LET'S THRIVE TOGETHER

Warren Averett
CPAs AND ADVISORS
www.warrenaverett.com

TAX RETURN

We sincerely appreciate the opportunity to serve you. If you have any questions regarding the enclosed, please do not hesitate to call.

TAX RETURN FILING INSTRUCTIONS

FORM 990

FOR THE YEAR ENDING
DECEMBER 31, 2024

PREPARED FOR:

MR. MICHAEL LOFTUS
HOUSTON HOSPITALS, INC.
1601 WATSON BOULEVARD
WARNER ROBINS, GA 31093

PREPARED BY:

WARREN AVERETT, LLC
2500 ACTON ROAD
BIRMINGHAM, AL 35243

AMOUNT DUE OR REFUND:

NOT APPLICABLE

MAKE CHECK PAYABLE TO:

NOT APPLICABLE

MAIL TAX RETURN AND CHECK (IF APPLICABLE) TO:

NOT APPLICABLE

RETURN MUST BE MAILED ON OR BEFORE:

NOT APPLICABLE

SPECIAL INSTRUCTIONS:

THIS RETURN HAS BEEN PREPARED FOR ELECTRONIC FILING. IF YOU WISH TO HAVE IT TRANSMITTED ELECTRONICALLY TO THE IRS, PLEASE SIGN, DATE, AND RETURN FORM 8879-TE TO OUR OFFICE. WE WILL THEN SUBMIT THE ELECTRONIC RETURN TO THE IRS. DO NOT MAIL A PAPER COPY OF THE RETURN TO THE IRS. RETURN FORM 8879-TE TO US BY NOVEMBER 17, 2025

PLEASE MAIL A SIGNED COPY OF THE FORM 990 TO:

GEORGIA DEPARTMENT OF REVENUE
P.O. BOX 740395
ATLANTA, GA 30374-0395

TAX RETURN FILING INSTRUCTIONS

FORM 990-T

FOR THE YEAR ENDING
DECEMBER 31, 2024

PREPARED FOR:

MR. MICHAEL LOFTUS
HOUSTON HOSPITALS, INC.
1601 WATSON BOULEVARD
WARNER ROBINS, GA 31093

PREPARED BY:

WARREN AVERETT, LLC
2500 ACTON ROAD
BIRMINGHAM, AL 35243

AMOUNT DUE OR REFUND:

OVERPAYMENT OF $11,111. THE ENTIRE OVERPAYMENT HAS BEEN APPLIED TO THE ESTIMATED TAX PAYMENTS.

MAKE CHECK PAYABLE TO:

NO AMOUNT IS DUE.

MAIL TAX RETURN AND CHECK (IF APPLICABLE) TO:

NOT APPLICABLE

RETURN MUST BE MAILED ON OR BEFORE:

NOT APPLICABLE

SPECIAL INSTRUCTIONS:

THE RETURN SHOULD BE SIGNED AND DATED.

THIS RETURN HAS BEEN PREPARED FOR ELECTRONIC FILING. IF YOU WISH TO HAVE IT TRANSMITTED ELECTRONICALLY TO THE IRS, PLEASE SIGN, DATE, AND RETURN FORM 8879-TE TO OUR OFFICE. WE WILL THEN SUBMIT THE ELECTRONIC RETURN TO THE IRS. DO NOT MAIL A PAPER COPY OF THE RETURN TO THE IRS. RETURN FORM 8879-TE TO US BY NOVEMBER 15, 2025.

2025 ESTIMATED TAX FILING INSTRUCTIONS

FORM 990-W

FOR THE YEAR ENDING
DECEMBER 31, 2025

PREPARED FOR:

MR. MICHAEL LOFTUS
HOUSTON HOSPITALS, INC.
1601 WATSON BOULEVARD
WARNER ROBINS, GA 31093

PREPARED BY:

WARREN AVERETT, LLC
2500 ACTON ROAD
BIRMINGHAM, AL 35243

AMOUNT OF TAX:

TOTAL ESTIMATED TAX	$	46,111
LESS CREDIT FROM PRIOR YEAR	$	11,111
LESS AMT ALREADY PAID ON 2025 ESTIMATE	$	0
BALANCE DUE	$	35,000

PAYABLE IN FULL OR IN INSTALLMENTS AS FOLLOWS:

VOUCHER		AMOUNT	DUE DATE
NO 1	$	0	
NO 2	$	0	
NO 3	$	0	
NO 4	$	35,000	DECEMBER 15, 2025

MAKE CHECK PAYABLE TO:

PAYMENTS SHOULD BE MADE USING THE ELECTRONIC FEDERAL TAX PAYMENT SYSTEM (EFTPS).

MAIL VOUCHER AND CHECK (IF APPLICABLE) TO:

NOT APPLICABLE

SPECIAL INSTRUCTIONS:

Form **8879-TE**

Department of the Treasury
Internal Revenue Service

IRS E-file Signature Authorization for a Tax Exempt Entity

For calendar year 2024, or fiscal year beginning _____ , 2024, and ending _____ , 20 ___

Do not send to the IRS. Keep for your records.
Go to www.irs.gov/Form8879TE for the latest information.

OMB No. 1545-0047

2024

Name of filer
HOUSTON HOSPITALS, INC

EIN or SSN
71-1045290

Name and title of officer or person subject to tax
MICHAEL LOFTUS
CFO

Part I Type of Return and Return Information

Check the box for the return for which you are using this Form 8879-TE and enter the applicable amount, if any, from the return. Form 8038-CP and Form 5330 filers may enter dollars and cents. For all other forms, enter whole dollars only. If you check the box on line **1a, 2a, 3a, 4a, 5a, 6a, 7a, 8a, 9a,** or **10a** below, and the amount on that line for the return being filed with this form was blank, then leave line **1b, 2b, 3b, 4b, 5b, 6b, 7b, 8b, 9b,** or **10b,** whichever is applicable, blank (do not enter -0-). But, if you entered -0- on the return, then enter -0- on the applicable line below. **Do not** complete more than one line in Part I.

1a	**Form 990** check here	X	**b Total revenue,** if any (Form 990, Part VIII, column (A), line 12)	1b	361,709,463.
2a	**Form 990-EZ** check here		**b Total revenue,** if any (Form 990-EZ, line 9)	2b	
3a	**Form 1120-POL** check here		**b Total tax** (Form 1120-POL, line 22)	3b	
4a	**Form 990-PF** check here		**b Tax based on investment income** (Form 990-PF, Part V, line 5)	4b	
5a	**Form 8868** check here		**b Balance due** (Form 8868, line 3c)	5b	
6a	**Form 990-T** check here		**b Total tax** (Form 990-T, Part III, line 4)	6b	
7a	**Form 4720** check here		**b Total tax** (Form 4720, Part III, line 1)	7b	
8a	**Form 5227** check here		**b FMV of assets at end of tax year** (Form 5227, Item D)	8b	
9a	**Form 5330** check here		**b Tax due** (Form 5330, Part II, line 19)	9b	
10a	**Form 8038-CP** check here		**b Amount of credit payment requested** (Form 8038-CP, Part III, line 22)	10b	

Part II Declaration and Signature Authorization of Officer or Person Subject to Tax

Under penalties of perjury, I declare that [X] I am an officer of the above entity or [ ] I am a person subject to tax with respect to (name of entity) _____ , (EIN) _____ and that I have examined a copy of the 2024 electronic return and accompanying schedules and statements, and, to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the return to the IRS and to receive from the IRS **(a)** an acknowledgement of receipt or reason for rejection of the transmission, **(b)** the reason for any delay in processing the return or refund, and **(c)** the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the electronic return and, if applicable, the consent to electronic funds withdrawal.

PIN: check one box only

[X] I authorize WARREN AVERETT, LLC to enter my PIN 35243

ERO firm name

Enter five numbers, but do not enter all zeros

as my signature on the tax year 2024 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

[ ] As an officer or person subject to tax with respect to the entity, I will enter my PIN as my signature on the tax year 2024 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Signature of officer or person subject to tax _____ Date _____

Part III Certification and Authentication

ERO's EFIN/PIN. Enter your six-digit electronic filing identification number (EFIN) followed by your five-digit self-selected PIN. 63056212345

Do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2024 electronically filed return indicated above. I confirm that I am submitting this return in accordance with the requirements of **Pub. 4163,** Modernized e-File (MeF) Information for Authorized IRS *e-file* Providers for Business Returns.

ERO's signature _____ Date 11/12/25

ERO Must Retain This Form - See Instructions
Do Not Submit This Form to the IRS Unless Requested To Do So

Form **8879-TE**

Department of the Treasury
Internal Revenue Service

IRS E-file Signature Authorization for a Tax Exempt Entity

For calendar year 2024, or fiscal year beginning _____, 2024, and ending _____, 20___

Do not send to the IRS. Keep for your records.
Go to www.irs.gov/Form8879TE for the latest information.

OMB No. 1545-0047

2024

Name of filer
HOUSTON HOSPITALS, INC

EIN or SSN
71-1045290

Name and title of officer or person subject to tax
MICHAEL LOFTUS
CFO

Part I Type of Return and Return Information

Check the box for the return for which you are using this Form 8879-TE and enter the applicable amount, if any, from the return. Form 8038-CP and Form 5330 filers may enter dollars and cents. For all other forms, enter whole dollars only. If you check the box on line **1a, 2a, 3a, 4a, 5a, 6a, 7a, 8a, 9a,** or **10a** below, and the amount on that line for the return being filed with this form was blank, then leave line **1b, 2b, 3b, 4b, 5b, 6b, 7b, 8b, 9b,** or **10b,** whichever is applicable, blank (do not enter -0-). But, if you entered -0- on the return, then enter -0- on the applicable line below. **Do not** complete more than one line in Part I.

1a	**Form 990** check here	☐	**b Total revenue,** if any (Form 990, Part VIII, column (A), line 12)	1b	
2a	**Form 990-EZ** check here	☐	**b Total revenue,** if any (Form 990-EZ, line 9)	2b	
3a	**Form 1120-POL** check here	☐	**b Total tax** (Form 1120-POL, line 22)	3b	
4a	**Form 990-PF** check here	☐	**b Tax based on investment income** (Form 990-PF, Part V, line 5)	4b	
5a	**Form 8868** check here	☐	**b Balance due** (Form 8868, line 3c)	5b	
6a	**Form 990-T** check here	☒	**b Total tax** (Form 990-T, Part III, line 4)	6b	45,198.
7a	**Form 4720** check here	☐	**b Total tax** (Form 4720, Part III, line 1)	7b	
8a	**Form 5227** check here	☐	**b FMV of assets at end of tax year** (Form 5227, Item D)	8b	
9a	**Form 5330** check here	☐	**b Tax due** (Form 5330, Part II, line 19)	9b	
10a	**Form 8038-CP** check here	☐	**b Amount of credit payment requested** (Form 8038-CP, Part III, line 22)	10b	

Part II Declaration and Signature Authorization of Officer or Person Subject to Tax

Under penalties of perjury, I declare that ☒ I am an officer of the above entity or ☐ I am a person subject to tax with respect to (name of entity) _____, (EIN)_____ and that I have examined a copy of the 2024 electronic return and accompanying schedules and statements, and, to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the return to the IRS and to receive from the IRS **(a)** an acknowledgement of receipt or reason for rejection of the transmission, **(b)** the reason for any delay in processing the return or refund, and **(c)** the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the electronic return and, if applicable, the consent to electronic funds withdrawal.

PIN: check one box only

☒ I authorize WARREN AVERETT, LLC to enter my PIN 35243

ERO firm name

Enter five numbers, but do not enter all zeros

as my signature on the tax year 2024 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

☐ As an officer or person subject to tax with respect to the entity, I will enter my PIN as my signature on the tax year 2024 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Signature of officer or person subject to tax _____ Date _____

Part III Certification and Authentication

ERO's EFIN/PIN. Enter your six-digit electronic filing identification number (EFIN) followed by your five-digit self-selected PIN. 63056212345

Do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2024 electronically filed return indicated above. I confirm that I am submitting this return in accordance with the requirements of **Pub. 4163,** Modernized e-File (MeF) Information for Authorized IRS *e-file* Providers for Business Returns.

ERO's signature _____ Date 11/12/25

ERO Must Retain This Form - See Instructions
Do Not Submit This Form to the IRS Unless Requested To Do So

EXTENDED TO NOVEMBER 17, 2025

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)
Do not enter social security numbers on this form as it may be made public.
Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2024

Open to Public Inspection

A For the 2024 calendar year, or tax year beginning **and ending**

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

C Name of organization
HOUSTON HOSPITALS, INC

Doing business as

Number and street (or P.O. box if mail is not delivered to street address) | Room/suite
1601 WATSON BOULEVARD

City or town, state or province, country, and ZIP or foreign postal code
WARNER ROBINS, GA 31093

F Name and address of principal officer: CHARLES BRISCOE
SAME AS C ABOVE

D Employer identification number
71-1045290

E Telephone number
478-542-7959

G Gross receipts $ 548,387,597.

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.HHC.ORG

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

L Year of formation: 2009 **M** State of legal domicile: GA

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities: TO IMPROVE THE HEALTHCARE OF THE COMMUNITIES WE SERVE BY PROVIDING PATIENT-FOCUSED, HIGH-QUALITY,

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

3	Number of voting members of the governing body (Part VI, line 1a)	3	10
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	10
5	Total number of individuals employed in calendar year 2024 (Part V, line 2a)	5	3052
6	Total number of volunteers (estimate if necessary)	6	131
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	219,486.
b	Net unrelated business taxable income from Form 990-T, Part I, line 11	7b	215,227.

Revenue

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	0.	0.
9	Program service revenue (Part VIII, line 2g)	278,000,480.	355,347,940.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	3,705,746.	5,449,550.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	883,185.	911,973.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	282,589,411.	361,709,463.

Expenses

13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	151,500.	150,000.
14	Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	166,458,820.	208,972,736.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
b	Total fundraising expenses (Part IX, column (D), line 25) 0.		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	139,364,228.	142,774,267.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	305,974,548.	351,897,003.
19	Revenue less expenses. Subtract line 18 from line 12	-23,385,137.	9,812,460.

Net Assets or Fund Balances

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	363,634,989.	438,351,392.
21	Total liabilities (Part X, line 26)	77,331,558.	109,089,053.
22	Net assets or fund balances. Subtract line 21 from line 20	286,303,431.	329,262,339.

Part II Signature Block

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

Sign Here

Signature of officer — Date

MICHAEL LOFTUS, CFO
Type or print name and title

Paid Preparer Use Only

Preparer's name	Preparer's signature	Date	Check if self-employed	PTIN
MEGAN RANDOLPH		11/12/25	☐	P00989558

Firm's name WARREN AVERETT, LLC — Firm's EIN 45-4084437

Firm's address 2500 ACTON ROAD
BIRMINGHAM, AL 35243 — Phone no. 205-979-4100

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

SEE SCHEDULE O FOR ORGANIZATION MISSION STATEMENT CONTINUATION

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:
TO IMPROVE THE HEALTHCARE OF THE COMMUNITIES WE SERVE BY PROVIDING PATIENT-FOCUSED, HIGH-QUALITY, COST-EFFECTIVE SERVICES WHILE PROMOTING HEALTH AND WELLNESS.

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 $ 320,328,329. including grants of $ 150,000.) (Revenue $ 354,881,806.)
THE HOSPITALS' PRIMARY PROGRAM ACTIVITY IS THE PROVISION OF PATIENT CARE. THE HOSPITALS PROVIDED NURSING CARE IN THE AREAS OF MEDICAL, POST-SURGICAL, PSYCHIATRIC, CRITICAL CARE, INTERMEDIATE CARE, LABOR AND DELIVERY, POST PARTUM, NURSERY, PEDIATRICS, AND WOUND OSTOMY CARE. THE UTILIZATION DATA INCLUDES 14,266 ADULT AND PEDIATRIC ADMISSIONS, 63,497 PATIENT DAYS, 1,994 BIRTHS, AND 70,316 EMERGENCY ROOM VISITS. THE HOSPITALS ALSO PROVIDED 11,486 SURGICAL SERVICES TO PATIENTS WHICH INCLUDED 1,946 INPATIENTS, 6,409 OUTPATIENTS, AND 3,131 ENDOSCOPY PATIENTS.

4b (Code:) (Expenses $ 1,617,530. including grants of $ 0.) (Revenue $ 466,134.)
EDUCARE, THE COMMUNITY EDUCATION DEPARTMENT OF HOUSTON HOSPITALS PROVIDED HEALTH FAIRS, SENIOR CARE LUNCHEONS, BLOOD PRESSURE SCREENINGS, AND EXERCISE CLASSES. EDUCARE ALSO PROVIDED EDUCATION CLASSES AND SUPPORT GROUPS FOR THE FOLLOWING HEALTH ISSUES AND TOPICS: ALZHEIMERS, ARTHRITIS, BREAST CANCER, BREASTFEEDING, CARDIAC HEALTH, CHILDBIRTH, COOKING, DIABETES, DIET, DIVORCE, HYPERTENSION, LUPUS, MULTIPLE SCLEROSIS, PREGNANCY, SIBLINGS, STRESS MANAGEMENT, TOBACCO CESSATION, WALKING, AND WEIGHT LOSS.

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

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

4e Total program service expenses 321,945,859.

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules *(continued)*

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

				Yes	No
1a	Enter the number reported in box 3 of Form 1096. Enter -0- if not applicable	1a	315		
b	Enter the number of Forms W-2G included on line 1a. Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		X	

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

				Yes	No
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	3052		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b		X	
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?	3a		X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation on Schedule O*	3b		X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a			X
b	If "Yes," enter the name of the foreign country				
	See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a			X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b			X
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?	5c			
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	6a			X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b			
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	7a			X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b			
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c			X
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e			X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f			X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g		N/A	
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h		N/A	
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? N/A	8			
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the sponsoring organization make any taxable distributions under section 4966? N/A	9a			
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? N/A	9b			
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12 N/A	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders N/A	11a			
b	Gross income from other sources. (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	12a			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year N/A	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state? N/A	13a			
	Note: See the instructions for additional information the organization must report on Schedule O.				
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a			X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation on Schedule O*	14b			
15	Is the organization subject to the section 4960 tax on payment(s) of more than $1,000,000 in remuneration or excess parachute payment(s) during the year?	15			X
	If "Yes," see the instructions and file Form 4720, Schedule N.				
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income?	16			X
	If "Yes," complete Form 4720, Schedule O.				
17	**Section 501(c)(21) organizations.** Did the trust, or any disqualified or other person engage in any activities that would result in the imposition of an excise tax under section 4951, 4952 or 4953? N/A	17			
	If "Yes," complete Form 6069.				

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

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

Section A. Governing Body and Management

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

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

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

Section C. Disclosure

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

18 Section 6104 requires an organization to make its Forms 1023 (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.

[X] Own website [ ] Another's website [X] Upon request [ ] Other *(explain on Schedule O)*

19 Describe on 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

MICHAEL LOFTUS - 478-542-7959

1601 WATSON BOULEVARD, WARNER ROBBINS, GA 31093

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, box 6 of 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, and highest compensated employees who received more than $100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than $10,000 of reportable compensation from the organization and any related organizations.

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 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) LUKE COUCH	45.00									
PHYSICIAN	0.00					X		724,899.	0.	23,626.
(2) CHARLES G. BRISCOE	45.00									
PRESIDENT & CHIEF EXEC. OFFICER	5.00			X				442,428.	0.	23,374.
(3) LARRY D. STEWART, M.D.	45.00									
VP & CHIEF MEDICAL OFFICER	5.00			X				377,765.	0.	16,403.
(4) SEAN S. WHILDEN	45.00									
VP & CFO (INTERIM COO)	5.00			X				315,407.	0.	25,168.
(5) PETER IZZO	45.00									
PHYSICIAN	0.00					X		278,977.	0.	22,294.
(6) JACINTA TRAN	45.00									
PHYSICIAN	0.00					X		271,879.	0.	19,557.
(7) MARIAM LARO	45.00									
PHYSICIAN	0.00					X		265,476.	0.	6,934.
(8) ANJALI MAGAR	45.00									
PHYSICIAN	0.00					X		265,452.	0.	784.
(9) SIGISMUND D. TETTEH	45.00									
VP CHIEF INFORMATION OFFICER	0.00			X				192,148.	0.	16,682.
(10) SHELLISA HOUSTON-MARTIN	45.00									
VP PATIENT CARE SERVICES	5.00			X				204,096.	0.	5,012.
(11) TODD EDENFIELD	45.00									
VP ADMINISTRATOR PH	5.00				X			166,879.	0.	13,622.
(12) TOMMY STALNAKER	4.00									
CHAIRMAN	0.00	X						0.	0.	0.
(13) JOHN D. HALL, M.D.	4.00									
VICE CHAIRMAN	0.00	X						0.	0.	0.
(14) MOHAMMAD AL-SHROOF, M.D.	4.00									
TRUSTEE	0.00	X						0.	0.	0.
(15) SHAWN CARPENTER	4.00									
TRUSTEE	0.00	X						0.	0.	0.
(16) HEATHER DEXTER	4.00									
TRUSTEE	0.00	X						0.	0.	0.
(17) LEWANZA HARRIS, M.D.	4.00									
TRUSTEE	0.00	X						0.	0.	0.

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 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) RAHIL KAZI, M.D.	4.00									
TRUSTEE	0.00	X						0.	0.	0.
(19) GAIL ROBINSON	4.00									
TRUSTEE	0.00	X						0.	0.	0.
(20) APPAVUCHETTY SOUNDAPAAN, M.D.	4.00									
TRUSTEE	0.00	X						0.	0.	0.
(21) D. SCOTT WESTMORELAND, DMV	4.00									
TRUSTEE	0.00	X						0.	0.	0.
1b Subtotal								3,505,406.	0.	173,456.
c Total from continuation sheets to Part VII, Section A								0.	0.	0.
d Total (add lines 1b and 1c)								3,505,406.	0.	173,456.

