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Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

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

OMB No. 1545-0047

2018

Open to Public Inspection

A For the 2019 calendar year, or tax year beginning 07-01-2018 , and ending 06-30-2019

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

C Name of organization
GRAYSON COUNTY HOSPITAL FOUNDATION

Doing business as
DBA TWIN LAKES REGIONAL MEDICAL

Number and street (or P.O. box if mail is not delivered to street address) | Room/suite
910 WALLACE AVE

City or town, state or province, country, and ZIP or foreign postal code
LEITCHFIELD, KY 42754

D Employer identification number
61-0523298

E Telephone number
(270) 259-9509

G Gross receipts $ 48,033,639

F Name and address of principal officer:
WAYNE MERIWETHER
910 WALLACE AVE
LEITCHFIELD, KY 42754

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

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

H(c) Group exemption number ▶

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

J Website: ▶ WWW.TLRMC.COM

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

L Year of formation: 1956

M State of legal domicile: KY

Part I Summary

1 Briefly describe the organization's mission or most significant activities:
TO PROVIDE QUALITY MEDICAL HEALTHCARE TO THE GRAYSON COUNTY, KENTUCKY AREA.

2 Check this box ▶ ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.

3	Number of voting members of the governing body (Part VI, line 1a)	**3**	10
4	Number of independent voting members of the governing body (Part VI, line 1b)	**4**	10
5	Total number of individuals employed in calendar year 2018 (Part V, line 2a)	**5**	475
6	Total number of volunteers (estimate if necessary)	**6**	45
7a	Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	0
b	Net unrelated business taxable income from Form 990-T, line 34	**7b**	

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	10,649	2,299
9	Program service revenue (Part VIII, line 2g)	42,243,675	45,812,739
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	382,410	179,774
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	1,579,714	1,703,726
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	44,216,448	47,698,538
13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)		0
14	Benefits paid to or for members (Part IX, column (A), line 4)		0
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	13,517,385	14,013,765
16a	Professional fundraising fees (Part IX, column (A), line 11e)		0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶0		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	26,504,646	28,411,224
18	Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	40,022,031	42,424,989
19	Revenue less expenses. Subtract line 18 from line 12	4,194,417	5,273,549

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	105,923,455	110,745,874
21	Total liabilities (Part X, line 26)	13,601,895	13,150,765
22	Net assets or fund balances. Subtract line 21 from line 20	92,321,560	97,595,109

Part II Signature Block

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

Sign Here

****** 2020-05-07
Signature of officer Date

WAYNE MERIWETHER CEO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
		2020-05-07		P01224802

Firm's name ▶ BUCKLES TRAVIS & HART PLLC — Firm's EIN ▶ 61-1189912

Firm's address ▶ PO BOX 4069
LEITCHFIELD, KY 427554069 — Phone no. (270) 259-5604

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:

TO PROVIDE QUALITY MEDICAL HEALTHCARE TO THE GRAYSON COUNTY, KENTUCKY AREA.

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 $ 27,471,257 including grants of $) (Revenue $ 45,812,739)

See Additional Data

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

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

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

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

4e **Total program service expenses ▶** 27,471,257

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	Yes	
2	Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)?	2		No
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		No
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4		No
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		No
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		No
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		No
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		No
9	Did the organization report an amount in Part X, line 21 for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		No
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10		No
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI.*	11a	Yes	
b	Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b		No
c	Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		No
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d		No
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	Yes	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f	Yes	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a	Yes	
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	Yes	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		No
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		No
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b		No
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV*	15		No
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV*	16		No
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I* (see instructions)	17		No
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		No
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		No
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	Yes	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	Yes	
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21		No
22	Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22		No

Part IV Checklist of Required Schedules *(continued)*

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable	**1a**	36		
b	Enter the number of Forms W-2G included in line 1a. *Enter -0-* if not applicable	**1b**	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	**1c**			

2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	**2a**	475		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)			**2b**	Yes
3a	Did the organization have unrelated business gross income of $1,000 or more during the year? . . .			**3a**	No
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O* . . .			**3b**	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . .			**4a**	No
b	If "Yes," enter the name of the foreign country: ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . .			**5a**	No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?			**5b**	No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?			**5c**	
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . .			**6a**	No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?			**6b**	
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?			**7a**	
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?			**7b**	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?			**7c**	
d	If "Yes," indicate the number of Forms 8282 filed during the year	**7d**			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?			**7e**	
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . .			**7f**	
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?			**7g**	
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?			**7h**	
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?			**8**	
9a	Did the sponsoring organization make any taxable distributions under section 4966? . . .			**9a**	
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . .			**9b**	
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12 . . .	**10a**			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	**10b**			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	**11a**			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	**11b**			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?			**12a**	
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year.	**12b**			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state? **Note.** See the instructions for additional information the organization must report on Schedule O.			**13a**	
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	**13b**			
c	Enter the amount of reserves on hand	**13c**			
14a	Did the organization receive any payments for indoor tanning services during the tax year?			**14a**	No
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* . .			**14b**	
15	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			**15**	No
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O			**16**	No

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

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	**1a**	10		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.				
b	Enter the number of voting members included in line 1a, above, who are independent	**1b**	10		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?		**2**		No
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?		**3**	Yes	
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?		**4**		No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?		**5**		No
6	Did the organization have members or stockholders?		**6**	Yes	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?		**7a**	Yes	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?		**7b**		No
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:				
a	The governing body?		**8a**	Yes	
b	Each committee with authority to act on behalf of the governing body?		**8b**	Yes	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*		**9**		No

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

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

Section C. Disclosure

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

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

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

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

20 State the name, address, and telephone number of the person who possesses the organization's books and records:
▶COMPANY OFFICIALS 910 WALLACE AVE LEITCHFIELD, KY 42754 (270) 259-9400

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, or highest compensated employees who received more than $100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than $10,000 of reportable compensation from the organization and any related organizations.

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
(1) JOEL BERNARD DIRECTOR	1.00	X						0	0	0
(2) RYAN BRATCHER DIRECTOR	1.00	X						0	0	0
(3) EDWIN MCKINNEY SECRETARY/TR	1.00	X						0	0	0
(4) WENDY LEE DO DIRECTOR	1.00	X						0	0	0
(5) DAVID DOWNS VICE-PRESIDE	1.00	X						0	0	0
(6) TREVOR RAY PRESIDENT	1.00	X						0	0	0
(7) KEVIN BROOKS DIRECTOR	1.00	X						0	0	0
(8) GLENNA BLACK DIRECTOR	1.00	X						0	0	0
(9) BRETT ABNEY DIRECTOR	1.00	X						0	0	0
(10) DENNIS FENTRESS DIRECTOR	1.00	X						0	0	0
(11) WAYNE MERIWETHER CEO	40.00			X				0	0	0
(12) CATHERINE D CLEMONS CHIEF OPERAT	40.00					X		148,395	0	14,522
(13) ANGELA GIBSON DIRECTOR OF	40.00					X		139,900	0	4,197
(14) TRINA DAVES CHIEF NURSIN	40.00					X		128,819	0	10,571
(15) ANITA PLEACHER PHARMACIST	40.00					X		127,512	0	1,275
(16) RICHARD DONOVAN PHARMACIST	40.00					X		126,628	0	6,806

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			
1b Sub-Total ▶										
c Total from continuation sheets to Part VII**, Section A** ▶										
d Total (add lines 1b and 1c) ▶								671,254		37,371

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 ▶ 6

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
SAMER BLEIBEL MD 304 WALLACE AVE LEITCHFIELD, KY 42754	PROFESSIONAL SE	481,800
ANDREW JENKINS MD 223 BYRTLE GROVE RD LEITCHFIELD, KY 42754	PROFESSIONAL SE	339,200
LEITCHFIELD PEDIATRIC CLINIC 908 WALLACE AVE LEITCHFIELD, KY 42754	PROFESSIONAL SE	162,625

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 ▶ 3

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			
	f All other contributions, gifts, grants, and similar amounts not included above	1f 2,299			
	g Noncash contributions included in lines 1a - 1f:$ 2,274				
	h **Total.** Add lines 1a-1f . . . . . ▶	2,299			
Program Service Revenue		Business Code			
	2a PATIENT SERVICES		45,613,944	45,613,944	
	b CAFETERIA REVENUE		180,249	180,249	
	c FITNESS CENTER & OTHER INCOME		18,546	18,546	
	d				
	e				
	f All other program service revenue.				
	g **Total.** Add lines 2a–2f . . . . ▶	45,812,739			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts) . . . . . ▶	179,774			179,774
	4 Income from investment of tax-exempt bond proceeds ▶				
	5 Royalties . . . . . ▶				
		(i) Real	(ii) Personal		
	6a Gross rents	494,618			
	b Less: rental expenses	335,101			
	c Rental income or (loss)	159,517			
	d Net rental income or (loss) . . . . . ▶	159,517	159,517		
		(i) Securities	(ii) Other		
	7a Gross amount from sales of assets other than inventory				
	b Less: cost or other basis and sales expenses				
	c Gain or (loss)				
	d Net gain or (loss) . . . . . ▶				
	8a Gross income from fundraising events (not including $ _____ of contributions reported on line 1c). See Part IV, line 18 . . . . a				
	b Less: direct expenses . . . b				
	c Net income or (loss) from fundraising events . . ▶				
	9a Gross income from gaming activities. See Part IV, line 19 . . . a				
	b Less: direct expenses . . . b				
	c Net income or (loss) from gaming activities . . ▶				
	10a Gross sales of inventory, less returns and allowances . . a				
	b Less: cost of goods sold . . b				
	c Net income or (loss) from sales of inventory . . ▶				
	Miscellaneous Revenue	Business Code			
	11a NONOPERATING GAIN(LOSS)		753,727	753,727	
	b TAX REVENUE		648,012	648,012	
	c MANAGEMENT FEES		142,470	142,470	
	d All other revenue				
	e **Total.** Add lines 11a–11d . . . . . ▶	1,544,209			
	12 **Total revenue.** See Instructions. . . . . ▶	47,698,538	47,516,465		179,774

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) Fundraisingexpenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21				
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees				
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	14,013,765	11,405,721	2,608,044	
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)				
9 Other employee benefits				
10 Payroll taxes				
11 Fees for services (non-employees):				
a Management				
b Legal				
c Accounting				
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)				
12 Advertising and promotion				
13 Office expenses				
14 Information technology				
15 Royalties				
16 Occupancy				
17 Travel				
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings				
20 Interest	317,272		317,272	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	2,282,408	1,983,413	298,995	
23 Insurance				
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a ADMINISTRATIVE & GENERAL	11,729,421		11,729,421	
b PROVISION FOR BAD DEBTS	3,705,668	3,705,668		
c LABORATORY	1,988,036	1,988,036		
d PHARMACY	1,865,583	1,865,583		
e All other expenses	6,522,836	6,522,836		
25 **Total functional expenses.** Add lines 1 through 24e	42,424,989	27,471,257	14,953,732	0
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720).				

