUALLY BY THE EXECUTIVE COMPENSATION COMMITTEE OF THE BOARD OF TRUSTEES. THIS COMMITTEE WORKS WITH AN INDEPENDENT COMPENSATION CONSULTANT TO ENSURE THAT HENRY FORD ALLEGIANCE HEALTH COMPENSATION PRACTICES ARE CONSISTENT WITH INDUSTRY STANDARDS AND THAT COMPENSATION LEVELS ARE FAIR COMPARED TO SIMILAR HEALTHCARE ORGANIZATIONS NATIONALLY. THE COMPENSATION CONSULTANT BENCHMARKS HENRY FORD ALLEGIANCE HEALTH'S POSITIONS AGAINST DATA FROM MULTIPLE PUBLISHED SURVEYS OF HEALTH CARE EXECUTIVE COMPENSATION IN THE NATIONAL HEALTH CARE LABOR MARKET. BASED UPON THE CONSULTANTS RECOMMENDATIONS, THE EXECUTIVE COMPENSATION COMMITTEE MAKES A RECOMMENDATION TO THE BOARD OF TRUSTEES FOR APPROVAL OF THE EXECUTIVE COMPENSATION PROGRAM. ONLY INDEPENDENT TRUSTEES VOTE ON THIS RECOMMENDATION.
PART I, LINES 4A-B	4B. CERTAIN MEMBERS OF THE ORGANIZATION'S SENIOR LEADERSHIP TEAM PARTICIPATE IN SUPPLEMENTAL RETIREMENT PROGRAMS THAT RESULT IN REPORTABLE TAXABLE INCOME AS THE BENEFITS ACCRUE, AND/OR AS PAID. IT IS AN ELEMENT OF SOME PLAN DESIGNS TO ABSORB THE ADVANCE TAX IMPACT OF THESE PLANS FOR THE PARTICIPANTS. IN SUCH CASES THE RELATED AMOUNTS ARE REPORTED AS TAXABLE INCOME TO THE INDIVIDUAL AND INCLUDED IN THE DETERMINATION OF REASONABLE COMPENSATION. THE FOLLOWING PROVIDES THE REQUIRED LISTING OF THE PARTICIPATING INDIVIDUALS: PART 1 LINE 4A: SEVERANCE PAYMENTS GEORGIA FOJTASEK, R.N. (PART YEAR CEO) \$283,695 KEVIN LEONARD. (PART YEAR CFO) \$107,014 SEC 457(F)-NON-QUALIFIED DEFERRED COMPENSATION RETIREMENT PLAN - W.A. FOOTE MEMORIAL HOSPITAL REPORTABLE ACCRUAL DISTRIBUTION NON-VESTED W-2 AMOUNTS VISHAL GUPTA, M.D. 340,760 - 340,760 SEC 457(F) - SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN (SERP) - HENRY FORD HEALTH SYSTEM PARTICIPANT ACCRUAL DISTRIBUTION NON-VESTED REPORTABLE W-2 ROBERT G. RINEY 267,664 - - 267,664 GEORGIA FOJTASEK 126,716 - - 126,716 ADNAN R. MUNKARAH - - 174,231 - SEC 457(B)-NON-QUALIFIED DEFERRED COMPENSATION RETIREMENT PLAN - HENRY FORD HEALTH SYSTEM EMPLOYEE EMPLOYER MEDICARE REPORTABLE 2019 CONTR. 2019 CONTR. TAX GROSS-UP W-2 AMOUNTS ROBERT G. RINEY 19,000 - - 19,000 ADNAN R. MUNKARAH 19,000 - - 19,000 GEORGIA FOJTASEK 19,000 - - 19,000 VISHAL GUPTA, M.D. 19,000 - - 19,000
PART I, LINE 7	COLUMN B(II) OF PART II, SCHEDULE J INCLUDES NON-FIXED PAYMENTS TO CERTAIN PHYSICIANS BASED ON THEIR PRODUCTIVITY AND OTHER PERFORMANCE METRICS.

