

Form **990**  
Department of the Treasury  
Internal Revenue Service

# Return of Organization Exempt From Income Tax

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

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

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

OMB No. 1545-0047  
**2021**  
Open to Public Inspection

**A** For the 2021 calendar year, or tax year beginning 10-01-2021, and ending 09-30-2022

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

**C** Name of organization  
 BAPTIST MEMORIAL HOSPITAL-  
 GOLDEN TRIANGLE INC  
 Doing business as

Number and street (or P.O. box if mail is not delivered to street address) Room/suite  
 2520 5TH STREET NORTH

City or town, state or province, country, and ZIP or foreign postal code  
 COLUMBUS, MS 39705

**D** Employer identification number  
 62-1519754

**E** Telephone number  
 (662) 244-1500

**F** Name and address of principal officer:  
 JASON M LITTLE  
 350 N HUMPHREYS BLVD  
 MEMPHIS, TN 38120

**G** Gross receipts \$ 236,028,493

**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.BAPTISTONLINE.ORG/LOCATIONS/GOLDEN-TRIANGLE

**K** Form of organization:  Corporation  Trust  Association  Other ▶

**L** Year of formation: 1983 **M** State of legal domicile: MS

## Part I Summary

**1** Briefly describe the organization's mission or most significant activities:  
 BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC. PROVIDES QUALITY HEALTH CARE SERVICES TO THE COMMUNITY REGARDLESS OF RACE, CREED, SEX, NATIONAL ORIGIN, HANDICAP, OR AGE.

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

<b>3</b> Number of voting members of the governing body (Part VI, line 1a)	<b>3</b>	6
<b>4</b> Number of independent voting members of the governing body (Part VI, line 1b)	<b>4</b>	6
<b>5</b> Total number of individuals employed in calendar year 2021 (Part V, line 2a)	<b>5</b>	1,468
<b>6</b> Total number of volunteers (estimate if necessary)	<b>6</b>	55
<b>7a</b> Total unrelated business revenue from Part VIII, column (C), line 12	<b>7a</b>	0
<b>7b</b> Net unrelated business taxable income from Form 990-T, Part I, line 11	<b>7b</b>	0

	Prior Year	Current Year
<b>8</b> Contributions and grants (Part VIII, line 1h)	103,750	8,496,742
<b>9</b> Program service revenue (Part VIII, line 2g)	222,433,824	223,527,256
<b>10</b> Investment income (Part VIII, column (A), lines 3, 4, and 7d)	44,233	24,895
<b>11</b> Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	4,086,657	3,979,600
<b>12</b> Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	226,668,464	236,028,493
<b>13</b> Grants and similar amounts paid (Part IX, column (A), lines 1–3)	187,100	297,901
<b>14</b> Benefits paid to or for members (Part IX, column (A), line 4)	0	0
<b>15</b> Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	78,107,702	80,463,871
<b>16a</b> Professional fundraising fees (Part IX, column (A), line 11e)	0	0
<b>b</b> Total fundraising expenses (Part IX, column (D), line 25) ▶ 0		
<b>17</b> Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	124,474,129	135,048,108
<b>18</b> Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	202,768,931	215,809,880
<b>19</b> Revenue less expenses. Subtract line 18 from line 12	23,899,533	20,218,613

	Beginning of Current Year	End of Year
<b>20</b> Total assets (Part X, line 16)	268,427,008	260,175,338
<b>21</b> Total liabilities (Part X, line 26)	46,787,290	18,158,082
<b>22</b> Net assets or fund balances. Subtract line 21 from line 20	221,639,718	242,017,256

## Part II Signature Block

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

**Sign Here**

Signature of officer: JASON M LITTLE PRESIDENT  
 Date: 2023-08-14

**Paid Preparer Use Only**

Print/Type preparer's name: DELOITTE TAX LLP  
 Preparer's signature: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Check  if self-employed  
 PTIN: P01222873  
 Firm's EIN: ▶ 86-1065772  
 Firm's address: ▶ 111 MONUMENT CIRCLE SUITE 4200 INDIANAPOLIS, IN 462045108  
 Phone no. (317) 464-8600

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:

BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC. PROVIDES QUALITY MEDICAL HEALTH CARE SERVICES TO THE COMMUNITY REGARDLESS OF RACE, CREED, SEX, NATIONAL ORIGIN, HANDICAP, OR AGE.

**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 \$ 200,095,591 including grants of \$ 297,901 ) (Revenue \$ 226,605,307 )  
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 ▶ 200,095,591

Part IV Checklist of Required Schedules

Table with 3 columns: Question ID, Question Text, and Yes/No response columns. Rows include questions 1 through 21 regarding organizational requirements and reporting.

Part IV Checklist of Required Schedules (continued)

Table with 3 columns: Question, Yes, No. Rows 22-38 covering various organizational requirements and schedules.

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 [checked]

Table with 3 columns: Question, Yes, No. Rows 1a, 1b, 1c regarding Form 1096, Forms W-2G, and backup withholding rules.

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

Table with 5 main columns: Question ID, Question Text, Answer Field, Yes/No, and other. Rows include questions 2a through 17 regarding employee reporting, federal employment tax returns, business income, foreign accounts, prohibited transactions, charitable contributions, and various organizational requirements.

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

Table with 3 columns: Question, Yes, No. Rows include: 1a (6), 1b (6), 2, 3, 4, 5, 6, 7a, 7b, 8a, 8b, 9.

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

Table with 3 columns: Question, Yes, No. Rows include: 10a, 10b, 11a, 11b, 12a, 12b, 12c, 13, 14, 15a, 15b, 16a, 16b.

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 (1024 or 1024-A, if applicable), 990, and 990-T (section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
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:
THOMAS STEADMAN 2520 5TH STREET NORTH COLUMBUS, MS 39705 (662) 244-2568

**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 the 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, Form 1099-MISC, and/or box 1 of Form 1099-NEC) of more than \$100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, or highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.

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

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

(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/1099-NEC)	(E) Reportable compensation from related organizations (W-2/1099-MISC/1099-NEC)	(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) ALLEGRA BRIGHAM CHAIRMAN	0.23 ..... 0.20	X						0	0	0
(2) ALLEN B PUCKETT III DIRECTOR	0.23 ..... 0.95	X						0	0	0
(3) DENNIS ERBY DIRECTOR	0.23 ..... 0.00	X						0	0	0
(4) DON DAVIS DIRECTOR	0.23 ..... 0.00	X						0	0	0
(5) JEFF FARNHAM DIRECTOR	0.23 ..... 0.75	X						0	0	0
(6) MIKE WATERS DIRECTOR	0.23 ..... 0.00	X						0	0	0
(7) JASON M LITTLE PRESIDENT	0.23 ..... 39.77			X				0	3,403,662	97,789
(8) PAUL D DEPRIEST MD VICE PRESIDENT	0.23 ..... 39.77			X				0	2,006,787	84,638
(9) GREGORY M DUCKETT SECRETARY	0.23 ..... 39.77			X				0	1,562,524	80,090
(10) EDWIN P CADE CEO	40.00 ..... 0.00			X				0	415,808	93,711
(11) JAMES MARTIN MD CMO	40.00 ..... 0.00			X				416,819	0	55,888
(12) ALICIA C GRANT CHIEF NURSING OFFICER (AS OF 01/22)	40.00 ..... 0.00			X				160,612	0	47,923
(13) THOMAS STEADMAN CFO	40.00 ..... 0.00			X				149,595	0	23,979
(14) JAYCE D MISKEL PHYSICIAN	40.00 ..... 0.00					X		413,839	0	57,083
(15) SALEEM A ALI MD PHYSICIAN	40.00 ..... 0.00					X		368,765	0	47,727
(16) VANESSA LAFAYETTE REGISTERED NURSE	40.00 ..... 0.00					X		193,970	0	44,399
(17) DEBORAH K SEELY CLINICAL RESOURCE NURSE	40.00 ..... 0.00					X		193,774	0	14,138

**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/1099-NEC)	(E) Reportable compensation from related organizations (W-2/1099-MISC/1099-NEC)	(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			
(18) CHRISTOPHER LEBRUN ..... DIRECTOR-RESIDENCY PROGRAM	40.00 ..... 0.00					X		189,234	0	0
(19) ASHLEY HARRIS ..... FORMER CMO	0.00 ..... 40.00						X	0	447,895	48,237
(20) MARY E SUMRALL ..... FORMER CHIEF NURSING OFFICER	0.00 ..... 40.00						X	64,947	138,360	70,595
<b>1b Sub-Total</b> . . . . .										
<b>c Total from continuation sheets to Part VII, Section A</b> . . . . .										
<b>d Total (add lines 1b and 1c)</b> . . . . .								2,151,555	7,975,036	766,197

**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 ▶ 61

	Yes	No
<b>3</b> Did the organization list any <b>former</b> officer, director or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i> . . . . .	3 Yes	
<b>4</b> For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? <i>If "Yes," complete Schedule J for such individual</i> . . . . .	4 Yes	
<b>5</b> Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? <i>If "Yes," complete Schedule J for such person</i> . . . . .	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
COLUMBUS ANESTHESIA ASSOCIATES PO BOX 8055 COLUMBUS, MS 39705	ANESTHESIA SERVICES	2,242,827
MORRISON MANAGEMENT SPECIALISTS INC PO BOX 102289 ATLANTA, GA 30368	MANAGEMENT SERVICES	1,685,063
JMORGAN COMPANY PO BOX 9533 COLUMBUS, MS 39705	MAINTENANCE SERVICES	1,058,408
MIDSOUTH PICCS LLC 432 HIGHWAY 72 W 3 COLLIERVILLE, TN 38017	PROFESSIONAL SERVICES	459,893
COLUMBUS ORTHOPAEDIC CLINIC 670 LEIGH DR COLUMBUS, MS 39705	PHYSICIAN SERVICES	430,700

**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 ▶ 22

**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	
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<b>1a</b> Federated campaigns . . . . .	<b>1a</b>					
	<b>b</b> Membership dues . . . . .	<b>1b</b>					
	<b>c</b> Fundraising events . . . . .	<b>1c</b>					
	<b>d</b> Related organizations	<b>1d</b>	181,724				
	<b>e</b> Government grants (contributions)	<b>1e</b>	8,315,018				
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above	<b>1f</b>					
	<b>g</b> Noncash contributions included in lines 1a - 1f:\$	<b>1g</b>					
	<b>h Total.</b> Add lines 1a-1f . . . . .			8,496,742			
	<b>Program Service Revenue</b>						
<b>Program Service Revenue</b>	<b>2a</b> PATIENT SERVICE REV.	Business Code					
		622110	223,527,249	223,527,249			
	<b>b</b> RENT FROM AFFILIATES	900099	7	7			
	<b>c</b>						
	<b>d</b>						
	<b>e</b>						
	<b>f</b> All other program service revenue.						
<b>g Total.</b> Add lines 2a-2f. . . . .		223,527,256					
<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts) . . . . .		23,395			23,395	
	<b>4</b> Income from investment of tax-exempt bond proceeds						
	<b>5</b> Royalties . . . . .						
	<b>6a</b> Gross rents	(i) Real	165,183				
		(ii) Personal					
		<b>b</b> Less: rental expenses	0				
		<b>c</b> Rental income or (loss)	165,183				
	<b>d</b> Net rental income or (loss) . . . . .		165,183			165,183	
	<b>7a</b> Gross amount from sales of assets other than inventory	(i) Securities			1,500		
		(ii) Other					
		<b>b</b> Less: cost or other basis and sales expenses			0		
		<b>c</b> Gain or (loss)			1,500		
	<b>d</b> Net gain or (loss) . . . . .		1,500			1,500	
	<b>8a</b> Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18 . . . . .						
		<b>b</b> Less: direct expenses . . . . .					
<b>c</b> Net income or (loss) from fundraising events . . . . .							
<b>9a</b> Gross income from gaming activities. See Part IV, line 19 . . . . .							
	<b>b</b> Less: direct expenses . . . . .						
	<b>c</b> Net income or (loss) from gaming activities . . . . .						
<b>10a</b> Gross sales of inventory, less returns and allowances . . . . .							
	<b>b</b> Less: cost of goods sold . . . . .						
	<b>c</b> Net income or (loss) from sales of inventory . . . . .						
<b>Miscellaneous Revenue</b>		<b>Business Code</b>					
<b>11a</b> MINORITY INTEREST		621400	1,897,553	1,897,553			
<b>b</b> OTHER OPERATING REV.		900099	1,180,498	1,180,498			
<b>c</b> CAFETERIA REVENUE		722514	736,366	0	736,366		
<b>d</b> All other revenue . . . . .							
<b>e Total.</b> Add lines 11a-11d . . . . .			3,814,417				
<b>12 Total revenue.</b> See instructions . . . . .			236,028,493	226,605,307	0	926,444	

**Part IX Statement of Functional Expenses**

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 . . . . .	297,901	297,901		
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22 . . . . .				
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16. . . . .				
<b>4</b> Benefits paid to or for members . . . . .				
<b>5</b> Compensation of current officers, directors, trustees, and key employees . . . . .	928,221	835,399	92,822	
<b>6</b> Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) . . . . .				
<b>7</b> Other salaries and wages . . . . .	64,328,155	57,895,340	6,432,815	
<b>8</b> Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions) . . . . .	1,601,761	1,441,585	160,176	
<b>9</b> Other employee benefits . . . . .	8,893,835	8,004,451	889,384	
<b>10</b> Payroll taxes . . . . .	4,711,899	4,240,709	471,190	
<b>11</b> Fees for services (non-employees):				
<b>a</b> Management . . . . .				
<b>b</b> Legal . . . . .				
<b>c</b> Accounting . . . . .				
<b>d</b> Lobbying . . . . .	23,536		23,536	
<b>e</b> Professional fundraising services. See Part IV, line 17				
<b>f</b> Investment management fees . . . . .				
<b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	23,133,955	20,820,560	2,313,395	
<b>12</b> Advertising and promotion . . . . .	434,472	391,025	43,447	
<b>13</b> Office expenses . . . . .	5,482,555	4,934,300	548,255	
<b>14</b> Information technology . . . . .				
<b>15</b> Royalties . . . . .				
<b>16</b> Occupancy . . . . .	3,573,631	3,216,268	357,363	
<b>17</b> Travel . . . . .	77,529	31,012	46,517	
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials . . . . .				
<b>19</b> Conferences, conventions, and meetings . . . . .	40,477	16,191	24,286	
<b>20</b> Interest . . . . .	205,533	184,980	20,553	
<b>21</b> Payments to affiliates . . . . .				
<b>22</b> Depreciation, depletion, and amortization . . . . .	5,582,787	5,024,508	558,279	
<b>23</b> Insurance . . . . .	2,783,638	2,505,273	278,365	
<b>24</b> Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
<b>a</b> MEDICAL SUPPLIES	57,932,882	57,932,882	0	
<b>b</b> CORPORATE MGMT FEE	16,256,628	14,630,965	1,625,663	
<b>c</b> CORPORATE ALLOCATIONS	10,066,368	9,059,731	1,006,637	
<b>d</b> REPAIRS AND MAINTENANCE	5,327,261	4,794,535	532,726	
<b>e</b> All other expenses	4,126,856	3,837,976	288,880	
<b>25</b> Total functional expenses. Add lines 1 through 24e	215,809,880	200,095,591	15,714,289	0
<b>26</b> Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

**Part X Balance Sheet**

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

		(A) Beginning of year		(B) End of year
<b>Assets</b>	<b>1</b> Cash—non-interest-bearing . . . . .	3,600	<b>1</b>	3,700
	<b>2</b> Savings and temporary cash investments . . . . .	3,356,313	<b>2</b>	2,311,568
	<b>3</b> Pledges and grants receivable, net . . . . .		<b>3</b>	
	<b>4</b> Accounts receivable, net . . . . .	27,959,820	<b>4</b>	25,524,311
	<b>5</b> Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons		<b>5</b>	
	<b>6</b> Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B) . . . . .		<b>6</b>	
	<b>7</b> Notes and loans receivable, net . . . . .		<b>7</b>	
	<b>8</b> Inventories for sale or use . . . . .	6,430,867	<b>8</b>	7,063,534
	<b>9</b> Prepaid expenses and deferred charges . . . . .	2,986,702	<b>9</b>	3,737,083
	<b>10a</b> Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	<b>10a</b> 196,314,613		
	<b>b</b> Less: accumulated depreciation	<b>10b</b> 125,711,236	69,837,091	<b>10c</b> 70,603,377
	<b>11</b> Investments—publicly traded securities . . . . .		<b>11</b>	
	<b>12</b> Investments—other securities. See Part IV, line 11 . . . . .	16,678,698	<b>12</b>	16,667,453
	<b>13</b> Investments—program-related. See Part IV, line 11 . . . . .		<b>13</b>	
	<b>14</b> Intangible assets . . . . .		<b>14</b>	
	<b>15</b> Other assets. See Part IV, line 11 . . . . .	141,173,917	<b>15</b>	134,264,312
<b>16 Total assets.</b> Add lines 1 through 15 (must equal line 33) . . . . .	268,427,008	<b>16</b>	260,175,338	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses . . . . .	11,882,058	<b>17</b>	12,715,014
	<b>18</b> Grants payable . . . . .		<b>18</b>	
	<b>19</b> Deferred revenue . . . . .		<b>19</b>	
	<b>20</b> Tax-exempt bond liabilities . . . . .		<b>20</b>	
	<b>21</b> Escrow or custodial account liability. Complete Part IV of Schedule D		<b>21</b>	
	<b>22</b> Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons . . . . .		<b>22</b>	
	<b>23</b> Secured mortgages and notes payable to unrelated third parties . . . . .		<b>23</b>	
	<b>24</b> Unsecured notes and loans payable to unrelated third parties . . . . .		<b>24</b>	
	<b>25</b> Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24). Complete Part X of Schedule D	34,905,232	<b>25</b>	5,443,068
	<b>26 Total liabilities.</b> Add lines 17 through 25 . . . . .	46,787,290	<b>26</b>	18,158,082
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33.</b>			
	<b>27</b> Net assets without donor restrictions . . . . .	221,639,718	<b>27</b>	242,017,256
	<b>28</b> Net assets with donor restrictions . . . . .		<b>28</b>	
	<b>Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> and complete lines 29 through 33.</b>			
	<b>29</b> Capital stock or trust principal, or current funds . . . . .		<b>29</b>	
	<b>30</b> Paid-in or capital surplus, or land, building or equipment fund . . . . .		<b>30</b>	
	<b>31</b> Retained earnings, endowment, accumulated income, or other funds		<b>31</b>	
<b>32</b> Total net assets or fund balances . . . . .	221,639,718	<b>32</b>	242,017,256	
<b>33</b> Total liabilities and net assets/fund balances . . . . .	268,427,008	<b>33</b>	260,175,338	

**Part XI Reconciliation of Net Assets**

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

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	236,028,493
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	215,809,880
<b>3</b>	Revenue less expenses. Subtract line 2 from line 1	<b>3</b>	20,218,613
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	<b>4</b>	221,639,718
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	158,925
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	0
<b>10</b>	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	<b>10</b>	242,017,256

**Part XII Financial Statements and Reporting**

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

- 1** Accounting method used to prepare the Form 990:  Cash  Accrual  Other \_\_\_\_\_  
 If the organization changed its method of accounting from a prior year or checked "Other," explain on Schedule O.
- 2a** Were the organization's financial statements compiled or reviewed by an independent accountant?  
 If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both:  
 Separate basis  Consolidated basis  Both consolidated and separate basis
- b** Were the organization's financial statements audited by an independent accountant?  
 If 'Yes,' check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both:  
 Separate basis  Consolidated basis  Both consolidated and separate basis
- c** If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?  
 If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.
- 3a** As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?
- b** If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits.

