GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2018 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP406

Facility Name: Coffee Regional Medical Center

County: Coffee

Street Address: PO Box 1287

City: Douglas

Zip: 31534

Mailing Address: PO Box 1287

Mailing City: Douglas

Mailing Zip: 31534

Medicaid Provider Number: 000000448A

Medicare Provider Number: 11-0089

2. Report Period

Report Data for the full twelve month period- January 1, 2018 through December 31, 2018.
Do not use a different report period.

Check the box to the right if your facility was **not** operational for the entire year. ☐
If your facility was **not** operational for the entire year, provide the dates the facility was operational.

Part B : Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey.

Contact Name: Lavonda Cravey

Contact Title: VP Corporate Revenue Cycle

Phone: 912-383-5600

Fax: 912-389-2112

E-mail: lavonda.cravey@coffeeregional.org

Part C : Ownership, Operation and Management

1. Ownership, Operation and Management

As of the last day of the report period, indicate the operation/management status of the facility and provide the effective date. Using the drop-down menus, select the organization type. If the category is not applicable, the form requires you only to enter Not Applicable in the legal name field. You must enter something for each category.

A. Facility Owner

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Coffee County Hospital Authority	Hospital Authority	6/30/1949

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Coffee County	Local Govt	1/1/1900

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Coffee Regional Medical Center, Inc.	Not for Profit	1/1/1995

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
CRH Health Care, Inc.	Not for Profit	10/28/1994

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Not Applicable	Not Applicable	

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Not Applicable	Not Applicable	

2. Changes in Ownership, Operation or Management

Check the box to the right if there were any changes in the ownership, operation, or management of the facility during the report period or since the last day of the Report Period. ☐
If checked, please explain in the box below and include effective dates.

3. Check the box to the right if your facility is part of a health care system ☑
Name: CRH Health Care, Inc.
City: Douglas **State:** GA

4. Check the box to the right if your hospital is a division or subsidiary of a holding company. ☑
Name: CRH Health Care, Inc.
City: Douglas **State:** GA

5. Check the box to the right if the hospital itself operates subsidiary corporations ☑
Name: CRH Health Care, Inc.
City: Douglas **State:** GA

6. Check the box to the right if your hospital is a member of an alliance. ☐
Name:
City: **State:**

7. Check the box to the right if your hospital is a participant in a health care network ☐
Name:
City: **State:**

8. Check the box to the right if the hospital has a policy or policies and a peer review process related to medical errors. ☑

9. Check the box to the right if the hospital owns or operates a primary care physician group practice. ☑

10a. Managed Care Information: Formal Written Contract
Does the hospital have a formal written contract that specifies the obligations of each party with each of the following? (check the appropriate boxes)

1. Health Maintenance Organization(HMO) ☐

2. Preferred Provider Organization(PPO) ☐

3. Physician Hospital Organization(PH0) ☑

4. Provider Service Organization(PSO) ☐

5. Other Managed Care or Prepaid Plan ☐

10b. Managed Care Information: Insurance Products
Check the appropriate boxes to indicate if any of the following insurance products have been developed by the hospital, health care system, network, or as a joint venture with an insurer:

Type of Insurance Product	Hospital	Health Care System	Network	Joint Venture with Insurer
Health Maintenance Organization	☐	☐	☐	☐
Preferred Provider Organization	☐	☐	☐	☐
Indemnity Fee-for-Service Plan	☐	☐	☐	☐
Another Insurance Product Not Listed Above	☐	☐	☐	☐

11. Owner or Owner Parent Based in Another State
If the owner or owner parent at Part C, Question 1(A&B) is an entity based in another state please report the location in which the entity is based. (City and State)

Part D : Inpatient Services

1. Utilization of Beds as Set Up and Staffed(SUS):

Please indicate the following information. Dod not include newborn and neonatal services. Do not include long-term care untits, such as Skilled Nursing Facility beds, if not licensed as hospital beds. If your facility is approved for LTCH beds report them below.

Category	SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
Obstetrics (no GYN, include LDRP)	6	587	1,168	587	1,747
Pediatrics (Non ICU)	4	81	177	80	247
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	5	43	84	43	127
General Medicine	40	2,429	10,048	2,423	12,342
General Surgery	23	672	3,523	675	4,218
Medical/Surgical	0	0	0	0	0
Intensive Care	10	386	1,278	386	1,630
Psychiatry	0	0	0	0	0
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	0	0	0	0	0
Pediatric Physical Rehabilitation (0-17)	0	0	0	0	0
Burn Care	0	0	0	0	0
Swing Bed (Include All Utilization)	0	0	0	0	0
Long Term Care Hospital (LTCH)	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Total	**88**	**4,198**	**16,278**	**4,194**	**20,311**

2. Race/Ethnicity

Please report admissions and inpatient days for the hospital by the following race and ethnicity categories. Exclude newborn and neonatal.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	3	14
Asian	3	6
Black/African American	1,000	4,071
Hispanic/Latino	225	671
Pacific Islander/Hawaiian	2	12
White	2,963	11,495
Multi-Racial	2	9
Total	**4,198**	**16,278**

3. Gender

Please report admissions and inpatient days by gender. Exclude newborn and neonatal.

Gender	Admissions	Inpatient Days
Male	1,561	6,502
Female	2,637	9,776
Total	**4,198**	**16,278**

4. Payment Source

Please report admissions and inpatient days by primary payment source. Exclude newborn and neonatal.

Primary Payment Source	Admissions	Inpatient Days
Medicare	2,164	10,018
Medicaid	841	2,442
Peachare	1	4
Third-Party	657	2,050
Self-Pay	535	1,764
Other	0	0

5. Discharges to Death

Report the total number of inpatient admissions discharged during the reporting period due to death.

109

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2018 (to the nearest whole dollar).

Service	Charge
Private Room Rate	760
Semi-Private Room Rate	0
Operating Room: Average Charge for the First Hour	5,268
Average Total Charge for an Inpatient Day	5,395

Part E : Emergency Department and Outpatient Services

1. Emergency Visits
Please report the number of emergency visits only.

34,101

2. Inpatient Admissions from ER
Please report inpatient admssions to the Hospital from the ER for emergency cases ONLY.

5,788

3. Beds Available
Please report the number of beds available in ER as of the last day of the report period.

18

4. Utilization by Specific type of ER bed or room for the report period.

Type of ER Bed or Room	Beds	Visits
Beds dedicated for Trauma	2	78
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	1	697
General Beds	15	32,852
	0	0
	0	0
	0	0
	0	0

5. Transfers
Please provide the number of Transfers to another institution from the Emergency Department.

492

6. Non-Emergency Visits
Please provide the number of Outpatient/Clinic/All Other Non-Emergency visits to the hospital.

11,374

7. Observation Visits/Cases
Please provide the total number of Observation visits/cases for the entire report period.

2,394

8. Diverted Cases
Please provide the number of cases your ED diverted while on Ambulance Diversion for the entire report period.

0

9. Ambulance Diversion Hours
Please provide the total number of Ambulance Diversion hours for your ED for the entire report period

0

10. Untreated Cases

Please provide the number of patients who sought care in your ED but who left without or before being treated. Do not include patients who were transferred or cases that were diverted.

604

Part F : Services and Facilities

1a. Services and Facilities

Please report services offered onsite for in-house and contract services as requested. Please reflect the status of the service during the report period. *(Use the blank lines to specify other services.)*

Site Codes
1 = In-House - Provided by the Hospital
2 = Contract - Provided by a contractor but onsite
3 = Not Applicable

Status Codes
1 = On-Going
2 = Newly Initiated
3 = Discontinued
4 = Not Applicable

Service/Facilities	Site Code	Service Status
Podatric Services	1	1
Renal Dialysis	2	1
ESWL	2	1
Billiary Lithotropter	3	4
Kidney Transplants	3	4
Heart Transplants	3	4
Other-Organ/Tissues Transplants	3	4
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	1	1
Radioisotope, Diagnositic	1	1
Positron Emission Tomography (PET)	2	2
Radioisotope, Therapeutic	3	4
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	1	1
Respiratory Therapy	1	1
Occupational Therapy	2	1
Physical Therapy	2	1
Speech Pathology Therapy	2	1
Gamma Ray Knife	3	4
Audiology Services	1	1
HIV/AIDS Diagnostic Treatment/Services	1	1
Ambulance Services	1	1
Hospice	2	1
Respite Care Services	2	1
Ultrasound/Medical Sonography	1	1
Wound Care Services	2	1
	0	0
	0	0

1b. Report Period Workload Totals

Please report the workload totals for in-house and contract services as requested. The number of units should equal the number of machines.

Category	Total
Number of Podiatric Patients	474
Number of Dialysis Treatments	760
Number of ESWL Patients	59
Number of ESWL Procedures	69
Number of ESWL Units	1
Number of Biliary Lithotripter Procedures	0
Number of Biliary Lithotripter Units	0
Number of Kidney Transplants	0
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	0
Number of Diagnostic X-Ray Procedures	31,815
Number of CTS Units (machines)	2
Number of CTS Procedures	13,940
Number of Diagnostic Radioisotope Procedures	4,504
Number of PET Units (machines)	1
Number of PET Procedures	44
Number of Therapeautic Radioisotope Procedures	0
Number of Number of MRI Units	1
Number of Number of MRI Procedures	2,239
Number of Chemotherapy Treatments	1,556
Number of Respiratory Therapy Treatments	95,715
Number of Occupational Therapy Treatments	4,335
Number of Physical Therapy Treatments	37,223
Number of Speech Pathology Patients	234
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	542
Number of HIV/AIDS Diagnostic Procedures	158
Number of HIV/AIDS Patients	35
Number of Ambulance Trips	7,039
Number of Hospice Patients	63
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	4
Number of Ultrasound/Medical Sonography Procedures	6,736
Number of Treatments, Procedures, or Patients (Other 1)	267
Number of Treatments, Procedures, or Patients (Other 2)	520
Number of Treatments, Procedures, or Patients (Other 3)	2,614

2. Medical Ventilators

Provide the number of computerized/mechanical Ventilator Machines that were in use or available

for immediate use as of the last day of the report period (12/31).

11

3. Robotic Surgery System

Please report the number of units, number of procedures, and type of unit(s).

# Units	# Procedures	Type of Unit(s)
0	0	

Part G : Facility Workforce Information

1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2018. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2018.

Profession	Profession	Profession	Profession
Licensed Physicians	5.00	0.00	1.00
Physician Assistants Only (not including Licensed Physicians)	1.00	0.00	0.00
Registered Nurses (RNs-Advanced Practice*)	168.00	15.00	0.00
Licensed Practical Nurses (LPNs)	34.00	3.00	2.00
Pharmacists	9.00	0.00	0.00
Other Health Services Professionals*	169.00	6.00	2.00
Administration and Support	213.00	9.00	2.00
All Other Hospital Personnel (not included above)	0.00	0.00	0.00

2. Filling Vacancies

Using the drop-down menus, please select the average time needed during the past six months to fill each type of vacant position.

Type of Vacancy	Average Time Needed to Fill Vacancies
Physician's Assistants	31-60 Days
Registered Nurses (RNs-Advance Practice)	61-90 Days
Licensed Practical Nurses (LPNs)	31-60 Days
Pharmacists	31-60 Days
Other Health Services Professionals	31-60 Days
All Other Hospital Personnel (not included above)	31-60 Days

3. Race/Ethnicity of Physicians

Please report the number of physicians with admitting privileges by race.

Race/Ethnicity	Number of Physicians
American Indian/Alaska Native	0
Asian	13
Black/African American	3
Hispanic/Latino	0
Pacific Islander/Hawaiian	0
White	39
Multi-Racial	0

4. Medical Staff

Please report the number of active and associate/provisional medical staff for the following specialty categories. Keep in mind that physicians may be counted in more than one specialty. Please

indicate whether the specialty group(s) is hospital-based. Also, indicate how many of each medical specialty are enrolled as providers in Georgia Medicaid/PeachCare for Kids and/or the Public Employee Health Benefit Plans (PEHB-State Health Benefit Plant and/or Board of Regents Benefit Plan).

Medical Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
General and Family Practice	8	☐	0	0
General Internal Medicine	10	☐	0	0
Pediatricians	4	☐	0	0
Other Medical Specialties	8	☐	0	0

Surgical Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
Obstetrics	5	☐	0	0
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	5	☐	0	0
Ophthalmology Surgery	5	☐	0	0
Orthopedic Surgery	5	☐	0	0
Plastic Surgery	0	☐	0	0
General Surgery	4	☐	0	0
Thoracic Surgery	0	☐	0	0
Other Surgical Specialties	4	☐	0	0

Other Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
Anesthesiology	4	☑	0	0
Dermatology	0	☐	0	0
Emergency Medicine	10	☐	0	0
Nuclear Medicine	0	☐	0	0
Pathology	1	☑	0	0
Psychiatry	0	☐	0	0
Radiology	2	☑	0	0
Oncology	3	☐	0	0
Neurology/Pulmonology	4	☐	0	0
Gastro	1	☐	0	0

5a. Non-Physicians

Please report the number of professionals for the categories below. Exclude any hospital-based staff reported in Part G, Questions 1,2,3 and 4 above.

Profession	Number
Dentists (include oral surgeions) with Admitting Privleges	2
Podiatrists	2
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	49

5b. Name of Other Professions

Please provide the names of professions classified as "Other Staff Affiliates with Clinical Privileges" above.

Nurse Practitioner / Physician Assistant / CRNA

Comments and Suggestions:

Part H : Physician Name and License Number

1. Physicians on Staff

Please report the full name and license number of each physician on staff. **(Due to the large number of entries, this section has been moved to a separate PDF file.)**

Part I : Patient Origin Table

1. Patient Origin

Please report the county of origin for the inpatient admissions or discharges excluding newborns (except surgical services should include outpatients only).

Inpat=Inpatient Services
Surg=Outpatient Surgical
OB=Obstetric
P18+=Acute psychiatric adult 18 and over
P13-17=Acute psychiatric adolescent 13-17
P0-12=Acute psychiatric children 12 and under
Rehab=Inpatient Rehabilitation
S18+=Substance abuse adult 18 and over
S13-17=Substance abuse adolescent 13-17
E18+=Extended care adult 18 and over
E13-17=Extended care adolescent 13-17
E0-12=Extended care children 0-12
LTCH=Long Term Care Hospital

County	Inpat	Surg	OB	P18+	P13-17	P0-12	S18+	S13-17	E18+	E13-17	E0-12	LTCH	Rehab
Appling	29	42	15	0	0	0	0	0	0	0	0	0	0
Atkinson	507	466	83	0	0	0	0	0	0	0	0	0	0
Bacon	92	167	49	0	0	0	0	0	0	0	0	0	0
Barrow	1	0	0	0	0	0	0	0	0	0	0	0	0
Ben Hill	64	163	7	0	0	0	0	0	0	0	0	0	0
Berrien	13	30	2	0	0	0	0	0	0	0	0	0	0
Bibb	0	1	0	0	0	0	0	0	0	0	0	0	0
Brantley	4	11	0	0	0	0	0	0	0	0	0	0	0
Brooks	1	1	0	0	0	0	0	0	0	0	0	0	0
Bryan	1	0	0	0	0	0	0	0	0	0	0	0	0
Burke	0	1	0	0	0	0	0	0	0	0	0	0	0
Camden	0	1	0	0	0	0	0	0	0	0	0	0	0
Charlton	3	7	1	0	0	0	0	0	0	0	0	0	0
Chatham	0	3	0	0	0	0	0	0	0	0	0	0	0
Cherokee	0	1	0	0	0	0	0	0	0	0	0	0	0
Clinch	41	56	6	0	0	0	0	0	0	0	0	0	0
Cobb	3	0	0	0	0	0	0	0	0	0	0	0	0
Coffee	2,909	2,369	286	0	0	0	0	0	0	0	0	0	0
Colquitt	4	10	0	0	0	0	0	0	0	0	0	0	0
Cook	6	12	0	0	0	0	0	0	0	0	0	0	0
Decatur	0	1	0	0	0	0	0	0	0	0	0	0	0
Dodge	0	6	0	0	0	0	0	0	0	0	0	0	0
Dougherty	3	4	0	0	0	0	0	0	0	0	0	0	0
Emanuel	0	5	0	0	0	0	0	0	0	0	0	0	0
Fulton	1	0	0	0	0	0	0	0	0	0	0	0	0
Glynn	8	4	1	0	0	0	0	0	0	0	0	0	0
Gwinnett	1	1	0	0	0	0	0	0	0	0	0	0	0

Irwin	68	89	10	0	0	0	0	0	0	0	0	0	0
Jeff Davis	217	217	65	0	0	0	0	0	0	0	0	0	0
Jenkins	1	3	0	0	0	0	0	0	0	0	0	0	0
Jones	0	1	0	0	0	0	0	0	0	0	0	0	0
Lamar	1	1	0	0	0	0	0	0	0	0	0	0	0
Lanier	4	15	1	0	0	0	0	0	0	0	0	0	0
Laurens	2	1	0	0	0	0	0	0	0	0	0	0	0
Liberty	0	1	0	0	0	0	0	0	0	0	0	0	0
Lowndes	6	38	1	0	0	0	0	0	0	0	0	0	0
Montgomery	3	2	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	28	15	0	0	0	0	0	0	0	0	0	0	0
Pierce	17	59	3	0	0	0	0	0	0	0	0	0	0
Pulaski	1	1	0	0	0	0	0	0	0	0	0	0	0
Richmond	0	1	0	0	0	0	0	0	0	0	0	0	0
Rockdale	0	1	0	0	0	0	0	0	0	0	0	0	0
Sumter	1	0	0	0	0	0	0	0	0	0	0	0	0
Tattnall	3	0	0	0	0	0	0	0	0	0	0	0	0
Telfair	62	59	13	0	0	0	0	0	0	0	0	0	0
Tift	12	35	1	0	0	0	0	0	0	0	0	0	0
Toombs	1	2	0	0	0	0	0	0	0	0	0	0	0
Turner	1	12	0	0	0	0	0	0	0	0	0	0	0
Union	0	1	0	0	0	0	0	0	0	0	0	0	0
Walton	0	1	0	0	0	0	0	0	0	0	0	0	0
Ware	70	176	13	0	0	0	0	0	0	0	0	0	0
Washington	1	2	0	0	0	0	0	0	0	0	0	0	0
Wayne	3	6	3	0	0	0	0	0	0	0	0	0	0
Wheeler	2	4	0	0	0	0	0	0	0	0	0	0	0
Wilcox	2	12	1	0	0	0	0	0	0	0	0	0	0
Worth	1	2	0	0	0	0	0	0	0	0	0	0	0
Total	**4,198**	**4,119**	**561**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Surgical Services Addendum

Part A : Surgical Services Utilization

1. Surgery Rooms in the OR Suite

Please report the Number of Surgery Rooms, (as of the end of the report period). Report only the rooms in CON-Approved Operating Room Suites pursuant to Rule 111-2-2-.40 and 111-8-48-.28.

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Rooms
General Operating	0	0	5
Cystoscopy (OR Suite)	0	0	0
Endoscopy (OR Suite)	0	0	2
	0	0	0
Total	**0**	**0**	**7**

2. Procedures by Type of Room

Please report the number of procedures by type of room.

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Inpatient Rooms	Shared Outpatient Rooms
General Operating	0	0	865	2,860
Cystoscopy	0	0	40	227
Endoscopy	0	0	342	780
	0	0	0	0
Total	**0**	**0**	**1,247**	**3,867**

3. Patients by Type of Room

Please report the number of patients by type of room.

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Inpatient Rooms	Shared Outpatient Rooms
General Operating	0	0	865	2,860
Cystoscopy	0	0	40	227
Endoscopy	0	0	367	869
	0	0	0	0
Total	**0**	**0**	**1,272**	**3,956**

Part B : Ambulatory Patient Race/Ethnicity, Age, Gender and Payment Source

1. Race/Ethnicity of Ambulatory Patients

Please report the total number of ambulatory patients for both dedicated outpatient and shared room environment.

Race/Ethnicity	Number of Ambulatory Patients
American Indian/Alaska Native	2
Asian	7
Black/African American	946
Hispanic/Latino	221
Pacific Islander/Hawaiian	1
White	2,930
Multi-Racial	12
Total	**4,119**

2. Age Grouping

Please report the total number of ambulatory patients by age grouping.

Age of Patient	Number of Ambulatory Patients
Ages 0-14	154
Ages 15-64	2,618
Ages 65-74	828
Ages 75-85	431
Ages 85 and Up	88
Total	**4,119**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	1,762
Female	2,357
Total	**4,119**

4. Payment Source

Please report the total number of ambulatory patients by payment source.

Primary Payment Source	Number of Patients
Medicare	1,763
Medicaid	711
Third-Party	1,371
Self-Pay	274

Perinatal Services Addendum

Part A : Obstetrical Services Utilization

Please report the following obstetrical services information for the report period. Include all deliveries and births in any unit of th hospital or anywhere on its grounds.

1. Number of Delivery Rooms: 0

2. Number of Birthing Rooms: 0

3. Number of LDR Rooms: 0

4. Number of LDRP Rooms: 6

5. Number of Cesarean Sections: 232

6. Total Live Births: 566

7. Total Births (Live and Late Fetal Deaths): 568

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 590

Part B : Newborn and Neonatal Nursery Services

1. Nursery Services

Please Report the following newborn and neonatal nursery information for the report period.

Type of Nursery	Set-Up and Staffed Beds/Station	Neonatal Admissions	Inpatient Days	Transfers within Hospital
Normal Newborn (Basic)	12	570	964	0
Specialty Care (Intermediate Neonatal Care)	0	0	0	0
Subspecialty Care (Intensive Neonatal Care)	0	0	0	0

Part C : Obstetrical Charges and Utilization by Mother's Race/Ethnicity and Age

1. Race/Ethnicity

Please provide the number of admissions and inpatient days for mothers by the mother's race using race/ethnicity classifications.