Additional Data

Software ID:

Software Version:

EIN: 38-2027689

Name: WA FOOTE MEMORIAL HOSPITAL

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				
1FRANK LAMARCA MD PHYSICIAN	(i)	1,055,641	903,871	494,677	6,300	25,732	2,486,221	0
	(ii)	0	0	0	0	0	0	0
1ROBERT G RINEY TRUSTEE	(i)	0	0	0	0	0	0	0
	(ii)	1,102,897	686,691	294,188	26,920	25,033	2,135,729	0
2AZAM BASHEER MD PHYSICIAN	(i)	746,330	988,914	308,544	7,000	21,889	2,072,677	0
	(ii)	0	0	0	0	0	0	0
3AMRITRAJ G LOGANATHAN MD PHYSICIAN	(i)	740,357	578,219	283,003	5,600	25,186	1,632,365	0
	(ii)	0	0	0	0	0	0	0
4VISHAL GUPTA MD PHYSICIAN	(i)	742,890	399,994	441,231	9,100	15,045	1,608,260	0
	(ii)	0	0	0	0	0	0	0
5GEORGIA R FOJTASEK RN EDD TRUSTEE-PRESIDENT & CEO (THRU 7/19)	(i)	0	0	0	0	0	0	0
	(ii)	395,067	420,157	431,450	26,920	14,456	1,288,050	115,375
6ADNAN R MUNKARAH MD PHYSICIAN TRUSTEE	(i)	0	0	0	0	0	0	0
	(ii)	758,924	397,753	23,902	25,519	36,594	1,242,692	0
7TUDOR TIEN MD PHYSICIAN	(i)	572,042	482,768	66,319	10,500	33,593	1,165,222	0
	(ii)	0	0	0	0	0	0	0
8MOHAN G KULKARNI MD PHYSICIAN TRUSTEE	(i)	436,004	259,731	428,646	7,700	32,528	1,164,609	0
	(ii)	0	0	0	0	0	0	0
9ONDREA L BATES RN SVP PATIENT CARE	(i)	292,527	184,821	79,483	7,700	27,763	592,294	0
	(ii)	0	0	0	0	0	0	0
10MARK A SMITH MD CMO/CEO HFAHMG	(i)	334,736	111,997	83,585	4,200	31,279	565,797	0
	(ii)	0	0	0	0	0	0	0
11KEVIN P LEONARD VP FINANCE/ CFO (THRU 7/19)	(i)	117,912	123,443	151,463	4,365	6,043	403,226	0
	(ii)	0	0	0	0	0	0	0
12MICHAEL GRISDELA CFO (THRU 7/19)	(i)	0	0	0	0	0	0	0
	(ii)	299,495	25,000	22,377	0	31,233	378,105	0
13KENNETH W EMPEY GENERAL COUNSEL	(i)	184,696	121,824	41,318	14,700	14,036	376,574	0
	(ii)	74,836	0	0	0	5,122	79,958	0
14PAULA AUTRY TRUSTEE-PRESIDENT & CEO (START 8/19)	(i)	238,787	75,000	3,302	0	12,884	329,973	0
	(ii)	0	0	0	0	0	0	0
15JIM BONGIORNO CFO (START 7/19)	(i)	0	0	0	0	0	0	0
	(ii)	180,950	34,160	862	14,594	23,839	254,405	0

Schedule L

(Form 990 or 990-EZ)

Department of the Treasury

Internal Revenue Service

Transactions with Interested Persons

▶ Complete if the organization answered "Yes" on Form 990, Part IV, lines 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.
▶ Attach to Form 990 or Form 990-EZ.
▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
WA FOOTE MEMORIAL HOSPITAL

Employer identification number
38-2027689

Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and section 501(c)(29) organizations only).
Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

1	(a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected?	
				Yes	No

2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958. ▶ \$

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization. ▶ \$

Part II Loans to and/or From Interested Persons.
Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a, or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization?		(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?		(i) Written agreement?	
			To	From			Yes	No	Yes	No	Yes	No
(1) PATRICK NALLY	SON OF CURRENT TRUSTEE	EMPLOYEE RECRUITMENT LOAN		X	115,000	115,000		No	Yes		Yes	
Total						115,000						

