

Form **990**

**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  
**2018**  
**Open to Public Inspection**

**A For the 2018 calendar year, or tax year beginning 08/01/18, and ending 07/31/19**

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

**C** Name of organization: Phoebe Worth Medical Center, Inc.  
 Doing business as:  
 Number and street (or P.O. box if mail is not delivered to street address): 807 South Isabella, P.O. Box 545  
 City or town, state or province, country, and ZIP or foreign postal code: Sylvester GA 31791-0545

**D** Employer identification number: 38-3647394  
**E** Telephone number: 229-776-6961  
**G** Gross receipts: 18,849,217

**F** Name and address of principal officer:  
Kim Gilman  
P.O. Box 545  
Sylvester GA 31791-0545

**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)

**I** Tax-exempt status:  501(c)(3)  501(c) ( ) **t** (insert no.)  4947(a)(1) or  527

**J** Website: www.phoebehealth.com **H(c)** Group exemption number **U**

**K** Form of organization:  Corporation  Trust  Association  Other **U** **L** Year of formation: 2002 **M** State of legal domicile: GA

**Part I Summary**

<b>Activities &amp; Governance</b>	<b>1</b> Briefly describe the organization's mission or most significant activities: <u>Providing charitable healthcare activities</u>		
	<b>2</b> Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	<b>3</b> Number of voting members of the governing body (Part VI, line 1a)	<b>3</b>	<u>9</u>
	<b>4</b> Number of independent voting members of the governing body (Part VI, line 1b)	<b>4</b>	<u>6</u>
	<b>5</b> Total number of individuals employed in calendar year 2018 (Part V, line 2a)	<b>5</b>	<u>206</u>
	<b>6</b> Total number of volunteers (estimate if necessary)	<b>6</b>	<u>8</u>
	<b>7a</b> Total unrelated business revenue from Part VIII, column (C), line 12	<b>7a</b>	<u>5,601</u>
<b>b</b> Net unrelated business taxable income from Form 990-T, line 38	<b>7b</b>	<u>3,210</u>	
<b>Revenue</b>	<b>8</b> Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
	<b>9</b> Program service revenue (Part VIII, line 2g)	<u>267,957</u>	<u>2,651,541</u>
	<b>10</b> Investment income (Part VIII, column (A), lines 3, 4, and 7d)	<u>15,551,102</u>	<u>15,767,337</u>
	<b>11</b> Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	<u>14,731</u>	<u>52,511</u>
	<b>12</b> Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	<u>184,546</u>	<u>357,467</u>
<b>Expenses</b>	<b>13</b> Grants and similar amounts paid (Part IX, column (A), lines 1-3)	<u>16,018,336</u>	<u>18,828,856</u>
	<b>14</b> Benefits paid to or for members (Part IX, column (A), line 4)	<u>45,619</u>	<u>45,619</u>
	<b>15</b> Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	<u>6,782,944</u>	<u>7,732,238</u>
	<b>16a</b> Professional fundraising fees (Part IX, column (A), line 11e)		<u>0</u>
	<b>b</b> Total fundraising expenses (Part IX, column (D), line 25) <b>U</b>	<u>0</u>	
	<b>17</b> Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	<u>8,874,673</u>	<u>8,591,276</u>
	<b>18</b> Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	<u>15,703,236</u>	<u>16,369,133</u>
<b>19</b> Revenue less expenses. Subtract line 18 from line 12	<u>315,100</u>	<u>2,459,723</u>	
<b>Net Assets or Fund Balances</b>	<b>20</b> Total assets (Part X, line 16)	Beginning of Current Year	End of Year
	<b>21</b> Total liabilities (Part X, line 26)	<u>9,026,099</u>	<u>10,783,074</u>
	<b>22</b> Net assets or fund balances. Subtract line 21 from line 20	<u>15,099,078</u>	<u>14,396,330</u>
		<u>-6,072,979</u>	<u>-3,613,256</u>

**Part II Signature Block**

Under penalty 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: Candace Guarnieri CFO Date: \_\_\_\_\_  
 Type or print name and title

**Paid Preparer Use Only**

Print/Type preparer's name: Jeffrey S. Wright Preparer's signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Check  if PTIN self-employed P00226270

Firm's name: Draffin & Tucker LLP Firm's EIN: 58-0914992  
 PO Box 71309  
 Firm's address: Albany, GA 31708-1309 Phone no. 229-883-7878

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

**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:

Providing charitable healthcare activities



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 \$ 13,218,753 including grants of \$ 45,619 ) (Revenue \$ 15,948,477 )

To be the leading provider of quality, cost effective, patient-centered health care services to all residents of Southwest Georgia. PWMC pursues its mission through a patient-centered environment of care reflecting high standards and promoting a balance of professional preparation and service, continuous improvement based on our core values of people, relationships, reputation, excellence, efficiency and commitment. For further information, please see Schedule H Part VI Community Information section.

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

N/A

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

N/A

4d Other program services (Describe in Schedule O.)

(Expenses \$ including grants of \$ ) (Revenue \$ )

4e Total program service expenses u 13,218,753

**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	X	
2 Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?	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		X
4 <b>Section 501(c)(3) organizations.</b> Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II	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		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		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		X
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III		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		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		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	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		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		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		X
e Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	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	X	
12a Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII	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	X	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E		X
14a Did the organization maintain an office, employees, or agents outside of the United States?		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		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		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		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 (see instructions)		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		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		X
20a Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H	X	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	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	X	

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

		Yes	No
22	Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i>		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? <i>If "Yes," complete Schedule J</i>	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? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i>		X
24b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		
24c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?		
24d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		
25a	<b>Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.</b> Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i>		X
25b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i>		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? <i>If "Yes," complete Schedule L, Part II</i>		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? <i>If "Yes," complete Schedule L, Part III</i>		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):		
28a	a A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>		X
28b	b A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>		X
28c	c An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV</i>		X
29	Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i>		X
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i>		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i>		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i>		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? <i>If "Yes," complete Schedule R, Part I</i>		X
34	Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i>	X	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?		X
35b	b If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i>		
36	<b>Section 501(c)(3) organizations.</b> Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i>		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? <i>If "Yes," complete Schedule R, Part VI</i>		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? <b>Note.</b> All Form 990 filers are required to complete Schedule O.	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		
1b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable		
1c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?		

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

		Yes	No
<b>2a</b>	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return <b>2a</b> 206		
<b>b</b>	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? <b>Note.</b> If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	X	
<b>3a</b>	Did the organization have unrelated business gross income of \$1,000 or more during the year?	X	
<b>b</b>	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O	X	
<b>4a</b>	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?		X
<b>b</b>	If "Yes," enter the name of the foreign country: <b>u</b> See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).		
<b>5a</b>	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		X
<b>b</b>	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		X
<b>c</b>	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?		
<b>6a</b>	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?		X
<b>b</b>	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		
<b>7</b>	<b>Organizations that may receive deductible contributions under section 170(c).</b>		
<b>a</b>	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?		X
<b>b</b>	If "Yes," did the organization notify the donor of the value of the goods or services provided?		
<b>c</b>	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		X
<b>d</b>	If "Yes," indicate the number of Forms 8282 filed during the year <b>7d</b>		
<b>e</b>	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		X
<b>f</b>	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		X
<b>g</b>	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		
<b>h</b>	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		
<b>8</b>	<b>Sponsoring organizations maintaining donor advised funds.</b> Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?		
<b>9</b>	<b>Sponsoring organizations maintaining donor advised funds.</b>		
<b>a</b>	Did the sponsoring organization make any taxable distributions under section 4966?		
<b>b</b>	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?		
<b>10</b>	<b>Section 501(c)(7) organizations.</b> Enter:		
<b>a</b>	Initiation fees and capital contributions included on Part VIII, line 12 <b>10a</b>		
<b>b</b>	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities <b>10b</b>		
<b>11</b>	<b>Section 501(c)(12) organizations.</b> Enter:		
<b>a</b>	Gross income from members or shareholders <b>11a</b>		
<b>b</b>	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.) <b>11b</b>		
<b>12a</b>	<b>Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?		
<b>b</b>	If "Yes," enter the amount of tax-exempt interest received or accrued during the year <b>12b</b>		
<b>13</b>	<b>Section 501(c)(29) qualified nonprofit health insurance issuers.</b>		
<b>a</b>	Is the organization licensed to issue qualified health plans in more than one state? <b>Note.</b> See the instructions for additional information the organization must report on Schedule O.		
<b>b</b>	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans <b>13b</b>		
<b>c</b>	Enter the amount of reserves on hand <b>13c</b>		
<b>14a</b>	Did the organization receive any payments for indoor tanning services during the tax year?		X
<b>b</b>	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O		
<b>15</b>	Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see instructions and file Form 4720, Schedule N.		X
<b>16</b>	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O.		X

**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

**Section A. Governing Body and Management**

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

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

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

**Section C. Disclosure**

- 17** List the states with which a copy of this Form 990 is required to be filed **u** GA
- 18** Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A 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 **u**  
 Candace Guarnieri, CFO P.O. Box 545  
 Sylvester

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

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

**Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees**

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

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) Joel Wernick ..... Past Bd Mem/PPHS CEO	1.00 54.00	X		X				0	1,396,243	27,010
(2) Joe Austin ..... Bd Mbr/PPHS VP COO	1.00 53.00	X		X				0	603,255	163,612
(3) Grace Davis, MD ..... Board Member	1.00 40.00	X						0	39,000	0
(4) Don Monk ..... Chairman	1.00 0.00	X		X				0	0	0
(5) Johnny Cochran ..... Vice Chair	1.00 0.00	X		X				0	0	0
(6) Chris Shipp ..... Board Member	1.00 0.00	X						0	0	0
(7) Mary King Givens ..... Board Member	1.00 2.00	X						0	0	0
(8) Wayne Senkbeil ..... Board Member	1.00 0.00	X						0	0	0
(9) Shirley Thomas ..... Board Member	1.00 0.00	X						0	0	0
(10) Scott Steiner ..... PPHS CEO	1.00 54.00	X		X				0	0	0
(11) Brian Church ..... PPHS CFO	1.00 54.00			X				0	519,927	92,531

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(12) Kim Gilman ..... CEO/CNO	25.00 ..... 25.00			X				0	258,240	61,932
(13) Candace Guarnieri ..... CFO	25.00 ..... 25.00			X				0	132,368	14,721
(14) Benjamin Lee Hudson ..... Pharmacist	40.00 ..... 0.00					X		130,205	0	18,940
(15) Mary Houston ..... Speech Therapist	40.00 ..... 0.00					X		112,903	0	3,345
(16) Laurie Martin ..... Physical Therapist	40.00 ..... 0.00					X		100,072	0	2,985
<b>1b Sub-total</b> .....								343,180	2,949,033	385,076
<b>c Total from continuation sheets to Part VII, Section A</b> .....										
<b>d Total (add lines 1b and 1c)</b> .....								343,180	2,949,033	385,076

**2** Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization **u 3**

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

**Section B. Independent Contractors**

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

(A) Name and business address	(B) Description of services	(C) Compensation
Aramark Corporation Chicago IL 60673-1252	25271 Network Place Dietary Service	478,031
Powell Contract Services Ashburn GA 31714	129 Lake Estate Drive Construction	178,808

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



**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					
	e Government grants (contributions)	1e	114,596				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	2,536,945				
	g Noncash contributions included in lines 1a-1f: \$						
	<b>h Total.</b> Add lines 1a-1f	<b>u</b>	<b>2,651,541</b>				
Program Service Revenue			<b>Busn. Code</b>				
	2a Net Patient Service Revenue		623000	15,761,736	15,761,736		
	b Reference Lab		621500	5,601		5,601	
	c						
	d						
	e						
	f All other program service revenue						
<b>g Total.</b> Add lines 2a-2f	<b>u</b>	<b>15,767,337</b>					
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)	<b>u</b>		52,511		52,511	
	4 Income from investment of tax-exempt bond proceeds	<b>u</b>					
	5 Royalties	<b>u</b>					
	6a Gross rents	(i) Real	47,410				
		(ii) Personal					
	b Less: rental exps.		20,361				
	c Rental inc. or (loss)		27,049				
	<b>d Net rental income or (loss)</b>	<b>u</b>		27,049		27,049	
	7a Gross amount from sales of assets other than inventory	(i) Securities					
		(ii) Other					
	b Less: cost or other basis & sales exps.						
	c Gain or (loss)						
	<b>d Net gain or (loss)</b>	<b>u</b>					
	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						
<b>c Net income or (loss) from fundraising events</b>	<b>u</b>						
9a Gross income from gaming activities. See Part IV, line 19	a						
b Less: direct expenses	b						
<b>c Net income or (loss) from gaming activities</b>	<b>u</b>						
10a Gross sales of inventory, less returns and allowances	a						
b Less: cost of goods sold	b						
<b>c Net income or (loss) from sales of inventory</b>	<b>u</b>						
Miscellaneous Revenue		<b>Busn. Code</b>					
11a EHR Revenue		621990	179,505	179,505			
b Cafeteria		722513	125,189		125,189		
c Medical Records		621990	11,514		11,514		
d All other revenue		621990	14,210	7,236	6,974		
<b>e Total.</b> Add lines 11a-11d	<b>u</b>		330,418				
<b>12 Total revenue.</b> See instructions.	<b>u</b>		18,828,856	15,948,477	5,601	223,237	

**Part IX Statement of Functional Expenses**

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.