Part X Balance Sheet

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

			(A) Beginning of year		(B) End of year
Assets	1	Cash–non-interest-bearing	21,882,393	1	25,242,413
	2	Savings and temporary cash investments		2	
	3	Pledges and grants receivable, net		3	
	4	Accounts receivable, net	6,023,179	4	5,304,676
	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	46,408,868	7	49,277,616
	8	Inventories for sale or use	1,672,239	8	1,807,383
	9	Prepaid expenses and deferred charges	503,936	9	459,222
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 72,596,492			
	b	Less: accumulated depreciation — 10b: 46,159,715	27,328,387	10c	26,436,777
	11	Investments—publicly traded securities	2,104,453	11	2,217,787
	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		15	
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	105,923,455	16	110,745,874
Liabilities	17	Accounts payable and accrued expenses	3,540,345	17	4,026,286
	18	Grants payable		18	
	19	Deferred revenue		19	
	20	Tax-exempt bond liabilities	9,405,000	20	8,680,000
	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	656,550	25	444,479
	26	**Total liabilities.** Add lines 17 through 25	13,601,895	26	13,150,765
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ ☑ and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	92,321,560	27	97,595,109
	28	Temporarily restricted net assets		28	
	29	Permanently restricted net assets		29	
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	92,321,560	33	97,595,109
	34	Total liabilities and net assets/fund balances	105,923,455	34	110,745,874

Part XI Reconcilliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	47,698,538
2	Total expenses (must equal Part IX, column (A), line 25)	2	42,424,989
3	Revenue less expenses. Subtract line 2 from line 1	3	5,273,549
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	92,321,560
5	Net unrealized gains (losses) on investments	5	
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	97,595,109

Part XII Financial Statements and Reporting

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

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

Additional Data

Software ID:

Software Version:

EIN: 61-0523298

Name: GRAYSON COUNTY HOSPITAL FOUNDATION

Form 990 (2018)

Form 990, Part III, Line 4a:

TWIN LAKES REGIONAL MEDICAL CENTER PROVIDES QUALITY MEDICAL HEALTH CARE SERVICES TO PATIENTS REGARDLESS OF RACE, CREED, SEX, NATIONAL ORIGIN, HANDICAP, AGE, OR THE ABILITY TO PAY. ALTHOUGH REIMBURSEMENT FOR SERVICES RENDERED IS CRITICAL TO THE OPERATION AND FINANCIAL STABILITY OF TWIN LAKES REGIONAL MEDICAL CENTER, IT IS RECOGNIZED THAT NOT ALL INDIVIDUALS POSSESS THE ABILITY TO PURCHASE ESSENTIAL MEDICAL SERVICES. IN KEEPING WITH OUR COMMITMENT TO SERVE ALL MEMBERS OF THIS AREA, THE HOSPITAL PROVIDES FREE CARE TO THE MOST INDIGENT OF PATIENTS AND WRITES OFF PORTIONS OF BILLS TO OTHER PATIENTS WHO HAVE DEMONSTRATED THE INABILITY TO PAY FOR ALL HEALTH CARE SERVICES RECEIVED. ADDITIONAL CHARGES ARE WRITTEN OFF DUE TO ARRANGEMENTS WITH MEDICARE, MEDICAID, AND OTHER THIRD PARTIES. THE TOTAL UNREIMBURSED CHARGES FORGONE IN FISCAL YEAR 2019 DUE TO CONTRACTUAL AGREEMENTS WITH PAYERS AMOUNTED TO 98,866,644. ALSO, 696,857 WAS PAID AS A "PROVIDER TAX" TO THE COMMONWEALTH OF KENTUCKY TO HELP DEFRAY THE COSTS OF COVERING INDIGENT PATIENTS UNDER A SPECIAL STATE PROGRAM. WRITE-OFFS FROM PATIENTS "UNWILLING" TO PAY - I.E. BAD DEBTS - ACCOUNTED FOR 5,736,509. THE PRIMARY MISSION OF TWIN LAKES REGIONAL MEDICAL CENTER IS TO HEAL THE SICK, RELIEVE PAIN AND SUFFERING, AND IMPROVE THE QUALITY OF LIFE FOR THE PEOPLE WE SERVE. TLRMC'S VISION IS TO BE RECOGNIZED BY THE PEOPLE WE SERVE AS THE PROVIDER OF CHOICE FOR THEIR HEALTH CARE NEEDS AND AS A LEADING FORCE FOR PROGRESSIVE CHANGE WITHIN OUR COMMUNITY. TO ENHANCE QUALITY, THE HOSPITAL ACTIVELY OPERATES A PERFORMANCE IMPROVEMENT PROGRAM WHICH HELPS IDENTIFY BETTER PATIENT CARE AS WELL AS EFFICIENCIES IN OPERATIONS. TO ENHANCE OUR COMMUNITY, TLRMC PROVES TO BE A DRIVING FORCE IN CHANGE BY EDUCATING THE COMMUNITY ON HEALTH & WELLNESS ISSUES AND BY RECOGNIZING COMMUNITY NEEDS AND WORKING TO FULFILL THOSE NEEDS. THE HOSPITAL CARED FOR 2,333 INPATIENTS AND 88,444 OUTPATIENTS. TO ASSIST THOSE PATIENTS WITH LIMITED RESOURCES, TLRMC ALSO OFFERS A PATIENT FINANCIAL ASSISTANCE PROGRAM. THERE ARE SEVERAL OPTIONS FOR PATIENTS WHO ARE UNINSURED OR UNDERINSURED, AND TLRMC'S PATIENT FINANCIAL SERVICES DEPARTMENT EDUCATES THE PATIENTS OF THE DIFFERENT PROGRAMS. BASED ON THE RESULTS OF OUR LATEST COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA), TWIN LAKES REGIONAL MEDICAL CENTER CREATED THE POPULATION HEALTH COMMITTEE. THIS GROUP IS MADE UP OF HOSPITAL EMPLOYEES AND REPRESENTATIVES FROM THE LOCAL HEALTH DEPARTMENT, SCHOOL SYSTEM, LOCAL FACTORIES, EXTENSION SERVICE LEADERS, GOVERNMENT OFFICIALS AND OTHERS. THE COMMITTEE MEETS MONTHLY AT THE HOSPITAL AND LED THE EFFORT TO GET A SMOKE FREE COMMUNITY ORDINANCE PASSED. THE GROUP IS NOW WORKING ON MAKING POSITIVE DIFFERENCES IN THE HEALTH OF OUR COMMUNITY IN SUCH TOPICS AS DIABETES, EXERCISE, NUTRITION AND GENERAL HEALTH. UNDER THE LEADERSHIP OF THE HOSPITAL AND THE LOCAL MASTER GARDENERS ASSOCIATION, THE WALLACE AVENUE COMMUNITY GARDEN BECAME A REALITY IN THE SPRING OF 2018. AT THE RIBBON CUTTING FOR THE GARDEN IN MAY 2018, WAYNE MERIWETHER, CEO OF TWIN LAKES REGIONAL MEDICAL CENTER TOLD THE FORTY PLUS PEOPLE THERE THE STORY ABOUT HOW THE COMMUNITY GARDEN PROJECT CAME TO BE. "IN THE MOST RECENT COMMUNITY HEALTH NEEDS ASSESSMENT THE HOSPITAL PERFORMED, NUTRITION AND OBESITY WERE TWO OF THE TOP HEALTH CHALLENGES FACING THE PEOPLE LIVING HERE. WHEN COMPARED NATIONALLY AND STATEWIDE, GRAYSON COUNTY RANKS LOW IN SEVERAL KEY AREAS INCLUDING DIABETES AND DIABETES DEATHS; ADULT OBESITY; LIMITED ACCESS TO HEALTHY FOOD; AND THE PERCENT OF LOW INCOME RESIDENTS THAT DO NOT LIVE CLOSE TO A GROCERY STORE." THE POPULATION HEALTH COMMITTEE PARTNERED WITH THE MASTER GARDENERS IN BUILDING THE COMMUNITY GARDEN TO HELP REVERSE THE NEGATIVE NUTRITION TRENDS. RESEARCH AND PLANNING FOR THE COMMUNITY GARDEN HAD BEEN GOING ON FOR OVER THREE YEARS. THE GROUP FOUND SEVERAL COMMUNITY GARDENS TO BASE A GRAYSON COUNTY PROGRAM ON INCLUDING ONES IN OWENSBORO AND BOWLING GREEN. EACH GARDENEER WAS ASSIGNED EITHER A 48 SQUARE FOOT OR 80 SQUARE FOOT RAISED BED PLOT TO USE THROUGHOUT THE GROWING SEASON FOR A NOMINAL FEE. THE HOSPITAL PROVIDED FREE MEETING SPACE TO SEVERAL GROUPS THROUGHOUT THE YEAR AND SEVERAL CLASSES WERE SPONSORED BY THE HOSPITAL THAT EDUCATED INTERESTED COMMUNITY RESIDENTS ON HEALTH & WELLNESS ISSUES. THEY INCLUDE: A. C.P.R. TO HEALTHCARE PROVIDERS AND TO THE COMMUNITY B. PREPARED CHILDBIRTH AND BREAST FEEDING CLASSES C. COUNTY-WIDE BABY SHOWER IN GRAYSON COUNTY - PROVIDES INFORMATION TO WOMEN WHO ARE PREGNANT OR WANT TO BECOME PREGNANT D. COMMUNITYWIDE BABY SHOWER IN BRECKINRIDGE COUNTY - PROVIDES INFORMATION TO WOMEN WHO ARE PREGNANT OR WANT TO BECOME PREGNANT E. SPONSORS THE AMERICAN RED CROSS BLOOD MOBILE TWO OR THREE TIMES EACH YEAR F. PROVIDED HEALTH INFORMATION AT THE RELAY FOR LIFE G. PARTICIPATED IN UNITED WAY MEETNGS UPON REQUEST, THE HOSPITAL ALSO PARTICIPATES IN LOCAL EDUCATION BY PROVIDING HOSPITAL EMPLOYEES AS SPEAKERS FOR CLASSROOMS OR CIVIC ORGANIZATIONS SUCH AS THE FOLLOWING EXAMPLES: H. PARTICIPATED IN OPERATION PREPARATION I. WRECC SAFETY DAY J. ASSISTED IN PROVIDING TRANSLATION SERVICES K. BEN JOHNSON ELEMENTARY SCHOOL WELLNESS DAY L. PROVIDED SPEAKERS FOR MANY HEALTH FAIRS, SCHOOLS, AND COMMUNITY EVENTS M. NARCAN TRAINING FOR LEITCHFIELD CITY POLICE AND GRAYSON COUNTY SHERIFF DEPARTMENT N. OPIOID STEWARDSHIP PRESENTATIONS IN ADDITION TO SERVING OUR LOCAL COMMUNITY NEEDS, TLRMC HAS ALSO TAKEN ON MEASURES TO IMPROVE AMERICA. BY PARTICIPATING IN THE CODE GREEN - RECYCLING PROJECT, TLRMC HOPES TO REDUCE WASTE AND IMPROVE THE ENVIRONMENT. TWIN LAKES REGIONAL MEDICAL CENTER'S BOARD OF DIRECTORS HAS PLEDGED TO BUY AMERICAN-MADE PRODUCTS WHEN WE CAN FIND A PRODUCT OF EQUAL OR GREATER QUALITY. TLRMC ENCOURAGES OTHER COMPANIES AND INDIVIDUALS TO DO THE SAME.