Part III Grants or Assistance Benefiting Interested Persons.
Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance

Part IV Business Transactions Involving Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) PATRICK NALLY	FAMILY MEMBER/OFFICER	170,162	EMPLOYEE COMPENSATION		No

Part V Supplemental Information

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

Return Reference	Explanation
SCHEDULE L, PART IV, BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS:	(A) NAME OF PERSON: INDEPENDENT EMERGENCY PHYSICIANS P.C.(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DONOR AS LISTED ON SCH. B(C) AMOUNT OF TRANSACTION \$ 1,665,031(D) DESCRIPTION OF TRANSACTION: PROVIDED HEALTH CARE AND MEDICAL SERVICES(E) SHARING OF ORGANIZATION'S REVENUE? NO (A) NAME OF PERSON: PULMONARY CLINICS OF SOUTHERN MI P.C.(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: OWNER/BOARD MEMBER (C) AMOUNT OF TRANSACTION \$ 5,056,632(D) DESCRIPTION OF TRANSACTION: PROVIDED HEALTH CARE SERVICES(E) SHARING OF ORGANIZATION'S REVENUE? NO

SCHEDULE M
(Form 990)

Department of the Treasury
Internal Revenue Service

Noncash Contributions

►Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.
► Attach to Form 990.
►Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
WA FOOTE MEMORIAL HOSPITAL

Employer identification number
38-2027689

Part I

Types of Property

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art—Works of art				
2 Art—Historical treasures . .				
3 Art—Fractional interests . .				
4 Books and publications . .				
5 Clothing and household goods				
6 Cars and other vehicles . . .				
7 Boats and planes				
8 Intellectual property				
9 Securities—Publicly traded .	X	2	28,326	MARKET VALUE
10 Securities—Closely held stock .				
11 Securities—Partnership, LLC, or trust interests				
12 Securities—Miscellaneous . .				
13 Qualified conservation contribution—Historic structures				
14 Qualified conservation contribution—Other				
15 Real estate—Residential . .				
16 Real estate—Commercial . .				
17 Real estate—Other				
18 Collectibles				
19 Food inventory				
20 Drugs and medical supplies .				
21 Taxidermy				
22 Historical artifacts				
23 Scientific specimens				
24 Archeological artifacts				
25 Other ► ()				
26 Other ► ()				
27 Other ► ()				
28 Other ► ()				

29

Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement

29

30a

During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 28, that it must hold for at least three years from the date of the initial contribution, and which isn't required to be used for exempt purposes for the entire holding period?

30a

Yes

No

No

b If "Yes," describe the arrangement in Part II.

31

Does the organization have a gift acceptance policy that requires the review of any nonstandard contributions?

31

Yes

No

No

32a

Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions?

32a

Yes

No

No

b If "Yes," describe in Part II.

33

If the organization didn't report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II.

33

Yes

No

No

Part II **Supplemental Information.** Provide the information required by Part I, lines 30b, 32b, and 33, and whether the organization is reporting in Part I, column (b), the number of contributions, the number of items received, or a combination of both. Also complete this part for any additional information.

Return Reference	Explanation
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SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury

Name of the organization
WA FOOTE MEMORIAL HOSPITAL

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

▶ Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Employer identification number

38-2027689

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 6	THE CORPORATION IS ORGANIZED ON A MEMBERSHIP BASIS. THE SOLE CORPORATE MEMBER OF THE CORPORATION IS HENRY FORD ALLEGIANCE HEALTH GROUP (FORMERLY ALLEGIANCE HEALTH SERVICES).