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

# Additional Data

**Software ID:**

**Software Version:**

**EIN:** 62-1519754

**Name:** BAPTIST MEMORIAL HOSPITAL-  
GOLDEN TRIANGLE INC

Form 990 (2021)

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

BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC. PROVIDES QUALITY MEDICAL HEALTH CARE REGARDLESS OF RACE, CREED, SEX, NATIONAL ORIGIN, HANDICAP, OR AGE. ALTHOUGH REIMBURSEMENT FOR SERVICES RENDERED IS CRITICAL TO THE OPERATION AND STABILITY OF BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC., IT IS RECOGNIZED THAT NOT ALL INDIVIDUALS POSSESS THE ABILITY TO PURCHASE ESSENTIAL MEDICAL SERVICES, AND FURTHER, THAT OUR MISSION IS TO SERVE THE COMMUNITY WITH RESPECT TO PROVIDING HEALTH CARE SERVICES AND HEALTH CARE EDUCATION. THEREFORE, IN KEEPING WITH ITS COMMITMENT TO SERVE ALL MEMBERS OF ITS COMMUNITY, BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC. PROVIDES THE FOLLOWING:- FREE CARE AND/OR SUBSIDIZED CARE WHERE THE NEED AND/OR AN INDIVIDUAL'S INABILITY TO PAY COEXIST, - CARE PROVIDED TO PERSONS COVERED BY GOVERNMENTAL PROGRAMS AT BELOW COST, AND- HEALTH ACTIVITIES AND PROGRAMS TO SUPPORT THE COMMUNITY.THESE ACTIVITIES INCLUDE WELLNESS PROGRAMS, COMMUNITY EDUCATION PROGRAMS, PROGRAMS FOR THE ELDERLY, HANDICAPPED, MEDICALLY UNDERSERVED, AND A VARIETY OF BROAD COMMUNITY SUPPORT ACTIVITIES.BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC. SERVICED 9,393 INPATIENTS, AND PROVIDED MORE THAN 136,693 OUTPATIENT SERVICES DURING THE FISCAL YEAR ENDED SEPTEMBER 30, 2022.DURING THE FISCAL YEAR ENDED SEPTEMBER 30, 2022, BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC.'S PROGRAM SERVICES PRODUCED THE FOLLOWING RESULTS:- THE SKILLED NURSING DEPARTMENT HAD 38,791 PATIENT DAYS AT A COST OF \$22,133,819. - THE LABORATORY DEPARTMENT PERFORMED 567,861 PROCEDURES AT A COST OF \$9,176,718. - THE RADIOLOGY DEPARTMENT PERFORMED 110,888 PROCEDURES AT A COST OF \$7,920,036.- THE EMERGENCY ROOM HAD 58,593 PATIENT VISITS AT A COST OF \$10,041,971.BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC. PROVIDES CARE TO PERSONS COVERED BY GOVERNMENTAL PROGRAMS FROM WHICH THE HOSPITAL RECEIVES PAYMENT AT LESS THAN MARKET VALUE REIMBURSEMENT. RECOGNIZING ITS MISSION TO THE COMMUNITY, SERVICES ARE PROVIDED TO BOTH MEDICARE AND MEDICAID PATIENTS. TO THE EXTENT REIMBURSEMENT IS BELOW COST, BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC. RECOGNIZES THESE AMOUNTS AS CHARITY CARE IN MEETING ITS MISSION TO THE ENTIRE COMMUNITY. DURING THE FISCAL YEAR ENDED SEPTEMBER 30, 2022, THE UNREIMBURSED VALUE OF PROVIDING CARE TO THESE PATIENTS WAS \$554,053,590.CHARITY CARE IS ALSO PROVIDED THROUGH MANY REDUCED PRICE SERVICES AND FREE PROGRAMS OFFERED THROUGHOUT THE YEAR BASED UPON ACTIVITIES AND SERVICES WHICH BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC. BELIEVES WILL SERVE A BONA FIDE COMMUNITY HEALTH NEED.BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC. HAS PROVIDED A NUMBER OF SERVICES IN THE COMMUNITY SUCH AS:- BONE DENSITY SCREENINGS- DIABETES SUPPORT GROUP- CANCER SUPPORT GROUP- FREE KIDNEY SCREENINGS- FREE FLU SHOT EVENT FOR THE COMMUNITY- FREE BONE DENSITY SCREENINGS FOR THE COMMUNITY- FREE DIABETES SCREENINGS- FREE MONTHLY PSA SCREENINGS FOR MEN OVER 40- BACK TO SCHOOL HEALTH FAIR (STRESSING BACKPACK SAFETY)- FREE BLOOD PRESSURE CHECKS AND SCREENINGS AT AREA BUSINESSES- QUARTERLY BLOOD DRIVES- FREE SPORTS PHYSICALS FOR AREA ATHLETES- SPEAKERS FOR VARIOUS EVENTS- FREE BABY FAIR INCLUDING LABOR AND DELIVERY TOUR - RELAY FOR LIFE - AMERICAN CANCER SOCIETY (LOWNDES AND OKTIBBEHA COUNTIES)- OTHER ACS EVENTS SUCH AS BOOTS AND BLING- BREAST CANCER AWARENESS KICK-OFF - PINK LEMONADE AND COOKIES RECEPTION- PINK DOG WALK ON MSU CAMPUS FOR BREAST CANCER AWARENESS- FREE COMMUNITY SCREENINGS IN UNDERSERVED AREAS SUCH AS HAMILTON, BROOKSVILLE AND CRAWFORD, MISSISSIPPI.- FREE COMMUNITY EDUCATION PROGRAMS ADDRESSING ISSUES SUCH AS: HEALTHY EATING, HOLIDAY DEPRESSION, ALZHEIMER'S DISEASE, COLON CANCER, SKIN CANCER, BPH, AND DOMESTIC VIOLENCE.BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC. FEELS THAT ITS PEOPLE ARE ITS MOST VALUABLE ASSET. TO SHARE THIS ASSET WITH THE COMMUNITY AT LARGE, ALL PERSONNEL ARE ENCOURAGED TO GET INVOLVED BY VOLUNTEERING. BELOW IS A PARTIAL LISTING OF ORGANIZATIONS AND ACTIVITIES THAT BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC. SUPPORTED THROUGH ITS VOLUNTEER EFFORTS:- UNITED WAY 9/11 DAY OF SERVICE- COLUMBUS MUNICIPAL SCHOOLS- LOWNDES COUNTY SCHOOLS- HERITAGE ACADEMY- ANNUNCIATION CATHOLIC SCHOOLS- LOWNDES COUNTY PUBLIC SCHOOLS- AMERICAN RED CROSS- COLUMBUS CHAMBER OF COMMERCE- MISSISSIPPI UNIVERSITY FOR WOMEN (PASSPORT TO WELLNESS, LIFE ENRICHMENT PROGRAMS, NURSING PROGRAMS)- LOWNDES YOUNG LEADERS- PINK DAWG WALK AT MSU - AWARENESS EVENT FOR AMERICAN CANCER SOCIETY- SALLY KATE WINTERS HOME FOR CHILDREN- COLUMBUS BOYS AND GIRLS CLUB- GOOD SAMARITAN CLINIC FOR UNDERSERVED AND HOMELESS- NORTH MISSISSIPPI TRAUMA SYSTEM- COLUMBUS AIR FORCE BASE (ANTI-SMOKING PROGRAMS, PILOT PARTNER CLASS, COMMUNITY COALITION INITIATIVE)- COMMUNITY CPR CLASSES- CPR AND FIRST AID CLASSES- DIABETIC EDUCATION CLASS/SUPPORT GROUP- AMERICAN HEART ASSOCIATION- AMERICAN CANCER SOCIETY- MARCH OF DIMES- LOWNDES COUNTY UNITED WAY- GIRL SCOUTS OF THE MIDSOUTH- COLUMBUS KIWANIS CLUB, ROTARY CLUB, LIONS CLUB- SAFEHAVEN SHELTER FOR BATTERED WOMEN AND THEIR CHILDREN- BOY SCOUTS OF AMERICA- BOYS AND GIRLS CLUBS OF COLUMBUS- ALZHEIMER'S ASSOCIATIONBAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC. ALSO CONTRIBUTED TO NUMEROUS OTHER HELPFUL ORGANIZATIONS AND ACTIVITIES THROUGH DONATED USE OF HOSPITAL FACILITIES INCLUDING:- MISSISSIPPI UNIVERSITY FOR WOMEN NURSING STUDENTS- CONTACT HELPLINE - SUICIDE PREVENTION HOTLINE- SAFEHAVEN SHELTER SUPPORT GROUP- ALCOHOLICS ANONYMOUS- UNITED WAY OF LOWNDES COUNTY (CAMPAIGN KICK-OFF BREAKFAST)- VOLUNTEER CHAPLAIN'S BREAKFAST (MONTHLY)- GOLDEN TRIANGLE FOUNDATION- AMERICAN HEART ASSOCIATION HEART WALK MEETINGS- COMMUNITY EDUCATION PROGRAMS- MARCH OF DIMES- MULTIPLE SCLEROSIS- COMMUNITY CPR COURSES- COLUMBUS LOWNDES CHAMBER OF COMMERCE- ACS RELAY FOR LIFE- ACLS/PALS CLASSES

**SCHEDULE A**  
**(Form 990)**

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

OMB No. 1545-0047

**2021**

**Open to Public Inspection**

Name of the organization BAPTIST MEMORIAL HOSPITAL- GOLDEN TRIANGLE INC	Employer identification number 62-1519754
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**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).)
- 3  A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- 4  A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state:
  
- 5  An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)
- 6  A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- 7  An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
- 8  A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
- 9  An agricultural research organization described in **170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture. See instructions. Enter the name, city, and state of the college or university:
- 10  An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)
- 11  An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**
- 12  An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box on lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.
  - a  **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**
  - b  **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**
  - c  **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**
  - d  **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**
  - e  Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.
  - f Enter the number of supported organizations . . . . . \_\_\_\_\_
- g Provide the following information about the supported organization(s).

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

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

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ▶	(a) 2017	(b) 2018	(c) 2019	(d) 2020	(e) 2021	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grant.") . . .						
<b>2</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . . .						
<b>3</b> The value of services or facilities furnished by a governmental unit to the organization without charge..						
<b>4 Total.</b> Add lines 1 through 3						
<b>5</b> 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) . . .						
<b>6 Public support.</b> Subtract line 5 from line 4.						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ▶	(a) 2017	(b) 2018	(c) 2019	(d) 2020	(e) 2021	(f) Total
<b>7</b> Amounts from line 4. . .						
<b>8</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . . .						
<b>9</b> Net income from unrelated business activities, whether or not the business is regularly carried on. . .						
<b>10</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.). . .						
<b>11 Total support.</b> Add lines 7 through 10						
<b>12</b> Gross receipts from related activities, etc. (see instructions) . . . . .					<b>12</b>	
<b>13 First 5 years.</b> If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and <b>stop here</b> . . . . . ▶ <input type="checkbox"/>						

**Section C. Computation of Public Support Percentage**

<b>14</b> Public support percentage for 2021 (line 6, column (f) divided by line 11, column (f)) . . . . .	<b>14</b>	
<b>15</b> Public support percentage for 2020 Schedule A, Part II, line 14 . . . . .	<b>15</b>	
<b>16a 33 1/3% support test—2021.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization . . . . . ▶ <input type="checkbox"/>		
<b>b 33 1/3% support test—2020.</b> If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization . . . . . ▶ <input type="checkbox"/>		
<b>17a 10%-facts-and-circumstances test—2021.</b> If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ <input type="checkbox"/>		
<b>b 10%-facts-and-circumstances test—2020.</b> If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ <input type="checkbox"/>		
<b>18 Private foundation.</b> If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions . . . . . ▶ <input type="checkbox"/>		

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

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

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ►		(a) 2017	(b) 2018	(c) 2019	(d) 2020	(e) 2021	(f) Total
<b>1</b>	Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .						
<b>2</b>	Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
<b>3</b>	Gross receipts from activities that are not an unrelated trade or business under section 513 . . . . .						
<b>4</b>	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . .						
<b>5</b>	The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>6</b>	<b>Total.</b> Add lines 1 through 5						
<b>7a</b>	Amounts included on lines 1, 2, and 3 received from disqualified persons						
<b>b</b>	Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year.						
<b>c</b>	Add lines 7a and 7b. . . . .						
<b>8</b>	<b>Public support.</b> (Subtract line 7c from line 6.)						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►		(a) 2017	(b) 2018	(c) 2019	(d) 2020	(e) 2021	(f) Total
<b>9</b>	Amounts from line 6. . . . .						
<b>10a</b>	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . .						
<b>b</b>	Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975.						
<b>c</b>	Add lines 10a and 10b.						
<b>11</b>	Net income from unrelated business activities not included on line 10b, whether or not the business is regularly carried on.						
<b>12</b>	Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) . . . . .						
<b>13</b>	<b>Total support.</b> (Add lines 9, 10c, 11, and 12.) . . . . .						

**14 First 5 years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here.** . . . . .

**Section C. Computation of Public Support Percentage**

<b>15</b>	Public support percentage for 2021 (line 8, column (f) divided by line 13, column (f)) . . . . .	<b>15</b>	
<b>16</b>	Public support percentage from 2020 Schedule A, Part III, line 15 . . . . .	<b>16</b>	

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

<b>17</b>	Investment income percentage for <b>2021</b> (line 10c, column (f) divided by line 13, column (f)) . . . . .	<b>17</b>	
<b>18</b>	Investment income percentage from <b>2020</b> Schedule A, Part III, line 17 . . . . .	<b>18</b>	

**19a 33 1/3% support tests—2021.** 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—2020.** 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 box 12a, of Part I, complete Sections A and B. If you checked box 12b, of Part I, complete Sections A and C. If you checked box 12c, of Part I, complete Sections A, D, and E. If you checked box 12d, of Part I, complete Sections A and D, and complete Part V.)