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SCHEDULE A (Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

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

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

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
GRAYSON COUNTY HOSPITAL FOUNDATION

Employer identification number
61-0523298

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

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

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

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

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

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

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

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

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

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

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

10 ☐ An organization that normally receives: (1) more than 331/3% 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 331/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)

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

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

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

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

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

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

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

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

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

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

Part II **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv), 170(b)(1)(A)(vi), and 170 (b)(1)(A)(ix)**

(Complete only if you checked the box on line 5, 7, 8, or 9 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grant.") . .						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . . .						
3 The value of services or facilities furnished by a governmental unit to the organization without charge..						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f). .						
6 **Public support.** Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a)2014	(b)2015	(c)2016	(d)2017	(e)2018	(f)Total
7 Amounts from line 4. .						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . .						
9 Net income from unrelated business activities, whether or not the business is regularly carried on. .						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.). .						
11 **Total support.** Add lines 7 through 10						

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

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2018 (line 6, column (f) divided by line 11, column (f)) 14

15 Public support percentage for 2017 Schedule A, Part II, line 14 15

16a **33 1/3% support test—2018.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **33 1/3% support test—2017.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

17a **10%-facts-and-circumstances test—2018.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **10%-facts-and-circumstances test—2017.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

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

Part III **Support Schedule for Organizations Described in Section 509(a)(2)**
(Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513 . . .						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . .						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year.						
c Add lines 7a and 7b. .						
8 **Public support.** (Subtract line 7c from line 6.)						

Section B. Total Support

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

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

Section C. Computation of Public Support Percentage

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

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2018** (line 10c, column (f) divided by line 13, column (f))	17	
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 on line 12 of Part I. If you checked 12a of Part I, complete Sections A and B. If you checked 12b of Part I, complete Sections A and C. If you checked 12c of Part I, complete Sections A, D, and E. If you checked 12d of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

- **a** ☐ The organization satisfied the Activities Test. Complete **line 2** below.
- **b** ☐ The organization is the parent of each of its supported organizations. Complete **line 3** below.
- **c** ☐ The organization supported a governmental entity. Describe in **Part VI** how you supported a government entity (see instructions)

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

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

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

	Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1	Net short-term capital gain	1		
2	Recoveries of prior-year distributions	2		
3	Other gross income (see instructions)	3		
4	Add lines 1 through 3	4		
5	Depreciation and depletion	5		
6	Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6		
7	Other expenses (see instructions)	7		
8	**Adjusted Net Income** (subtract lines 5, 6 and 7 from line 4)	8		

	Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):	1		
a	Average monthly value of securities	1a		
b	Average monthly cash balances	1b		
c	Fair market value of other non-exempt-use assets	1c		
d	**Total** (add lines 1a, 1b, and 1c)	1d		
e	**Discount** claimed for blockage or other factors (explain in detail in Part VI):			
2	Acquisition indebtedness applicable to non-exempt use assets	2		
3	Subtract line 2 from line 1d	3		
4	Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions).	4		
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5		
6	Multiply line 5 by .035	6		
7	Recoveries of prior-year distributions	7		
8	**Minimum Asset Amount** (add line 7 to line 6)	8		

	Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1		
2	Enter 85% of line 1	2		
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3		
4	Enter greater of line 2 or line 3	4		
5	Income tax imposed in prior year	5		
6	**Distributable Amount.** Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6		

7 ☐ Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)

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

Section D - Distributions	**Current Year**
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in **Part VI**). See instructions	
7 **Total annual distributions.** Add lines 1 through 6.	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in **Part VI**). See instructions	
9 Distributable amount for 2018 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)	**(i) Excess Distributions**	**(ii) Underdistributions Pre-2018**	**(iii) Distributable Amount for 2018**
1 Distributable amount for 2018 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2018 (reasonable cause required-- explain in Part VI). See instructions.			
3 Excess distributions carryover, if any, to 2018:			
a From 2013.			
b From 2014.			
c From 2015.			
d From 2016.			
e From 2017.			
f **Total** of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2018 distributable amount			
i Carryover from 2013 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4 Distributions for 2018 from Section D, line 7: $			
a Applied to underdistributions of prior years			
b Applied to 2018 distributable amount			
c Remainder. Subtract lines 4a and 4b from 4.			
5 Remaining underdistributions for years prior to 2018, if any. Subtract lines 3g and 4a from line 2. If the amount is greater than zero, explain in Part VI. See instructions.			
6 Remaining underdistributions for 2018. Subtract lines 3h and 4b from line 1. If the amount is greater than zero, explain in Part VI. See instructions.			
7 **Excess distributions carryover to 2019.** Add lines 3j and 4c.			
8 Breakdown of line 7:			
a Excess from 2014.			
b Excess from 2015.			
c Excess from 2016.			
d Excess from 2017.			
e Excess from 2018.			

Additional Data

Software ID:

Software Version:

EIN: 61-0523298

Name: GRAYSON COUNTY HOSPITAL FOUNDATION

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

Facts And Circumstances Test

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SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
GRAYSON COUNTY HOSPITAL FOUNDATION

Employer identification number
61-0523298

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

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

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

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

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

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

☐ Preservation of land for public use (e.g., recreation or education)
☐ Preservation of an historically important land area
☐ Protection of natural habitat
☐ Preservation of a certified historic structure
☐ Preservation of open space

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

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

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

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

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? ☐ Yes ☐ No

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

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

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? ☐ Yes ☐ No

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

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

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

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

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

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

(ii) Assets included in Form 990, Part X ▶ $ _____

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

a Revenue included on Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $ _____

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

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

a ☐ Public exhibition

b ☐ Scholarly research

c ☐ Preservation for future generations

d ☐ Loan or exchange programs

e ☐ Other .....

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

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

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

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

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

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

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

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

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

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

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

a Board designated or quasi-endowment ▶ .....

b Permanent endowment ▶ .....

c Temporarily restricted endowment ▶ .....

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

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

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

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

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		654,229		654,229
b Buildings		44,159,185	23,072,664	21,086,521
c Leasehold improvements				
d Equipment		24,983,463	21,277,964	3,705,499
e Other		2,799,615	1,809,087	990,528
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				26,436,777

Part VII **Investments—Other Securities.** Complete if the organization answered "Yes" on Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

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

Part VIII **Investments—Program Related.** Complete if the organization answered 'Yes' on Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

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

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

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

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
CAPITAL LEASE	242,238
LONG-TERM DEBT	202,241
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col.(B) line 25.)* ▶	444,479

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	47,636,560
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	47,636,560
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	61,978		
c	Add lines **4a** and **4b**			4c	61,978
5	Total revenue. Add lines **3** and **4c.** (This must equal Form 990, Part I, line 12.)			5	47,698,538

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	46,181,153
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	3,818,142		
e	Add lines **2a** through **2d**			2e	3,818,142
3	Subtract line **2e** from line **1**			3	42,363,011
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	61,978		
c	Add lines **4a** and **4b**			4c	61,978
5	Total expenses. Add lines **3** and **4c.** (This must equal Form 990, Part I, line 18.)			5	42,424,989

Part XIII Supplemental Information

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

Return Reference	Explanation
See Additional Data Table	

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

Additional Data

Software ID:

Software Version:

EIN: 61-0523298

Name: GRAYSON COUNTY HOSPITAL FOUNDATION

Supplemental Information

Return Reference	Explanation
SCHEDULE D, PAGE 3, PART X	THE HOSPITAL AS WELL AS THE FOUNDATION ARE NOT-FOR-PROFIT CORPORATIONS AS DESCRIBED IN SEC TION 501(C)(3) OF THE INTERNAL REVENUE CODE AND ARE EXEMPT FROM FEDERAL AND STATE INCOME T AXES ON RELATED INCOME PURSUANT TO SECTION 501(A) OF THE CODE. ACCORDINGLY, NO PROVISION F OR INCOME TAXES HAS BEEN REFLECTED IN THE HOSPITAL'S FINANCIAL STATEMENTS. MANAGEMENT IS N OT AWARE OF ANY ACTIVITY WITHIN THE HOSPITAL OR FOUNDATION DURING THE CURRENT OR PRIOR REP ORTING PERIODS THAT WOULD JEOPARDIZE OR OTHERWISE CALL INTO QUESTION THE HOSPITAL OR FOUND ATION'S COMPLIANCE WITH THE ABOVE INTERNAL REVENUE CODE SECTION. THE ORGANIZATION'S FEDERA L RETURN OF ORGANIZATION EXEMPT FROM INCOME TAX (FORM 990) FOR FISCAL YEARS 2017, 2018 AND 2019 ARE SUBJECT TO EXAMINATION BY THE INTERNAL REVENUE SERVICE FOR THREE YEARS AFTER THE Y WERE FILED. CURRENTLY, THE HOSPITAL AND FOUNDATION HAVE NO REPORTING REQUIREMENTS WITH A NY STATE OR LOCAL TAX JURISDICTIONS. THE HOSPITAL HAS INVESTMENT INTEREST IN THREE COMPANI ES AS DESCRIBED IN NOTE 8. THE HOSPITAL BELIEVES THAT IT HAS APPROPRIATE SUPPORT FOR ANY T AX POSITIONS TAKEN, AND AS SUCH DOES NOT HAVE ANY UNCERTAIN TAX POSITIONS THAT ARE MATERIA L TO THE FINANCIAL STATEMENTS. THE HOSPITAL AND FOUNDATION'S POLICY FOR RECORDING ANY TAX RELATED INTEREST AND PENALTIES IS TO RECOGNIZE THESE ITEMS AS OPERATING EXPENSES; HOWEVER, NONE WERE INCURRED OR RECORDED DURING THE CURRENT OR PRIOR OPEN OPERATING PERIODS.

Supplemental Information

Return Reference	Explanation
SCHEDULE D, PAGE 4, PART XI, LINE 4B	VALUE OF DONATED ITEMS 2,383 DONATED SERVICES 59,595

Supplemental Information

Return Reference	Explanation
SCHEDULE D, PAGE 4, PART XII, LINE 2D	OPERATING LOSS REPORTED UNDER ID 61-1269278 3,818,142

Supplemental Information

Return Reference	Explanation
SCHEDULE D, PAGE 4, PART XII, LINE 4B	DONATED SERVICES 59,595 USE OF DONATED ITEMS 2,383

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SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
GRAYSON COUNTY HOSPITAL FOUNDATION

Employer identification number
61-0523298

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)	1	66	29,792		29,792	0.070 %
b Medicaid (from Worksheet 3, column a)	1	23,570	1,609,266	492,436	1,116,830	2.630 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs	2	23,636	1,639,058	492,436	1,146,622	2.700 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4).	9	3,360	9,215		9,215	0.020 %
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j **Total.** Other Benefits	9	3,360	9,215		9,215	0.020 %
k **Total.** Add lines 7d and 7j	11	26,996	1,648,273	492,436	1,155,837	2.720 %

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development	1		10,912		10,912	0.030 %
3 Community support	1	1,000	1,000		1,000	
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development						
9 Other						
10 Total	2	1,000	11,912		11,912	0.030 %

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

			Yes	No
1	Did the organization report bad debt expense in accordance with Heathcare Financial Management Association Statement No. 15?	1	Yes	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount. 2 1,504,538			
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit. 3 664,967			
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	14,483,157
6	Enter Medicare allowable costs of care relating to payments on line 5	6	15,478,385
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-995,228
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:		

☐ Cost accounting system ☑ Cost to charge ratio ☐ Other

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures (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 %
1	TWIN LAKES MEDICAL F	MEDICAL PRACTICES	100.000 %		
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

Part V Facility Information

Section A. Hospital Facilities

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

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

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
See Additional Data Table										

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group GRAYSON COUNTY HOSPITAL FOUNDATION TWIN LAKES REGIONAL MEDICAL CENTER

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1

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

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group GRAYSON COUNTY HOSPITAL FOUNDATION
TWIN LAKES REGIONAL MEDICAL CENTER

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	

If "Yes," indicate the eligibility criteria explained in the FAP:

- a ☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150.000000000000 % and FPG family income limit for eligibility for discounted care of 400.000000000000 %
- b ☐ Income level other than FPG (describe in Section C)
- c ☑ Asset level
- d ☑ Medical indigency
- e ☑ Insurance status
- f ☑ Underinsurance discount
- g ☑ Residency
- h ☐ Other (describe in Section C)

14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	

If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):

- a ☑ Described the information the hospital facility may require an individual to provide as part of his or her application
- b ☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application
- c ☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process
- d ☑ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications
- e ☐ Other (describe in Section C)

16	Was widely publicized within the community served by the hospital facility?	16	Yes	

If "Yes," indicate how the hospital facility publicized the policy (check all that apply):

- a ☑ The FAP was widely available on a website (list url): WWW.TLRMC.COM
- b ☐ The FAP application form was widely available on a website (list url):
- c ☐ A plain language summary of the FAP was widely available on a website (list url):
- d ☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)
- e ☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)
- f ☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)
- g ☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention
- h ☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP
- i ☐ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations
- j ☑ Other (describe in Section C)

Part V Facility Information *(continued)*

Billing and Collections

Name of hospital facility or letter of facility reporting group GRAYSON COUNTY HOSPITAL FOUNDATION
TWIN LAKES REGIONAL MEDICAL CENTER

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

GRAYSON COUNTY HOSPITAL FOUNDATION

Name of hospital facility or letter of facility reporting group TWIN LAKES REGIONAL MEDICAL CENTER

		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a ☐	The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b ☑	The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
c ☐	The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
d ☐	The hospital facility used a prospective Medicare or Medicaid method		
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? **23**		No
	If "Yes," explain in Section C.		
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? **24**		No
	If "Yes," explain in Section C.		

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

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

Form and Line Reference	Explanation
See Add'l Data	

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

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility (list in order of size, from largest to smallest)