	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	45,619	45,619		
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22				
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
<b>4</b> Benefits paid to or for members				
<b>5</b> Compensation of current officers, directors, trustees, and key employees				
<b>6</b> Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
<b>7</b> Other salaries and wages	5,561,535	5,097,124	464,411	
<b>8</b> Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	109,454	100,314	9,140	
<b>9</b> Other employee benefits	1,649,131	1,511,422	137,709	
<b>10</b> Payroll taxes	412,118	377,704	34,414	
<b>11</b> Fees for services (non-employees):				
<b>a</b> Management				
<b>b</b> Legal				
<b>c</b> Accounting	64,500		64,500	
<b>d</b> Lobbying				
<b>e</b> Professional fundraising services. See Part IV, line 17				
<b>f</b> Investment management fees				
<b>g</b> Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.)	4,918,459	3,610,755	1,307,704	
<b>12</b> Advertising and promotion	28,043		28,043	
<b>13</b> Office expenses	683,698	631,173	52,525	
<b>14</b> Information technology				
<b>15</b> Royalties				
<b>16</b> Occupancy	285,107	217,907	67,200	
<b>17</b> Travel	19,053	5,155	13,898	
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials				
<b>19</b> Conferences, conventions, and meetings				
<b>20</b> Interest				
<b>21</b> Payments to affiliates				
<b>22</b> Depreciation, depletion, and amortization	503,615	384,913	118,702	
<b>23</b> Insurance	433,712		433,712	
<b>24</b> Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
<b>a</b> Medical supplies	622,478	622,478		
<b>b</b> Repairs & Maintenance	509,026	408,923	100,103	
<b>c</b> Dues & Subscriptions	242,477	92,559	149,918	
<b>d</b> Miscellaneous	206,096	37,695	168,401	
<b>e</b> All other expenses	75,012	75,012		
<b>25</b> Total functional expenses. Add lines 1 through 24e	16,369,133	13,218,753	3,150,380	0
<b>26</b> Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)				

<b>Part X Balance Sheet</b>					
Check if Schedule O contains a response or note to any line in this Part X <input type="checkbox"/>					
		(A)		(B)	
		Beginning of year		End of year	
<b>Assets</b>	1 Cash—non-interest bearing	2,325,098	1	3,439,561	
	2 Savings and temporary cash investments		2		
	3 Pledges and grants receivable, net		3		
	4 Accounts receivable, net	1,558,848	4	1,951,400	
	5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5		
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L		6		
	7 Notes and loans receivable, net		7		
	8 Inventories for sale or use	147,518	8	212,908	
	9 Prepaid expenses and deferred charges	59,424	9	65,355	
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 12,749,549			
	b Less: accumulated depreciation	10b 7,645,000	4,921,575	10c	5,104,549
	11 Investments—publicly traded securities		11		
	12 Investments—other securities. See Part IV, line 11		12		
	13 Investments—program-related. See Part IV, line 11		13		
	14 Intangible assets		14		
	15 Other assets. See Part IV, line 11		13,636	15	9,301
16 <b>Total assets.</b> Add lines 1 through 15 (must equal line 34)		9,026,099	16	10,783,074	
<b>Liabilities</b>	17 Accounts payable and accrued expenses	577,424	17	637,935	
	18 Grants payable		18		
	19 Deferred revenue		19		
	20 Tax-exempt bond liabilities		20		
	21 Escrow or custodial account liability. Complete Part IV of Schedule D		21		
	22 Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		22		
	23 Secured mortgages and notes payable to unrelated third parties		23		
	24 Unsecured notes and loans payable to unrelated third parties		24		
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D		14,521,654	25	13,758,395
	26 <b>Total liabilities.</b> Add lines 17 through 25		15,099,078	26	14,396,330
	<b>Net Assets or Fund Balances</b>	<b>Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.</b>			
27 Unrestricted net assets		-6,072,979	27	-3,613,256	
28 Temporarily restricted net assets			28		
29 Permanently restricted net assets			29		
<b>Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.</b>					
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		-6,072,979	33	-3,613,256	
34 <b>Total liabilities and net assets/fund balances</b>		9,026,099	34	10,783,074	

**Part XI Reconciliation of Net Assets**

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

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	18,828,856
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	16,369,133
<b>3</b>	Revenue less expenses. Subtract line 2 from line 1	<b>3</b>	2,459,723
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	-6,072,979
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	
<b>10</b>	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	<b>10</b>	-3,613,256

**Part XII Financial Statements and Reporting**

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

		Yes	No
<b>1</b>	Accounting method used to prepare the Form 990: <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.		
<b>2a</b>	Were the organization's financial statements compiled or reviewed by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		X
<b>2b</b>	Were the organization's financial statements audited by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input checked="" type="checkbox"/> Both consolidated and separate basis	X	
<b>2c</b>	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.	X	
<b>3a</b>	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?		X
<b>3b</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.		

**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.

**u Attach to Form 990 or Form 990-EZ.**

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

OMB No. 1545-0047

**2018**

**Open to Public Inspection**

Name of the organization **Phoebe Worth Medical Center, Inc.** Employer identification number **38-3647394**

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

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

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

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1–10 above (see instructions))	(iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
(A)						
(B)						
(C)						
(D)						
(E)						
<b>Total</b>						

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

Table with 6 columns: (a) 2014, (b) 2015, (c) 2016, (d) 2017, (e) 2018, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Tax revenues levied for the organization's benefit; 3 The value of services or facilities furnished by a governmental unit; 4 Total. Add lines 1 through 3; 5 The portion of total contributions by each person; 6 Public support. Subtract line 5 from line 4.

Section B. Total Support

Table with 6 columns: (a) 2014, (b) 2015, (c) 2016, (d) 2017, (e) 2018, (f) Total. Rows include: 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; 10 Other income. Do not include gain or loss from the sale of capital assets; 11 Total support. Add lines 7 through 10; 12 Gross receipts from related activities, etc. (see instructions); 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

Table with 2 columns: Line number, Description. Rows include: 14 Public support percentage for 2018 (line 6, column (f) divided by line 11, column (f)); 15 Public support percentage from 2017 Schedule A, Part II, line 14; 16a 33 1/3% support test—2018; b 33 1/3% support test—2017; 17a 10%-facts-and-circumstances test—2018; b 10%-facts-and-circumstances test—2017; 18 Private foundation.

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

Table with 7 columns: (a) 2014, (b) 2015, (c) 2016, (d) 2017, (e) 2018, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Gross receipts from admissions, merchandise sold or services performed; 3 Gross receipts from activities that are not an unrelated trade or business; 4 Tax revenues levied for the organization's benefit; 5 The value of services or facilities furnished by a governmental unit; 6 Total. Add lines 1 through 5; 7a Amounts included on lines 1, 2, and 3 received from disqualified persons; 7b Amounts included on lines 2 and 3 received from other than disqualified persons; 7c Add lines 7a and 7b; 8 Public support. (Subtract line 7c from line 6.)

Section B. Total Support

Table with 7 columns: (a) 2014, (b) 2015, (c) 2016, (d) 2017, (e) 2018, (f) Total. Rows include: 9 Amounts from line 6; 10a Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources; 10b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975; 10c Add lines 10a and 10b; 11 Net income from unrelated business activities not included in line 10b; 12 Other income. Do not include gain or loss from the sale of capital assets; 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

Table with 3 columns: Description, Line Number, Percentage. Row 15: Public support percentage for 2018 (line 8, column (f), divided by line 13, column (f)) - 15 - %; Row 16: Public support percentage from 2017 Schedule A, Part III, line 15 - 16 - %

Section D. Computation of Investment Income Percentage

Table with 3 columns: Description, Line Number, Percentage. Row 17: Investment income percentage for 2018 (line 10c, column (f), divided by line 13, column (f)) - 17 - %; Row 18: Investment income percentage from 2017 Schedule A, Part III, line 17 - 18 - %

19a 33 1/3% support tests—2018. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and stop here. The organization qualifies as a publicly supported organization

b 33 1/3% support tests—2017. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and stop here. The organization qualifies as a publicly supported organization

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

**Part IV Supporting Organizations**

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



**Part IV Supporting Organizations** (continued)

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

**Section B. Type I Supporting Organizations**

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

**Section C. Type II Supporting Organizations**

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

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

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

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

<b>1</b> Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions).		
<b>a</b> <input type="checkbox"/> The organization satisfied the Activities Test. <i>Complete line 2 below.</i>		
<b>b</b> <input type="checkbox"/> The organization is the parent of each of its supported organizations. <i>Complete line 3 below.</i>		
<b>c</b> <input type="checkbox"/> The organization supported a governmental entity. <i>Describe in Part VI how you supported a government entity (see instructions).</i>		
<b>2</b> Activities Test. <i>Answer (a) and (b) below.</i>		
<b>a</b> Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <i>If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.</i>	Yes	No
<b>2a</b>		
<b>b</b> Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? <i>If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.</i>		
<b>2b</b>		
<b>3</b> Parent of Supported Organizations. <i>Answer (a) and (b) below.</i>		
<b>a</b> Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>Provide details in Part VI.</i>		
<b>3a</b>		
<b>b</b> Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i>		
<b>3b</b>		

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

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

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	<b>Adjusted Net Income</b> (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	<b>Total</b> (add lines 1a, 1b, and 1c)	1d	
e	<b>Discount</b> claimed for blockage or other factors (explain in detail in <b>Part VI</b> ):		
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	<b>Minimum Asset Amount</b> (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	<b>Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions).	6	
7	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally integrated Type III supporting organization (see instructions).		

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

Section D - Distributions		Current Year		
1	Amounts paid to supported organizations to accomplish exempt purposes			
2	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity			
3	Administrative expenses paid to accomplish exempt purposes of supported organizations			
4	Amounts paid to acquire exempt-use assets			
5	Qualified set-aside amounts (prior IRS approval required)			
6	Other distributions (describe in Part VI). See instructions.			
7	<b>Total annual distributions.</b> Add lines 1 through 6.			
8	Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions.			
9	Distributable amount for 2018 from Section C, line 6			
10	Line 8 amount divided by line 9 amount			
Section E - Distribution Allocations (see instructions)		(i) Excess Distributions	(ii) Underdistributions Pre-2018	(iii) Distributable Amount for 2018
1	Distributable amount for 2018 from Section C, line 6			
2	Underdistributions, if any, for years prior to 2018 (reasonable cause required-explain in Part VI). See instructions.			
3	Excess distributions carryover, if any, to 2018			
a	From 2013 .....			
b	From 2014 .....			
c	From 2015 .....			
d	From 2016 .....			
e	From 2017 .....			
f	<b>Total</b> of lines 3a through e			
g	Applied to underdistributions of prior years			
h	Applied to 2018 distributable amount			
i	Carryover from 2013 not applied (see instructions)			
j	Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4	Distributions for 2018 from Section D, line 7: \$			
a	Applied to underdistributions of prior years			
b	Applied to 2018 distributable amount			
c	Remainder. Subtract lines 4a and 4b from 4.			
5	Remaining underdistributions for years prior to 2018, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, explain in Part VI. See instructions.			
6	Remaining underdistributions for 2018. Subtract lines 3h and 4b from line 1. For result greater than zero, explain in Part VI. See instructions.			
7	<b>Excess distributions carryover to 2019.</b> Add lines 3j and 4c.			
8	Breakdown of line 7:			
a	Excess from 2014 .....			
b	Excess from 2015 .....			
c	Excess from 2016 .....			
d	Excess from 2017 .....			
e	Excess from 2018 .....			