**Section A. All Supporting Organizations**

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

**Part IV Supporting Organizations** (continued)

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

**Section B. Type I Supporting Organizations**

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

**Section C. Type II Supporting Organizations**

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

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

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

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

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

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

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

<b>Section A - Adjusted Net Income</b>		(A) Prior Year	(B) Current Year (optional)
<b>1</b>	Net short-term capital gain	<b>1</b>	
<b>2</b>	Recoveries of prior-year distributions	<b>2</b>	
<b>3</b>	Other gross income (see instructions)	<b>3</b>	
<b>4</b>	Add lines 1 through 3	<b>4</b>	
<b>5</b>	Depreciation and depletion	<b>5</b>	
<b>6</b>	Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	<b>6</b>	
<b>7</b>	Other expenses (see instructions)	<b>7</b>	
<b>8</b>	<b>Adjusted Net Income</b> (subtract lines 5, 6 and 7 from line 4)	<b>8</b>	
<b>Section B - Minimum Asset Amount</b>		(A) Prior Year	(B) Current Year (optional)
<b>1</b>	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):	<b>1</b>	
<b>a</b>	Average monthly value of securities	<b>1a</b>	
<b>b</b>	Average monthly cash balances	<b>1b</b>	
<b>c</b>	Fair market value of other non-exempt-use assets	<b>1c</b>	
<b>d</b>	<b>Total</b> (add lines 1a, 1b, and 1c)	<b>1d</b>	
<b>e</b>	<b>Discount</b> claimed for blockage or other factors ( <i>explain in detail in Part VI</i> ):		
<b>2</b>	Acquisition indebtedness applicable to non-exempt use assets	<b>2</b>	
<b>3</b>	Subtract line 2 from line 1d	<b>3</b>	
<b>4</b>	Cash deemed held for exempt use. Enter 0.015 of line 3 (for greater amount, see instructions).	<b>4</b>	
<b>5</b>	Net value of non-exempt-use assets (subtract line 4 from line 3)	<b>5</b>	
<b>6</b>	Multiply line 5 by 0.035	<b>6</b>	
<b>7</b>	Recoveries of prior-year distributions	<b>7</b>	
<b>8</b>	<b>Minimum Asset Amount</b> (add line 7 to line 6)	<b>8</b>	
<b>Section C - Distributable Amount</b>			Current Year
<b>1</b>	Adjusted net income for prior year (from Section A, line 8, Column A)	<b>1</b>	
<b>2</b>	Enter 85% of line 1	<b>2</b>	
<b>3</b>	Minimum asset amount for prior year (from Section B, line 8, Column A)	<b>3</b>	
<b>4</b>	Enter greater of line 2 or line 3	<b>4</b>	
<b>5</b>	Income tax imposed in prior year	<b>5</b>	
<b>6</b>	<b>Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	<b>6</b>	
<b>7</b>	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)		

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

<b>Section D - Distributions</b>		<b>Current Year</b>
<b>1</b> Amounts paid to supported organizations to accomplish exempt purposes	<b>1</b>	
<b>2</b> Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	<b>2</b>	
<b>3</b> Administrative expenses paid to accomplish exempt purposes of supported organizations	<b>3</b>	
<b>4</b> Amounts paid to acquire exempt-use assets	<b>4</b>	
<b>5</b> Qualified set-aside amounts ( <i>prior IRS approval required - provide details in Part VI</i> )	<b>5</b>	
<b>6</b> Other distributions ( <i>describe in Part VI</i> ). See instructions	<b>6</b>	
<b>7 Total annual distributions.</b> Add lines 1 through 6.	<b>7</b>	
<b>8</b> Distributions to attentive supported organizations to which the organization is responsive ( <i>provide details in Part VI</i> ). See instructions	<b>8</b>	
<b>9</b> Distributable amount for 2021 from Section C, line 6	<b>9</b>	
<b>10</b> Line 8 amount divided by Line 9 amount	<b>10</b>	

<b>Section E - Distribution Allocations</b> (see instructions)	<b>(i) Excess Distributions</b>	<b>(ii) Underdistributions Pre-2021</b>	<b>(iii) Distributable Amount for 2021</b>
<b>1</b> Distributable amount for 2021 from Section C, line 6			
<b>2</b> Underdistributions, if any, for years prior to 2021 (reasonable cause required-- <i>explain in Part VI</i> ). See instructions.			
<b>3</b> Excess distributions carryover, if any, to 2021:			
<b>a</b> From 2016. . . . .			
<b>b</b> From 2017. . . . .			
<b>c</b> From 2018. . . . .			
<b>d</b> From 2019. . . . .			
<b>e</b> From 2020. . . . .			
<b>f Total</b> of lines 3a through e			
<b>g</b> Applied to underdistributions of prior years			
<b>h</b> Applied to 2021 distributable amount			
<b>i</b> Carryover from 2016 not applied (see instructions)			
<b>j</b> Remainder. Subtract lines 3g, 3h, and 3i from line 3f.			
<b>4</b> Distributions for 2021 from Section D, line 7:			
\$			
<b>a</b> Applied to underdistributions of prior years			
<b>b</b> Applied to 2021 distributable amount			
<b>c</b> Remainder. Subtract lines 4a and 4b from line 4.			
<b>5</b> Remaining underdistributions for years prior to 2021, if any. Subtract lines 3g and 4a from line 2. If the amount is greater than zero, <i>explain in Part VI</i> . See instructions.			
<b>6</b> Remaining underdistributions for 2021. Subtract lines 3h and 4b from line 1. If the amount is greater than zero, <i>explain in Part VI</i> . See instructions.			
<b>7 Excess distributions carryover to 2022.</b> Add lines 3j and 4c.			
<b>8</b> Breakdown of line 7:			
<b>a</b> Excess from 2017. . . . .			
<b>b</b> Excess from 2018. . . . .			
<b>c</b> Excess from 2019. . . . .			
<b>d</b> Excess from 2020. . . . .			
<b>e</b> Excess from 2021. . . . .			

**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).

<b>Facts And Circumstances Test</b>

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

**Political Campaign and Lobbying Activities**  
**For Organizations Exempt From Income Tax Under section 501(c) and section 527**  
**▶Complete if the organization is described below. ▶Attach to Form 990 or Form 990-EZ.**  
**▶Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.**

OMB No. 1545-0047  
**2021**  
**Open to Public Inspection**

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

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

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

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

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

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

Name of the organization BAPTIST MEMORIAL HOSPITAL- GOLDEN TRIANGLE INC	Employer identification number 62-1519754
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**Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.**

**1** Provide a description of the organization's direct and indirect political campaign activities in Part IV. See instructions for definition of "political campaign activities."

**2** Political campaign activity expenditures. See instructions ..... ▶ \$ \_\_\_\_\_

**3** Volunteer hours for political campaign activities. See instructions ..... \_\_\_\_\_

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

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

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

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

**4a** Was a correction made? .....  Yes  No

**b** If "Yes," describe in Part IV.

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

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

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

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

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

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

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



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

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

		(a)		(b)
		Yes	No	Amount
<b>1</b>	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
<b>a</b>	Volunteers? .....		No	
<b>b</b>	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)? .....		No	
<b>c</b>	Media advertisements? .....		No	
<b>d</b>	Mailings to members, legislators, or the public? .....		No	
<b>e</b>	Publications, or published or broadcast statements? .....		No	
<b>f</b>	Grants to other organizations for lobbying purposes? .....		No	
<b>g</b>	Direct contact with legislators, their staffs, government officials, or a legislative body? .....		No	
<b>h</b>	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means? .....		No	
<b>i</b>	Other activities? .....	Yes		23,536
<b>j</b>	Total. Add lines 1c through 1i .....			23,536
<b>2a</b>	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)? .....		No	
<b>b</b>	If "Yes," enter the amount of any tax incurred under section 4912 .....			
<b>c</b>	If "Yes," enter the amount of any tax incurred by organization managers under section 4912 .....			
<b>d</b>	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year? .....			

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

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

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

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

**Part IV Supplemental Information**

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

Return Reference	Explanation
PART II-B, LINE 1:	BAPTIST MEMORIAL HEALTH CARE CORPORATION PAYS MEMBERSHIP DUES TO VARIOUS HOSPITAL ASSOCIATIONS SUCH AS THE TENNESSEE HOSPITAL ASSOCIATION, MISSISSIPPI HOSPITAL ASSOCIATION, AND ARKANSAS HOSPITAL ASSOCIATION. A PORTION OF THE MEMBERSHIP DUES IS DESIGNATED AS LOBBYING FEES BY THE HOSPITAL ASSOCIATIONS. EACH HOSPITAL ASSOCIATION ALLOCATES A DIFFERENT PERCENTAGE, AND THE PERCENTAGE MAY VARY ANNUALLY. THE HOSPITAL ASSOCIATIONS PAY CONSULTANTS WHO MONITOR AND ADVISE THE ORGANIZATIONS ON LEGISLATIVE AND REGULATORY MATTERS THAT MAY AFFECT THE MEMBER ORGANIZATIONS AND THE MEMBERS' AFFILIATES. THESE CONSULTANTS MAY ADVOCATE POSITIONS WITH LEGISLATIVE AND REGULATORY BODIES OF GOVERNMENT AT LOCAL, STATE AND FEDERAL LEVELS. BAPTIST MEMORIAL HEALTH CARE CORPORATION ALLOCATES A PORTION OF THESE FEES AMONG ITS HOSPITALS.

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

# Supplemental Financial Statements

OMB No. 1545-0047  
**2021**  
**Open to Public Inspection**

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

**Name of the organization**  
BAPTIST MEMORIAL HOSPITAL-  
GOLDEN TRIANGLE INC

**Employer identification number**  
62-1519754

**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
<b>1</b> Total number at end of year . . . . .		
<b>2</b> Aggregate value of contributions to (during year)		
<b>3</b> Aggregate value of grants from (during year)		
<b>4</b> 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
<b>a</b> Total number of conservation easements . . . . .	<b>2a</b>
<b>b</b> Total acreage restricted by conservation easements . . . . .	<b>2b</b>
<b>c</b> Number of conservation easements on a certified historic structure included in (a) . . . . .	<b>2c</b>
<b>d</b> Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register . . . . .	<b>2d</b>

**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 FASB 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 FASB 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 FASB 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:

- c** Beginning balance . . . . .
- d** Additions during the year . . . . .
- e** Distributions during the year . . . . .
- f** Ending balance . . . . .

	Amount
<b>1c</b>	
<b>1d</b>	
<b>1e</b>	
<b>1f</b>	

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

**b** If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided 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
<b>1a</b> Beginning of year balance . . . . .					
<b>b</b> Contributions . . . . .					
<b>c</b> Net investment earnings, gains, and losses					
<b>d</b> Grants or scholarships . . . . .					
<b>e</b> Other expenditures for facilities and programs . . . . .					
<b>f</b> Administrative expenses . . . . .					
<b>g</b> End of year balance . . . . .					

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

- a** Board designated or quasi-endowment ▶ .....
- b** Permanent endowment ▶ .....
- c** Term 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:

- (i)** Unrelated organizations . . . . .
- (ii)** Related organizations . . . . .

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

	Yes	No
<b>3a(i)</b>		
<b>3a(ii)</b>		
<b>3b</b>		

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

**Part VI Land, Buildings, and Equipment.**

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
<b>1a</b> Land . . . . .		816,534		816,534
<b>b</b> Buildings . . . . .		113,025,244	72,912,517	40,112,727
<b>c</b> Leasehold improvements				
<b>d</b> Equipment . . . . .		80,570,999	51,541,607	29,029,392
<b>e</b> Other . . . . .		1,901,836	1,257,112	644,724
<b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).) . . . ▶				70,603,377

**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) INVESTMENT IN COLUMBUS IMAGING CENTER, LLC	1,734,879	C
(B) INVESTMENT IN PENSION FUND	262,575	C
(C) INVESTMENT IN COLUMBUS ORTHOPEDIC SURGERY CENTER	14,669,999	C
(D)		
(E)		
(F)		
(G)		
(H)		
(H)		
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 12.)	16,667,453	

**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)		
(10)		
<b>Total.</b> (Column (b) must equal Form 990, Part X, col.(B) line 13.)		

**Part IX Other Assets.**

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

(a) Description	(b) Book value
(1) DUE FROM AFFILIATES	130,093,031
(2) CONSTRUCTION IN PROCESS	2,720,580
(3) ESTIMATED SETTLEMENTS WITH THIRD PARTIES	121,000
(4) OTHER RECEIVABLES	744,952
(5) MEDICARE COST SETTLEMENT	584,749
(6)	
(7)	
(8)	
(9)	
(10)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col.(B) line 15.)	134,264,312

**Part X Other Liabilities.**

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) MEDICARE COST SETTLEMENT	238,768
(3) OTHER LONG-TERM LIABILITIES	5,204,300
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col.(B) line 25.)	5,443,068

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

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

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

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

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

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

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

**Part XIII Supplemental Information**

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

Return Reference	Explanation
See Additional Data Table	



## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 62-1519754

**Name:** BAPTIST MEMORIAL HOSPITAL-  
GOLDEN TRIANGLE INC

## Supplemental Information

Return Reference	Explanation
PART X, LINE 2:	FROM THE COMBINED AUDITED FINANCIAL STATEMENTS OF BAPTIST MEMORIAL HEALTH CARE CORPORATION AND AFFILIATES: AS OF SEPTEMBER 30, 2022, BAPTIST MEMORIAL HEALTH CARE CORPORATION (BMHCC ) HAD NOT IDENTIFIED ANY UNCERTAIN TAX POSITIONS UNDER FASB ASC TOPIC 740, INCOME TAXES, REQUIRING ADJUSTMENTS TO ITS COMBINED FINANCIAL STATEMENTS. IN THE EVENT BMHCC WERE TO RECOGNIZE INTEREST AND PENALTIES RELATED TO UNCERTAIN TAX POSITIONS, IT WOULD BE RECOGNIZED IN THE COMBINED FINANCIAL STATEMENTS AS INTEREST EXPENSE. GENERALLY, BMHCC IS NO LONGER SUBJECT TO INCOME TAX EXAMINATIONS FOR TAX YEARS PRIOR TO 2018 (FISCAL YEAR ENDED SEPTEMBER 30, 2019).

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

# Hospitals

OMB No. 1545-0047  
**2021**  
Open to Public Inspection

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

**Name of the organization**  
BAPTIST MEMORIAL HOSPITAL-  
GOLDEN TRIANGLE INC

**Employer identification number**  
62-1519754

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

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

<b>Financial Assistance and Means-Tested Government Programs</b>	<b>(a)</b> Number of activities or programs (optional)	<b>(b)</b> Persons served (optional)	<b>(c)</b> Total community benefit expense	<b>(d)</b> Direct offsetting revenue	<b>(e)</b> Net community benefit expense	<b>(f)</b> Percent of total expense
<b>a</b> Financial Assistance at cost (from Worksheet 1) . . . . .			14,986,759	91,499	14,895,260	6.900 %
<b>b</b> Medicaid (from Worksheet 3, column a) . . . . .			28,837,231	31,853,352	0	0 %
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b) . . . . .			2,341,536	1,427,075	914,461	0.420 %
<b>d Total</b> Financial Assistance and Means-Tested Government Programs . . . . .			46,165,526	33,371,926	15,809,721	7.320 %
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4).			66,433	0	66,433	0.030 %
<b>f</b> Health professions education (from Worksheet 5) . . . . .			5,019,741	0	5,019,741	2.330 %
<b>g</b> Subsidized health services (from Worksheet 6) . . . . .			68,430,239	70,943,597	0	0 %
<b>h</b> Research (from Worksheet 7) . . . . .			6,231	4,966	1,265	0 %
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8) . . . . .			174,669	0	174,669	0.080 %
<b>j Total.</b> Other Benefits . . . . .			73,697,313	70,948,563	5,262,108	2.440 %
<b>k Total.</b> Add lines 7d and 7j . . . . .			119,862,839	104,320,489	21,071,829	9.760 %

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
<b>1</b> Physical improvements and housing						
<b>2</b> Economic development			13,058		13,058	0.010 %
<b>3</b> Community support			10,801		10,801	0.010 %
<b>4</b> Environmental improvements						
<b>5</b> Leadership development and training for community members						
<b>6</b> Coalition building						
<b>7</b> Community health improvement advocacy						
<b>8</b> Workforce development			21,425		21,425	0.010 %
<b>9</b> Other						
<b>10 Total</b>			45,284		45,284	0.030 %

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

**Section A. Bad Debt Expense**

		Yes	No
<b>1</b> Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?		<b>1</b> Yes	
<b>2</b> Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	<b>2</b> 632,830		
<b>3</b> Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	<b>3</b> 82,801		
<b>4</b> Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

**Section B. Medicare**

<b>5</b> Enter total revenue received from Medicare (including DSH and IME)	<b>5</b> 46,330,123
<b>6</b> Enter Medicare allowable costs of care relating to payments on line 5	<b>6</b> 39,385,936
<b>7</b> Subtract line 6 from line 5. This is the surplus (or shortfall)	<b>7</b> 6,944,187
<b>8</b> Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input checked="" type="checkbox"/> Cost accounting system <input type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other	

**Section C. Collection Practices**

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

**Part IV Management Companies and Joint Ventures**

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

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

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

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

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)

See Additional Data Table	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

**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)  
 BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGL

Name of hospital facility or letter of facility reporting group \_\_\_\_\_

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

		Yes	No
<b>Community Health Needs Assessment</b>			
<b>1</b>	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? . . . . .		No
<b>2</b>	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C. . . . .		No
<b>3</b>	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12. . . . . If "Yes," indicate what the CHNA report describes (check all that apply):	Yes	
<b>a</b>	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b>	<input checked="" type="checkbox"/> Demographics of the community		
<b>c</b>	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b>	<input checked="" type="checkbox"/> How data was obtained		
<b>e</b>	<input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b>	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b>	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b>	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b>	<input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>4</b>	Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>21</u>		
<b>5</b>	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .	Yes	
<b>6 a</b>	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	Yes	
<b>b</b>	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C. . . . .		No
<b>7</b>	Did the hospital facility make its CHNA report widely available to the public? . . . . . If "Yes," indicate how the CHNA report was made widely available (check all that apply):	Yes	
<b>a</b>	<input checked="" type="checkbox"/> Hospital facility's website (list url): <u>HTTPS://WWW.BAPTISTONLINE.ORG/ABOUT/CHNA</u>		
<b>b</b>	<input type="checkbox"/> Other website (list url): _____		
<b>c</b>	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>8</b>	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11. . . . .	Yes	
<b>9</b>	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>21</u>		
<b>10</b>	Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url): <u>HTTPS://WWW.BAPTISTONLINE.ORG/ABOUT/CHNA</u>	Yes	
<b>a</b>			
<b>b</b>	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .		
<b>11</b>	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
<b>12a</b>	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .		No
<b>b</b>	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .		
<b>c</b>	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

**Part V Facility Information** (continued)

**Financial Assistance Policy (FAP)**

BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANG

Name of hospital facility or letter of facility reporting group \_\_\_\_\_

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
<b>13</b>	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	13	Yes
<b>a</b>	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200.000000000000</u> % and FPG family income limit for eligibility for discounted care of <u>400.000000000000</u> %		
<b>b</b>	<input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b>	<input type="checkbox"/> Asset level		
<b>d</b>	<input checked="" type="checkbox"/> Medical indigency		
<b>e</b>	<input checked="" type="checkbox"/> Insurance status		
<b>f</b>	<input checked="" type="checkbox"/> Underinsurance discount		
<b>g</b>	<input checked="" type="checkbox"/> Residency		
<b>h</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>14</b>	Explained the basis for calculating amounts charged to patients? . . . . .	14	Yes
<b>15</b>	Explained the method for applying for financial assistance? . . . . . If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	15	Yes
<b>a</b>	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</b>	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
<b>c</b>	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
<b>d</b>	<input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>16</b>	Was widely publicized within the community served by the hospital facility? . . . . . If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	16	Yes
<b>a</b>	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>SEE PART V, SECTION C</u>		
<b>b</b>	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE PART V, SECTION C</u>		
<b>c</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V, SECTION C</u>		
<b>d</b>	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b>	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>f</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>g</b>	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
<b>h</b>	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b>	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information** (continued)

**Billing and Collections**

BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGL

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

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

**Policy Relating to Emergency Medical Care**

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

BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGL

Name of hospital facility or letter of facility reporting group \_\_\_\_\_

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

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

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

If "Yes," explain in Section C.