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

Name and address	Type of Facility (describe)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 3C - OTHER INCOME BASED CRITERIA FOR FREE OR DISCOUNTED CARE	TWIN LAKES REGIONAL MEDICAL CENTER'S PATIENT FINANCIAL ASSISTANCE PROGRAM UTILIZES THE FEDERAL POVERTY GUIDELINES AND AN ASSET TEST CONSISTING OF RESIDENCE, VEHICLES, AND CASH INVESTMENTS TO DETERMINE ELIGIBILITY FOR FREE OR DISCOUNTED CARE.
PART I, LINE 7 - COSTING METHODOLOGY EXPLANATION	IN DETERMINING THE AMOUNTS FOR PART 1, LINE 7, COST ACCOUNTING WAS USED. THE COST-TO-CHARGE RATIO WAS DERIVED FROM WORKSHEET 2, RATIO OF PATIENT CARE COST-TO-CHARGES.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 2 - BAD DEBT EXPENSE METHODOLOGY	THE TOTAL BAD DEBT EXPENSE AT COST REPRESENTS THE TOTAL AMOUNT EXPECTED TO BE COLLECTED, BUT DEEMED UNCOLLECTIBLE. BASED ON THE COMMUNITY'S DEMOGRAPHICS, INCOME LEVEL, INDIVIDUAL ASSETS, AND HEALTH COVERAGE, 44.20% WAS DETERMINED TO BE ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE HOSPITAL'S PATIENT FINANCIAL ASSISTANCE PROGRAM.
BAD DEBT EXPENSE FOOTNOTE TO FINANCIAL STATEMENTS	DELINQUENT RECEIVABLES ARE WRITTEN OFF BASED ON INDIVIDUAL CREDIT EVALUATION AND SPECIFIC CIRCUMSTANCES OF THE PATIENT OR THIRD-PARTY PAYOR. IF THE HOSPITAL RECEIVES NO PAYMENT OR COMMUNICATION TO ARRANGE PAYMENT THE ACCOUNT IS SENT TO COLLECTION AND RECOGNIZED AS BAD DEBT AT THAT TIME.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 8 - MEDICARE EXPLANATION	TWIN LAKES REGIONAL MEDICAL CENTER BELIEVES THAT ALL OF THE 1.0 MILLION MEDICARE SHORTFALL SHOULD BE CONSIDERED COMMUNITY BENEFIT. THE COSTS TO CARE FOR THE ELDERLY AND MEDICARE PATIENTS ARE ABSORBED BY THE HOSPITAL DUE TO LACK OF REIMBURSEMENTS FROM MEDICARE. THE HOSPITAL CONTINUES TO PROVIDE CARE REGARDLESS OF THIS SHORTFALL AND THEREBY RELIEVES THE FEDERAL GOVERNMENT OF THE BURDEN OF PAYING THE FULL COST OF MEDICARE BENEFICIARIES. THEREFORE, TWIN LAKES REGIONAL MEDICAL CENTER IS FULFILLING A COMMUNITY NEED BY CARING FOR MEDICARE PATIENTS, WHO TYPICALLY HAVE LOW, FIXED INCOMES; AND RELIEVING THE GOVERNMENT FOR THEIR LACK OF PROVIDING SUFFICIENT PAYMENTS TO COVER THE COST OF CARING FOR THEM.
PART III, LINE 9B - COLLECTION PRACTICES EXPLANATION	IF THE PATIENT DOES NOT HAVE ANY INSURANCE COVERAGE, AND THE PATIENT DOES NOT QUALIFY FOR ANY TYPE OF FINANCIAL ASSISTANCE UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE PROGRAM, THEN THE ACCOUNT CAN BE CONSIDERED FOR BAD DEBT PLACEMENT FORTY-FIVE DAYS AFTER THE PATIENT RECEIVED THEIR FIRST STATEMENT IF THERE HAS BEEN NO RESPONSE FROM THE PATIENT. AFTER A PERIOD OF TIME HAS PASSED WITH NO RESOLUTION, THE ACCOUNT WILL BE SENT TO OUR COLLECTION AGENCY.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 2 - NEEDS ASSESSMENT	TWIN LAKES REGIONAL MEDICAL CENTER ASSESSES THE COMMUNITY'S HEALTH CARE NEEDS BY OBTAINING INFORMATION FROM A VARIETY OF SOURCES INCLUDING: A. COMMUNITY HEALTH NEEDS ASSESSMENT CONDUCTED BY TWIN LAKES REGIONAL MEDICAL CENTER B. DEMOGRAPHIC DATABASES C. LOCAL AND REGIONAL HEALTH DEPARTMENTS AND RELATED DATABASES D. KENTUCKY HOSPITAL ASSOCIATION REPORTS AND DATABASES E. MARKET ANALYSIS F. FEEDBACK FROM PHYSICIANS AND EMPLOYEES AND OTHER INTERESTED COMMUNITY GROUPS G. HOSPITAL-GENERATED REPORTS ON UTILIZATION OF SERVICES H. BOARD OF DIRECTORS MADE UP OF LOCAL, COUNTY RESIDENTS
PART VI, LINE 3 - PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE	TWIN LAKES REGIONAL MEDICAL CENTER REACHES OUT TO EDUCATE PATIENTS ABOUT THEIR PATIENT FINANCIAL ASSISTANCE PROGRAM. A BROCHURE IS AVAILABLE AT SEVERAL LOCATIONS THROUGHOUT THE HOSPITAL INCLUDING THE BUSINESS OFFICE AND REGISTRATION AREA. A PDF VERSION OF THE BROCHURE IS POSTED ON THE HOSPITAL'S WEBSITE. THE HOSPITAL ALSO PUBLISHED THE COMMUNITY BENEFITS REPORT ON THE HOSPITAL'S WEBSITE AND FACEBOOK PAGE IN JUNE 2018, AND SUBSEQUENTLY IN THE TWO LOCAL NEWSPAPERS, WHICH INCLUDED THE SAME INFORMATION PROMINENTLY DISPLAYED. WHEN SELF PAY PATIENTS PRESENT TO THE HOSPITAL FOR SERVICES, THE REGISTRAR DIRECTS THE PATIENTS TO THE FINANCIAL COUNSELOR FOR ASSISTANCE ON MEDICAID/COMMERCIAL PLANS AVAILABLE THROUGH THE ACA. ALSO, AT THAT TIME OUR FINANCIAL ASSISTANCE PROGRAM IS ALSO APPLIED TO THEIR PERSONAL SITUATION FOR POSSIBLE HELP.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 4 - COMMUNITY INFORMATION	THE PRIMARY SERVICE AREA FOR TWIN LAKES REGIONAL MEDICAL CENTER IS GRAYSON COUNTY, KY (POPULATION 26,000) LOCATED 75 MILES SOUTHWEST OF LOUISVILLE, KY. THE HOSPITAL'S SECONDARY SERVICE AREA INCLUDES PARTS OF 6 SURROUNDING COUNTIES. THE ESTIMATED PERCENTAGE OF PEOPLE LIVING BELOW THE POVERTY LEVEL, AS DETERMINED BY THE U.S. CENSUS BUREAU, IS 22.1% FOR THE PRIMARY SERVICE AREA. THE AREA IS MOSTLY RURAL WITH A HIGHER PERCENTAGE OF PERSONS OVER THE AGE OF 65 AND A SIGNIFICANTLY LOWER MEDIAN HOUSEHOLD INCOME COMPARED TO THE STATE OF KENTUCKY. THE UNEMPLOYMENT RATE FOR THE MOST RECENT 12 MONTHS AVERAGED 4.9%.
PART VI, LINE 5 - PROMOTION OF COMMUNITY HEALTH	TWIN LAKES REGIONAL MEDICAL CENTER AND ITS EMPLOYEES HAVE A RICH HISTORY OF PLANNING AND/OR SPONSORING EVENTS DESIGNED TO EDUCATE THE COMMUNITY ON HEALTHY LIVING AND WELLNESS FACTORS. EVENTS DURING FYE 2019 INCLUDED THE COMMUNITY BABY SHOWER, NUTRITION DAY AT LOCAL SCHOOLS, CPR CLASSES, PREPARED CHILDBIRTH AND BREAST FEEDING CLASSES, AND HEALTH FAIRS AND SCREENINGS FOR THE COMMUNITY AND PRIVATE ORGANIZATIONS. TWIN LAKES REGIONAL MEDICAL CENTER ADHERES TO THE FOLLOWING IRS EXEMPTION REQUIREMENTS: A. ACCEPT AND TREAT MEDICARE AND MEDICAID PATIENTS B. EMERGENCY DEPARTMENT OPEN TO ALL EMERGENT CASES, REGARDLESS OF ABILITY TO PAY C. OPEN MEDICAL STAFF THAT ALLOWS CREDENTIALED PHYSICIANS TO PRACTICE AT FACILITY D. OPERATE UNDER COMMUNITY BOARD'S CONTROL IT IS THE MISSION AND ONGOING GOAL OF THE LEADERSHIP AND EMPLOYEES OF TWIN LAKES REGIONAL MEDICAL CENTER TO DO THE BEST JOB POSSIBLE TREATING THE SICK AND INJURED, ADDRESSING COMMUNITY WELLNESS NEEDS AND PROMOTING HEALTHY LIVING AT EVERY OPPORTUNITY. THROUGH OUR MANY COMMUNITY BENEFIT ACTIVITIES, OUR CHARITY CARE PROGRAM AND OUR ACCEPTANCE OF PATIENTS COVERED BY FEDERAL AND STATE PROGRAMS, TLRMC MAKES A POSITIVE DIFFERENCE IN THE QUALITY OF LIFE IN THE COMMUNITIES WE SERVE.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
ADDITIONAL INFORMATION	IN ADDITION TO PROVIDING THE COMMUNITY BENEFIT REPORT IN THE LOCAL PAPER, TLRMC ALSO PARTICIPATES IN THE STATE-WIDE COMMUNITY BENEFIT REPORT WITH KENTUCKY HOSPITAL ASSOCIATION THAT IS PRESENTED TO OUR COMMONWEALTH.

Additional Data

Software ID:

Software Version:

EIN: 61-0523298

Name: GRAYSON COUNTY HOSPITAL FOUNDATION

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

Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? **1** Name, address, primary website address, and state license number		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	**Other (Describe)**	**Facility reporting group**
1	GRAYSON COUNTY HOSPITAL FOUNDATION TWIN LAKES REGIONAL MEDICAL CENTER 910 WALLACE AVE LEITCHFIELD, KY 42754 WWW.TLRMC.COM	X	X					X			

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

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

Form and Line Reference	Explanation
FACILITY 1, GRAYSON COUNTY HOSPITAL FOUNDATION - PART V, LINE 3E	SIGNIFICANT HEALTH NEEDS THAT HAVE BEEN IDENTIFIED ARE MENTAL HEALTH, SUBSTANCE ABUSE, CHILDHOOD HEALTH AND COMMUNITY HEALTH INFORMATION.

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

Form and Line Reference	Explanation
FACILITY 1, GRAYSON COUNTY HOSPITAL FOUNDATION - PART V, LINE 5	IN CONDUCTING THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA), TWIN LAKES REGIONAL MEDICAL CE NTER (TLRMC) DEVELOPED A SURVEY TO GATHER HEALTH INFORMATION AND OPINIONS OF GRAYSON COUNT Y RESIDENTS 18 AND OVER. THE SURVEY WAS CONDUCTED IN OCTOBER AND NOVEMBER 2018 USING AN ON LINE SURVEY TOOL AND BY DISTRIBUTING PRINTED COPIES IN VARIOUS LOCATIONS THROUGHOUT THE CO MMUNITY. THE ONLINE SURVEY WAS PROMOTED THROUGH NEWSPAPER STORIES, EMAILS AND ON THE TLRMC FACEBOOK PAGE. EMAILS WITH A LINK TO THE SURVEY WERE SENT TO GRAYSON COUNTY CHAMBER OF CO MMERCE MEMBERS, LOCAL INDUSTRIES, AND EMPLOYEES OF THE GRAYSON COUNTY SCHOOL SYSTEM AND TH E HOSPITAL. PRINTED COPIES WERE DELIVERED TO AN ASSISTED LIVING FACILITY, THE GRAYSON COUN TY ALLIANCE FOOD BANK, THE GRAYSON COUNTY HEALTH DEPARTMENT, BIG CLIFTY MEDICAL COMPLEX AN D THE CANEYVILLE FAMILY PRACTICE. INFORMATION GAPS THAT LIMITED THE ABILITY OF TLRMC TO AS SESS THE COMMUNITY'S HEALTH NEEDS WERE IDENTIFIED. THE PRIMARY OBSTACLE WAS REACHING ELDER LY, LOW-INCOME AND/OR RURAL RESIDENTS DUE TO A LACK OF INTERNET ACCESS AND WILLINGNESS TO PARTICIPATE. TLRMC MADE EFFORTS TO REACH THESE INDIVIDUALS WITH WRITTEN SURVEYS. 457 GRAYS ON COUNTY RESIDENTS PARTICIPATED IN THE SURVEY. THE QUESTIONS WERE IN THREE PRIMARY CATEGO RIES: DEMOGRAPHICS, PERSONAL HEALTH INFORMATION, AND PERCEIVED HEALTH NEEDS OF THE COMMUNI TY. THE TWIN LAKES REGIONAL MEDICAL CENTER'S DIRECTOR OF MARKETING TABULATED THE RESULTS F ROM THE SURVEYS (ONLINE AND PRINTED) AND SUPPLEMENTED THEM WITH HEALTH STATISTICS AND DEMO GRAPHIC INFORMATION. TLRMC THEN INVITED REPRESENTATIVES FROM A VARIETY OF BACKGROUNDS TO A COMMUNITY FORUM/FOCUS GROUP ON APRIL 23, 2019 TO REVIEW THE SURVEY RESULTS AND PROVIDE RE COMMENDATIONS FOR THE HOSPITAL'S COMMUNITY HEALTH FOCUS. PROFESSIONS REPRESENTED INCLUDED PHYSICIANS; SCHOOL ADMINISTRATORS AND STAFF; THE GRAYSON COUNTY HEALTH DEPARTMENT; DIETICI AN; LOCAL INDUSTRY/MANUFACTURING; CANCER ADVOCATE; HOSPITAL BOARD MEMBERS; LAW ENFORCEMENT ; HOSPITAL LEADERSHIP AND CITY GOVERNMENT LEADERS. ONCE THE INFORMATION WAS PRESENTED A GR OUP DISCUSSION WAS HELD. ATTENDEES WERE ASKED FOR THEIR TOP HEALTH PRIORITIES WITHOUT CONC ERN ABOUT THE PRACTICALITY OF THE HOSPITAL'S ABILITY TO IMPACT THE ISSUES. AFTER CAREFULLY CONSIDERING THE RESULTS OF THE COMMUNITY HEALTH SURVEY, THE MOST RECENT HEALTH AND DEMOGR APHIC INFORMATION AVAILABLE, AND INPUT FROM THE COMMUNITY HEALTH FOCUS GROUP, THE FOLLOWIN G NEEDS WERE IDENTIFIED BY HOSPITAL LEADERSHIP AS THE COMMUNITY HEALTH FOCUS POINTS FOR TW IN LAKES REGIONAL MEDICAL CENTER IN 2019 - 2022. MENTAL HEALTH, SUBSTANCE ABUSE, CHILDHOOD HEALTH AND COMMUNITY HEALTH INFORMATION. THE 2018 COMMUNITY HEALTH NEEDS ASSESSMENT WAS A PPROVED BY THE BOARD OF DIRECTORS FOR TWIN LAKES REGIONAL MEDICAL CENTER ON TUESDAY, MAY 2 1, 2019. TO PUT THE 2012 AND 2015 CHNA REPORTS INTO ACTION, TWIN LAKES REGIONAL MEDICAL CE NTER CREATED THE POPULATION HEALTH COMMITTEE. THIS GROUP OF PEOPLE WORKS ON IMPROVING THE HEALTH OF OUR COMMUNITY GUIDED