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 211

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
MCKESSON FILE 57256, LOS ANGELES, CA 90074-7526	DRUGS	16,386,496.
HWL, 2655 NORTHWINDS PARKWAY, ALPHARETTA, GA 30009	NURSING AGENCY	10,160,011.
QUEST DIAGNOSTICS, 4380 FEDERAL DRIVE SUITE 100, GREENSBORO, NC 27410	LABORATORY SERVICES	8,519,224.
HOUSTON HOSPITALIST GROUP PO BOX 740666, ATLANTA, GA 30374-0666	HOSPITALIST SERVICES	4,965,094.
OWENS & MINOR, INC. PO BOX 1327, KENNESAW, GA 30144	MEDICAL SUPPLY SUPPLIER	4,594,309.

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 226

Part VIII Statement of Revenue

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

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns	1a				
	b	Membership dues	1b				
	c	Fundraising events	1c				
	d	Related organizations	1d				
	e	Government grants (contributions)	1e				
	f	All other contributions, gifts, grants, and similar amounts not included above	1f				
	g	Noncash contributions included in lines 1a-1f	1g $				
	h	**Total.** Add lines 1a-1f					
Program Service Revenue			**Business Code**				
	2a	NET PATIENT REVENUE	621300	345437498.	345437498.		
	b	GA PHYSICIAN WORKFORCE	621110	1,426,140.	1,426,140.		
	c	PERRY FAMILY PRACTICE	621110	950,000.	950,000.		
	d	GEORGIA MEDICAID GME	621300	838,175.	838,175.		
	e	EMPLOYEE PHARMACY	456110	226,694.	226,694.		
	f	All other program service revenue	621300	6,469,433.	6,469,433.		
	g	**Total.** Add lines 2a-2f		355347940.			
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts)		2,569,054.			2569054.
	4	Income from investment of tax-exempt bond proceeds					
	5	Royalties					
			(i) Real	(ii) Personal			
	6a	Gross rents 6a	692,487.	312,349.			
	b	Less: rental expenses 6b	0.	92,863.			
	c	Rental income or (loss) 6c	692,487.	219,486.			
	d	Net rental income or (loss)		911,973.		219,486.	692,487.
			(i) Securities	(ii) Other			
	7a	Gross amount from sales of assets other than inventory 7a	189,465,767.				
	b	Less: cost or other basis and sales expenses 7b	186,583,670.	1,601.			
	c	Gain or (loss) 7c	2,882,097.	-1,601.			
	d	Net gain or (loss)		2,880,496.			2880496.
	8a	Gross income from fundraising events (not including $ _____ of contributions reported on line 1c). See Part IV, line 18 8a					
	b	Less: direct expenses 8b					
	c	Net income or (loss) from fundraising events					
	9a	Gross income from gaming activities. See Part IV, line 19 9a					
	b	Less: direct expenses 9b					
	c	Net income or (loss) from gaming activities					
	10a	Gross sales of inventory, less returns and allowances 10a					
	b	Less: cost of goods sold 10b					
	c	Net income or (loss) from sales of inventory					
Miscellaneous Revenue			**Business Code**				
	11a						
	b						
	c						
	d	All other revenue					
	e	**Total.** Add lines 11a-11d					
	12	**Total revenue.** See instructions		361709463.	355347940.	219,486.	6142037.

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 X

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	150,000.	150,000.		
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	1,777,290.	541,380.	1,235,910.	
6 Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	133,984,561.	126,629,679.	7,354,882.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	48,765,884.	44,827,101.	3,938,783.	
9 Other employee benefits	15,390,809.	15,161,772.	229,037.	
10 Payroll taxes	9,054,192.	8,484,276.	569,916.	
11 Fees for services (nonemployees):				
a Management				
b Legal	1,713,911.		1,713,911.	
c Accounting	787,079.		787,079.	
d Lobbying	116,250.		116,250.	
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other. (If line 11g amount exceeds 10% of line 25, column (A), amount, list line 11g expenses on Sch O.)	48,104,571.	42,054,451.	6,050,120.	
12 Advertising and promotion	393,237.	65,287.	327,950.	
13 Office expenses	3,324,401.	3,224,903.	99,498.	
14 Information technology	7,659,691.	5,447,018.	2,212,673.	
15 Royalties				
16 Occupancy	5,800,906.	5,496,529.	304,377.	
17 Travel	54,391.	46,340.	8,051.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings				
20 Interest	115,883.	115,883.		
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	8,927,108.	8,927,108.		
23 Insurance	3,090,204.	2,804,545.	285,659.	
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses on line 24e. If line 24e amount exceeds 10% of line 25, column (A), amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLIES & PHAR	44,913,740.	44,848,483.	65,257.	
b EQUIPMENT MAINTENANCE	8,757,329.	7,897,726.	859,603.	
c PROVIDER TAX	3,744,412.		3,744,412.	
d MINOR EQUIPMENT	1,217,682.	1,217,682.		
e All other expenses	4,053,472.	4,005,696.	47,776.	
25 **Total functional expenses.** Add lines 1 through 24e	351,897,003.	321,945,859.	29,951,144.	0.
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ☐ if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

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

				(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing		9,853,115.	1	20,590,437.
	2	Savings and temporary cash investments			2	
	3	Pledges and grants receivable, net			3	
	4	Accounts receivable, net		113,175,192.	4	155,967,804.
	5	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			5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)			6	
	7	Notes and loans receivable, net		2,596,142.	7	0.
	8	Inventories for sale or use		4,285,862.	8	4,714,759.
	9	Prepaid expenses and deferred charges		4,192,835.	9	0.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 344,056,261.			
	b	Less: accumulated depreciation	10b 232,407,975.	112,321,215.	10c	111,648,286.
	11	Investments - publicly traded securities		101,552,602.	11	83,503,040.
	12	Investments - other securities. See Part IV, line 11			12	
	13	Investments - program-related. See Part IV, line 11		4,785,918.	13	4,816,363.
	14	Intangible assets			14	
	15	Other assets. See Part IV, line 11		10,872,108.	15	57,110,703.
	16	**Total assets.** Add lines 1 through 15 (must equal line 33)		363,634,989.	16	438,351,392.
Liabilities	17	Accounts payable and accrued expenses		53,431,209.	17	44,431,124.
	18	Grants payable			18	
	19	Deferred revenue			19	
	20	Tax-exempt bond liabilities			20	
	21	Escrow or custodial account liability. Complete Part IV of Schedule D			21	
	22	Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons			22	
	23	Secured mortgages and notes payable to unrelated third parties		6,522,559.	23	0.
	24	Unsecured notes and loans payable to unrelated third parties			24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D		17,377,790.	25	64,657,929.
	26	**Total liabilities.** Add lines 17 through 25		77,331,558.	26	109,089,053.
Net Assets or Fund Balances		**Organizations that follow FASB ASC 958, check here** ☒ **and complete lines 27, 28, 32, and 33.**				
	27	Net assets without donor restrictions		286,303,431.	27	329,262,339.
	28	Net assets with donor restrictions			28	
		Organizations that do not follow FASB ASC 958, check here ☐ **and complete lines 29 through 33.**				
	29	Capital stock or trust principal, or current funds			29	
	30	Paid-in or capital surplus, or land, building, or equipment fund			30	
	31	Retained earnings, endowment, accumulated income, or other funds			31	
	32	Total net assets or fund balances		286,303,431.	32	329,262,339.
	33	Total liabilities and net assets/fund balances		363,634,989.	33	438,351,392.

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	361,709,463.
2	Total expenses (must equal Part IX, column (A), line 25)	2	351,897,003.
3	Revenue less expenses. Subtract line 2 from line 1	3	9,812,460.
4	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	4	286,303,431.
5	Net unrealized gains (losses) on investments	5	33,243,421.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain on Schedule O)	9	-96,973.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	10	329,262,339.

Part XII Financial Statements and Reporting

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

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ Cash ☒ Accrual ☐ Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain on Schedule O.			
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?	2a		X
	If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis			
b	Were the organization's financial statements audited by an independent accountant?	2b	X	
	If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: ☐ Separate basis ☒ Consolidated basis ☐ Both consolidated and separate basis			
c	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?	2c	X	
	If the organization changed either its oversight process or selection process during the tax year, explain on 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 Uniform Guidance, 2 C.F.R. Part 200, Subpart F?	3a		X
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why on Schedule O and describe any steps taken to undergo such audits	3b		

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 for instructions and the latest information.

OMB No. 1545-0047

2024

Open to Public Inspection

Name of the organization

HOUSTON HOSPITALS, INC

Employer identification number

71-1045290

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 **section 170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land-grant college of agriculture (see instructions). Enter the name, city, and state of the college or university: _____
10 ☐ An organization that normally receives (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions, subject to certain exceptions; and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)
11 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**
12 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2)**. See **section 509(a)(3).** Check the box 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? Yes	(iv) No	(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
Total						

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in)	(a) 2020	(b) 2021	(c) 2022	(d) 2023	(e) 2024	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in)	(a) 2020	(b) 2021	(c) 2022	(d) 2023	(e) 2024	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 **Total support.** Add lines 7 through 10						

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

13 **First 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

14 Public support percentage for 2024 (line 6, column (f), divided by line 11, column (f)) 14 %

15 Public support percentage from 2023 Schedule A, Part II, line 14 15 %

16a **33 1/3% support test - 2024.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ☐

b **33 1/3% support test - 2023.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ☐

17a **10% -facts-and-circumstances test - 2024.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and **stop here.** Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization ☐

b **10% -facts-and-circumstances test - 2023.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and **stop here.** Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization ☐

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

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in)	(a) 2020	(b) 2021	(c) 2022	(d) 2023	(e) 2024	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support.** (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in)	(a) 2020	(b) 2021	(c) 2022	(d) 2023	(e) 2024	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included on line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 **Total support.** (Add lines 9, 10c, 11, and 12.)						

14 **First 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

15 Public support percentage for 2024 (line 8, column (f), divided by line 13, column (f))	15	%
16 Public support percentage from 2023 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for **2024** (line 10c, column (f), divided by line 13, column (f))	17	%
18 Investment income percentage from **2023** Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2024.** 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 - 2023.** 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, Part I, complete Sections A and B. If you checked box 12b, Part I, complete Sections A and C. If you checked box 12c, Part I, complete Sections A, D, and E. If you checked box 12d, Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

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

Part IV Supporting Organizations *(continued)*

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally Integrated Supporting Organizations

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

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

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

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

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

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

Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1 Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):			
a Average monthly value of securities	**1a**		
b Average monthly cash balances	**1b**		
c Fair market value of other non-exempt-use assets	**1c**		
d **Total** (add lines 1a, 1b, and 1c)	**1d**		
e **Discount** claimed for blockage or other factors (*explain in detail in* **Part VI**):			
2 Acquisition indebtedness applicable to non-exempt-use assets	**2**		
3 Subtract line 2 from line 1d.	**3**		
4 Cash deemed held for exempt use. Enter 0.015 of line 3 (for greater amount, see instructions).	**4**		
5 Net value of non-exempt-use assets (subtract line 4 from line 3)	**5**		
6 Multiply line 5 by 0.035.	**6**		
7 Recoveries of prior-year distributions	**7**		
8 **Minimum Asset Amount** (add line 7 to line 6)	**8**		

Section C - Distributable Amount			Current Year
1 Adjusted net income for prior year (from Section A, line 8, column A)	**1**		
2 Enter 0.85 of line 1.	**2**		
3 Minimum asset amount for prior year (from Section B, line 8, column A)	**3**		
4 Enter greater of line 2 or line 3.	**4**		
5 Income tax imposed in prior year	**5**		
6 **Distributable Amount.** Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions).	**6**		

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

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

Section D - Distributions		**Current Year**
1 Amounts paid to supported organizations to accomplish exempt purposes	1	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	2	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	3	
4 Amounts paid to acquire exempt-use assets	4	
5 Qualified set-aside amounts (prior IRS approval required - *provide details in* **Part VI**)	5	
6 Other distributions (describe in **Part VI**). See instructions.	6	
7 **Total annual distributions.** Add lines 1 through 6.	7	
8 Distributions to attentive supported organizations to which the organization is responsive (*provide details in* **Part VI**). See instructions.	8	
9 Distributable amount for 2024 from Section C, line 6	9	
10 Line 8 amount divided by line 9 amount	10	

Section E - Distribution Allocations (see instructions)	**(i) Excess Distributions**	**(ii) Underdistributions Pre-2024**	**(iii) Distributable Amount for 2024**
1 Distributable amount for 2024 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2024 (reasonable cause required - *explain in* **Part VI**). See instructions.			
3 Excess distributions carryover, if any, to 2024			
a From 2019			
b From 2020			
c From 2021			
d From 2022			
e From 2023			
f **Total** of lines 3a through 3e			
g Applied to under distributions of prior years			
h Applied to 2024 distributable amount			
i Carryover from 2019 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from line 3f.			
4 Distributions for 2024 from Section D, line 7: $			
a Applied to underdistributions of prior years			
b Applied to 2024 distributable amount			
c Remainder. Subtract lines 4a and 4b from line 4.			
5 Remaining underdistributions for years prior to 2024, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, *explain in* **Part VI.** See instructions.			
6 Remaining underdistributions for 2024. Subtract lines 3h and 4b from line 1. For result greater than zero, *explain in* **Part VI**. See instructions.			
7 **Excess distributions carryover to 2025.** Add lines 3j and 4c.			
8 Breakdown of line 7:			
a Excess from 2020			
b Excess from 2021			
c Excess from 2022			
d Excess from 2023			
e Excess from 2024			

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

SCHEDULE C
(Form 990)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

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

Complete if the organization is described below. Attach to Form 990 or Form 990-EZ.
Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2024

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

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

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

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

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

Name of organization	Employer identification number (EIN)
HOUSTON HOSPITALS, INC	71-1045290

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

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV.
2 Political campaign activity expenditures ..... $
3 Volunteer hours for political campaign activities .....

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

1 Enter the amount of any excise tax incurred by the organization under section 4955 ..... $
2 Enter the amount of any excise tax incurred by organization managers under section 4955 ..... $
3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? ..... ☐ Yes ☐ No
4a Was a correction made? ..... ☐ Yes ☐ No
b If "Yes," describe in Part IV.

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

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

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

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

A Check ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).

B Check ☐ if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grassroots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.		

IF the amount on line 1e, column (a) or (b), is:	THEN the lobbying nontaxable amount is:
not over $500,000	20% of the amount on line 1e.
over $500,000 but not over $1,000,000	$100,000 plus 15% of the excess over $500,000.
over $1,000,000 but not over $1,500,000	$175,000 plus 10% of the excess over $1,000,000.
over $1,500,000 but not over $17,000,000	$225,000 plus 5% of the excess over $1,500,000.
over $17,000,000	$1,000,000.

g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a. If zero or less, enter -0-		
i Subtract line 1f from line 1c. If zero or less, enter -0-		

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

4-Year Averaging Period Under Section 501(h)

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

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	(a) 2021	(b) 2022	(c) 2023	(d) 2024	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a) Yes	(a) No	(b) Amount
1 During the year, did the filing organization attempt to influence foreign, national, state, or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X	
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		116,250.
j Total. Add lines 1c through 1i			116,250.
2a Did the activities in line 1 cause the organization to not be described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

Part IV Supplemental Information

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

PART II-B, LINE 1, LOBBYING ACTIVITIES:
A PORTION OF DUES PAID TO MEMBERSHIP ORGANIZATIONS (SUCH AS THE GEORGIA HOSPITAL ASSOCIATION) IS ALLOCATED TO LOBBYING.

SCHEDULE D
(Form 990)
(Rev. December 2024)
Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

OMB No. 1545-0047

Open to Public Inspection

Name of the organization
HOUSTON HOSPITALS, INC

Employer identification number
71-1045290

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

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

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

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

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

Part II Conservation Easements.

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

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

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

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

			Held at the End of the Tax Year
a	Total number of conservation easements	2a	
b	Total acreage restricted by conservation easements	2b	
c	Number of conservation easements on a certified historic structure included on line 2a	2c	
d	Number of conservation easements included on line 2c acquired after July 25, 2006, and not on a historic structure listed in the National Register	2d	

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

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

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

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

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

8 Does each conservation easement reported on line 2d 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 make 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 program
e ☐ Other _____

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

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

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

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

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

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

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

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

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

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

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

a Board designated or quasi-endowment _____%
b Permanent endowment _____%
c 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:

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

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

Part VI Land, Buildings, and Equipment

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		8,483,719.		8,483,719.
b Buildings		195,914,212.	126,713,504.	69,200,708.
c Leasehold improvements		3,392,949.	2,981,927.	411,022.
d Equipment		130,276,965.	99,990,744.	30,286,221.
e Other		5,988,416.	2,721,800.	3,266,616.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, line 10c, column (B))*				111,648,286.

Part VII Investments - Other Securities

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

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

Part VIII Investments - Program Related.

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

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

Part IX Other Assets

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

(a) Description	(b) Book value
(1) OTHER ASSETS	4,273,539.
(2) DUE TO AFFILIATES	45,962,417.
(3) ROU ASSETS	6,874,747.
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, line 15, col. (B))*	57,110,703.

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) SELF-INSURANCE RESERVES	22,462,126.
(3) DUE FROM AFFILIATES	35,170,449.
(4) ROU LIABILITIES	7,025,354.
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, line 25, col. (B))*	64,657,929.

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 FASB ASC 740. Check here if the text of the footnote has been provided in Part XIII ... X

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

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

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

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

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

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

Part XIII Supplemental Information

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

PART X, LINE 2:

HOUSTON HOSPITALS, INC. IS PART OF THE HOUSTON HEALTHCARE SYSTEM, INC. THE FOLLOWING IS A FOOTNOTE FROM THE COMBINED FINANCIAL STATEMENTS:

THE SYSTEM APPLIES ACCOUNTING POLICIES THAT PRESCRIBE WHEN TO RECOGNIZE AND HOW TO MEASURE THE COMBINED FINANCIAL STATEMENTS EFFECTS OF INCOME TAX POSITIONS TAKEN OR EXPECTED TO BE TAKEN ON ITS INCOME TAX RETURNS. THESE RULES REQUIRE MANAGEMENT TO EVALUATE THE LIKELIHOOD THAT, UPON EXAMINATION BY THE RELEVANT TAXING JURISDICTIONS, THOSE INCOME TAX POSITIONS WOULD BE SUSTAINED.

BASED ON THAT EVALUATION, THE SYSTEM ONLY RECOGNIZES THE MAXIMUM BENEFIT OF EACH INCOME TAX POSITION THAT IS MORE THAN 50% LIKELY OF BEING SUSTAINED. TO THE EXTENT THAT ALL OR A PORTION OF THE BENEFITS OF AN INCOME TAX POSITION ARE NOT RECOGNIZED, A LIABILITY WOULD BE RECOGNIZED FOR THE UNRECOGNIZED BENEFITS, ALONG WITH ANY INTEREST AND PENALTIES THAT WOULD RESULT FROM DISALLOWANCE OF THE POSITION. SHOULD ANY SUCH PENALTIES AND INTEREST BE INCURRED, THEY WOULD BE RECOGNIZED AS OPERATING EXPENSES.

BASED ON THE RESULTS OF MANAGEMENT'S EVALUATION, NO LIABILITY IS RECOGNIZED IN THE ACCOMPANYING COMBINED BALANCE SHEETS FOR UNRECOGNIZED INCOME TAX POSITIONS. FURTHER, NO INTEREST OR PENALTIES HAVE BEEN ACCRUED OR CHARGED TO EXPENSE AS OF DECEMBER 31, 2024 AND 2023 OR FOR THE YEARS THEN ENDED. THE SYSTEM'S TAX RETURNS ARE SUBJECT TO POSSIBLE EXAMINATION BY TAXING AUTHORITIES. FOR FEDERAL INCOME TAX PURPOSES, THE TAX RETURNS

Part XIII Supplemental Information *(continued)*

ESSENTIALLY REMAIN OPEN FOR POSSIBLE EXAMINATION FOR A PERIOD OF THREE YEARS AFTER THE RESPECTIVE FILING DEADLINES OF THOSE RETURNS.

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No. 1545-0047

2024

Open to Public Inspection

Name of the organization
HOUSTON HOSPITALS, INC

Employer identification number
71-1045290

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial assistance at cost (from Worksheet 1)		15,763	8245973.	11,995.	8233978.	2.34%
b Medicaid (from Worksheet 3, column a)		16,585	34473823.	24979424.	9494399.	2.70%
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total.** Financial assistance and means-tested government programs		32,348	42719796.	24991419.	17728377.	5.04%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	41	26,252	1187600.	56,115.	1131485.	.32%
f Health professions education (from Worksheet 5)	6	1,933	3088810.	3472031.	0.	.00%
g Subsidized health services (from Worksheet 6)	2		3742603.	0.	3742603.	1.06%
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)	3	760	550,925.	0.	550,925.	.16%
j **Total.** Other benefits	52	28,945	8569938.	3528146.	5425013.	1.54%
k **Total.** Add lines 7d and 7j	52	61,293	51289734.	28519565.	23153390.	6.58%

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

		(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing						
2	Economic development	1	40	15,714.	0.	15,714.	.01%
3	Community support	1	4	19,572.	0.	19,572.	.01%
4	Environmental improvements						
5	Leadership development and training for community members						
6	Coalition building						
7	Community health improvement advocacy						
8	Workforce development	1		174,597.	0.	174,597.	.05%
9	Other						
10	Total	3	44	209,883.		209,883.	.07%

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

				Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1			X
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2	29,787,498.		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's FAP. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit	3	0.		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.				