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

If "Yes," explain in Section C.

	Yes	No
<b>23</b>		No
<b>24</b>		No



**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? 3

Name and address	Type of Facility (describe)
<b>1</b> 1 - GTR STARKVILLE INFUSION CLINIC 104 DOCTORS PARK STARKVILLE, MS 39759	INFUSION CLINIC
<b>2</b> 2 - GTR STARKVILLE ONCOLOGY CLINIC 305 CARVER DRIVE STARKVILLE, MS 39759	ONCOLOGY PHYSICIAN CLINIC
<b>3</b> 3 - GTR RHEUMATOLOGY CLINIC 255 BAPTIST BLVD SUITE 301 COLUMBUS, MS 39705	RHEUMATOLOGY PHYSICIAN CLINIC
<b>4</b>	
<b>5</b>	
<b>6</b>	
<b>7</b>	
<b>8</b>	
<b>9</b>	
<b>10</b>	

**Part VI Supplemental Information**

Provide the following information.

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

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART I, LINE 3C:	BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC. USES FEDERAL POVERTY GUIDELINES (FPG) TO DETERMINE ELIGIBILITY FOR FREE OR REDUCED CARE FOR LOW INCOME AND MEDICALLY INDIGENT INDIVIDUALS. IN ADDITION TO THE FEDERAL POVERTY GUIDELINES, BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC. USES MEDICAL INDIGENCY, INSURANCE STATUS, UNDERINSURANCE STATUS, AND RESIDENCY TO DETERMINE ELIGIBILITY FOR FINANCIAL ASSISTANCE.
PART I, LINE 6A:	THE COMMUNITY BENEFIT REPORT IS PREPARED BY BAPTIST MEMORIAL HEALTH CARE CORPORATION (EIN: 58-1521475), THE SOLE MEMBER OF BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC. THE COMMUNITY BENEFIT REPORT IS MADE AVAILABLE TO THE PUBLIC BY MAIL AND AVAILABLE AT EACH AFFILIATE OF BAPTIST MEMORIAL HEALTH CARE CORPORATION.

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART I, LINE 7:	OUR COST ACCOUNTING PROCESS REFLECTS FULLY LOADED COST FOR ALL OF OUR PATIENT POPULATIONS. FULLY LOADED COST INCLUDES DIRECT, CAPITAL, AND INDIRECT COST. AFTER WORKING WITH OUR DEPARTMENT DIRECTORS AND CFOS TO MAKE SURE THE DOLLARS IN THE GENERAL LEDGER ARE IN THE CORRECT PLACE TO REFLECT OUR TIME AND EFFORT SPENT THROUGHOUT THE YEAR, WE DEVELOP RELATIVE VALUE UNITS TO ALLOCATE THE ACTUAL GENERAL LEDGER COST DOWN TO THE PROCEDURE CHARGE CODES FROM OUR PATIENT ACCOUNTING SYSTEM. ALL OVERHEAD IS ALLOCATED DOWN TO THE REVENUE PRODUCING DEPARTMENTS BASED ON VARIOUS STATISTICS. ONCE EVERY CHARGE CODE HAS GONE THROUGH THE COST AND AUDIT PROCESS, WE CAN RUN THE PATIENT LEVEL REPORTS USED FOR THE FORM 990 TO GET TO THE COST INFORMATION NEEDED.
PART I, LINE 7G:	SUBSIDIZED HEALTH SERVICES DO NOT INCLUDE ANY COSTS ATTRIBUTABLE TO PHYSICIAN CLINICS.

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART II, COMMUNITY BUILDING ACTIVITIES:	BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC. CONDUCTS SEVERAL HEALTH FAIRS, SEMINARS AND CLASSES THROUGHOUT THE YEAR FOR THE COMMUNITIES IT SERVES. BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC. ALSO IS INVOLVED IN LOCAL COMMUNITY AND NON-PROFIT ORGANIZATIONS SUCH AS THE AMERICAN CANCER SOCIETY, SUSAN G. KOMEN RACE FOR THE CURE, WALK AMERICA, ST. JUDE CHILDREN'S RESEARCH HOSPITAL, AND MANY OTHERS. NOT ONLY DO WE PROVIDE MONETARY DONATIONS, BUT OUR EMPLOYEES ARE ACTIVE VOLUNTEERS IN THESE WORTHY CAUSES.
PART III, LINE 2:	BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC.'S BAD DEBT EXPENSE WAS DETERMINED AS FOLLOWS:A BAD DEBT REPORT IS RUN TO PULL ALL PATIENTS THAT HAVE BEEN MOVED TO A BAD DEBT ACCOUNT LOCATION. WE THEN TAKE THE TOTAL ACCOUNT BALANCE OF ALL THE PATIENTS IN THE BAD DEBT LOCATION AND DIVIDE IT BY THE TOTAL CHARGES OF THE SAME PATIENT LOCATION. WE MULTIPLY THE RESULTING RATIO BY THE TOTAL COST OF THE SAME PATIENT POPULATION WHICH PROVIDES US WITH THE COST ASSOCIATED WITH THE TOTAL AMOUNT OF THE ACCOUNT BALANCE MOVED TO BAD DEBT STATUS.

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART III, LINE 3:	BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC.'S BAD DEBT EXPENSE ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE BAPTIST MEMORIAL HEALTH CARE CORPORATION'S FINANCIAL ASSISTANCE POLICY WAS DETERMINED AS FOLLOWS:WE IDENTIFY THE PATIENTS ELIGIBLE FOR FREE OR DISCOUNTED CARE UNDER BAPTIST MEMORIAL HEALTH CARE CORPORATION'S FINANCIAL ASSISTANCE POLICY. THIS INFORMATION IS INCLUDED IN THE PATIENT'S RECORD. WE ALSO INCLUDE PATIENTS WHO REFUSE TO COMPLETE THE FINANCIAL ASSISTANCE PAPERWORK. IF A PATIENT IS DETERMINED TO BE ELIGIBLE FOR FINANCIAL ASSISTANCE, IF INFORMATION PROVIDED BY THE PATIENT IS INCOMPLETE, OR WHEN A SELF-PAY MINIMUM DISCOUNT NOTE IS ENTERED IN THE PATIENT RECORD, WE RUN A REPORT WHICH PROVIDES US THE COST ASSOCIATED WITH THE TOTAL AMOUNT OF BAD DEBT ATTRIBUTABLE TO THOSE PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE.
PART III, LINE 4:	BAPTIST MEMORIAL HEALTH CARE CORPORATION, THE SOLE MEMBER OF BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC., HAS ADOPTED HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION STATEMENT NO. 15, VALUATION AND FINANCIAL STATEMENT PRESENTATION OF CHARITY CARE AND BAD DEBTS BY INSTITUTIONAL PROVIDERS.THERE IS NOT A SEPARATE BAD DEBT EXPENSE FOOTNOTE IN BAPTIST MEMORIAL HEALTH CARE CORPORATION'S COMBINED AUDITED FINANCIAL STATEMENTS.

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART III, LINE 8:	THE SHORTFALL, IF ANY, IS NOT TREATED AS COMMUNITY BENEFIT. WE CANNOT GET THE PAYMENT AND MEDICARE ALLOWABLE COST INFORMATION FROM THE COST REPORT IN THE FORMAT WE NEED. THEREFORE, WE TAKE THE FOLLOWING STEPS. FOR LINE 5, WE TAKE THE TOTAL PAYMENTS FOR MEDICARE PATIENTS FROM SCHEDULE 6, PATIENT POPULATION, AND DIVIDE THAT BY THE TOTAL HOSPITAL MEDICARE PAYMENTS. WE MULTIPLY THE RESULTING RATIO BY THE REVENUE NUMBERS THAT COME FROM THE COST REPORT. FOR LINE 6, WE USE THE SAME CONCEPT TO GET THE COST INFORMATION. WE GET THE TOTAL COST OF MEDICARE PATIENTS FROM SCHEDULE 6 AND DIVIDE THAT NUMBER BY THE TOTAL COST OF THE TOTAL MEDICARE PATIENT POPULATION OF THE HOSPITAL. WE THEN MULTIPLY THIS RATIO BY THE COST INFORMATION FROM THE COST REPORT.
PART III, LINE 9B:	THE HOSPITAL'S COLLECTION AGENCY WILL DETERMINE IF THE PATIENT HAS A FINANCIAL ASSISTANCE APPLICATION ON FILE AND WAS DEEMED TO QUALIFY FOR FINANCIAL ASSISTANCE BY THE HOSPITAL. IF IT WAS DETERMINED THAT THE PATIENT QUALIFIES FOR FINANCIAL ASSISTANCE, THEN THE COLLECTION AGENCY WILL REVIEW THE REMAINING UNPAID BALANCE AFTER THE APPLICATION OF THE FINANCIAL ASSISTANCE DISCOUNT, AND PURSUE APPROPRIATE COLLECTION EFFORTS. DEPENDING UPON THE CIRCUMSTANCES AT THE TIME, THE ENTIRE AMOUNT OWED MAY BE WRITTEN OFF.

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 2:	<p>BAPTIST MEMORIAL HEALTH CARE CORPORATION (BMHCC), AS SOLE MEMBER OF BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC., PROVIDES NEEDS ASSESSMENTS THROUGH THE HEALTH SERVICES RESEARCH DEPARTMENT. IN ADDITION, LOCAL ADVISORY BOARDS PROVIDE FEEDBACK TO THE LOCAL HOSPITAL ADMINISTRATORS.REPUTATION.COM IS CONTRACTED TO ANALYZE AND GARNER ADDITIONAL FEEDBACK FROM ONLINE REVIEWS POSTED ON SOCIAL MEDIA AS WELL AS TO SOLICIT REVIEWS FROM BAPTIST PATIENTS. THESE EFFORTS ARE GEARED TOWARDS RAPID RESPONSE AND CORRECTION OF SUBOPTIMAL PERFORMANCE AS WELL AS TO BETTER UNDERSTAND THE CUSTOMER SERVICE NEEDS OF BMHCC'S PATIENT CONSTITUENCY. THIS APPLIES TO BOTH HOSPITALS AND PHYSICIAN PRACTICES.PROVIDER ENGAGEMENT SURVEYS ARE CONDUCTED YEARLY TO DETERMINE LEVELS OF ENGAGEMENT AND ALIGNMENT OF PHYSICIANS AND ADVANCE PRACTICE PROVIDERS. ENGAGEMENT ASSESSES PRIDE IN THE ORGANIZATION, INTENT TO STAY, WILLINGNESS TO RECOMMEND, AND OVERALL WORKPLACE SATISFACTION. ALIGNMENT ASSESSES THE EXTENT TO WHICH PHYSICIANS FEEL A STRONG PARTNERSHIP AND CONNECTION WITH LEADERSHIP, INCLUDING A SHARED VISION OF HOW TO EXECUTE THE ORGANIZATIONAL MISSION. AN IMPORTANT FACET OF ALIGNMENT IS THE PHYSICIANS' SENSE THAT THEIR INPUT AND FEEDBACK ARE VALUED AND HAVE AN IMPACT ON GOAL SETTING AND DIRECTION. QUESTIONS SEEK INPUT ON THEIR PATIENTS' EXPERIENCES, STAFF INTERACTIONS AND SERVICES PROVIDED, QUALITY STATUS AND IMPROVEMENT INITIATIVES, NEEDED EQUIPMENT AND SERVICES, RESOURCES AVAILABLE TO PATIENTS AND PROVIDERS, CONTINUING MEDICAL EDUCATION OPPORTUNITIES AND OUR COMMITMENT TO DIVERSITY. SURVEY INVITATIONS ARE EMAILED TO BOTH SYSTEM AFFILIATED PROVIDERS AND COMMUNITY PROVIDERS BY PRESS GANEY ASSOCIATES, LLC.COMMUNITY NEEDS ASSESSMENTS (CNA) FOR ADDITIONAL PHYSICIANS IN THE COMMUNITY ARE ALSO CONDUCTED. POPULATION-BASED DEMAND ESTIMATES ARE OBTAINED FROM THE MILLIMAN DATA DRIVEN MODELS CREATED IN COLLABORATION WITH BMHCC'S CNA VENDOR, 3DHEALTH. THEY TAKE INTO ACCOUNT THE AGE AND GENDER OF THE POPULATION. THIS IS THEN COMPARED TO THE SUPPLY OF PHYSICIANS AS DETERMINED THROUGH AN IQVIA NATIONAL PHYSICIAN DATABASE. 3DHEALTH ALSO CALLS PHYSICIAN OFFICES IN EACH SERVICE AREA TO DETERMINE THE FULL TIME EQUIVALENT OF PHYSICIANS AVAILABLE IN THE SPECIALTY OF INTEREST FOR EACH ASSESSMENT. THE DEMAND MINUS THE SUPPLY GIVES THE "NET NEED" CURRENTLY, AND IN YEARS TO COME. THE REQUEST FOR THESE ANALYSES ARE MADE BY THE HOSPITAL'S CHIEF EXECUTIVE OFFICER BASED ON THE PRIORITIES GIVEN BY THE MEDICAL STAFF AND ACCORDING TO KNOWLEDGE OF PHYSICIANS THAT ARE LIKELY TO LEAVE THE AREA IN THE NEXT YEAR OR TWO. GENERALLY, THE DEMAND AND SUPPLY ESTIMATES ARE FOR A GEOGRAPHIC AREA DEFINED BY THE PRIMARY SERVICE AREA OF THE HOSPITAL AS DEFINED BY THE STARK ACT.BMHCC ALSO CONSULTS WITH MULTIPLE OUTSIDE VENDORS IN THE REAL ESTATE AND HEALTH CARE FACILITY PLANNING BUSINESS TO ASSESS FACILITY NEED AND OPTIMAL LOCATION TO BEST SERVE THE PUBLIC. MULTIPLE SOFTWARE PACKAGES WITH PROPRIETARY ALGORITHMS TO ASSESS BEST LOCATION FOR PROSPECTIVE NEW FACILITIES ARE USED. NATIONAL CLAIMS DATABASES OF HEALTH CARE VISITS, AS WELL AS DATA SETS GATHERED FROM SOCIAL MEDIA AND CELL COMPANIES THAT ASSESS POPULATION TRAFFIC MOVEMENTS, PROVIDE CUTTING EDGE DATA TO ULTIMATELY PROVIDE OPTIMAL LOCATIONS FOR THE MARKETS BAPTIST SERVES.PATIENT EXPERIENCE SURVEYS ARE USED TO ASSESS COMMUNITY NEED AND TO SOLICIT FEEDBACK ON OUR SERVICES. THROUGH PRESS GANEY ASSOCIATES, LLC, BMHCC UTILIZES MAIL, E-MAIL AND TEXT TO SEEK FEEDBACK FROM OVER 1.2 MILLION PATIENT VISITS PER YEAR. SERVICES FOR THESE VISITS MAY BE PROVIDED IN ONE OF SEVEN SETTINGS: INPATIENT, OUTPATIENT TEST AND TREATMENT, ONCOLOGY CENTER, EMERGENCY DEPARTMENT, AMBULATORY SURGERY, URGENT CARE CENTER, AND PHYSICIAN PRACTICE CLINIC. THE SURVEY MEASURES THE PATIENT'S PERCEPTION OF KEY COMPONENTS OF THEIR JOURNEY WITH OUR HEALTH CARE ORGANIZATION. THESE COMPONENTS INCLUDE ADMISSION, REGISTRATION, COMMUNICATION WITH NURSES, COMMUNICATION WITH DOCTORS, WAIT TIME, RESPONSE TO NEEDS, HOSPITAL ENVIRONMENT, DISCHARGE, CARE TRANSITION, ETC. THE RATINGS ON EACH QUESTION ARE USED, ALONG WITH COMMENTS, TO IDENTIFY THE CONTINUATION OF BEST PRACTICES ALONG WITH ANY CHANGES IN PROCESSES OR BEHAVIORS THAT ARE NECESSARY TO MEET THE NEEDS OF THE COMMUNITIES WE SERVE.</p>
PART VI, LINE 3:	<p>PATIENTS ARE INFORMED OF THEIR ELIGIBILITY FOR ASSISTANCE IN PERSON UPON ENTERING THE HOSPITAL FACILITY. EACH PATIENT IS ASSIGNED AN ADMISSIONS PERSON WHO PROVIDES WRITTEN INFORMATION AS WELL AS VERBAL INFORMATION. IN ADDITION, THE PATIENT MAY OBTAIN INFORMATION AS FOLLOWS:(A) A COPY IS GIVEN TO THE PATIENT DURING THE ADMISSIONS AND/OR DISCHARGE PROCESS FOR EACH VISIT FOR MEDICAL TREATMENT.(B) A COPY IS SENT WITH THE FIRST POST-DISCHARGE BILLING STATEMENT.(C) COPIES ARE POSTED AND AVAILABLE UPON REQUEST AT ALL ADMISSIONS, EMERGENCY AND BUSINESS OFFICE DEPARTMENT AREAS AT ALL BAPTIST MEMORIAL HEALTH CARE CORPORATION FACILITIES.(D) COPIES ARE ALSO AVAILABLE FOR DOWNLOAD AND PRINTING ONLINE ON THE BAPTIST MEMORIAL HEALTH CARE CORPORATION WEBSITE UNDER "FINANCIAL ASSISTANCE OR BY CONTACTING THE FACILITY WHERE SERVICES WERE RECEIVED AND REQUESTING A COPY BY MAIL OR EMAIL AT FAP@BMHCC.ORG.(E) COPIES OF ALL FINANCIAL ASSISTANCE POLICY DOCUMENTS WILL BE PROVIDED ELECTRONICALLY TO ANY INDIVIDUAL WHO INDICATES THAT IS THEIR PREFERENCE.</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART VI, LINE 4:	BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC. SERVICES THE LOWNDES COUNTY, MISSISSIPPI AND GOLDEN TRIANGLE AREA. SOME PATIENTS COME FROM ALABAMA AND OTHER MISSISSIPPI COUNTIES SURROUNDING THE GOLDEN TRIANGLE AREA. THE AFRICAN AMERICAN COMMUNITY COMPRISES ABOUT 39.5% OF OUR PRIMARY SERVICE AREA. HISPANICS MAKE UP ABOUT 2.1%, AND CAUCASIANS ARE ABOUT 54.5%.DEMOGRAPHIC SNAPSHOTS ARE PROVIDED BY THE INDEPENDENT OUTSIDE FIRM OF CLARITAS, INC. OUR OWN HEALTH SERVICES RESEARCH DEPARTMENT AT BAPTIST MEMORIAL HEALTH CARE CORPORATION (OUR PARENT) CALCULATES THE DISTRIBUTION OF INPATIENT DISCHARGES (EXCLUDING NEWBORNS) BY COUNTY. THIS IS SORTED IN DESCENDING NUMBER PER COUNTY AND DETERMINES THOSE COUNTIES WITH UP TO 75-77% OF THE DISCHARGES AND THESE CONTIGUOUS COUNTIES COMPRISE THE PRIMARY MARKET AREA. COUNTIES COMPRISES 78-95% OF THE DISCHARGES ARE DESIGNATED THE SECONDARY MARKET, WHILE THE REMAINING 5% IS THE TERTIARY MARKET.BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC.'S PRIMARY MARKET SERVICE AREA HAS 185,256 PERSONS WITH THE COMBINED PRIMARY AND SECONDARY AREA HAVING 761,108 PERSONS. OTHER ITEMS SUCH AS AGE, HOUSEHOLD INCOME, AND RACE/ETHNICITY PERCENTAGES, AS COMPARED TO THE NATION AS A WHOLE, ARE ALSO USED IN THE MIX.DUNN AND BRADSTREET DATA IS ALSO USED TO DETERMINE THE COMMUNITIES' LARGEST EMPLOYERS.
PART VI, LINE 5:	THE HOSPITALS HAVE OPEN MEDICAL STAFFS, COMMUNITY BOARD INVOLVEMENT, SUPPORT SERVICES, FREE AND/OR REDUCED MAMMOGRAMS, HEALTH FAIRS, DONATION OF SUPPLIES AND MONEY, AND MANY OTHER THINGS.