Race/Ethnicity	Admissions by Mother's Race	Inpatient Days
American Indian/Alaska Native	0	0
Asian	1	1
Black/African American	123	270
Hispanic/Latino	78	140
Pacific Islander/Hawaiian	0	0
White	359	706
Multi-Racial	0	0
Total	**561**	**1,117**

2. Age Grouping
Please provide the number of admissions by the following age groupings.

Age of Patient	Number of Admissions	Inpatient Days
Ages 0-14	0	0
Ages 15-44	561	1,117
Ages 45 and Up	0	0
Total	**561**	**1,117**

3. Average Charge for an Uncomplicated Delivery
Please report the average hospital charge for an uncomplicated delivery(CPT 59400)

$6,618.00

4. Average Charge for a Premature Delivery
Please report the average hospital charge for a premature delivery.

$12,783.00

LTCH Addendum

Part A : General Information

1a. Accreditation Check the box to the right if your Long Term Care Hospital is accredited. ☐
If you checked the box for yes, please specify the agency that accredits your facility in the space below.

1b. Level/Status of Accreditation
Please provide your organization's level/status of accreditation.

2. Number of Licensed LTCH Beds: 0

3. Permit Effective Date:

4. Permit Designation:

5. Number of CON Beds: 0

6. Number of SUS Beds: 0

7. Total Patient Days: 0

8. Total Discharges: 0

9. Total LTCH Admissions: 0

Part B : Utilization by Race, Age, Gender and Payment Source

1. Race/Ethnicity
Please provide the number of admissions and inpatient days using the following race/ethnicity classifications.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	0	0
Asian	0	0
Black/African American	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0
Total	**0**	**0**

2. Age of LTCH Patient

Please provide the number of admissions and inpatient days by the following age groupings.

Age of Patient	Admissions	Inpatient Days
Ages 0-64	0	0
Ages 65-74	0	0
Ages 75-84	0	0
Ages 85 and Up	0	0
Total	**0**	**0**

3. Gender

Please provide the number of admissions and inpatient days by the following gender classifications.

Gender of Patient	Admissions	Inpatient Days
Male	0	0
Female	0	0
Total	**0**	**0**

4. Payment Source

Please indicate the number of patients by the payment source. Please note that individuals may have multiple payment sources.

Primary Payment Source	Number of Patients	Inpatient Days
Medicare	0	0
Third-Party	0	0
Self-Pay	0	0
Other	0	0

Psychiatric/Substance Abuse Services Addendum

Part A : Psychiatric and Substance Abuse Data by Program

1. Beds

Please report the number of beds as of the last day of the report period. Report beds only for officially recognized programs. Use the blank row to report combined beds. For combined bed programs, please report each of the combined bed programs and the number of combined beds. Indicate the combined programs using letters A through H, for example,"AB"

Patient Type	Distribution of CON-Authorized Beds	Set-Up and Staffed Beds
A- General Acute Psychiatric Adults 18 and over	0	0
B- General Acute Psychiatric Adolescents 13-17	0	0
C- General Acute Psychiatric Children 12 and under	0	0
D- Acute Substance Abuse Adults 18 and over	0	0
E- Acute Substance Abuse Adolescents 13-17	0	0
F-Extended Care Adults 18 and over	0	0
G- Extended Care Adolescents 13-17	0	0
H- Extended Care Adolescents 0-12	0	0
	0	0

2. Admissions, Days, Discharges, Accreditation

Please report the following utilization for the report period. Report only for officially recognized programs.

Program Type	Admissions	Inpatient Days	Discharges	Discharge Days	Average Charge Per Patient Day	Check if the Program is JCAHO Accredited
General Acute Psychiatric Adults 18 and over	0	0	0	0	0	☐
General Acute Psychiatric Adolescents 13-17	0	0	0	0	0	☐
General Acute Psychiatric Children 12 and Under	0	0	0	0	0	☐
Acute Substance Abuse Adults 18 and over	0	0	0	0	0	☐
Acute Substance Abuse Adolescents 13-17	0	0	0	0	0	☐
Extended Care Adults 18 and over	0	0	0	0	0	☐
Extended Care Adolescents 13-17	0	0	0	0	0	☐
Extended Care Adolescents 0-12	0	0	0	0	0	☐

Part B : Psych/SA Utilization by Race/Ethnicity, Gender, and Payment Source

1. Race/Ethnicity

Please provide the number of admissions and inpatient days using the following race/ethnicity classifications.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	0	0
Asian	0	0
Black/African American	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0
Total	**0**	**0**

2. Gender

Please provide the number of admissions and inpatient days by the following gender classifications.

Gender of Patient	Admissions	Inpatient Days
Male	0	0
Female	0	0
Total	**0**	**0**

3. Payment Source

Please indicate the number of patients by the following payment sources. Please note that individuals may have multiple payment sources.

Primary Payment Source	Number of Patients	Inpatient Days
Medicare	0	0
Medicaid	0	0
Third Party	0	0
Self-Pay	0	0
PeachCare	0	0

Georgia Minority Health Advisory Council Addendum

Because of Georgia's racial and ethnic diversity, and a dramatic increase in segments of the population with Limited English Proficiency, the Georgia Minority Health Advisory Council is working with the Department of Community Health to assess our health systems' ability to provide Culturally and Linguistically Appropriate Services (CLAS) to all segments of our population. We appreciate your willingness to provide information on the following questions:

1. Do you have paid medical interpreters on staff? *(Check the box, if yes.)* ☐
If you checked yes, how many? 0 (FTE's)
What languages do they interpret?

2. When a paid medical interpreter is not available for a limited-English proficiency patient, what alternative mechanisms do you use to assure the provision of Linguistically Appropriate Services? *(Check all that apply)*

Bilingual Hospital Staff Member ☑ Bilingual Member of Patient's Family ☑

Community Volunteer Intrepreter ☐ Telephone Interpreter Service ☑

Refer Patient to Outside Agency ☐ Other (please describe): ☐

3. Please complete the following grid to show the proportion of patients you serve who prefer speaking various languages (name the 3 most common non-English languages spoken.)

Top 3 most common non-English languages spoken by your patients	Percent of patients for whom this is their preferred language	# of physicians on staff who speak this language	# of nurses on staff who speak this language	# of other employed staff who speak this language
Spanish	NA	0	0	0
		0	0	0
		0	0	0

4. What **training** have you provided to your staff to assure cultural competency and the provision of **Culturally and Linguistically Appropriate Services (CLAS)** to your patients?

We use Healthstream Rapid Regulatory courses for Clinical and Non-clincal new employees and

annually for all employees. We also teach about the Cultural Competence and Language Line use in Nursing and PCT orientation.

5. What is the most urgent tool or resource you need in order to increase your ability to provide **Culturally and Linguistically Appropriate Services (CLAS)** to your patients?

6. In what languages are the signs written that direct patients within your facility?

1. English
2. Spanish
3.
4.

7. If an uninsured patient visits your emergency department, is there a community health center, federally-qualified health center, free clinic, or other reduced-fee safety net clinic nearby to which you could refer that patient in order to provide him or her an affordable primary care medical home regardless of ability to pay? *(Check the box, if yes)* ☐
If you checked yes, what is the name and location of that health care center or clinic?

South Central Primary Care, 1004 W Ward ST, Douglas, GA 31533

Comprehensive Inpatient Physical Rehabilitation Addendum

Part A : Rehab Utilization by Race/Ethnicity, Gender, and Payment Source

1. Admissions and Days of Care by Race

Please report the number of inpatient physical rehabilitation admissions and inpatient days for the hospital by the following race and ethnicity categories.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	0	0
Asian	0	0
Black/African American	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0

2. Admissions and Days of care by Gender

Please report the number of inpatient physical rehabilitation admissions and inpatient days by gender.

Gender	Admissions	Inpatient Days
Male	0	0
Female	0	0

3. Admissions and Days of Care by Age Cohort

Please report the number of inpatient physical rehabilitation admissions and inpatient days by age cohort.

Gender	Admissions	Inpatient Days
0-17	0	0
18-64	0	0
65-84	0	0
85 Up	0	0

Part B : Referral Source

1. Referral Source

Please report the number of inpatient physical rehabilitation admissions during the report period from each of the following sources.

Referral Source	Admissions
Acute Care Hospital/General Hospital	0
Long Term Care Hospital	0
Skilled Nursing Facility	0
Traumatic Brain Injury Facility	0

	0

1. Payers

Please report the number of inpatient physical rehabilitation admissions by each of the following payer categories.

Primary Payment Source	Admissions
Medicare	0
Third Party/Commercial	0
Self Pay	0
Other	0

2. Uncompensated Indigent and Charity Care

Please report the number of inpatietn physical rehabilitation patients qualifying as uncompensated indigent or charity care

0

Part D : Admissions by Diagnosis Code

1. Admissions by Diagnosis Code

Please report the number of inpatient physical rehabilitation admissions by the "CMS 13" diagnosis of the patient listed below.

Diagnosis	Admissions
1. Stroke	0
2. Brain Injury	0
3. Amputation	0
4. Spinal Cord	0
5. Fracture of the femur	0
6. Neurological disorders	0
7. Multiple Trauma	0
8. Congenital deformity	0
9. Burns	0
10. Osteoarthritis	0
11. Rheumatoid arthritis	0
12. Systemic vasculidities	0
13. Joint replacement	0
All Other	0

Electronic Signature

Please note that the survey WILL NOT BE ACCEPTED without the authorized signature of the Chief Executive Officer or Executive Director (principal officer) of the facility. The signature can be completed only AFTER all survey data has been finalized. By law, the signatory is attesting under penalty of law that the information is accurate and complete.

I state, certify and attest that to the best of my knowledge upon conducting due diligence to assure the accuracy and

completeness of all data, and based upon my affirmative review of the entire completed survey, this completed survey contains no untrue statement, or incaccurate data, nor omits requested material information or data. I further state, certify and attest that I have reviewed the entire contents of the completed survey with all appropriate staff of the facility. I further understand that inaccurate, incomplete or omitted data could lead to sanctions against me or my facility. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Authorized Signature: Vicki Lewis

Date: 3/1/2019

Title: CEO

Comments:

Section F (subsection 1b): The last numbers added at the bottom are for 1) Vascular procedures, 2) Cath Lab procedures and 3) Wound Care Center Procedures respectively.

State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2017

DSH Version 5.20 11/01/2017

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2016	06/30/2017

2. Select Your Facility from the Drop-Down Menu Provided: COFFEE REGIONAL MEDICAL CENTER

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	01/01/2017	12/31/2017
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES

	Data
6. Medicaid Provider Number:	000000448A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110089

B. DSH OB Qualifying Information

Questions 1-3, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

During the DSH Examination Year:

	DSH Examination Year (07/01/16 - 06/30/17)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	09/01/1953

Questions 4-6, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

During the Interim DSH Payment Year:

	DSH Payment Year (07/01/18 - 06/30/19)
4. Does the hospital have at least two obstetricians who have staff privileges at the hospital who have agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes

List the Names of the two Obstetricians (or case of rural hospital, Physicians) who have agreed to perform OB services:

5. Is the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
6. Is the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for DSH Year 07/01/2016 - 06/30/2017**
   (Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

$ 1,077,892

Certification:

Answer
Yes

1. **Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year? Matching the federal share with an IGT/CPE is not a basis for answering this question "no". If your hospital was not allowed to retain 100% of its DSH payments, please explain what circumstances were present that prevented the hospital from retaining its payments.**

Explanation for "No" answers: _____

The following certification is to be completed by the hospital's CEO or CFO:

I hereby certify that the information in Sections A, B, C, D, E, F, G, H, I, J, K and L of the DSH Survey files are true and accurate to the best of our ability, and supported by the financial and other records of the hospital. All Medicaid eligible patients, including those who have private insurance coverage, have been reported on the DSH survey regardless of whether the hospital received payment on the claim. I understand that this information will be used to determine the Medicaid program's compliance with federal Disproportionate Share Hospital (DSH) eligibility and payments provisions. Detailed support exists for all amounts reported in the survey. These records will be retained for a period of not less than 5 years following the due date of the survey, and will be made available for inspection when requested.

Hospital CEO or CFO Signature	CFO Title	Date
Lavonda Cravey Hospital CEO or CFO Printed Name	912-383-5600 Hospital CEO or CFO Telephone Number	lavonda.cravey@coffeeregional.org Hospital CEO or CFO E-Mail

Contact Information for individuals authorized to respond to inquiries related to this survey:

Hospital Contact:

Name	Deborah Massey
Title	Patient Financial Services Director
Telephone Number	912-383-6982
E-Mail Address	deborah.massey@coffeeregional.org
Mailing Street Address	1101 Ocilla Rd
Mailing City, State, Zip	Douglas, Ga 31533

Outside Preparer:

Name	
Title:	
Firm Name:	
Telephone Number	
E-Mail Address	

DSH Version 7.25 05/03/2018

D. General Cost Report Year Information 01/01/2017 - 12/31/2017

The following information is provided based on the information we received from the state. Please review this information for items 4 through 8 and select "Yes" or "No" to either agree or disagree with the accuracy of the information. If you disagree with one of these items, please provide the correct information along with supporting documentation when you submit your survey.

1. Select Your Facility from the Drop-Down Menu Provided:	COFFEE REGIONAL MEDICAL CENTER		
	01/01/2017 through 12/31/2017		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		
3. Status of Cost Report Used for this Survey (Should be audited if available):	1 - As Submitted		
3a. Date CMS processed the HCRIS file into the HCRIS database:	06/25/2018		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	COFFEE REGIONAL MEDICAL CENTER	Yes	
5. Medicaid Provider Number:	000000448A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110089	Yes	
8a. Owner/Operator (Private, State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
8b. DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Small Rural	Yes	

Out-of-State Medicaid Provider Number. List all states where you had a Medicaid provider agreement during the cost report year:

	State Name	Provider No.
9. State Name & Number	FLORIDA STATE MEDICAID	014116100
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (01/01/2017 - 12/31/2017)

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	
4. **Total Section 1011 Payments Related to Hospital Services (See Note 1)**	$-
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)	
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	
7. **Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**	$-
8. **Out-of-State DSH Payments (See Note 2)**	

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 77,109	$ 692,446	$769,555
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 463,300	$ 3,110,490	$3,573,790
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)	$540,409	$3,802,936	$4,343,345
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	14.27%	18.21%	17.72%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** No

Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services	
15. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services	
16. Total Medicaid managed care non-claims payments (see question 13 above) received	$-

Note 1: Subtitle B - Miscellaneous Provision, Section 1011 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 provides federal reimbursement for emergency health services furnished to undocumented aliens. If your hospital received these funds during any cost report year covered by the survey, they must be reported here. If you can document that a portion of the payment received is related to non-hospital services (physician or ambulance services), report that amount in the section titled "Section 1011 Payments Related to Non-Hospital Services." Otherwise report 100 percent of the funds you received in the section related to hospital services.

Note 2: Report any DSH payments your hospital received from a state Medicaid program (other than your home state). In-state DSH payments will be reported directly from the Medicaid program and should not be included in this section of the survey.

F. MIUR / LIUR Qualifying Data from the Cost Report (01/01/2017 - 12/31/2017)

F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	14,923	(See Note in Section F-3, below)

F-2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges (Used in Low-Income Utilization Ratio (LIUR) Calculation):

2.	Inpatient Hospital Subsidies	
3.	Outpatient Hospital Subsidies	36,550
4.	Unspecified I/P and O/P Hospital Subsidies	
5.	Non-Hospital Subsidies	
6.	Total Hospital Subsidies	$ 36,550
7.	Inpatient Hospital Charity Care Charges	5,842,438
8.	Outpatient Hospital Charity Care Charges	5,034,625
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 10,877,063

F-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR) (W/S G-2 and G-3 of Cost Report)

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

		Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$22,579,581.00			$ 15,099,518	$ -	$ -	$ 7,480,063
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$0.00			$ -	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$81,063,403.00	$166,462,186.00		$ 54,209,080	$ 111,317,334	$ -	$ 81,999,175
20.	Outpatient Services		$55,606,364.00			$ 37,185,335	$ -	$ 18,421,029
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance			$ 4,138,670			$ 2,767,630	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$0.00			$ -	
26.	Other	$0.00	$257,121.00	$1,915,190.00	$ -	$ 171,943	$ 1,280,734	$ 85,178
27.	Total	$ 103,642,984	$ 222,325,671	$ 6,053,860	$ 69,308,598	$ 148,674,612	$ 4,048,364	$ 107,985,445
28.	Total Hospital and Non Hospital		Total from Above	$ 332,022,515		Total from Above	$ 222,031,574	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	332,022,515	Total Contractual Adj. (G-3 Line 2)	222,031,574
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	

34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)		-
35. Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"		-
35. Adjusted Contractual Adjustments		222,031,574

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2017-12/31/2017) COFFEE REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
126	**Total Ancillary**	$ 43,244,185	$ -	$ -	$ 43,244,185	$ 86,473,197	$ 192,678,432	$ 279,151,629	
127	**Weighted Average**								0.171602
128	**Sub Totals**	$ 61,392,393	$ -	$ -	$ 61,392,393	$ 98,590,650	$ 192,678,432	$ 291,269,082	
129	NF, SNF, and Swing Bed Cost for Medicaid *(Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)*				$0.00				
130	NF, SNF, and Swing Bed Cost for Medicare *(Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)*				$0.00				
131	NF, SNF, and Swing Bed Cost for Other Payors *(Hospital must calculate. Submit support for calculation of cost.)*								
131.01	Other Cost Adjustments (support must be submitted)								
132	**Grand Total**				$ 61,392,393				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost				0.00%				

* Note A - Final cost-to-charge ratios should include teaching cost. Only enter Intern & Resident costs if it was removed in Column 25 of Worksheet B, Pt. I of the cost report you are using.

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (01/01/2017-12/31/2017): COFFEE REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Diem Cost for Routine Cost Centers	Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
	Routine Cost Centers (from Section G):			Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	$ 749.93		1,190		908		1,618		494		1,212		4,208		45.88%
2	03100 INTENSIVE CARE UNIT	$ 1,396.70		249		59		194		40		293		542		38.71%
3	03200 CORONARY CARE UNIT	$ -												-		
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -												-		
6	03500 OTHER SPECIAL CARE UNIT	$ -												-		
7	04000 SUBPROVIDER I	$ -												-		
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ 1,709.38		57		608				134		19		799		88.11%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			Total Days	1,496		1,573		1,812		668		1,524		5,549		38.46%
19	Total Days per PS&R or Exhibit D#1&2			1,496		1,573		1,812		668		1,524				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 1,244,612		$ 1,262,410		$ 1,773,656		$ 551,481		$ 1,363,570		$ 4,832,159		51.14%
21.01	Calculated Routine Charge Per Diem			$ 831.96		$ 802.55		$ 978.84		$ 825.57		$ 894.73		$ 870.82		
	Ancillary Cost Centers (from W/S C) (from Section G):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	
22	09200 Observation (Non-Distinct)		0.575685	104,037	1,030,708	152,704	774,808	225,204	1,672,978	58,554	153,034	180,095	617,795	$ 600,499	$ 3,632,228	67.21%
23	5000 OPERATING ROOM		0.110430	1,449,175	1,758,339	1,284,045	3,080,081	1,705,981	3,920,475	465,027	244,467	949,545	1,590,298	$ 5,005,108	$ 9,905,302	49.81%
24	5100 RECOVERY ROOM		0.291927	47,428	69,472	90,156	222,444	49,408	132,932	32,708	17,368	47,428	88,178	$ 219,700	$ 447,210	49.11%
25	5200 DELIVERY ROOM & LABOR ROOM		0.952158	48,718	593	645,700	9,358	7,555	619,352	168,780	1,779	13,527	2,320	$ 870,850	$ 631,082	91.25%
26	5300 ANESTHESIOLOGY		0.012651	165,147	261,874	301,073	789,251	177,234	2,505,900	120,493	61,549	158,816	316,356	$ 763,941	$ 3,698,574	73.46%
27	5400 RADIOLOGY-DIAGNOSTIC		0.087492	65,102	1,140,309	103,016	1,777,333	512,809	3,140,456	64,844	316,300	468,859	1,697,530	$ 745,831	$ 6,373,518	39.61%
28	5700 CT SCAN		0.106765	504,846	1,489,201	129,492	1,892,173	784,208	812,003	94,156	357,464	783,660	4,998,005	$ 1,517,702	$ 9,550,841	40.49%
29	5800 MRI		0.105425	354,980	334,475	3,022	437,622	112,441	1,743,322	8,475	77,552	168,924	238,694	$ 478,918	$ 2,592,911	56.11%
30	5900 CARDIAC CATHETERIZATION		0.114740	433,562	512,305	47,444	104,731	510,811	4,189,103	7,763	124,220	470,491	528,648	$ 1,608,540	$ 5,930,359	53.87%
31	6000 LABORATORY		0.093643	2,019,223	2,290,548	995,031	3,764,644	3,008,050	504,056	543,487	602,368	2,372,828	4,001,302	$ 6,564,391	$ 7,151,914	48.51%
32	6500 RESPIRATORY THERAPY		0.124633	641,326	217,195	147,798	208,459	975,622	359,083	150,172	32,704	516,538	272,104	$ 1,916,818	$ 878,421	41.71%
33	6600 PHYSICAL THERAPY		0.300123	95,663	54,885	5,057	261,382	197,760	6,405	18,996	60,627	129,715	61,895	$ 320,368	$ 389,299	23.96%
34	6800 SPEECH PATHOLOGY		0.677779	10,710	610	306	2,135	3,010	-	610	305	8,190	-	$ 15,235	$ 3,050	47.69%
35	6900 ELECTROCARDIOLOGY		0.013374	258,003	249,233	46,431	267,137	712,438	1,303,326	72,413	57,003	504,432	788,223	$ 1,089,885	$ 1,900,759	46.56%
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.221266	647,808	1,009,918	801,103	1,586,267	1,149,509	2,317,522	325,945	237,722	803,399	2,069,626	$ 2,923,765	$ 5,161,429	50.12%
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.392150	661,573	482,690	230,205	308,664	1,031,495	1,687,718	16,301	21,532	117,083	138,378	$ 1,945,725	$ 2,560,594	35.54%
38	7300 DRUGS CHARGED TO PATIENTS		0.208998	1,444,193	787,544	437,904	740,788	1,885,401	2,280,535	450,895	120,897	1,325,980	1,052,409	$ 4,218,483	$ 3,924,774	38.91%
39	7400 RENAL DAYSIS		0.367448	32,706	-	-		156,570	41,028	12,798	789	44,082	15,024	$ 202,080	$ 41,817	36.78%
40	9001 WOUND CARE CLINIC		0.577436	-	-	-	1,731	7,280	226,783	203	32,745		14,500	$ 7,483	$ 261,259	32.62%
41	9002 INFUSION CLINIC		0.179153	540	108,849	-	-		16,747		-		1,252	$ 540	$ 125,598	27.34%
42	9100 EMERGENCY		0.314025	232,676	1,442,397	84,718	3,049,254	355,077	1,766,383	47,594	291,355	349,767	4,358,441	$ 720,085	$ 7,433,309	65.63%
43														$ -	$ -	
44			-											$ -	$ -	
45			-											$ -	$ -	
46			-											$ -	$ -	
47			-											$ -	$ -	
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63			-											$ -	$ -	
64			-											$ -	$ -	