**Schedule B**  
**(Form 990, 990-EZ,**  
**or 990-PF)**  
Department of the Treasury  
Internal Revenue Service

**Schedule of Contributors**

OMB No. 1545-0047

**2018**

**u Attach to Form 990, Form 990-EZ, or Form 990-PF.**  
**u Go to *www.irs.gov/Form990* for the latest information.**

Name of the organization **Phoebe Worth Medical Center, Inc.** Employer identification number **38-3647394**

**Organization type** (check one):

**Filers of:**

**Section:**

- Form 990 or 990-EZ  501(c)( 3 ) (enter number) organization
- 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation
- 527 political organization
- Form 990-PF  501(c)(3) exempt private foundation
- 4947(a)(1) nonexempt charitable trust treated as a private foundation
- 501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule**.

**Note:** Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

**General Rule**

- For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, contributions totaling \$5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.

**Special Rules**

- For an organization described in section 501(c)(3) filing Form 990 or 990-EZ that met the 33<sup>1</sup>/<sub>3</sub>% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), that checked Schedule A (Form 990 or 990-EZ), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions of the greater of **(1)** \$5,000; or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h; or (ii) Form 990-EZ, line 1. Complete Parts I and II.
- For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than \$1,000 *exclusively* for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals. Complete Parts I (entering "N/A" in column (b) instead of the contributor name and address), II, and III.
- For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc., purposes, but no such contributions totaled more than \$1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Don't complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions totaling \$5,000 or more during the year ..... ▶ \$ .....

**Caution:** An organization that isn't covered by the General Rule and/or the Special Rules doesn't file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on its Form 990-PF, Part I, line 2, to certify that it doesn't meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization

Employer identification number

Phoebe Worth Medical Center, Inc.

38-3647394

**Part I Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	..... ..... .....	\$ ..... 9,700	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	..... ..... .....	\$ ..... 24,250	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
3	..... ..... .....	\$ ..... 9,700	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
4	..... ..... .....	\$ ..... 77,600	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
5	..... ..... .....	\$ ..... 9,700	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
6	..... ..... .....	\$ ..... 9,700	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization

Phoebe Worth Medical Center, Inc.

Employer identification number

38-3647394

**Part I Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7	..... ..... .....	\$ 20,478	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
8	..... ..... .....	\$ 20,478	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
9	..... ..... .....	\$ 9,700	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
10	..... ..... .....	\$ 9,700	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
11	..... ..... .....	\$ 9,700	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
12	..... ..... .....	\$ 8,245	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization

Employer identification number

Phoebe Worth Medical Center, Inc.

38-3647394

**Part I Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
13	..... ..... .....	\$ 8,730	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
14	..... ..... .....	\$ 20,467	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
15	..... ..... .....	\$ 9,700	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
16	..... ..... .....	\$ 9,700	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
17	..... ..... .....	\$ 5,778	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
18	..... ..... .....	\$ 9,700	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)



Name of organization

Phoebe Worth Medical Center, Inc.

Employer identification number

38-3647394

**Part I Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
19	..... ..... .....	\$ ..... 9,700	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
20	..... ..... .....	\$ ..... 5,820	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
21	..... ..... .....	\$ ..... 10,778	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
22	..... ..... .....	\$ ..... 10,778	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
23	..... ..... .....	\$ ..... 10,778	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
24	..... ..... .....	\$ ..... 10,778	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization

Phoebe Worth Medical Center, Inc.

Employer identification number

38-3647394

**Part I Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
25	..... ..... .....	\$ ..... 7,760	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
26	..... ..... .....	\$ ..... 10,778	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
27	..... ..... .....	\$ ..... 10,778	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
28	..... ..... .....	\$ ..... 10,778	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
29	..... ..... .....	\$ ..... 10,778	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
30	..... ..... .....	\$ ..... 10,778	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization

Phoebe Worth Medical Center, Inc.

Employer identification number

38-3647394

**Part I Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
31	..... ..... .....	\$ 10,778	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
32	..... ..... .....	\$ 5,389	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
33	..... ..... .....	\$ 9,700	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
34	..... ..... .....	\$ 5,820	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
35	..... ..... .....	\$ 10,778	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
36	..... ..... .....	\$ 10,778	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization **Phoebe Worth Medical Center, Inc.** Employer identification number **38-3647394**

**Part I Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
37	..... ..... .....	\$ 10,778	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
38	..... ..... .....	\$ 5,388	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
39	..... ..... .....	\$ 10,778	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
40	..... ..... .....	\$ 10,778	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
41	..... ..... .....	\$ 1,950,778	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
42	..... ..... .....	\$ 10,778	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization

Phoebe Worth Medical Center, Inc.

Employer identification number

38-3647394

**Part I Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
43	..... ..... .....	\$ ..... 5,335	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
44	..... ..... .....	\$ ..... 9,700	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
45	..... ..... .....	\$ ..... 10,778	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
46	..... ..... .....	\$ ..... 9,700	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
47	..... ..... .....	\$ ..... 114,596	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
48	..... ..... .....	\$ ..... 5,500	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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

**Political Campaign and Lobbying Activities**

OMB No. 1545-0047

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

**2018**

Department of the Treasury  
Internal Revenue Service

**U** Complete if the organization is described below.

**U** Attach to Form 990 or Form 990-EZ.

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

**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 <b>Phoebe Worth Medical Center, Inc.</b>	Employer identification number <b>38-3647394</b>
--	---

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

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

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

- 1 Enter the amount of any excise tax incurred by the organization under section 4955 **U** \$ .....
- 2 Enter the amount of any excise tax incurred by organization managers under section 4955 **U** \$ .....
- 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 **U** \$ .....
- 2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities **U** \$ .....
- 3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b **U** \$ .....
- 4 Did the filing organization file **Form 1120-POL** for this year?  Yes  No
- 5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

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

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

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

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

	(a) Filing organization's totals	(b) Affiliated group totals												
<b>1a</b> Total lobbying expenditures to influence public opinion (grass roots lobbying) .....														
<b>b</b> Total lobbying expenditures to influence a legislative body (direct lobbying) .....														
<b>c</b> Total lobbying expenditures (add lines 1a and 1b) .....														
<b>d</b> Other exempt purpose expenditures .....														
<b>e</b> Total exempt purpose expenditures (add lines 1c and 1d) .....														
<b>f</b> Lobbying nontaxable amount. Enter the amount from the following table in both columns.														
<table border="1"> <thead> <tr> <th>If the amount on line 1e, column (a) or (b) is:</th> <th>The lobbying nontaxable amount is:</th> </tr> </thead> <tbody> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e.</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000.</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000.</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000.</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000.</td> </tr> </tbody> </table>	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.		
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.													
<b>g</b> Grassroots nontaxable amount (enter 25% of line 1f) .....														
<b>h</b> Subtract line 1g from line 1a. If zero or less, enter -0- .....														
<b>i</b> Subtract line 1f from line 1c. If zero or less, enter -0- .....														
<b>j</b> If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? .....		<input type="checkbox"/> Yes <input type="checkbox"/> No												

**4-Year Averaging Period Under Section 501(h)**

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

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) Total
<b>2a</b> Lobbying nontaxable amount					
<b>b</b> Lobbying ceiling amount (150% of line 2a, column (e))					
<b>c</b> Total lobbying expenditures					
<b>d</b> Grassroots nontaxable amount					
<b>e</b> Grassroots ceiling amount (150% of line 2d, column (e))					
<b>f</b> Grassroots lobbying expenditures					

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

For each "Yes," response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a)		(b)
	Yes	No	Amount
<b>1</b> During the year, did the filing organization attempt to influence foreign, national, state, or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
<b>a</b> Volunteers?		X	
<b>b</b> Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X	
<b>c</b> Media advertisements?		X	
<b>d</b> Mailings to members, legislators, or the public?		X	
<b>e</b> Publications, or published or broadcast statements?		X	
<b>f</b> Grants to other organizations for lobbying purposes?		X	
<b>g</b> Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
<b>h</b> Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
<b>i</b> Other activities?	X		1,433
<b>j</b> Total. Add lines 1c through 1i			1,433
<b>2a</b> Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
<b>b</b> If "Yes," enter the amount of any tax incurred under section 4912			
<b>c</b> If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
<b>d</b> If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

	Yes	No
<b>1</b> Were substantially all (90% or more) dues received nondeductible by members?	1	
<b>2</b> Did the organization make only in-house lobbying expenditures of \$2,000 or less?	2	
<b>3</b> 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."**

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

Part II-B, Line 1i

The organization pays membership dues to a national healthcare organization. A portion of those dues is allocated to lobbying activities in which the national healthcare organization participate.



**Part IV** Supplemental Information *(continued)*

Public Inspection Copy

SCHEDULE D (Form 990)

Department of the Treasury Internal Revenue Service

Supplemental Financial Statements

u 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. u Attach to Form 990.

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

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization

Employer identification number

Phoebe Worth Medical Center, Inc.

38-3647394

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.

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows include: 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... Yes No, 6 Did the organization inform all grantees... Yes No.

Part II Conservation Easements.

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

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows include: 1 Purpose(s) of conservation easements held by the organization, 2 Complete lines 2a through 2d if the organization held a qualified conservation contribution, 3 Number of conservation easements modified, 4 Number of states where property subject to conservation easement is located, 5 Does the organization have a written policy regarding the periodic monitoring, 6 Staff and volunteer hours devoted to monitoring, 7 Amount of expenses incurred in monitoring, 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)?, 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.

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows include: 1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items. 1b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items: (i) Revenue included on Form 990, Part VIII, line 1 u \$, (ii) Assets included in Form 990, Part X u \$. 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 u \$, b Assets included in Form 990, Part X u \$.

**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    |
|--|-----------|
| <b>c</b> Beginning balance             | <b>1c</b> |
| <b>d</b> Additions during the year     | <b>1d</b> |
| <b>e</b> Distributions during the year | <b>1e</b> |
| <b>f</b> Ending balance                | <b>1f</b> |
- 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
<b>1a</b> Beginning of year balance					
<b>b</b> Contributions					
<b>c</b> Net investment earnings, gains, and losses					
<b>d</b> Grants or scholarships					
<b>e</b> Other expenditures for facilities and programs					
<b>f</b> Administrative expenses					
<b>g</b> 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 **u** %
  - b** Permanent endowment **u** %
  - c** Temporarily restricted endowment **u** %
- 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 |
|---|---------------|----|
| <b>(i)</b> unrelated organizations  | <b>3a(i)</b>  |    |
| <b>(ii)</b> related organizations   | <b>3a(ii)</b> |    |
| <b>b</b> If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R? | <b>3b</b>     |    |
- 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
<b>1a</b> Land		175,676		175,676
<b>b</b> Buildings		5,004,864	2,176,885	2,827,979
<b>c</b> Leasehold improvements				
<b>d</b> Equipment		7,363,640	5,468,115	1,895,525
<b>e</b> Other		205,369		205,369
<b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				<b>u</b> 5,104,549

**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)		
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 12.) <b>u</b>		

**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)		
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 13.) <b>u</b>		

**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)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 15.) <b>u</b>	

**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 Phoebe Putney Health System	13,758,395	
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 25.) <b>u</b>	13,758,395	

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

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

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

1	Total revenue, gains, and other support per audited financial statements		1	18,849,217
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	18,849,217
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	-20,361	
	c Add lines 4a and 4b		4c	-20,361
5	Total revenue. Add lines 3 and 4c. (This must equal Form 990, Part I, line 12.)		5	18,828,856

**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	16,389,494
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	20,361	
	e Add lines 2a through 2d		2e	20,361
3	Subtract line 2e from line 1		3	16,369,133
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	16,369,133

**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 - FIN 48 Footnote**

The Hospital is a not-for-profit corporation that has been recognized as tax-exempt pursuant to Section 501(c)(3) of the Internal Revenue Code.

The Hospital 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 Hospital 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

**Part XIII Supplemental Information** (continued)

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 balance sheet for unrecognized income tax positions. Further, no interest or penalties have been accrued or charged to expense as of July 31, 2019 and 2018 or for the years then ended. The Hospital'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.

Part XI, Line 4b - Revenue Amounts Included on Return - Other

Rental Expenses \$ -20,361

Part XII, Line 2d - Expense Amounts Included in Financials - Other

Rental Expenses \$ 20,361

**SCHEDULE H  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Hospitals**

u Complete if the organization answered "Yes" on Form 990, Part IV, question 20.

u Attach to Form 990.