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7A	THE SOLE MEMBER OF THE ORGANIZATION MAY ELECT AND REMOVE, WITH OR WITHOUT CAUSE, THE CORPORATION'S TRUSTEES.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B	<p>THE FOLLOWING POWERS ARE RESERVED FOR THE SOLE CORPORATE MEMBER OF THE HOSPITAL. APPROVE ANY CHANGE IN THE ARTICLES OF INCORPORATION, PURPOSES OR PHILOSOPHY OF THE CORPORATION; APPROVE CHANGES IN THOSE PROVISIONS OF THE CORPORATION'S BYLAWS WHICH AFFECT THE SIZE, COMPOSITION, AND METHOD OF SELECTION OF THE BOARD OF TRUSTEES, OR WHICH AFFECT THIS ARTICLE; APPROVE PLANS OF MERGER, CONSOLIDATION OR DISSOLUTION OF THE CORPORATION; ELECT AND REMOVE, WITH OR WITHOUT CAUSE, THE CORPORATION'S TRUSTEES, UPON A SIMPLE MAJORITY VOTE OF THE DIRECTORS THEN SERVING ON THE BOARD OF THE MEMBER PRESENT AT A MEETING AT WHICH A QUORUM IS PRESENT; APPROVE GUARANTEES BY THE CORPORATION OF THE DEBT OF OTHERS IN EXCESS OF MAXIMUM LIMITS ESTABLISHED BY THE MEMBER, UPON A SIMPLE MAJORITY VOTE OF THE DIRECTORS THEN SERVING ON THE BOARD OF THE MEMBER PRESENT AT A MEETING AT WHICH A QUORUM IS PRESENT; AUTHORIZE THE SALE, LEASE, MORTGAGE OR OTHER DISPOSITION OF ALL OR SUBSTANTIALLY ALL OF THE ASSETS OWNED, HELD OR LEASED BY OR TO THE CORPORATION, APPROVE ANY DECISION BY THE CORPORATION WHICH WOULD HAVE THE NET EFFECT OF DIMINUTION OF GOVERNANCE CONTROL OF THE MEMBER, AND ANY DECISION BY THE CORPORATION WHICH WOULD HAVE THE NET EFFECT OF DIMINUTION IN THE CORPORATION'S GOVERNANCE CONTROL OVER IT'S OWN SUBSIDIARY; RATIFY OR REJECT OPERATING AND CAPITAL BUDGETS DEVELOPED BY THE BOARD AND ANY NON-BUDGETARY EXPENDITURES OR CREATIONS OF DEBT IN EXCESS OF AN AMOUNT DESIGNATED BY THE MEMBER FROM TIME TO TIME, UPON A SIMPLE MAJORITY VOTE OF THE DIRECTORS THEN SERVING ON THE BOARD OF THE MEMBER PRESENT AT A MEETING AT WHICH A QUORUM IS PRESENT; AND AUTHORIZE THE FORMATION OR ACQUISITION OF NEW SUBSIDIARIES OF THE CORPORATION OR THE SALE OR OTHER DISPOSITION OF EXISTING SUBSIDIARIES.</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	THE ORGANIZATION IS AN AFFILIATE OF HENRY FORD HEALTH SYSTEM (HFHS) AND THE TAX DEPARTMENT OF HFHS PREPARES THE ORGANIZATION'S FORM 990. AS PART OF THE PREPARATION AND REVIEW PROCESS PRIOR TO FILING THE RETURN, THE FOLLOWING REVIEW PROCESS IS CONDUCTED: - REVIEWED BY THE ORGANIZATION'S DIRECTOR AND VP OF FINANCE, CHIEF EXECUTIVE OFFICER, GENERAL COUNSEL, AND COMPLIANCE OFFICER. - REVIEW OF THE ENTIRE RETURN WITH THE HFHS AND ORGANIZATION'S SENIOR VICE PRESIDENT FINANCIAL OPERATIONS AND CHIEF FINANCIAL OFFICER, - REVIEW OF ALL COMPENSATION MATTERS AND DISCLOSURES WITH THE COMPENSATION COMMITTEE OF THE HFHS BOARD OF DIRECTORS - REVIEW OF THE RETURN WITH THE HFHS AUDIT AND COMPLIANCE COMMITTEE OF THE BOARD OF DIRECTOR, INCLUDING THE CEO AND COO - FINAL COPIES OF THE RETURN ARE DISTRIBUTED TO THE HOSPITAL'S BOARD OF TRUSTEES BEFORE THE RETURN IS FILED.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	<p>THE ORGANIZATION IS AN AFFILIATE OF HENRY FORD HEALTH SYSTEM (HFHS) WHO OVERSEES THE CONFLICT OF INTEREST PROCESS WITH REGARD TO THE ORGANIZATION. HFHS HAS A STANDING CONFLICT OF INTEREST COMMITTEE (THE COMMITTEE) THAT IS RESPONSIBLE FOR OVERSIGHT OF ALL CONFLICT OF INTEREST MATTERS. THE HFHS CONFLICT OF INTEREST POLICY APPLIES TO ALL DIRECTORS AND EMPLOYEES. ANNUALLY, DIRECTORS, EMPLOYEES OF A MANAGEMENT LEVEL, RESEARCHERS, AS WELL AS EMPLOYEES ASSOCIATED WITH PROCUREMENT, OR IN CERTAIN OTHER PREDEFINED ROLES MUST COMPLETE AN ANNUAL DISCLOSURE DESIGNED TO IDENTIFY ACTIVITIES AND RELATIONSHIPS THAT COULD POTENTIALLY GIVE RISE TO A CONFLICT OF INTEREST. IT IS THE RESPONSIBILITY OF THE COMMITTEE TO REVIEW THESE DISCLOSURES AND DETERMINE THE NEED FOR ANY ACTION TO MANAGE THE POTENTIAL CONFLICT. THE COMMITTEE ANNUALLY REPORTS THE RESULTS OF ITS ACTIVITIES TO THE AUDIT AND COMPLIANCE COMMITTEE OF THE HFHS BOARD OF DIRECTORS.