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART VI, LINE 6:	BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC. IS AN AFFILIATE OF BAPTIST MEMORIAL HEALTH CARE CORPORATION. BAPTIST MEMORIAL HEALTH CARE CORPORATION IS THE SOLE MEMBER OF A NUMBER OF HOSPITALS, MINOR MEDICAL CENTERS, HOME CARE AND HOSPICE SERVICES, AND PHYSICIAN SERVICES IN WEST TENNESSEE, NORTH AND CENTRAL MISSISSIPPI, AND EAST ARKANSAS. EACH FACILITY PROVIDES HEALTH CARE SERVICES TO MEET THE NEEDS OF THE COMMUNITIES SERVED.

**Additional Data****Software ID:****Software Version:****EIN:** 62-1519754**Name:** BAPTIST MEMORIAL HOSPITAL-  
GOLDEN TRIANGLE INC**Form 990 Schedule H, Part V Section A. Hospital Facilities**

<b>Section A. Hospital Facilities</b>		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (Describe)	Facility reporting group
(list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? <b>1</b>											
Name, address, primary website address, and state license number											
1	BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE 2520 5TH STREET NORTH COLUMBUS, MS 39705 WWW.BAPTISTONLINE.ORG/GOLDEN-TRIANGLE 13-253	X	X					X			

**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
BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE	<p>PART V, SECTION B, LINE 5: THE FY2022 CHNA FOR BAPTIST'S NORTH MISSISSIPPI SERVICE AREA WAS CONDUCTED FROM JULY 2021 TO AUGUST 2022 AND INCLUDED QUANTITATIVE AND QUALITATIVE RESEARCH METHODS TO DETERMINE HEALTH TRENDS AND DISPARITIES AFFECTING SERVICE AREA RESIDENTS. THROUGH A COMPREHENSIVE VIEW OF STATISTICAL HEALTH INDICATORS AND COMMUNITY STAKEHOLDER FEEDBACK, A PROFILE OF PRIORITY AREAS WAS DETERMINED. THE FINDINGS WILL GUIDE HEALTH CARE SERVICES AND HEALTH IMPROVEMENT EFFORTS, AS WELL AS SERVE AS A COMMUNITY RESOURCE FOR GRANT MAKING AND ADVOCACY, AND SUPPORT THE MANY PROGRAMS PROVIDED BY HEALTH AND SOCIAL SERVICE PARTNERS. COMMUNITY ENGAGEMENT WAS AN INTEGRAL PART OF THE FY2022 CHNA. IN ASSESSING COMMUNITY HEALTH NEEDS, INPUT WAS SOLICITED AND RECEIVED FROM PERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY, AS WELL AS UNDERSERVED, LOW-INCOME AND MINORITY POPULATIONS. THESE INDIVIDUALS PROVIDED WIDE PERSPECTIVES ON HEALTH TRENDS, EXPERTISE ABOUT EXISTING COMMUNITY RESOURCES AVAILABLE TO MEET THOSE NEEDS AND INSIGHTS INTO SERVICE DELIVERY GAPS THAT CONTRIBUTE TO HEALTH DISPARITIES AND INEQUITIES. BAPTIST SOUGHT TO ENGAGE INDIVIDUALS AND COMMUNITIES HISTORICALLY UNDERREPRESENTED AND UNDERSERVED BY HEALTH CARE SERVICES TO ILLUMINATE DIVERSE PERSPECTIVES ON COMMUNITY NEEDS AND INFORM COMMUNITY HEALTH IMPROVEMENT STRATEGY. CONSUMER INTERVIEWS AND FOCUS GROUPS WERE HOSTED ACROSS THE BAPTIST SERVICE AREAS WITH THE GOAL OF GARNERING STAKEHOLDER FEEDBACK AND RECOMMENDATIONS TO IMPROVE HEALTH AND THE HEALTH CARE EXPERIENCE BY ADDRESSING ACCESS TO CARE CHALLENGES AND UNDERLYING SOCIAL DETERMINANTS OF HEALTH AND INEQUITIES. THIS FEEDBACK IS REFLECTED IN BAPTIST'S APPROACH TO DEFINING THE FY2022 - FY2025 PRIORITY AREAS AND DEVELOPING EACH HOSPITAL COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP). THE FOLLOWING RESEARCH METHODS WERE USED TO DETERMINE COMMUNITY HEALTH NEEDS:- ANALYSIS OF EXISTING SECONDARY DATA SOURCES, INCLUDING PUBLIC HEALTH STATISTICS, DEMOGRAPHIC AND SOCIAL MEASURES AND HEALTH CARE UTILIZATION.- KEY INFORMANT SURVEYS TO ASSESS PERCEIVED HEALTH PRIORITIES, PERSPECTIVES ON EMERGING HEALTH TRENDS AND RECOMMENDATIONS TO ADVANCE COMMUNITY HEALTH IMPROVEMENT.- PATIENT ACCESS TO CARE AND SERVICES SURVEY TO UNDERSTAND HEALTH CARE PROVIDERS' PERSPECTIVES ON BARRIERS TO CARE, THE IMPACT OF SOCIAL DETERMINANTS OF HEALTH, CULTURAL COMPETENCIES AND OTHER FACTORS THAT IMPEDE OPTIMAL OUTCOMES FOR PATIENTS.- CONSUMER INTERVIEWS AND FOCUS GROUPS WITH INDIVIDUALS REPRESENTING BLACK, INDIGENOUS AND PEOPLE OF COLOR (BIPOC) AND OTHER POPULATIONS HISTORICALLY UNDERSERVED BY HEALTH CARE SERVICES TO INFORM COMMUNITY HEALTH IMPROVEMENT STRATEGY. CHNA LEADERSHIP: A BAPTIST MEMORIAL HEALTH CARE STEERING COMMITTEE, ALONG WITH COMMUNITY REPRESENTATIVES AND PARTNERS, OVERSAW THE FY2022 CHNA. THESE INDIVIDUALS SERVED AS LIAISONS TO THEIR ORGANIZATIONS AND THE COMMUNITIES SERVED BY THEIR ENTITIES. THE FOLLOWING CONTRIBUTED TO THE CHNA PROCESS AS COMMUNITY PARTNERS: AGAPE H</p>

**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
BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE	HEALTH SERVICES AMERICAN CANCER SOCIETY BANCORP SOUTH CALHOUN COUNTY SCHOOL DISTRICT CALHOUN ECONOMIC DEVELOPMENT ASSOCIATION, INC. CHILDREN'S ADVOCACY CENTERS OF MISSISSIPPI CITY OF COLUMBUS CITY OF YAZOO CITY COLUMBUS POLICE DEPARTMENT COMMUNICARE CREEKMORE CLINIC FIRST BAPTIST CHURCH FIRST CHOICE CENTER FOR WOMEN, INC. FIRST UNITED METHODIST CHURCH GOLDEN TRIANGLE CONTACT TELEMINISTRY, INC. HEALTH PROMOTION & WELLNESS HELPING HANDS OF COLUMBUS HOPE HOUSE OF HOSPITALITY, INC. HOUSE OF GRACE, DOMESTIC VIOLENCE CENTER INTERNATIONAL PAPER LOWNDES COUNTY COUNCIL ON AGING MISSISSIPPI FOOD NETWORK MISSISSIPPI STATE DEPARTMENT OF HEALTH MISSISSIPPI UNIVERSITY FOR WOMEN MSDH/MCCCP NEONFROG, INC. NEW ALBANY MAIN STREET NEW ALBANY SCHOOL DISTRICT OXFORD MEDICAL MINISTRIES CLINIC ST. JUDE CHILDREN'S RESEARCH HOSPITAL ST. MARY'S CATHOLIC CHURCH ST. PAUL BAPTIST CHURCH, MINISTER STANFORD DENTAL CLINIC SUSAN G. KOMEN MEMPHIS - MIDSOUTH MISSISSIPPI THE COMMERCIAL DISPATCH NEWSPAPER TK ELEVATOR NORTH AMERICA SUPPLY CHAIN AND MANUFACTURING GUCCA UNION COUNTY EXTENSION OFFICE UNITED WAY OF LOWNDES & NOXUBEE UNIVERSITY OF MISSISSIPPI, UNIVERSITY HEALTH SERVICES VIBRANT CHURCH WEST POINT MINISTERIAL ALLIANCE

**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
BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE	PART V, SECTION B, LINE 6A: BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE CONDUCTED ITS CHNA WITH THE FOLLOWING OTHER HOSPITAL FACILITIES: BAPTIST MEMORIAL HOSPITAL-BOONEVILLE BAPTIST MEMORIAL HOSPITAL-CALHOUN BAPTIST MEMORIAL HOSPITAL-NORTH MISSISSIPPI BAPTIST MEMORIAL HOSPITAL-UNION COUNTY

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

Form and Line Reference	Explanation
<p>BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE</p>	<p>PART V, SECTION B, LINE 11: BAPTIST MEMORIAL HEALTH CARE (BAPTIST) IS DEDICATED TO THE HEALTH AND WELL-BEING OF THE MANY COMMUNITIES WE SERVE ACROSS THE MID-SOUTH. WE BELIEVE STRONGLY IN CORPORATE CITIZENSHIP AND THE IMPORTANCE OF COLLABORATION WITH LOCAL ORGANIZATIONS TO BUILD STRONGER AND HEALTHIER COMMUNITIES. TO HELP US TRACK COMMUNITY HEALTH AND RESPOND TO THE NEEDS OF RESIDENTS, EVERY THREE YEARS WE CONDUCT A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) AND DEVELOP COMMUNITY HEALTH IMPROVEMENT PLANS (CHIP) FOR EACH COMMUNITY HOSPITAL. THESE ENDEAVORS HELP TO ENSURE OUR INITIATIVES, ACTIVITIES AND PARTNERSHIPS ALIGN WITH OUR COMMUNITIES' MOST PRESSING CONCERNS, AND GUIDE OUR COMMUNITY BENEFIT INVESTMENTS. THEY ARE VITAL TOOLS TO GUIDE COMMUNITY HEALTH IMPROVEMENT ACTIVITIES AS WELL AS ENHANCE CARE DELIVERY, IMPROVE PATIENT ENGAGEMENT STRATEGIES AND DIRECT POPULATION HEALTH MANAGEMENT. IT IS IMPERATIVE TO PRIORITIZE RESOURCES AND ACTIVITIES TOWARD THE MOST PRESSING AND CROSS-CUTTING HEALTH NEEDS WITHIN OUR COMMUNITY. IN DETERMINING THE ISSUES ON WHICH TO FOCUS EFFORTS OVER THE NEXT THREE-YEAR CYCLE, BAPTIST COLLECTED FEEDBACK FROM COMMUNITY PARTNERS AND SOUGHT TO ALIGN WITH COMMUNITY PROGRAMS, POPULATION HEALTH MANAGEMENT STRATEGIES AND DIVERSITY, EQUITY AND INCLUSION INITIATIVES. BAPTIST WILL FOCUS EFFORTS ON THE FOLLOWING COMMUNITY HEALTH PRIORITIES OVER THE NEXT THREE-YEAR CYCLE: 1. BEHAVIORAL HEALTH 2. CHRONIC DISEASES 3. MATERNAL AND CHILD HEALTH BEHAVIORAL HEALTH THE GOAL IS TO STRENGTHEN EQUITY AND QUALITY IN BEHAVIORAL HEALTH CARE AND IMPROVE ACCESS TO PREVENTION, TREATMENT AND RECOVERY SERVICES. BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE HAS OUTLINED THE FOLLOWING OBJECTIVES: 1. INCREASE THE NUMBER OF PEOPLE WHO ARE SCREENED FOR BEHAVIORAL HEALTH CONDITIONS. 2. INCREASE THE NUMBER OF PEOPLE RECEIVING BEHAVIORAL HEALTH CARE AND SUPPORT. BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE WILL IMPLEMENT THE FOLLOWING STRATEGIES: 1. INITIATE UNIVERSAL BEHAVIORAL HEALTH SCREENINGS ACROSS ALL CARE SETTINGS 2. EDUCATE PEOPLE TO RECOGNIZE SIGNS AND SYMPTOMS OF MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE AND WHERE TO GET HELP 3. SUPPORT, PROMOTE AND PARTICIPATE IN COMMUNITY BEHAVIORAL HEALTH AWARENESS EFFORTS 4. EXPAND WORKFORCE TRAINING AND CAPABILITY IN THE DETECTION, DIAGNOSIS AND MANAGEMENT OF BEHAVIORAL HEALTH CONDITIONS 5. PROVIDE INFORMATION ON THE MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) AND COVERAGE OF ESSENTIAL BEHAVIORAL HEALTH SERVICES FOR CHILDREN AND YOUTH 6. EXPAND ACCESS TO COMMUNITY-BASED SERVICES AND RESOURCES SUCH AS PEER SUPPORT, COMMUNITY HEALTH WORKERS, HOME AND COMMUNITY-BASED SERVICES AND SOCIAL SUPPORTS 7. STRENGTHEN AND SUPPORT COMMUNITY ORGANIZATIONS PROVIDING YOUTH MENTAL HEALTH SUPPORT, INCLUDING MENTORSHIP, CAREER DEVELOPMENT AND SOCIAL EMOTIONAL LEARNING OPPORTUNITIES 8. PROVIDE EDUCATION AND SUPPORT ABOUT BEHAVIORAL HEALTH FOR HEALTH CARE PROVIDERS AND PROFESSIONALS. CHRONIC DISEASES THE GOAL IS TO ENSURE ALL RESIDENTS HAVE</p>