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

OMB No. 1545-0047

**2018**

Open to Public Inspection

Name of the organization

Phoebe Worth Medical Center, Inc.

Employer identification number

38-3647394

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

	Yes	No
<b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	<input checked="" type="checkbox"/>	
<b>1b</b> If "Yes," was it a written policy?	<input checked="" type="checkbox"/>	
<b>2</b> If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
<b>3</b> Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
<b>a</b> Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other <u>125%</u>	<input checked="" type="checkbox"/>	
<b>b</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: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input checked="" type="checkbox"/> 400% <input type="checkbox"/> Other _____%	<input checked="" type="checkbox"/>	
<b>c</b> If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.		
<b>4</b> Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	<input checked="" type="checkbox"/>	
<b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	<input checked="" type="checkbox"/>	
<b>b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?		<input checked="" type="checkbox"/>
<b>c</b> If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		
<b>6a</b> Did the organization prepare a community benefit report during the tax year?	<input checked="" type="checkbox"/>	
<b>b</b> If "Yes," did the organization make it available to the public?	<input checked="" type="checkbox"/>	

**7 Financial Assistance and Certain Other Community Benefits at Cost**

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
<b>a</b> Financial Assistance at cost (from Worksheet 1)			1,922,373		1,922,373	11.73
<b>b</b> Medicaid (from Worksheet 3, column a)			3,007,321	3,293,377	0	0.00
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b)					0	0.00
<b>d</b> <b>Total</b> Financial Assistance and Means-Tested Government Programs			4,929,694	3,293,377	1,922,373	11.73
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4)		107	900		900	0.01
<b>f</b> Health professions education (from Worksheet 5)						0.00
<b>g</b> Subsidized health services (from Worksheet 6)		3,941	4,135,744	3,574,113	561,631	3.43
<b>h</b> Research (from Worksheet 7)					0	0.00
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8)			51,619		51,619	0.31
<b>j</b> <b>Total</b> Other Benefits		4,048	4,188,263	3,574,113	614,150	3.75
<b>k</b> <b>Total.</b> Add lines 7d and 7j		4,048	9,117,957	6,867,490	2,536,523	15.48

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
<b>1</b> Physical improvements and housing					0	0.00
<b>2</b> Economic development					0	0.00
<b>3</b> Community support					0	0.00
<b>4</b> Environmental improvements					0	0.00
<b>5</b> Leadership development and training for community members					0	0.00
<b>6</b> Coalition building					0	0.00
<b>7</b> Community health improvement advocacy					0	0.00
<b>8</b> Workforce development					0	0.00
<b>9</b> Other					0	0.00
<b>10 Total</b>					0	0.00

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

**Section A. Bad Debt Expense**

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

**Section B. Medicare**

<b>5</b> Enter total revenue received from Medicare (including DSH and IME)	3,807,052
<b>6</b> Enter Medicare allowable costs of care relating to payments on line 5	3,835,577
<b>7</b> Subtract line 6 from line 5. This is the surplus (or shortfall)	-28,525
<b>8</b> Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input type="checkbox"/> Cost to charge ratio <input checked="" type="checkbox"/> Other	

**Section C. Collection Practices**

<b>9a</b> Did the organization have a written debt collection policy during the tax year?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>9b</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	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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

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





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

**Part V Facility Information** (continued)

**Financial Assistance Policy (FAP)**

Name of hospital facility or letter of facility reporting group Phoebe Worth Medical Center, Inc.

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
<b>13</b>	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? .....	X	
If "Yes," indicate the eligibility criteria explained in the FAP:			
<b>a</b>	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>125</u> % and FPG family income limit for eligibility for discounted care of <u>400</u> %		
<b>b</b>	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b>	<input checked="" type="checkbox"/> Asset level		
<b>d</b>	<input checked="" type="checkbox"/> Medical indigency		
<b>e</b>	<input checked="" type="checkbox"/> Insurance status		
<b>f</b>	<input checked="" type="checkbox"/> Underinsurance status		
<b>g</b>	<input checked="" type="checkbox"/> Residency		
<b>h</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>14</b>	Explained the basis for calculating amounts charged to patients? .....	X	
<b>15</b>	Explained the method for applying for financial assistance? .....	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):			
<b>a</b>	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</b>	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
<b>c</b>	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
<b>d</b>	<input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>16</b>	Was widely publicized within the community served by the hospital facility? .....	X	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
<b>a</b>	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>www.phoebehealth.com</u>		
<b>b</b>	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>www.phoebehealth.com</u>		
<b>c</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>www.phoebehealth.com</u>		
<b>d</b>	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b>	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>f</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>g</b>	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
<b>h</b>	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b>	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information** (continued)

**Billing and Collections**

Name of hospital facility or letter of facility reporting group Phoebe Worth Medical Center, Inc.

		Yes	No
<b>17</b>	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	
<b>18</b>	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:		
<b>a</b>	<input type="checkbox"/> Reporting to credit agency(ies)		
<b>b</b>	<input type="checkbox"/> Selling an individual's debt to another party		
<b>c</b>	<input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
<b>d</b>	<input type="checkbox"/> Actions that require a legal or judicial process		
<b>e</b>	<input type="checkbox"/> Other similar actions (describe in Section C)		
<b>f</b>	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<b>19</b>	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? ..... If "Yes," check all actions in which the hospital facility or a third party engaged:		X
<b>a</b>	<input type="checkbox"/> Reporting to credit agency(ies)		
<b>b</b>	<input type="checkbox"/> Selling an individual's debt to another party		
<b>c</b>	<input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
<b>d</b>	<input type="checkbox"/> Actions that require a legal or judicial process		
<b>e</b>	<input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b>	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):		
<b>a</b>	<input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)		
<b>b</b>	<input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)		
<b>c</b>	<input checked="" type="checkbox"/> Processed incomplete and complete FAP applications (if not, describe in Section C)		
<b>d</b>	<input checked="" type="checkbox"/> Made presumptive eligibility determinations (if not, describe in Section C)		
<b>e</b>	<input checked="" type="checkbox"/> Other (describe in Section C)		
<b>f</b>	<input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

<b>21</b>	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? .....	X	
	If "No," indicate why:		
<b>a</b>	<input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
<b>b</b>	<input type="checkbox"/> The hospital facility's policy was not in writing		
<b>c</b>	<input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)		
<b>d</b>	<input type="checkbox"/> Other (describe in Section C)		

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

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

Name of hospital facility or letter of facility reporting group Phoebe Worth Medical Center, Inc.

		Yes	No
<b>22</b>	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.		
<b>a</b>	<input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
<b>b</b>	<input checked="" type="checkbox"/> 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		
<b>c</b>	<input type="checkbox"/> 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		
<b>d</b>	<input type="checkbox"/> The hospital facility used a prospective Medicare or Medicaid method		
<b>23</b>	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? ..... If "Yes," explain in Section C.		X
<b>24</b>	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? ..... If "Yes," explain in Section C.		X

**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, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

Facility 1, Phoebe Worth Medical Center, Inc. - Part V, Line 5

The Internal Assessment Team, 16 members in all, was a blend of hospital staff, and strategic community partners located in Worth County, GA. Early on, hospital leadership made the decision to use the Multiple Organization Partnership Model as the approach to Determine How the Community Health Needs Assessment Will Be Conducted. This approach engages multiple organizations, provides a broader focus, and allows greater input in need identification and determining appropriate strategy for action.

Members of the internal assessment team performed key leader interviews, the purpose of which was to gather information, gain knowledge and receive input regarding health issues facing the organization's service area. The interview selection process was careful to include representation that reflects the make-up of patients receiving services in the organization's service area (religious, medical practices, community volunteers, business, political, public health, and the elderly).

Facility 1, Phoebe Worth Medical Center, Inc. - Part V, Line 11

Using the Catholic Health Association's Selection filter as a means to prioritize competing significant needs, below is a list of needs that were not included as priorities but remain a concern to the community.

1) Transportation:

Vulnerable populations have access to Medicaid van option.

2) Cancer:

Phoebe Putney Memorial Hospital offers oncology clinic and chemo services in Worth County.

**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, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

3) Specialty Care Physicians:

Phoebe Worth is actively seeking collaboration within its Health System to expand specialty care services in Worth County.

4) Homelessness:

Other county agencies working to address.

5) Drugs and Substance Abuse:

Other healthcare sources available in county.

A complete copy of the community health needs assessment, community priorities, and implementation plan can be found at

<https://www.phoebehealth.com/locations/phoebe-worth-medical-center/phoebe-worth-medical-center-chna>

Facility 1, Phoebe Worth Medical Center, Inc. - Part V, Line 20e

Written notice of the availability of financial assistance is included on hospital patient statements, and on written communications sent by contracted third party collection agencies. These agencies may refer accounts for reporting to major credit bureaus, after a series of statements and letters are sent throughout multiple collection cycles.





**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, Line 7, Column (f) - Exclusions from Percent of Total Expense

In deriving the denominator to be used for column (f), the following  
adjustments were made to the total expenses reported on form 990, part IX,  
line 25:

<u>Form 990, part IX, line 25</u>	<u>\$16,369,133</u>
<u>Add: expenses reported in part VIII</u>	<u>20,361</u>
<u>Denominator for column (f)</u>	<u>\$16,389,494</u>

Part I, Line 7 - Costing Methodology Explanation

The cost was calculated using the cost-to-charge ratio as calculated using  
worksheet 2 from the IRS Form 990 instructions.

The cost on line 7i was generated from the organization's accounting  
records.

Part III, Line 2 - Bad Debt Expense Methodology

The amounts on part III, line 2 represent the amount of charges  
considered uncollectible after reasonable attempts to collect, and written  
off to bad debt expense.

**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 III, Line 4 - Bad Debt Expense Footnote to Financial Statements

See page 13 on the accompanying audited financial statements for the section relating to uninsured patients.

Part III, Line 8 - Medicare Explanation

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 - Collection Practices Explanation

The organization provides care to patients who meet certain criteria under its financial assistance policy without charge or at amounts less than its established rates. The organization writes off patient accounts receivable balances for patients qualifying for charity care or financial assistance and does not make further

**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.

collection efforts.

Part VI, Line 2 - Needs Assessment

Needs assessments have traditionally led to the creation of community-based delivery systems that expand access to health care, meet the needs of the people and build healthy communities in the broadest sense by impacting major determinants, such as economic development, employment, children's safety, education and adequate housing.

The organization conducts regular needs assessment through formal and informal surveys and processes, including collaborations with public and community agencies. Through strategic planning and community interviews, the organization develops programs and services that consider the economic imperatives of the region, the effect of legislation and the involvement of other community-based organizations and partners.

The organization regularly conducts focus groups in the community to understand issues affecting its patients, and has created programs in

**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.

response to health disparities prevalent in the area.

The organization also collects health needs information from nurses, who provide direct care to students and staff and who collaborate with other agencies to develop health awareness and disease prevention programs.

The organization also conducts regular physician workforce studies through its strategic planning arm to determine unmet physician needs and barriers to accessing care.

The organization measures the success of its commitment by how well it keeps people healthy and how well it impacts the social/cultural bonds that will secure the communities of the future.

The hospital last conducted a Community Health Needs Assessment in 2019.

A complete copy of the community health needs assessment, community priorities, and implementation plan can be found at

<https://www.phoebehealth.com/locations/phoebe-worth-medical-center/phoebe-worth-medical-center-chna>

**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 VI, Line 3 - Patient Education of Eligibility for Assistance

The board has clearly written financial assistance policy that is available on the organization's web site and through the Business Office. Signs are prominently posted on the availability of free and charity care. Patient education on the organization's financial assistance is conducted during pre-registration, through floor visits by business office representatives for patients that stress concern in meeting the financial obligations for their services, and through our customer service department. Brochures are prominently displayed at each registration booth. The Business Office continuously provides updated material to physician offices for issuance to their patients that highlight the financial assistance program and policies. The patient statements highlight the organization's financial assistance policy and encourages patients to call for financial assistance.

---

Part VI, Line 4 - Community Information

Worth County is Phoebe Worth's primary service area. There are

**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.

approximately 20,300 residents of Worth County with a racial mix of 70% Caucasian, 28% African American and 2% other. Population projections for Worth County show minor overall population growth, with ages 65+ having the greatest growth rate. The average hourly wage for Worth County is \$17.88, which is low compared to surrounding cities and Georgia. Based on a 40 hour work week, Worth County's average annual wages are equal to \$37,180, which is down from 2012 data reported at \$38,800.