</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15	THE ORGANIZATION IS AN AFFILIATE OF HENRY FORD HEALTH SYSTEM (HFHS) WHO HAS RESPONSIBILITY TO OVERSEE THE COMPENSATION PRACTICES OF THE ORGANIZATION. HFHS HAS A COMPENSATION COMMITTEE OF THE BOARD OF DIRECTORS CONSISTING OF ALL EXTERNAL DIRECTORS. THEY MEET PERIODICALLY THROUGHOUT THE YEAR. THEY ARE CHARGED WITH APPROVAL OF THE ORGANIZATION'S OVERALL COMPENSATION AND BENEFIT PROGRAMS AS WELL AS THE SPECIFIC REVIEW AND APPROVAL OF THE COMPENSATION OF CERTAIN EMPLOYEES INCLUDING THE CHIEF EXECUTIVE OFFICER, ALL OFFICERS AND KEY EMPLOYEES OF THE ORGANIZATION. THEY DIRECTLY ENGAGE AN INDEPENDENT COMPENSATION ADVISOR TO ASSIST WITH THIS PROCESS. THE PROCESS INCLUDES EVALUATION OF THE INDIVIDUAL'S PERFORMANCE, UTILIZATION OF COMPENSATION STUDIES OF SIMILARLY SITUATED POSITIONS, AS WELL AS COMPARISONS TO COMPENSATION AS REPORTED BY OTHER HEALTH CARE ORGANIZATIONS. THE REASONABLENESS OF COMPENSATION IS EVALUATED BASED UPON THESE AND OTHER FACTORS. THE COMMITTEE ALSO REVIEWS THE COMPENSATION DISCLOSURES TO BE MADE ON FORM 990 IN ADVANCE OF FILING.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	FORMS 1023, 990 AND 990-T ARE AVAILABLE UPON REQUEST. THE CONFLICT OF INTEREST POLICY IS NOT AVAILABLE TO THE PUBLIC. PART IV, LINE 12 THE ORGANIZATION IS AN ELEMENT OF THE EXTERNAL AUDIT REPORT OBTAINED FOR THE CONSOLIDATED OPERATIONS OF HENRY FORD HEALTH SYSTEM. FORM 990, PART IV, LINE 24A, TAX-EXEMPT BOND ISSUE: THE ORGANIZATION IS AN AFFILIATE OF HENRY FORD HEALTH SYSTEM. THE ALLOCATED TAX-EXEMPT BOND LIABILITY OF THE ORGANIZATION IS REPORTED UNDER THE FORM 990, SCHEDULE K OF ITS PARENT, HENRY FORD HEALTH SYSTEM.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9:	PENSION LIABILITY ADJUSTMENT -2,992,460. AFFILIATE EQUITY TRANSFERS 79,675,478.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XII, LINE 2C	HENRY FORD ALLEGIANCE HEALTH IS INCLUDED IN THE CONSOLIDATED FINANCIAL STATEMENTS OF HENRY FORD HEALTH SYSTEM (THE SOLE MEMBER OF HENRY FORD ALLEGIANCE HEALTH GROUP). THE GOVERNING BODY OF HENRY FORD HEALTH SYSTEM HAS DELEGATED THE OVERSIGHT OF ITS FINANCIAL STATEMENTS, INCLUDING THE CHOICE OF INDEPENDENT AUDITORS, TO ITS AUDIT COMMITTEE.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VII:	AVERAGE HOURS PER WEEK DEVOTED TO RELATED ORGANIZATIONS: MANY EXECUTIVE EMPLOYEES OF HENRY FORD HEALTH SYSTEM AND AFFILIATES PROVIDE SERVICES TO MULTIPLE AFFILIATED ENTITIES. HENRY FORD HEALTH SYSTEM AND AFFILIATES USE ESTIMATES FOR REPORTING AVERAGE HOURS PER WEEK IN ALL SECTIONS OF FORM 990. GENERALLY 60 HOURS ARE REPORTED FOR THE HOURS ASSOCIATED FOR THE ORGANIZATION THAT THE INDIVIDUAL HAS PRINCIPAL RESPONSIBILITY FOR. HOURS ASSOCIATED WITH OTHER HOSPITALS OR AFFILIATES ARE REPORTED AT BETWEEN 1 TO 5 HOURS PER WEEK.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 5713 - INTERNATIONAL BOYCOTT ACTIVITY:	A FORM 5713, INTERNATIONAL BOYCOTT REPORT, HAS BEEN FILED ON OUR BEHALF BY HENRY FORD HEALTH SYSTEM (SOLE MEMBER OF HENRY FORD ALLEGIANCE HEALTH GROUP). HENRY FORD ALLEGIANCE HEALTH DID NOT ITSELF HAVE ANY ACTIVITIES ASSOCIATED WITH AN INTERNATIONAL BOYCOTT COUNTRY.