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (01/01/2017-12/31/2017) COFFEE REGIONAL MEDICAL CENTER

				In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey
65			-											$ -	$ -	-
66			-											$ -	$ -	
67			-											$ -	$ -	
68			-											$ -	$ -	
69			-											$ -	$ -	
70			-											$ -	$ -	
71			-											$ -	$ -	
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73			-											$ -	$ -	
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123			-											$ -	$ -	
124			-											$ -	$ -	

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (01/01/2017-12/31/2017) COFFEE REGIONAL MEDICAL CENTER

		In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey
125												$ -	$ -	
126												$ -	$ -	
127												$ -	$ -	
	Totals / Payments	$ 9,280,717	$ 13,253,295	$ 5,522,260	$ 21,229,322	$ 13,666,036	$ 29,296,077	$ 2,659,424	$ 2,817,498	$ 9,300,240	$ 22,578,732			
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 10,525,329	$ 13,253,295	$ 6,784,670	$ 21,229,322	$ 15,439,692	$ 29,296,077	$ 3,210,905	$ 2,817,498	$ 10,753,810 (Agrees to Exhibit A)	$ 22,578,732 (Agrees to Exhibit A)	$ 35,960,596	$ 66,596,192	46.71%
129	Total Charges per PS&R or Exhibit Detail	$ 10,525,329	$ 13,253,295	$ 6,784,670	$ 21,229,322	$ 15,439,692	$ 29,296,077	$ 3,210,905	$ 2,817,498	$ 10,753,810	$ 22,578,732			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 2,903,903	$ 2,475,249	$ 3,204,620	$ 3,756,944	$ 3,746,145	$ 5,541,125	$ 1,198,599	$ 493,098	$ 2,750,662	$ 3,846,764	$ 11,053,267	$ 12,266,416	48.77%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 2,990,206	$ 1,938,304			$ 434,062	$ 317,756	$ 1,254,565	$ 769,126			$ 4,678,833	$ 3,025,186	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 2,348,039	$ 3,288,256	$ -	$ -					$ 2,348,039	$ 3,288,256	
134	Private Insurance (including primary and third party liability)	$ 100,039	$ 32,358			$ 1,271	$ 7,198					$ 101,310	$ 39,556	
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ 48	$ 1,653			$ 13	$ 14,465			$ 61	$ 16,118	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 3,090,245	$ 1,970,662	$ 2,348,087	$ 3,289,909									
137	Medicaid Cost Settlement Payments (See Note B)											$ -	$ -	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 3,412,820	$ 3,976,546					$ 3,412,820	$ 3,976,546	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)											$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments					$ 188,833	$ 325,761			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 188,833	$ 325,761	
142	Other Medicare Cross-Over Payments (See Note D)											$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 77,109	$ 692,446			
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)									$ -	$ -			
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ (186,342)	$ 504,587	$ 856,533	$ 467,035	$ (290,841)	$ 913,864	$ (55,979)	$ (290,493)	$ 2,673,553	$ 3,154,318	$ 323,371	$ 1,594,993	
146	**Calculated Payments as a Percentage of Cost**	106%	80%	73%	88%	108%	84%	105%	159%	3%	18%	97%	87%	
147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)**					7,828								
148	**Percent of cross-over days to total Medicare days from the cost report**					24%								

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
Note E - Medicaid Managed Care payments should include *all* Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2017-12/31/2017) | COFFEE REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost	Medicaid Cost to Charge Ratio for Ancillary Cost	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
	Routine Cost Centers (list below):			**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000 ADULTS & PEDIATRICS	$ 749.23						1				1	
2	03100 INTENSIVE CARE UNIT	$ 1,396.70										-	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ -										-	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 1,709.36										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	-		-		1		-		1	
19	Total Days per PS&R or Exhibit Detail			-		-		1		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges							$ 687				$ 687	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ 687.00		$ -		$ 687.00	
	Ancillary Cost Centers (from W/S C) (list below):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**
22	09200 Observation (Non-Distinct)		0.575685		1,165			1,173	5,989			$ 1,173	$ 7,154
23	5000 OPERATING ROOM		0.110436									$ -	$ -
24	5100 RECOVERY ROOM		0.261927									$ -	$ -
25	5200 DELIVERY ROOM & LABOR ROOM		0.952158									$ -	$ -
26	5300 ANESTHESIOLOGY		0.012651									$ -	$ -
27	5400 RADIOLOGY-DIAGNOSTIC		0.087492		1,198			2,171	13,990			$ 2,171	$ 15,188
28	5700 CT SCAN		0.106765		7,666				8,128			$ -	$ 15,794
29	5800 MRI		0.105425						5,451			$ -	$ 5,451
30	5900 CARDIAC CATHETERIZATION		0.114740		12,422							$ -	$ 12,422
31	6000 LABORATORY		0.093643		11,394			4,416	18,919			$ 4,416	$ 30,313
32	6500 RESPIRATORY THERAPY		0.124633		228			1,632	4,574			$ 1,632	$ 4,802
33	6600 PHYSICAL THERAPY		0.360123						1,065			$ -	$ 1,065
34	6800 SPEECH PATHOLOGY		0.677779									$ -	$ -
35	6900 ELECTROCARDIOLOGY		0.013374		3,554			1,462	6,525			$ 1,462	$ 10,079
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.221266		2,329			896	9,507			$ 896	$ 11,836
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.392150		729							$ -	$ 729
38	7300 DRUGS CHARGED TO PATIENTS		0.208998		1,591			1,498	5,021			$ 1,498	$ 6,612
39	7400 RENAL DIALYSIS		0.367448									$ -	$ -
40	9001 WOUND CARE CLINIC		0.577436									$ -	$ -
41	9002 INFUSION CLINIC		0.170153									$ -	$ -
42	9100 EMERGENCY		0.314025		6,864			795	9,135			$ 795	$ 15,999
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
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I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2017-12/31/2017) COFFEE REGIONAL MEDICAL CENTER

		Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
79										$ -	$ -
80										$ -	$ -
81										$ -	$ -
82										$ -	$ -
83										$ -	$ -
84										$ -	$ -
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126										$ -	$ -
127										$ -	$ -
		$ -	$ 49,140	$ -	$ -	$ 14,043	$ 88,304	$ -	$ -		

Totals / Payments

128	**Total Charges (Includes organ acquisition from Section K)**	$ -	$ 49,140	$ -	$ -	$ 14,730	$ 88,304	$ -	$ -	$ 14,730	$ 137,444
129	Total Charges per PS&R or Exhibit Detail	$ -	$ 49,140	$ -	$ -	$ 14,730	$ 88,304	$ -	$ -		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (Includes organ acquisition from Section K)**	$ -	$ 7,451	$ -	$ -	$ 3,012	$ 14,948	$ -	$ -	$ 3,012	$ 22,399
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		$ 4,405			$ 4,004	$ 11,491			$ 4,004	$ 15,896
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)									$ -	$ -
134	Private Insurance (including primary and third party liability)									$ -	$ -
135	Self-Pay (including Co-Pay and Spend-Down)									$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ 4,405	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)									$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)									$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)									$ -	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									$ -	$ -
141	Medicare Cross-Over Bad Debt Payments									$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)									$ -	$ -
143	**Calculated Payment Shortfall / (Longfall)**	$ -	$ 3,046	$ -	$ -	$ (992)	$ 3,457	$ -	$ -	$ (992)	$ 6,503
144	**Calculated Payments as a Percentage of Cost**	0%	59%	0%	0%	133%	77%	0%	0%	133%	71%

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey)
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R)
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments)
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments

J. Transplant Facilities Only: Organ Acquisition Cost In-State Medicaid and Uninsured

Cost Report Year (01/01/2017-12/31/2017) COFFEE REGIONAL MEDICAL CENTER

		Total Organ Acquisition Cost	Additional Add-in Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured) See Note C below*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Organ Acquisition Cost Centers (list below):															
1	Lung Acquisition	$0.00	$ -	$ -		0										
2	Kidney Acquisition	$0.00	$ -	$ -		0										
3	Liver Acquisition	$0.00	$ -	$ -		0										
4	Heart Acquisition	$0.00	$ -	$ -		0										
5	Pancreas Acquisition	$0.00	$ -	$ -		0										
6	Intestinal Acquisition	$0.00	$ -	$ -		0										
7	Islet Acquisition	$0.00	$ -	$ -		0										
8		$0.00	$ -	$ -		0										
9	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
10	**Total Cost**							-		-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).
Note B: Enter Organ Acquisition Payments in Section H as part of your In-State Medicaid total payments.
Note C: Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

K. Transplant Facilities Only: Organ Acquisition Cost Out-of-State Medicaid

Cost Report Year (01/01/2017-12/31/2017) COFFEE REGIONAL MEDICAL CENTER

		Total Organ Acquisition Cost	Additional Add-in Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured) See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	$ -	$ -	$ -	$ -	0								
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0								
13	Liver Acquisition	$ -	$ -	$ -	$ -	0								
14	Heart Acquisition	$ -	$ -	$ -	$ -	0								
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0								
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0								
17	Islet Acquisition	$ -	$ -	$ -	$ -	0								
18		$ -	$ -	$ -	$ -	0								
19	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20	**Total Cost**							-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).
Note B: Enter Organ Acquisition Payments in Section I as part of your Out-of-State Medicaid total payments.

L. Provider Tax Assessment Reconciliation / Adjustment

An adjustment is necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals. The Medicaid and uninsured share of the provider tax assessment collected is an allowable cost in determining hospital-specific DSH limits and, therefore, can be included in the DSH examination survey. However, depending on how your hospital reports it on the Medicare cost report, an adjustment may be necessary to ensure the cost is properly reflected in determining your hospital-specific DSH limit. For instance, if your hospital removed part or all of the provider tax assessment on the Medicare cost report, the full amount of the provider tax assessment would not have been apportioned to the various payers through the step down allocation process, resulting in the Medicaid and uninsured share being understated in determining the hospital-specific DSH limit. If your hospital needs to make an adjustment for the Medicaid and uninsured share of the provider tax assessment, please fill out the reconciliation below, and submit the supporting general ledger entries and other supporting documentation to Myers and Stauffer, LC along with your hospital's DSH examination surveys.

Cost Report Year (01/01/2017-12/31/2017) COFFEE REGIONAL MEDICAL CENTER

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 1,238,310		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Expense	7701-3570	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 1,238,310	Administrative and General	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)		$ 0		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*				*(Reclassified to / (from))*
5	*Reclassification Code*				*(Reclassified to / (from))*
6	*Reclassification Code*				*(Reclassified to / (from))*
7	*Reclassification Code*				*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*				*(Adjusted to / (from))*
9	*Reason for adjustment*				*(Adjusted to / (from))*
10	*Reason for adjustment*				*(Adjusted to / (from))*
11	*Reason for adjustment*				*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*				
13	*Reason for adjustment*				
14	*Reason for adjustment*				
15	*Reason for adjustment*				
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ 1,238,310		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report	$ 0	

** Assessment must exclude any non-hospital assessment such as Nursing Facility.*

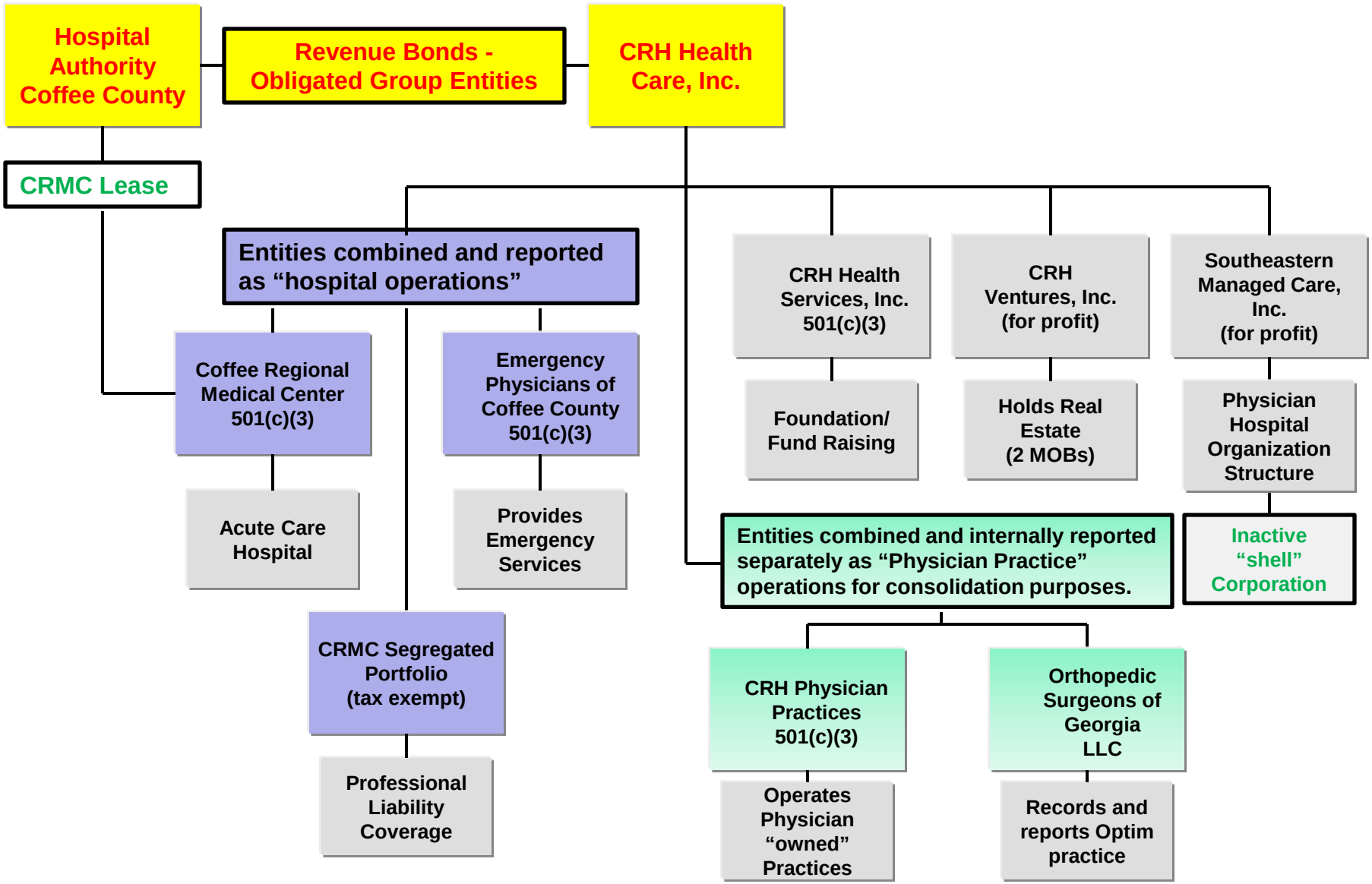
Real Property Holdings Owned by the Hospital (HB 321)								
Location[1]	**Parcel ID Number**	**Estimated Size**	**Purchase Price**[2]	**Current HealthCare Purpose?**[3]		**Improvements?**[4]		**Notes** (Optional)
				Yes	No	Yes	No	
1101 Ocilla Rd. Douglas, GA 31533	D006 142	5.09 acres	$802,482	Yes		Yes		
100 Doctors Drive, Douglas, GA 31533	D002009X	1.93 acres	$109.508	Yes		Yes		
100 Drs. Dr. Suite G Douglas, GA 31533	D002009C	UNK	$545,000	Yes		Yes		
200 Doctors Drive, Douglas, GA	UNK	1.93 acres	$109.507	Yes		Yes		
200 Doctors Drive Suite 106 / N, Douglas, GA 31533	D002009J	UNK	$675,000	Yes		Yes		
223 Shirley Ave Douglas, GA 31533	D007154	0.31 acres	$103,081	No		Yes		
101 Seymour Ave Douglas, GA 31533	D006005	0.93 acres	$410,000	Yes		Yes		
1200 Ward Street Douglas, GA 31533	D003001	4.4 acres	$180,000	Yes		Yes		

[1] Location may be the county, address, or site identification/description.
[2] Purchase price to be listed as of the date of acquisition of the property by the hospital, if known. If unknown, state "UNK".
[3] Health care purpose includes the provision of patient care; the provision or delivery of healthcare services, including supportive administrative services; the training and education of physicians, nurses, and other healthcare personnel; and community education and outreach relating to health care or wellness.
[4] Improvement means the permanent addition or construction of a building or structure.

1305 Ocilla Road Douglas, GA 31533	D002008	0.58 acres	$545,000	Yes		Yes		
2010 Ocilla Rd, Douglas, GA 31533	0097B010	1.04 acres	$750,000	Yes		Yes		
1100 Ward St. Ext. Douglas, GA 31533	D006003	0.67 acres	107,422	Yes		Yes		
523 Bowens Mill Rd Douglas, GA 31533	0098183	0.97 acres	$225,000	Yes		Yes		
205 Shirley Ave. Douglas, GA 31533	D007143	0.58 acres	$110,000	Yes		Yes		
304 Westside Drive, Douglas, GA 31533	D006130	0.56 acres	225,000	Yes		Yes		
196 Westside Drive, Douglas, GA 31533	D006127	1.18 acres	552,713	Yes		Yes		
Date: _____. Revised: _____.								

List of Hospital Joint Ventures and Ownership Interests (HB 321)				
Entity Name	**Domicile**	**Nature of Ownership or Interest**	**Book Value of Ownership or Interest**	**Notes** (Optional)
Coffee Regional Medical Center Segregated Portfolio	Cayman Islands	The entity was created as a segregated portfolio of the Georgia Health Care Insurance Company SPC. The entity is funded by CRMC, who retains contractual rights to all beneficial interest in the entity.	See consolidated financial statements	Purpose of entity is to provide CRMC and affiliates with professional and general liability coverage.

CRH Health Care, Inc. (Parent Company) > Consolidating Entities Organization Reporting Chart



For the Year Ended December 31, 2017

Compensation/Benefits Report – Administrative Positions in the Hospital (HB 321)						
(A) Position Title*	**(B) Breakdown of W-2 and/or 1099-MISC Compensation**				**(C) Retirement and other Deferred Compensation**	**(D) Nontaxable Benefits**
	(i) Base Compensation	(ii) Bonus & Incentive Comp.	(iii) Taxable Deferred Comp. Accrued in Prior Years	(iv) Other Reportable Compensation		
1. President / CEO	385,449					13,765
2. Executive VP / Chief Nursing Executive	260,292					19,941
3. VP / Executive Director of Foundation (1)	190,020					0
4. VP of Performance Improvement & Director of Pharmacy (2)	188,009					19,941
5. VP / Controller (3)	148,282					19,941
6. VP of Nursing Services (4)	125,795					0
7. VP of CRH Physician Practices	120,204					19,941
8. VP of Operations	117,871					19,941
9. VP of Human Resources (5)	106,867					4,588
10. Nursing Director of Emergency Services	103,342					13,765

(1) Transition from VP/Controller
(2) In position for 9 months
(3) CFO not listed as it was a contract position for 2017. Total paid to CFO contractor was $260,565
(4) In position for 9 months
(5) In position for 10 months – resigned October 2017

Note, all individuals in the list above were full-time employees.

CERTIFICATE OF ACCREDITATION

Certificate No.:	Initial date:	Valid until:
276419-2018-AHC-USA-NIAHO	9/14/2018	9/14/2021

This is to certify that:

Coffee Regional Medical Center

1101 Ocilla Hwy, Douglas, GA 31533

has been found to comply with the requirements of the:

NIAHO® Hospital Accreditation Program

Pursuant to the authority granted to DNV GL Healthcare USA, Inc. by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, this organization is deemed in compliance with the Medicare Conditions of Participation for Hospitals (42 C.F.R. §482).

This certificate is valid for a period of three (3) years from the Effective Date of Accreditation.

For the Accreditation Body:
DNV GL - Healthcare
Katy, TX

Patrick Horine
Chief Executive Officer

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Financial Assistance/Charity Policy

Department(s)	Financial Counseling, Patient Financial Services, Patient Access
Original Effective Date	03/01/1998
Scope	Departmental

Cross Reference TJC Standard			
Current Review Date	01/08/2014, 12/22/2015, 05/18/2017, 02/14/2018		
Signatures	Deborah Massey	Date	02/14/2018
Prepared by	Deborah Massey	Title	PFS Director
Signatures	Lavonda Cravey	Date	02/14/2018
Approved by	Lavonda Cravey	Title	VP Corporate Revenue

PURPOSE

Coffee Regional Medical Center ("CRMC") is a non-profit healthcare provider recognized by the Internal Revenue Service as a tax-exempt organization under Internal Revenue Code Section 501(c)(3). CRMC's mission is to be the recognized regional center of health care excellence in South Georgia through the promotion of health and the delivery of health related services. We will work as a community partner, providing quality, cost-effective, personal and progressive healthcare, serving the health care needs of Coffee County and the surrounding area for more than half a century. "TO SERVE, TO HEAL, TO SAVE"

POLICY STATEMENT

CRMC is committed to providing Financial Assistance Program ("FAP") to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. CRMC strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. CRMC will provide, without discrimination, care for emergency medical conditions (within the meaning of EMTALA) and medically necessary care to individuals regardless of their eligibility for financial assistance or for government assistance.

Accordingly, this written policy;

- Includes eligibility criteria for financial assistance – free and discounted (partial charity) care;
- Describes the basis for calculating amounts charged to patients eligible for financial assistance under this policy;
- Describes the method by which patients may apply for financial assistance;
- Describes how the hospital will widely publicize the policy within the community served by the hospital;
- Limits the amounts that the hospital will charge for emergency or other medically necessary care provided to individuals eligible for financial assistance to amount generally billed (received by) the hospital for commercially insured or Medicare patients.