Part VI, Line 5 - Promotion of Community Health

The organization and its volunteer board is composed of community members with diverse professional and community service backgrounds, as well as physician members. The organization's emergency center is operated 24/7 and open to all persons, regardless of ability to pay. The board maintains open medical staff policies with privileges available to all qualifying physicians. The board has a clearly written financial assistance policy that is available on the organization's web site and through the Business Office. Signs are prominently posted on the availability of free and charity care.

**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.

The organization has a multi-pronged approach to improving the health of the communities it serves: increasing access, building capacity, investing in "upstream" programs that get at the cause of disease and illness, building community partnerships, advocating change, and developing leadership. Surplus funds are reinvested in resources to improve the delivery of medical and health care services.

Primary care is first and creates a profound impact on the communities served. Primary care services are established in areas where residents are most likely to suffer from severe manpower shortages, high poverty levels and a lack of access to care.

Part VI, Line 6 - Affiliated Health Care System

Phoebe Putney Health System, Inc. (PPHS) is the not-for-profit parent company of Phoebe Putney Memorial Hospital, Inc. (PPMH), a not-for-profit entity, Phoebe Putney Health Ventures, Inc. (PPHV), a for-profit corporation, Phoebe Physician Group, Inc. (PPG), a not-for-profit corporation, Phoebe Worth Medical Center, Inc. (PWMC), a not-for-profit entity, Phoebe Sumter Medical Center, Inc. (PSMC), a not-for-profit entity,

**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.

and Phoebe Foundation, Inc. (PF), a not-for-profit entity.

PPMH is located in Albany, Georgia, is an acute care hospital, which operates satellite clinics in the surrounding counties. It provides inpatient, outpatient and emergency care services for residents of Southwest Georgia. Admitting physicians are primarily practitioners in the local area.

PPHV engages in healthcare and related activities in furtherance of the exempt purposes of PPHS and PPMH.

PWMC, located in Sylvester, Georgia, is a 25 bed rural critical access hospital. It provides inpatient, outpatient, and emergency care services for residents of Worth County, Georgia.

PSMC, located in Americus, Georgia, is an acute care hospital. It provides inpatient, outpatient and emergency care services for residents of Sumter County, Georgia.



**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.

PPG was established to organize and operate medical practices exclusively for the benefit of PPMH, PWMC, and PSMC.

PF was established to raise funds of any kind or character to be used exclusively for charitable, medical, educational and scientific purposes at or in connection with each and every non-profit organization of which PPHS is the sole member, and any other non-profit hospital which is managed or controlled by PPHS whether through ownership, management contract or otherwise.

Part VI, Line 7 - State Filing of Community Benefit Report

Georgia

Additional Information

Service to the Community

Phoebe Worth Medical Center (PWMC) is a not-for-profit health care organization that exists to serve the community. PWMC has no stockholders or owners, and is part of the not-for-profit Phoebe Putney Health System,

**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.

Inc. After operating expenses are covered, any remaining revenues are reinvested in the operation of PWMC in order to enhance our ability to carry out our local mission of taking care of our communities' citizens.

The Hospital participates in the Medicare and Medicaid programs which cover many Georgian's health care needs, and by so doing, foregoes some charges and has unreimbursed expenses. The Hospital also offers Financial Assistance to individuals unable to pay for their healthcare services. Indigent Financial Assistance, or free care, is offered to patients whose household income is at or below 125% of the Federal Poverty Guidelines. Patients whose income level is between 126% - 400% of the Federal Poverty Levels will be classified as charity and receive their needed healthcare services at a discounted rate. The following table summarizes the amounts of charges forgone (i.e., contractual adjustments) and estimates the losses incurred by the Hospital due to inadequate payments by these programs and for indigent/charity services. The Hospital also operates a Rural Health Clinic (RHC) which also foregoes some charges and has costs not reimbursed through patients qualifying for these same

**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.

indigent and charity programs. The amounts listed below are all inclusive of both Hospital and Clinic activities.

	Charges	Estimated Unreimbursed Cost
Medicare	\$ 9,000,000	\$ 3,000,000
Medicaid	5,000,000	2,000,000
Indigent/charity care	5,000,000	2,000,000
Totals	\$ 19,000,000	\$ 7,000,000

The following is a summary of the community benefit activities and health improvement services offered by the Hospital and illustrates the activities and donations during fiscal year 2019.

I. Community Health Improvement Services

Community Health Education

Senior Center Health Fair

**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.

The Hospital provides time throughout the year to speak to Seniors about services offered at Phoebe Worth and various other health and wellness topics. The Hospital also offers medical screenings at these events. The Hospital incurred expenses of \$300 for these services.

#### Various Other Speaking Engagements and Health Fairs

The Hospital participated in various other community events throughout the year, including church gatherings, Health Fairs for County employees, New School System employee orientations, etc. At these events, the Hospital offered health screenings and/or speaking on various health and wellness topics. Expenses for these types of gatherings are nominal but serve an important role with community ties within Worth County.

#### II. Financial and In-Kind Support

The Hospital supports the community through providing office space for ASPIRE Behavioral Health so that they are able to offer more behavioral health services to the citizens of Worth County. The support provides much needed mental health services as determined by our Community Health Needs

**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.

Assessment. The fair market value of the Hospital's contribution of space totals \$4,800 per year.

The Hospital supports the Health Department through contributions towards their programs directed at educating, screening, treating, and assisting with the costs of supplies and medications for low income individuals battling high blood pressure and diabetes. The financial support enables the Health Department to operate its Stroke and Heart Attack Prevention (SHAPP) and Diabetes Program. The Hospital's contribution totaled \$45,619.

The Hospital participates in the Worth County disaster drill each year as the Community Emergency Responders host a Community-Wide Drive-Thru Flu Clinic. The Hospital assists with staffing the event that offers community members flu vaccinations. At the 2019 clinic, over 107 vaccinations were given. The Hospital incurred expenses of \$600 for the nurse staff involved in servicing the event.

**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.

The Hospital supports the local Sylvester/Worth County Cancer Coalition and the events they offer the community. During the Christmas season, the Hospital hosted the Coalition and community at a tree-lighting event and offered snacks and hot chocolate. The Hospital coordinated a local speaker who provided her testimonial of her experience with Cancer and her story of survival. The Hospital has also provided staff and all food products and meal preparation for the annual Worth County Cancer Survivor Dinner. This event is inspiring for the community and the Hospital hosted community survivors with a wonderful meal to help celebrate each of their survivor stories. The Hospital incurred expenses of \$1,200 for the dinner.

The Hospital engages with the community in various other ways as well, including participation in local events ranging from the local law enforcement "Night Out Against Crime" to the annual community Peanut Festival. The Hospital acts as corporate sponsors to ensure the community can offer these types of events. The Hospital also provides staffing for the informational tents, which inform the community about the service offerings at the Hospital. The Hospital participates in local civic clubs

**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.

and supports leadership in their roles on the local chamber boards and  
other community clubs.

**SCHEDULE I  
(Form 990)**

**Grants and Other Assistance to Organizations,  
Governments, and Individuals in the United States**  
Complete if the organization answered "Yes" on Form 990, Part IV, line 21 or 22.  
u Attach to Form 990.  
u Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No. 1545-0047

**2018**

**Open to Public  
Inspection**

Department of the Treasury  
Internal Revenue Service

Name of the organization

Phoebe Worth Medical Center, Inc.

Employer identification number

38-3647394

**Part I General Information on Grants and Assistance**

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

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

1	(a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of noncash assistance	(h) Purpose of grant or assistance
(1)	Worth County Health Department 1012 W. Franklin Street Sylvester GA 31791-1978	58-1568404	GOV	45,619				See Part IV
(2)								
(3)								
(4)								
(5)								
(6)								
(7)								
(8)								
(9)								

- 2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table 1
- 3 Enter total number of other organizations listed in the line 1 table 0



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

Part III can be duplicated if additional space is needed.

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

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

See Schedule I Supplemental Information Worksheet

Supplemental Information

SCHEDULE I (Form 990)

For calendar year 2018, or tax year beginning 08/01/18, and ending 07/31/19

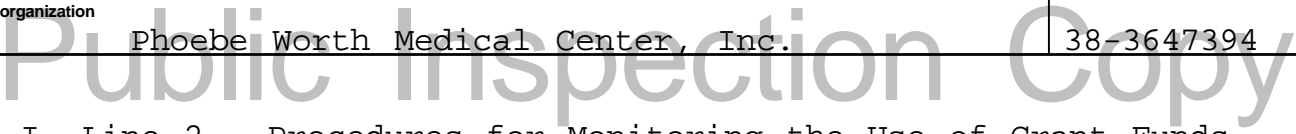
2018

Name of the organization

Phoebe Worth Medical Center, Inc.

Employer identification number

38-3647394



Part I, Line 2 - Procedures for Monitoring the Use of Grant Funds

The Worth County Health Department sends a letter to PWMC asking for financial assistance related to specific programs that are provided by the health department. Once received, PWMC's board approves the amount of assistance to the health department. The funds that are given to the health department are deemed to be used for the specific purposes mentioned in the original letter from the health department.

In 2019, PWMC worked with the health department to enable them to support two health prevention type programs. One program was Stroke and Heart Attack Prevention (SHAPP), the second program was a Diabetes program.

**SCHEDULE J  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Compensation Information**

For certain Officers, Directors, Trustees, Key Employees, and Highest  
Compensated Employees

u Complete if the organization answered "Yes" on Form 990, Part IV, line 23.

u Attach to Form 990.

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

OMB No. 1545-0047

**2018**

Open to Public  
Inspection

Name of the organization

Phoebe Worth Medical Center, Inc.

Employer identification number

38-3647394

**Part I Questions Regarding Compensation**

**1a** Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.

- |  |  |
|--|--|
| <input type="checkbox"/> First-class or charter travel             | <input type="checkbox"/> Housing allowance or residence for personal use   |
| <input type="checkbox"/> Travel for companions                     | <input type="checkbox"/> Payments for business use of personal residence   |
| <input type="checkbox"/> Tax indemnification and gross-up payments | <input type="checkbox"/> Health or social club dues or initiation fees     |
| <input type="checkbox"/> Discretionary spending account            | <input type="checkbox"/> Personal services (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

**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?

**3** Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.

- |  |  |
|--|--|
| <input type="checkbox"/> Compensation committee              | <input type="checkbox"/> Written employment contract                     |
| <input type="checkbox"/> Independent compensation consultant | <input type="checkbox"/> Compensation survey or study                    |
| <input type="checkbox"/> Form 990 of other organizations     | <input type="checkbox"/> Approval by the board or compensation committee |

**4** During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:

- a** Receive a severance payment or change-of-control payment? **4a**
- b** Participate in, or receive payment from, a supplemental nonqualified retirement plan? **4b**
- c** Participate in, or receive payment from, an equity-based compensation arrangement? **4c**
- 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**
- b** Any related organization? **5b**
- 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**
- b** Any related organization? **6b**
- 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

**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

**9** If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?

	Yes	No
<b>1a</b>		
<b>1b</b>		
<b>2</b>		
<b>3</b>		
<b>4a</b>		X
<b>4b</b>	X	
<b>4c</b>		X
<b>5a</b>		X
<b>5b</b>		X
<b>6a</b>		X
<b>6b</b>		X
<b>7</b>		X
<b>8</b>		X
<b>9</b>		

**Part II Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees.** Use duplicate copies if additional space is needed.

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

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

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)–(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
Joel Wernick	(i) 0	(ii) 0	(iii) 0	0	0	0	0
1 Past Bd Mem/PPHS CEO	(ii) 850,182	515,706	30,355	8,250	18,760	1,423,253	0
Joe Austin	(i) 0	(ii) 0	(iii) 0	0	0	0	0
2 Bd Mbr/PPHS VP COO	(ii) 485,695	112,453	5,107	142,388	21,224	766,867	0
Brian Church	(i) 0	(ii) 0	(iii) 0	0	0	0	0
3 PPHS CFO	(ii) 405,539	95,476	18,912	71,223	21,308	612,458	0
Kim Gilman	(i) 0	(ii) 0	(iii) 0	0	0	0	0
4 CEO/CNO	(ii) 213,690	40,556	3,994	60,612	1,320	320,172	0
5	(i)	(ii)	(iii)				
6	(i)	(ii)	(iii)				
7	(i)	(ii)	(iii)				
8	(i)	(ii)	(iii)				
9	(i)	(ii)	(iii)				
10	(i)	(ii)	(iii)				
11	(i)	(ii)	(iii)				
12	(i)	(ii)	(iii)				
13	(i)	(ii)	(iii)				
14	(i)	(ii)	(iii)				
15	(i)	(ii)	(iii)				
16	(i)	(ii)	(iii)				

**Part III Supplemental Information**

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

Part I, Line 3 - Related Org Methods Used for Compensation Explanation

None of the individual board members or officers are compensated by the filing organization. The filing organization, instead, relies on the methods used by PPHS, the sole member, to establish compensation of the CEO and executive officers. Compensation determination by PPHS includes an independent compensation committee, independent compensation consultant and surveys, and board approval. These methods are well documented.