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 for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
WA FOOTE MEMORIAL HOSPITAL

Employer identification number
38-2027689

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) PHYSICIANS CHOICE NETWORK LLC 205 N EAST AVENUE JACKSON, MI 49201	PROVIDER NETWORK	MI	95,849	85,040	HENRY FORD ALLEGIANCE HEALTH
(2) JACKSON HEALTH NETWORK L3C 205 N EAST AVENUE JACKSON, MI 49201 45-3253643	CLINICALLY INTEGRATED NETWORK	MI	3,025,967	3,833,804	HENRY FORD ALLEGIANCE HEALTH
(3) IT'S YOUR LIFE SERVICES LLC 205 N EAST AVENUE JACKSON, MI 49201	PREVENTION AND COMMUNITY HEALTH	MI	0	0	HENRY FORD ALLEGIANCE HEALTH

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

See Additional Data Table

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512- 514)	(f) Share of total income	(g) Share of end- of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) FOOTE HEALTH CENTER ASSOCIATES 1100 E MICHIGAN AVENUE JACKSON, MI 49201 38-3017711	LESSOR OF MEDICAL CONDOMINIUMS	MI	HENRY FORD ALLEGIANCE HEALTH	RELATED	134,074	1,141,863		No			No	62.000 %
(2) NORTHWEST DETROIT DIALYSIS 30100 TELEGRAPH BINGHAM FARMS, MI 48025 38-3232668	OPERATE DIALYSIS CLINIC	MI	HENRY FORD HEALTH SYSTEM	RELATED				No			No	
(3) MACOMB REGIONAL DIALYSIS CENTERS 16151 NINETEEN MILE RD CLINTON TOWNSHIP, MI 48038 26-0423581	OPERATE DIALYSIS CLINIC	MI	HENRY FORD HEALTH SYSTEM	RELATED				No			No	