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	55,258,126.		
6	Enter Medicare allowable costs of care relating to payments on line 5	6	57,632,970.		
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-2,374,844.		
8	Describe in Part VI the extent to which any shortfall reported on line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: ☐ Cost accounting system ☐ Cost to charge ratio ☒ Other				

Section C. Collection Practices

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

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

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

Part V Facility Information

Section A. Hospital Facilities

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

How many hospital facilities did the organization operate during the tax year? 2

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility):	Licensed hospital	Gen. medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 HOUSTON HEALTHCARE - WARNER ROBINS 1601 WATSON BOULEVARD WARNER ROBINS, GA 31093 WWW.HHC.ORG 076-656	X	X		X			X			A
2 HOUSTON HEALTHCARE - PERRY 1120 MORNINGSIDE DRIVE PERRY, GA 31069 WWW.HHC.ORG 076-655	X	X					X			A

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group: FACILITY REPORTING GROUP A

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1,2

		Yes	No
Community Health Needs Assessment (CHNA)			
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		X
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		X
3 During the tax year or either of the 2 immediately preceding tax years, did the hospital facility conduct a CHNA? If "No," skip to line 12	3	X	
If "Yes," indicate what the CHNA report describes (check all that apply):			
a [X] A definition of the community served by the hospital facility			
b [X] Demographics of the community			
c [X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d [X] How data was obtained			
e [X] The significant health needs of the community			
f [X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g [X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h [X] The process for consulting with persons representing the community's interests			
i [X] The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA			
j [ ] Other (describe in Section C)			
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 23			
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	X	
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	X	
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b		X
7 Did the hospital facility make its CHNA report widely available to the public?	7	X	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a [X] Hospital facility's website (list url): WWW.HHC.ORG			
b [ ] Other website (list url):			
c [X] Made a paper copy available for public inspection without charge at the hospital facility			
d [X] Other (describe in Section C)			
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	X	
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 23			
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	X	
a If "Yes," list url: WWW.HHC.ORG			
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		X
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? **$**			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group: FACILITY REPORTING GROUP A

			Yes	No
	Did the hospital facility have in place during the tax year a written FAP that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	X	
	If "Yes," indicate the eligibility criteria explained in the FAP:			
a	[X] FPG, with FPG family income limit for eligibility for free care of and FPG family income limit 125 % for eligibility for discounted care of 300 %			
b	[ ] Income level other than FPG (describe in Section C)			
c	[ ] Asset level			
d	[X] Medical indigency			
e	[ ] Insurance status			
f	[ ] Underinsurance status			
g	[ ] Residency			
h	[ ] Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	X	
15	Explained the method for applying for financial assistance?	15	X	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	[X] Described the information the hospital facility may require an individual to provide as part of their application			
b	[X] Described the supporting documentation the hospital facility may require an individual to submit as part of their application			
c	[X] Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	[ ] Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	[ ] Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[X] The FAP was widely available on a website (list url): WWW.HHC.ORG			
b	[X] The FAP application form was widely available on a website (list url): WWW.HHC.ORG			
c	[X] A plain language summary of the FAP was widely available on a website (list url): WWW.HHC.ORG			
d	[X] The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	[X] The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	[X] A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	[X] Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	[ ] Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	[ ] The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by limited-English proficiency (LEP) populations			
j	[X] Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

Name of hospital facility or letter of facility reporting group: FACILITY REPORTING GROUP A

			Yes	No
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written FAP that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17	X	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:			
a	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d	☐ Actions that require a legal or judicial process			
e	☐ Other similar actions (describe in Section C)			
f	☒ None of these actions or other similar actions were permitted			
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	19		X
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d	☐ Actions that require a legal or judicial process			
e	☐ Other similar actions (describe in Section C)			

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

- **a** ☐ Provided a written notice about upcoming extraordinary collection actions (ECAs) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)
- **b** ☐ Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)
- **c** ☐ Processed incomplete and complete FAP applications (if not, describe in Section C)
- **d** ☐ Made presumptive eligibility determinations (if not, describe in Section C)
- **e** ☒ Other (describe in Section C)
- **f** ☐ None of these efforts were made

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

Name of hospital facility or letter of facility reporting group: FACILITY REPORTING GROUP A

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

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

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

SCHEDULE H, PART V, SECTION B. FACILITY REPORTING GROUP A
FACILITY REPORTING GROUP A CONSISTS OF:
- FACILITY 1: HOUSTON HEALTHCARE - WARNER ROBINS
- FACILITY 2: HOUSTON HEALTHCARE - PERRY

FACILITY REPORTING GROUP A
PART V, SECTION B, LINE 5: PROFESSIONAL RESEARCH CONSULTANTS (PRC) A NATIONALLY RECOGNIZED HEALTHCARE CONSULTING FIRM CONDUCTED A COMMUNITY HEALTH NEEDS ASSESSMENT FOR HOUSTON HEALTHCARE IN 2020, FROM WHICH THE 2021, 2022 AND 2023 PLAN WAS DEVELOPED. THIS CHNA, SIMILAR STUDIES PREVIOUSLY CONDUCTED, IS A SYSTEMATIC, DATA DRIVEN APPROACH TO DETERMINING THE HEALTH STATUS, BEHAVIORS, AND NEEDS OF RESIDENTS IN THE COMMUNITIES WE SERVE. A NEW CHNA WAS CONDUCTED IN 2023 BY PRC. THE 2023 CHNA INCORPORATES DATA FROM MULTIPLE SOURCES, INCLUDING PRIMARY RESEARCH (THROUGH THE COMMUNITY HEALTH SURVEY AND PRC ONLINE KEY INFORMANT SURVEY) AS WELL AS SECONDARY RESEARCH (VITAL STATISTICS AND OTHER EXISTING HEALTH RELATED DATA). THIS ALSO INCLUDED QUALITATIVE AND QUANTITATIVE DATA SOURCES. QUALITATIVE DATA INCLUDED RESEARCH GATHERED FROM THE ONLINE KEY INFORMANT SURVEY GROUP, WITH PARTICIPANTS FROM PUBLIC HEALTH, ALONG WITH PROFESSIONALS, SOCIAL SERVICE PROVIDERS, AND BUSINESS AND COMMUNITY LEADERS. THROUGHOUT THIS PROCESS, INPUT WAS GATHERED FROM INDIVIDUALS WHOSE ORGANIZATIONS WORK WITH LOW INCOME, MINORITY, OR OTHER MEDICALLY UNDERSERVED POPULATIONS. SECONDARY DATA SOURCES WERE ALSO CONSULTED TO COMPLEMENT THE RESEARCH QUALITY OF THE CHNA. THE ASSESSMENT ALSO INCORPORATED COMMUNITY TELEPHONE INTERVIEWS OF 200 INDIVIDUALS AGE 18 AND OLDER. INFORMATION CAME FROM LOCAL SURVEYS, PARTICIPANTS AT COMMUNITY EVENTS AS WELL AS INPUT FROM VARIOUS COALITIONS. SEVERAL PRESENTATIONS OF THE CHNA WERE GIVEN WHICH INCLUDED DISCUSSION OF PRIORITY AREAS.

FACILITY REPORTING GROUP A
PART V, SECTION B, LINE 6A: AS OF 2023, HOUSTON HEALTHCARE INCLUDES TWO LOCATIONS, HOUSTON HEALTHCARE-WARNER ROBINS AND HOUSTON HEALTHCARE-PERRY, WITH BOTH FACILITIES UNDER THE SAME BOARDS AND LEADERSHIP. BOTH HOSPITAL FACILITIES ARE LOCATED IN HOUSTON COUNTY AND SERVE THE SAME POPULATIONS. RESIDENTS CAN, AND OFTEN DO, UTILIZE BOTH FACILITIES ALONG WITH THE OTHER RESOURCES PROVIDED THROUGH HOUSTON HEALTHCARE.

FACILITY REPORTING GROUP A
PART V, SECTION B, LINE 7D: A COPY OF THE CHNA WAS SHARED INTERNALLY WITH EXECUTIVE LEADERSHIP AND BOARDS AND IS POSTED ON THE HOUSTON HEALTHCARE WEBSITE. (WWW.HHC.ORG) PRESENTATIONS ON THE CHNA WERE SHARED WITH EXECUTIVE LEADERSHIP, THE COMMUNITY BENEFIT WORK GROUP, OTHER STAFF, COMMUNITY COALITIONS AND COMMUNITY GROUPS. PRESENTATIONS REGARDING COMMUNITY EDUCATION SERVICES AND THE COMMUNITY BENEFIT PROGRAM WERE MADE TO THE COUNTY LEADERSHIP PROGRAM, LEADERSHIP WARNER ROBINS, WHICH REPRESENTS VARIOUS INDUSTRIES AND ORGANIZATIONS THROUGHOUT HOUSTON COUNTY THAT ARE SEEN AS LEADERS IN OUR COMMUNITY. IN ADDITION, AN ARTICLE ABOUT THE CHNA WAS PLACED IN HOUSTON HEALTHCARE'S EXTERNAL PUBLICATION, "HOUSECALLS", WHICH WAS MAILED OUT TO OVER 20,000 HOUSEHOLDS IN MIDDLE GEORGIA.

FACILITY REPORTING GROUP A
PART V, SECTION B, LINE 11: A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) WAS COMPLETED IN 2020 BY PRC. THE RELATED IMPLEMENTATION STRATEGY PLAN WAS

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

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

ADOPTED IN NOVEMBER OF 2020 AND WENT INTO EFFECT IN TAX YEAR 2021, CONTINUING FOR 2021, 2022 AND 2023 AND INCLUDES AN ANNUAL WORK PLAN WITH GOALS, OBJECTIVES, EXPECTED OUTCOMES AS WELL AS ACTUAL OUTCOMES FOR THE YEAR. A THREE YEAR SCORE CARD WAS CREATED TO MEASURE LONG TERM PROGRESS IN MEETING THE GOALS AND OBJECTIVES OF THE 2020 PRC. A NEW CHNA WAS CONDUCTED IN 2023 WHICH WILL BE THE BASIS OF THE IMPLEMENTATION PLAN FOR 2024, 2025 AND 2026 TAX YEARS. THE FOCUS AREAS FOR HOUSTON HEALTHCARE'S IMPLEMENTATION PLAN ADDRESSED THESE NEEDS AND ALL ARE ADDRESSED DIRECTLY BY HOUSTON HEALTHCARE INITIATIVES EXCLUDING THE FOLLOWING FOUR AREAS OF NEEDS, WHICH ARE ADDRESSED BY OTHER COMMUNITY AGENCIES:

(1) BEHAVIORAL HEALTH AND SUBSTANCE ABUSE- IS ADDRESSED WITH MIDDLE FLINT BEHAVIORAL HEALTH, DISTRICT PUBLIC HEALTH, RAFB FAMILY SERVICES, MIDDLE GEORGIA RESCUE MISSION, THE SUICIDE PREVENTION COALITION OF HOUSTON COUNTY AS WELL AS OTHERS WHO LEAD THESE EFFORTS.
(2) SEXUALLY TRANSMITTED DISEASES-TREATMENT AND PREVENTION EDUCATION IS LED BY HOUSTON COUNTY HEALTH DEPARTMENT ALONG WITH DISTRICT PUBLIC HEALTH.

(3)TRANSPORTATION TO HEALTHCARE SERVICES- IS PROVIDED BY PRIVATE COMPANIES, AS WELL AS SOME CHURCHES PROVIDING ASSISTANCE, ALONG WITH LOGISTICARE FOR MEDICAID RECIPIENTS, PERRY VOLUNTEER OUTREACH, AND THE AMERICAN CANCER SOCIETY FOR PERSONS DIAGNOSED WITH CANCER. HOUSTON HEALTHCARE'S "POPULATION HEALTH" INITIATIVE PROVIDES TAXI VOUCHERS TO AT RISK PATIENTS.
(4) ACCIDENT PREVENTION/SAFETY- HOUSTON COUNTY SAFE KIDS LEADS THE EFFORTS ON CHILD SAFETY FOR ISSUES SUCH AS INFANT/CHILD CARE SEAT SAFETY, MEDICATION SAFETY, FIRE AND WATER SAFETY, CPR AND AED USE. A "HANDS-ONLY" CPR TRAINING WAS INITIATED COMMUNITY WIDE IN 2023 BY HOUSTON HEALTHCARE. DRIVING SAFETY CLASSES FOR ADULTS ARE PROVIDED BY AARP.

FACILITY REPORTING GROUP A
PART V, SECTION B, LINE 16J: ALTHOUGH THE ORGANIZATION'S WRITTEN POLICY DOES NOT INDICATE THE MEASURES TAKEN TO PUBLICIZE THE FACILITY'S POLICY WITHIN THE COMMUNITY SERVED, IT DOES PUBLICIZE AS REQUIRED BY THE STATE'S INDIGENT CARE TRUST FUND (ICTF) POLICY. THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY IS POSTED ON THE FACILITY'S WEBSITE ALONG WITH THE INDIGENT AND CHARITY CARE GUIDELINES. A NOTICE IS PRINTED ON THE PATIENTS' BILLS, IN COMMUNITY NEWSPAPERS TWICE A YEAR, POSTED ON THE WALLS AT ALL ADMISSION AREAS, CARDS ARE AVAILABLE ON THE COUNTERS IN BOTH ENGLISH AND SPANISH, AND THE POLICY AND INDIGENT APPLICATIONS ARE AVAILABLE UPON REQUEST. HOUSTON HEALTHCARE INFORMS AND EDUCATES THE COMMUNITY ABOUT THE AVAILABILITY AND ELIGIBILITY FOR FINANCIAL ASSISTANCE BY PROVIDING THESE CARDS AT COMMUNITY EVENTS, HEALTH FAIRS AND EDUCATION SEMINARS. THE CARDS AND SIGNAGE ARE PROVIDED IN ENGLISH AND SPANISH. INFORMATION IS ALSO GIVEN OUT REGARDING AVAILABILITY AND ELIGIBILITY FOR FINANCIAL SERVICES IN ENGLISH AND SPANISH AT NUMEROUS COMMUNITY EVENTS SUCH AS HEALTH FAIRS.

FACILITY REPORTING GROUP A
PART V, SECTION B, LINE 20E: DURING 2015 HOUSTON HOSPITALS BEGAN USING PRESUMPTIVE ELIGIBILITY TO IDENTIFY PATIENTS ELIGIBLE FOR FREE CARE. THE FINANCIAL ASSISTANCE POLICY DETAILS PRESUMPTIVE ELIGIBILITY AS FOLLOWS: PRIOR TO THE ISSUANCE OF THE FIRST POST DISCHARGE BILLING STATEMENT, ALL UNINSURED PATIENT ACCOUNTS WILL BE REVIEWED USING PREDICTIVE ANALYTICS TO ESTIMATE THE HOUSEHOLD INCOME OF THE PATIENT/GUARANTOR. IF THE ESTIMATED

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

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

HOUSEHOLD INCOME IS EQUAL TO, OR LESS THAN OR EQUAL TO, 125% OF FEDERAL POVERTY GUIDELINES, THE PATIENT SHALL NOT BE REQUIRED TO PAY FOR THEIR CARE. PRESUMPTIVE ELIGIBILITY DETERMINATIONS ARE BASED UPON PUBLICLY AVAILABLE INFORMATION FROM CREDIT BUREAUS, US CENSUS DATA, US POSTAL SERVICE, INSURANCE DATABASES, STATE AND LOCAL PUBLIC RECORDS, TELEPHONE COMPANY DATABASES AND THE WHITE PAGES.

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? 7

Name and address	Type of facility (describe)
1 HOUSTON LAKE MED-STOP 2510 HIGHWAY 127 KATHLEEN, GA 31047	HOSPITAL-BASED URGENT CARE FACILITY
2 HOUSTON LAKE REHAB 2510 HIGHWAY 127 KATHLEEN, GA 31047	HOSPITAL-BASED OUTPATIENT REHAB FACILITY
3 PAVILION MED-STOP 233 N. HOUSTON ROAD, SUITE 140 WARNER ROBINS, GA 31093	HOSPITAL-BASED URGENT CARE FACILITY
4 PAVILION REHAB 233 N. HOUSTON ROAD, SUITE 140 WARNER ROBINS, GA 31093	HOSPITAL-BASED OUTPATIENT REHAB FACILITY
5 PAVILION DIAGNOSTIC CENTER 233 N. HOUSTON ROAD, SUITE 140 WARNER ROBINS, GA 31093	HOSPITAL-BASED OUTPATIENT IMAGING CENTER
6 LAKE JOY MED-STOP 1118 HIGHWAY 96 WEST KATHLEEN, GA 31047	HOSPITAL-BASED URGENT CARE FACILITY
7 HOUSTON HEALTHCARE IMAGING SERVICES 114 SUTHERLIN DRIVE WARNER ROBINS, GA 31088	HOSPITAL-BASED OUTPATIENT IMAGING CENTER

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 FAP.

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 (for example, open medical staff, community board, use of surplus funds, etc.).

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

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

PART I, LINE 6A:
THE ORGANIZATION IS IN THE PROCESS OF PREPARING A WRITTEN (ANNUAL) REPORT THAT DESCRIBES HOUSTON HEALTHCARE'S PROGRAMS AND SERVICES THAT PROMOTE THE HEALTH OF THE COMMUNITY. THE 2024 ANNUAL REPORT WILL BE AVAILABLE ON THE HOUSTON HEALTHCARE WEBSITE AS WELL AS DISTRIBUTED TO THE PUBLIC MID-YEAR.

PART I, LINE 7:
HOUSTON HEALTHCARE PROVIDES THE FREE STANDING FACILITY FOR THE HOUSTON COUNTY VOLUNTEER MEDICAL CLINIC. THIS CLINIC IS AN INTEGRAL PART OF OUR COMMUNITY HEALTHCARE SYSTEM AND PROVIDES FREE MEDICAL AND PHARMACEUTICAL HELP FOR THOSE CITIZENS OF HOUSTON COUNTY THAT HAVE AN EMPLOYED FAMILY MEMBER IN THEIR HOUSEHOLD BUT DO NOT HAVE HEALTH INSURANCE. THE TOTAL INCOME FOR THE HOUSEHOLD MUST BE LESS THAN 200% OF THE IDENTIFIED POVERTY LEVEL.

IN ADDITION TO PROVIDING THE BUILDING, A HOUSTON HEALTHCARE STAFF MEMBER SERVES ON THE BOARD OF TRUSTEES FOR THE FREE HEALTH CLINIC. HOUSTON HEALTHCARE PROVIDES A SECRETARY FOR THE BOARD WHO TAKES MINUTES, AND COORDINATES MEETING PLANS AS WELL AS OTHER COMMUNICATION FOR THE BOARD MEETINGS.

HOUSTON HEALTHCARE PROVIDES A COMMUNITY EDUCATION DEPARTMENT THAT PROVIDES FREE/LOW COST SERVICES AND EDUCATION FOR CHRONIC DISEASE MANAGEMENT, DISEASE PREVENTION, WELLNESS PROMOTION, AND COMMUNITY HEALTH SCREENINGS AND EDUCATION. THIS DEPARTMENT APPLIES FOR AND MANAGES A GRANT FOR MAMMOGRAPHY/DIAGNOSTIC TESTING AND ASSISTS WITH OBTAINING GRANTS AND OTHER FUNDING AS THEY BECOME AVAILABLE. A PHYSICIAN REFERRAL HOTLINE SERVES AS A CALL CENTER FOR INDIVIDUALS LOOKING FOR SPECIFIC HEALTH AND SUPPORT RELATED RESOURCES AVAILABLE IN THE COMMUNITY.

PART II, COMMUNITY BUILDING ACTIVITIES:
HOUSTON HEALTHCARE STAFF PROVIDE AND PARTICIPATE IN NUMEROUS COMMUNITY BUILDING ACTIVITIES. SOME EXAMPLES INCLUDE: 1. SERVING ON THE BOARD OF THE COMMUNITY FOUNDATION OF CENTRAL GEORGIA, WHICH WORKS TO BRING MEANINGFUL CHANGE TO HOUSTON COUNTY THROUGH LOCAL PHILANTHROPY. BOARD MEMBERS ALSO HELP DETERMINE GRANT ALLOCATIONS TO ORGANIZATIONS. 2023 GRANTS WERE PROVIDED TO FIRST CHOICE PRIMARY CARE, THE HALO GROUP, AND KEEP WARNER ROBINS BEAUTIFUL. 2. SERVING ON THE ROBINS REGIONAL CHAMBER OF COMMERCE

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

BOARD, WHICH FOCUSES ON EDUCATION, BUSINESS DEVELOPMENT AND COMMUNITY AND GOVERNMENT AFFAIRS.

HOUSTON HEALTHCARE ALSO WORKS DILIGENTLY TO RECRUIT NEEDED PHYSICIANS TO THE AREA AND CONDUCTS A "PHYSICIAN NEEDS ASSESSMENT" EVERY 3 YEARS TO DETERMINE THE GREATEST NEED FOR SPECIFIC HEALTH SERVICES IN HOUSTON COUNTY. THE PRIMARY PURPOSE OF THIS ASSESSMENT IS TO IDENTIFY GAPS IN PHYSICIAN SERVICES, UNDERSTAND THE DISTRIBUTION AND AVAILABILITY OF HEALTHCARE PROVIDERS, AND PLAN FOR THE RECRUITMENT AND RETENTION OF MEDICAL PROFESSIONALS TO MEET THE HEALTHCARE NEEDS OF THE COMMUNITY. THE 2023 ASSESSMENT DETERMINED TARGETED NEEDS FOR PHYSICIANS IN THE AREAS OF URGENT CARE, FAMILY MEDICINE (INCLUDING A FAMILY MEDICINE FACILITY), OB/GYN, GASTROENTEROLOGY, GENERAL SURGERY, ANESTHESIOLOGY, UROLOGY, INTERNAL MEDICINE AND PSYCHIATRY.