Part I, Line 4 - Severance, Nonqualified, and Equity-Based Payments

	Severance	Nonqualified	Equity-based
Joe Austin	0	134,138	0
Brian Church	0	62,973	0
Kim Gilman	0	55,473	0

Part III - Other Additional Information

Schedule J, Part I, Line 4 - Supplemental Nonqualified Retirement Plans:

Deferred Compensation Plan 457(b):

The Deferred Compensation Plan is an additional retirement plan offered

**Part III Supplemental Information**

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

through Phoebe Putney. The 457(b) plan is an eligible deferred compensation plan that allows one to defer additional dollars towards retirement.

Highlights Include:

- o Not limited by the amounts deferred into the Phoebe 403(b)
- o Plan is subject to annual deferral limits set by the IRS
- o Per IRS regulations, each participant is a general unsecured creditor of the plan sponsor.

An eligible Employee is one who is determined by the Employer to be a member of a select group of management or highly compensated employees within the meaning of Sections 201(2), 301(a)(3), and 401(a)(1) of ERISA.

Supplemental Executive Retirement Plan (SERP) 457(f):

PPHS relies on an independent compensation committee, independent compensation consultant, surveys, well documented methods and board approval to establish total compensation of the CEO and executive officers.

Certain board approved employees are eligible to participate in a SERP that provides certain defined annual pay credits that are subject to a substantial risk of forfeiture. The purpose of the SERP is to provide a

**Part III Supplemental Information**

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

long-term incentive and retirement benefit for affected executives consistent with the benefit available to employees not impacted by IRS compensation limits on defined benefit plans. The amounts reported as supplemental executive retirement compensation for eligible employees in Schedule J represent credited, but not vested, benefits, and the amounts are available in future periods to the employee subject to continuing employment. PPHS maintains ownership of the funds allocated to each participant until vesting and payment.

For a participant in the SERP prior to 1/1/2017 (a "grandfathered participant"), the first vesting date will occur on the date the participant attains five years of participation under the plan. After the initial vesting date, a grandfathered participant shall have a new vesting date once every 5 years. These additional vesting dates will occur on the 5th anniversary of each vesting date after the initial vesting date. On each vesting date, a grandfathered participant will become 100% vested in an amount equal to the participant's account balance reduced by any pay credits credited to the account for the 2 most recent plan years.

**Part III Supplemental Information**

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

For participants initially participating in the SERP after 12/31/2016, each year's annual pay credit plus subsequent earnings and/or losses will 100% vest on that pay credits' 5th anniversary, provided that the participant remains in the continuous employment throughout the 5-year period for each annual pay credit.

If any eligible participant attains normal retirement age prior to this separation from service, they shall vest in 100% of the account balance. Once vested, each participant shall receive a distribution of their entire vested amount within a reasonable period not to exceed 2.5 months. This distribution is treated as reportable compensation to the participant and is included in Part II, Column B(iii). Therefore, Part II, Column B(iii) includes prior year SERP deferrals previously reported in Part II, Column C. Any distribution amount included in Part II, Column B(iii) that was previously reported in prior periods as deferred compensation in Part II, Column C is disclosed in Part II, Column F.

Schedule J, Part II, Column B(ii)



**Part III Supplemental Information**

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

Certain executive officers and physicians are eligible for bonus/incentive payments. These bonuses are determined based on the achievement of various organizational and personal performance goals established by a formal process in keeping with the organization's tax-exempt status.

Compensation Process for Top Official as Determined by PPHS  
The organization's formal process for determining total compensation for the CEO is intended to provide reasonable compensation for accomplishing the organization's mission, achieve its strategic goals, to recognize performance, and to operate in keeping with the organization's obligations as a tax-exempt charitable organization.

The Executive Compensation Committee of the PPHS's Board of Directors conducts an annual review of the compensation of the CEO. The Committee retains a qualified independent compensation consultant to conduct competitive market analysis of the market ranges of base, incentive and total cash compensation. The information the committee may consider can include but is not limited to the performance of an individual, the

**Part III Supplemental Information**

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

performance of the organization, an individual's length of service, credentials and experience, the elements of total compensation and salary history, the organization's compensation targets, and comparability data, including the data prepared by the independent consultant and reviewed with the committee.

The committee incorporates a formal performance appraisal process in the CEO compensation review. It utilizes a multi-perspective approach and performance measures which are linked to the organization's long-term strategic plan and achievement of annual system objectives. The CEO is not present when the committee discusses and establishes his compensation.

**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.u Attach to Form 990 or 990-EZ.  
u Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No. 1545-0047

**2018****Open to Public  
Inspection**

Name of the organization

Phoebe Worth Medical Center, Inc.

Employer identification number

38-3647394

## Form 990, Part VI, Line 6 - Classes of Members or Stockholders

The sole member of Phoebe Worth Medical Center, Inc. shall be Phoebe Putney Health System, Inc. (PPHS).

## Form 990, Part VI, Line 7a - Election of Members and Their Rights

The board of directors of PPHS, the sole member, shall appoint all directors of the filing organization.

## Form 990, Part VI, Line 7b - Decisions Subject to Approval of Members

The sole member, PPHS, shall have the following responsibilities:

- The member shall appoint or remove the organization's directors.
- The member shall select or remove the organization's officers.
- The member shall approve all amendments to the organization's Articles of Incorporation and Bylaws before they may become effective.
- The member shall approve any annual operating or capital budgets.
- The member shall appoint or remove the independent auditors.

## Form 990, Part VI, Line 11b - Organization's Process to Review Form 990

The independent accounting firm that prepares the Form 990 (based upon information provided by the organization) provides a complete copy of the return with applicable schedules to be reviewed by management. Management performs a detailed review which consists of reviewing the financial data, the narratives disclosed, and other facts presented on the return. Upon review, the Form 990 is then forwarded to the Finance Committee for their review, to gain their comments and approval. Upon approval from the Finance

Name of the organization	Employer identification number
Phoebe Worth Medical Center, Inc.	38-3647394

Committee, the Form 990 and related schedules are provided to all board members for review and feedback. Once the Form 990 is reviewed by all applicable parties, a copy of the final version is provided to all members of the governing body prior to filing with the Internal Revenue Service.

At the request of a donor, the organization redacted the name and address of that donor from the copy of its Form 990, Schedule B, that was provided to the governing body members for the fiscal year ending June 30, 2019. The Board members received and had the opportunity to review a complete copy of the Form 990, except for the redacted name, prior to filing.

Form 990, Part VI, Line 12c - Enforcement of Conflicts Policy

On an annual basis, Phoebe Worth Medical Center, Inc. (PWMC) Board Members as well as all officers complete a Conflict of Interest questionnaire. This questionnaire is administered by the Phoebe Putney Health System (PPHS) Compliance Department and the document asks each individual to disclose any personal, business, or other affiliations and monetary amount if applicable that they or their immediate family members have had within the past 12 months with PWMC or any related entities. All responses are then evaluated by the PPHS Compliance Department. In the case of an existing conflict, the individual with the conflict of interest is excluded from the discussion and approval to such transactions.

Form 990, Part VI, Line 19 - Governing Documents Disclosure Explanation

The organization makes available to the public its conflict of interest and audited financial statements on the organization's website, by providing copies upon request, and by inspection at the administrative offices of the

Name of the organization Phoebe Worth Medical Center, Inc.	Employer identification number 38-3647394
---	--

organization.

Public Inspection Copy

Form 990, Part IX, Line 11g - Other Fees for Services

Description

	Tot/Prog Service	Mgt & General	Fundraising
Physician Fees	\$ 2,961,420	\$ 0	\$ 0
Collection Services	\$ 0	\$ 126,415	\$ 0
Consultant Fees	\$ 486,515	\$ 0	\$ 0
Contract Services	\$ 105,614	\$ 1,181,289	\$ 0
Contract Staffing	\$ 57,206	\$ 0	\$ 0
<b>Total</b>	<b>\$ 3,610,755</b>	<b>\$ 1,307,704</b>	<b>\$ 0</b>

**SCHEDULE R  
(Form 990)**

**Related Organizations and Unrelated Partnerships**

OMB No. 1545-0047

**2018**

**Open to Public  
Inspection**

u Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.

u Attach to Form 990.

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

Phoebe Worth Medical Center, Inc.

Employer identification number

38-3647394

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)					
(2)					
(3)					
(4)					
(5)					

**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	No
(1) Phoebe Putney Health System, Inc. P.O. Box 3770 58-2001014 Albany GA 31706-3770	Healthcare	GA	501c3	12c	N/A		X
(2) Phoebe Putney Memorial Hospital Inc P.O. Box 3770 58-1928247 Albany GA 31706-3770	Healthcare	GA	501c3	3	PPHS		X
(3) Phoebe Physician Group, Inc. P.O. Box 3770 26-3792403 Albany GA 31706-3770	Healthcare	GA	501c3	10	PPHS		X
(4) Phoebe Sumter Medical Center, Inc. 126 Highway 280 West 26-3975185 Americus GA 31719-8645	Healthcare	GA	501c3	3	PPHS		X
(5) Phoebe Foundation, Inc. P.O. Box 3770 58-1847104 Albany GA 31706-3770	Foundation	GA	501c3	12a	PPHS		X

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

Schedule R (Form 990) 2018

**SCHEDULE R  
(Form 990)**

**Related Organizations and Unrelated Partnerships**

OMB No. 1545-0047

**2018**

**Open to Public  
Inspection**

u Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.

u Attach to Form 990.

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

Phoebe Worth Medical Center, Inc.

Employer identification number

38-3647394

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)					
(2)					
(3)					
(4)					
(5)					

**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	No
(1) South Georgia Shared Services, Inc. 417 West Third Avenue 46-2746977 Albany GA 31701-1943	Cooperativ	GA	501c3	3	PPHS		X
(2) Phoebe Dorminy Medical Center, Inc. P.O. Box 3770 45-2041878 Albany GA 31706-3770	Healthcare	GA	501c3	3	PPHS		X
(3)							
(4)							
(5)							

**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 alloc.?		(i) Code V—UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) .....												
(2) .....												
(3) .....												
(4) .....												

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
(1) Phoebe Putney Health Ventures, Inc. P.O. Box 3770 Albany GA 31706-3770 58-1963401	Healthcare	GA	N/A	C	N/A	N/A	N/A		X
(2) Phoebe Putney Indemnity Ltd 113 S Church St 5th Fl Queensgate Grand Cayman, CJ KY1-1102 98-1492026	Insurance	CJ	N/A	C	N/A	N/A	N/A		X
(3) .....									
(4) .....									



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

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

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

	Yes	No
<b>a</b> Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity		X
<b>b</b> Gift, grant, or capital contribution to related organization(s)		X
<b>c</b> Gift, grant, or capital contribution from related organization(s)		X
<b>d</b> Loans or loan guarantees to or for related organization(s)		X
<b>e</b> Loans or loan guarantees by related organization(s)	X	
<b>f</b> Dividends from related organization(s)		X
<b>g</b> Sale of assets to related organization(s)		X
<b>h</b> Purchase of assets from related organization(s)		X
<b>i</b> Exchange of assets with related organization(s)		X
<b>j</b> Lease of facilities, equipment, or other assets to related organization(s)		X
<b>k</b> Lease of facilities, equipment, or other assets from related organization(s)		X
<b>l</b> Performance of services or membership or fundraising solicitations for related organization(s)		X
<b>m</b> Performance of services or membership or fundraising solicitations by related organization(s)	X	
<b>n</b> Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)		X
<b>o</b> Sharing of paid employees with related organization(s)	X	
<b>p</b> Reimbursement paid to related organization(s) for expenses		X
<b>q</b> Reimbursement paid by related organization(s) for expenses	X	
<b>r</b> Other transfer of cash or property to related organization(s)		X
<b>s</b> Other transfer of cash or property from related organization(s)		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 section 501(c)(3) organizations?		(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V—UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
				Yes	No			Yes	No		Yes	No	
(1) .....													
(2) .....													
(3) .....													
(4) .....													
(5) .....													
(6) .....													
(7) .....													
(8) .....													
(9) .....													
(10) .....													
(11) .....													