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

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

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

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

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

e Loans or loan guarantees by related organization(s)

f Dividends from related organization(s)

g Sale of assets to related organization(s)

h Purchase of assets from related organization(s)

i Exchange of assets with related organization(s)

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

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

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

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

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

o Sharing of paid employees with related organization(s)

p Reimbursement paid to related organization(s) for expenses

q Reimbursement paid by related organization(s) for expenses

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

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

Yes

No

1a

No

1b

No

1c

No

1d

No

1e

No

1f

No

1g

No

1h

No

1i

No

1j

Yes

1k

No

1l

Yes

1m

Yes

1n

No

1o

No

1p

Yes

1q

Yes

1r

Yes

1s

Yes

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.

See Additional Data Table

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved

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

[illegible]

Part VII **Supplemental Information**

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

Return Reference	Explanation
SCHEDULE R, PART V, LINE 1D & 1E:	THE ORGANIZATION IS A MEMBER OF THE HENRY FORD HEALTH SYSTEM OBLIGATED GROUP. MEMBERS OF THE OBLIGATED GROUP ARE JOINTLY AND SEVERALLY LIABLE FOR OUTSTANDING OBLIGATIONS ISSUED UNDER THE 2016 HFHS BOND MASTER INDENTURE.

Additional Data

Software ID:
Software Version:
EIN: 38-2027689
Name: WA FOOTE MEMORIAL HOSPITAL

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
205 N EAST AVENUE JACKSON, MI 49201 38-2756428	EXEMPT HEALTH SYSTEM	MI	501(C)(3)	LINE 12B, II	HENRY FORD HEALTH SYSTEM	Yes	
205 N EAST AVENUE JACKSON, MI 49201 38-3607833	SUPPORTS ALLEGIANCE HEALTH	MI	501(C)(3)	LINE 12B, II	HENRY FORD ALLEGIANCE HEALTH GROUP	Yes	
205 N EAST AVENUE JACKSON, MI 49201 38-2336367	HOSPICE CARE	MI	501(C)(3)	LINE 7	HEATHLINK	Yes	
205 N EAST AVENUE JACKSON, MI 49201 38-2756425	HOME HEALTH CARE	MI	501(C)(3)	LINE 12A, I	HENRY FORD ALLEGIANCE HEALTH GROUP	Yes	
110 NORTH ELM AVENUE JACKSON, MI 49202 38-1218485	LONG TERM ACUTE CARE HOSPITAL	MI	501(C)(3)	LINE 3	HENRY FORD ALLEGIANCE HEALTH GROUP	Yes	
ONE FORD PLACE DETROIT, MI 48202 38-1357020	HEALTHCARE SERVICE PROVIDER	MI	501(C)(3)	LINE 3	N/A		No
2333 BIDDLE AVE WYANDOTTE, MI 48192 38-2791823	HEALTHCARE SERVICE PROVIDER	MI	501(C)(3)	LINE 3	HENRY FORD HEALTH SYSTEM	Yes	
ONE FORD PLACE DETROIT, MI 48202 23-7383042	SUPPORTING ORGANIZATION	MI	501(C)(3)	LINE 12A, I	HENRY FORD HEALTH SYSTEM	Yes	
2850 W GRAND BLVD DETROIT, MI 48202 38-2242827	HEALTH MAINTENANCE ORGANIZATION	MI	501(C)(4)	N/A	HENRY FORD HEALTH SYSTEM	Yes	
ONE FORD PLACE DETROIT, MI 48202 90-0840304	SCIENTIFIC RESEARCH	MI	501(C)(3)	LINE 7	HENRY FORD HEALTH SYSTEM	Yes	
ONE FORD PLACE DETROIT, MI 48202 46-4064067	ADVOCACY SERVICES FOR HFHS AND AFFILIATES	ME	501(C)(4)	N/A	HENRY FORD HEALTH SYSTEM	Yes	
ONE FORD PLACE DETROIT, MI 48202 38-2947657	HEALTHCARE SERVICE PROVIDER	DE	501(C)(3)	LINE 3	HENRY FORD HEALTH SYSTEM	Yes	
3031 WEST GRAND BOULEVARD DETROIT, MI 48202 38-2682321	SUPPORTING ORGANIZATION	MI	501(C)(3)	LINE 12B, II	HENRY FORD HEALTH SYSTEM	Yes	