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

Form and Line Reference	Explanation
<p>BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE</p>	<p>E KNOWLEDGE OF, AND EQUITABLE ACCESS TO, THE RESOURCES THEY NEED TO MAINTAIN AND IMPROVE THEIR HEALTH. BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE HAS OUTLINED THE FOLLOWING OBJECTIVES: 1. INCREASE ACCESS TO TRADITIONAL AND ALTERNATIVE PLACES PEOPLE CAN ACCESS HEALTH CARE. 2. REDUCE DISPARITIES IN CHRONIC DISEASE PREVALENCE AND DEATH RATES. BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE WILL IMPLEMENT THE FOLLOWING STRATEGIES: 1. PROVIDE INFORMATION ON THE MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) AND COVERAGE OF ESSENTIAL BEHAVIORAL HEALTH SERVICES FOR CHILDREN AND YOUTH. 2. CONTINUE TO ASSESS COMMUNITY NEED FOR SPECIALTY CARE SERVICES AND OPPORTUNITIES TO EXPAND AVAILABLE CLINICS. 3. EXPAND EQUITABLE ACCESS TO TELEHEALTH VISITS BY INCREASING TECHNOLOGY KNOW-HOW AND USE OF TELEHEALTH AMONG PRIORITY POPULATIONS. 4. SUPPORT, PROMOTE, AND PARTICIPATE IN EVENTS OFFERING AFFORDABLE PREVENTIVE SCREENINGS AND OTHER MOBILE HEALTH SERVICES, BRINGING CARE TO THE COMMUNITY. 5. OPTIMIZE DATA COLLECTION, STANDARDIZATION AND TRANSPARENCY TO IDENTIFY DISPARITIES AND TRACK IMPROVEMENT. 6. INCREASE CHRONIC DISEASE SCREENING RATES AMONG UNDERSERVED POPULATIONS. 7. PROVIDE EDUCATION AND SUPPORT PROGRAMS THAT ADDRESS PHYSICAL, MENTAL, SPIRITUAL AND FINANCIAL CONCERNS. MATERNAL AND CHILD HEALTH THE GOAL IS TO ACHIEVE EQUITABLE OUTCOMES FOR MOTHERS AND BABIES BY STRENGTHENING COMMUNITIES AND ADDRESSING UNDERLYING BARRIERS TO CARE. BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE HAS OUTLINED THE FOLLOWING OBJECTIVES: 1. REDUCE HEALTH DISPARITIES IN BIRTH OUTCOMES FOR BLACK/AFRICAN AMERICAN WOMEN AND BABIES. 2. INCREASE ACCESS TO COMPREHENSIVE PRE- AND POST-NATAL CARE SERVICES. BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE WILL IMPLEMENT THE FOLLOWING STRATEGIES: 1. OPTIMIZE DATA COLLECTION, STANDARDIZATION AND TRANSPARENCY TO IDENTIFY DISPARITIES AND TRACK IMPROVEMENT. 2. EXPAND AND DIVERSIFY THE PERINATAL WORKFORCE. 3. STRENGTHEN ECONOMIC AND SOCIAL SUPPORT FOR PEOPLE BEFORE, DURING AND AFTER PREGNANCY. 4. CREATE INCLUSIVE AND WELCOMING CARE SETTINGS THAT HONOR DIVERSITY AND REFLECT THE COMMUNITY. 5. PARTNER WITH COMMUNITY-BASED ORGANIZATIONS INCLUDING FAITH-BASED INSTITUTIONS TO PROVIDE EDUCATION AND CARE IN COMMUNITIES. 6. PROVIDE MOBILE, IN-HOME, AND TELEHEALTH CARE TO INCREASE ACCESS FOR UNDERSERVED POPULATIONS. WE RECOGNIZE THAT OUR HOSPITALS ARE VITAL ORGANIZATIONS WITHIN THE COMMUNITIES WE SERVE. AND WE KNOW THAT WE CANNOT ADDRESS EVERY COMMUNITY NEED BY OURSELVES. TO PROMOTE HEALTH AND QUALITY OF LIFE, WE COLLABORATE WITH COMMUNITY PARTNERS WHO HAVE EXPERTISE IN SOCIAL NEEDS, SPECIALTY SERVICES, FAITH LEADERSHIP, ADVOCACY AND ESSENTIAL RESOURCES. WE FOSTER ONGOING RELATIONSHIPS WITH THESE PARTNERS AND PROVIDE FINANCIAL AND IN-KIND GIFTS TO SUPPORT THEIR WORK. NO ACTIONS WERE TAKEN DURING THE FISCAL YEAR RELATED TO THE MOST RECENT CHNA BECAUSE THE CHNA WAS ADOPTED AT THE END OF THE TAX YEAR. HOWEVER, THE HOSPITAL DID THE FOLLOWING DURING FY'22 TO ADDRESS THE SIGNIFICANT HEALTH NEEDS OF T</p>

**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
BAPTIST MEMORIAL HOSPITAL- GOLDEN TRIANGLE	<p>HE COMMUNITY RELATED TO THE PRIOR CHNA.- PROVIDED DIABETES AND CANCER SUPPORT GROUPS.- HOS TED COMMUNITY EVENT WHERE FREE FLU SHOTS WERE OFFERED.- PROVIDED FREE COMMUNITY SCREENINGS , INCLUDING BONE DENSITY, BLOOD PRESSURE, BLOOD GLUCOSE, HEIGHT/WEIGHT/BMI, DIABETES, AND OTHERS.- PROVIDED FREE MONTHLY PROSTATE-SPECIFIC ANTIGEN (PSA) TESTS FOR MEN OVER 40.- HOS TED QUARTERLY BLOOD DRIVES.- COLLABORATED WITH LOCAL NONPROFITS TO ADDRESS VARIOUS HEALTH NEEDS, INCLUDING AMERICAN CANCER SOCIETY, LOAVES AND FISHES COMMUNITY KITCHEN, HELPING HAN DS, UNITED WAY, BOYS AND GIRLS CLUBS, MAKE-A-WISH FOUNDATION AND FATHER'S CHILD MINISTRY. - COORDINATED MEDICAL EXPERTS TO SPEAK AT VARIOUS COMMUNITY EVENTS RELATED TO DISEASE AWAR ENESS AND PREVENTION.- HOSTED BREAST CANCER AWARENESS MONTH ACTIVITIES TO RAISE AWARENESS OF BREAST CANCER.- PROVIDED FREE HEALTH SCREENINGS TO COMMUNITY MEMBERS IN RURAL, UNDERSER VED AREAS.- PARTICIPATED IN COMMUNITY PROGRAMS TO HIGHLIGHT AWARENESS AND PREVENTION OF HE ALTH NEED PRIORITIES, INCLUDING CANCER, TRAUMA, STROKE, MENTAL HEALTH, AND MATERNAL AND CH ILD HEALTH.- PROVIDED HEALTH SCREENINGS, CPR/FIRST AID TRAINING, AND DRUG SCREENS AT AREA BUSINESSES AND INDUSTRIES.- PROVIDED FREE SCREENING AND DIAGNOSTIC MAMMOGRAMS TO UNINSURED /UNDERINSURED WOMEN USING SUSAN G. KOMEN AND OTHER GRANT FUNDS.- PROVIDED FREE MONTHLY LEA RN AT LUNCH PROGRAMS FOR THE COMMUNITY ON CHNA-RELATED TOPICS SUCH AS MENTAL HEALTH, DIABE TES, A-FIB AND STRUCTURAL HEART PROCEDURES.- USED STAFF PHYSICIANS, CLINICIANS AND OTHER S TAFF MEMBERS TO VIDEO HEALTH TALK WITH BAPTIST SPONSORSHIP SPOTS FOR OUR LOCAL CBS AFFILIA TE ON VARIOUS HEALTH-RELATED TOPICS, INCLUDING: TOBACCO ADDICTION AND CESSATION, MENTAL IL NNESS, DIABETES, HEART HEALTHY EATING, BREASTFEEDING, HEART ATTACK, CONGESTIVE HEART FAILU RE AND OPIOID ADDICTION. - PROMOTED AMBULANCE/ER/TRAUMA AWARENESS USING MONTHLY VIDEOS FEA TURING STAFF PHYSICIANS AND OTHER CLINICIANS.</p>

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

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

Form and Line Reference	Explanation
BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE	PART V, SECTION B, LINE 13B: 1. MONEY INCOME INCLUDING: EARNINGS, UNEMPLOYMENT COMPENSATION, WORKERS' COMPENSATION, SOCIAL SECURITY, SUPPLEMENTAL SECURITY INCOME, DISABILITY PAYMENTS, PUBLIC ASSISTANCE, VETERANS' PAYMENTS, SURVIVOR BENEFITS, PENSION OR RETIREMENT INCOME, INTEREST, DIVIDENDS, RENTS, ROYALTIES, INCOME FROM ESTATES AND/OR TRUSTS, EDUCATIONAL ASSISTANCE, ALIMONY, CHILD SUPPORT, ASSISTANCE FROM OUTSIDE THE HOUSEHOLD, AND OTHER MISCELLANEOUS SOURCES OF INCOME. THE GROSS AMOUNT IS USED WHEN CALCULATING INCOME FROM ANY OF THE PRECEDING SOURCES. 2. NON-CASH BENEFITS, SUCH AS FOOD STAMPS AND HOUSING SUBSIDIES, DO NOT COUNT AS INCOME. 3. IF A PERSON LIVES WITH A FAMILY, THE TOTAL GROSS INCOME OF ALL FAMILY MEMBERS IS CALCULATED WHEN DETERMINING INCOME. PLEASE NOTE: (A) NON-RELATIVES, INCLUDING HOUSEMATES, DO NOT COUNT; (B) A CHILD WHO IS A FULL-TIME STUDENT AWAY FROM HOME AT AN ACCREDITED COLLEGE MAY BE COUNTED; (C) MINOR CHILDRENS' EARNED WAGES ARE NOT INCLUDED IN DETERMINING INCOME; AND (D) COURT-ORDERED OR STATE/FEDERAL ISSUED ASSISTANCE RELATED TO A MINOR SHOULD BE INCLUDED IN DETERMINING INCOME. 4. PRIMARY RESIDENCE OF INDIVIDUALS CLAIMED IN A FAMILY UNIT SHOULD BE VERIFIED USING TAX RETURNS OR FEDERAL, STATE OR GOVERNMENTAL COURT DOCUMENTS INDICATING RESIDENCY.

**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
BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE:	PART V, SECTION B, LINE 16A: THE FAP FOR BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE CAN BE FOUND AT THE FOLLOWING LINK: <a href="https://www.baptistonline.org/patients-and-visitors/financial-assistance">HTTPS://WWW.BAPTISTONLINE.ORG/PATIENTS-AND-VISITORS/FINANCIAL-ASSISTANCE</a> BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE:PART V, SECTION B, LINE 16B: THE FAP APPLICATION FOR BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE CAN BE FOUND AT THE FOLLOWING LINK: <a href="https://www.baptistonline.org/patients-and-visitors/financial-assistance">HTTPS://WWW.BAPTISTONLINE.ORG/PATIENTS-AND-VISITORS/FINANCIAL-ASSISTANCE</a> BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE:PART V, SECTION B, LINE 16C: THE PLAIN LANGUAGE SUMMARY OF THE FAP FOR BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE CAN BE FOUND AT THE FOLLOWING LINK: <a href="https://www.baptistonline.org/patients-and-visitors/financial-assistance">HTTPS://WWW.BAPTISTONLINE.ORG/PATIENTS-AND-VISITORS/FINANCIAL-ASSISTANCE</a>

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

Schedule I (Form 990)

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

OMB No. 1545-0047

2021

Open to Public Inspection

Department of the Treasury Internal Revenue Service

Complete if the organization answered "Yes," on Form 990, Part IV, line 21 or 22.

Attach to Form 990.

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

Name of the organization BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE INC

Employer identification number 62-1519754

Part I General Information on Grants and Assistance

- 1 Does the organization maintain records to substantiate the amount of the grants or assistance...
2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

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

Table with 8 columns: (a) Name and address of organization or government, (b) EIN, (c) IRC section (if applicable), (d) Amount of cash grant, (e) Amount of non-cash assistance, (f) Method of valuation (book, FMV, appraisal, other), (g) Description of noncash assistance, (h) Purpose of grant or assistance. Rows 1-12.

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

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

Part III can be duplicated if additional space is needed.

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

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

Return Reference	Explanation
PART I, LINE 2:	ALL ORGANIZATIONS ARE REQUIRED TO SUBMIT PROOF OF TAX EXEMPT STATUS THAT IS VERIFIED BY THE INTERNAL REVENUE SERVICE DATABASE BEFORE THEY CAN PROCEED WITH THEIR REQUEST. THEY MAY USE OUR ONLINE CHARITABLE REQUEST APPLICATION TO SUBMIT A REQUEST. IF THEY ARE NOT A 501(C)(3) ORGANIZATION, THEY ARE REQUIRED TO SUBMIT A COPY OF THEIR DETERMINATION LETTER FROM THE INTERNAL REVENUE SERVICE VALIDATING THEIR EXEMPT STATUS BEFORE WE CAN PROVIDE ANY IN-KIND GIVEAWAYS OR SERVICES. WE ALSO MONITOR THE FUNDS TO ENSURE THEY ARE USED FOR THE PURPOSE GRANTED. WE MAKE EVERY EFFORT TO DIRECT OUR FUNDING TO A PROGRAM FOR A SPECIFIC PURPOSE. ORGANIZATIONS ARE ASKED TO SHOW RESULTS AND DOCUMENTATION ANNUALLY BEFORE THEIR REQUEST CAN BE CONSIDERED FOR FUTURE FUNDING. THE REQUESTS ARE REVIEWED AND APPROVED BY VARIOUS INDIVIDUALS DEPENDING UPON THE TYPE AND AMOUNT OF THE REQUEST. SMALL AMOUNTS MAY BE APPROVED BY THE SYSTEM DIRECTOR OF COMMUNICATIONS. ANYTHING OVER \$10,000 MAY BE APPROVED BY THE BAPTIST MEMORIAL HEALTH CARE FOUNDATION SENIOR VICE PRESIDENT, AND ANYTHING OVER \$50,000 NEEDS APPROVAL BY THE BAPTIST MEMORIAL HEALTH CARE CORPORATION PRESIDENT/CEO. FOR MORE INFORMATION ABOUT BAPTIST MEMORIAL HEALTH CARE CORPORATION'S CHARITABLE GIVING GUIDELINES, PLEASE VISIT: <a href="https://www.bmhgiving.org/">HTTPS://WWW.BMHGIVING.ORG/</a> .

**Additional Data**

**Software ID:**  
**Software Version:**  
**EIN:** 62-1519754  
**Name:** BAPTIST MEMORIAL HOSPITAL-  
GOLDEN TRIANGLE INC

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

<b>(a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section if applicable	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of non-cash assistance	<b>(h)</b> Purpose of grant or assistance
MISSISSIPPI UNIVERSITY FOR WOMEN FOUNDATION 1100 COLLEGE STREET COLUMBUS, MS 39701	23-7050717	501(C)(3)	165,880	0			CCU/NURSING PROGRAM AND SUMMER EXTERN PROGRAM
THE GOLDEN TRIANGLE DEVELOPMENT TRUST PO BOX 1328 COLUMBUS, MS 39703	64-0387161	501(C)(6)	12,500	0			ANNUAL CONTRIBUTION

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

<b>(a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section if applicable	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of non-cash assistance	<b>(h)</b> Purpose of grant or assistance
BAPTIST MEMORIAL HEALTH CARE FOUNDATION INC 350 N HUMPHREYS BLVD MEMPHIS, TN 38120	58-1544781	501(C)(3)	18,000	0			SUPPORT GRADUATE MEDICAL EDUCATION PROGRAM
EMCC DEVELOPMENT FOUNDATION 1512 KEMPER ST PO BOX 158 SCOOBA, MS 39358	64-0654912	501(C)(3)	100,000	0			EMCC NURSING SCHOLARSHIP FUND

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

OMB No. 1545-0047

# 2021

**Open to Public Inspection**

Name of the organization  
BAPTIST MEMORIAL HOSPITAL-  
GOLDEN TRIANGLE INC

**Employer identification number**  
62-1519754

**Part I Questions Regarding Compensation**

		Yes	No								
<p><b>1a</b> Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> First-class or charter travel</td> <td style="width: 50%; border: none;"><input type="checkbox"/> Housing allowance or residence for personal use</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Travel for companions</td> <td style="border: none;"><input type="checkbox"/> Payments for business use of personal residence</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Tax idemnification and gross-up payments</td> <td style="border: none;"><input type="checkbox"/> Health or social club dues or initiation fees</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Discretionary spending account</td> <td style="border: none;"><input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)</td> </tr> </table>	<input type="checkbox"/> First-class or charter travel	<input type="checkbox"/> Housing allowance or residence for personal use	<input type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence	<input type="checkbox"/> Tax idemnification and gross-up payments	<input type="checkbox"/> Health or social club dues or initiation fees	<input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)	<b>1a</b>		
<input type="checkbox"/> First-class or charter travel	<input type="checkbox"/> Housing allowance or residence for personal use										
<input type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence										
<input type="checkbox"/> Tax idemnification and gross-up payments	<input type="checkbox"/> Health or social club dues or initiation fees										
<input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)										
<p><b>b</b> If any of the boxes on Line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain</p>	<b>1b</b>										
<p><b>2</b> Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked on Line 1a? . . . . .</p>	<b>2</b>										
<p><b>3</b> Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Compensation committee</td> <td style="width: 50%; border: none;"><input type="checkbox"/> Written employment contract</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Independent compensation consultant</td> <td style="border: none;"><input type="checkbox"/> Compensation survey or study</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Form 990 of other organizations</td> <td style="border: none;"><input type="checkbox"/> Approval by the board or compensation committee</td> </tr> </table>	<input type="checkbox"/> Compensation committee	<input type="checkbox"/> Written employment contract	<input type="checkbox"/> Independent compensation consultant	<input type="checkbox"/> Compensation survey or study	<input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Approval by the board or compensation committee					
<input type="checkbox"/> Compensation committee	<input type="checkbox"/> Written employment contract										
<input type="checkbox"/> Independent compensation consultant	<input type="checkbox"/> Compensation survey or study										
<input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Approval by the board or compensation committee										
<p><b>4</b> During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:</p> <p><b>a</b> Receive a severance payment or change-of-control payment? . . . . .</p> <p><b>b</b> Participate in, or receive payment from, a supplemental nonqualified retirement plan? . . . . .</p> <p><b>c</b> Participate in, or receive payment from, an equity-based compensation arrangement? . . . . .</p> <p>If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.</p>	<b>4a</b>		No								
	<b>4b</b>	Yes									
	<b>4c</b>		No								
<p><b>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</b></p> <p><b>5</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:</p> <p><b>a</b> The organization? . . . . .</p> <p><b>b</b> Any related organization? . . . . .</p> <p>If "Yes," on line 5a or 5b, describe in Part III.</p>	<b>5a</b>		No								
	<b>5b</b>		No								
<p><b>6</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:</p> <p><b>a</b> The organization? . . . . .</p> <p><b>b</b> Any related organization? . . . . .</p> <p>If "Yes," on line 6a or 6b, describe in Part III.</p>	<b>6a</b>		No								
	<b>6b</b>		No								
<p><b>7</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III . . . . .</p>	<b>7</b>	Yes									
<p><b>8</b> Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III . . . . .</p>	<b>8</b>		No								
<p><b>9</b> If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)? . . . . .</p>	<b>9</b>										