**Part VII**

**Supplemental Information.**

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

Public Inspection Copy

Form **990-T**

**Exempt Organization Business Income Tax Return**  
(and proxy tax under section 6033(e))

OMB No. 1545-0687

**2018**

Department of the Treasury  
Internal Revenue Service

For calendar year 2018 or other tax year beginning 08/01/18, and ending 07/31/19

Go to [www.irs.gov/Form990T](http://www.irs.gov/Form990T) for instructions and the latest information.

Do not enter SSN numbers on this form as it may be made public if your organization is a 501(c)(3).

Open to Public Inspection for  
501(c)(3) Organizations Only

**A**  Check box if address changed

**B** Exempt under section

501(c)(3)  220(e)

408(e)  530(a)

408A  529(a)

Name of organization  Check box if name changed and see instructions.)

**Print** Phoebe Worth Medical Center, Inc.

**or**

**Type** 807 South Isabella, P.O. Box 545

Number, street, and room or suite no. If a P.O. box, see instructions.

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

Sylvester GA 31791-0545

**D** Employer identification number (Employees' trust, see instructions.)

38-3647394

**E** Unrelated business activity code (See instructions.)

621500

**C** Book value of all assets at end of year

10,783,074

**F** Group exemption number (See instructions.) **u**

**G** Check organization type **u**  501(c) corporation  501(c) trust  401(a) trust  Other trust

**H** Enter the number of the organization's unrelated trades or businesses. **u** 1 Describe the only (or first) unrelated trade or business here

**u** Reference Lab

Parts I-V. If more than one, describe the first in the blank space at the end of the previous sentence, complete Parts I and II, complete Schedule M for each additional trade or business, then complete Parts III-V.

**I** During the tax year, was the corporation a subsidiary in an affiliated group or a parent-subsidiary controlled group? **u**  Yes  No

If "Yes," enter the name and identifying number of the parent corporation.

**J** The books are in care of **u** Candace Guarnieri, CFO Telephone number **u** 229-776-6961

Part I Unrelated Trade or Business Income		(A) Income	(B) Expenses	(C) Net
1a	Gross receipts or sales <u>5,601</u>			
b	Less returns and allowances			
c	Balance <b>u</b>	5,601		
2	Cost of goods sold (Schedule A, line 7)			
3	Gross profit. Subtract line 2 from line 1c	5,601		5,601
4a	Capital gain net income (attach Schedule D)			
b	Net gain (loss) (Form 4797, Part II, line 17) (attach Form 4797)			
c	Capital loss deduction for trusts			
5	Income (loss) from partnership and S corporation (attach statement)			
6	Rent income (Schedule C)			
7	Unrelated debt-financed income (Schedule E)			
8	Interest, annuities, royalties, and rents from controlled organization (Schedule F)			
9	Investment income of a section 501(c)(7), (9), or (17) organization (Schedule G)			
10	Exploited exempt activity income (Schedule I)			
11	Advertising income (Schedule J)			
12	Other income (See instructions; attach schedule)			
13	<b>Total.</b> Combine lines 3 through 12	5,601		5,601

Part II Deductions Not Taken Elsewhere (See instructions for limitations on deductions.) (Except for contributions, deductions must be directly connected with the unrelated business income.)			
14	Compensation of officers, directors, and trustees (Schedule K)	14	
15	Salaries and wages	15	
16	Repairs and maintenance	16	
17	Bad debts	17	
18	Interest (attach schedule) (see instructions)	18	
19	Taxes and licenses	19	
20	Charitable contributions (See instructions for limitation rules)	20	
21	Depreciation (attach Form 4562)	21	
22	Less depreciation claimed on Schedule A and elsewhere on return	22a	0
23	Depletion	23	
24	Contributions to deferred compensation plans	24	
25	Employee benefit programs	25	
26	Excess exempt expenses (Schedule I)	26	
27	Excess readership costs (Schedule J)	27	
28	Other deductions (attach schedule) <u>See Statement 1</u>	28	1,391
29	<b>Total deductions.</b> Add lines 14 through 28	29	1,391
30	Unrelated business taxable income before net operating loss deduction. Subtract line 29 from line 13	30	4,210
31	Deduction for net operating loss arising in tax years beginning on or after January 1, 2018 (see instructions)	31	
32	Unrelated business taxable income. Subtract line 31 from line 30	32	4,210

**Part III Total Unrelated Business Taxable income**

33	Total of unrelated business taxable income computed from all unrelated trades or businesses (see instructions)	33	4,210
34	Amounts paid for disallowed fringes	34	
35	Deductions for net operating loss arising in tax years beginning before January 1, 2018 (see instructions)	35	
36	Total of unrelated business taxable income before specific deduction. Subtract line 35 from the sum of lines 33 and 34	36	4,210
37	Specific deduction (Generally \$1,000, but see line 37 instructions for exceptions)	37	1,000
38	<b>Unrelated business taxable income.</b> Subtract line 37 from line 36. If line 37 is greater than line 36, enter the smaller of zero or line 36	38	3,210

**Part IV Tax Computation**

39	<b>Organizations Taxable as Corporations.</b> Multiply line 38 by 21% (0.21)	39	674
40	<b>Trusts Taxable at Trust Rates.</b> See instructions for tax computation. Income tax on the amount on line 38 from: <input type="checkbox"/> Tax rate schedule or <input type="checkbox"/> Schedule D (Form 1041)	40	
41	<b>Proxy tax.</b> See instructions	41	
42	Alternative minimum tax (trusts only)	42	
43	<b>Tax on Noncompliant Facility Income.</b> See instructions	43	
44	<b>Total.</b> Add lines 41, 42, and 43 to line 39 or 40, whichever applies	44	674

**Part V Tax and Payments**

45a	Foreign tax credit (corporations attach Form 1118; trusts attach Form 1116)	45a	
b	Other credits (see instructions)	45b	
c	General business credit. Attach Form 3800 (see instructions)	45c	
d	Credit for prior year minimum tax (attach Form 8801 or 8827)	45d	
e	<b>Total credits.</b> Add lines 45a through 45d	45e	
46	Subtract line 45e from line 44	46	674
47	Other taxes. Check if from: <input type="checkbox"/> Form 4255 <input type="checkbox"/> Form 8611 <input type="checkbox"/> Form 8697 <input type="checkbox"/> Form 8866 <input type="checkbox"/> Other (att. sch.)	47	
48	<b>Total tax.</b> Add lines 46 and 47 (see instructions)	48	674
49	2018 net 965 tax liability paid from Form 965-A or Form 965-B, Part II, column (k) line 2	49	
50a	Payments: A 2017 overpayment credited to 2018	50a	
b	2018 estimated tax payments	50b	3,400
c	Tax deposited with Form 8868	50c	
d	Foreign organizations: Tax paid or withheld at source (see instructions)	50d	
e	Backup withholding (see instructions)	50e	
f	Credit for small employer health insurance premiums (attach Form 8941)	50f	
g	Other credits, adjustments, and payments: <input type="checkbox"/> Form 2439 <input type="checkbox"/> Form 4136 <input type="checkbox"/> Other Total <b>u</b>	50g	
51	<b>Total payments.</b> Add lines 50a through 50g	51	3,400
52	Estimated tax penalty (see instructions). Check if Form 2220 is attached <b>u</b> <input checked="" type="checkbox"/>	52	9
53	<b>Tax due.</b> If line 51 is less than the total of lines 48, 49, and 52, enter amount owed <b>u</b>	53	0
54	<b>Overpayment.</b> If line 51 is larger than the total of lines 48, 49, and 52, enter amount overpaid <b>u</b>	54	2,717
55	Enter the amount of line 54 you want: Credited to 2019 estimated tax <b>u</b> 800   Refunded <b>u</b>	55	1,917

**Part VI Statements Regarding Certain Activities and Other Information** (see instructions)

56	At any time during the 2018 calendar year, did the organization have an interest in or a signature or other authority over a financial account (bank, securities, or other) in a foreign country? If "YES," the organization may have to file FinCEN Form 114, Report of Foreign Bank and Financial Accounts. If "YES," enter the name of the foreign country here <b>u</b>	Yes	No
57	During the tax year, did the organization receive a distribution from, or was it the grantor of, or transferor to, a foreign trust? If "YES," see instructions for other forms the organization may have to file.		X
58	Enter the amount of tax-exempt interest received or accrued during the tax year <b>u</b> \$		

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 taxpayer) is based on all information of which preparer has any knowledge.

**Sign Here** **u** \_\_\_\_\_ **u** CFO \_\_\_\_\_  
 Signature of officer Date Title

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

**Paid** Print/Type preparer's name Jeffrey S. Wright Preparer's signature Date Check  if self-employed PTIN P00226270

**Preparer Use Only** Firm's name } Draffin & Tucker LLP Firm's EIN } 58-0914992  
 PO Box 71309  
 Firm's address } Albany, GA 31708-1309 Phone no. 229-883-7878

**Schedule A – Cost of Goods Sold.** Enter method of inventory valuation **u**

<b>1</b> Inventory at beginning of year ...	<b>1</b>		<b>6</b> Inventory at end of year .....	<b>6</b>	
<b>2</b> Purchases .....	<b>2</b>		<b>7</b> <b>Cost of goods sold.</b> Subtract line 6 from line 5. Enter here and in Part I, line 2 .....	<b>7</b>	
<b>3</b> Cost of labor .....	<b>3</b>				
<b>4a</b> Additional sec. 263A costs (attach schedule) .....	<b>4a</b>		<b>8</b> Do the rules of section 263A (with respect to property produced or acquired for resale) apply to the organization? .....		<b>Yes</b> <b>No</b>
<b>b</b> Other costs (attach schedule) .....	<b>4b</b>				
<b>5</b> <b>Total.</b> Add lines 1 through 4b ...	<b>5</b>				

**Schedule C – Rent Income (From Real Property and Personal Property Leased With Real Property)**  
(see instructions)

<b>1.</b> Description of property		
(1) <b>N/A</b>		
(2)		
(3)		
(4)		
<b>2.</b> Rent received or accrued		
<b>(a)</b> From personal property (if the percentage of rent for personal property is more than 10% but not more than 50%)	<b>(b)</b> From real and personal property (if the percentage of rent for personal property exceeds 50% or if the rent is based on profit or income)	<b>3(a)</b> Deductions directly connected with the income in columns 2(a) and 2(b) (attach schedule)
(1)		
(2)		
(3)		
(4)		
<b>Total</b>	<b>Total</b>	<b>(b)</b> Total deductions. Enter here and on page 1, Part I, line 6, column (B) <b>u</b>
<b>(c) Total income.</b> Add totals of columns 2(a) and 2(b). Enter here and on page 1, Part I, line 6, column (A) <b>u</b>		

**Schedule E – Unrelated Debt-Financed Income** (see instructions)

<b>1.</b> Description of debt-financed property		<b>2.</b> Gross income from or allocable to debt-financed property	<b>3.</b> Deductions directly connected with or allocable to debt-financed property	
			<b>(a)</b> Straight line depreciation (attach schedule)	<b>(b)</b> Other deductions (attach schedule)
(1) <b>N/A</b>				
(2)				
(3)				
(4)				
<b>4.</b> Amount of average acquisition debt on or allocable to debt-financed property (attach schedule)	<b>5.</b> Average adjusted basis of or allocable to debt-financed property (attach schedule)	<b>6.</b> Column 4 divided by column 5	<b>7.</b> Gross income reportable (column 2 x column 6)	<b>8.</b> Allocable deductions (column 6 x total of columns 3(a) and 3(b))
(1)		%		
(2)		%		
(3)		%		
(4)		%		
			Enter here and on page 1, Part I, line 7, column (A).	Enter here and on page 1, Part I, line 7, column (B).
<b>Totals</b> .....			<b>u</b>	
<b>Total dividends-received deductions</b> included in column 8 .....			<b>u</b>	

**Schedule F – Interest, Annuities, Royalties, and Rents From Controlled Organizations** (see instructions)

1. Name of controlled organization	2. Employer identification number	Exempt Controlled Organizations			
		3. Net unrelated income (loss) (see instructions)	4. Total of specified payments made	5. Part of column 4 that is included in the controlling organization's gross income	6. Deductions directly connected with income in column 5
(1) N/A					
(2)					
(3)					
(4)					

**Nonexempt Controlled Organizations**

7. Taxable Income	8. Net unrelated income (loss) (see instructions)	9. Total of specified payments made	10. Part of column 9 that is included in the controlling organization's gross income	11. Deductions directly connected with income in column 10
(1)				
(2)				
(3)				
(4)				
<b>Totals</b> .....			Add columns 5 and 10. Enter here and on page 1, Part I, line 8, column (A).	Add columns 6 and 11. Enter here and on page 1, Part I, line 8, column (B).