HOUSTON HEALTHCARE STAFF SERVE ON THE BOARD OF UNITED WAY WHICH WORKS TO ENSURE RESOURCES ARE AVAILABLE TO MEET THE NEEDS OF THE COMMUNITY. EACH YEAR HOUSTON HEALTHCARE EMPLOYEES PROMOTE AND RAISE FUNDS FOR ORGANIZATIONS SUCH AS UNITED WAY OF CENTRAL GEORGIA.

COMMUNITY PHYSICAL IMPROVEMENTS- HOUSTON HEALTHCARE DEVELOPED THE OLD HOUSTON MALL WHICH IS A PHYSICAL IMPROVEMENT FOR THE COUNTY AS WELL AS MUCH NEEDED SPACE FOR HEALTH-RELATED SERVICES, COMMUNITY EDUCATION, SUPPORT GROUPS AND OTHER TRAINING, AS WELL AS PHYSICIAN PRACTICES INCLUDING FAMILY MEDICINE, UROLOGY, ENT, BEHAVIORAL HEALTH AND GENERAL SURGERY.

HOUSTON HEALTHCARE COLLABORATED WITH THE HOUSTON COUNTY BOARD OF COMMISSIONERS TO PROVIDE FACILITIES THAT HOUSE FIRE, SHERIFF, AND EMS SERVICES FOR THE COMMUNITY. A NEW PUBLIC SAFETY COMPLEX AND MEDICAL OFFICE BUILDING OPENED IN BONAIRE DURING 2023 AND INCLUDES A FIRE STATION, EMS BAY WITH 24 HOUR AMBULANCE SERVICE AND SHERIFF'S OFFICE. THE "HOUSTON HEALTHCARE MEDICAL OFFICE BUILDING" NEXT DOOR HOUSES AN OB/GYN OFFICE AND A FAMILY CARE OFFICE AS WELL AS SPACE FOR FUTURE IMAGING AND LABORATORY SERVICES ON SITE.

HOUSTON HEALTHCARE, ALONG WITH ATRIUM HEALTH NAVICENT, PROVIDED LARGE GIFTS TO THE CENTRAL GEORGIA TECHNICAL COLLEGE FOUNDATION AND CENTRAL GEORGIA TECHNICAL COLLEGE (CGTC) FOR A NEW HEALTH AND WELLNESS FACILITY ON THE CGTC WARNER ROBINS CAMPUS. ATRIUM HEALTH FIELD HOUSED AT THE ROY H. "SONNY" WATSON WELLNESS COMPLEX HOSTS A VARIETY OF SPORTS AND STUDENT ACTIVITIES AND BECAME THE FIRST FOOTBALL FIELD ON A TECHNICAL COLLEGE CAMPUS IN GEORGIA. THE COMPLEX AIDS IN LOCAL WORKFORCE DEVELOPMENT AS AN INVESTMENT IN FUTURE HEALTHCARE FOR THE COMMUNITY.

A HOUSTON HEALTHCARE STAFF PERSON SERVES AS A BOARD MEMBER OF THE WORRALL FOUNDATION WHICH HAS THE GOAL OF PURCHASING LAND TO CREATE ADDITIONAL OUTDOOR PARKS IN THE AREA IN ORDER TO ENCOURAGE FAMILIES TO BECOME MORE PHYSICALLY ACTIVE. MOST RECENTLY COMPLETED PARKS AND TRAILS INCLUDE: HERITAGE PARK IN PERRY, 'THE WALK AT SANDY RUN' TRAIL IN WARNER ROBINS, CENTER PARK IN CENTERVILLE AND UPGRADES AND RENOVATIONS TO TED WRIGHT PARK AND MEMORIAL PARK. THERE HAVE ALSO BEEN RECENT UPGRADES TO SEVERAL PARK PLAYGROUNDS IN THE COUNTY. THERE ARE PLANS FOR MORE PARKS AND FITNESS TRAILS IN THE NEAR FUTURE. A NEW RECREATION/SPORTS COMPLEX (NORTH HOUSTON SPORTS COMPLEX) OPENED IN 2022.

Part VI Supplemental Information *(Continuation)*

ECONOMIC DEVELOPMENT- HOUSTON HEALTHCARE WORKS DIRECTLY WITH THE WARNER ROBINS HOUSING AUTHORITY WHICH PROVIDES LOWER COST HOUSING FOR RESIDENTS WITH LIMITED INCOMES, BY PROVIDING HEALTH RELATED EDUCATIONAL CLASSES AND HEALTH SCREENINGS FOR THE RESIDENTS. HOUSTON HEALTHCARE STAFF SERVE ON THE FAMILY CONNECTIONS COALITION, WHICH ADDRESSES THE ISSUE OF THE HOMELESS, AND COLLABORATES WITH OTHER COMMUNITY PARTNERS AND THE VECTR CENTER TO IMPROVE NEIGHBORHOOD HOUSING.

COMMUNITY SUPPORT: DISASTER READINESS BEYOND WHAT IS REQUIRED BY ACCREDITING BODIES- DISASTER READINESS PREPAREDNESS PROVIDED BY HOUSTON HEALTHCARE IS OVER AND ABOVE LICENSURE REQUIREMENTS AND INCLUDES COMMUNICATION AWARENESS EVENTS AND GENERAL EDUCATION AS WELL AS EFFORTS ABOVE LICENSURE RELATED TO THE COVID PANDEMIC.

OTHER EFFORTS ABOVE LICENSURE INCLUDE THE ARES (AMATEUR RADIO EMERGENCY SERVICES) PROGRAM, WHICH PROVIDES SUPPORT TO THE GENERAL PUBLIC AND OTHER HEALTHCARE PARTNERS IN THE AREA OF EMERGENCY COMMUNICATION IN THE EVENT OF A COMMUNITY DISASTER AS WELL AS DETECTION OF SEVERE WEATHER CONDITIONS THROUGH THE USE OF COMMUNICATION WEATHER SPOTTERS TRAINED BY THE NATIONAL WEATHER SERVICE VIA AMATEUR RADIO OPERATORS WITHIN THE COMMUNITY. THIS IS PROVIDED AND INSTALLED WITHIN HOUSTON HEALTHCARE- AS A FREE ACCESS COMMUNICATION USE REPORTER FOR PUBLIC USE.

HOUSTON HEALTHCARE WARNER ROBINS, IS CERTIFIED AS A 'STORM READY' LOCATION BY THE NATIONAL WEATHER SERVICE, BECOMING JUST THE 5TH "COMMERCIAL" SITE IN THE STATE OF GEORGIA. HOUSTON HEALTHCARE PERRY RECEIVED "STORM READY" STATUS IN DECEMBER OF 2023 MAKING IT THE 8TH COMMERCIAL SITE IN GEORGIA. STORM READY ENCOURAGES COMMUNITIES TO TAKE A PROACTIVE APPROACH TO IMPROVING LOCAL HAZARDOUS WEATHER OPERATIONS AND PUBLIC AWARENESS IN PARTNERSHIP WITH THEIR LOCAL NATIONAL WEATHER SERVICE OFFICE.

HOUSTON HEALTHCARE IS ALSO A CHEMPACK CONTAINER SITE, ONE OF 47 LOCATIONS IN THE STATE, IN COOPERATION WITH THE CDC CHEMPACK PROGRAM, GEORGIA DIVISION OF PUBLIC HEALTH THAT PROVIDES FIRST RESPONDERS AND FIRST RECEIVERS THE RESOURCES THEY NEED TO RAPIDLY RESPOND TO LARGE SCALE NERVE AGENT OR ORGANOPHOSPHATE PESTICIDE RELEASES.

HOUSTON HEALTHCARE RECOGNIZES THAT PREPAREDNESS AND EMERGENCY MANAGEMENT EXTEND BEYOND THE LIMITS OF THE ORGANIZATION, THEREFORE PLANNING AND COORDINATION WILL CONTINUE WITH PARTNERS INCLUDING WITH, BUT NOT LIMITED TO HOUSTON COUNTY EMERGENCY MANAGEMENT AGENCY (HEMA), THE GEORGIA HOSPITAL ASSOCIATION AND THE GEORGIA DEPARTMENT OF PUBLIC HEALTH.

LEADERSHIP DEVELOPMENT AND TRAINING- HOUSTON HEALTHCARE PARTICIPATES IN ROBINS REGIONAL AND PERRY AREA CHAMBER OF COMMERCE YOUTH AND ADULT LEADERSHIP PROGRAMS. A YOUTH VOLUNTEEN PROGRAM IS PROVIDED EVERY SUMMER FOR STUDENTS INTERESTED IN PURSUING HEALTH RELATED FIELDS.

HOUSTON HEALTHCARE STAFF SERVE ON REGIONAL AREA COMMERCE BOARDS, WHICH FOCUS ON BUSINESS DEVELOPMENT, EDUCATION, AS WELL AS COMMUNITY AND GOVERNMENT AFFAIRS. HOUSTON HEALTHCARE STAFF ALSO SERVE ON BOARDS OF LOCAL COLLEGES AND TECHNICAL SCHOOLS INCLUDING THE HOUSTON COUNTY CAREER ACADEMY, MIDDLE GEORGIA STATE UNIVERSITY, GEORGIA COLLEGE AND STATE UNIVERSITY, AND CENTRAL GEORGIA TECHNICAL COLLEGE.

HOUSTON HEALTHCARE PARTNERS WITH THE HOUSTON COUNTY CAREER ACADEMY,

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

CENTRAL GEORGIA TECHNICAL COLLEGE AND THE HOUSTON COUNTY DEVELOPMENT AUTHORITY TO PROVIDE A "MORE THAN SCRUBS" SUMMIT TO 150 HIGH SCHOOL STUDENTS TO TEACH THEM ABOUT DIVERSE CAREERS IN HEALTHCARE.

HOUSTON HEALTHCARE PROVIDES AN INTENSIVE 3-YEAR PHYSICIAN RESIDENCY PROGRAM FOR NEW DOCTORS AS WELL AS AN INTERN PROGRAM FOR MEDICAL STUDENTS.

HOUSTON HEALTHCARE HAS VOLUNTEER CHAPLAINS FOR HOUSTON HEALTHCARE WARNER ROBINS AND HOUSTON HEALTHCARE PERRY WHO ARE COMMUNITY MEMBERS.

COALITION BUILDING- COALITIONS INITIATED AND LED BY HOUSTON HEALTHCARE:
FAITH COMMUNITY NURSES- THIS COALITION IS MADE UP OF VOLUNTEER REGISTERED NURSES SERVING CHURCHES IN THE CENTRAL GEORGIA AREA. HOUSTON HEALTHCARE PROVIDES AN ORIENTATION PROGRAM AS WELL AS MONTHLY MEETINGS AND TRAINING FOR THIS GROUP. THE FAITH COMMUNITY NURSES PROVIDE HEALTH EDUCATION AND SCREENINGS, AS WELL AS LINK PERSONS TO HEALTH RESOURCES. THIS GROUP SERVES AREA CHURCHES AND THEIR SURROUNDING NEIGHBORHOODS. IN ADDITION, THE GROUP ADDRESSES SOCIAL CONCERNS. (PROVIDING FOOD BANKS, CLOTHING CLOSETS, SOUP KITCHENS, ETC.) HOUSTON HEALTHCARE SERVES AS THE RESOURCE CENTER AND PARTNER FOR THESE ACTIVITIES.

CENTRAL GEORGIA PERINATAL COALITION -THIS HOUSTON HEALTHCARE LED COALITION INCLUDES THE DEPARTMENT OF PUBLIC HEALTH, SCHOOL COUNSELORS, RAINBOW HOUSE, NURSE FAMILY PARTNERSHIP, ROBINS AIR FORCE BASE, LOCAL OB/GYN/MIDWIVES REPRESENTATIVES AND OTHERS. IT SEEKS TO PROVIDE OPTIMAL SERVICES FOR PREGNANT WOMEN AND DECREASE RATES OF PRE-TERM BIRTHS, AND OTHER POOR BIRTH OUTCOMES. THE COALITION ADDRESSES ACCESS TO CARE FOR ALL PREGNANT WOMEN, FOCUSES AND PROVIDES ADDITIONAL SERVICES/RESOURCES FOR WOMEN WHO ARE LOWER INCOME AND UNINSURED, AS WELL AS FOR WOMEN WHO HAVE A MEDICAL CONDITION THAT COMPLICATES THEIR PREGNANCY. INCREASED FOCUS IS ALSO ON THE IMPORTANCE OF BREASTFEEDING AND INCREASING POST-PARTUM MATERNAL SUPPORT.

PART III, LINE 3:
BAD DEBT IS TREATED AS A DEDUCTION FROM REVENUE AND INCLUDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS. BAD DEBT IS NOT INCLUDED IN TOTAL EXPENSES FOR BOOK OR TAX PURPOSES. THE ALLOWANCE FOR BAD DEBTS IS CALCULATED ON OUTSTANDING ACCOUNTS RECEIVABLE (NET OF PAYMENTS AND DISCOUNTS) AND CONSIDERS HISTORICAL COLLECTION RATES, THE INSURED STATUS.

PART II LINE 8:
WORKFORCE DEVELOPMENT- RECRUITMENT EFFORTS CONTINUE DUE TO PHYSICIAN SHORTAGES IN SPECIALTY AREAS AND PRIMARY CARE. EXAMPLES OF TARGETED AREAS INCLUDE: FAMILY MEDICINE (TRADITIONAL & OUTPATIENT), OTOLARYNGOLOGY, OB/GYN, UROLOGY, INTERNAL MEDICINE, GASTROENTEROLOGY, URGENT CARE, GENERAL SURGERY, PSYCHIATRY, AND ANESTHESIOLOGY. EFFORTS MADE INCLUDE ADDING ANOTHER ENT, GENERAL SURGEON, AND A MENTAL HEALTH PROVIDER, A NEW INTERNAL MEDICINE PRACTICE, AND A NEW OB/GYN PRACTICE.

HOUSTON HEALTHCARE PROVIDED DONATIONS IN 2024 TO ASSIST WITH COSTS OF INSTRUCTORS FOR HEALTH PROFESSIONAL TRAINING AT CENTRAL GEORGIA TECHNICAL COLLEGE AND MIDDLE GEORGIA STATE COLLEGE AND SERVES AS A CLINICAL SITE FOR SEVERAL HEALTH PROFESSIONS TO INCLUDE NURSING, PHARMACY, RADIOLOGY, RESPIRATORY THERAPY, PHYSICAL THERAPY AND OCCUPATIONAL THERAPY. HOUSTON HEALTHCARE STAFF OPERATE AS "CLINICAL INSTRUCTORS" TO FILL THE GAP AND MEET NEED OF STUDENT-TO-INSTRUCTOR

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

RATIOS TO COMPLY WITH GEORGIA STANDARDS OF 10:1 FOR CLINICAL ROTATIONS.

HOUSTON HEALTHCARE OFFERS A FAMILY MEDICINE RESIDENCY PROGRAM, WHICH PROVIDES CLINICAL AS WELL AS HANDS-ON PATIENT TRAINING TO PHYSICIANS ENTERING THE FIELD OF FAMILY MEDICINE, WHILE HELPING TO FULFILL A NEED FOR PRIMARY CARE PHYSICIANS IN THE MIDDLE GEORGIA AREA AND IMPROVE ACCESS TO HEALTHCARE FOR THE COMMUNITIES WE SERVE.

PART III, LINE 8:
SECTION B, LINES 5-7 ARE CALCULATED USING WORKSHEET A, PROVIDED IN THE SCHEDULE H INSTRUCTIONS, AND THE 2019 AS-FILED MEDICARE COST REPORTS. 100% OF THE HOSPITAL'S MEDICARE SHORTFALL SHOULD BE TREATED AS COMMUNITY BENEFITS SINCE THE ORGANIZATION PROVIDES HEALTHCARE ACCESS FOR MEDICARE PATIENTS AND ACCEPTS PAYMENT BELOW COST BENEFITING OUR COMMUNITY LARGELY MADE UP OF MEDICARE BENEFICIARIES.

PART III, LINE 9B:
THE BAD DEBT COLLECTION PRACTICES POLICY FOR HOUSTON HOSPITALS STATES THAT COLLECTIONS ARE CEASED UPON THE PATIENT'S APPROVAL FOR INDIGENT OR CHARITY CARE. THE PATIENT LIABILITY BILLING AND COLLECTION POLICY PROVIDED THE GUIDELINE FOR THE COLLECTION OF PATIENT LIABILITY. COLLECTION EFFORT SHOULD ONLY BE CONDUCTED FOR THE PATIENT LIABILITY. THE POLICY DEFINES THE PATIENT LIABILITY AS THE AMOUNT OWED BY THE PATIENT AND /OR GUARANTOR AFTER APPLICATION OF ALL INSURANCE BENEFITS AND FINANCIAL ASSISTANCE POLICY DISCOUNTS. IF THE PERSON IS A 100% SELF-PAY PATIENT AND DOES NOT QUALIFY FOR FINANCIAL ASSISTANCE, THEN IT IS THE ENTIRE BALANCE LESS ANY DISCOUNTS. THE FINANCIAL ASSISTANCE POLICY PROVIDES GUIDELINES TO QUALIFY FOR FREE OR DISCOUNTED FINANCIAL ASSISTANCE.

PART VI, LINE 2:
IN ADDITION TO THE CHNA - OTHER METHODS UTILIZED IN OBTAINING HEALTH NEEDS OF THE COMMUNITY INCLUDED:

*KEY INFORMANT SURVEY GROUP- THE FOCUS GROUP PARTICIPANTS INCLUDED KEY INFORMANTS-INCLUDING PHYSICIANS, OTHER HEALTH PROFESSIONALS, SOCIAL SERVICE PROVIDERS, AND BUSINESS AND COMMUNITY LEADERS. A LIST OF RECOMMENDED PARTICIPANTS FOR THE GROUP WAS PROVIDED BY HOUSTON HEALTHCARE, WITH POTENTIAL PARTICIPANTS CHOSEN BECAUSE OF THEIR ABILITY TO IDENTIFY PRIMARY CONCERNS OF THE POPULATIONS WITH WHOM THEY WORK, AS WELL AS THE COMMUNITY OVERALL. PARTICIPANTS INCLUDED A REPRESENTATIVE OF PUBLIC HEALTH, AS WELL AS SEVERAL INDIVIDUALS WHO WORK WITH LOW-INCOME, MINORITIES AND OTHER MEDICALLY UNDERSERVED POPULATIONS.

*COMMUNITY HEALTH SURVEY- THIS SURVEY WAS BASED LARGELY ON THE CENTERS FOR DISEASE CONTROL AND PREVENTION BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM AS WELL AS OTHER PUBLIC HEALTH SURVEYS AND CUSTOMIZED QUESTIONS ADDRESSING GAPS IN INDICATOR DATA RELATIVE TO HEALTH PROMOTION AND DISEASE PREVENTION OBJECTIVES. THE FINAL SURVEY INSTRUMENT WAS DEVELOPED BY HOUSTON HEALTHCARE AND PRC. THE STUDY AREA FOR THE SURVEY INCLUDED EACH OF THE ZIP CODES DEFINING HOUSTON COUNTY AND INCLUDED A RANDOM SAMPLE OF 200 INDIVIDUALS AGE 18 AND OLDER IN HOUSTON COUNTY.

*PHYSICIAN COMMUNITY NEEDS ASSESSMENT- CONDUCTED EVERY 3 YEARS TO DETERMINE THE GREATEST NEED FOR SPECIFIC HEALTH SERVICES IN HOUSTON COUNTY. THE PRIMARY PURPOSE OF THIS ASSESSMENT IS TO IDENTIFY GAPS IN PHYSICIAN SERVICES, UNDERSTAND THE DISTRIBUTION AND AVAILABILITY OF

Part VI Supplemental Information *(Continuation)*

HEALTHCARE PROVIDERS, AND PLAN FOR THE RECRUITMENT AND RETENTION OF MEDICAL PROFESSIONALS TO MEET THE HEALTHCARE NEEDS OF THE COMMUNITY.

*COMMUNITY COALITIONS INPUT -SEVERAL COALITIONS WERE ASKED FOR THEIR INPUT IN IDENTIFYING COMMUNITY HEALTH NEEDS. FEEDBACK FROM COALITIONS WAS CONSIDERED IMPORTANT BECAUSE THIS INFORMATION WAS FROM PEOPLE WORKING DIRECTLY WITH A CERTAIN POPULATION. IT WAS NOTED THAT THE NUMBER ONE PRIORITY WAS DIFFERENT, DEPENDING ON WHICH GROUP OR COALITION PROVIDED INFORMATION BUT OVERALL, THE SAME CONCERNS WERE SHARED. EACH COALITION WAS ASKED TO LIST THE TOP FIVE HEALTH NEEDS. COALITIONS PARTICIPATING IN THE DISCUSSIONS INCLUDED:1-PERINATAL COALITION, 2-FAITH COMMUNITY NURSES, 3-FAMILY CONNECTION COALITION, 4-SAFE KIDS COALITION 5-COMMUNITY BENEFIT WORK TEAM.