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

Form and Line Reference	Explanation
FACILITY 1, GRAYSON COUNTY HOSPITAL FOUNDATION - PART V, LINE 5	BY THE COMMUNITY HEALTH FOCUS POINTS SET IN THE 2012 CHNA AND REFOCUSED BASED ON THE 2015 CHNA. THE POPULATION HEALTH COMMITTEE IS MADE UP OF HOSPITAL EMPLOYEES, INDUSTRIAL LEADER S, THE GRAYSON COUNTY SCHOOLS SUPERINTENDENT, REGISTERED DIETICIANS, A PHARMACIST, A REPRE SENTATIVE FROM THE KENTUCKY CANCER PROGRAM AND A REPRESENTATIVE FROM THE GRAYSON COUNTY HE ALTH DEPARTMENT. THE TWIN LAKES REGIONAL MEDICAL CENTER CEO CHAIRS THE COMMITTEE. THE POPU LATION HEALTH COMMITTEE MEETS MONTHLY TO DISCUSS AND IMPLEMENT PLANS ON IMPROVING THE HEAL TH OF THE COMMUNITY. THE PUBLICATION OF THIS REPORT IS ANOTHER STEP TO A HEALTHIER GRAYSON COUNTY. IT IS THE INTENTION OF TWIN LAKES REGIONAL MEDICAL CENTER THAT THE CONTENTS OF TH IS REPORT BE USED TO INFORM GRAYSON COUNTY RESIDENTS OF WHAT THEIR FELLOW CITIZENS THINK A RE THE MOST IMPORTANT HEALTH ISSUES IN THEIR COMMUNITY. ADDITIONALLY, TLRMC HOPES THIS REP ORT WILL SERVE AS A FOUNDATION TO BUILD LASTING RELATIONSHIPS BETWEEN TWIN LAKES REGIONAL MEDICAL CENTER, COMMUNITY PARTNERS AND RESIDENTS OF GRAYSON COUNTY. IN ORDER TO ADDRESS TH E PRIORITIZED NEEDS, TLRMC WILL ENGAGE KEY INTERNAL AND COMMUNITY PARTNERS. CUSTOMIZED STR ATEGIES HAVE BEEN DEVELOPED AND WILL BE CONTINUED. THE STRATEGIES INCLUDE, BUT ARE NOT LIM ITED TO, MODIFYING POLICIES, PUBLIC AND PRIVATE; PROVIDING SUPPORT, INFORMATION AND INCENT IVES; IMPROVING ACCESS; ENHANCING SKILLS; AND CHANGING CONSEQUENCES. FOLLOW-UP SURVEYS WIL L MEASURE THE SUCCESS OF EACH INITIATIVE AND PROVIDE THE NEXT AREAS OF FOCUS FOR THE HOSPI TAL. TO INFORM THE PUBLIC AND PARTNERS OF OUR GOALS AND TO INCREASE AWARENESS OF OUR PLAN, TWIN LAKES REGIONAL MEDICAL CENTER WILL PUBLISH THE FULL CHNA REPORT ON THE HOSPITAL'S WE BSITE (WWW.TLRMC.COM), PROMOTE THE REPORT ON SOCIAL MEDIA CHANNELS SUCH AS FACEBOOK AND TW ITTER, AND SUBMIT TO LOCAL NEWS MEDIA. PRINTED COPIES WILL BE AVAILABLE FOR THE PUBLIC AT THE HOSPITAL AS WELL.

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

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

Form and Line Reference	Explanation
FACILITY 1, GRAYSON COUNTY HOSPITAL FOUNDATION - PART V, LINE 7D	LOCAL NEWSPAPERS.

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

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

Form and Line Reference	Explanation
FACILITY 1, GRAYSON COUNTY HOSPITAL FOUNDATION - PART V, LINE 11	AFTER CAREFULLY CONSIDERING THE RESULTS OF THE COMMUNITY HEALTH SURVEY, THE MOST RECENT HEALTH AND DEMOGRAPHIC INFORMATION AVAILABLE, AND INPUT FROM THE COMMUNITY HEALTH FOCUS GROUP, THE FOLLOWING NEEDS WERE IDENTIFIED BY HOSPITAL LEADERSHIP AS THE COMMUNITY HEALTH FOCUS POINTS FOR TLRMC IN 2019 - 2022: MENTAL HEALTH, SUBSTANCE ABUSE, CHILDHOOD HEALTH AND COMMUNITY HEALTH INFORMATION. THE 2018 COMMUNITY HEALTH NEEDS ASSESSMENT WAS APPROVED BY THE BOARD OF DIRECTORS FOR TLRMC ON TUESDAY, MAY 21, 2019. TLRMC CREATED THE POPULATION HEALTH COMMITTEE, A GROUP THAT WORKS ON IMPROVING THE HEALTH OF OUR COMMUNITY GUIDED BY THE COMMUNITY HEALTH FOCUS POINTS SET IN THE 2012 CHNA AND REFOCUSED BASED ON THE 2015 CHNA. THE POPULATION HEALTH COMMITTEE MEETS MONTHLY TO DISCUSS AND IMPLEMENT PLANS ON IMPROVING THE HEALTH OF THE COMMUNNITY. THE FOLLOWING NEEDS WERE IDENTIFIED BUT NOT ADOPTED AS TOP PRIORITIES OF THE HOSPITAL AND THE REASONS WHY. DIABETES - EXISTING RESOURCES ARE AVAILABLE IN THE COUNTY. OBESITY - THE FOCUS ON CHILDHOOD HEALTH WOULD INCORPORATE IMPROVING NUTRITIONAL HABITS.

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

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

Form and Line Reference	Explanation
FACILITY 1, GRAYSON COUNTY HOSPITAL FOUNDATION - PART V, LINE 16J	THE POLICY WAS PROVIDED TO PATIENTS AT REGISTRATION.

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Schedule J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

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

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
GRAYSON COUNTY HOSPITAL FOUNDATION

Employer identification number
61-0523298

Part I Questions Regarding Compensation

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

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 are not listed on Form 990, Part VII.

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

(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				
1 CATHERINE D CLEMONS CHIEF OPERATING OFFI	**(i)**	148,395			14,522		162,917	
	(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.

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

Schedule K (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

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

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
GRAYSON COUNTY HOSPITAL FOUNDATION

Employer identification number
61-0523298

Part I Bond Issues

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pool financing	
							Yes	No	Yes	No	Yes	No
A	GRAYSON COUNTY PUBLIC HOSPITAL DIST GRAYSON COUNTY PUBLIC HOSPITAL DIST	61-0523298		08-28-2014	9,970,000	REFUND EXISTING 2009 BOND ISSUE.		X		X		X

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	1,290,000			
2	Amount of bonds legally defeased				
3	Total proceeds of issue	9,970,000			
4	Gross proceeds in reserve funds	3,703,162			
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows				
7	Issuance costs from proceeds	131,358			
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds				
11	Other spent proceeds				
12	Other unspent proceeds				
13	Year of substantial completion	2014			

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

Part III Private Business Use

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

Part III Private Business Use (Continued)

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

Part IV Arbitrage

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

Part IV Arbitrage (Continued)

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

Part V Procedures To Undertake Corrective Action

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

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

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Schedule L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions with Interested Persons

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

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
GRAYSON COUNTY HOSPITAL FOUNDATION

Employer identification number
61-0523298

Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 501(c)(29) organizations only).