In order to manage its resources responsibly and to allow CRMC to provide the appropriate level of assistance to the greatest number of persons in need, the Board of Directors establishes the following guidelines for the provision of patient financial assistance.

Financial assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with CRMC's procedures for obtaining financial assistance or other forms of payment and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services, for their overall personal health, and for the protection of their individual assets.

The Financial Counseling Department will provide information and applications to all patients/guarantors seeking financial assistance for services rendered at CRMC that are deemed medically necessary.

Financial Counselors will discuss eligibility for Medical Assistance Programs through the Department of Family & Children Services and Social Security Administration. If eligibility is not met for any Medical Assistance Program, the Financial Counseling Department will seek eligibility through CRMC's FAP.

Funds available for patient care under the FAP are directly tied to annual allocations to CRMC by the State of Georgia Department of Community Health through the Indigent Care Trust Fund and are subject to variations in amounts from year to year. Per FAP guidelines, CRMC shall not be required to provide services without charge, or at a reduced charge once the Hospital's expenditures meet the medical indigence services requirement described on Page R-7 subsection II B(e)12(c) of the Financial Assistance Program manual, and as required meeting emergencies and as required by EMTALA.

Given the limited funding available through the FAP, priority for use of funds will apply to Emergency Room and Inpatient care provided to patients. Elective procedures, those services determined to be of a non-emergent nature, and services which can be performed in a lower cost setting, (i.e., outside of the hospital) will carry the lowest priority for use of Financial Assistance funds and will only be adjusted at maximum of 85%.

A. **Services Eligible Under This Policy.** For purposes of this policy, "financial assistance" refers to healthcare services provided by CRMC without charge or at a discount to qualifying patients. The following services are considered medically necessary and are eligible for financial assistance:

1. Emergency medical services provided in an emergency room setting or posing a threat to the patient's ongoing health or well-being;

2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;

3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and

4. Medically necessary services, evaluated on a case-by-case basis at CRMC's discretion based on an examining physician's determination.

B. **Eligibility for Financial Assistance.** Eligibility for financial assistance will be considered for those individuals who are uninsured, underinsured, ineligible for any government health care benefit program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this FAP. The granting of financial assistance shall be based on an individualized determination of financial need, and shall not take into account age,

gender, race, social or immigrant status, sexual orientation or religious affiliation. Each request for financial assistance will be reviewed independently and reviewed on a case-by-case basis.

C. **Method by Which Patients May Apply for Financial Assistance.**

1. Financial need will be determined in accordance with procedures that involve an individual assessment of financial need; and may

    a. Include an application process, in which the patient or the patient's guarantor are required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need;

    b. Include the use of external publically available data sources that provide information on a patient's or a patient's guarantor's ability to pay (such as credit scoring);

    c. Include reasonable efforts by CRMC to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs;

    d. Take into account the patient's available assets, and all other financial resources available to the patient; and

    e. Include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history.

2. It is preferred but not required that a request for financial assistance and a determination of financial need occur prior to rendering of non-emergent medically necessary services. However, the determination may be done at any point in the collection cycle. The need for financial assistance shall be re-evaluated at each subsequent time of services if the last financial evaluation was completed more than a six month period, or at any time additional information relevant to the eligibility of the patient for charity becomes known.

3. CRMC's values of human dignity and stewardship shall be reflected in the application process, financial needs determination and granting of financial assistance. Requests for charity shall be processed promptly and CRMC shall notify the patient or applicant in writing within five (5) days of receipt of a completed application.

D. **Presumptive Financial Assistance Eligibility.** There are instances when a patient may appear eligible for financial assistance discounts, but there is no financial assistance form on file due to a lack of supporting documentation. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, CRMC could use outside agencies in determining estimated income amounts for the basis of determining financial assistance eligibility and potential discount amounts. Once determined, due to the inherent nature of the presumptive circumstances, the only discount that can be granted is a 100% write off of the account balance. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

1. State-funded prescription programs;

2. Homeless or received care from a homeless clinic;

3. Participation in Women, Infants and Children programs (WIC);

4. Food stamp eligibility;

5. Subsidized school lunch program eligibility;

6. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down);

7. Low income/subsidized housing is provided as a valid address; and

8. Patient is deceased with no known estate.

DEFINITIONS

For the purpose of this policy, the terms below are defined as follows:

Financial Assistance: Healthcare services that have been or will be provided but are never expected to result in cash inflows. Financial Assistance results from a provider's policy to provide healthcare services free or at a discount to individuals who meet the established criteria.

Family: Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service rules, if the patient claims an individual as a dependent on his or her income tax return, the individual may be considered a dependent for purposes of the provision of financial assistance.

Family Income: Family Income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:

- Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;
- Noncash benefits (such as food stamps and housing subsidies) do not count;
- Determined on a before-tax basis;
- Excludes capital gains or losses; and
- If a person lives with a family, includes the income of all family members. (Non-relatives, such as housemates, do not count).

Federal Poverty Guidelines (FPG): guidelines published annually in the Federal Register; amounts are driven based on income and family size; FPG is used as the basis for determining categorization of financial assistance program

Plain Language Summary: a description of the application process, appropriate times to apply for financial assistance, and contact information for CRMC's financial assistance counselor who can provide assistance with the application process

Insured: a patient with health insurance coverage

Uninsured: The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations.

Underinsured: The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed his/her financial abilities

Discount: an adjustment to reduce the balance due on an account

Gross charges: The total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied.

Emergency medical conditions: Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

Medically necessary: As defined by Medicare (services or items reasonable and necessary for the diagnosis or treatment of illness or injury).

Emergent Admission: a condition requiring immediate medical attention, time delay would be harmful to the patient; illness is acute and/or potentially threatening to life or function

Urgent Admission: a condition requiring medical attention within a short period; a possible danger exists to the patient if medically unattended

Non-Urgent Admission: a condition which does not require the resources of an Emergency Department or emergency services; referral for routine medical care may or may not be needed; illness is non-acute or minor in severity

PROCEDURES

1. Patients/guarantors requesting financial assistance are referred to the Financial Counselors (FC) or Benefit Specialist at the time of registration for outpatient services and emergency department, (after medical screening has been completed), social services request, physician offices request or from the Patient Financial Services Department. Patients admitted for inpatient or observation services may be visited by the FC after the patient has been placed in a room and stabilized.

2. FC will discuss with the patient/guarantor the FAP requirements and application process. If verification is not provided at the time of the interview, the patient/guarantor will be required to provide within 30 days. CRMC cannot deny assistance due to an applicant's failure to provide information or documentation not specified in the FAP or the application. The patient/guarantor will be required to complete a Financial Assistance application, provide proof of the following:

- Most recent bank statements for personal and business checking and savings accounts;
- Recent pay stub(s) with validation of pay frequency;
- Current year w-2 form and/or recent year tax return;
- Written verification of wage from employer;
- Written verification from public welfare agencies or other government agencies which can attest to the patients gross income status for the past 12 months;
- Social security award letter;
- Verification of pension or retirement income
- Attorney and/or child support court order or divorce decree;
- Statement of no income
- State of Georgia separation notice and status of unemployment filing;
- Verification of student status;
- Monthly expenses (i.e., utilities, auto payment, insurance, loans, etc.)
- Patients seeking assistance due to medical indigence may need to submit evidence of assets.

Applications made on behalf of deceased patients must have verification of income and information concerning the value of the patients' estate and provide a death certificate. CRMC will make an attempt to verify patient's estate through websites, court documents, and newspapers.

3. **CRMC shall make available on request, free of charge, by mail and at the hospital** (in at the emergency department and admissions) in English and Spanish: the FAP, application form, and plain language summary

4. Patients/guarantors may contact CRMC's financial assistance counselor directly at 912-383-6969, if they feel they may qualify for financial assistance. Financial Counseling services are also provided in, but are not limited to , the following points of service:

- All registration areas
- Insurance Verification/Pre-admission/Pre-certification
- Inpatient hospital rooms
- Direct contact with patients or their families/friends
- Physicians and/or office representatives
- Emergency room
- Billing and Collections
- All other departments in CRMC

4. Upon receipt of the completed application including necessary documentation, calculation of the household size and annual household income is computed and compared to the Federal Poverty Guidelines (FPL) to determine the percentage of assistance a patient/guarantor is eligible to receive. Patients whose annual household income is below the Gross Income Ceiling for potential Medicaid eligibility are required to apply for Medicaid. Assistance is provided to patients in filing for other benefits and completing Medicaid applications.

- Patients who choose not to utilize current benefits they are eligible for, i.e. Veterans benefits, Medicare, Medicaid, and commercial insurance will not be considered for the FAP Program.

- Patients who choose to apply CRMC's accounts for the purpose of meeting medically needy spend down to receive ongoing Medicaid will not be allowed to apply for the financial assistance program for that account.

- Patients/guarantors over eighteen (18) years of age, but classified as dependents for tax purposes due to student eligibility, will have a total household size including parents and subsequent income.

- Patients/guarantors under twenty-one (21) years of age living in the home with their parents will have a total household size including parents and parents' income. If the patient/guarantor can provide proof of self-sufficiency, the situation will be evaluated and may be considered on patient's/guarantor's income alone.

- Patients applying for prior year dates of service eligibility will be determined based on the income of that year.

4. Patients/guarantors not eligible for other medical assistance programs will be processed under the FAP guidelines using the following categories:

- **Indigent** - Patients whose annual household income is below 125% of the FPL, the applicable accounts will be adjusted to zero balances.

- **Charity** - Patients whose annual household income is greater than or equal to 125% but not greater than 200% of the FPL, the applicable accounts will be adjusted by the appropriate percentages.

    1. An adjustment of 85% of gross charges for emergency or other medically necessary care for patients whose annual household income is between 125% and 150% of FPL.
    2. An adjustment of 70% of gross charges for emergency or other medically necessary care for whose annual household income is between 150% and 175% of FPL.
    3. An adjustment of 62% of gross charges for emergency or other medically necessary care for whose annual household income is between 175% and 200% of FPL.

- **Catastrophic** - Patients whose annual household income is greater than 200% FPL may qualify for

charity adjustments on applicable accounts if consideration of CRMC patient obligations reduces the annual household income to the appropriate FPL.

1. In the instance that the patient's total annual household income is less than the total liability or charges, and the liability results in the income falling below the 200% of the FPL, then the patient may be eligible up to a maximum of a 85% adjustment.

5. Notification of status of completed application is provided to the patient/guarantor within five (5) working days of receipt of needed information. Approved applications are valid for ninety (90) days from the date of signature. After the initial ninety (90) days, a re-validation may be completed in writing or verbally between the financial counselor and patient/guarantor. A new financial assistance application is required after the six (6) month period.

6. Incomplete applications are held for thirty (30) days. If no documentation is provided to complete the application, a denial letter is sent to the patient/guarantor. The application may be completed if the patient/guarantor provides the requested information within fifteen (15) working days of the denial. Notification of status of completed application will be mailed within fifteen (15) working days of receipt of needed information.

7. The application and documentation will become property of CRMC and is to be kept confidential in the same manner as medical records. However, this information will be used for aggregate reporting purposes only.

8. Patients who are insured or have a third-party liability claim are only eligible to apply for financial assistance in the event they have a remaining balance after all payment resources are exhausted. Additionally, CRMC may make adjustments for medically indigent patients whose medical or hospital bills from all related and unrelated health care providers, after payment by all third-party sources, would cause the patient significant financial hardship

9. If a patient has already established a payment plan or made payments on their account, and subsequently approved for financial assistance, any payments over the co-pay amount will either be applied to other outstanding accounts, or refunded to the patient if no other outstanding accounts exist.

Calculations of amounts charged to patients

1. CRMC uses the look back method to determine the Amounts Generally Billed (AGB) to patients whom qualify for financial assistance. That means that CRMC reviews the actual past claims paid to the hospital by Medicare Fee-for service together with all private health insurers paying claims to the hospital. CRMC will not bill a financial assistance eligible person more that the AGB rate specific to emergency or other medically necessary care.

2. The AGB percentage is readily available upon request. For a written description of how CRMC determined this percentage please contact our Financial Counselor. CRMC will mail the patient a copy of the information free of charge.

3. CRMC does not bill or expect payment of gross/total charges from individuals whom qualify for financial Assistance, or who have no health insurance but does not qualify for financial assistance (i.e. self pay)

Publication of Policy

1. CRMC will take the following measures to publicize its FAP policy, free of charge:

- Provide copies of policy at access points in the facility
- Post this policy and FAP (in English and Spanish) on the CRMC internet page for the public to view and print.
- Include in the annual Community Benefit Report
- Provide/mail copies or email copies when requested via phone or mail from Financial Counselors, Financial Advisors, or any collection agencies working on our behalf.

- Offer a paper copy of the FAP, the application, and a plain language summary (in English and Spanish) to patients as part of the intake or discharge process

2. Plain language versions of the Financial Assistance summary document and application will also be provided in Spanish, free of charge, when requested. Spanish versions will also be posted on the CRMC internet site.

Patient Collections

CRMC makes reasonable efforts to ensure that patients are billed for their services accurately and timely. CRMC will attempt to work with all patients to establish suitable payment arrangements if payment in full cannot be made at the time services are provided on or upon the first patient bill being delivered to the patient. Typically, patients will receive their first statement within 6 days of discharge from the facility.

CRMC established a self-pay fee schedule to consistently discount uninsured patient bills. At the time of admission if a patient is uninsured the patient is registered as self pay. CRMC management system will automatically discount each self pay visit registered. Once a FAP is complete and approved the discount will be reversed and appropriate FAP discount applied.

Patient Billing Notices & Time Frames

- Uninsured patients will receive their first statement within 5 days of discharge from the facility
- The first three statements will include an overview of CRMC's FAP that will contain information about the program, contact information for CRMC Financial Counselor, where to obtain a copy of the FAP free of charge,
- Before pursuing extraordinary collection actions (defined below), CRMC makes reasonable efforts to determine whether an individual is FAP-eligible. The Patient Billing Supervisor has final authority for determining whether reasonable efforts have been made and the required information to submit with an application for financial assistance.
    - A plain language summary and application before discharge and in one post-discharge mailing
    - A "conspicuous written notice" (availability of FAP, phone number for assistance, and URL for FAP documents) with every bill during the 120 days post-discharge
    - Oral notice of intended ECA(s) during all oral communications with patients against whom ECA(s) are intended
    - At least one written notice of intended ECA(s)
- Patients **will not** be referred for collection agency follow up in less than 120 days from date of the first post-discharge billing statement. Patients will be allowed to request financial assistance up to 240 days from the date of the first post-discharge billing statement, or at any time during the collection process.

Extraordinary Collections Actions (ECA's)

- CRMC is responsible for its patient and/or guarantor collection process, to include pre-collection agency follow up and bad debt collection, hospital liens for accounts involved in litigation that could result in a financial judgment for the patient and Civil Action and Garnishments that would result in a financial judgment for the patient. However after 240 days accounts are subject to the following ECAs only after written notice (informing the individual of potential ECAs if the individual does not submit a complete FAP application or pay the amount due by a deadline specified in the notice) provided at least 30 days in advance of initiating intended ECAs
    - Placement with collection agency

- Credit Agency Reporting

If during the course of the collections follow up, a patient or guarantor requests financial assistance or indicates that they are uninsured and cannot pay for their care, they will be referred to CRMC Financial Advisors and Financial Counselor to be screened for potential program eligibility. If the Financial Assistance team determines a patient may be eligible for assistance, collection activity will continue until the patient returns the appropriate application. Once the application is received, regardless of the completeness, all further collection activity will be stopped pending a decision from the Financial Counselor.

Billing and Collection Policy

Department(s)	Patient Financial Services
Original Effective Date	07/14/2011
Scope	Departmental

Cross Reference TJC Standard			
Current Review Date	03/12/2014, 09/24/2019		
Signatures	Deborah Massey	Date	09/24/2019
	Deborah Massey	Title	Director of PFS
Signatures Approved by	Lavonda Cravey	Date	09/24/2019
	Lavonda Cravey	Title	VP of Corporate Revenue

POLICY

It is the policy of Coffee Regional Medical Center (CRMC) to provide outstanding medical care to our patients while maintaining patient confidentiality in accordance with the HIPPA established guidelines. CRMC's goal it to create a fair and efficient process of collecting payment for services rendered to the community it serves regardless of race, creed, color, sex, national origin, sexual orientation, handicap, age, or ability to pay.

CRMC has established a goal of meeting the needs of the community by treating all patients equally with dignity, respect, and confidentiality. Also CRMC goals is to respond promptly to patient inquiries regarding their bills and request for assistance, ensure hospital billing and collection guidelines are followed, and communicate financial responsibility to the patient before services are rendered when possible.

CRMC will evaluate all requests for financial assistance in accordance to the Financial Assistance/Charity policy for Coffee Regional Medical Center and will also communicate financial responsibilities prior to and/or after medical services have been rendered. All services will be billed in a timely and accurate manner, in accordance with all applicable federal, state and local laws and regulations.

CRMC will pre-admit/pre-register patients for services when possible. Pre-service payments will be requested prior to or at the time of service for uncovered portions of patient's charges. The amount requested for payment will be determined after verification of eligibility and insurance benefits.

Coffee Regional Medical Center as a courtesy will submit the standard UB or 1500 claim form to insurance carriers electronically and/or hardcopy if the patient provides required insurance information and signs a consent/assignment of benefits. Patient responsibility with insurance coverage will be determined by contractual agreements with third party payers and the patient's health benefit plan. Patients will be responsible for any unpaid balances including deductibles, co-pays, co-insurance, or non-covered services.

Internal collections and external collection agencies may be used to collect outstanding balances owed.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2018 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP406

Facility Name: Coffee Regional Medical Center

County: Coffee

Street Address: 1101 Ocilla Road

City: Douglas

Zip: 31533

Mailing Address: PO Box 1287

Mailing City: Douglas

Mailing Zip: 31534

2. Report Period

Please report data for the hospital fiscal year ending during calender year 2018 only.
Do not use a different report period.

Please indicate your hospital fiscal year.
From: 1/1/2018 To:12/31/2018

Please indicate your cost report year.
From: 01/01/2018 To:12/31/2018

Check the box to the right if your facility was **not** operational for the entire year. ☐
If your facility was **not** operational for the entire year, provide the dates the facility was operational.

3. Trauma Center Designation Change During the Report Period

Check the box to the right if your facility experienced a change in trauma center designation during the report period.
If your facility's trauma center designation changed, provide the date and type of change. ☐

Part B : Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey.

Contact Name: John McLeod
Contact Title: Controller
Phone: 912-384-1900
Fax: 912-383-5667
E-mail: john.mcleod@coffeeregional.org

Part C : Financial Data and Indigent and Charity Care

1. Financial Table

Please report the following data elements. Data reported here must balance in other parts of the HFS.

Revenue or Expense	Amount
Inpatient Gross Patient Revenue	115,785,783
Total Inpatient Admissions accounting for Inpatient Revenue	4,792
Outpatient Gross Patient Revenue	230,698,296
Total Outpatient Visits accounting for Outpatient Revenue	81,113
Medicare Contractual Adjustments	137,247,632
Medicaid Contractual Adjustments	49,412,137
Other Contractual Adjustments:	36,666,980
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	17,075,169
Gross Indigent Care:	17,119,670
Gross Charity Care:	4,174,515
Uncompensated Indigent Care (net):	17,119,670
Uncompensated Charity Care (net):	4,174,515
Other Free Care:	1,049,875
Other Revenue/Gains:	7,304,859
Total Expenses:	93,090,995

2. Types of Other Free Care

Please enter the amount for each type of other free care. The amounts entered here must equal the total "Other Free Care" reported in Part C. Question 1. Use the blank line to indicate the type description and amount for other free care that is not included in the types listed.

Other Free Care Type	Other Free Care Amount
Self-Pay/Uninsured Discounts	0
Admin Discounts	25,908
Employee Discounts	0
Negotiated, Point of Service, Courtesy	1,023,967
Total	**1,049,875**

Part D : Indigent/Charity Care Policies and Agreements

1. Formal Written Policy

Did the hospital have a formal written policy or written policies concerning the provision of indigent and/or charity care during 2018? (Check box if yes.) ☑

2. Effective Date

What was the effective date of the policy or policies in effect during 2018?

12/22/2015

3. Person Responsible

Please indicate the title or position held by the person most responsible for adherence to or interpretation of the policy or policies you will provide the department.?

PFS Director

4. Charity Care Provisions

Did the policy or policies include provisions for the care that is defined as charity pursuant to HFMA guidelines and the definitions contained in the Glossary that accompanies this survey (i.e., a sliding fee scale or the accomodation to provide care without the expectation of compensation for patients whose individual or family income exceeds 125% of federal poverty level guidelines)? (Check box if yes.) ☑

5. Maximum Income Level

If you had a provision for charity care in your policy, as reflected by responding yes to item 4, what was the maximum income level, expressed as a percentage of the federal poverty guidelines, for a patient to be considered for charity care (e.g., 185%, 200%, 235%, etc.)?

200%

6. Agreements Concerning the Receipt of Government Funds

Did the hospital have an agreement or agreements with any city or county concerning the receipt of government funds for indigent and/or charity care during 2018? (Check box if yes.) ☐

Part E : Indigent And Charity Care

1. Gross Indigent and Charity Care Charges

Please indicate the totals for indigent and charity care for the categories provided below. If the hospital used a sliding fee scale for certain charity patients, only the net charges to charity should be reported (i.e., gross patient charges less any payments received from or billed to the patient.) Total Uncompensated I/C Care must balance to totals reported in Part C.

Patient Type	Indigent Care	Charity Care	Total
Inpatient	7,988,750	565,685	8,554,435
Outpatient	9,130,920	3,608,830	12,739,750
Total	**17,119,670**	**4,174,515**	**21,294,185**

2. Sources of Indigent and Charity Care Funding

Please indicate the source of funding for indigent and/or charity care in the table below.