RESOURCES FROM OTHER ORGANIZATIONS WERE REVIEWED TO PREVENT DUPLICATION OF SERVICES AND ENHANCE RESOURCES. RESOURCES OF OTHER ORGANIZATIONS WERE ALSO REVIEWED TO ENSURE IDENTIFIED NEEDS WERE MET.

REVIEW OF OTHER COMMUNITY SURVEYS OR ASSESSMENTS CONDUCTED, WITH SOME EXAMPLES INCLUDING:
*2019 GA KIDS COUNT DATA
*GA DEPARTMENT OF PUBLIC HEALTH, NORTH CENTRAL HEALTH DISTRICT, HOUSTON COUNTY, HEALTH STATUS REPORT AND COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)
*2021 COUNTY HEALTH RANKINGS AND ROADMAPS- ROBERT WOOD JOHNSON FOUNDATION
*2022 MARCH OF DIMES PREMATURE BIRTH RATE FOR GEORGIA AND 2022 REPORT CARD
*HEALTHY PEOPLE 2030
*WARNER ROBINS COMMUNITY TRANSFORMATION PLAN - HOUSING DEVELOPMENT
*SENIOR CARE SURVEYS 2022
*COMMUNITY EDUCATION SURVEYS 2022

REVIEW/EVALUATION OF THE PAST YEAR COMMUNITY BENEFIT OUTCOMES ALSO CONTRIBUTED TO THE TOTAL ASSESSMENT. OUR PROCESS INCLUDES THE COMPLETION OF THE 2020 CHNA (COMMUNITY HEALTH NEEDS ASSESSMENT) WITH PRIORITIES, AS WELL AS THE IMPLEMENTATION PLAN. IN ORDER TO EVALUATE OUR PROGRESS, HOUSTON HEALTHCARE DEVELOPED AN ANNUAL WORK PLAN WITH GOALS, OBJECTIVES, EXPECTED OUTCOMES AND ACTUAL OUTCOMES THE ANNUAL WORK PLAN (FOR 2024) WITH ACTUAL IMPACT IS ATTACHED AS AN ADDENDUM.

PART VI, LINE 3:
INFORMATION REGARDING THE INDIGENT CARE TRUST FUND IS AVAILABLE AT EACH OF OUR REGISTRATION AREAS AND DISPLAYED WITH SIGNAGE AND CARDS. WE ALSO INFORM OUR PATIENTS AND FAMILIES OF OUR FINANCIAL ASSISTANCE POLICY DURING THE INPATIENT AND OUTPATIENT ADMISSION PROCESS. OUR SYSTEM WEBSITE PROVIDES INFORMATION ON OUR PATIENT FINANCIAL SERVICES, WHICH INCLUDES BILLING, INSURANCE, AND OUR INDIGENT AND CHARITY CARE GUIDELINES AND POLICY. THE FIRST BILLING STATEMENT SENT OUT TO PATIENTS ALSO ADDRESSES THIS PROCESS WITH SPECIFIC INSTRUCTIONS. THESE CARDS WITH FINANCIAL INFORMATION ARE AVAILABLE AT COMMUNITY EVENTS, HEALTH FAIRS AND EDUCATION SEMINARS. THE CARDS AND SIGNAGE ARE PROVIDED IN ENGLISH AND SPANISH.

PART VI, LINE 4:
GEOGRAPHIC SERVICE AREA- HOUSTON HEALTHCARE SERVES THE MEDICAL NEEDS OF RESIDENTS IN THE CENTRAL GEORGIA AREA WITH THE PRIMARY SERVICE AREA BEING HOUSTON AND PEACH COUNTIES. RESIDENTS IN SURROUNDING COUNTIES ALSO TURN TO HOUSTON HEALTHCARE FOR THEIR MEDICAL SERVICES, WITH THESE COUNTIES

Part VI Supplemental Information *(Continuation)*

INCLUDING BLECKLEY, CRAWFORD, DODGE, DOOLY, MACON, PULASKI, TAYLOR, TWIGGS AND BIBB COUNTY WHICH ARE CONSIDERED OUR SECONDARY SERVICE AREA. ALL HOUSTON HEALTHCARE FACILITIES ARE LOCATED IN HOUSTON COUNTY AND ARE GOVERNED BY TWO BOARDS OF TRUSTEES. THE EXECUTIVE TEAM ALSO OVERSEES ALL OPERATIONS AND ACTIVITIES FOR THE HOUSTON HEALTHCARE SYSTEM.

DEMOGRAPHICS - HOUSTON HEALTHCARE'S DIVERSE POPULATION SERVED INCLUDES: 57.5% WHITE, 35.2% BLACK, AND 7.7% HISPANIC. 51.6% OF THE POPULATION IS FEMALE. 35.1% IS LESS THAN 18 YEARS OF AGE WHILE 14.0% IS 65 YEAR OR OLDER. (US CENSUS BUREAU QUICK FACTS JULY 1, 2023)

WITH 2,454 EMPLOYEES, HOUSTON HEALTHCARE IS THE 4TH LARGEST EMPLOYER IN HOUSTON COUNTY. ROBINS AIR FORCE BASE IS THE LARGEST WITH OVER 24,500 CONTRACTORS, CIVIL SERVICE AND MILITARY STAFF, FOLLOWED BY HOUSTON COUNTY BOARD OF EDUCATION WITH 5,500 TEACHERS AND STAFF. PERDUE FARMS, WITH OVER 2,520 POULTRY WORKERS, MANY OF WHOM ARE HISPANIC, IS THE 3RD LARGEST AND FRITO-LAY, PRODUCER OF SNACK FOOD WITH OVER 1,500 WORKERS IS THE 5TH LARGEST. (HOUSTON DEVELOPMENT AUTHORITY)

THE POPULATION OF HOUSTON COUNTY IS ESTIMATED BY THE CENSUS REPORT AT 171,974 AS OF JULY 1, 2023, AN INCREASE OF 5.1% FROM THE 2020 CENSUS. THE MEDIAN HOUSEHOLD INCOME IS $76,968 PER YEAR AND A PER CAPITA INCOME OF $35,223 PER YEAR WITH 10.7% OF INDIVIDUALS LIVING BELOW THE FEDERAL POVERTY LEVEL (US CENSUS BUREAU QUICK FACTS JULY 1, 2023). THE LATEST CENSUS ESTIMATE SHOWS 12.8% (OR 5,194) OF HOUSTON COUNTY CHILDREN LIVE BELOW THE FEDERAL POVERTY LEVEL. (PRC 2023)

THE FOUR LEADING CAUSES OF DEATH FROM 2020-2023 INCLUDE HEART DISEASE/STROKE, CANCER, COVID-19 AND ALZHEIMER 'S DISEASE. THE PRC COMMUNITY HEALTH NEEDS ASSESSMENT REPORTS THAT AN AVERAGE OF 20% OF PERSONS IN HOUSTON COUNTY ARE DIAGNOSED WITH DIABETES WHICH IS AN INCREASING NUMBER AND 7.2% HAVE BEEN DIAGNOSED WITH PRE-DIABETES. GEORGIA ALSO CONTINUES WITH HIGHER RATES OF PRE-TERM DELIVERIES. HOUSTON COUNTY REPORTED A LOW BIRTH WEIGHT OF 9% FOR NEWBORNS WHICH IS MORE THAN THE 8.2% AVERAGE FOR THE US.

HOUSTON COUNTY'S OVERALL RATE OF TOBACCO USAGE IS 12.3% WHICH IS LOWER THAN THE STATE AVERAGE OF 23.9% BUT VAPING CONTINUES TO BE HIGH AT 9.4% AMONG THE LOWER INCOME POPULATION. THE OBESITY RATE IN HOUSTON COUNTY RESIDENTS HAS DECREASED TO 45.8% (BMI<30) AND OVERWEIGHT (BMI<25) 78.5%. THESE FACTS DEMONSTRATE THE NEED FOR EDUCATION ON LIFESTYLE CHANGES RELATED TO NUTRITION, EXERCISE AND TOBACCO AVOIDANCE. THESE STATS AND OTHERS PROMPTED OUR DEDICATION TO IMPROVING THE COMMUNITY WE SERVE BY ESTABLISHING AN IMPLEMENTATION PLAN THAT INCLUDES PRIORITY AREAS, MEASURABLE GOALS AND OBJECTIVES ALONG WITH COLLABORATION AMONG HOUSTON HEALTHCARE LEADERSHIP AND OTHER COMMUNITY LEADERS.

OTHER HOSPITALS SERVING THE COMMUNITY- THERE ARE NO OTHER HOSPITALS WITHIN HOUSTON COUNTY BESIDES HOUSTON HEALTHCARE; HOWEVER, SOME COMMUNITY MEMBERS UTILIZE HOSPITALS OUTSIDE OF OUR COUNTY.

NUMBER OF FEDERALLY DESIGNATED MEDICALLY UNDERSERVED AREAS IN OUR SERVICE AREA, CRAWFORD, PEACH, TWIGGS AND MACON COUNTIES ARE UNDERSERVED BY PRIMARY HEALTH PROFESSIONALS, ACCORDING TO THE STATE OFFICE OF RURAL HEALTH, GENERALLY MEANING MORE THAN 3,000 PEOPLE PER DOCTOR. BIBB AND HOUSTON COUNTIES CONTINUE TO HAVE POCKETS OF UNDERSERVED POPULATIONS.

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

PART VI, LINE 5:
PROMOTION OF COMMUNITY HEALTH- HOUSTON HEALTHCARE BOARD MEMBERS ARE ACTIVE COMMUNITY MEMBERS, EMPLOYED OR RETIRED FROM VARIOUS COMMUNITY ORGANIZATIONS SUCH AS LOCAL SCHOOLS, LOCAL AND STATE GOVERNMENT, PHYSICIAN PRACTICES, LAW FIRMS AND INSURANCE AGENCIES. THEIR EDUCATION, EXPERIENCE AND COMMUNITY INVOLVEMENT ENABLE OUR ORGANIZATION TO PROVIDE MUCH NEEDED SERVICES AND BENEFITS TO MEET COMMUNITY NEEDS. AN OPEN MEDICAL STAFF ENABLES THE ORGANIZATION TO PROVIDE THE SERVICES NEEDED BY THE COMMUNITY AND ALLOWS NEEDED ACCESS TO THE INDIGENT, AS WELL AS MEDICARE, MEDICAID AND TRICARE POPULATIONS.

HOUSTON HEALTHCARE SUPPORTS THE VOLUNTEER MEDICAL CLINIC BY PROVIDING A BUILDING FOR THE FREE CLINIC AS WELL AS ACCEPTING REFERRALS FROM THE CLINIC FOR REQUIRED SERVICES SUCH AS RADIOLOGY AND LAB.

ADVOCACY INITIATIVES ARE ONGOING TO IMPROVE HEALTH AND INCREASE ACCESS THROUGH LOCAL PARTNERSHIPS WITH OTHERS IN THE COMMUNITY INCLUDING PUBLIC HEALTH AND ROBINS AIR FORCE BASE. HOUSTON HEALTHCARE COLLABORATES WITH ROBINS AIR FORCE BASE THROUGH RELAY HEALTH (ACCESS MEDICAL RECORDS), MENTAL HEALTH COLLABORATION EFFORTS TO IMPROVE TRANSITION OF CARE, PHYSICIAN GRAND ROUNDS, EDUCATIONAL TRAINING CLASSES AND MOU FOR PHYSICAL THERAPY TECHNICIANS.

HOUSTON HEALTHCARE PROVIDES HEALTH EDUCATION THROUGH A SPEAKERS BUREAU WHICH INCLUDES TOPICS THAT ADDRESS HEALTH CONCERNS RELATED TO HEART HEALTH, STROKE, DIABETES, CANCER PREVENTION, BRAIN AND MENTAL HEALTH, AND HEALTH PROMOTION TO ANY GROUP OR ORGANIZATION IN THE COMMUNITY. THE SPEAKERS BUREAU ALSO FACILITATES REQUESTS FOR "HANDS-ONLY CPR", AN INITIATIVE STARTED IN 2022, TO INCREASE POSITIVE OUTCOMES OF OUT-OF-HOSPITAL CARDIAC EVENTS IN THE COMMUNITY.

EDUCARE, A DEPARTMENT DESIGNATED BY HOUSTON HEALTHCARE FOR COMMUNITY EDUCATION, PROVIDES CLASSES TO ADDRESS PREVENTION AND MANAGEMENT OF CHRONIC DISEASE, WELLNESS PROMOTION AND HEALTHY LIVING FROM CHILDBIRTH THROUGH SENIOR CARE . THE EDUCARE DEPARTMENT ALSO PROVIDES HEALTH SCREENINGS/HEALTH FAIRS TO LOCAL INDUSTRY, FAITH BASED GROUPS, AS WELL AS VULNERABLE POPULATIONS INCLUDING FOOD PANTRIES/SHELTERS, SENIOR CENTERS AND GROUPS AND MATERNAL SUPPORT ORGANIZATIONS. AN EXTENSIVE SENIOR EXERCISE PROGRAM IS PROVIDED AT NO COST TO PARTICIPANTS. 2023 INCLUDED THE SECOND #HOUSTONHEALTHY 5K/FUN RUN AND WELLNESS EXPO TO ENCOURAGE ACTIVITY AND PROMOTE HEALTHY OPTIONS AVAILABLE IN HOUSTON COUNTY.

PART VI, LINE 6:
HOUSTON HEALTHCARE IS NOT AFFILIATED WITH ANY OTHER HEALTH CARE SYSTEM.

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

SCHEDULE I (Form 990)
(Rev. December 2024)
Department of the Treasury
Internal Revenue Service

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

Complete if the organization answered "Yes" on Form 990, Part IV, line 21 or 22.
Attach to Form 990.
Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

Open to Public Inspection

Name of the organization
HOUSTON HOSPITALS, INC

Employer identification number
71-1045290

Part I General Information on Grants and Assistance

1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? [X] Yes [ ] No

2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

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

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of noncash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of noncash assistance	(h) Purpose of grant or assistance
MIDDLE GEORGIA STATE UNIVERSITY FOUNDATION - 100 UNIVERSITY PARKWAY - MACON, GA 31206	23-7066010	501(C)(3)	75,000.	0.	N/A	N/A	NURSING EDUCATION
CENTRAL GEORGIA TECHNICAL COLLEGE FOUNDATION - 3300 MACON TECH DRIVE - MACON, GA 31206	58-1923671	501(C)(3)	75,000.	0.	N/A	N/A	NURSING EDUCATION

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

3 Enter total number of other organizations listed in the line 1 table ..... 0.

Part III **Grants and Other Assistance to Domestic Individuals.** Complete if the organization answered "Yes" on Form 990, Part IV, line 22. Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of noncash assistance

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

PART I, LINE 2:
THE ORGANIZATION HAS GUIDELINES IN PLACE THAT ARE USED IN REVIEWING THE ELIGIBILITY AND APPROPRIATENESS OF GRANTEES AND CONTRIBUTION RECIPIENTS. GRANTS ARE NOT MADE TO INDIVIDUALS OR POLITICAL ORGANIZATIONS, BUT TO CHARITIES AND RELATED ORGANIZATIONS THAT COMPLEMENT AND/OR FURTHER THE MISSION OF HOUSTON HEALTHCARE AND REFLECT POSITIVELY ON OUR ORGANIZATION. EACH GRANT IS MADE ON AN ANNUAL BASIS. ALL GRANTS REQUIRE WRITTEN DOCUMENTATION OF APPROVAL.

SCHEDULE J (Form 990)

(Rev. December 2024)

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees
Complete if the organization answered "Yes" on Form 990, Part IV, line 23.
Attach to Form 990.
Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

Open to Public Inspection

Name of the organization

HOUSTON HOSPITALS, INC

Employer identification number

71-1045290

Part I Questions Regarding Compensation

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

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

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC and/or 1099-NEC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) LUKE COUCH	(i)	366,631.	25,000.	333,268.	1,484.	23,258.	749,641.	0.
PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.
(2) CHARLES G. BRISCOE	(i)	401,196.	0.	41,232.	6,900.	18,214.	467,542.	0.
PRESIDENT & CHIEF EXEC. OFFICER	(ii)	0.	0.	0.	0.	0.	0.	0.
(3) LARRY D. STEWART, M.D.	(i)	377,765.	0.	0.	6,187.	20,740.	404,692.	0.
VP & CHIEF MEDICAL OFFICER	(ii)	0.	0.	0.	0.	0.	0.	0.
(4) SEAN S. WHILDEN	(i)	268,383.	0.	47,024.	5,207.	21,701.	342,315.	0.
VP & CFO (INTERIM COO)	(ii)	0.	0.	0.	0.	0.	0.	0.
(5) PETER IZZO	(i)	231,916.	25,000.	22,061.	5,820.	18,214.	303,011.	0.
PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.
(6) JACINTA TRAN	(i)	232,263.	25,000.	14,616.	3,263.	17,328.	292,470.	0.
PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.
(7) MARIAM LARO	(i)	253,021.	6,045.	6,410.	1,313.	6,689.	273,478.	0.
PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) ANJALI MAGAR	(i)	216,652.	48,800.	0.	0.	784.	266,236.	0.
PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.
(9) SIGISMUND D. TETTEH	(i)	192,148.	0.	0.	3,948.	15,098.	211,194.	0.
VP CHIEF INFORMATION OFFICER	(ii)	0.	0.	0.	0.	0.	0.	0.
(10) SHELLISA HOUSTON-MARTIN	(i)	204,096.	0.	0.	4,164.	2,114.	210,374.	0.
VP PATIENT CARE SERVICES	(ii)	0.	0.	0.	0.	0.	0.	0.
(11) TODD EDENFIELD	(i)	166,879.	0.	0.	3,297.	15,111.	185,287.	0.
VP ADMINISTRATOR PH	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

Part III **Supplemental Information**

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

PART I, LINE 3:
A COMPREHENSIVE REVIEW OF THE CEO'S TOTAL COMPENSATION IS CONDUCTED BY THE
MINUTES REFLECTING THE DELIBERATIONS OF THE COMMITTEE ARE RECORDED AND
DIRECTORS. IN CONSIDERING AN ADJUSTMENT TO THE COMPENSATION PACKAGE FOR THE
INCLUDING THE GEORGIA VHA EXECUTIVE COMPENSATION SURVEY-CEO, THE GEORGIA
BENEFITS AND COMPENSATION COMMITTEE OF HOUSTON HEALTHCARE SYSTEM, INC.
FILED. THE COMMITTEE IS COMPRISED OF THREE MEMBERS OF THE BOARD OF CEO,
VARIOUS STUDIES ARE CONSIDERED AND FACTORED INTO THE FINAL DECISION,
HOSPITAL ASSOCIATION SURVEY OF EXECUTIVE COMPENSATION, AND AN EXECUTIVE
SALARY SURVEY OF GEORGIA HOSPITAL EXECUTIVES CONDUCTED ANNUALLY BY HR
ADVANTAGE, A COMPENSATION CONSULTANT WITH NATION-WIDE REACH. ALL OF THE
ENTITIES AND INDIVIDUALS PROVIDE COMPENSATION DATA INDEPENDENT OF THE
OTHERS. SUBSEQUENT TO THE REVIEW, A RECOMMENDATION REGARDING THE CEO'S
COMPENSATION IS REVIEWED AND MODIFIED/APPROVED BY THE BOARD OF DIRECTORS OF
HOUSTON HOSPITALS, INC. A SIMILAR PROCESS IS EMPLOYED FOR THE CFO. THE
REVIEWS ARE PERFORMED ON AN ANNUAL BASIS.

SCHEDULE L
(Form 990)
(Rev. December 2024)
Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

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

OMB No. 1545-0047

Open to Public Inspection

Name of the organization
HOUSTON HOSPITALS, INC

Employer identification number
71-1045290

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

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

1 **(a)** Name of disqualified person	**(b)** Relationship between disqualified person and organization	**(c)** Description of transaction	**(d)** Corrected? Yes	No
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				

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

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

Part II Loans to and/or From Interested Persons

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

(a) Name of interested person	**(b)** Relationship with organization	**(c)** Purpose of loan	**(d)** Loan to or from the organization? To	From	**(e)** Original principal amount	**(f)** Balance due	**(g)** In default? Yes	No	**(h)** Approved by board or committee? Yes	No	**(i)** Written agreement? Yes	No
(1)												
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												
(8)												
(9)												
(10)												
Total ..... $												

Part III Grants or Assistance Benefiting Interested Persons

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

(a) Name of interested person	**(b)** Relationship between interested person and the organization	**(c)** Amount of assistance	**(d)** Type of assistance	**(e)** Purpose of assistance
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				
(7)				
(8)				
(9)				
(10)				

Part IV Business Transactions Involving Interested Persons

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) STEPHEN TETTEH	FAMILY MEMBER OF OF	73,911.	EMPLOYMENT		X
(2) BEAU'ELISE HOUSTON	FAMILY MEMBER OF OF	11,224.	EMPLOYMENT		X
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

Part V Supplemental Information

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

SCH L, PART IV, BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS:
(A) NAME OF PERSON: STEPHEN TETTEH
(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:
FAMILY MEMBER OF OFFICER
(C) AMOUNT OF TRANSACTION $ 73,911.
(D) DESCRIPTION OF TRANSACTION: EMPLOYMENT
(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: BEAU'ELISE HOUSTON
(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:
FAMILY MEMBER OF OFFICER
(C) AMOUNT OF TRANSACTION $ 11,224.
(D) DESCRIPTION OF TRANSACTION: EMPLOYMENT
(E) SHARING OF ORGANIZATION REVENUES? = NO

SCHEDULE O (Form 990)
(Rev. December 2024)
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 Form 990-EZ.
Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

Open to Public Inspection

Name of the organization
HOUSTON HOSPITALS, INC

Employer identification number
71-1045290

FORM 990, PART I, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:
COST-EFFECTIVE SERVICES WHILE PROMOTING HEALTH AND WELLNESS.