**Schedule G – Investment Income of a Section 501(c)(7), (9), or (17) Organization** (see instructions)

1. Description of income	2. Amount of income	3. Deductions directly connected (attach schedule)	4. Set-asides (attach schedule)	5. Total deductions and set-asides (col. 3 plus col.4)
(1) N/A				
(2)				
(3)				
(4)				
<b>Totals</b> .....		Enter here and on page 1, Part I, line 9, column (A).		Enter here and on page 1, Part I, line 9, column (B).

**Schedule I – Exploited Exempt Activity Income, Other Than Advertising Income** (see instructions)

1. Description of exploited activity	2. Gross unrelated business income from trade or business	3. Expenses directly connected with production of unrelated business income	4. Net income (loss) from unrelated trade or business (column 2 minus column 3). If a gain, compute cols. 5 through 7.	5. Gross income from activity that is not unrelated business income	6. Expenses attributable to column 5	7. Excess exempt expenses (column 6 minus column 5, but not more than column 4).
(1) N/A						
(2)						
(3)						
(4)						
<b>Totals</b> .....		Enter here and on page 1, Part I, line 10, col. (A).	Enter here and on page 1, Part I, line 10, col. (B).			Enter here and on page 1, Part II, line 26.

**Schedule J – Advertising Income** (see instructions)

**Part I Income From Periodicals Reported on a Consolidated Basis**

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1) N/A						
(2)						
(3)						
(4)						
<b>Totals</b> (carry to Part II, line (5)).						

**Part II** **Income From Periodicals Reported on a Separate Basis** (For each periodical listed in Part II, fill in columns 2 through 7 on a line-by-line basis.)

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1) N/A						
(2)						
(3)						
(4)						
<b>Totals from Part I</b> . . . . . <b>u</b>						
<b>Totals, Part II (lines 1-5)</b> . . . . . <b>u</b>	Enter here and on page 1, Part I, line 11, col. (A).	Enter here and on page 1, Part I, line 11, col. (B).				Enter here and on page 1, Part II, line 27.

**Schedule K – Compensation of Officers, Directors, and Trustees** (see instructions)

1. Name	2. Title	3. Percent of time devoted to business	4. Compensation attributable to unrelated business
(1) N/A		%	
(2)		%	
(3)		%	
(4)		%	
<b>Total.</b> Enter here and on page 1, Part II, line 14			<b>u</b>



Form **2220**

**Underpayment of Estimated Tax by Corporations**

OMB No. 1545-0123

Department of the Treasury  
Internal Revenue Service

**u Attach to the corporation's tax return.**  
**uGo to [www.irs.gov/Form2220](http://www.irs.gov/Form2220) for instructions and the latest information.**

**2018**

Name Phoebe Worth Medical Center, Inc. Employer identification number 38-3647394

**Note:** Generally, the corporation is not required to file Form 2220 (see Part II below for exceptions) because the IRS will figure any penalty owed and bill the corporation. However, the corporation may still use Form 2220 to figure the penalty. If so, enter the amount from page 2, line 38, on the estimated tax penalty line of the corporation's income tax return, but **do not** attach Form 2220.

**Part I Required Annual Payment**

<b>1</b> Total tax (see instructions) .....	<b>1</b>	674
<b>2a</b> Personal holding company tax (Schedule PH (Form 1120), line 26) included on line 1	<b>2a</b>	
<b>b</b> Look-back interest included on line 1 under section 460(b)(2) for completed long-term contracts or section 167(g) for depreciation under the income forecast method .....	<b>2b</b>	
<b>c</b> Credit for federal tax paid on fuels (see instructions) .....	<b>2c</b>	
<b>d Total.</b> Add lines 2a through 2c .....	<b>2d</b>	
<b>3</b> Subtract line 2d from line 1. If the result is less than \$500, <b>do not</b> complete or file this form. The corporation does not owe the penalty .....	<b>3</b>	674
<b>4</b> Enter the tax shown on the corporation's 2017 income tax return. See instructions. <b>Caution: If the tax is zero or the tax year was for less than 12 months, skip this line and enter the amount from line 3 on line 5</b> .....	<b>4</b>	1,626
<b>5 Required annual payment.</b> Enter the <b>smaller</b> of line 3 or line 4. If the corporation is required to skip line 4, enter the amount from line 3 .....	<b>5</b>	674

**Part II Reasons for Filing**—Check the boxes below that apply. If any boxes are checked, the corporation **must** file Form 2220 even if it does not owe a penalty. See instructions.

- 6** The corporation is using the adjusted seasonal installment method.
- 7** The corporation is using the annualized income installment method.
- 8** The corporation is a "large corporation" figuring its first required installment based on the prior year's tax.

**Part III Figuring the Underpayment**

	(a)	(b)	(c)	(d)
<b>9</b> Installment due dates. Enter in columns (a) through (d) the 15th day of the 4th (Form 990-PF filers: Use 5th month), 6th, 9th, and 12th months of the corporation's tax year .....	<b>9</b> 11/15/18	01/15/19	04/15/19	07/15/19
<b>10</b> Required installments. If the box on line 6 and/or line 7 above is checked, enter the amounts from Schedule A, line 38. If the box on line 8 (but not 6 or 7) is checked, see instructions for the amounts to enter. If none of these boxes are checked, enter 25% (0.25) of line 5 above in each column .....	<b>10</b> 169	169	169	167
<b>11</b> Estimated tax paid or credited for each period. For column (a) only, enter the amount from line 11 on line 15. See instructions .....	<b>11</b>			3,400
<i>Complete lines 12 through 18 of one column before going to the next column.</i>				
<b>12</b> Enter amount, if any, from line 18 of the preceding column .....	<b>12</b>			3,400
<b>13</b> Add lines 11 and 12 .....	<b>13</b>			507
<b>14</b> Add amounts on lines 16 and 17 of the preceding column .....	<b>14</b>	169	338	507
<b>15</b> Subtract line 14 from line 13. If zero or less, enter -0- .....	<b>15</b> 0	0	0	2,893
<b>16</b> If the amount on line 15 is zero, subtract line 13 from line 14. Otherwise, enter -0- .....	<b>16</b>	169	338	
<b>17</b> Underpayment. If line 15 is less than or equal to line 10, subtract line 15 from line 10. Then go to line 12 of the next column. Otherwise, go to line 18 .....	<b>17</b> 169	169	169	0
<b>18</b> Overpayment. If line 10 is less than line 15, subtract line 10 from line 15. Then go to line 12 of the next column .....	<b>18</b>			

Go to Part IV on page 2 to figure the penalty. Do not go to Part IV if there are no entries on line 17—no penalty is owed.

For Paperwork Reduction Act Notice, see separate instructions.

Form **2220** (2018)

**Part IV Figuring the Penalty**

	(a)	(b)	(c)	(d)
<b>19</b> Enter the date of payment or the 15th day of the 4th month after the close of the tax year, whichever is earlier. (C corporations with tax years ending June 30 and S corporations: Use 3rd month instead of 4th month. Form 990-PF and Form 990-T filers: Use 5th month instead of 4th month.) See instructions	<b>19</b> See Worksheet			
<b>20</b> Number of days from due date of installment on line 9 to the date shown on line 19	<b>20</b>			
<b>21</b> Number of days on line 20 after 4/15/2018 and before 7/1/2018	<b>21</b>			
<b>22</b> Underpayment on line 17 x $\frac{\text{Number of days on line 21}}{365}$ x 5% (0.05)	<b>22</b> \$	\$	\$	\$
<b>23</b> Number of days on line 20 after 6/30/2018 and before 10/1/2018	<b>23</b>			
<b>24</b> Underpayment on line 17 x $\frac{\text{Number of days on line 23}}{365}$ x 5% (0.05)	<b>24</b> \$	\$	\$	\$
<b>25</b> Number of days on line 20 after 9/30/2018 and before 1/1/2019	<b>25</b>			
<b>26</b> Underpayment on line 17 x $\frac{\text{Number of days on line 25}}{365}$ x 5% (0.05)	<b>26</b> \$	\$	\$	\$
<b>27</b> Number of days on line 20 after 12/31/2018 and before 4/1/2019	<b>27</b>			
<b>28</b> Underpayment on line 17 x $\frac{\text{Number of days on line 27}}{365}$ x 6% (0.06)	<b>28</b> \$	\$	\$	\$
<b>29</b> Number of days on line 20 after 3/31/2019 and before 7/1/2019	<b>29</b>			
<b>30</b> Underpayment on line 17 x $\frac{\text{Number of days on line 29}}{365}$ x %	<b>30</b> \$	\$	\$	\$
<b>31</b> Number of days on line 20 after 6/30/2019 and before 10/1/2019	<b>31</b>			
<b>32</b> Underpayment on line 17 x $\frac{\text{Number of days on line 31}}{365}$ x %	<b>32</b> \$	\$	\$	\$
<b>33</b> Number of days on line 20 after 9/30/2019 and before 1/1/2020	<b>33</b>			
<b>34</b> Underpayment on line 17 x $\frac{\text{Number of days on line 33}}{365}$ x %	<b>34</b> \$	\$	\$	\$
<b>35</b> Number of days on line 20 after 12/31/2019 and before 3/16/2020	<b>35</b>			
<b>36</b> Underpayment on line 17 x $\frac{\text{Number of days on line 35}}{366}$ x %	<b>36</b> \$	\$	\$	\$
<b>37</b> Add lines 22, 24, 26, 28, 30, 32, 34, and 36	<b>37</b> \$	\$	\$	\$
<b>38</b> Penalty. Add columns (a) through (d) of line 37. Enter the total here and on Form 1120, line 34; or the comparable line for other income tax returns				<b>38</b> \$ 9

\*Use the penalty interest rate for each calendar quarter, which the IRS will determine during the first month in the preceding quarter. These rates are published quarterly in an IRS News Release and in a revenue ruling in the Internal Revenue Bulletin. To obtain this information on the Internet, access the IRS website at [www.irs.gov](http://www.irs.gov). You can also call 1-800-829-4933 to get interest rate information.

Form <b>2220</b>	<b>Form 2220 Worksheet</b>	<b>2018</b>
For calendar year 2018, or tax year beginning <u>08/01/18</u> , and ending <u>07/31/19</u>		

Name Phoebe Worth Medical Center, Inc. Employer Identification Number 38-3647394

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Due date of estimated payment	<u>11/15/18</u>	<u>01/15/19</u>	<u>04/15/19</u>	<u>07/15/19</u>
Amount of underpayment	<u>169</u>	<u>169</u>	<u>169</u>	<u>169</u>

Prior year overpayment applied \_\_\_\_\_

	1st Payment	2nd Payment	3rd Payment	4th Payment	5th Payment
Date of payment	_____	_____	_____	<u>06/11/19</u>	_____
Amount of payment	_____	_____	_____	<u>3,400</u>	_____

Qtr	From	To	Underpayment	#Days	Rate	Penalty
1	11/15/18	12/31/18	169	46	5.00	1
1	12/31/18	5/15/19	169	135	6.00	4
2	1/15/19	5/15/19	169	120	6.00	3
3	4/15/19	5/15/19	169	30	6.00	1
Total Penalty						9
						=====

68205 Phoebe Worth Medical Center, Inc.

38-3647394

## Federal Statements

FYE: 7/31/2019

### Statement 1 - Form 990-T, Part II, Line 28 - Other Deductions

Description	Amount
Allocated costs	\$ 1,391
Total	\$ <u>1,391</u>