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

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

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

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

Part II Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a, or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization? To	(d) Loan to or from the organization? From	(e) Original principal amount	(f) Balance due	(g) In default? Yes	(g) In default? No	(h) Approved by board or committee? Yes	(h) Approved by board or committee? No	(i) Written agreement? Yes	(i) Written agreement? No
Total . . . . . ▶ $												

Part III Grants or Assistance Benefiting Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

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

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) ISAAC MILLER	SON OF DIRECTOR	54,167	PHYSICIAN ASSIST PRO		No
(2) MIDWAY PHARMACY OF CLARKSON INC	DIRECTOR	52,524	RENT OF PHARMACY SPA		No
(3) FUTURE DESIGNS INC	DIRECTOR	1,325	PURCHASE OF BLDG MAT		No
(4) DR KENNETH GREEN	DIRECTOR	9,210	RENT OF OFFICE SPACE		No

Part V Supplemental Information

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

Return Reference	Explanation
SCHEDULE L, PART V	ISAAC MILLER IS THE SON OF FORMER DIRECTOR BECKY MILLER. HE IS PARTICIPATING IN THE PHYSICIAN ASSISTANCE PROGRAM. DIRECTOR TREVOR RAY IS A SHAREHOLDER IN MIDWAY PHARMACY OF CLARKSON, INC. MIDWAY PHARMACY OF CLARKSON, INC. RENTS SPACE FROM TWIN LAKES REGIONAL MEDICAL CENTER FOR TWO PHARMACY LOCATIONS. KEVIN BROOKS IS A SHAREHOLDER IN FUTURE DESIGNS, INC. FUTURE DESIGNS, INC. SOLD BUILDING MATERIALS TO TLRMC. DR. KENNETH GREEN IS A DIRECTOR OF TWIN LAKES REGIONAL MEDICAL CENTER. HIS MEDICAL PRACTICE RENTS OFFICE SPACE FROM TLRMC. THE HOSPITAL AND GRAYSON COUNTY HOSPITAL DISTRICT BOTH MAINTAIN BANK ACCOUNTS AT THE CECILIAN BANK. LARRY PERKINS AND DAVID DOWNS, BOTH DIRECTORS OF GRAYSON COUNTY HOSPITAL FOUNDATION, INC., ARE EMPLOYED BY THE CECILIAN BANK. GARRY WATKINS, A DIRECTOR OF GRAYSON COUNTY HOSPITAL DISTRICT, IS ALSO A DIRECTOR OF THE CECILIAN BANK. THE CASH BALANCES HELD AT JUNE 30, 2019 AND 2018 WERE 16,404,127 AND 16,091,314, RESPECTIVELY. THE HOSPITAL AND FOUNDATION BOTH MAINTAIN BANK ACCOUNTS AT WILSON & MUIR BANK & TRUST. RYAN BRATCHER, A DIRECTOR OF THE HOSPITAL, IS EMPLOYED BY WILSON & MUIR BANK & TRUST. THE CASH BALANCES HELD AT JUNE 30, 2019 AND 2018 WERE 7,123,436 AND 4,866,388, RESPECTIVELY.

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SCHEDULE O (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.
▶ **Attach to Form 990 or 990-EZ.**
▶ **Go to *www.irs.gov/Form990* for the latest information.**

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
GRAYSON COUNTY HOSPITAL FOUNDATION

Employer identification number
61-0523298

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 1, PART I, LINE 6	THE PURPOSE OF THE HOSPITAL VOUNTEER AUXILIARY IS TO RENDER SERVICE TO TWIN LAKES REGIONAL MEDICAL CENTER, ITS PATIENTS AND STAFF, AND TO ASSIST THE HOSPITAL IN PROMOTING THE HEALTH AND WELFARE OF THE COMMUNITY IN ACCORDANCE WITH OBJECTIVES ESTABLISHED BY THE HOSPITAL. THE MISSION OF THE VOLUNTEER AUXILIARY IS TO "SUPPORT TWIN LAKES REGIONAL MEDICAL CENTER IN MEETING THE HEALTH CARE NEEDS OF THE PEOPLE IT SERVES IN THE MOST CARING, COMPASSIONATE, AND EFFECTIVE MANNER POSSIBLE." THE AUXILIARY'S PRIMARY DUTY WITHIN THE HOSPITAL IS STAFFING THE INFORMATION DESK IN THE MAIN LOBBY FROM 8 A.M. - 4 P.M., MONDAY - FRIDAY. ROUTINE DUTIES THERE INCLUDE PROVIDING GENERAL HOSPITAL INFORMATION AND DIRECTIONS TO PATIENTS AND THE PUBLIC; MAKING WHEELCHAIRS AVAILABLE TO VISITORS AND PATIENTS; ASSISTING PEOPLE REGISTER USING THE DIGITAL REGISTRATION KIOSK; PROVIDING ESCORTS WHEN NEEDED; AND DELIVERING FLOWERS TO PATIENTS. THE VOLUNTEERS ALSO OPERATE THE TLRMC GIFT SHOP. PROCEEDS FROM THE GIFT SHOP ARE USED BY THE VOLUNTEERS TO PROVIDE SCHOLARSHIPS AND TO PURCHASE EQUIPMENT FOR THE HOSPITAL SUCH AS BLANKET WARMERS, WHEELCHAIRS, TELEVISIONS, AND OTHER ITEMS. MEMBERS OF THE AUXILIARY HAND MAKE SOCK MONKEYS AND OTHER STUFFED ANIMALS FOR CHILDREN COMING TO THE HOSPITAL. THE ANIMALS ARE GIVEN TO THE YOUNG PATIENTS AND THEIR FAMILIES AT NO CHARGE. THE VOLUNTEERS RAISE THE MONEY NEEDED TO PURCHASE ANY SUPPLIES AND DONATE MATERIALS IN ADDITION TO THEIR TIME AND TALENTS. THE SOCK MONKEY PROGRAM HAS BEEN HONORED BY THE KENTUCKY HOSPITAL ASSOCIATION.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 2, PART III, LINE 4A	TWIN LAKES REGIONAL MEDICAL CENTER PROVIDES QUALITY MEDICAL HEALTH CARE SERVICES TO PATIEN TS REGARDLESS OF RACE, CREED, SEX, NATIONAL ORIGIN, HANDICAP, AGE, OR THE ABILITY TO PAY. ALTHOUGH REIMBURSEMENT FOR SERVICES RENDERED IS CRITICAL TO THE OPERATION AND FINANCIAL ST ABILITY OF TWIN LAKES REGIONAL MEDICAL CENTER, IT IS RECOGNIZED THAT NOT ALL INDIVIDUALS P OSSESS THE ABILITY TO PURCHASE ESSENTIAL MEDICAL SERVICES. IN KEEPING WITH OUR COMMITMENT TO SERVE ALL MEMBERS OF THIS AREA, THE HOSPITAL PROVIDES FREE CARE TO THE MOST INDIGENT OF PATIENTS AND WRITES OFF PORTIONS OF BILLS TO OTHER PATIENTS WHO HAVE DEMONSTRATED THE INA BILITY TO PAY FOR ALL HEALTH CARE SERVICES RECEIVED. ADDITIONAL CHARGES ARE WRITTEN OFF DU E TO ARRANGEMENTS WITH MEDICARE, MEDICAID, AND OTHER THIRD PARTIES. THE TOTAL UNREIMBURSED CHARGES FORGONE IN FISCAL YEAR 2019 DUE TO CONTRACTUAL AGREEMENTS WITH PAYERS AMOUNTED TO 98,866,644. ALSO, 696,857 WAS PAID AS A "PROVIDER TAX" TO THE COMMONWEALTH OF KENTUCKY TO HELP DEFRAY THE COSTS OF COVERING INDIGENT PATIENTS UNDER A SPECIAL STATE PROGRAM. WRITE- OFFS FROM PATIENTS "UNWILLING" TO PAY - I.E. BAD DEBTS - ACCOUNTED FOR 5,736,509. THE PRIM ARY MISSION OF TWIN LAKES REGIONAL MEDICAL CENTER IS TO HEAL THE SICK, RELIEVE PAIN AND SU FFERING, AND IMPROVE THE QUALITY OF LIFE FOR THE PEOPLE WE SERVE. TLRMC'S VISION IS TO BE RECOGNIZED BY THE PEOPLE WE SERVE AS THE PROVIDER OF CHOICE FOR THEIR HEALTH CARE NEEDS AN D AS A LEADING FORCE FOR PROGRESSIVE CHANGE WITHIN OUR COMMUNITY. TO ENHANCE QUALITY, THE HOSPITAL ACTIVELY OPERATES A PERFORMANCE IMPROVEMENT PROGRAM WHICH HELPS IDENTIFY BETTER P ATIENT CARE AS WELL AS EFFICIENCIES IN OPERATIONS. TO ENHANCE OUR COMMUNITY, TLRMC PROVES TO BE A DRIVING FORCE IN CHANGE BY EDUCATING THE COMMUNITY ON HEALTH & WELLNESS ISSUES AND BY RECOGNIZING COMMUNITY NEEDS AND WORKING TO FULFILL THOSE NEEDS. THE HOSPITAL CARED FOR 2,333 INPATIENTS AND 88,444 OUTPATIENTS. TO ASSIST THOSE PATIENTS WITH LIMITED RESOURCES, TLRMC ALSO OFFERS A PATIENT FINANCIAL ASSISTANCE PROGRAM. THERE ARE SEVERAL OPTIONS FOR P ATIENTS WHO ARE UNINSURED OR UNDERINSURED, AND TLRMC'S PATIENT FINANCIAL SERVICES DEPARTME NT EDUCATES THE PATIENTS OF THE DIFFERENT PROGRAMS. BASED ON THE RESULTS OF OUR LATEST COM MUNITY HEALTH NEEDS ASSESSMENT (CHNA), TWIN LAKES REGIONAL MEDICAL CENTER CREATED THE POPU LATION HEALTH COMMITTEE. THIS GROUP IS MADE UP OF HOSPITAL EMPLOYEES AND REPRESENTATIVES F ROM THE LOCAL HEALTH DEPARTMENT, SCHOOL SYSTEM, LOCAL FACTORIES, EXTENSION SERVICE LEADERS , GOVERNMENT OFFICIALS AND OTHERS. THE COMMITTEE MEETS MONTHLY AT THE HOSPITAL AND LED THE EFFORT TO GET A SMOKE FREE COMMUNITY ORDINANCE PASSED. THE GROUP IS NOW WORKING ON MAKING POSITIVE DIFFERENCES IN THE HEALTH OF OUR COMMUNITY IN SUCH TOPICS AS DIABETES, EXERCISE, NUTRITION AND GENERAL HEALTH. UNDER THE LEADERSHIP OF THE HOSPITAL AND THE LOCAL MASTER G ARDENERS ASSOCIATION, THE WALLACE AVENUE COMMUNITY GARDEN BECAME A REALITY IN THE SPRING O F 2018. AT THE RIBBON CUTTING