**Part III Supplemental Information**

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

Return Reference	Explanation
PART I, LINE 3	BAPTIST MEMORIAL HEALTH CARE CORPORATION, A RELATED ORGANIZATION OF BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC., USES THE FOLLOWING TO ESTABLISH THE COMPENSATION OF THE ORGANIZATION'S TOP MANAGEMENT OFFICIAL: - COMPENSATION COMMITTEE - INDEPENDENT COMPENSATION CONSULTANT - COMPENSATION SURVEY OR STUDY - APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE

**Part III Supplemental Information**

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

Return Reference	Explanation
PART I, LINE 4B:	ELIGIBLE EXECUTIVES PARTICIPATE IN VARIOUS NON-QUALIFIED DEFERRED COMPENSATION PLANS ORGANIZED UNDER CODE SECTION 457(F). THE EXACT PURPOSE OF EACH PLAN VARIES BUT THEY INCLUDE: COMPENSATION LIMITATION MAKE-UP PLANS, VOLUNTARY DEFERRAL PLANS, DEFERRAL OF A PORTION OF INCENTIVE BONUS TYPE PLANS, ETC. ANY AMOUNT ULTIMATELY PAID UNDER THE PROGRAM TO THE EXECUTIVE IS REPORTED AS COMPENSATION ON FORM 990, SCHEDULE J, PART II, COLUMN B IN THE YEAR PAID. THE FOLLOWING INDIVIDUAL(S) LISTED ON PART VII RECEIVED SUPPLEMENTAL NON-QUALIFIED PLAN PAYMENTS DURING THE CALENDAR YEAR: JASON M. LITTLE - \$440,539 GREGORY M. DUCKETT - \$439,607 PAUL D. DEPRIEST, MD - \$118,214

**Part III Supplemental Information**

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

Return Reference	Explanation
PART I, LINE 7:	THE BAPTIST MEMORIAL HEALTH CARE SYSTEM HAS ESTABLISHED A MANAGEMENT ACCOUNTABILITY AND FINANCIAL INCENTIVE PLAN THAT ENCOURAGES MANAGEMENT PARTICIPATION IN THE SIGNIFICANT IMPROVEMENTS OF THE QUALITY, FINANCIAL, GROWTH, AND HUMAN RESOURCE RELATED OPERATIONS OF THE ORGANIZATION. AN INCENTIVE BONUS IS PAID TO ALL MANAGEMENT BASED ON ATTAINMENT OF GOALS IN THE AREAS OF 1) PATIENT SATISFACTION; 2) EMPLOYEE SATISFACTION; 3) PHYSICIAN SATISFACTION; 4) QUALITY AND SAFETY; 5) OPERATIONAL PERFORMANCE METRICS; AND 6) OPERATING INCOME MARGIN. PARTICIPANTS RECEIVE POINTS UNDER A PLAN SCORING SYSTEM FOR MEETING THEIR PREDETERMINED GOALS. THE POINTS ARE THEN ENTERED INTO THE PLAN FORMULA TO DETERMINE THE INCENTIVE COMPENSATION.

**Additional Data**

**Software ID:**

**Software Version:**

**EIN:** 62-1519754

**Name:** BAPTIST MEMORIAL HOSPITAL-  
GOLDEN TRIANGLE INC

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

(A) Name and Title		(B) Breakdown of W-2, 1099-MISC compensation, and/or 1099-NEC			(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 JASON M LITTLE PRESIDENT	(i)	0	0	0	0	0	0	0
	(ii)	1,205,689	1,603,706	594,267	60,750	37,039	3,501,451	0
1 PAUL D DEPRIEST MD VICE PRESIDENT	(i)	0	0	0	0	0	0	0
	(ii)	783,402	927,651	295,734	56,375	28,263	2,091,425	0
2 GREGORY M DUCKETT SECRETARY	(i)	0	0	0	0	0	0	0
	(ii)	474,740	510,349	577,435	47,032	33,058	1,642,614	0
3 EDWIN P CADE CEO	(i)	0	0	0	0	0	0	0
	(ii)	271,020	97,522	47,266	67,080	26,631	509,519	0
4 ASHLEY HARRIS FORMER CMO	(i)	0	0	0	0	0	0	0
	(ii)	385,960	61,505	430	24,113	24,124	496,132	0
5 JAMES MARTIN MD CMO	(i)	375,700	0	41,119	30,375	25,513	472,707	0
	(ii)	0	0	0	0	0	0	0
6 JAYCE D MISKEL PHYSICIAN	(i)	289,391	93,375	31,073	26,215	30,868	470,922	0
	(ii)	0	0	0	0	0	0	0
7 SALEEM A ALI MD PHYSICIAN	(i)	300,211	52,952	15,602	37,658	10,069	416,492	0
	(ii)	0	0	0	0	0	0	0
8 MARY E SUMRALL FORMER CHIEF NURSING OFFICER	(i)	42,221	22,657	69	11,181	9,207	85,335	0
	(ii)	137,516	350	494	29,088	21,119	188,567	0
9 VANESSA LAFAYETTE REGISTERED NURSE	(i)	186,497	6,595	878	19,176	25,223	238,369	0
	(ii)	0	0	0	0	0	0	0
10 ALICIA C GRANT CHIEF NURSING OFFICER (AS OF 01/22)	(i)	140,993	19,167	452	37,794	10,129	208,535	0
	(ii)	0	0	0	0	0	0	0
11 DEBORAH K SEELY CLINICAL RESOURCE NURSE	(i)	188,271	5,395	108	11,541	2,597	207,912	0
	(ii)	0	0	0	0	0	0	0
12 CHRISTOPHER LEBRUN DIRECTOR-RESIDENCY PROGRAM	(i)	188,959	250	25	0	0	189,234	0
	(ii)	0	0	0	0	0	0	0
13 THOMAS STEADMAN CFO	(i)	133,910	15,427	258	0	23,979	173,574	0
	(ii)	0	0	0	0	0	0	0

**SCHEDULE O**  
(Form 990)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](http://www.irs.gov/Form990) for the latest information.

OMB No. 1545-0047

**2021****Open to Public  
Inspection**Name of the organization  
BAPTIST MEMORIAL HOSPITAL-  
GOLDEN TRIANGLE INC

Employer identification number

62-1519754

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART V, LINE 1A:	ALL FORMS 1099 ARE PREPARED BY THE ACCOUNTS PAYABLE DEPARTMENT OF BAPTIST MEMORIAL HEALTH CARE CORPORATION, THE SOLE MEMBER OF BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC. ALL FORMS 1099 ARE ISSUED USING THE FEDERAL TAX IDENTIFICATION NUMBER OF BAPTIST MEMORIAL HEALTH CARE CORPORATION. FORMS 1099 ARE NOT PROCESSED BY ENTITY, BUT BY VENDOR GROUP. MANY VENDORS PERFORM SERVICES FOR MULTIPLE BAPTIST MEMORIAL HEALTH CARE CORPORATION ENTITIES, SO ONLY ONE 1099 IS ISSUED PER VENDOR WITH THE TOTAL AMOUNT PAID FOR SERVICES. THIS NUMBER IS REPORTED ON BAPTIST MEMORIAL HEALTH CARE CORPORATION'S FORM 990, PART V, LINE 1A.

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART V, LINE 2A:	THE PAYROLL FUNCTION IS CENTRALIZED AT THE CORPORATE PAYROLL DEPARTMENT OF BAPTIST MEMORIAL HEALTH CARE CORPORATION, THE SOLE MEMBER OF BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC. THE CORPORATE PAYROLL DEPARTMENT IS RESPONSIBLE FOR ALL SALARIES AND WAGES OF EMPLOYEES FOR THE ENTIRE BAPTIST MEMORIAL HEALTH CARE CORPORATION SYSTEM. FORMS W-2 AND W-3 ARE SUBMITTED ELECTRONICALLY TO THE INTERNAL REVENUE SERVICE USING BAPTIST MEMORIAL HEALTH CARE CORPORATION'S FEDERAL TAX IDENTIFICATION NUMBER, ACCORDING TO THE GUIDELINES ASSOCIATED WITH COMMON PAYMASTER. HOWEVER, THE EMPLOYEE INFORMATION IS ALLOCATED TO ITS RESPECTIVE FACILITY FOR FINANCIAL REPORTING PURPOSES AND THEY ARE REPORTED TO THE STATE BY EACH FACILITY. THUS, THE AMOUNT REPORTED ON FORM 990, PART V, LINE 2A REFLECTS THE NUMBER OF EMPLOYEES AT THIS FACILITY WHO RECEIVED A W-2. THE TOTAL NUMBER OF FORMS W-2 FOR ALL BAPTIST MEMORIAL HEALTH CARE CORPORATION ENTITIES IS REPORTED ON THE BAPTIST MEMORIAL HEALTH CARE CORPORATION W-3.

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 2	THE FOLLOWING INDIVIDUALS HAVE A BUSINESS RELATIONSHIP BECAUSE THEY ARE BOARD MEMBERS OR SHARED OFFICERS OF A TAXABLE ENTITY WITHIN BAPTIST MEMORIAL HEALTH CARE CORPORATION: GREGORY M. DUCKETT JASON M. LITTLE PAUL D. DEPRIEST, MD ALICIA C. GRANT EDWIN P. CADE

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 3	BAPTIST MEMORIAL HEALTH CARE CORPORATION, AS SOLE MEMBER OF BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC., PROVIDES CERTAIN LEGAL, FINANCE, QUALITY, AND PERSONNEL SERVICES PURSUANT TO A SHARED SERVICES AGREEMENT.

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 6	BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC. IS A NON-PROFIT, NON-STOCK CORPORATION WHO SE SOLE MEMBER IS BAPTIST MEMORIAL HEALTH CARE CORPORATION.

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, SECTION A, LINE 7A	BAPTIST MEMORIAL HEALTH CARE CORPORATION, AS THE SOLE MEMBER OF BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC., APPOINTS ITS BOARD OF DIRECTORS.

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B	BAPTIST MEMORIAL HEALTH CARE CORPORATION, AS THE SOLE MEMBER OF BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC., APPROVES THE BOARD OF DIRECTORS' ACTIONS.

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, SECTION B, LINE 11B	THE FORM 990 IS REVIEWED BY BAPTIST MEMORIAL HEALTH CARE CORPORATION'S EXECUTIVE VICE-PRESIDENT/CFO, THE ENTITY'S TOP FINANCIAL OFFICIAL, AND AN OUTSIDE INDEPENDENT ACCOUNTING AND TAX FIRM PRIOR TO SUBMITTING THE FORM 990 TO THE IRS. THE FORM 990 WAS NOT REVIEWED BY THE ORGANIZATION'S BOARD OF DIRECTORS BEFORE SUBMITTING IT TO THE IRS. BAPTIST MEMORIAL HEALTH CARE CORPORATION, AS SOLE MEMBER OF THE ORGANIZATION, HAS A FINANCE, AUDIT AND COMPLIANCE COMMITTEE THAT IS APPOINTED BY ITS BOARD OF DIRECTORS. THE FINANCE, AUDIT AND COMPLIANCE COMMITTEE WILL REVIEW THE FORM 990 AFTER SUBMITTING IT TO THE IRS. THE COMMITTEE REPORTS THE COMPLETION OF THE REVIEW TO THE CORPORATE BOARD OF DIRECTORS.

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, SECTION B, LINE 12C	<p>BAPTIST MEMORIAL HEALTH CARE CORPORATION, THE SOLE MEMBER OF BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC., REQUIRES THAT ALL EMPLOYEES, INCLUDING OFFICERS AND KEY EMPLOYEES, PERIODICALLY COMPLETE A CERTIFICATION AND ACKNOWLEDGEMENT OF THE BAPTIST MEMORIAL HEALTH CARE CORPORATION STANDARDS OF CONDUCT, WHICH INCORPORATES THE CONFLICT OF INTEREST POLICY. BOARD MEMBERS DISCLOSE AND SIGN A CONFLICT OF INTEREST STATEMENT EACH DECEMBER. IN THE EVENT THAT AN EMPLOYEE OR BOARD MEMBER BECOMES AWARE OF A POTENTIAL CONFLICT OF INTEREST, HE/SHE IS REQUIRED TO REPORT IT TO THEIR CHIEF EXECUTIVE OFFICER BEFORE TAKING ANY ACTION. IF HE/SHE IS THE CHIEF EXECUTIVE OFFICER, THEN HE/SHE IS TO REPORT TO THE CHAIRMAN OF THE BOARD OF DIRECTORS. THE SIGNED CONFLICT OF INTEREST STATEMENTS ARE REVIEWED BY THE SENIOR VICE PRESIDENT AND CORPORATE COUNSEL AND ARE MAINTAINED IN THE BAPTIST MEMORIAL HEALTH CARE CORPORATION LEGAL DEPARTMENT. IF A CONFLICT OF INTEREST IS FOUND TO EXIST, IT WILL BE THE RESPONSIBILITY OF THE CHIEF EXECUTIVE OFFICER, WITH THE INVOLVEMENT OF THE BAPTIST MEMORIAL HEALTH CARE CORPORATION LEGAL DEPARTMENT TO RESOLVE THE ISSUE.</p>

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, SECTION B, LINE 15	AS SOLE MEMBER OF BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC., BAPTIST MEMORIAL HEALTH CARE CORPORATION'S HUMAN RESOURCE DEPARTMENT, THE GOVERNANCE COMMITTEE OF THE BOARD OF DIRECTORS, AND AN INDEPENDENT COMPENSATION CONSULTING FIRM PERFORM ANNUAL REVIEWS EACH DECEMBER AND APPROVE COMPENSATION OF THE CEO AND OTHER TOP MANAGEMENT PERSONNEL. THEY USE COMPARABILITY DATA AND OTHER SOURCES AS NEEDED. THE CEO AND OTHER TOP MANAGEMENT USE THE SAME TYPE OF INFORMATION TO APPROVE COMPENSATION OF OTHER OFFICERS AND KEY EMPLOYEES. ON DECEMBER 7, 2020, THE COMPENSATION WAS REVIEWED AND APPROVED FOR THE CALENDAR YEAR ENDED DECEMBER 31, 2021 FOR THE PRESIDENT, THE VICE PRESIDENTS, AND THE CEO/ADMINISTRATOR.

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 18	BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC. MAKES COPIES OF ITS FORM 1023 AND FORM 990 AVAILABLE FOR PUBLIC INSPECTION TO ANYONE WHO REQUESTS THEM AS REQUIRED BY THE INTERNAL REVENUE SERVICE.

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC. MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC UPON REQUEST.

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VII CONTACT ADDRESSES FOR OFFICERS, DIRECTORS, ETC	JASON M. LITTLE - 350 N. HUMPHREYS BLVD., MEMPHIS, TN 38120. PAUL D. DEPRIEST, MD - 350 N. HUMPHREYS BLVD., MEMPHIS, TN 38120. GREGORY M. DUCKETT - 350 N. HUMPHREYS BLVD., MEMPHIS, TN 38120. ALLEGRA BRIGHAM - 350 N. HUMPHREYS BLVD., MEMPHIS, TN 38120. ALLEN B. PUCKETT, III - 350 N. HUMPHREYS BLVD., MEMPHIS, TN 38120. JEFF FARNHAM - 350 N. HUMPHREYS BLVD., ME MPHIS, TN 38120.

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART IX, LINE 11G	OTHER PURCHASED SERVICES: PROGRAM SERVICE EXPENSES 6,543,446. MANAGEMENT AND GENERAL EXPENSES 727,049. FUNDRAISING EXPENSES 0. TOTAL EXPENSES 7,270,495. RECRUITING EXPENSES: PROGRAM SERVICE EXPENSES 239,980. MANAGEMENT AND GENERAL EXPENSES 26,664. FUNDRAISING EXPENSES 0. TOTAL EXPENSES 266,644. OTHER PROFESSIONAL FEES: PROGRAM SERVICE EXPENSES 9,722,320. MANAGEMENT AND GENERAL EXPENSES 1,080,258. FUNDRAISING EXPENSES 0. TOTAL EXPENSES 10,802,578. CONTRACT LABOR: PROGRAM SERVICE EXPENSES 4,314,814. MANAGEMENT AND GENERAL EXPENSES 479,424. FUNDRAISING EXPENSES 0. TOTAL EXPENSES 4,794,238.

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART XII, LINE 2C:	BAPTIST MEMORIAL HEALTH CARE CORPORATION, AS THE SOLE MEMBER OF BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE, INC., HAS AN AUDIT COMMITTEE THAT CHOOSES THE AUDIT FIRM, OVERSEES AND REVIEWS THE AUDIT REPORTS, AND THEN FOLLOWS UP ON ANY NECESSARY CHANGES AND RECOMMENDATIONS. THE PROCESS HAS NOT CHANGED FROM PRIOR YEARS.