Source of Funding	Amount
Home County	0
Other Counties	0
City Or Cities	0
Hospital Authority	0
State Programs And Any Other State Funds (Do Not Include Indigent Care Trust Funds)	0
Federal Government	0
Non-Government Sources	0
Charitable Contributions	0
Trust Fund From Sale Of Public Hospital	0
All Other	0
Total	**0**

3. Net Uncompensated Indigent and Charity Care Charges

Total net indigent care must balance to Part C net indigent care and total net charity care must balance to Part C net charity care.

Patient Type	Indigent Care	Charity Care	Total
Inpatient	7,988,750	565,685	8,554,435
Outpatient	9,130,920	3,608,830	12,739,750
Total	**17,119,670**	**4,174,515**	**21,294,185**

Part F : Patient Origin

1. Total Gross Indigent/Charity Care By Charges County

Please report Indigent/Charity Care by County in the following categories. For non Georgia use Alabama, Florida, North Carolina, South Carolina, Tennessee, or Other-Out-of-State.
To add a row press the button. To delete a row press the minus button at the end of the row.
(You may enter the data on the web form or upload the data to the web form using the .csv file.)

Inp Ad-I = Inpatient Admissions (Indigent Care)
Inp Ch-I = Inpatient Charges (Indigent Care)
Out Vis-I = Outpatient Visits (Indigent Care)
Out Ch-I = Outpatient Charges (Indigent Care)

Inp Ad-C = Inpatient Admissions (Charity Care)
Inp Ch-C = Inpatient Charges (Charity Care)
Out Vis-C = Outpatient Visits (Charity Care)
Out Ch-C = Outpatient Charges (Charity Care)

County	Inp Ad-I	Inp Ch-I	Out Vis-I	Out Ch-I	Inp Ad-C	Inp Ch-C	Out Vis-C	Out Ch-C
Appling	1	12	16	3,007	0	0	7	18,048
Atkinson	110	1,977,109	778	1,261,238	11	57,925	305	642,311
Bacon	12	132,989	57	36,504	1	1,412	23	31,180
Baldwin	0	0	1	36,508	0	0	1	12,168
Ben Hill	13	51,289	102	17,750	1	1,403	31	28,266
Berrien	0	12,712	25	37,754	2	38,732	9	11,992
Brantley	0	0	20	60	0	0	2	11,019
Brooks	0	0	1	3	0	0	0	0
Bulloch	0	0	0	0	0	0	1	272
Camden	0	0	2	6	0	0	0	0
Charlton	0	0	2	3	0	0	0	0
Clinch	2	16	40	9,582	0	0	10	36,093
Cobb	0	0	6	5,251	0	0	0	0
Coffee	425	5,341,768	4,506	7,357,505	47	359,656	1,259	2,320,606
Colquitt	0	0	1	3	0	0	5	15,848
COOK	1	12	1	3	0	0	0	0
CRISP	1	12	0	0	0	0	0	0
DODGE	1	20,025	11	8,416	0	0	0	0
DOOLY	0	0	1	3	0	0	0	0
Dougherty	0	0	4	12	0	0	1	46,725
FLORIDA	0	0	1	1,083	0	0	1	444
GLYNN	0	0	1	3	0	0	6	2,604
HOUSTON	0	0	2	1,270	0	0	0	0
IRWIN	7	72,347	72	83,986	0	0	16	10,148
JEFF DAVIS	22	179,360	141	44,588	5	13,224	67	177,035
JENKINS	0	0	0	0	1	980	1	207
LAMAR	0	0	1	3	0	0	0	0
LANIER	0	0	7	2,717	0	0	0	0
LAURENS	0	0	2	940	0	0	0	0
LOWNDES	0	0	12	33	0	0	1	3,111
MITCHELL	0	0	0	0	0	0	0	0
MONTGOMERY	0	0	2	6	0	0	0	0

NEWTON	0	0	1	568	0	0	0	0
Other Out of State	1	45,585	5	11,293	0	0	2	2,114
PIERCE	3	122,457	30	37,472	0	0	8	7,049
SUMTER	0	0	1	3	0	0	0	0
TELFAIR	5	32,970	100	118,309	1	6,700	26	92,802
TIFT	1	13	8	30	0	0	6	14,599
TOOMBS	0	0	1	3	0	0	0	0
WALKER	0	0	2	390	0	0	0	0
WARE	5	62	78	34,475	2	65,702	36	78,369
WAYNE	1	12	8	15,206	0	0	0	0
WHEELER	0	0	4	13	0	0	0	0
WILCOX	0	0	6	4,922	1	19,951	4	45,819
Total	**611**	**7,988,750**	**6,059**	**9,130,921**	**72**	**565,685**	**1,828**	**3,608,829**

Indigent Care Trust Fund Addendum

1. Indigent Care Trust Fund

Did your hospital receive funds from the Indigent Care Trust Fund during its Fiscal Year 2018? (Check box if yes.) ☑

2. Amount Charged to ICTF

Indicate the amount charged to the ICTF by each State Fiscal Year (SFY) and for each of the patient categories indicated below during Hospital Fiscal Year 2018.

	Patient Category	SFY 2017 7/1/16-6/30/17	SFY2018 7/1/17-6/30/18	SFY2019 7/1/18-6/30/19
A.	Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	7,583,302	11,464,353	16,027,881
B.	Medically Indigent Patients with incomes between 125% and 200% of the Federal Poverty Level Guidelines where adjustments were made to patient amounts due in accordance with an established sliding scale.	2,866,427	3,230,906	5,775,288
C.	Other Patients in accordance with the department approved policy.	0	0	0

3. Patients Served

Indicate the number of patients served by SFY.

SFY 2017 7/1/16-6/30/17	SFY2018 7/1/17-6/30/18	SFY2019 7/1/18-6/30/19
6,845	8,395	9,086

Reconciliation Addendum

This section is printed in landscape format on a separate PDF file.

Electronic Signature

Please note that the survey WILL NOT BE ACCEPTED without the authorized signature of the Chief Executive Officer or Executive Director (principal officer) of the facility. The signature can be completed only AFTER all survey data has been finalized. By law, the signatory is attesting under penalty of law that the information is accurate and complete.

I state, certify and attest that to the best of my knowledge upon conducting due diligence to assure the accuracy and completeness of all data, and based upon my affirmative review of the entire completed survey, this completed survey contains no untrue statement, or incaccurate data, nor omits requested material information or data. I further state, certify and attest that I have reviewed the entire contents of the completed survey with all appropriate staff of the facility. I further understand that inaccurate, incomplete or omitted data could lead to sanctions against me or my facility. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Signature of Chief Executive: Vicki Lewis

Date: 9/17/2019

Title: CEO

I hereby certify that I am the financial officer authorized to sign this form and that the information is true and accurate. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Signature of Financial Officer: Martin Hutson

Date: 9/17/2019

Title: CFO

Comments:

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2018 Positron Emission Tomography (PET) Services Survey

Part A : General Information

1. Identification

UID:HOSP406

Facility Name: Coffee Regional Medical Center

County: Coffee

Street Address: PO Box 1287

City: Douglas

Zip: 31534

Mailing Address: PO Box 1287

Mailing City: Douglas

Mailing Zip: 31534

Medicaid Provider Number: 000000448A

Medicare Provider Number: 11-0089

2. Report Period

Report Data for the full twelve month period- January 1, 2018 through December 31, 2018.
Do not use a different report period.

Check the box to the right if your facility was **not** operational for the entire year. ☑
If your facility was **not** operational for the entire year, provide the dates the facility was operational.

08/13/2018 - 12/31/2018

Part B : Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey.

Contact Name: Lavonda L Cravey

Contact Title: VP Corporate Revenue Cycle

Phone: 912-383-5600

Fax: 912-383-5680

E-mail: lavonda.cravey@coffeeregional.org

Part C : Ownership, Operation and Management

1. Ownership, Operation and Management

As of the last day of the report period, indicate the operation/management status of the facility and provide the effective date. Using the drop-down menus, select the organization type. If the category is not applicable, the form requires you only to enter Not Applicable in the legal name field. You must enter something for each category.

A. Facility Owner

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Coffee County Hospital Authority	Hospital Authority	06/30/1949

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Coffee County	Local Govt	01/01/1900

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Coffee Regional Medical Center, Inc.	Not for Profit	01/01/1995

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
CRH Health Care, Inc.	Not for Profit	10/28/1994

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Not Applicable	Not Applicable	

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Not Applicable	Not Applicable	

2. Changes in Ownership, Operation or Management

Check the box to the right if there were any changes in the ownership, operation, or management of the facility during the report period or since the last day of the Report Period. ☐
If checked, please explain in the box below and include effective dates.

3a. Type of PET Authorization (Select one only.)

Mobile Vendor CON Holder

3b. Certificate of Need Project Number

Please enter the Certificate of Need project number.

GA 017-01

3c. Name of Mobile Vendor (If selected PET CON (Mobile Contract) at 3A. above.)

Diversified Imaging Services, Inc. Diagnostic Pet, LLC

Part D : PET Imaging Services Technology and volume by Diagnostic Type

1. Manufacturer and Model

Please document the manufacturer and model of PET equipment and select PET only or PET/CT Hybrid Unit. NOTE: IF you have more than one scanner, please complete one survey for each machine.

PET / CT Hybrid Unit
Siemens Biograph 16 TruePoint PET/CT

2. Patients and Scans for PET Imaging Services

Please report the patients and scans for PET imaging services during the reporting period by the patient's primary diagnostic area. Please provide unduplicated patient counts within each of the three subgroups. The sum total of all patients for all three diagnostic areas (automatically calculated by the web page) may include some duplication.

Oncology Patients	Number of Patients	Total Number of Scans	Follow Up Scans
Lung and Bronchus Cancers	12	13	1
Colon and Rectal Cancers	2	3	1
Lymphoma Cancers	6	7	1
Melanoma Cancers	2	2	0
Esophageal Cancers	1	1	0
Head and Neck Cancers	2	2	0
Breast Cancers	6	6	0
Other Cancers	9	9	0
Total	**40**	**43**	**3**

Cardiovascular Patients	Number of Patients	Number of Scans
All Cardiovascular Patients	0	0
Total	**0**	**0**

Neurology Patients	Number of Patients	Number of Scans
Dementias (incuding Alzheimer's)	0	0
Other Neurological Use	1	1
Total	**1**	**1**

Other Diagnostic Areas	Number of Patients	Number of Scans
All Other Patients	0	0
Total	**0**	**0**

Part E : PET Services Financial Summary and Patient Demographics

1. Patients by Primary Payment Source

Please report the total number of patients (unduplicated) receiving PET services by primary payment source.

Primary Payment Source	Number of Patients (unduplicated)
Medicare	28
Medicaid	5
Third-Party	7
Self-Pay	1
Total	**41**

2. Total Charges and Adjusted Gross Revenue

Please report the total charges and adjusted gross revenues for PET services.

Total Charges	Adjusted Gross Revenue
260,140	175,354

3. Total Uncompensated Charges and I/C Patients

Please report the total amount of uncompensated PET services charges that can be attributed to persons who are indigent or eligible for charity care. Also provide the number of I/C patients in the PET program.

Total Uncompensated Charges	I/C Patients
4,983	8

4. Average Treatment Charge

What is your program's average treatment charge for a PET scan or study (one patient visit regardless of number of images)?

5,800

5. Patients by Race/Ethnicity

Please report the number of patient served during the entire report period by the following race and ethnicity categories.

Race/Ethnicity	Number of Patients
American Indian/Alaska Native	0
Asian	0
Black/African American	3
Hispanic/Latino	1
Pacific Islander/Hawaiian	1
White	36
Multi-Racial	0
Total	**41**

6. Patients by Age Group and Gender

Please report the number of patients served during the entire report period by the gender and age

grouping below.

Age Group	Male	Female
Ages 0-14	0	0
Ages 15-64	10	9
Ages 65-74	7	6
Ages 75-85	1	7
Ages 85 and Up	1	0
Total	**19**	**22**

7. Participation in Reporting

Does your facility/service participate in and report to the Georgia Comprehensive Cancer Registry? (check box for YES, leave unchecked for NO) ☑

8. Days and Hours of Operation

Please indicate the days and hours of operation for your program's PET services.

Mon	Tue	Wed	Thurs	Fri	Sat	Sun
☑	☐	☐	☐	☐	☐	☐

Hours of Operation: 1:30pm until 7:00pm

9. Total Number of Days that PET Scans Were Offered

Please report the total number of days that PET scans were offered during the report period.

Total Days PET Scans Offered
10

Part F : Mobile PET Services

1. Mobile PET Services- (For mobile vendors holding a CON to provide PET services.)

Please report each location served during the reporting period and the number of days of services provided at each loacation for each month. If your PET service is fixed-based, or your facility holds a CON for mobile PET services under contract, continue with Part G.

Site Name	Site County	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec

Part G : Patient Origin Table (Must be completed by all providers)

1. Patient Origin by County

Please report the county of origin for patients served by your PET program during the report period. Note to Mobile PET Providers who hold a CON: You must complete this section for every site visit location. Please select from the list of site visit ocations(s) provided above.

Name	County	Patients Served	Patient County
Coffee Regional Medical Center	Coffee	1	Appling
Coffee Regional Medical Center	Coffee	7	Atkinson
Coffee Regional Medical Center	Coffee	1	Bacon
Coffee Regional Medical Center	Coffee	1	Clinch
Coffee Regional Medical Center	Coffee	26	Coffee
Coffee Regional Medical Center	Coffee	1	Jeff Davis
Coffee Regional Medical Center	Coffee	3	Telfair
Coffee Regional Medical Center	Coffee	1	Ware
Total		**41**	

Electronic Signature

Please note that the survey WILL NOT BE ACCEPTED without the authorized signature of the Chief Executive Officer or Executive Director (principal officer) of the facility. The signature can be completed only AFTER all survey data has been finalized. By law, the signatory is attesting under penalty of law that the information is accurate and complete.

I state, certify and attest that to the best of my knowledge upon conducting due diligence to assure the accuracy and completeness of all data, and based upon my affirmative review of the entire completed survey, this completed survey contains no untrue statement, or incaccurate data, nor omits requested material information or data. I further state, certify and attest that I have reviewed the entire contents of the completed survey with all appropriate staff of the facility. I further understand that inaccurate, incomplete or omitted data could lead to sanctions against me or my facility. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Authorized Signature: Vicki Lewis

Date: 05/10/2019

Title: CEO

Comments:

Please note that for Part A, Question 2 regarding the Report Period: This period (08/13/2018 - 12/31/2018) is specifically in reference to our facility offering PET services to our patients. Our facility was fully operational for the entire year.

Form **8879-EO**

Department of the Treasury
Internal Revenue Service

IRS e-file Signature Authorization for an Exempt Organization

For calendar year 2017, or fiscal year beginning _____, 2017, and ending _____, 20___

▶ **Do not send to the IRS. Keep for your records.**

▶ **Go to www.irs.gov/Form8879EO for the latest information.**

OMB No. 1545-1878

2017

Name of exempt organization

COFFEE REGIONAL MEDICAL CENTER, INC.

Employer identification number

65-0543088

Name and title of officer

VICKI LEWIS
PRESIDENT AND CEO

Part I Type of Return and Return Information (Whole Dollars Only)

Check the box for the return for which you are using this Form 8879-EO and enter the applicable amount, if any, from the return. If you check the box on line **1a, 2a, 3a, 4a,** or **5a,** below, and the amount on that line for the return being filed with this form was blank, then leave line **1b, 2b, 3b, 4b,** or **5b,** whichever is applicable, blank (do not enter -0-). But, if you entered -0- on the return, then enter -0- on the applicable line below. **Do not** complete more than 1 line in Part I.

1a Form 990 check here ▶ [X]	**b Total revenue,** if any (Form 990, Part VIII, column (A), line 12)	**1b**	117,903,948.
2a Form 990-EZ check here ▶	**b Total revenue,** if any (Form 990-EZ, line 9)	**2b**	
3a Form 1120-POL check here ▶	**b Total tax** (Form 1120-POL, line 22)	**3b**	
4a Form 990-PF check here ▶	**b Tax based on investment income** (Form 990-PF, Part VI, line 5)	**4b**	
5a Form 8868 check here ▶	**b Balance Due** (Form 8868, line 3c)	**5b**	

Part II Declaration and Signature Authorization of Officer

Under penalties of perjury, I declare that I am an officer of the above organization and that I have examined a copy of the organization's 2017 electronic return and accompanying schedules and statements and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS **(a)** an acknowledgement of receipt or reason for rejection of the transmission, **(b)** the reason for any delay in processing the return or refund, and **(c)** the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

Officer's PIN: check one box only

[X] I authorize PYA, P.C. to enter my PIN 43088

ERO firm name

Enter five numbers, but do not enter all zeros

as my signature on the organization's tax year 2017 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

As an officer of the organization, I will enter my PIN as my signature on the organization's tax year 2017 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ▶ Vicki Lewis Date ▶ 11.9.18

Part III Certification and Authentication

ERO's EFIN/PIN. Enter your six-digit electronic filing identification number (EFIN) followed by your five-digit self-selected PIN. 62073216401

Do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2017 electronically filed return for the organization indicated above. I confirm that I am submitting this return in accordance with the requirements of **Pub. 4163,** Modernized e-File (MeF) Information for Authorized IRS *e-file* Providers for Business Returns.

ERO's signature ▶ Deborah O. Emberger, C.P.A Date ▶ **10/4/2018**

ERO Must Retain This Form - See Instructions

Do Not Submit This Form to the IRS Unless Requested To Do So

EXTENDED TO NOVEMBER 15, 2018

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

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

OMB No. 1545-0047

2017

Open to Public Inspection

A For the 2017 calendar year, or tax year beginning and ending

B Check if applicable: Address change; Name change; Initial return; Final return/ termin-ated; Amended return; Applica-tion pending

C Name of organization
COFFEE REGIONAL MEDICAL CENTER, INC.

Doing business as

Number and street (or P.O. box if mail is not delivered to street address) Room/suite
1101 OCILLA ROAD/P.O. BOX 1287

City or town, state or province, country, and ZIP or foreign postal code
DOUGLAS, GA 31533-2207

F Name and address of principal officer: VICKI LEWIS
SAME AS C ABOVE

D Employer identification number
65-0543088

E Telephone number
912-384-1900

G Gross receipts $ 117,903,948.

H(a) Is this a group return for subordinates? ☐ Yes ☒ No

H(b) Are all subordinates included? Yes No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

I Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW.COFFEEREGIONAL.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1995 **M** State of legal domicile: GA

Part I Summary

Activities & Governance	1	Briefly describe the organization's mission or most significant activities: TO BE A LEADING PROVIDER OF A COMPREHENSIVE RANGE OF HIGH-QUALITY, REASONABLY PRICED HEALTH CARE	
	2	Check this box ▶ if the organization discontinued its operations or disposed of more than 25% of its net assets.	
	3	Number of voting members of the governing body (Part VI, line 1a)	11
	4	Number of independent voting members of the governing body (Part VI, line 1b)	11
	5	Total number of individuals employed in calendar year 2017 (Part V, line 2a)	956
	6	Total number of volunteers (estimate if necessary)	54
	7a	Total unrelated business revenue from Part VIII, column (C), line 12	39,418.
	b	Net unrelated business taxable income from Form 990-T, line 34	-15,232.

			Prior Year	Current Year
Revenue	8	Contributions and grants (Part VIII, line 1h)	347,161.	320,348.
	9	Program service revenue (Part VIII, line 2g)	111,278,694.	111,647,875.
	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	2,528,161.	2,657,167.
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	2,468,917.	3,278,558.
	12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	116,622,933.	117,903,948.
Expenses	13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0.	2,487.
	14	Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
	15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	49,078,880.	57,962,299.
	16a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
	b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 0.		
	17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	67,282,002.	66,443,879.
	18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	116,360,882.	124,408,665.
	19	Revenue less expenses. Subtract line 18 from line 12	262,051.	-6,504,717.

			Beginning of Current Year	End of Year
Net Assets or Fund Balances	20	Total assets (Part X, line 16)	74,611,549.	73,466,466.
	21	Total liabilities (Part X, line 26)	43,664,903.	46,727,531.
	22	Net assets or fund balances. Subtract line 21 from line 20	30,946,646.	26,738,935.

Part II Signature Block

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

Sign Here

▶ Signature of officer — Date: 11.9.18

▶ VICKI LEWIS, PRESIDENT AND CEO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check if self-employed	PTIN
DEBORAH O. ERNSBERGER	Deborah O. Ernsberger, CPA			P00364912

Firm's name ▶ PYA, P. C. — Firm's EIN ▶ 62-1517792

Firm's address ▶ 2220 SUTHERLAND AVE.
KNOXVILLE, TN 37919 — Phone no. 865-673-0844

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

SEE SCHEDULE O FOR ORGANIZATION MISSION STATEMENT CONTINUATION

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:
TO BE A LEADING PROVIDER OF A COMPREHENSIVE RANGE OF HIGH-QUALITY, REASONABLY PRICED HEALTH CARE SERVICES IN COFFEE COUNTY, GEORGIA, AND THE SURROUNDING REGION. THESE HEALTH CARE SERVICES ARE PROVIDED TO ALL PERSONS REGARDLESS OF ABILITY TO PAY.

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 $ 109,637,879. including grants of $ 2,487.) (Revenue $ 114,192,639.)
HOSPITAL SERVICES - SHORT TERM CARE FOR INPATIENT AND OUTPATIENT SERVICES FOR DOUGLAS AND COFFEE COUNTY. COFFEE REGIONAL MEDICAL CENTER (CRMC) SERVED 4,111 PATIENTS FOR A TOTAL OF 14,638 INPATIENT DAYS IN 2017. NURSERY DAYS WERE 950 IN 2017. COFFEE REGIONAL MEDICAL CENTER PROVIDED APPROXIMATELY $10,877,062 OF INDIGENT AND CHARITY SERVICES IN 2017.

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

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

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

4e Total program service expenses ▶ 109,637,879.