FORM 990, PART VI, SECTION A, LINE 6:
THE BOARD OF DIRECTORS OF HOUSTON HEALTHCARE SYSTEM, INC., A RELATED 501(C)(3) ORGANIZATION, APPOINTS THE BOARD OF DIRECTORS OF HOUSTON HOSPITALS, INC.

FORM 990, PART VI, SECTION A, LINE 7A:
THE BOARD OF DIRECTORS OF HOUSTON HEALTHCARE SYSTEM, INC., A RELATED 501(C)(3) ORGANIZATION, APPOINTS THE BOARD OF DIRECTORS OF HOUSTON HOSPITALS, INC.

FORM 990, PART VI, SECTION A, LINE 7B:
CERTAIN ACTIONS OF THE BOARD OF DIRECTORS OF HOUSTON HOSPITALS, INC. MUST BE APPROVED BY THE BOARD OF DIRECTORS OF HOUSTON HEALTHCARE SYSTEM, INC., A RELATED 501(C)(3) ORGANIZATION.

FORM 990, PART VI, SECTION B, LINE 11B:
A DRAFT OF THE FORM 990 IS PREPARED BY AN INDEPENDENT TAX ACCOUNTANT AND SENT TO THE OFFICERS FOR REVIEW. AFTER REVIEW AND COMMENTS FROM THE OFFICERS, THE RETURN IS FINALIZED. PRIOR TO FILING, A COPY OF THE FINALIZED RETURN IS PROVIDED TO THE ORGANIZATION'S BOARD OF DIRECTORS.

FORM 990, PART VI, SECTION B, LINE 12C:
ON AN ANNUAL BASIS, BOARD MEMBERS COMPLETE A CONFLICT OF INTEREST STATEMENT DISCLOSING ANY POTENTIAL CONFLICTS. THE STATEMENTS ARE REVIEWED BY MANAGEMENT FOR DISCLOSURES.

FORM 990, PART VI, SECTION B, LINE 15:
A COMPREHENSIVE REVIEW OF THE CEO'S TOTAL COMPENSATION IS CONDUCTED BY THE BENEFITS AND COMPENSATION COMMITTEE OF HOUSTON HEALTHCARE SYSTEM, INC. MINUTES REFLECTING THE DELIBERATIONS OF THE COMMITTEE ARE RECORDED AND FILED. THE COMMITTEE IS COMPRISED OF THREE MEMBERS OF THE BOARD OF DIRECTORS. IN CONSIDERING AN ADJUSTMENT TO THE COMPENSATION PACKAGE FOR THE CEO, VARIOUS STUDIES ARE CONSIDERED AND FACTORED INTO THE FINAL DECISION, INCLUDING GA VHA EXECUTIVE COMPENSATION SURVEY, THE GHA SURVEY OF COMPENSATION SURVEY, AND AN EXECUTIVE SALARY SURVEY CONDUCTED HR ADVANTAGE, A COMPENSATION CONSULTANT WITH NATION-WIDE REACH. ALL OF THE ENTITIES AND INDIVIDUALS PROVIDED COMPENSATION DATA INDEPENDENT OF THE OTHERS. SUBSEQUENT TO THE REVIEW, A RECOMMENDATION REGARDING THE CEO'S COMPENSATION IS REVIEWED AND MODIFIED/APPROVED BY THE BOARD OF DIRECTORS OF HOUSTON HEALTHCARE SYSTEM, INC. A SIMILAR PROCESS IS EMPLOYED FOR THE COO AND CFO. THE REVIEWS ARE PERFORMED ON AN ANNUAL BASIS.

FORM 990, PART VI, SECTION C, LINE 19:
GOVERNING DOCUMENTS, THE CONFLICT OF INTEREST POLICY, AND ANNUAL FINANCIAL STATEMENTS ARE AVAILABLE TO THE PUBLIC UPON REQUEST.

FORM 990, PART IX, LINE 11G, OTHER FEES:
OTHER FEES:

PROGRAM SERVICE EXPENSES	42,054,451.

Name of the organization: HOUSTON HOSPITALS, INC
Employer identification number: 71-1045290

MANAGEMENT AND GENERAL EXPENSES	6,050,120.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	48,104,571.
TOTAL OTHER FEES ON FORM 990, PART IX, LINE 11G, COL A	48,104,571.

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

CHANGE IN PENSION OBLIGATION	
BOOK TO TAX DIFFERENCE - HOUSTON ASC	-96,973.
TOTAL TO FORM 990, PART XI, LINE 9	-96,973.

FORM 990, PART XII, LINE 2C:

THERE HAS BEEN NO CHANGE IN EITHER THE OVERSIGHT OR SELECTION PROCESS.

SCHEDULE R (Form 990)
(Rev. January 2025)
Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No. 1545-0047

Open to Public Inspection

Name of the organization
HOUSTON HOSPITALS, INC

Employer identification number
71-1045290

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
HOUSTON HEALTHCARE SYSTEM, INC. - 71-1045299 P.O. BOX 2886 WARNER ROBINS, GA 31099	PARENT	GEORGIA	501(C)(3)	LINE 12C, III-FI	N/A		X
HOUSTON HEALTHCARE EMS, INC. - 26-3941348 P.O. BOX 2886 WARNER ROBINS, GA 31099	AMBULANCE SERVICE	GEORGIA	501(C)(3)	LINE 10	HOUSTON HEALTHCARE SYSTEM, INC.		X
HOUSTON HEALTHCARE PROPERTIES, INC. - 27-0174397, P.O. BOX 2886, WARNER ROBINS, GA 31099	REAL ESTATE MANAGEMENT	GEORGIA	501(C)(2)		HOUSTON HEALTHCARE SYSTEM, INC.		X

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) Disproportionate allocations? No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) General or managing partner? No	(k) Percentage ownership
PATIENT SELECT, LLC - 58-2345231, 1601 WATSON BOULEVARD, WARNER ROBINS, GA 31093	MSO	GA	N/A	N/A	N/A	N/A		X	N/A		X	N/A
HOUSTON ASC, LLC - 85-3448933 1601 WATSON BOULEVARD WARNER ROBINS, GA 31093	PATIENT SERVICES	GA	HOUSTON HOSPITALS, INC.	RELATED	96,973.	2,183,983.		X	N/A	X		97.28%

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) Section 512(b)(13) controlled entity? No
HOUSTON HEALTH VENTURES, INC. - 27-2814306 1601 WATSON BOULEVARD WARNER ROBINS, GA 31093	PATIENT SERVICES	GA	HOUSTON HEALTCARE SYSTEM, INC.	C CORP	0.	0.	.00%		X

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

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

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

	(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)	HOUSTON HEALTHCARE PROPERTIES, INC.	K	637,803.	CASH
(2)	HOUSTON HEALTHCARE PROPERTIES, INC.	R	553,755.	CASH
(3)	HOUSTON HEALTHCARE EMS, INC.	R	2,742,499.	CASH
(4)	HOUSTON HEALTHCARE SYSTEM, INC.	R	12,012,115.	CASH
(5)	HOUSTON HEALTH VENTURES, INC.	R	148,050.	CASH
(6)				

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

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

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

Part VII **Supplemental Information**

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

HOUSTON HOSPITALS, INC 71-1045290

Form **990-W** (Worksheet)

Estimated Tax on Unrelated Business Taxable Income for Tax-Exempt Organizations

(and on Investment Income for Private Foundations) FORM 990-T

▶ Keep for your records. Do not send to the Internal Revenue Service.

2025

1	Unrelated business taxable income expected in the tax year	1	
2	**Tax on the amount on line 1**	2	
3	Alternative minimum tax for trusts	3	
4	Total. Add lines 2 and 3	4	
5	Estimated tax credits	5	
6	Subtract line 5 from line 4	6	
7	Other taxes	7	
8	Total. Add lines 6 and 7	8	
9	Credit for federal tax paid on fuels	9	
10a	Subtract line 9 from line 8. **Note:** If less than $500, the organization does not need to make estimated tax payments	10a	
b	Enter the tax shown on the 2024 return. **Caution:** If zero or the tax year was for less than 12 months, skip this line and enter the amount from line 10a on line 10c	10b	
c	**2025 Estimated Tax.** Enter the smaller of line 10a or line 10b. If the organization is required to skip line 10b, enter the amount from line 10a on line 10c	10c	46,111.

		(a)	(b)	(c)	(d)
11	**Installment due dates**	11			12/15/25
12	**Installments.** Enter 25% of line 10c in columns **(a)** through **(d)**	12			46,111.
13	**2024 Overpayment**	13			11,111.
14	**Payment due** (Subtract line 13 from line 12)	14			35,000.

Form **990-W**

ESTIMATED TAX	46,111.
OVERPAYMENT APPLIED	11,111.
AMOUNT DUE	35,000.

EXTENDED TO NOVEMBER 17, 2025

Form **990-T**

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

For calendar year 2024 or other tax year beginning _____ , and ending _____ .

Department of the Treasury
Internal Revenue Service

Go to www.irs.gov/Form990T for instructions and the latest information.
Do not enter SSN numbers on this form as it may be made public if your organization is an 501(c)(3).

OMB No. 1545-0047

2024

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

A ☐ Check box if address changed.

B Exempt under section
☒ 501(c)(3)
☐ 408(e) ☐ 220(e)
☐ 408A ☐ 530(a)
☐ 529(a) ☐ 529A

Print or Type

Name of organization (☐ Check box if name changed and see instructions.)
HOUSTON HOSPITALS, INC

D Employer identification number
71-1045290

Number, street, and room or suite no. If a P.O. box, see instructions.
1601 WATSON BOULEVARD

E Group exemption number (see instructions)

City or town, state or province, country, and ZIP or foreign postal code
WARNER ROBINS, GA 31093

F ☐ Check box if an amended return.

C Book value of all assets at end of year 364,706,543.

G Check organization type ☒ 501(c) corporation ☐ 501(c) trust ☐ 401(a) trust ☐ Other trust ☐ State college/university ☐ 6417(d)(1)(A) Applicable entity

H Check if filing only to claim ☐ Credit from Form 8941 ☐ Refund shown on Form 2439 ☐ Elective payment amount from Form 3800

I Check if a 501(c)(3) organization filing a consolidated return with a 501(c)(2) titleholding corporation ☐

J Enter the number of attached Schedules A (Form 990-T) 1

K During the tax year, was the corporation a subsidiary in an affiliated group or a parent-subsidiary controlled group? ☐ Yes ☒ No
If "Yes," enter the name and identifying number of the parent corporation

L The books are in care of MICHAEL LOFTUS Telephone number 478-542-7959

Part I Total Unrelated Business Taxable Income

1	Total of unrelated business taxable income computed from all unrelated trades or businesses (see instructions)	1	216,227.
2	Reserved	2	
3	Add lines 1 and 2	3	216,227.
4	Charitable contributions (see instructions for limitation rules)	4	0.
5	Total unrelated business taxable income before net operating losses. Subtract line 4 from line 3	5	216,227.
6	Deduction for net operating loss. See instructions	6	
7	Total of unrelated business taxable income before specific deduction and section 199A deduction. Subtract line 6 from line 5	7	216,227.
8	Specific deduction (generally $1,000, but see instructions for exceptions)	8	1,000.
9	**Trusts.** Section 199A deduction. See instructions	9	
10	**Total deductions.** Add lines 8 and 9	10	1,000.
11	**Unrelated business taxable income.** Subtract line 10 from line 7. If line 10 is greater than line 7, enter zero	11	215,227.

Part II Tax Computation

1	**Organizations taxable as corporations.** Multiply Part I, line 11 by 21% (0.21)	1	45,198.
2	**Trusts taxable at trust rates.** See instructions for tax computation. Income tax on the amount on Part I, line 11, from: ☐ Tax rate schedule or ☐ Schedule D (Form 1041)	2	
3	**Proxy tax.** See instructions	3	
4a	Amount from Form 4255, Part I , line 3, column (q)	4a	
b	Other tax amounts. See instructions	4b	
5	Alternative minimum tax	5	
6	**Tax on noncompliant facility income.** See instructions	6	
7	**Total.** Add lines 3 through 6 to line 1 or 2, whichever applies	7	45,198.

Part III Tax and Payments

1a	Foreign tax credit (corporations attach Form 1118; trusts attach Form 1116)	1a			
b	Other credits (see instructions)	1b			
c	General business credit. Attach Form 3800 (see instructions)	1c			
d	Credit for prior-year minimum tax (attach Form 8801 or 8827)	1d			
e	**Total credits.** Add lines 1a through 1d			1e	
2	Subtract line 1e from Part II, line 7			2	45,198.
3a	Amount from Form 4255, Part I, line 3, column (r) (see instructions)	3a			
b	Amount due from Form 8611	3b			
c	Amount due from Form 8697	3c			
d	Amount due from Form 8866	3d			
e	Other amounts due (see instructions)	3e			
f	Total amounts due. Add lines 3a through 3e			3f	0.
4	**Total tax.** Add lines 2 and 3f (see instructions). ☐ Check if includes tax previously deferred under section 1294. Enter tax amount here			4	45,198.

Part III Tax and Payments *(continued)*

5	Current net 965 tax liability paid from Form 965-A, Part II, column (k)			5	0.
6 a	Payments: Preceding year's overpayment credited to the current year	6a			
b	Current year's estimated tax payments. Check if section 643(g) election applies ☐	6b	46,000.		
c	Tax deposited with Form 8868	6c	11,500.		
d	Foreign organizations: Tax paid or withheld at source (see instructions)	6d			
e	Backup withholding (see instructions)	6e			
f	Credit for small employer health insurance premiums (attach Form 8941)	6f			
g	Elective payment election amount from Form 3800	6g			
h	Payment from Form 2439	6h			
i	Credit from Form 4136	6i			
j	Other (see instructions)	6j			
7	**Total payments.** Add lines 6a through 6j			7	57,500.
8	Estimated tax penalty (see instructions). Check if Form 2220 is attached ☒			8	1,191.
9	**Tax due.** If line 7 is smaller than the total of lines 4, 5, and 8, enter amount owed			9	
10	**Overpayment.** If line 7 is larger than the total of lines 4, 5, and 8, enter amount overpaid			10	11,111.
11	Enter the amount of line 10 you want: **Credited to 2025 estimated tax** 11,111. **Refunded**			11	0.

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

		Yes	No
1	At any time during the 2024 calendar year, did the organization have an interest in or a signature or other authority over a financial account (bank, securities, or other) in a foreign country? If "Yes," the organization may have to file FinCEN Form 114, Report of Foreign Bank and Financial Accounts. If "Yes," enter the name of the foreign country here _____		X
2	During the tax year, did the organization receive a distribution from, or was it the grantor of, or transferor to, a foreign trust? If "Yes," see instructions for other forms the organization may have to file.		X
3	Enter the amount of tax-exempt interest received or accrued during the tax year $ _____		
4	Enter available pre-2018 NOL carryovers here $ _____ Do not include any post-2017 NOL carryover shown on Schedule A (Form 990-T). Don't reduce the NOL carryover shown here by any deduction reported on Part I, line 6.		
5	Post-2017 NOL carryovers. Enter the Business Activity Code and available post-2017 NOL carryovers. Don't reduce the amounts shown below by any NOL claimed on any Schedule A, Part II, line 17 for the tax year. See instructions.		

Business Activity Code	Available post-2017 NOL carryover
	$
	$
	$
	$

6 a	Reserved for future use		
b	Reserved for future use		

Part V Supplemental Information

Provide any additional information. See instructions.

Sign Here

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

Signature of officer | Date | Title: CFO

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

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
MEGAN RANDOLPH		11/12/25		P00989558

Firm's name WARREN AVERETT, LLC — Firm's EIN 45-4084437

Firm's address 2500 ACTON ROAD BIRMINGHAM, AL 35243 — Phone no. 205-979-4100

SCHEDULE A (Form 990-T)

Department of the Treasury
Internal Revenue Service

Unrelated Business Taxable Income From an Unrelated Trade or Business

Go to www.irs.gov/Form990T for instructions and the latest information.

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

OMB No. 1545-0047

2024

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

A Name of the organization: HOUSTON HOSPITALS, INC

B Employer identification number: 71-1045290

C Unrelated business activity code (see instructions): 532420

D Sequence: 1 of 1

E Describe the unrelated trade or business: EQUIPMENT

Part I Unrelated Trade or Business Income

			(A) Income	(B) Expenses	(C) Net
1a	Gross receipts or sales				
b	Less returns and allowances c Balance	1c			
2	Cost of goods sold (Part III, line 8)	2			
3	Gross profit. Subtract line 2 from line 1c	3			
4a	Capital gain net income (attach Schedule D (Form 1041 or Form 1120)). See instructions	4a			
b	Net gain (loss) (Form 4797) (attach Form 4797). See instructions	4b			
c	Capital loss deduction for trusts	4c			
5	Income (loss) from a partnership or an S corporation (attach statement)	5			
6	Rent income (Part IV)	6	318,834.	92,863.	225,971.
7	Unrelated debt-financed income (Part V)	7			
8	Interest, annuities, royalties, and rents from a controlled organization (Part VI)	8			
9	Investment income of section 501(c)(7), (9), or (17) organizations (Part VII)	9			
10	Exploited exempt activity income (Part VIII)	10			
11	Advertising income (Part IX)	11			
12	Other income (see instructions; attach statement)	12			
13	**Total.** Combine lines 3 through 12	13	318,834.	92,863.	225,971.

Part II Deductions Not Taken Elsewhere. See instructions for limitations on deductions. Deductions must be directly connected with the unrelated business income

1	Compensation of officers, directors, and trustees (Part X)			1	
2	Salaries and wages			2	
3	Repairs and maintenance			3	
4	Bad debts			4	
5	Interest (attach statement). See instructions			5	
6	Taxes and licenses			6	9,744.
7	Depreciation (attach Form 4562). See instructions	7			
8	Less depreciation claimed in Part III and elsewhere on return	8a		8b	
9	Depletion			9	
10	Contributions to deferred compensation plans			10	
11	Employee benefit programs			11	
12	Excess exempt expenses (Part VIII)			12	
13	Excess readership costs (Part IX)			13	
14	Other deductions (attach statement)			14	
15	**Total deductions.** Add lines 1 through 14			15	9,744.
16	Unrelated business income before net operating loss deduction. Subtract line 15 from Part I, line 13, column (C)			16	216,227.
17	Deduction for net operating loss. See instructions			17	0.
18	**Unrelated business taxable income.** Subtract line 17 from line 16			18	216,227.

Part III Cost of Goods Sold

Enter method of inventory valuation

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

Part IV Rent Income (From Real Property and Personal Property Leased With Real Property)

1 Description of property (property street address, city, state, ZIP code). Check if a dual-use. See instructions.

A ☐ EQUIPMENT 1601NWATSON BOULEVARD, WARREN ROBINS, GA 31093

B ☐

C ☐

D ☐

		A	B	C	D
2	Rent received or accrued				
a	From personal property (if the percentage of rent for personal property is more than 10% but not more than 50%)	318,834.			
b	From real and personal property (if the percentage of rent for personal property exceeds 50% or if the rent is based on profit or income)	0.			
c	Total rents received or accrued by property. Add lines 2a and 2b, columns A through D	318,834.			

3	Total rents received or accrued. Add line 2c, columns A through D. Enter here and on Part I, line 6, column (A)	318,834.
4	Deductions directly connected with the income in lines 2a and 2b (attach statement) STMT 1	92,863.
5	**Total deductions.** Add line 4, columns A through D. Enter here and on Part I, line 6, column (B)	92,863.

Part V Unrelated Debt-Financed Income (see instructions)

1 Description of debt-financed property (street address, city, state, ZIP code). Check if a dual-use. See instructions.

A ☐

B ☐

C ☐

D ☐

		A	B	C	D
2	Gross income from or allocable to debt-financed property				
3	Deductions directly connected with or allocable to debt-financed property				
a	Straight line depreciation (attach statement)				
b	Other deductions (attach statement)				
c	Total deductions (add lines 3a and 3b, columns A through D)				
4	Amount of average acquisition debt on or allocable to debt-financed property (attach statement)				
5	Average adjusted basis of or allocable to debt-financed property (attach statement)				
6	Divide line 4 by line 5	%	%	%	%
7	Gross income reportable. Multiply line 2 by line 6				

8	**Total gross income** (add line 7, columns A through D). Enter here and on Part I, line 7, column (A)	0.
9	Allocable deductions. Multiply line 3c by line 6	
10	**Total allocable deductions.** Add line 9, columns A through D. Enter here and on Part I, line 7, column (B)	0.
11	**Total dividends-received deductions** included in line 10	0.

Part VI Interest, Annuities, Royalties, and Rents From Controlled Organizations (see instructions)

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

Nonexempt Controlled Organizations: 7. Taxable Income	8. Net unrelated income (loss) (see instructions)	9. Total of specified payments made	10. Part of column 9 that is included in the controlling organization's gross income	11. Deductions directly connected with income in column 10
(1)				
(2)				
(3)				
(4)				
Totals			Add columns 5 and 10. Enter here and on Part I, line 8, column (A). 0.	Add columns 6 and 11. Enter here and on Part I, line 8, column (B). 0.

Part VII Investment Income of a Section 501(c)(7), (9), or (17) Organization (see instructions)

1. Description of income	2. Amount of income	3. Deductions directly connected (attach statement)	4. Set-asides (attach statement)	5. Total deductions and set-asides (add cols 3 and 4)
(1)				
(2)				
(3)				
(4)				
Totals	Add amounts in column 2. Enter here and on Part I, line 9, column (A). 0.			Add amounts in column 5. Enter here and on Part I, line 9, column (B). 0.