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 2, PART III, LINE 4A	FOR THE GARDEN IN MAY 2018, WAYNE MERIWETHER, CEO OF TWIN LAKES REGIONAL MEDICAL CENTER TO LD THE FORTY PLUS PEOPLE THERE THE STORY ABOUT HOW THE COMMUNITY GARDEN PROJECT CAME TO BE . "IN THE MOST RECENT COMMUNITY HEALTH NEEDS ASSESSMENT THE HOSPITAL PERFORMED, NUTRITION AND OBESITY WERE TWO OF THE TOP HEALTH CHALLENGES FACING THE PEOPLE LIVING HERE. WHEN COMP ARED NATIONALLY AND STATEWIDE, GRAYSON COUNTY RANKS LOW IN SEVERAL KEY AREAS INCLUDING DIA BETES AND DIABETES DEATHS; ADULT OBESITY; LIMITED ACCESS TO HEALTHY FOOD; AND THE PERCENT OF LOW INCOME RESIDENTS THAT DO NOT LIVE CLOSE TO A GROCERY STORE." THE POPULATION HEALTH COMMITTEE PARTNERED WITH THE MASTER GARDENERS IN BUILDING THE COMMUNITY GARDEN TO HELP REV ERSE THE NEGATIVE NUTRITION TRENDS. RESEARCH AND PLANNING FOR THE COMMUNITY GARDEN HAD BEE N GOING ON FOR OVER THREE YEARS. THE GROUP FOUND SEVERAL COMMUNITY GARDENS TO BASE A GRAYS ON COUNTY PROGRAM ON INCLUDING ONES IN OWENSBORO AND BOWLING GREEN. EACH GARDENEER WAS ASS IGNED EITHER A 48 SQUARE FOOT OR 80 SQUARE FOOT RAISED BED PLOT TO USE THROUGHOUT THE GROW ING SEASON FOR A NOMINAL FEE. THE HOSPITAL PROVIDED FREE MEETING SPACE TO SEVERAL GROUPS T HROUGHOUT THE YEAR AND SEVERAL CLASSES WERE SPONSORED BY THE HOSPITAL THAT EDUCATED INTERE STED COMMUNITY RESIDENTS ON HEALTH & WELLNESS ISSUES. THEY INCLUDE: A. C.P.R. TO HEALTHCAR E PROVIDERS AND TO THE COMMUNITY B. PREPARED CHILDBIRTH AND BREAST FEEDING CLASSES C. COUN TY-WIDE BABY SHOWER IN GRAYSON COUNTY - PROVIDES INFORMATION TO WOMEN WHO ARE PREGNANT OR WANT TO BECOME PREGNANT D. COMMUNITYWIDE BABY SHOWER IN BRECKINRIDGE COUNTY - PROVIDES INF ORMATION TO WOMEN WHO ARE PREGNANT OR WANT TO BECOME PREGNANT E. SPONSORS THE AMERICAN RED CROSS BLOOD MOBILE TWO OR THREE TIMES EACH YEAR F. PROVIDED HEALTH INFORMATION AT THE REL AY FOR LIFE G. PARTICIPATED IN UNITED WAY MEETNGS UPON REQUEST, THE HOSPITAL ALSO PARTICIP ATES IN LOCAL EDUCATION BY PROVIDING HOSPITAL EMPLOYEES AS SPEAKERS FOR CLASSROOMS OR CIVI C ORGANIZATIONS SUCH AS THE FOLLOWING EXAMPLES: H. PARTICIPATED IN OPERATION PREPARATION I . WRECC SAFETY DAY J. ASSISTED IN PROVIDING TRANSLATION SERVICES K. BEN JOHNSON ELEMENTARY SCHOOL WELLNESS DAY L. PROVIDED SPEAKERS FOR MANY HEALTH FAIRS, SCHOOLS, AND COMMUNITY EV ENTS M. NARCAN TRAINING FOR LEITCHFIELD CITY POLICE AND GRAYSON COUNTY SHERIFF DEPARTMENT N. OPIOID STEWARDSHIP PRESENTATIONS IN ADDITION TO SERVING OUR LOCAL COMMUNITY NEEDS, TLRM C HAS ALSO TAKEN ON MEASURES TO IMPROVE AMERICA. BY PARTICIPATING IN THE CODE GREEN - RECY CLING PROJECT, TLRMC HOPES TO REDUCE WASTE AND IMPROVE THE ENVIRONMENT. TWIN LAKES REGIONA L MEDICAL CENTER'S BOARD OF DIRECTORS HAS PLEDGED TO BUY AMERICAN-MADE PRODUCTS WHEN WE CA N FIND A PRODUCT OF EQUAL OR GREATER QUALITY. TLRMC ENCOURAGES OTHER COMPANIES AND INDIVID UALS TO DO THE SAME.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 3	THE CHIEF EXECUTIVE OFFICER AND CHIEF FINANCIAL OFFICER OF THE HOSPITAL ARE EMPLOYED BY ALLIANT MANAGEMENT SERVICES AND ARE RESPONSIBLE FOR CONTROLLING MANAGEMENT DUTIES.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 6	THE ORGANIZATION HAS STOCKHOLDERS. EACH SHARE OF STOCK IS VALUED AT 25. STOCKHOLDERS MUST BE AT LEAST 18 YEARS OLD AND A RESIDENT OF GRAYSON COUNTY, KENTUCKY.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 7A	NINE MEMBERS OF THE BOARD OF DIRECTORS ARE ELECTED BY THE STOCKHOLDERS AND THE OTHER MEMBER IS THE PRESIDENT OF THE MEDICAL STAFF (WHOM IS VOTED ON BY THE MEDICAL STAFF).

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 11B	THE FORM 990 IS SUBMITTED TO THE GOVERNING BOARD FOR REVIEW AND APPROVAL BEFORE IT IS FILED WITH THE INTERNAL REVENUE SERVICE.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 12C	CORPORATE COMPLIANCE REQUIRES EACH EMPLOYEE AND BOARD MEMBER TO UPDATE AND SIGN OFF ON A CONFLICT OF INTEREST POLICY ON AN ANNUAL BASIS.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 15A	ALLIANT MANAGEMENT SERVICES, ACTING AS THE MANAGEMENT COMPANY, BRINGS COMPARABLE NATIONAL DATA TO THE BOARD OF DIRECTORS FOR THE BOARD TO DETERMINE WHAT COMPENSATION IS TO BE PAID.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 15B	ALLIANT MANAGEMENT SERVICES, ACTING AS THE MANAGEMENT COMPANY, BRINGS COMPARABLE NATIONAL DATA TO THE BOARD OF DIRECTORS FOR THE BOARD TO DETERMINE WHAT COMPENSATION IS TO BE PAID.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 19	GOVERNING DOCUMENTS ARE MADE AVAILABLE UPON REQUEST.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART IX, LINE 24E	MATERIALS MANAGEMENT 1,102,926 0 0 MEDICAL & SURGICAL 1,045,510 0 0 PHYSICAL THERAPY 984,570 0 0 SURGERY 688,889 0 0 EMERGENCY ROOM 563,628 0 0 WOUND CARE 430,338 0 0 RADIOLOGY 370,303 0 0 PAIN MANAGEMENT 216,201 0 0 NUCLEAR MEDICINE 159,994 0 0 PROVIDER BASED CLINICS 154,624 0 0 MRI 136,098 0 0 RESPIRATORY THERAPY 120,300 0 0 OBSTETRICS 116,790 0 0 CT SCANS 111,444 0 0 SLEEP CENTER 104,699 0 0 INTENSIVE CARE 84,360 0 0 ANESTHESIOLOGY 70,255 0 0 INFUSION CENTER 29,149 0 0 SPECIALTY CLINIC 15,318 0 0 CARDIAC 12,921 0 0 USE OF DONATED ITEMS 2,274 0 0 OCCUPATIONAL THERAPY 1,697 0 0 FITNESS CENTER 328 0 0 OCCUPATIONAL MEDICINE 220 0 0 TOTAL 6,522,836 0 0

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SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
GRAYSON COUNTY HOSPITAL FOUNDATION

Employer identification number
61-0523298

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) No
(1)TWIN LAKES MEDICAL FOUNDATION INC 910 WALLACE AVE LEITCHFIELD, KY 42754 61-1269278	MEDICAL PR	KY	501C3	10	GCHF GRAYSON COUNTY HOSPITAL FOUNDATION		No

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1) TWIN LAKES HOME HEALTH AGENCY LLC 901 S HUGH WALLIS ROAD LAFAYETTE, LA 70508 27-1000828	HOME HEALT	LA	N/A	RELATED	81,747	100,671		No			No	25.000 %
(2) TWIN LAKES REGIONAL PAIN MANAGEMENT 908 WALLACE AVE LEITCHFIELD, KY 42754 47-2329929	PAIN MANAG	KY	N/A	RELATED	41,259	296,186		No			No	51.000 %

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No
(1)WTK HOLDINGS INC 910 WALLACE AVE LEITCHFIELD, KY 42754 61-0608823	HOLDING CO	KY	GCHF GRAYSON COUNTY HOSPITAL FOUNDATION	C CORP	104,298	1,962,639	100.000 %		No

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

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

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

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)TWIN LAKES MEDICAL FOUNDATION INC	D	2,868,748	FAIR MARKET VALUE
(2)TWIN LAKES MEDICAL FOUNDATION INC	J	227,501	FAIR MARKET VALUE
(3)TWIN LAKES MEDICAL FOUNDATION INC	L	142,470	FAIR MARKET VALUE
(4)TWIN LAKES MEDICAL FOUNDATION INC	Q	2,498,777	FAIR MARKET VALUE

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) Disproprtionate 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	

Part VII Supplemental Information

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

Return Reference	Explanation