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
HENRY FORD ALLEGIANCE PHARMACY 205 N EAST AVENUE JACKSON, MI 49201 38-3370242	PHARMACY	MI	HENRY FORD ALLEGIANCE HEALTH GROUP	C				Yes	
SHA REALTY INC ONE FORD PLACE DETROIT, MI 48202 38-1378121	REAL ESTATE HOLDING	MI	HENRY FORD HEALTH SYSTEM FOUNDATION	C				Yes	
FAIRLANE HEALTH SERVICES 30100 TELEGRAPH BINGHAM FARMS, MI 48025 38-2565235	HEALTHCARE MANAGEMENT	MI	HENRY FORD HEALTH SYSTEM	C				Yes	
ALLIANCE HEALTH AND LIFE INSURNACE 2850 W GRAND BLVD DETROIT, MI 48202 38-3291563	HEALTH INSURANCE PROVIDER	MI	HEALTH ALLIANCE PLAN	C				Yes	
HAP PREFERRED INC 2850 W GRAND BLVD DETROIT, MI 48202 38-2513504	PROVIDER NETWORK LEASING	MI	HEALTH ALLIANCE PLAN	C				Yes	
ONIKA INSURANCE LTD FIRST CARRIBEAN HOUSE GRAND CAYMAN CJ	CAPTIVE INSURANCE	CJ	HENRY FORD HEALTH SYSTEM	C				Yes	
HENRY FORD PHYSICIAN NETWORK ONE FORD PLACE DETROIT, MI 48202 32-0306774	PHYSICIAN NETWORK	MI	HENRY FORD HEALTH SYSTEM	C				Yes	
ADMINISTRATION SYSTEMS RESEARCH CORPORATION 2850 W GRAND BLVD DETROIT, MI 48202 38-2651185	THIRD PARTY INSURANCE ADMIN.	MI	HEALTH ALLIANCE PLAN	C				Yes	
HAP EMPOWERED HEALTH PLAN INC 2850 W GRAND BLVD DETROIT, MI 48202 38-3123777	HEALTH INSURANCE PROVIDER	MI	HEALTH ALLIANCE PLAN	C				Yes	
HENRY FORD ELIJAH MCCOY CONDOMINIUM ASSOCIATION 1150 ELIJAH MCCOY DR DETROIT, MI 48202 85-2144748	CONDOMINIUM ASSOCIATION	MI	HENRY FORD HEALTH SYSTEM	C				Yes	

Form 990, Schedule R, Part V - Transactions With Related Organizations

(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
HOSPICE OF JACKSON DBA HENRY FORD ALLEGIANCE HOSPICE	J	86,630	COST
HOSPICE OF JACKSON DBA HENRY FORD ALLEGIANCE HOSPICE	L	867,338	COST
ALLEGIANCE HEALTH FOUNDATION	S	46,293	COST
CARELINK OF JACKSON	L	1,831,419	COST
JACKSON COMMUNITY AMBULANCE	M	250,565	COST
HEALTH ALLIANCE PLAN	M	3,278,041	COST
ONIKA INSURANCE LTD	P	1,134,218	COST
ONIKA INSURANCE LTD	Q	3,760,185	COST
HOSPICE OF JACKSON DBA HENRY FORD ALLEGIANCE HOSPICE	Q	2,003,800	COST
CARELINK OF JACKSON	Q	92,384	COST
HEALTH ALLIANCE PLAN	L	4,453,356	COST
VOLUNTEERS OF HENRY FORD ALLEGIANCE HEALTH	R	226,131	COST