Part VIII Exploited Exempt Activity Income, Other Than Advertising Income (see instructions)

1	Description of exploited activity:		
2	Gross unrelated business income from trade or business. Enter here and on Part I, line 10, column (A)	2	
3	Expenses directly connected with production of unrelated business income. Enter here and on Part I, line 10, column (B)	3	
4	Net income (loss) from unrelated trade or business. Subtract line 3 from line 2. If a gain, complete lines 5 through 7	4	
5	Gross income from activity that is not unrelated business income	5	
6	Expenses attributable to income entered on line 5	6	
7	Excess exempt expenses. Subtract line 5 from line 6, but do not enter more than the amount on line 4. Enter here and on Part II, line 12	7	

Part IX Advertising Income

1 Name(s) of periodical(s). Check box if reporting two or more periodicals on a consolidated basis.

A ☐ _____

B ☐ _____

C ☐ _____

D ☐ _____

Enter amounts for each periodical listed above in the corresponding column.

		A	B	C	D
2	Gross advertising income				
a	Add columns A through D. Enter here and on Part I, line 11, column (A)				0.
3	Direct advertising costs by periodical				
a	Add columns A through D. Enter here and on Part I, line 11, column (B)				0.
4	Advertising gain (loss). Subtract line 3 from line 2. For any column in line 4 showing a gain, complete lines 5 through 8. For any column in line 4 showing a loss or zero, do not complete lines 5 through 7, and enter -0- on line 8				
5	Readership costs				
6	Circulation income				
7	Excess readership costs. If line 6 is less than line 5, subtract line 6 from line 5. If line 5 is less than line 6, enter -0-				
8	Excess readership costs allowed as a deduction. For each column showing a gain on line 4, enter the lesser of line 4 or line 7				
a	Add line 8, columns A through D. Enter the greater of the line 8a columns total or -0- here and on Part II, line 13				0.

Part X Compensation of Officers, Directors, and Trustees (see instructions)

1. Name	2. Title	3. Percentage of time devoted to business	4. Compensation attributable to unrelated business
(1)		%	
(2)		%	
(3)		%	
(4)		%	
Total. Enter here and on Part II, line 1			0.

Part XI Supplemental Information (see instructions)

FORM 990-T (A) DEDUCTIONS CONNECTED WITH RENTAL INCOME STATEMENT 1

DESCRIPTION	ACTIVITY NUMBER	AMOUNT	TOTAL
DEPRECIATION EXPENSE		92,863.	
- SUBTOTAL -	1		92,863.
TOTAL TO FORM 990-T, SCHEDULE A, PART IV, LINE 4			92,863.

FORM 990-T

UNDERPAYMENT OF ESTIMATED TAX WORKSHEET

Name(s)	Identifying Number
HOUSTON HOSPITALS, INC	71-1045290

(A) *Date	(B) Amount	(C) Adjusted Balance Due	(D) Number Days Balance Due	(E) Daily Penalty Rate	(F) Penalty
		-0-			
04/15/24	10,522.	10,522.	61	.000218579	140.
06/15/24	10,523.	21,045.	92	.000218579	423.
09/15/24	10,522.	31,567.	91	.000218579	628.
12/15/24	10,522.	42,089.			
12/15/24	-46,000.	-3,911.			
12/31/24	0.	-3,911.	135	.000191781	

Penalty Due (Sum of Column F). .....

* Date of estimated tax payment, withholding credit date or installment due date.

Form **2220**

Department of the Treasury
Internal Revenue Service

Underpayment of Estimated Tax by Corporations

Attach to the corporation's tax return. FORM 990-T

Go to www.irs.gov/Form2220 for instructions and the latest information.

OMB No. 1545-0123

2024

Name

HOUSTON HOSPITALS, INC

Employer identification number

71-1045290

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

Part I Required Annual Payment

1	Total tax (see instructions)		1	45,198.
2a	Personal holding company tax (Schedule PH (Form 1120), line 26) included on line 1	2a		
b	Look-back interest included on line 1 under section 460(b)(2) for completed long-term contracts or section 167(g) for depreciation under the income forecast method	2b		
c	Credit for federal tax paid on fuels (see instructions)	2c		
d	**Total.** Add lines 2a through 2c		2d	
3	Subtract line 2d from line 1. If the result is less than $500, **do not** complete or file this form. The corporation does not owe the penalty		3	45,198.
4	Enter the tax shown on the corporation's 2023 income tax return. See instructions. **Caution:** If the tax is zero or the tax year was for less than 12 months, skip this line and enter the amount from line 3 on line 5		4	42,089.
5	**Required annual payment.** Enter the **smaller** of line 3 or line 4. If the corporation is required to skip line 4, enter the amount from line 3		5	42,089.

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

6 ☐ The corporation is using the adjusted seasonal installment method.

7 ☐ The corporation is using the annualized income installment method.

8 ☐ The corporation is a "large corporation" figuring its first required installment based on the prior year's tax.

Part III Figuring the Underpayment

		(a)	(b)	(c)	(d)
9	**Installment due dates.** Enter in columns (a) through (d) the 15th day of the 4th (**Form 990-PF filers:** Use 5th month), 6th, 9th, and 12th months of the corporation's tax year	04/15/24	06/15/24	09/15/24	12/15/24
10	**Required installments.** If the box on line 6 and/or line 7 above is checked, enter the amounts from Sch A, line 38. If the box on line 8 (but not 6 or 7) is checked, see instructions for the amounts to enter. If none of these boxes are checked, enter 25% (0.25) of line 5 above in each column	10,522.	10,523.	10,522.	10,522.
11	Estimated tax paid or credited for each period. For column (a) only, enter the amount from line 11 on line 15. See instructions				46,000.
	Complete lines 12 through 18 of one column before going to the next column.				
12	Enter amount, if any, from line 18 of the preceding column				
13	Add lines 11 and 12				46,000.
14	Add amounts on lines 16 and 17 of the preceding column		10,522.	21,045.	31,567.
15	Subtract line 14 from line 13. If zero or less, enter -0-	0.	0.	0.	14,433.
16	If the amount on line 15 is zero, subtract line 13 from line 14. Otherwise, enter -0-		10,522.	21,045.	
17	**Underpayment.** If line 15 is less than or equal to line 10, subtract line 15 from line 10. Then go to line 12 of the next column. Otherwise, go to line 18	10,522.	10,523.	10,522.	
18	**Overpayment.** If line 10 is less than line 15, subtract line 10 from line 15. Then go to line 12 of the next column				

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

Part IV Figuring the Penalty

		(a)	(b)	(c)	(d)
19 Enter the date of payment or the 15th day of the 4th month after the close of the tax year, whichever is earlier. **(C corporations with tax years ending June 30 and S corporations:** Use 3rd month instead of 4th month. **Form 990-PF and Form 990-T filers:** Use 5th month instead of 4th month.) See instructions	19				
20 Number of days from due date of installment on line 9 to the date shown on line 19	20				
21 Number of days on line 20 after 4/15/2024 and before 7/1/2024	21				
22 Underpayment on line 17 x Number of days on line 21 / 366 x 8% (0.08)	22	$	$	$	$
23 Number of days on line 20 after 6/30/2024 and before 10/1/2024	23				
24 Underpayment on line 17 x Number of days on line 23 / 366 x 8% (0.08)	24	$	$	$	$
25 Number of days on line 20 after 9/30/2024 and before 1/1/2025	25				
26 Underpayment on line 17 x Number of days on line 25 / 366 x 8% (0.08)	26	$	$	$	$
27 Number of days on line 20 after 12/31/2024 and before 4/1/2025	27	SEE ATTACHED WORKSHEET			
28 Underpayment on line 17 x Number of days on line 27 / 365 x 7% (0.07)	28	$	$	$	$
29 Number of days on line 20 after 3/31/2025 and before 7/1/2025	29				
30 Underpayment on line 17 x Number of days on line 29 / 365 x *%	30	$	$	$	$
31 Number of days on line 20 after 6/30/2025 and before 10/1/2025	31				
32 Underpayment on line 17 x Number of days on line 31 / 365 x *%	32	$	$	$	$
33 Number of days on line 20 after 9/30/2025 and before 1/1/2026	33				
34 Underpayment on line 17 x Number of days on line 33 / 365 x *%	34	$	$	$	$
35 Number of days on line 20 after 12/31/2025 and before 3/16/2026	35				
36 Underpayment on line 17 x Number of days on line 35 / 365 x *%	36	$	$	$	$
37 Add lines 22, 24, 26, 28, 30, 32, 34, and 36	37	$	$	$	$

38 Penalty. Add columns (a) through (d) of line 37. Enter the total here and on Form 1120, line 34; or the comparable line for other income tax returns ..... 38 $ 1,191.

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

FORM 990-T

UNDERPAYMENT OF ESTIMATED TAX WORKSHEET

Name(s)	Identifying Number
HOUSTON HOSPITALS, INC	71-1045290

(A) *Date	(B) Amount	(C) Adjusted Balance Due	(D) Number Days Balance Due	(E) Daily Penalty Rate	(F) Penalty
		-0-			
04/15/24	10,522.	10,522.	61	.000218579	140.
06/15/24	10,523.	21,045.	92	.000218579	423.
09/15/24	10,522.	31,567.	91	.000218579	628.
12/15/24	10,522.	42,089.			
12/15/24	-46,000.	-3,911.			
12/31/24	0.	-3,911.	135	.000191781	

Penalty Due (Sum of Column F). ..... 1,191.

* Date of estimated tax payment, withholding credit date or installment due date.

Form **8868**
(Rev. January 2025)

Department of the Treasury
Internal Revenue Service

Application for Extension of Time To File an Exempt Organization Return or Excise Taxes Related to Employee Benefit Plans

File a separate application for each return.
Go to www.irs.gov/Form8868 for the latest information.

OMB No. 1545-0047

Electronic filing (e-file). You can electronically file Form 8868 to request up to a 6-month extension of time to file any of the forms listed below except for Form 8870, Information Return for Transfers Associated With Certain Personal Benefit Contracts. An extension request for Form 8870 must be sent to the IRS in a paper format (see instructions). For more details on the electronic filing of Form 8868, visit www.irs.gov/e-file-providers/e-file-for-charities-and-non-profits.

Caution: If you are going to make an electronic funds withdrawal (direct debit) with this Form 8868, see Form 8453-TE and Form 8879-TE for payment instructions.

All corporations required to file an income tax return other than Form 990-T (including 1120-C filers), partnerships, REMICs, and trusts must use Form 7004 to request an extension of time to file income tax returns.

Part I - Identification

Type or Print

File by the due date for filing your return. See instructions.

Name of exempt organization, employer, or other filer, see instructions.
HOUSTON HOSPITALS, INC

Taxpayer identification number (TIN)
71-1045290

Number, street, and room or suite no. If a P.O. box, see instructions.
1601 WATSON BOULEVARD

City, town or post office, state, and ZIP code. For a foreign address, see instructions.
WARNER ROBINS, GA 31093

Enter the Return Code for the return that this application is for (file a separate application for each return) 01

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01	Form 4720 (other than individual)	09
Form 4720 (individual)	03	Form 5227	10
Form 990-PF	04	Form 6069	11
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 8870	12
Form 990-T (trust other than above)	06	Form 5330 (individual)	13
Form 990-T (corporation)	07	Form 5330 (other than individual)	14
Form 1041-A	08	Form 990-T (governmental entities)	15

- After you enter your Return Code, complete either Part II or Part III. Part III, including signature, is applicable only for an extension of time to file Form 5330.
- If this application is for an extension of time to file Form 5330, you must enter the following information.

Plan Name _____
Plan Number _____
Plan Year Ending (MM/DD/YYYY)

Part II - Automatic Extension of Time To File for Exempt Organizations (see instructions)

The books are in the care of MICHAEL LOFTUS
1601 WATSON BOULEVARD - WARNER ROBBINS, GA 31093

Telephone No. 478-542-7959 Fax No. _____

- If the organization does not have an office or place of business in the United States, check this box ..... ☐
- If this is for a Group Return, enter the organization's four-digit Group Exemption Number (GEN) _____. If this is for the whole group, check this box ..... ☐. If it is for part of the group, check this box ... ☐ and attach a list with the names and TINs of all members the extension is for.

1 I request an automatic 6-month extension of time until NOVEMBER 15, 20 25, to file the exempt organization return for the organization named above. The extension is for the organization's return for:

☒ calendar year 20 24 or

☐ tax year beginning _____, 20 _____, and ending _____, 20 _____

2 If the tax year entered in line 1 is for less than 12 months, check reason: ☐ Initial return ☐ Final return ☐ Change in accounting period

3a	If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	**3a**	$	0.
b	If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit.	**3b**	$	0.
c	**Balance due.** Subtract line 3b from line 3a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	**3c**	$	0.

For Privacy Act and Paperwork Reduction Act Notice, see instructions. Form **8868** (Rev. 1-2025)

LHA 423841 01-02-25

Form **8868**
(Rev. January 2025)

Department of the Treasury
Internal Revenue Service

Application for Extension of Time To File an Exempt Organization Return or Excise Taxes Related to Employee Benefit Plans

File a separate application for each return.
Go to www.irs.gov/Form8868 for the latest information.

OMB No. 1545-0047

Electronic filing (e-file). You can electronically file Form 8868 to request up to a 6-month extension of time to file any of the forms listed below except for Form 8870, Information Return for Transfers Associated With Certain Personal Benefit Contracts. An extension request for Form 8870 must be sent to the IRS in a paper format (see instructions). For more details on the electronic filing of Form 8868, visit www.irs.gov/e-file-providers/e-file-for-charities-and-non-profits.

Caution: If you are going to make an electronic funds withdrawal (direct debit) with this Form 8868, see Form 8453-TE and Form 8879-TE for payment instructions.

All corporations required to file an income tax return other than Form 990-T (including 1120-C filers), partnerships, REMICs, and trusts must use Form 7004 to request an extension of time to file income tax returns.

Part I - Identification

Type or Print

File by the due date for filing your return. See instructions.

Name of exempt organization, employer, or other filer, see instructions.
HOUSTON HOSPITALS, INC

Taxpayer identification number (TIN)
71-1045290

Number, street, and room or suite no. If a P.O. box, see instructions.
1601 WATSON BOULEVARD

City, town or post office, state, and ZIP code. For a foreign address, see instructions.
WARNER ROBINS, GA 31093

Enter the Return Code for the return that this application is for (file a separate application for each return) 07

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01	Form 4720 (other than individual)	09
Form 4720 (individual)	03	Form 5227	10
Form 990-PF	04	Form 6069	11
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 8870	12
Form 990-T (trust other than above)	06	Form 5330 (individual)	13
Form 990-T (corporation)	07	Form 5330 (other than individual)	14
Form 1041-A	08	Form 990-T (governmental entities)	15

- After you enter your Return Code, complete either Part II or Part III. Part III, including signature, is applicable only for an extension of time to file Form 5330.
- If this application is for an extension of time to file Form 5330, you must enter the following information.

Plan Name _____
Plan Number _____
Plan Year Ending (MM/DD/YYYY)

Part II - Automatic Extension of Time To File for Exempt Organizations (see instructions)

The books are in the care of MICHAEL LOFTUS
1601 WATSON BOULEVARD - WARNER ROBBINS, GA 31093

Telephone No. 478-542-7959 Fax No. _____

- If the organization does not have an office or place of business in the United States, check this box ..... ☐
- If this is for a Group Return, enter the organization's four-digit Group Exemption Number (GEN) _____. If this is for the whole group, check this box ..... ☐. If it is for part of the group, check this box ... ☐ and attach a list with the names and TINs of all members the extension is for.

1 I request an automatic 6-month extension of time until NOVEMBER 15, 20 25, to file the exempt organization return for the organization named above. The extension is for the organization's return for:

☒ calendar year 20 24 or

☐ tax year beginning _____, 20 _____, and ending _____, 20 _____

2 If the tax year entered in line 1 is for less than 12 months, check reason: ☐ Initial return ☐ Final return ☐ Change in accounting period

3a	If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	3a	$	57,500.
b	If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit.	3b	$	46,000.
c	**Balance due.** Subtract line 3b from line 3a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	3c	$	11,500.

For Privacy Act and Paperwork Reduction Act Notice, see instructions. Form **8868** (Rev. 1-2025)

LHA 423841 01-02-25

TAX RETURN FILING INSTRUCTIONS

GEORGIA FORM 600-T

FOR THE YEAR ENDING
DECEMBER 31, 2024

PREPARED FOR:

MR. MICHAEL LOFTUS
HOUSTON HOSPITALS, INC.
1601 WATSON BOULEVARD
WARNER ROBINS, GA 31093

PREPARED BY:

WARREN AVERETT, LLC
2500 ACTON ROAD
BIRMINGHAM, AL 35243

TO BE SIGNED AND DATED BY:

THE AUTHORIZED INDIVIDUAL(S).

AMOUNT OF TAX:

TOTAL TAX	$	9,744
LESS: PAYMENTS AND CREDITS	$	15,300
PLUS: OTHER AMOUNT		0
PLUS: INTEREST AND PENALTIES	$	420
OVERPAYMENT	$	5,556

OVERPAYMENT:

CREDITED TO YOUR ESTIMATED TAX	$	5,136
OTHER AMOUNT	$	0
REFUNDED TO YOU	$	0

MAKE CHECK PAYABLE TO:

GEORGIA DEPARTMENT OF REVENUE.

MAIL TAX RETURN AND CHECK (IF APPLICABLE) TO:

GEORGIA DEPARTMENT OF REVENUE
PROCESSING CENTER
P.O. BOX 740397
ATLANTA, GA 30374-0397

RETURN MUST BE MAILED ON OR BEFORE:

NOVEMBER 17, 2025

SPECIAL INSTRUCTIONS:

2025 ESTIMATED TAX FILING INSTRUCTIONS

GEORGIA ESTIMATED TAX

FOR THE YEAR ENDING
DECEMBER 31, 2025

PREPARED FOR:

MR. MICHAEL LOFTUS
HOUSTON HOSPITALS, INC.
1601 WATSON BOULEVARD
WARNER ROBINS, GA 31093

PREPARED BY:

WARREN AVERETT, LLC
2500 ACTON ROAD
BIRMINGHAM, AL 35243

AMOUNT OF TAX:

TOTAL ESTIMATED TAX	$	10,636
LESS CREDIT FROM PRIOR YEAR	$	5,136
LESS AMOUNT ALREADY PAID ON 2025 ESTIMATE	$	0
BALANCE DUE	$	5,500

PAYABLE IN FULL OR IN INSTALLMENTS AS FOLLOWS:

VOUCHER		AMOUNT	DUE DATE
NO 1	$	0	APRIL 15, 2025
NO 2	$	0	JUNE 16, 2025
NO 3	$	0	SEPTEMBER 15, 2025
NO 4	$	5,500	DECEMBER 15, 2025

MAKE CHECK PAYABLE TO:

GEORGIA DEPARTMENT OF REVENUE

MAIL VOUCHER AND CHECK TO:

GEORGIA DEPARTMENT OF REVENUE
PROCESSING CENTER
P.O. BOX 740397
ATLANTA, GA 30374-0397

SPECIAL INSTRUCTIONS:

PLEASE MAIL THE VOUCHER AND CHECK TO THE ADDRESS ABOVE.
VOUCHER WILL NEED TO B E SIGNED AND DATED.

Form **IT-303** (Rev. 06/07/24)

2530315015

MAIL TO:
Georgia Department of Revenue
Processing Center
PO Box 740320
Atlanta, GA 30374-0320

Georgia Department of Revenue

APPLICATION FOR EXTENSION OF TIME FOR FILING STATE INCOME TAX RETURNS

Important! Acceptance of Federal Extensions

A federal extension will be accepted as a Georgia extension if: (1) The return is received within the time as extended by the Internal Revenue Service, and (2) A copy of the federal extension(s) is attached to the return when filed. Note: There is no extension for payment of tax. Income Tax or Corporate Net Worth Tax must be paid by the prescribed due date to avoid the assessment of late payment penalties and interest.

THIS IS NOT A PAYMENT FORM! REMIT PAYMENT ON FORM IT-560 OR IT-560C.

COMPLETE THIS FORM IN TRIPLICATE. MAIL THE ORIGINAL PRIOR TO THE RETURN DUE DATE AND KEEP 2 COPIES. ATTACH ONE COPY TO RETURN WHEN FILED AND RETAIN ONE COPY FOR YOUR RECORDS. WE WILL NOTIFY YOU ONLY IF YOUR EXTENSION REQUEST IS DENIED.

SECTION 1

NAME			SOCIAL SECURITY NO. OR FEIN
HOUSTON HOSPITALS, INC			71-1045290
ADDRESS	**CITY**	**STATE**	**ZIP CODE**
1601 WATSON BOULEVARD	WARNER ROBINS	GA	31093

NAME OF TAXPAYER FOR WHOM EXTENSION IS FILED, IF DIFFERENT FROM ABOVE

ADDRESS	CITY	STATE	ZIP CODE

SECTION 2

APPLICATION IS HEREBY MADE FOR AN EXTENSION OF TIME FOR THE FOLLOWING STATE TAX RETURN:

1. Type of return (check proper type):	2. For Period Ending:	3. Extension Requested To:
☐ Individual--Form 500		
☐ Partnership--Form 700		
☐ Fiduciary--Form 501 (5 1/2 months only)		
☒ Corporate Income Tax	12/31/24	11/15/25
☐ Net Worth Tax (For Period Beginning) _____		
☐ Other _____		

NOTE: Except as noted above, extensions are limited by law to six (6) months, please see line 6 of instructions.