**SCHEDULE R  
(Form 990)**

**Related Organizations and Unrelated Partnerships**

OMB No. 1545-0047

**2021**

**Open to Public  
Inspection**

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

Department of the Treasury  
Internal Revenue Service

Name of the organization  
BAPTIST MEMORIAL HOSPITAL-  
GOLDEN TRIANGLE INC

**Employer identification number**

62-1519754

**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	No
See Additional Data Table							

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
<b>(1)</b> BAPTIST HEALTH SERVICES GROUP OF THE MID-SOUTH INC 350 N HUMPHREYS BLVD MEMPHIS, TN 38120 62-1534210	HEALTH INSURANCE CONTRACTING	TN	N/A	C				Yes	
<b>(2)</b> GERMANTOWN BUSINESS PARK OWNERS ASSOCIATION 350 N HUMPHREYS BLVD MEMPHIS, TN 38120 20-1158216	BOOKKEEPING & DATA PROCESSING GERMANTOWN BUS. PARK	TN	N/A	C				Yes	
<b>(3)</b> HEALTH TECH AFFILIATES INC 350 N HUMPHREYS BLVD MEMPHIS, TN 381202177 62-1278576	BUYING & LEASING REAL & PERSONAL PROPERTY	TN	N/A	C				Yes	
<b>(4)</b> MISSISSIPPI BAPTIST MEDICAL ENTERPRISES INC AND SUBS 1225 NORTH STATE STREET JACKSON, MS 39202 64-0776164	INVESTMENTS	MS	N/A	C				Yes	
<b>(5)</b> SOUTHCREST PROPERTY OWNERS ASSOCIATION INC 350 N HUMPHREYS BLVD MEMPHIS, TN 38120 64-0768703	BOOKKEEPING & DATA PROCESSING FOR THE SOUTHCREST DEVELOPMENT	MS	N/A	C				Yes	

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



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

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

<b>Return Reference</b>	<b>Explanation</b>

**Additional Data**

**Software ID:**

**Software Version:**

**EIN:** 62-1519754

**Name:** BAPTIST MEMORIAL HOSPITAL-  
GOLDEN TRIANGLE INC

**Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
350 N HUMPHREYS BLVD MEMPHIS, TN 381202177 83-1651534	HEALTH CARE SERVICE PROVIDER	TN	501(C)(3)	12 TYPE I	BAPTIST MEMORIAL HEALTH SERVICES INC	Yes	
350 N HUMPHREYS BLVD MEMPHIS, TN 38120 45-2842963	HEALTH CARE SERVICE PROVIDER	TN	501(C)(3)	3	BAPTIST MEMORIAL MEDICAL GROUP INC	Yes	
350 N HUMPHREYS BLVD MEMPHIS, TN 38120 45-3032246	FACILITATE MEDICAL & SCIENTIFIC RESEARCH	TN	501(C)(3)	4	BAPTIST MEMORIAL HEALTH CARE CORPORATION	Yes	
1225 NORTH STATE STREET JACKSON, MS 39202 47-3403762	SOLICIT, RAISE, MANAGE, APPLY & INVEST FUNDS IN SUPPORT OF BAPTIST ENTITIES	MS	501(C)(3)	12 TYPE I	MISSISSIPPI BAPTIST HEALTH SYSTEMS INC	Yes	
1225 NORTH STATE STREET JACKSON, MS 39202 45-2896080	HEALTH CARE FACILITY/HOSPITAL	MS	501(C)(3)	3	MISSISSIPPI BAPTIST HEALTH SYSTEMS INC	Yes	
823 GRAND AVENUE YAZOO CITY, MS 39194 64-0844470	HEALTH CARE FACILITY/HOSPITAL	MS	501(C)(3)	3	MISSISSIPPI BAPTIST HEALTH SYSTEMS INC	Yes	
1003 MONROE AVE MEMPHIS, TN 38104 62-1599670	EDUCATION OF HEALTH CARE PROFESSIONALS	TN	501(C)(3)	2	BAPTIST MEMORIAL HOSPITAL	Yes	
350 N HUMPHREYS BLVD MEMPHIS, TN 38120 58-1521475	MANAGEMENT, ADMINISTRATIVE & FINANCIAL SERVICES	TN	501(C)(3)	12 TYPE III-FI	N/A		No
350 N HUMPHREYS BLVD MEMPHIS, TN 38120 58-1544781	SOLICIT, RAISE, MANAGE, APPLY & INVEST FUNDS IN SUPPORT OF BAPTIST ENTITIES	TN	501(C)(3)	12 TYPE I	BAPTIST MEMORIAL HEALTH CARE CORPORATION	Yes	
350 N HUMPHREYS BLVD MEMPHIS, TN 38120 58-1456556	CARRY OUT THE HEALTH CARE MISSIONS OF THE BAPTIST CONVENTIONS OF AR, MS, TN	TN	501(C)(3)	12 TYPE I	N/A		No
350 N HUMPHREYS BLVD MEMPHIS, TN 381202177 62-1509127	PROVISIONS OF HEALTH CARE PROVIDERS & HOME MEDICAL EQUIPMENT/SERVICES	TN	501(C)(3)	12 TYPE I	BAPTIST MEMORIAL HEALTH CARE CORPORATION	Yes	
350 N HUMPHREYS BLVD MEMPHIS, TN 38120 58-1562973	HOME HEALTH CARE & HOSPICE SERVICES	TN	501(C)(3)	10	BAPTIST MEMORIAL HEALTH CARE CORPORATION	Yes	
350 N HUMPHREYS BLVD MEMPHIS, TN 38120 62-0123940	HEALTH CARE FACILITY/HOSPITAL	TN	501(C)(3)	3	BAPTIST MEMORIAL HEALTH CARE CORPORATION	Yes	
100 HOSPITAL STREET BOONEVILLE, MS 38829 64-0663760	HEALTH CARE FACILITY/HOSPITAL	MS	501(C)(3)	3	BAPTIST MEMORIAL HEALTH CARE CORPORATION	Yes	
350 N HUMPHREYS BLVD MEMPHIS, TN 38120 81-3257997	HEALTH CARE FACILITY/HOSPITAL	MS	501(C)(3)	3	BAPTIST MEMORIAL HEALTH CARE CORPORATION	Yes	
350 N HUMPHREYS BLVD MEMPHIS, TN 38120 82-3844150	HEALTH CARE FACILITY/HOSPITAL	AR	501(C)(3)	3	BAPTIST MEMORIAL HEALTH CARE CORPORATION	Yes	
7601 SOUTHCREST PARKWAY SOUTHAVEN, MS 38671 64-0682111	HEALTH CARE FACILITY/HOSPITAL	MS	501(C)(3)	3	BAPTIST MEMORIAL HEALTH CARE CORPORATION	Yes	
631 RB WILSON DRIVE HUNTINGDON, TN 38344 62-1166050	HEALTH CARE FACILITY/HOSPITAL	TN	501(C)(3)	3	BAPTIST MEMORIAL HEALTH CARE CORPORATION	Yes	
350 N HUMPHREYS BLVD MEMPHIS, TN 38120 26-1214372	HEALTH CARE FACILITY/HOSPITAL	AR	501(C)(3)	3	NEA BAPTIST HEALTH SYSTEM INC	Yes	
1100 BELK BOULEVARD OXFORD, MS 38655 64-0772726	HEALTH CARE FACILITY/HOSPITAL	MS	501(C)(3)	3	BAPTIST MEMORIAL HEALTH CARE CORPORATION	Yes	

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations							
(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
1995 HIGHWAY 51 SOUTH COVINGTON, TN 38019 62-1113167	HEALTH CARE FACILITY/HOSPITAL	TN	501(C)(3)	3	BAPTIST MEMORIAL HEALTH CARE CORPORATION	Yes	
1201 BISHOP ST UNION CITY, TN 38261 62-1138045	HEALTH CARE FACILITY/HOSPITAL	TN	501(C)(3)	3	BAPTIST MEMORIAL HEALTH CARE CORPORATION	Yes	
200 HWY 30 W NEW ALBANY, MS 38652 63-0997281	HEALTH CARE FACILITY/HOSPITAL	MS	501(C)(3)	3	BAPTIST MEMORIAL HEALTH CARE CORPORATION	Yes	
350 N HUMPHREYS BLVD MEMPHIS, TN 38120 62-1545731	PROVISION OF HEALTH CARE PROVIDERS FOR BAPTIST ENTITIES	TN	501(C)(3)	12 TYPE I	BAPTIST MEMORIAL HEALTH CARE CORPORATION	Yes	
350 N HUMPHREYS BLVD MEMPHIS, TN 38120 62-1407946	BAPTIST EMPLOYEE HEALTH PLAN	TN	501(C)(9)		BAPTIST MEMORIAL HEALTH CARE CORPORATION	Yes	
350 N HUMPHREYS BLVD MEMPHIS, TN 38120 58-1645396	HEALTH CARE FACILITY/HOSPITAL	TN	501(C)(3)	3	BAPTIST MEMORIAL HEALTH CARE CORPORATION	Yes	
350 N HUMPHREYS BLVD MEMPHIS, TN 38120 62-1538114	NON-EMERGENCY CLINICS	TN	501(C)(3)	3	BAPTIST MEMORIAL MEDICAL GROUP INC	Yes	
350 N HUMPHREYS BLVD MEMPHIS, TN 38120 81-3655778	HEALTH CARE FACILITY/HOSPITAL	MS	501(C)(3)	12 TYPE I	BAPTIST MEMORIAL HEALTH CARE CORPORATION	Yes	
350 N HUMPHREYS BLVD MEMPHIS, TN 38120 45-3032372	ESTABLISH, MAINTAIN & MANAGE A PATIENT SAFETY ORGANIZATION	TN	501(C)(3)	11	BAPTIST MEMORIAL HEALTH CARE CORPORATION	Yes	
350 N HUMPHREYS BLVD MEMPHIS, TN 38120 46-1953140	HEALTH CARE SERVICE PROVIDER	TN	501(C)(3)	3	BAPTIST MEMORIAL MEDICAL GROUP INC	Yes	
80 HUMPHREYS CENTER MEMPHIS, TN 38120 35-2461541	HEALTH CARE SERVICE PROVIDER	TN	501(C)(3)	3	BAPTIST MEMORIAL MEDICAL GROUP INC	Yes	
350 N HUMPHREYS BLVD MEMPHIS, TN 38120 45-3303687	HEALTH CARE SERVICE PROVIDER	TN	501(C)(3)	3	BAPTIST MEMORIAL MEDICAL GROUP INC	Yes	
350 N HUMPHREYS BLVD MEMPHIS, TN 38120 62-1112364	COLLECTION AGENCY FOR BAPTIST ENTITIES	TN	501(C)(3)	12 TYPE II	BAPTIST MEMORIAL HEALTH CARE CORPORATION	Yes	
1225 NORTH STATE STREET JACKSON, MS 39202 75-3068151	CLINICS	MS	501(C)(3)	3	MISSISSIPPI BAPTIST HEALTH SYSTEMS INC	Yes	
350 N HUMPHREYS BLVD MEMPHIS, TN 38120 45-2832975	HEALTH CARE SERVICE PROVIDER	TN	501(C)(3)	3	BAPTIST MEMORIAL MEDICAL GROUP INC	Yes	
1225 NORTH STATE STREET JACKSON, MS 39202 64-0306253	HOLDING COMPANY	MS	501(C)(3)	12 TYPE II	BAPTIST MEMORIAL HEALTH CARE CORPORATION	Yes	
1225 NORTH STATE STREET JACKSON, MS 39202 64-0881013	HEALTH CARE FACILITY/HOSPITAL	MS	501(C)(3)	3	MISSISSIPPI BAPTIST HEALTH SYSTEMS INC	Yes	
1225 NORTH STATE STREET JACKSON, MS 39202 64-0833383	HEALTH CARE FACILITY/HOSPITAL	MS	501(C)(3)	3	MISSISSIPPI BAPTIST HEALTH SYSTEMS INC	Yes	
1225 NORTH STATE STREET JACKSON, MS 39202 80-0812322	HOLDING COMPANY	MS	501(C)(3)	12 TYPE I	MISSISSIPPI BAPTIST HEALTH SYSTEMS INC	Yes	
350 N HUMPHREYS BLVD MEMPHIS, TN 38120 27-1799652	HEALTH CARE SERVICE PROVIDER	AR	501(C)(3)	12 TYPE II	BAPTIST MEMORIAL HEALTH CARE CORPORATION	Yes	

**Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c) (3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
4802 EAST JOHNSON AVE JONESBORO, AR 72401 71-0850123	HEALTH CARE SERVICE PROVIDER	AR	501(C)(3)	3	NEA BAPTIST HEALTH SYSTEM INC	Yes	
102 CLINTON PARKWAY CLINTON, MS 39056 64-0900902	PROMOTION OF HEALTH & FITNESS	MS	501(C)(3)	10	MISSISSIPPI BAPTIST HEALTH SYSTEMS INC	Yes	
8060 WOLF RIVER BLVD GERMANTOWN, TN 38138 27-4396698	HEALTH CARE SERVICE PROVIDER	TN	501(C)(3)	3	BAPTIST MEMORIAL MEDICAL GROUP INC	Yes	

**Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal Domicile (State or Foreign Country)	(d) Direct Controlling Entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in Box 20 of Schedule K-1 (Form 1065)	(j) General or Managing Partner?		(k) Percentage ownership
							Yes	No		Yes	No	
BAPTIST - DESOTO SURGERY CENTER LP  310 SEVEN SPRINGS WAY SUITE 500 BRENTWOOD, TN 37027 20-0804946	AMBULATORY SURGERY	MS	N/A					No		Yes		
BAPTIST - EMSC LP  80 HUMPHREYS CENTER SUITE 101 MEMPHIS, TN 38120 62-1846584	AMBULATORY SURGERY	TN	N/A					No		Yes		
BAPTIST - UT INSTITUTE FOR ACADEMIC EXCELLENCE LLC  350 N HUMPHREYS BLVD MEMPHIS, TN 38120 87-1722903	MEDICAL MANAGEMENT	TN	N/A					No		Yes		
BAPTIST-GERMANTOWN SURGERY CENTER LLC  6077 PRIMACY PKWY SUITE 140 MEMPHIS, TN 38119 62-1829424	AMBULATORY SURGERY	TN	N/A					No		Yes		
BAPTIST MEMORIAL REHABILITATION HOSPITAL GP  330 SEVEN SPRINGS WAY BRENTWOOD, TN 37027 46-1613457	REHABILITATION SERVICES	TN	N/A					No		Yes		
BMH NORTH MISSISSIPPI IMAGING SERVICES LLC  504 AZALEA DRIVE OXFORD, MS 38655 26-2641267	DIAGNOSTIC SERVICES	MS	N/A					No			No	
BAPTIST AND PHYSICIANS' OUTPATIENT SURGERY CENTER OF N MISSISSIPPI LP  310 SEVEN SPRINGS WAY SUITE 500 BRENTWOOD, TN 37027 64-0925692	AMBULATORY SURGERY	MS	N/A					No			No	
BAPTIST STERN CARDIOVASCULAR CO-MANAGEMENT LLC  350 N HUMPHREYS BLVD MEMPHIS, TN 38120 82-0605766	MEDICAL MANAGEMENT	TN	N/A					No		Yes		
BMHSIAEL MICROBIOLOGY LABORATORY GP  12357-A RIATA TRACE PARKWAY SUITE 2 AUSTIN, TX 78727 81-4211152	LABORATORY SERVICES	TX	N/A					No		Yes		
BAPTIST - UCH INSTITUTE FOR PLASTIC AND RECONSTRUCTIVE SURGERY LLC  350 N HUMPHREYS BLVD MEMPHIS, TN 38120 82-1046465	MEDICAL MANAGEMENT	TN	N/A					No			No	
BRAIN AND SPINE NETWORK BAPTIST SEMMES-MURPHEY LLC  350 N HUMPHREYS BLVD MEMPHIS, TN 38120 47-5240436	MEDICAL MANAGEMENT	TN	N/A					No		Yes		
DOWNTOWN FITNESS LLC  100 EAST CAPITOL STREET SUITE 107 JACKSON, MS 39201 61-1852202	FITNESS CENTER	MS	N/A					No			No	
EAST MEMPHIS UROLOGY CENTER LP  310 SEVEN SPRINGS WAY SUITE 500 BRENTWOOD, TN 37027 62-1810940	AMBULATORY UROLOGICAL SERVICES	TN	N/A					No		Yes		
MADISON HEALTHPLEX PERFORMANCE TRAINING CENTER LLC  1600 N STATE STREET SUITE 400 JACKSON, MS 39202 46-1218603	FITNESS CENTER	MS	N/A					No		Yes		
MAIN STREET FAMILY MEDICAL LLC  1225 NORTH STATE STREET JACKSON, MS 39202 45-2778113	MEDICAL SERVICES	MS	N/A					No		Yes		

**Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal Domicile (State or Foreign Country)	(d) Direct Controlling Entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end- of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in Box 20 of Schedule K-1 (Form 1065)	(j) General or Managing Partner?		(k) Percentage ownership
							Yes	No		Yes	No	
MAYS & SCHNAPP PAIN CLINIC  55 HUMPHREYS CENTER DRIVE SUITE 200 MEMPHIS, TN 38120 62-1512849	PAIN MANAGEMENT SERVICES	TN	N/A					No		Yes		
MEDICAL ALTERNATIVES  6949 APPLING FARMS PKWY STE 109 MEMPHIS, TN 38133 62-1488427	PROVIDE HOME INFUSION PRODUCTS AND SERVICES TO PATIENTS	TN	N/A					No		Yes		
MID-SOUTH IMAGING CENTER LLC  350 N HUMPHREYS BLVD MEMPHIS, TN 38120 87-2098257	DIAGNOSTIC SERVICES	MS	N/A					No		Yes		
WEST TENNESSEE IMAGING LLC  840 CRESCENT CENTRE DR SUITE 200 FRANKLIN, TN 37067 90-1022012	MEDICAL SERVICES	TN	N/A					No			No	

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

<b>(a)</b> Name of related organization	<b>(b)</b> Transaction type(a-s)	<b>(c)</b> Amount Involved	<b>(d)</b> Method of determining amount involved
BAPTIST MEMORIAL HEALTH CARE FOUNDATION INC	C	181,724	CASH
BAPTIST MEMORIAL HEALTH CARE CORPORATION	E	6,709,503	CASH
BAPTIST MEMORIAL HOSPITAL-DESOTO INC	E	201,007	CASH
BAPTIST MEMORIAL HEALTH CARE CORPORATION	M	16,256,628	CASH
BAPTIST MEMORIAL HOSPITAL	P	449,395	CASH
BMHSIAEL MICROBIOLOGY LABORATORY GP	P	987,100	CASH
BAPTIST MEMORIAL MEDICAL GROUP INC	R	16,551,852	CASH
BAPTIST MEMORIAL MEDICAL MINISTRIES EMPLOYEE HEALTH AND WELFARE TRUST	R	8,341,358	CASH