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	X	
2	Is the organization required to complete *Schedule B, Schedule of Contributors*?	2	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		X
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	X	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		X
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		X
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		X
9	Did the organization report an amount in Part X, line 21, for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		X
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		X
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.			
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	X	
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		X
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		X
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		X
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	X	
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	X	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a		X
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	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		X
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		X
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	X	
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV*	15		X
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV*	16		X
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I*	17		X
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		X
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		X

Part IV Checklist of Required Schedules *(continued)*

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	59		
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		X	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	956		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b		X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)				
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?	3a		X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No," to line 3b, provide an explanation in Schedule O*	3b		X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a		X	
b	If "Yes," enter the name of the foreign country: ▶ CAYMAN ISLANDS See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a			X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b			X
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	5c			
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	6a			X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b			
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	7a			X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b			
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c			X
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e			X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f			X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h			
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	8			
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the sponsoring organization make any taxable distributions under section 4966?	9a			
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	9b			
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	12a			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state? **Note.** See the instructions for additional information the organization must report on Schedule O.	13a			
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a			X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*	14b			

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

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

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	11		
	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	11		
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			X
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			X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4			X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5			X
6	Did the organization have members or stockholders?	6		X	
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		X	
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		X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:				
a	The governing body?	8a		X	
b	Each committee with authority to act on behalf of the governing body?	8b		X	
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			X

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		X
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	X	
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	X	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	X	
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	X	
13	Did the organization have a written whistleblower policy?	13	X	
14	Did the organization have a written document retention and destruction policy?	14	X	
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	X	
b	Other officers or key employees of the organization	15b	X	
	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		X
b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	16b		

Section C. Disclosure

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

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

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

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

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

LAVONDA CRAVEY - 912-384-1900

1101 OCILLA ROAD, DOUGLAS, GA 31533-2207

Part VIII Statement of Revenue

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

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns	1a				
	b	Membership dues	1b				
	c	Fundraising events	1c				
	d	Related organizations	1d	25,348.			
	e	Government grants (contributions)	1e	275,000.			
	f	All other contributions, gifts, grants, and similar amounts not included above	1f	20,000.			
	g	Noncash contributions included in lines 1a-1f: $					
	h	**Total.** Add lines 1a-1f			320,348.		
Program Service Revenue			Business Code				
	2a	PATIENT REVENUE	621990	111,608,457.	111,608,457.		
	b	REFERENCE LAB	621500	39,418.		39,418.	
	c						
	d						
	e						
	f	All other program service revenue					
	g	**Total.** Add lines 2a-2f		111,647,875.			
	3	Investment income (including dividends, interest, and other similar amounts)		2,613,662.			2,613,662.
	4	Income from investment of tax-exempt bond proceeds					
	5	Royalties					
			(i) Real / (ii) Personal				
	6a	Gross rents	202,992. /				
	b	Less: rental expenses	0. /				
	c	Rental income or (loss)	202,992. /				
	d	Net rental income or (loss)		202,992.			202,992.
			(i) Securities / (ii) Other				
	7a	Gross amount from sales of assets other than inventory	42,665. / 840.				
	b	Less: cost or other basis and sales expenses	0. / 0.				
	c	Gain or (loss)	42,665. / 840.				
	d	Net gain or (loss)		43,505.			43,505.
Other Revenue	8a	Gross income from fundraising events (not including $ _____ of contributions reported on line 1c). See Part IV, line 18	a				
	b	Less: direct expenses	b				
	c	Net income or (loss) from fundraising events					
	9a	Gross income from gaming activities. See Part IV, line 19	a				
	b	Less: direct expenses	b				
	c	Net income or (loss) from gaming activities					
	10a	Gross sales of inventory, less returns and allowances	a				
	b	Less: cost of goods sold	b				
	c	Net income or (loss) from sales of inventory					
		Miscellaneous Revenue	Business Code				
	11a	PHARMACY REVENUE	621990	1,309,240.	1,309,240.		
	b	CAFETERIA	722210	530,802.			530,802.
	c	EHR PAYMENT	621990	205,311.	205,311.		
	d	All other revenue	621990	1,030,213.	1,030,213.		
	e	**Total.** Add lines 11a-11d		3,075,566.			
	12	**Total revenue.** See instructions.		117,903,948.	114,153,221.	39,418.	3,390,961.

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	2,487.	2,487.		
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	385,449.	63,000.	322,449.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	45,570,858.	40,822,491.	4,748,367.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	809,464.	721,792.	87,672.	
9 Other employee benefits	8,356,561.	7,296,613.	1,059,948.	
10 Payroll taxes	2,839,967.	2,456,889.	383,078.	
11 Fees for services (non-employees):				
a Management	43,610.		43,610.	
b Legal	115,673.		115,673.	
c Accounting	136,343.		136,343.	
d Lobbying	19,025.	19,025.		
e Professional fundraising services. See Part IV, line 17				
f Investment management fees	178,694.		178,694.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)	6,936,113.	5,053,264.	1,882,849.	
12 Advertising and promotion	365,909.	104,260.	261,649.	
13 Office expenses	4,059,530.	3,543,256.	516,274.	
14 Information technology				
15 Royalties				
16 Occupancy	2,016,846.	1,746,185.	270,661.	
17 Travel	136,484.	111,210.	25,274.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	101,705.	98,178.	3,527.	
20 Interest	922,387.	922,387.		
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	5,628,337.	4,873,014.	755,323.	
23 Insurance	2,469,339.	412,434.	2,056,905.	
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 BAD DEBT	22,221,549.	22,221,549.		
b SUPPLIES	11,410,744.	11,410,744.		
c DEVELOPMENT	4,361,609.	4,361,609.		
d TAXES & LICENSES	1,387,540.		1,387,540.	
e All other expenses	3,932,442.	3,398,492.	533,950.	
25 **Total functional expenses.** Add lines 1 through 24e	124,408,665.	109,638,879.	14,769,786.	0.
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

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

			(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing	3,881,014.	1	768,052.
	2	Savings and temporary cash investments		2	
	3	Pledges and grants receivable, net		3	
	4	Accounts receivable, net	12,551,386.	4	13,026,255.
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instr). Complete Part II of Sch L		6	
	7	Notes and loans receivable, net		7	
	8	Inventories for sale or use	1,754,052.	8	1,690,375.
	9	Prepaid expenses and deferred charges	459,433.	9	653,444.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 101,409,840.			
	b	Less: accumulated depreciation — 10b: 77,302,080.	24,956,164.	10c	24,107,760.
	11	Investments - publicly traded securities	30,260,592.	11	31,913,939.
	12	Investments - other securities. See Part IV, line 11		12	
	13	Investments - program-related. See Part IV, line 11		13	
	14	Intangible assets		14	
	15	Other assets. See Part IV, line 11	748,908.	15	1,306,641.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	74,611,549.	16	73,466,466.
Liabilities	17	Accounts payable and accrued expenses	16,044,984.	17	18,900,920.
	18	Grants payable		18	
	19	Deferred revenue		19	339,653.
	20	Tax-exempt bond liabilities	26,018,432.	20	24,358,080.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		22	
	23	Secured mortgages and notes payable to unrelated third parties	1,601,487.	23	3,109,947.
	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	0.	25	18,931.
	26	**Total liabilities.** Add lines 17 through 25	43,664,903.	26	46,727,531.
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ [X] and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	30,946,646.	27	26,738,935.
	28	Temporarily restricted net assets		28	
	29	Permanently restricted net assets		29	
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	30,946,646.	33	26,738,935.
	34	Total liabilities and net assets/fund balances	74,611,549.	34	73,466,466.

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	117,903,948.
2	Total expenses (must equal Part IX, column (A), line 25)	2	124,408,665.
3	Revenue less expenses. Subtract line 2 from line 1	3	-6,504,717.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	30,946,646.
5	Net unrealized gains (losses) on investments	5	1,528,876.
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	768,130.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	26,738,935.

Part XII Financial Statements and Reporting

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

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ 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?	2a		X
	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?	2b	X	
	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?	2c	X	
	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?	3a		X
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	3b		

SCHEDULE A (Form 990 or 990-EZ)

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

2017

Open to Public Inspection

Name of the organization

COFFEE REGIONAL MEDICAL CENTER, INC.

Employer identification number

65-0543088

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

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

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

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

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

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

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

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

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

8 ☐ A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

9 ☐ An agricultural research organization described in **section 170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land-grant college of agriculture (see instructions). Enter the name, city, and state of the college or university: _____

10 ☐ An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)

11 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**

12 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.

a ☐ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**

b ☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**

c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**

d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**

e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.

f Enter the number of supported organizations .....

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

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-10 above (see instructions))	(iv) Is the organization listed in your governing document? Yes	(iv) No	(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
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 fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

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

Section B. Total Support

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

12 Gross receipts from related activities, etc. (see instructions) 12

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2017 (line 6, column (f) divided by line 11, column (f)) 14 %

15 Public support percentage from 2016 Schedule A, Part II, line 14 15 %

16a **33 1/3% support test - 2017.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support test - 2016.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

17a **10% -facts-and-circumstances test - 2017.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ ☐

b **10% -facts-and-circumstances test - 2016.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ ☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ ☐

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

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

Section A. Public Support

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

Section B. Total Support

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

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

Section C. Computation of Public Support Percentage

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

Section D. Computation of Investment Income Percentage

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

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

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

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations *(continued)*

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally Integrated Supporting Organizations

1 *Check the box next to the method that the organization used to satisfy the Integral Part Test during the year* **(see instructions).**

a ☐ The organization satisfied the Activities Test. *Complete* **line 2** *below.*

b ☐ The organization is the parent of each of its supported organizations. *Complete* **line 3** *below.*

c ☐ The organization supported a governmental entity. *Describe in* **Part VI** *how you supported a government entity (see instructions).*

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

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

1 ☐ Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970 (explain in Part VI.) **See instructions.** All other Type III non-functionally integrated supporting organizations must complete Sections A through E.

Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1 Net short-term capital gain	1		
2 Recoveries of prior-year distributions	2		
3 Other gross income (see instructions)	3		
4 Add lines 1 through 3	4		
5 Depreciation and depletion	5		
6 Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6		
7 Other expenses (see instructions)	7		
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):			
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 ☐ Check here if the current year is the organization's first as a non-functionally integrated Type III supporting organization (see instructions).

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

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

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

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

SCHEDULE 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

2017

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 organization	Employer identification number
COFFEE REGIONAL MEDICAL CENTER, INC.	65-0543088

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.

2 Political campaign activity expenditures ▶ $

3 Volunteer hours for political campaign activities

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

1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ $

2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ $

3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? ☐ Yes ☐ No

4a Was a correction made? ☐ Yes ☐ No

b If "Yes," describe in Part IV.

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

1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ $

2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ $

3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b ▶ $

4 Did the filing organization file **Form 1120-POL** for this year? ☐ Yes ☐ No

5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

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

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.		
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-		

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.

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ Yes ☐ No

4-Year Averaging Period Under section 501(h)

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

Lobbying Expenditures During 4-Year Averaging Period

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

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

For each "Yes," response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a) Yes	(a) No	(b) 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?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X	
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		19,025.
j Total. Add lines 1c through 1i			19,025.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
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 campaign activity 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.

SCHEDULE C, PART II-B, LINE 1

A PORTION OF THE ANNUAL DUES PAID TO THE GEORGIA HOSPITAL ASSOCIATION AND THE GEORGIA ALLIANCE OF COMMUNITY HOSPITALS IS ALLOCATED TO THE LOBBYING ACTIVITIES OF THE ASSOCIATION.

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

2017

Open to Public Inspection

Name of the organization
COFFEE REGIONAL MEDICAL CENTER, INC.

Employer identification number
65-0543088

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 a 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 Tax 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 ▶ $ _____

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

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

a ☐ Public exhibition
b ☐ Scholarly research
c ☐ Preservation for future generations
d ☐ Loan or exchange programs
e ☐ Other _____

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

5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? ☐ Yes No

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

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? Yes No

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

		Amount
c Beginning balance	1c	
d Additions during the year	1d	
e Distributions during the year	1e	
f Ending balance	1f	

2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? ☐ Yes No

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

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

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

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

a Board designated or quasi-endowment ▶ _____%
b Permanent endowment ▶ _____%
c Temporarily restricted endowment ▶ _____%

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

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

	Yes	No
(i) unrelated organizations (3a(i))		
(ii) related organizations (3a(ii))		
b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R? (3b)		

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

Part VI Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		441,214.		441,214.
b Buildings		56,277,950.	34,804,972.	21,472,978.
c Leasehold improvements		146,203.	122,696.	23,507.
d Equipment		42,896,430.	42,374,412.	522,018.
e Other		1,648,043.		1,648,043.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10c.)* ▶				24,107,760.

Schedule D (Form 990) 2017

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. (Col. (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. (Col. (b) must equal Form 990, Part X, col. (B) line 13.) ▶		

Part IX Other Assets.

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

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

Part X Other Liabilities.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) DUE TO AFFILIATES	18,931.
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 25.)* ▶	18,931.

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

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.

PART X, LINE 2:

CRH HEALTH CARE, INC., EXCLUDING COFFEE REGIONAL MEDICAL CENTER SEGREGATED PORTFOLIO, CRH VENTURES, INC. AND SOUTHEASTERN MANAGED CARE, INC. IS A NOT-FOR-PROFIT CORPORATION AS DESCRIBED IN SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE AND IS EXEMPT FROM FEDERAL INCOME TAXES ON RELATED INCOME PURSUANT TO SECTION 501(A) OF THE CODE.

COFFEE REGIONAL MEDICAL CENTER SEGREGATED PORTFOLIO IS AN EXEMPTED SEGREGATED PORTFOLIO COMPANY THAT WAS INCORPORATED UNDER THE PROVISIONS OF THE COMPANIES LAW OF THE CAYMAN ISLANDS AND HAS RECEIVED AN UNDERTAKING FROM THE CAYMAN ISLANDS GOVERNMENT EXEMPTING IT FROM ALL LOCAL INCOME, PROFITS AND CAPITAL GAINS TAXES.

Part XIII Supplemental Information *(continued)*

CRH VENTURES, INC. AND SOUTHEASTERN MANAGED CARE, INC. ARE TAXABLE ENTITIES AND ARE, THEREFORE, SUBJECT TO FEDERAL INCOME TAXES. CRH VENTURES, INC. AND SOUTHEASTERN MANAGED CARE, INC. FILE SEPARATE FEDERAL INCOME TAX RETURNS.

THE CORPORATION APPLIES ACCOUNTING POLICIES THAT PRESCRIBE WHEN TO RECOGNIZE AND HOW TO MEASURE THE FINANCIAL STATEMENT EFFECTS OF INCOME TAX POSITIONS TAKEN OR EXPECTED TO BE TAKEN ON ITS INCOME TAX RETURNS. THESE RULES REQUIRE MANAGEMENT TO EVALUATE THE LIKELIHOOD THAT, UPON EXAMINATION BY THE RELEVANT TAXING JURISDICTIONS, THOSE INCOME TAX POSITIONS WOULD BE SUSTAINED. BASED ON THAT EVALUATION, THE CORPORATION ONLY RECOGNIZES THE MAXIMUM BENEFIT OF EACH INCOME TAX POSITION THAT IS MORE THAN 50% LIKELY OF BEING SUSTAINED. TO THE EXTENT THAT ALL OR A PORTION OF THE BENEFITS OF AN INCOME TAX POSITION ARE NOT RECOGNIZED, A LIABILITY WOULD BE RECOGNIZED FOR THE UNRECOGNIZED BENEFITS, ALONG WITH ANY INTEREST AND PENALTIES THAT WOULD RESULT FROM DISALLOWANCE OF THE POSITION. SHOULD ANY SUCH PENALTIES AND INTEREST BE INCURRED, THEY WOULD BE RECOGNIZED AS OPERATING EXPENSES.

BASED ON THE RESULTS OF MANAGEMENT'S EVALUATION, NO LIABILITY IS RECOGNIZED IN THE ACCOMPANYING CONSOLIDATED BALANCE SHEETS FOR UNRECOGNIZED INCOME TAX POSITIONS. FURTHER, NO INTEREST OR PENALTIES HAVE BEEN ACCRUED OR CHARGED TO EXPENSE AS OF DECEMBER 31, 2017 AND 2016 OR FOR THE YEARS THEN ENDED. THE CORPORATION'S TAX RETURNS ARE SUBJECT TO POSSIBLE EXAMINATION BY THE TAXING AUTHORITIES. FOR FEDERAL INCOME TAX PURPOSES, THE TAX RETURNS ESSENTIALLY REMAIN OPEN FOR POSSIBLE EXAMINATION FOR A PERIOD OF THREE YEARS AFTER THE RESPECTIVE FILING DEADLINES OF THOSE RETURNS.

SCHEDULE F (Form 990)

Department of the Treasury
Internal Revenue Service

Statement of Activities Outside the United States

▶ Complete if the organization answered "Yes" on 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

2017

Open to Public Inspection

Name of the organization

COFFEE REGIONAL MEDICAL CENTER, INC.

Employer identification number

65-0543088

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 the 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 THE CARIBBEAN	1	1	INVESTMENTS		9,983,183.
3 a Sub-total	1	1			9,983,183.
b Total from continuation sheets to Part I	0	0			0.
c **Totals** (add lines 3a and 3b)	1	1			9,983,183.

LHA **For Paperwork Reduction Act Notice, see the Instructions for Form 990.** **Schedule F (Form 990) 2017**

732071 10-06-17

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.

(a) Type of grant or assistance	(b) Region	(c) Number of recipients	(d) Amount of cash grant	(e) Manner of cash disbursement	(f) Amount of noncash assistance	(g) Description of noncash assistance	(h) Method of valuation (book, FMV, appraisal, other)

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.

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
▶ Attach to Form 990.
▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2017

Open to Public Inspection

Name of the organization

COFFEE REGIONAL MEDICAL CENTER, INC.

Employer identification number

65-0543088

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	X	
b	If "Yes," was it a written policy?	X	
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. ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities		
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☐ 200% ☒ Other 125 %	X	
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☒ 200% ☐ 250% ☐ 300% ☐ 350% ☐ 400% ☐ Other _____ %	X	
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"?	X	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	X	
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?		X
6a	Did the organization prepare a community benefit report during the tax year?	X	
b	If "Yes," did the organization make it available to the public?	X	

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			3240046.		3240046.	3.17%
b Medicaid (from Worksheet 3, column a)			15953235.	10530005.	5423230.	5.31%
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			19193281.	10530005.	8663276.	8.48%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			21,572.		21,572.	.02%
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			3,687.		3,687.	.00%
j **Total.** Other Benefits			25,259.		25,259.	.02%
k **Total.** Add lines 7d and 7j			19218540.	10530005.	8688535.	8.50%

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			1,500.		1,500.	.00%
4	Environmental improvements						
5	Leadership development and training for community members			4,224.		4,224.	.00%
6	Coalition building						
7	Community health improvement advocacy						
8	Workforce development			3,900.		3,900.	.00%
9	Other						
10	Total			9,624.		9,624.	.00%

Part III Bad Debt, Medicare, & Collection Practices

			Yes	No
Section A. Bad Debt Expense				
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	X	
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 22,221,549.		
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 16,666,162.		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			
Section B. Medicare				
5	Enter total revenue received from Medicare (including DSH and IME)	5 17,859,019.		
6	Enter Medicare allowable costs of care relating to payments on line 5	6 18,005,137.		
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7 -146,118.		
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: ☐ Cost accounting system ☒ Cost to charge ratio ☐ Other			
Section C. Collection Practices				
9a	Did the organization have a written debt collection policy during the tax year?	9a	X	
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	X	

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

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %

Part V Facility Information

Section A. Hospital Facilities

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

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

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)	Licensed hospital	Gen. medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 COFFEE REGIONAL MEDICAL CENTER 1101 OCILLA ROAD, P.O. BOX 1287 DOUGLAS, GA 31533 034-490	X	X					X		PHYSICIAN OFFICES, RURAL HEALTH CLINIC	

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group COFFEE REGIONAL MEDICAL CENTER INC

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		X
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		X
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	X	
If "Yes," indicate what the CHNA report describes (check all that apply):			
a [X] A definition of the community served by the hospital facility			
b [X] Demographics of the community			
c [X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d [X] How data was obtained			
e [X] The significant health needs of the community			
f [X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g [X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h [X] The process for consulting with persons representing the community's interests			
i [ ] The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j [ ] Other (describe in Section C)			
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 16			
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	X	
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a		X
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		X
7 Did the hospital facility make its CHNA report widely available to the public?	7	X	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a [X] Hospital facility's website (list url): WWW.COFFEEREGIONAL.ORG			
b [ ] Other website (list url):			
c [ ] Made a paper copy available for public inspection without charge at the hospital facility			
d [ ] 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	X	
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 16			
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	X	
a If "Yes," (list url): WWW.COFFEEREGIONAL.ORG			
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		X
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group COFFEE REGIONAL MEDICAL CENTER INC

			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?	13	X	
	If "Yes," indicate the eligibility criteria explained in the FAP:			
a	[X] Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 100 % and FPG family income limit for eligibility for discounted care of 200 %			
b	[ ] Income level other than FPG (describe in Section C)			
c	[ ] Asset level			
d	[ ] Medical indigency			
e	[ ] Insurance status			
f	[ ] Underinsurance status			
g	[ ] Residency			
h	[ ] Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	X	
15	Explained the method for applying for financial assistance?	15	X	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	[X] Described the information the hospital facility may require an individual to provide as part of his or her application			
b	[X] Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	[X] Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	[X] Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	[ ] Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[X] The FAP was widely available on a website (list url): WWW.COFFEEREGIONAL.ORG			
b	[X] The FAP application form was widely available on a website (list url): WWW.COFFEEREGIONAL.ORG			
c	[X] A plain language summary of the FAP was widely available on a website (list url): WWW.COFFEEREGIONAL.ORG			
d	[X] The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	[X] The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	[X] 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	[X] 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	[X] Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	[X] The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	[ ] Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

Name of hospital facility or letter of facility reporting group COFFEE REGIONAL MEDICAL CENTER INC

		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?	X	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a	☐ Reporting to credit agency(ies)		
b	☐ Selling an individual's debt to another party		
c	☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d	☐ Actions that require a legal or judicial process		
e	☐ Other similar actions (describe in Section C)		
f	☒ None of these actions or other similar actions were permitted		
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?		X
	If "Yes," check all actions in which the hospital facility or a third party engaged:		
a	☐ Reporting to credit agency(ies)		
b	☐ Selling an individual's debt to another party		
c	☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d	☐ Actions that require a legal or judicial process		
e	☐ Other similar actions (describe in Section C)		

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

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

Name of hospital facility or letter of facility reporting group COFFEE REGIONAL MEDICAL CENTER INC

		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a	☐ 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? 23		X
	If "Yes," explain in Section C.		
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? 24		X
	If "Yes," explain in Section C.		