SECTION 3

REASON FOR EXTENSION:

I AFFIRM THAT THE ABOVE INFORMATION IS, TO THE BEST OF MY KNOWLEDGE AND BELIEF, TRUE AND ACCURATE. THIS AFFIRMATION IS MADE UNDER THE PENALTIES PRESCRIBED BY LAW.

11/12/25
DATE

CHARLES BRISCOE
SIGNATURE OF TAXPAYER OR AUTHORIZED AGENT

IF SIGNED BY AGENT, AGENT'S FIRM OR TRADE NAME

APPLICATION FOR EXTENSION OF TIME FOR FILING STATE INCOME TAX RETURNS

INSTRUCTIONS

1) Extensions of time for filing returns may be granted in cases of sickness, absence, or other disability or whenever reasonable cause exists.

2) This form must be completed in triplicate. Mail the original form prior to the return due date to:
Georgia Department of Revenue, Processing Center, P.O. Box 740320, Atlanta, GA 30374-0320.

3) **One copy of the extension must be attached to the completed return when filed.** Retain the other copy for your records.

4) Separate applications for extension must be submitted for husband and wife if separate returns are filed.

5) An extension request will not be accepted by telephone. Lists are not acceptable. Application must be made on this form, unless a copy of an approved federal extension is attached to your Georgia return when filed. If applicable, explain why it was not necessary to request a federal filing extension.

6) Additional time to file, within the six month limit, will require the submission of a new form along with a copy of the first extension request. **For tax years beginning on or after January 1, 2016, a fiduciary will only be granted an extension up to 5 and one-half months.**

Beginning with tax periods on or after January 1, 2025, Corporations will have one additional month to file.

7) Corporations filing consolidated returns must file a separate application for an extension of filing Net Worth Tax for each subsidiary on Form IT-303. Corporations not filing consolidated returns may request an extension for filing Income Tax and Net Worth Tax on the same form.

8) **Interest and Penalty**

Interest accruing for months beginning before July 1, 2016 accrues at the rate of 12 percent annually. Interest that accrues for months beginning on or after July 1, 2016 accrues as provided by Georgia Code Sections 48-7-81 and 48-13-79.

Late filling penalty on returns filed after the due date prescribed by law will be assessed at a rate of 5% per month computed on the tax not paid by the original due date.

Late payment penalty will be assessed at a rate of 1/2 of 1% per month if tax due on the return is not paid by the date prescribed by law. Late payment penalty accrues regardless of an approved extension request.

Late filing and late payment penalties together cannot exceed 25%.

For more information on Penalties and Interest, see: https://dor.georgia.gov/penalty-and-interest-rates

9) **What form should I use to remit payment?**

- Individuals and Fiduciaries should remit payment due on Form IT-560.
- Corporations and Partnerships should remit payment on Form IT-560C.
- Composite tax should be remitted on Form IT-560C.

NOTE: Remitting payment with Form IT-560 or IT-560C will not extend the due date for filing your return. For filing a Net Worth Tax Return after the date prescribed by law, there shall be assessed a penalty amounting to 10% of the tax shown to be due. For failure to pay tax within the time prescribed by law, there shall be due an additional penalty amounting to 10% of the tax shown to be due.

Dos and Don'ts Checklist for the Corporate, Composite and Partnership (IT-560C) Payment Voucher

Payments can be made electronically on the Georgia Tax Center (GTC) gtc.dor.ga.gov/ .

Do:

- Use a payment voucher with a valid scanline.
- Complete the voucher in its entirety.
- Write your Federal Identification number (FEIN) on your check or money order.
- Make your check or money order payable to: Georgia Department of Revenue
- Mail your voucher and payment to:

Processing Center
Georgia Department of Revenue
PO Box 740239
Atlanta, GA 30374-0239

Do not:

- Mail this entire page.
- Staple your payment and voucher together.
- Print on both sides of the paper.
- Handwrite any information.

Reminder:

- Use this form to submit any payment of tax when an extension has been requested or is enforced. Pay the tax that will be due as reflected on the final return.
- The extension is for filing the return only and does not extend the time for paying the tax.
- If you receive an automatic extension to file your Federal return, Georgia will honor that extension.
- Tax must be paid by the statutory due date. No penalty for late filing will be assessed if the Georgia return is filed by the extended date of the Federal return.
- The amount paid is to be credited as a payment on the liability that may be due as reflected on the completed return.
- If the due date falls on a weekend or holiday, the tax is due on the next day that is not a weekend or holiday
- If the tax is not paid by the original due date of the return, a penalty of 1/2 of 1% per month of the tax due will be assessed as a late payment penalty. Interest will also be due.
- Payments of $10,000 or more must be made electronically.

Georgia Public Revenue Code Section 48-2-31 stipulates that taxes shall be paid in lawful money of the United States, free of any expense to the State of Georgia.

445501 08-26-24

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IT 560 C (Rev. 08/13/24)
For Corporation, Composite and Partnership Only
Income/Net Worth Payment Voucher

2024

2501215014

MAIL TO:
Processing Center
Georgia Department of Revenue
PO Box 740239
Atlanta, Georgia 30374-0239

☐ Composite Tax ☐ Net Worth Tax ☐ Address Change ☐ Name Change **TYPE OF RETURN:** ☒ 03-Corporate ☐ 35-Partnership

FEI Number	Income Tax Year	Beginning Date	Ending Date	Vendor Code
71-1045290	2024	01-01-2024	12-31-2024	150

Name (Type or print plainly the exact Corporation Name)	Signature of Officer or Agent	Title	Date
HOUSTON HOSPITALS, INC			

Business Address	City	State	ZIP Code
1601 WATSON BOULEVARD	WARNER ROBINS	GA	31093

PLEASE DO NOT STAPLE. REMOVE ALL CHECK STUBS.

Amount Paid $ 2500.00

01271104529000912312420222030000000015000002500005

CORPORATION AND PARTNERSHIP ESTIMATED TAX

SHORT TAXABLE YEAR

Corporations that are required to file estimated tax for a short taxable period or whose accounting period has changed should use Form 602 ES and change applicable dates to coincide with the short period. Make check or money order payable to: Georgia Department of Revenue.
Mail payment to:

Processing Center
Georgia Department of Revenue
PO Box 105136
Atlanta, Georgia 30348-5136

Failure to comply with the provisions of the law may result in a penalty of 5% of the income tax for failure to pay estimated tax and a charge at the rate of 9% per annum for underpayment of estimated tax. See Form 600UET and the IT-611 Booklet for more information.

This form should also be used by a partnership or a Subchapter "S" Corporation that makes or is planning to make the irrevocable election to pay tax at the entity level.

Use a payment voucher with a valid scanline.

CORPORATION AND PARTNERSHIP ESTIMATED TAX WORKSHEET

1.	Amount of taxable income expected during the current year	$ 197,328.
2.	Estimated Tax (use applicable tax rate)	$ 10,636.
3.	Less Credits	$
4.	Less Credit for 2024 overpayment if credit was elected on Form 600, 600S or 700	$ 5,136.
5.	Unpaid balance (Line 2 less Line 3 and Line 4 but not less than zero)	$ 5,500.
6.	Computation of installment: (check box below and enter amount.)	$

If first payment is ☐ April 15, 2025, enter 1/4 of Line 5 ☐ Sept. 15, 2025, enter 1/2 of Line 5
due to be filed on ☐ June 15, 2025, enter 1/3 of Line 5 ☒ Dec. 15, 2025, enter amount of Line 5

If the due date falls on a weekend or holiday, the tax shall be due on the next day that is not on a weekend or holiday.

Amount Due $ 5500.

Corporations filing on a fiscal year ending after January 1 must file on corresponding dates. If your entity must pay estimated tax in the corporate manner, see the Estimated Income Tax page in the IT-611 Tax Booklet.

PLEASE DO NOT mail this entire page. Please cut along dotted line and mail only coupon and payment.
PLEASE DO NOT STAPLE. PLEASE REMOVE ALL CHECK STUBS.

445242 09-13-24

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VOUCHER 1

602 ES (Rev. 07/15/24)
Corporate and Partnership Estimated Tax


2560215014

BUSINESS NAME AND ADDRESS

HOUSTON HOSPITALS

2025
Fiscal Year Ending

TYPE OF RETURN: [X] 03-Corporate [ ] 35-Partnership [ ] Name Change [ ] Address Change [ ] Tax Year Change

FEI Number	Tax Year	Year Ending	Due Date	Payment #	Vendor Code
71-1045290	2025	12-31-2025	04-15-2025	1	**150**

PLEASE DO NOT STAPLE. REMOVE ALL CHECK STUBS.

Under penalty of perjury, I declare that this return has been examined by me and to the best of my knowledge and belief it is true, correct and complete. Georgia Public Revenue Code Section 48-2-31 stipulates that taxes shall be paid in lawful money of the United States, free of any expense to the State of Georgia.

Signature | Title

Telephone | Date

PROCESSING CENTER
GEORGIA DEPARTMENT OF REVENUE
PO BOX 105136
ATLANTA GA 30348-5136

Amount Paid $

602711045290009123125041525122203000150000000000001

PLEASE DO NOT mail this entire page. Please cut along dotted line and mail only coupon and payment.
PLEASE DO NOT STAPLE. PLEASE REMOVE ALL CHECK STUBS.

445242 09-13-24

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VOUCHER 2

602 ES (Rev. 07/15/24)
Corporate and Partnership Estimated Tax

2560215014

BUSINESS NAME AND ADDRESS

HOUSTON HOSPITALS
1601 WATSON BOULE
WARNER RGA 31093

2025
Fiscal Year Ending

TYPE OF RETURN: [X] 03-Corporate [ ] 35-Partnership [ ] Name Change [ ] Address Change [ ] Tax Year Change

FEI Number	Tax Year	Year Ending	Due Date	Payment #	Vendor Code
71-1045290	2025	12-31-2025	06-15-2025	2	**150**

PLEASE DO NOT STAPLE. REMOVE ALL CHECK STUBS.

Under penalty of perjury, I declare that this return has been examined by me and to the best of my knowledge and belief it is true, correct and complete. Georgia Public Revenue Code Section 48-2-31 stipulates that taxes shall be paid in lawful money of the United States, free of any expense to the State of Georgia.

Signature | Title

Telephone | Date

PROCESSING CENTER
GEORGIA DEPARTMENT OF REVENUE
PO BOX 105136
ATLANTA GA 30348-5136

Amount Paid $

602711045290009123125061525222203000150000000000008

PLEASE DO NOT mail this entire page. Please cut along dotted line and mail only coupon and payment.
PLEASE DO NOT STAPLE. PLEASE REMOVE ALL CHECK STUBS.

445242 09-13-24

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VOUCHER 3

602 ES (Rev. 07/15/24)
Corporate and Partnership Estimated Tax

2560215014

BUSINESS NAME AND ADDRESS

HOUSTON HOSPITALS
1601 WATSON BOULE
WARNER RGA 31093

2025
Fiscal Year Ending

TYPE OF RETURN: [X] 03-Corporate [ ] 35-Partnership [ ] Name Change [ ] Address Change [ ] Tax Year Change

FEI Number	Tax Year	Year Ending	Due Date	Payment #	Vendor Code
71-1045290	2025	12-31-2025	09-15-2025	3	**150**

PLEASE DO NOT STAPLE. REMOVE ALL CHECK STUBS.

Under penalty of perjury, I declare that this return has been examined by me and to the best of my knowledge and belief it is true, correct and complete. Georgia Public Revenue Code Section 48-2-31 stipulates that taxes shall be paid in lawful money of the United States, free of any expense to the State of Georgia.

Signature | Title

Telephone | Date

PROCESSING CENTER
GEORGIA DEPARTMENT OF REVENUE
PO BOX 105136
ATLANTA GA 30348-5136

Amount Paid $

602711045290009123125091525322203000150000000000003

PLEASE DO NOT mail this entire page. Please cut along dotted line and mail only coupon and payment.
PLEASE DO NOT STAPLE. PLEASE REMOVE ALL CHECK STUBS.

445242 09-13-24

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VOUCHER 4

602 ES (Rev. 07/15/24)
Corporate and Partnership Estimated Tax


2560215014

BUSINESS NAME AND ADDRESS

HOUSTON HOSPITALS
1601 WATSON BOULE
WARNER RGA 31093

2025
Fiscal Year Ending

TYPE OF RETURN: [X] 03-Corporate [ ] 35-Partnership [ ] Name Change [ ] Address Change [ ] Tax Year Change

FEI Number	Tax Year	Year Ending	Due Date	Payment #	Vendor Code
71-1045290	2025	12-31-2025	12-15-2025	4	150

PLEASE DO NOT STAPLE. REMOVE ALL CHECK STUBS.

Under penalty of perjury, I declare that this return has been examined by me and to the best of my knowledge and belief it is true, correct and complete. Georgia Public Revenue Code Section 48-2-31 stipulates that taxes shall be paid in lawful money of the United States, free of any expense to the State of Georgia.

Signature | Title

Telephone | Date

PROCESSING CENTER
GEORGIA DEPARTMENT OF REVENUE
PO BOX 105136
ATLANTA GA 30348-5136

Amount Paid $ 5500.00

602711045290009123125121525422203000150000055000000

Dos and Don'ts Checklist for the Corporate/Partnership (PV- Corp) Payment Voucher

Payments can be made electronically on the Georgia Tax Center (GTC) gtc.dor.ga.gov/.

Do:

- Use a payment voucher with a valid scanline.
- Complete this voucher if you owe taxes.
- Complete the voucher in its entirety.
- Remember **payments $10,000 or more must be made electronically.**
- Remember if the due date falls on a weekend or holiday, the tax shall be due on the next day that is not a weekend or holiday.
- Write your Federal Employer Identification Number (FEIN) on your check or money order.
- Make your check or money order payable to: Georgia Department of Revenue
- Mail your voucher and payment to the address on the voucher if your return was **filed electronically.**
- Mail your return, payment voucher and payment to the address that appears on the return if filing a **paper return.**

Do not:

- Mail this entire page.
- Staple payment and voucher together.
- Print on both sides of the paper.
- Handwrite any information

Georgia Public Revenue Code Section 48-2-31 stipulates that taxes shall be paid in lawful money of the United States, free of any expense to the State of Georgia.

445711 08-26-24

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PV CORP (Rev. 08/13/24)
Corporate and Partnership Payment Voucher
2024

2503015014

MAIL TO:
Processing Center
Georgia Department of Revenue
PO Box 740317
Atlanta, GA 30374-0317

[X] Paper Return [ ] Electronically Filed

TYPE OF RETURN: [X] 03-Corporate [ ] 35-Partnership

FEI Number	Income Tax Year	Beginning Date	Ending Date	Vendor Code
71-1045290	2024	01/01/24	12/31/24	**150**

Name (Type or print plainly the exact Company Name)	E-mail Address
HOUSTON HOSPITALS, INC	

Business Address	City	State	ZIP Code
1601 WATSON BOULEVARD	WARNER ROBINS	GA	31093

Title	Telephone	Signature	Date
CFO	478-542-7959		

PLEASE DO NOT STAPLE. REMOVE ALL CHECK STUBS.

Amount Paid $ -5136.00

0307110452900091231241200300000000001500000000003

Georgia Form 600-T (Rev. 06/28/24)
Exempt Organization
Unrelated Business Income Tax Return

2501615016

Mailing Address:
Georgia Department of Revenue
Processing Center
PO Box 740397
Atlanta, Georgia 30374-0397

Page 1

☐ Amended ☐ Amended due to IRS Audit ☐ Address Change ☐ UET Annualization Exception attached

For the taxable year beginning 01/01/2024 and ending 12/31/2024

Name of Organization	Name of Fiduciary	**Federal Employer ID No.** (in case of employees' trust described in section 401 (a) and exempt under section 501 (a), insert the trust's identification number.)
HOUSTON HOSPITALS, INC		71-1045290
Number and Street	Number and Street	
1601 WATSON BOULEVARD		
City or Town	City or Town	
WARNER ROBINS		
State / ZIP Code	State / ZIP Code	
GA 31093		

NAICS Code	Date of current exemption letter.	IRS code section for which you are exempt.

Georgia Unrelated Business Taxable Income		SCHEDULE 1
1. Unrelated business taxable income from Federal Form 990-T (attach copy)	1.	216227
2. Additions SEE STATEMENT 2	2.	9744
3. Total (add Line 1 and Line 2)	3.	225971
4. Subtractions SEE STATEMENT 1	4.	45198
5. Adjusted unrelated business taxable income (Line 3 less Line 4)	5.	180773
6. Income allocated everywhere	6.	
7. Unrelated business taxable income subject to apportionment (Line 5 less Line 6)	7.	180773
8. Apportionment ratio (Attach Computation Schedule)	8.	1.000000
9. Georgia apportioned unrelated business taxable income (Line 7 x Line 8)	9.	180773
10. Income allocated to Georgia (Attach Schedule)	10.	
11. Total of Lines 9 and 10	11.	180773
12. Georgia net operating loss deduction (Attach Schedule) (See IT-611 instructions for 80% limitation)	12.	
13. Georgia unrelated business taxable income (Line 11 less Line 12)	13.	180773

Georgia Form 600-T

Page 2

2501615026

Name HOUSTON HOSPITALS, INC

FEIN 71-1045290

COMPUTATION OF GEORGIA UNRELATED BUSINESS INCOME TAX		SCHEDULE 2
1. Line 13, Schedule 1 multiplied by 5.39%	1.	9744
2. Less: Credits used from Schedule 3, do not enter more than Line 1 of Schedule 2	2.	
3. Less: Payments	3.	15300
4. Withholding Credits (G2-A, G2-LP and/or G2-RP)	4.	
5. Schedule 3B Refundable tax credits	5.	
6. Balance of tax due OR overpayment	6.	-5556
7. Interest due (See Instructions)	7.	
8. Underestimated tax penalty	8.	420
9. Other penalties due (See Instructions)	9.	
10. Balance of tax, interest and penalties due with return	10.	-5136
11. If Line 6 is an overpayment, amount after any penalties and interest to be credited on 2025		
Estimated Tax ▶ 5136 **Refunded ▶**		

A COPY OF THE FEDERAL 990-T AND SUPPORTING SCHEDULES (AND ANY EXTENSION) MUST BE ATTACHED TO THIS RETURN.
DECLARATION: I/We declare under penalty of perjury that I/we have examined this return (including accompanying schedules and statements) and to the best of my/our knowledge and belief, it is true, correct, and complete. If prepared by a person other than the taxpayer, this declaration is based on all information of which the preparer has knowledge. Georgia Public Revenue Code Section 48-2-31 stipulates that taxes shall be paid in lawful money of the United States, free of any expense to the State of Georgia.

MICHAEL LOFTUS
Signature of Officer

Signature of Individual or Firm Preparing Return

CFO
Title

11/12/25
Date

P00989558
Employee ID or Social Security Number

GA 600-T SUBTRACTIONS TO TAXABLE INCOME STATEMENT 1

DESCRIPTION	AMOUNT
FEDERAL UNRELATED BUSINESS INCOME TAX	45,198.
TOTAL TO FORM 600-T, SCHEDULE 1, LINE 4	45,198.

GA 600-T ADDITIONS TO TAXABLE INCOME STATEMENT 2

DESCRIPTION	AMOUNT
STATE TAXES	9,744.
TOTAL TO FORM 600-T, SCHEDULE 1, LINE 2	9,744.

Georgia Form **600-T**

Page 3

2501615036

Name HOUSTON HOSPITALS, INC FEIN 71-1045290

CREDIT USAGE AND CARRYOVER (ROUND TO NEAREST DOLLAR) **SCHEDULE 3**

1. **Complete a separate schedule for each Credit Code.**
2. Total the amounts on Line 11 of each schedule and enter the total on the credit line of the return.
3. If there is a credit eligible for carryover, please complete a schedule even if the credit is not used for this tax year.
4. Enter credits which are attributable to unrelated trade or business income from Georgia sources. See Form 600 for the credit codes that may apply. Exempt organizations are only eligible for tax credits to the extent they apply to unrelated trade or business income from Georgia sources (note not all credits apply to 600T).
5. See the relevant forms, statutes, and regulations to determine how the credit is allocated to the owners, to determine when carryovers expire, and to see if the credit is limited to a certain percentage of tax.
6. If the credit for a particular credit code originated with more than one person or company, enter separate information on Lines 3 through 9 below.
7. The credit certificate number is issued by the Department of Revenue for credits that are preapproved. If applicable, please enter the Department of Revenue credit certificate number where indicated.
8. Before the Line 12 carryover is applied to the next year, the amount must be reduced by any carryovers that have expired.

For the credit generated this tax year, list the Company Name, ID number, and Credit Certificate number, if applicable. Purchased credits should also be included. If the credit originated with this taxpayer, enter this taxpayer's name and ID# below.

1. Credit Code		
2. Credit remaining from previous years		
3. Company Name		ID Number
Credit Certificate #		Credit Generated this tax year
4. Company Name		ID Number
Credit Certificate #		Credit Generated this tax year
5. Company Name		ID Number
Credit Certificate #		Credit Generated this tax year
6. Company Name		ID Number
Credit Certificate #		Credit Generated this tax year
7. Company Name		ID Number
Credit Certificate #		Credit Generated this tax year
8. Company Name		ID Number
Credit Certificate #		Credit Generated this tax year
9. Company Name		ID Number
Credit Certificate #		Credit Generated this tax year
10. Total available credit for this tax year (sum of Lines 2 through 9)	10.	
11. Credit Used this tax year (enter here and on Line 2, Schedule 2)	11.	
12. Potential carryover to next tax year (Line 10 less Line 11)	12.	