Part V **Facility Information** *(continued)*

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

COFFEE REGIONAL MEDICAL CENTER INC:

PART V, SECTION B, LINE 5: IN 2016, CRMC DEVELOPED A COMMUNITY SURVEY QUESTIONNAIRE TO PROVIDE TO PERSONS WITHIN ITS SERVICE AREA. PAPER COPIES AS WELL AS AN ONLINE SURVEY WERE MADE AVAILABLE IN BOTH ENGLISH AND SPANISH. CRMC PROVIDED THE SURVEY TO ALL PATIENTS WHO PRESENTED TO CRMC THROUGH FRONT ADMISSIONS AND TO ALL PATIENTS WHO PRESENTED TO THE THREE LARGEST PRIMARY CARE CLINICS: COFFEE WOMEN'S CARE CENTER, CRH OB/GYN, AND CRH PEDIATRICS. PATIENTS WERE INCENTIVIZED TO PARTICIPATE.

A WRITTEN SURVEY WAS PROVIDED TO PHYSICIANS AND LEADERS WITHIN THE COMMUNITY TO ASSESS THE HEALTH OF THE COMMUNITY, AS WELL AS ITS SPECIFIC NEEDS. THE LEADER BASE WAS DRAWN FROM COUNTY BOARD OF COMMISSIONERS, DFACS TECHNICAL COLLEGE, ENTREPRENEURS, COMMUNITY VOLUNTEERS AND MINISTRY.

COFFEE REGIONAL MEDICAL CENTER INC:

PART V, SECTION B, LINE 11: COFFEE REGIONAL MEDICAL CENTER IDENTIFIED THE FOUR TOP AREAS TO FOCUS ON OUT OF ALL NEEDS IDENTIFIED BY THE COMMUNITY HEALTH NEEDS ASSESSMENT. THESE FOUR ARE CONSIDERED THE MOST SIGNIFICANT HEALTH NEEDS IN THE COMMUNITY AND WILL BE COVERED BY THE IMPACT INITIATIVES. OTHER HEALTH NEEDS IDENTIFIED IN THE ASSESSMENT BUT NOT DEEMED SIGNIFICANT MAY BE INDIRECTLY IMPACTED BY THE INITIATIVES, BUT RESOURCE CONSTRAINTS PREVENT CRMC FROM DIRECTLY ADDRESSING THESE INITIATIVES.

PRIORITY HEALTH ISSUE #1: ADDITIONAL PRIMARY CARE RESOURCES

Part V Facility Information *(continued)*

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

THE RATIO OF THE NUMBER OF PRIMARY CARE PHYSICIANS TO POPULATION IN THE AREA IS LOW COMPARED TO NATIONAL AND GEORGIA AVERAGES.

HOSPITAL STRATEGY

CRMC WILL BE HEAVILY INVOLVED IN MEETING THE PRIMARY CARE NEEDS IN COFFEE AND ATKINSON COUNTIES THROUGH CONTINUED RECRUITMENT EFFORTS. IN THE PAST 24 MONTHS, CRMC HAS RECRUITED AND EMPLOYED PRIMARY CARE PHYSICIANS INTO THE CRH PHYSICIAN PRACTICES MODEL. WITH THESE ADDITIONS, THE HOSPITAL IS ABLE TO ENHANCE THE STABILITY OF PRIMARY CARE BY ENCOURAGING PATIENTS TO REMAIN WITHIN THE COMMUNITY AND ASSURE GREATER AVAILABILITY OF ACCESS POINTS.

ACCORDING TO THE LATEST PHYSICIAN TO POPULATION MANPOWER STUDY, THE PRIMARY SERVICE AREA FOR COFFEE REGIONAL MEDICAL CENTER WILL BE UNDERSERVED DUE TO A DEFICIT OF SIXTEEN INTERNAL MEDICINE PHYSICIANS, NINE FAMILY PRACTICE PHYSICIANS, THREE OB/GYN PHYSICIANS, AND THREE PEDIATRICIANS. COFFEE REGIONAL RECOGNIZES THE DEFICIT AND HAS A PHYSICIAN RECRUITER ON STAFF TO ASSIST IN BRINGING ADDITIONAL MEDICAL EXPERTISE TO THE AREA.

PRIORITY HEALTH ISSUE #2: ACCESS TO CARE/TRANSPORTATION

THROUGH THE CHNA PROCESS, ACCESS TO CARE AND TRANSPORTATION WAS IDENTIFIED AS A PREVALENT NEED IN THE COMMUNITY. ACCESS FOR SOME INDIVIDUALS IS LIMITED DUE TO INCOME OR INSURANCE STATUS.

Part V Facility Information *(continued)*

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

HOSPITAL STRATEGY

SEVERAL ORGANIZATIONS IN THE COMMUNITY ARE WORKING TO IMPROVE ACCESS TO CARE, INCLUDING CRMC. AS AN ORGANIZATION, CRMC WILL EDUCATE THE PUBLIC ON HEALTHCARE ACCESS AND MEANS OF TRANSPORTATION AVAILABLE TO AND FROM APPOINTMENTS. CRMC WILL CONTINUE TO WORK WITH PARTNERS OUTSIDE OF THE HOSPITAL TO EVALUATE THE FEASIBILITY OF COMBINING RESOURCES TO OPEN A FREE HEALTH CLINIC TO PROVIDE FREE AND/OR REDUCED COST TO PATIENTS IN OUR COMMUNITY AND SURROUNDING COUNTIES.

PRIORITY HEALTH ISSUE #3: HEALTH EDUCATION/OBESITY/DIET AND NUTRITION/PREVENTIVE CARE

THROUGH THE CHNA PROCESS, EDUCATION AND PREVENTATIVE CARE WERE IDENTIFIED AS NEEDS IN THE COMMUNITY. PREVENTATIVE DISEASES AND OBESITY ARE ASSOCIATED WITH LIFESTYLE, EDUCATION-LEVEL, AND INCOME-LEVELS OF THE LOCAL POPULATION.

HOSPITAL STRATEGY

CRMC OFFERS A DIABETES SUPPORT GROUP, DIETITIAN CONSULTS, AND EDUCATION AND WELLNESS PROGRAMS THROUGH THE WELLNESS CENTER. CARDIAC REHAB IS ALSO AN AVAILABLE SERVICE. CRMC THROUGH INDUSTRIAL MEDICINES IS OFFERING AND ENCOURAGING LOCAL INDUSTRY TO PROVIDE EDUCATION AND PREVENTATIVE CARE FOR THEIR EMPLOYEES. THROUGH THE INDUSTRIAL MEDICINE PROGRAM, EMPLOYEES ARE REWARDED FOR HEALTHY LIFESTYLES. COFFEE COUNTY OFFERS A NUMBER OF FREE OR

Part V Facility Information *(continued)*

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

REDUCED COST PROGRAMS FOR EDUCATION AND PREVENTION. OUR GOAL IS TO REACH MORE OF THE POPULATION WITH THESE PROGRAMS AND ENCOURAGE GREATER PARTICIPATION.

PRIORITY HEALTH ISSUE #4: CANCER TREATMENT OPTIONS

THROUGH THE CHNA PROCESS, THE AVAILABILITY OF CANCER TREATMENT OPTIONS WAS IDENTIFIED AS A PREVALENT NEED IN THE COMMUNITY.

HOSPITAL STRATEGY

CRMC CURRENTLY OFFERS PROGRAMS THAT PROVIDE SCREENING AND EDUCATION FOR EARLY CANCER DETECTION. SOME OF THESE SERVICES ARE PROVIDED AT EITHER A FREE OR REDUCED RATE. CRMC'S GOAL IS TO INCREASE THE PERCENTAGE OF COMMUNITY MEMBERS THAT UTILIZE THESE SERVICES.

- CRMC PROVIDES THE LATEST IN TECHNOLOGY TO AIDE IN THE EARLY DETECTION OF BREAST CANCER THROUGH THEIR RECENT PURCHASE OF THE HOLOGIC 3D MAMMOGRAPHY TECHNOLOGY, KNOWN AS "TOMOSYNTHESIS." AS THE NEXT GENERATION OF MAMMOGRAPHY, TOMOSYNTHESIS ENABLES CLINICIANS TO IDENTIFY AND CHARACTERIZE INDIVIDUAL BREAST STRUCTURES WITH CLARITY AND CERTAINTY NEVER BEFORE POSSIBLE. TOMOGRAPHY USES PRECISE, 3-DIMENSIONAL, DIGITAL IMAGERY TO CREATE A COMPLETE RECONSTRUCTION OF THE BREAST. THIS TECHNOLOGY ALLOWS A PHYSICIAN TO SEE MASSES AND DISTORTIONS ASSOCIATED WITH CANCERS MUCH MORE CLEARLY AND MUCH EARLIER.

- CRMC SUPPORTS EVIDENCE BASED PROSTATE CANCER SCREENINGS AND EARLY

Part V | **Facility Information** *(continued)*

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

DETECTION THROUGH ANNUAL, REDUCED FEE PROSTATE SCREENING FOR THE MEMBERS OF THE COMMUNITY AS WELL AS PSA SCREENING THROUGH LOCAL PHYSICIANS.

- CRMC CONTINUES TO ACTIVELY RECRUIT PHYSICIANS IN A MULTI-SPECIALTY FACET IN ORDER TO PROVIDE A LARGER SPECTRUM OF CANCER TREATMENT AND SCREENING SERVICES FOR THE COMMUNITY.

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? 1

Name and address	Type of Facility (describe)
1 COFFEE REGIONAL FIRST CARE 1101 OCILLA ROAD DOUGLAS, GA 31533	RURAL HEALTH CLINIC

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.

PART I, LN 7 COL(F):

THERE IS $22,221,549 OF BAD DEBT EXPENSE WHICH IS INCLUDED IN FORM 990, PART IX, LINE 24(A). THIS AMOUNT WAS REMOVED IN THE CALCULATION OF THE PERCENT OF TOTAL EXPENSE ON SCHEDULE H LINE 7F.

PART II, COMMUNITY BUILDING ACTIVITIES:

HEART TO HEART 5K RUN - FEBRUARY 2017

COFFEE REGIONAL'S ANNUAL FALL FITNESS 5K RUN/FUN WALK WAS HELD FEBRUARY 2017 WITH OVER 267 PARTICIPANTS. IN ADDITION TO THE 5K EVENT, A ONE MILE FUN RUN WAS HELD FOR THE YOUTH IN OUR COMMUNITY. A CHECK FOR $2,487 WAS DONATED TO THE CARDIAC REHAB AWARENESS PROGRAM. (APPROXIMATELY 40 MAN HOURS AT A COST OF $880)

HEALTH FAIR - OCTOBER 7, 2017

THE ANNUAL HEALTH & SAFETY FESTIVAL HELD OCTOBER 7, 2017, ATTRACTED NEARLY OVER 1000 VISITORS. WITH OVER 75 EXHIBITORS, DEMONSTRATIONS AND HEALTH

Part VI Supplemental Information *(Continuation)*

SCREENS, THE FESTIVAL OFFERED WONDERFUL, INTERACTIVE WAYS TO PROMOTE A HEALTHY LIFESTYLE. 450 VISITORS TOOK ADVANTAGE OF THE COMPLETE BIOCHEMICAL BLOOD PROFILES OFFERED AT A REDUCED FEE OF $30 (ACTUAL CHARGE OF $535.00) RESULTING IN A COMMUNITY SAVINGS OF $227,250. (APPROXIMATELY 100 MAN HOURS AT A COST OF $2,200)

PROSTATE CANCER SCREENING - OCTOBER 26 & 28, 2017

THE EARLIER PROSTATE CANCER IS DISCOVERED, THE BETTER THE CHANCES ARE THAT IT CAN BE TREATED EFFECTIVELY. WHEN PROSTATE CANCER IS IN ITS EARLIEST STAGES (STILL CONFINED TO THE PROSTATE GLAND), IT USUALLY CAUSES NO PAIN OR OTHER SYMPTOMS. THAT'S WHY EACH YEAR COFFEE REGIONAL MEDICAL CENTER OFFERS LOW COST PROSTATE CANCER SCREENINGS (DRE AND PSA BLOOD TEST) TO OUR COMMUNITY FOR A REDUCED LAB FEE OF ONLY $10.00 (ACTUAL CHARGE $147.00) RESULTING IN A COMMUNITY SAVINGS OF $13,700. IN 2017, OVER 100 MEN TOOK ADVANTAGE OF THIS LIFE-SAVING SCREEN. (APPROXIMATELY 13.5 PHYSICIAN HOURS AND 36 STAFF HOURS AT A COST OF $3,492)

SPORTS PHYSICALS - APRIL 2017

ATHLETIC PHYSICALS ARE REQUIRED BY BOTH THE GEORGIA HIGH SCHOOL AND GEORGIA INDEPENDENT SCHOOL ASSOCIATION FOR STUDENTS PLANNING ON PARTICIPATING IN SCHOOL ATHLETIC PROGRAMS. EACH YEAR COFFEE REGIONAL PROVIDES OVER 550 SPORTS PHYSICALS TO STUDENTS PARTICIPATING IN INTERSCHOLASTIC SPORTS DURING THE SUMMER AND THROUGHOUT THE FOLLOWING YEAR. THIS EVENT RESULTED IN A TOTAL COST SAVINGS TO THE COMMUNITY OF OVER $13,750. (APPROXIMATELY 40 PHYSICIAN HOURS AND 32 STAFF HOURS AT A COST OF $8,280.)

Part VI Supplemental Information *(Continuation)*

PROJECT SEARCH - 2017

PROJECT SEARCH IS A ONE-YEAR EDUCATIONAL PROGRAM FOR STUDENTS WITH DISABILITIES IN THEIR LAST YEAR OF HIGH SCHOOL. IT IS TARGETED FOR STUDENTS WHOSE MAIN GOAL IS COMPETITIVE EMPLOYMENT. COFFEE REGIONAL MEDICAL CENTER PROVIDES THE SETTING FOR TWELVE PROJECT SEARCH STUDENTS, THUS ALLOWING TOTAL IMMERSION IN THE WORKPLACE TO FACILITATE THE TEACHING AND LEARNING PROCESS THROUGH CONTINUOUS FEEDBACK AND APPLICATION OF NEW SKILLS. INDIVIDUALIZED JOB DEVELOPMENT AND PLACEMENT BEGINS AFTER ROTATIONS AT ONE OR MORE WORKSTATIONS ARE COMPLETED. STUDENTS RECEIVE SUPPORT THROUGH ON-THE-JOB COACHING AND WORKSITE ACCOMMODATIONS PROVIDED BY COFFEE REGIONAL. THE PROGRAM IS DEDICATED TO WORKFORCE DEVELOPMENT THAT BENEFITS THE INDIVIDUAL, COMMUNITY AND WORKPLACE. (CLASSROOM SPACE AT $300/MONTH TOTAL OF $2,700 AND APPROXIMATELY 60 STAFF HOURS OF TRAINING, MENTORING AND EDUCATION OF 12 STUDENTS/YEAR AT A COST OF $1,200)

DIABETES SUPPORT GROUP - MONTHLY 2017

COFFEE REGIONAL OFFERS A FREE MONTHLY DIABETES SUPPORT GROUP FOR THE GENERAL PUBLIC. CRMC'S CLINICAL EDUCATION DEPARTMENT LEADS AND ORGANIZES EACH MEETING PROVIDING SUPPORT, EDUCATION, RESOURCES AND EXPERT SPEAKERS AT EACH MEETING. EXPERTS SUCH AS DIETICIANS, PODIATRISTS AND PHYSICIANS PROVIDE VALUABLE EDUCATION TO OUR COMMUNITY REGARDING DIABETES. APPROXIMATELY 30 PEOPLE ATTEND EACH MONTHLY MEETING. (144 MAN HOURS PER YEAR AT A COST OF $4,320)

COMMUNITY CHILDBIRTH CLASSES - BIMONTHLY 2017

CRMC PROVIDES WEEKLY CHILDBIRTH CLASSES EVERY OTHER MONTH FOR THE COMMUNITY. THE WEEKLY SESSIONS ARE FACILITATED BY THE LABOR AND DELIVERY RN STAFF. THE CLASSES PROVIDE EDUCATIONAL LESSONS ABOUT NUTRITIONAL NEEDS OF MOTHER AND FETUS, ANESTHESIA, DELIVERY, BREASTFEEDING AND MANY OTHER INFORMATIVE TOPICS. (2 RN STAFF, 8 HOURS PER MONTH FOR 6 MONTHS AT $25 PER HOUR FOR A TOTAL ANNUAL COST OF $2,400).

COFFEE COUNTY CHILDHOOD CANCER SUPPORT GROUP - 2017

CRMC PROVIDES SPACE MONTHLY FOR THE COFFEE COUNTY CHILDHOOD CANCER SUPPORT GROUP AT NO COST TO THEM. THE CHILDHOOD CANCER SUPPORT GROUP IS A NON-PROFIT ORGANIZATION THAT PROVIDES FAMILIES AND PATIENTS WITH CHILDHOOD CANCER SUPPORT, EDUCATION, RESOURCES AND EXPERT SPEAKERS AT EACH MONTHLY MEETING. (CLASSROOM SPACE $100 PER MONTH FOR A TOTAL OF $1,200 ANNUALLY)

SIDELINE SERVICE - 2017

CRMC PROVIDES SIDELINE SERVICE FOR EACH HIGH SCHOOL FOOTBALL GAME IN COFFEE COUNTY. A FULLY EQUIPPED AMBULANCE, EMT, AND PARAMEDIC ARE PROVIDED FOR EACH HOME FOOTBALL GAME AS A COURTESY TO THE SCHOOL SYSTEM AND SPECTATORS. (AT A COST OF $250 PER GAME AND $1,500/YEAR)

COFFEE COUNTY CHAMBER OF COMMERCE LEADERSHIP COFFEE - 2017

PARTICIPANTS IN LEADERSHIP COFFEE COMMIT TO AN EIGHT-MONTH PROJECT THAT ALLOWS THEM TO TAKE A CLOSE LOOK AT GOVERNMENT, EDUCATION, ECONOMIC DEVELOPMENT, AND ALL ISSUES DEALING WITH QUALITY OF LIFE ON A LOCAL AND

Part VI Supplemental Information *(Continuation)*

STATE LEVEL. THE PROGRAM IS DESIGNED TO HELP PARTICIPANTS DEVELOP LEADERSHIP SKILLS FOR THE WORKPLACE AND THE COMMUNITY. CRMC SPONSORED 2 EMPLOYEES IN 2017 FOR THE NEW CENTURY LEADER PROGRAM. STAFF TIME, TRAVEL AND EXPENSES FOR THE PROGRAM IS APPROXIMATELY $4,224. (2 EMPLOYEES, 12 DAYS OF TRAINING AT 8 HOURS PER DAY = 192 STAFF HOURS AT $22 PER HOUR FOR $4,224)

STUDENTS - 2017

IN 2017 THE MEDICAL CENTER SUPPORTED HEALTHCARE EXCELLENCE THROUGHOUT GEORGIA BY TRAINING OVER 250 STUDENTS IN THE FOLLOWING PROGRAMS.

- ABAC (TIFTON, GA): NURSING (RN)
- ALBANY STATE UNIVERSITY (ALBANY, GA): MASTERS IN NURSING
- COFFEE HIGH SCHOOL (DOUGLAS, GA): HEALTH OCCUPATION STUDENTS , PROJECT SEARCH, STEM STUDENTS.
- GA HEALTH SCIENCE UNIVERSITY (AUGUSTA, GA): PHYSICIAN ASSISTANT
- GA SOUTHERN UNIVERSITY (STATESBORO, GA): NURSING, NURSE PRACTITIONER, DIETICIAN
- MERCER (MACON, GA): MEDICAL STUDENTS
- OKEFENOKEE TECHNICAL COLLEGE (WAYCROSS, GA): LAB, NURSING (LPN), RADIOLOGY TECHNOLOGY, RESPIRATORY THERAPY
- SOUTHEASTERN TECH (VIDALIA, GA): SURGICAL TECHNOLOGY
- SOUTH GEORGIA STATE COLLEGE (DOUGLAS, GA): NURSING (RN) 1ST YR & 2ND YR
- SOUTH UNIVERSITY (SAVANNAH, GA): PHARMACY, PHYSICIAN ASSISTANT
- VALDOSTA STATE UNIVERSITY: NURSING (RN), EXERCISE PHYSIOLOGY
- WALDEN UNIVERSITY (ONLINE): MASTERS IN NURSING
- WIREGRASS (DOUGLAS, GA): CNA, EMT, HIT CODING, LPN, PHLEBOTOMY,

Part VI Supplemental Information *(Continuation)*

RADIOLOGY

PART III, LINE 2:

AMOUNTS ON PART III, LINES 2 AND 3 REPRESENT CHARGES WRITTEN OFF AS UNCOLLECTIBLE AFTER REASONABLE ATTEMPTS TO COLLECT AND WRITTEN OFF TO BAD DEBT EXPENSE. LINE 3 IS ESTIMATED AT 75% OF THE AMOUNT ON LINE 2.

PART III, LINE 4:

ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FOR DOUBTFUL ACCOUNTS. IN EVALUATING THE COLLECTABILITY OF ACCOUNTS RECEIVABLE, THE CORPORATION 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 FOR THE ALLOWANCE FOR DOUBTFUL ACCOUNTS. FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, THE CORPORATION ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND PROVISION FOR BAD DEBTS, IF NECESSARY (FOR EXAMPLE, FOR EXPECTED UNCOLLECTIBLE DEDUCTIBLES AND COPAYMENTS ON ACCOUNTS FOR WHICH THE THIRD-PARTY PAYOR HAS NOT YET PAID, OR FOR PAYORS WHO ARE KNOWN TO BE HAVING FINANCIAL DIFFICULTIES THAT MAKE THE REALIZATION OF AMOUNTS DUE UNLIKELY). FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS, THE CORPORATION RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATES THAT MANY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE. THE DIFFERENCE BETWEEN THE STANDARD RATES (OR THE DISCOUNTED RATES IF NEGOTIATED) AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE

Part VI **Supplemental Information** *(Continuation)*

BEEN EXHAUSTED IS CHARGED OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS.

THE CORPORATION'S ALLOWANCE FOR DOUBTFUL ACCOUNTS FOR SELF-PAY PATIENTS WAS APPROXIMATELY 97% OF SELF-PAY ACCOUNTS RECEIVABLE AT DECEMBER 31, 2017 AND 2016. THE CORPORATION DID NOT HAVE A MATERIAL CHANGE IN THE ALLOWANCE PERCENTAGE FOR MEDICARE OR MEDICAID DURING 2017 AND 2016. THE ALLOWANCES DISCLOSED ON THE CONSOLIDATED BALANCE SHEETS REPRESENT THE ALLOWANCE FOR CONTRACTUAL ADJUSTMENTS WITH THIRD-PARTY PAYERS, AS WELL AS THE ESTIMATED ALLOWANCE FOR DOUBTFUL ACCOUNTS. THE CORPORATION'S PROVISION FOR BAD DEBTS INCREASED APPROXIMATELY $4,895,000 FROM APPROXIMATELY $17,327,000 FOR 2016 TO APPROXIMATELY $22,222,000 FOR 2017. THIS WAS THE RESULT OF INCREASED SELF-PAY PATIENT VOLUME. THE CORPORATION HAS NOT CHANGED ITS CHARITY CARE OR UNINSURED DISCOUNT POLICIES DURING FISCAL YEARS 2017 OR 2016.

PART III, LINE 8:

MEDICARE ALLOWABLE COSTS ARE COMPUTED IN ACCORDANCE WITH COST REPORTING METHODOLOGIES UTILIZED ON THE MEDICARE COST REPORT AND IN ACCORDANCE WITH RELATED REGULATIONS. INDIRECT COSTS ARE ALLOCATED TO DIRECT SERVICE AREAS USING THE MOST APPROPRIATE STATISTICAL BASIS.

PART III, LINE 9B:

THE ORGANIZATION WRITES OFF PATIENT ACCOUNTS RECEIVABLE BALANCES THAT QUALIFY FOR CHARITY CARE OR FINANCIAL ASSISTANCE AND DOES NOT MAKE FURTHER COLLECTION EFFORTS AGAINST THOSE BALANCES.

PART VI, LINE 2:

COFFEE REGIONAL MEDICAL CENTER EVALUATES THE NEEDS OF ITS PATIENT BASE THROUGH THE NUMBER OF PATIENTS REFERRED TO OTHER FACILITIES FOR SERVICES

Part VI **Supplemental Information** *(Continuation)*

NOT PROVIDED BY THE FACILITY ITSELF AND THROUGH OTHER INDICATORS. IN 2016, THE HOSPITAL ORGANIZATION COMPLETED ITS COMMUNITY HEALTH NEEDS ASSESSMENT. THE FINAL REPORT CAN BE FOUND AT THE FOLLOWING LINK:

HTTP://WWW.COFFEEREGIONAL.ORG/

THE IMPLEMENTATION STRATEGY PLAN IS INCLUDED AS A PART OF THE CHNA ON PAGES 25 THROUGH 29.

PART VI, LINE 3:
THE FINANCIAL COUNSELING DEPARTMENT WILL PROVIDE INFORMATION AND APPLICATIONS TO ALL PATIENTS OR GUARANTORS SEEKING FINANCIAL ASSISTANCE FOR SERVICES RENDERED AT COFFEE REGIONAL MEDICAL CENTER THAT ARE DEEMED MEDICALLY NECESSARY.

FINANCIAL COUNSELORS WILL DISCUSS ELIGIBILITY FOR MEDICAL ASSISTANCE PROGRAMS THROUGH THE DEPARTMENT OF FAMILY & CHILDREN SERVICES AND THE SOCIAL SECURITY ADMINISTRATION. IF ELIGIBILITY IS NOT MET FOR ANY MEDICAL ASSISTANCE PROGRAM, THE FINANCIAL COUNSELING DEPARTMENT WILL SEEK ELIGIBILITY THROUGH COFFEE REGIONAL MEDICAL CENTER'S INDIGENT CARE TRUST FUND PROGRAM.

PATIENTS OR GUARANTORS REQUESTING FINANCIAL ASSISTANCE ARE REFERRED TO THE FINANCIAL COUNSELORS (FC) OR THE BENEFIT SPECIALISTS CONTACT THE PATIENT AT THE TIME OF REGISTRATION FOR OUTPATIENT SERVICES OR IN THE EMERGENCY DEPARTMENT (AFTER MEDICAL SCREENING HAS BEEN COMPLETED). THE FC WILL ALSO CONTACT AN INDIVIDUAL IF THERE IS A REQUEST FROM SOCIAL SERVICES, A PHYSICIAN OFFICE, OR THE PATIENT FINANCIAL SERVICES DEPARTMENT. PATIENTS

Part VI Supplemental Information *(Continuation)*

ADMITTED FOR INPATIENT OR OBSERVATION SERVICES MAY BE VISITED BY THE FC AFTER THE PATIENT HAS BEEN PLACED IN A ROOM AND STABILIZED.

THE FC WILL DISCUSS WITH THE PATIENT OR GUARANTOR THE INDIGENT CARE TRUST FUND PROGRAM REQUIREMENTS AND APPLICATION PROCESS. THE PATIENT OR GUARANTOR WILL BE REQUIRED TO COMPLETE AN INDIGENT APPLICATION, PROVIDE PROOF OF IDENTITY, PROVIDE BIRTH CERTIFICATES OR PROOF OF DEPENDENCY FOR CHILDREN WITH NO IDENTITY, AND PROVIDE VERIFICATION OF INCOME (I.E. W-2'S, FEDERAL TAX RETURN, PAY STUBS, ETC.). IF VERIFICATION IS NOT PROVIDED AT THE TIME OF THE INTERVIEW, THE PATIENT OR GUARANTOR WILL BE REQUIRED TO PROVIDE WITHIN 30 DAYS. APPLICATIONS MADE ON BEHALF OF DECEASED PATIENTS MUST HAVE VERIFICATION OF INCOME AND INFORMATION CONCERNING THE VALUE OF THE PATIENT'S ESTATE.

PATIENTS WHO CHOOSE NOT TO UTILIZE CURRENT BENEFITS THEY ARE ELIGIBLE FOR (I.E. VETERANS BENEFITS, MEDICARE, AND COMMERCIAL INSURANCE) WILL NOT BE CONSIDERED FOR THE INDIGENT PROGRAM. UPON RECEIPT OF THE COMPLETED APPLICATION INCLUDING NECESSARY DOCUMENTATION, CALCULATION OF THE HOUSEHOLD SIZE AND ANNUAL HOUSEHOLD INCOME IS COMPUTED AND COMPARED TO THE FEDERAL POVERTY GUIDELINES (FPG) TO DETERMINE THE PERCENTAGE OF ASSISTANCE A PATIENT OR GUARANTOR IS ELIGIBLE TO RECEIVE. PATIENTS WHOSE ANNUAL HOUSEHOLD INCOME IS BELOW THE GROSS INCOME CEILING FOR POTENTIAL MEDICAID ELIGIBILITY ARE REQUIRED TO APPLY FOR MEDICAID. ASSISTANCE IS PROVIDED TO PATIENTS IN FILING FOR OTHER BENEFITS AND COMPLETING MEDICAID APPLICATIONS. PATIENTS WHO CHOOSE NOT TO APPLY FOR OTHER BENEFITS TO WHICH THEY MAY BE ENTITLED (I.E. MEDICAID) WILL NOT BE CONSIDERED FOR THE INDIGENT PROGRAM. PATIENTS WHO CHOOSE TO APPLY COFFEE REGIONAL MEDICAL CENTER'S ACCOUNTS FOR THE PURPOSE OF MEETING MEDICALLY NEEDY SPEND DOWN TO

Part VI Supplemental Information *(Continuation)*

RECEIVE ONGOING MEDICAID WILL NOT BE ALLOWED TO APPLY FOR THE INDIGENT PROGRAM FOR THAT ACCOUNT.

PATIENTS OR GUARANTORS OVER 18 YEARS OF AGE BUT CLASSIFIED AS DEPENDENTS FOR TAX PURPOSES DUE TO STUDENT ELIGIBILITY WILL HAVE A TOTAL HOUSEHOLD SIZE THAT INCLUDES PARENTS AND SUBSEQUENT INCOME. PATIENTS OR GUARANTORS NOT ELIGIBLE FOR OTHER MEDICAL ASSISTANCE PROGRAMS WILL BE PROCESSED UNDER THE INDIGENT CARE TRUST FUND GUIDELINES USING THE FOLLOWING CATEGORIES:

- INDIGENT - FOR PATIENTS WHOSE ANNUAL HOUSEHOLD INCOME IS BELOW 125% OF THE FPG, THE APPLICABLE ACCOUNTS WILL BE ADJUSTED TO ZERO BALANCES.

- CHARITY - FOR PATIENTS WHOSE ANNUAL HOUSEHOLD INCOME IS GREATER THAN OR EQUAL TO 125% BUT NOT GREATER THAN 200% OF THE FPG, THE APPLICABLE ACCOUNTS WILL BE ADJUSTED BY THE APPROPRIATE PERCENTAGES.

- AN ADJUSTMENT OF 85% OF APPLICABLE CHARGES FOR PATIENTS WHOSE ANNUAL HOUSEHOLD INCOME IS BETWEEN 125% AND 150% OF FPG

- AN ADJUSTMENT OF 70% OF APPLICABLE CHARGES FOR PATIENTS WHOSE ANNUAL HOUSEHOLD INCOME IS BETWEEN 150% AND 175% OF FPG

- AN ADJUSTMENT OF 62% OF APPLICABLE CHARGES FOR PATIENTS WHOSE ANNUAL HOUSEHOLD INCOME IS BETWEEN 175% AND 200% OF FPG

- CATASTROPHIC - PATIENTS WHOSE ANNUAL HOUSEHOLD INCOME IS GREATER THAN 200% FPG MAY QUALIFY FOR CHARITY ADJUSTMENTS ON APPLICABLE ACCOUNTS, IF CONSIDERATION OF THE CRMC PATIENT OBLIGATIONS REDUCES THE ANNUAL HOUSEHOLD INCOME TO THE APPROPRIATE FPG.

Part VI Supplemental Information *(Continuation)*

NOTIFICATION OF STATUS OF COMPLETED APPLICATION IS PROVIDED TO THE PATIENT OR GUARANTOR WITHIN 5 WORKING DAYS OF RECEIPT OF NEEDED INFORMATION. APPROVED APPLICATIONS ARE VALID FOR 180 DAYS FROM DATE OF SIGNATURE. INCOMPLETE APPLICATIONS ARE HELD FOR 30 DAYS. IF NO DOCUMENTATION IS PROVIDED TO COMPLETE THE APPLICATION, A DENIAL LETTER IS SENT TO THE PATIENT OR GUARANTOR. THE APPLICATION MAY BE COMPLETED IF THE PATIENT OR GUARANTOR PROVIDES THE REQUESTED INFORMATION WITHIN 15 WORKING DAYS OF THE DENIAL. NOTIFICATION OF STATUS OF COMPLETED APPLICATION WILL BE MAILED WITHIN 15 WORKING DAYS OF RECEIPT OF NEEDED INFORMATION.
THE APPLICATION AND DOCUMENTATION WILL BECOME PROPERTY OF COFFEE REGIONAL MEDICAL CENTER AND IS TO BE KEPT CONFIDENTIAL IN THE SAME MANNER AS MEDICAL RECORDS. HOWEVER, THIS INFORMATION WILL BE USED FOR AGGREGATE REPORTING PURPOSES ONLY.

PART VI, LINE 4:
COFFEE REGIONAL MEDICAL CENTER'S PRIMARY SERVICE AREA IS COFFEE COUNTY, GEORGIA. THE COUNTY HAD A POPULATION OF 43,014 CITIZENS IN 2017, OF WHICH APPROXIMATELY 23.0% FALL BELOW GOVERNMENTAL DEFINED POVERTY GUIDELINES. COFFEE COUNTY'S UNEMPLOYMENT RATE AT YEAR-END WAS 4.9%.

PART VI, LINE 5:
COFFEE REGIONAL MEDICAL CENTER IS GOVERNED BY A BOARD OF DIRECTORS CONSISTING OF 11 MEMBERS. CRH HEALTHCARE, INC., THE SOLE MEMBER, ELECTS ALL BOARD MEMBERS OF CRMC. THE BOARD IS MADE UP OF NINE COMMUNITY MEMBERS REFLECTING THE DIVERSITY OF THE COMMUNITY. THE REMAINING TWO MEMBERS ARE THE CHIEF OF STAFF OF CRMC AND THE CHIEF OF STAFF ELECT. IT IS THE PHILOSOPHY OF CRMC TO ASSURE THE CONTINUATION AND ENHANCEMENT OF PATIENT CARE BY REINVESTING EXCESS FUNDS BACK INTO THE OPERATIONS OF THE FACILITY.

Part VI **Supplemental Information** *(Continuation)*

THIS INCLUDES GREATER ACCESSIBILITY OF CARE THROUGH THE CREATION OF A RURAL HEALTH CENTER, IMPLEMENTATION OF A TELEMEDICINE PROGRAM AND RECRUITMENT OF PHYSICIANS TO THE UNDERSERVED ENVIRONMENT. ENHANCEMENT OF TECHNOLOGY IS ALSO IMPERATIVE TO ASSURE APPROPRIATE DIAGNOSTIC AND THERAPEUTIC OPTIONS FOR THE COMMUNITY. UPDATING THE AMBULANCE FLEET IS CONSISTENTLY HIGH ON THE FUNDING PRIORITY LIST TO ASSURE SERVICE TO THE MOST REMOTE AREAS OF THE COUNTY, WHICH IN SQUARE MILES IS THE SECOND LARGEST COUNTY IN THE STATE OF GEORGIA. CRMC HAS AN OPEN MEDICAL STAFF POLICY EXTENDING PRIVILEGES TO PROFESSIONALLY COMPETENT PRACTITIONERS WHO CONTINUOUSLY MEET THE QUALIFICATIONS, STANDARDS AND REQUIREMENTS OF CRMC.

PART VI, LINE 6:

N/A

PART VI, LINE 7, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:

GA

SCHEDULE J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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.**

OMB No. 1545-0047

2017

Open to Public Inspection

Name of the organization

COFFEE REGIONAL MEDICAL CENTER, INC.

Employer identification number

65-0543088

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.			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax indemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (such as, 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		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked on line 1a?	2		
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.			
	☒ Compensation committee	☒ Written employment contract		
	☒ Independent compensation consultant	☒ Compensation survey or study		
	☐ Form 990 of other organizations	☒ 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		X
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b		X
c	Participate in, or receive payment from, an equity-based compensation arrangement?	4c		X
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only section 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		X
b	Any related organization?	5b		X
	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	X	
b	Any related organization?	6b		X
	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 on lines 5 and 6? If "Yes," describe in Part III	7		X
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		X
9	If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9		

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

Supplemental Information on Tax-Exempt Bonds

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990. ▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047
2017
Open to Public Inspection

Name of the organization
COFFEE REGIONAL MEDICAL CENTER, INC.

Employer identification number
65-0543088

Part I Bond Issues

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
							Yes	No	Yes	No	Yes	No
A	COFFEE COUNTY HOSPITAL AUTHORITY	58-6003116	192137DW4	12/22/16	24367008.	DEFEASANCE OF PREVIOUS BONDS		X		X		X
B												
C												
D												

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired				
2	Amount of bonds legally defeased	24,963,471.			
3	Total proceeds of issue	24,367,008.			
4	Gross proceeds in reserve funds	2,171,000.			
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows	24,963,471.			
7	Issuance costs from proceeds	468,262.			
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds				
11	Other spent proceeds				
12	Other unspent proceeds				
13	Year of substantial completion	2016			

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue?		X						
15	Were the bonds issued as part of an advance refunding issue?	X							
16	Has the final allocation of proceeds been made?	X							
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X							

Part III Private Business Use

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X						
2	Are there any lease arrangements that may result in private business use of bond-financed property?		X						

Part III Private Business Use *(Continued)*

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?		X						
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
c Are there any research agreements that may result in private business use of bond-financed property?		X						
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶	%		%		%		%	
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶	%		%		%		%	
6 Total of lines 4 and 5	%		%		%		%	
7 Does the bond issue meet the private security or payment test?		X						
8a Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued?		X						
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of	%		%		%		%	
c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?	X							

Part IV Arbitrage

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X						
2 If "No" to line 1, did the following apply?								
a Rebate not due yet?		X						
b Exception to rebate?		X						
c No rebate due?		X						
If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3 Is the bond issue a variable rate issue?		X						
4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X						
b Name of provider								
c Term of hedge								
d Was the hedge superintegrated?								
e Was the hedge terminated?								

Part IV Arbitrage *(Continued)*

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
5a Were gross proceeds invested in a guaranteed investment contract (GIC)?		X						
b Name of provider								
c Term of GIC								
d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6 Were any gross proceeds invested beyond an available temporary period?		X						
7 Has the organization established written procedures to monitor the requirements of section 148?		X						

Part V Procedures To Undertake Corrective Action

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation isn't available under applicable regulations?		X						

Part VI Supplemental Information. Provide additional information for responses to questions on Schedule K. See instructions

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

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.

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2017

Open to Public Inspection

Name of the organization

COFFEE REGIONAL MEDICAL CENTER, INC.

Employer identification number

65-0543088

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

SERVICES IN COFFEE COUNTY, GEORGIA, AND THE SURROUNDING REGION. THESE HEALTH CARE SERVICES ARE PROVIDED TO ALL PERSONS REGARDLESS OF ABILITY TO PAY.

FORM 990, PART VI, SECTION A, LINE 6:

CRH HEALTHCARE, INC., THE PARENT ORGANIZATION, HAS THE AUTHORITY TO APPOINT OR REMOVE BOARD MEMBERS.

FORM 990, PART VI, SECTION A, LINE 7A:

BOARD MEMBERS OF THE ORGANIZATION ARE APPOINTED, AND CAN BE REMOVED, BY CRH HEALTHCARE, INC., THE PARENT ORGANIZATION.

FORM 990, PART VI, SECTION A, LINE 7B:

DECISIONS OF THE BOARD ARE SUBJECT TO APPROVAL BY CRH HEALTHCARE, INC., THE PARENT ORGANIZATION.

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

FORM 990 IS PREPARED BY AN INDEPENDENT FIRM AND IS PROVIDED TO THE BOARD PRIOR TO FILING WITH THE IRS. THE MANAGEMENT OF COFFEE REGIONAL MEDICAL CENTER, INC. PERFORMS A REVIEW OF FORM 990 BEFORE THE FILING DATE AND INCLUDES A REVIEW OF FINANCIAL DATA AND OTHER DETAILS.

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

BOARD MEMBERS, OFFICERS, AND KEY EMPLOYEES ARE REQUIRED TO DISCLOSE ANY POTENTIAL CONFLICTS ANNUALLY. THIS IS REVIEWED BY THE CEO AND BOARD

Name of the organization: COFFEE REGIONAL MEDICAL CENTER, INC.

Employer identification number: 65-0543088

CHAIRMAN, IF NEEDED. MEMBERS RECUSE THEMSELVES FROM CERTAIN DISCUSSIONS/DECISIONS AS A RESULT OF ANY CONFLICTS.

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

COMPENSATION OF THE CEO AND EXECUTIVE OFFICERS OF CRMC IS DETERMINED BY AN INDEPENDENT COMPENSATION COMMITTEE, INDEPENDENT COMPENSATION CONSULTANT AND SURVEYS, AND BOARD APPROVAL. THESE METHODS ARE WELL DOCUMENTED.

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

GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICIES, AND FINANCIAL STATEMENTS OF THE ORGANIZATION ARE ALL AVAILABLE TO THE PUBLIC UPON REQUEST AT THE ORGANIZATION'S CORPORATE HEADQUARTERS.

FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

PARTNERSHIP INCOME	18,130.
EQUITY DISTRIBUTION FROM CRH VENTURES	750,000.
TOTAL TO FORM 990, PART XI, LINE 9	768,130.

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.

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2017

Open to Public Inspection

Name of the organization

COFFEE REGIONAL MEDICAL CENTER, INC.

Employer identification number

65-0543088

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
CRH PHYSICIAN PRACTICES LLC - 20-5778734 1101 OCILLA ROAD DOUGLAS, GA 31533-2207	PHYSICIANS OFFICES	GEORGIA	9,369,507.	2,141,755.	CRMC
EMERGENCY PHYSICIANS OF COFFEE CO LLC - 45-1775790, PO BOX 1287, DOUGLAS, GA 31534-1287	ER PHYSICIANS	GEORGIA	1,805,462.	276,775.	CRMC
ORTHOPEDIC SURGEONS OF GEORGIA LLC - 45-2786844, PO BOX 1287, DOUGLAS, GA 31534-1287	PHYSICIANS OFFICES	GEORGIA	2,834,416.	1,460,350.	CRMC
COFFEE REGIONAL MEDICAL CENTER SEGREGATED PORTFOLIO, 62 FORUM LANE, 3RD FLOOR, BOX 30600, CAMANA BAY, CAYMAN ISLANDS	INSURANCE	CAYMAN ISLANDS	2,275,160.	10,852,718.	CRMC

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
CRH HEALTHCARE, INC. - 58-2163724 1101 OCILLA ROAD DOUGLAS, GA 31533-2207	MANAGEMENT SERVICES	GEORGIA	501(C)(3)	LINE 12D, III-O	N/A		X
CRH HEALTH SERVICES, INC. - 58-2165827 1101 OCILLA ROAD DOUGLAS, GA 31533-2207	FOUNDATION	GEORGIA	501(C)(3)	LINE 12C, III-FI	N/A		X

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? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No
CRH VENTURES INC. - 58-2165279 1101 OCILLA ROAD DOUGLAS, GA 31533-2207	OFFICE RENTAL	GA	N/A	C CORP	N/A	N/A	N/A		X
SOUTHEASTERN MANAGED CARE, INC. - 58-2236627 1101 OCILLA ROAD DOUGLAS, GA 31533-2207	MANAGED CARE	GA	N/A	C CORP	N/A	N/A	N/A		X

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

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

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

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

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

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners sec 501(c)(3) orgs.? Yes	(e) No	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership

Part VII Supplemental Information.

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