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Form 990

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

2018

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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.

A For the 2019 calendar year, or tax year beginning 10-01-2018 , and ending 09-30-2019

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

C Name of organization
MOSES H CONE MEMORIAL HOSPITAL
OPERATING CORPORATION
% ANDREW BARROW
Doing business as

Number and street (or P.O. box if mail is not delivered to street address) Room/suite
1200 NORTH ELM STREET

City or town, state or province, country, and ZIP or foreign postal code
GREENSBORO, NC 27401

F Name and address of principal officer:
ANDREW BARROW
1200 NORTH ELM STREET
GREENSBORO, NC 27401

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 ▶

D Employer identification number
58-1588823

E Telephone number
(336) 832-7000

G Gross receipts \$ 1,543,308,499

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

J Website: ▶ www.conehealth.com

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

L Year of formation: 1985

M State of legal domicile: NC

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities:
WE SERVE OUR COMMUNITIES BY PREVENTING ILLNESS, RESTORING HEALTH AND PROVIDING COMFORT, THROUGH EXCEPTIONAL PEOPLE DELIVERING EXCEPTIONAL CARE.

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

3	Number of voting members of the governing body (Part VI, line 1a)	17
4	Number of independent voting members of the governing body (Part VI, line 1b)	14
5	Total number of individuals employed in calendar year 2018 (Part V, line 2a)	10,067
6	Total number of volunteers (estimate if necessary)	
7a	Total unrelated business revenue from Part VIII, column (C), line 12	1,268,594
7b	Net unrelated business taxable income from Form 990-T, line 34	1,267,594

Revenue

	Prior Year	Current Year
8 Contributions and grants (Part VIII, line 1h)	5,660,587	4,307,338
9 Program service revenue (Part VIII, line 2g)	1,259,719,424	1,384,781,686
10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	1,521,401	-375,955
11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	18,702,110	15,446,346
12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	1,285,603,522	1,404,159,415

Expenses

13 Grants and similar amounts paid (Part IX, column (A), lines 1–3)	966,169	1,065,973
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)	601,210,522	704,534,370
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)	580,957,142	639,781,877
18 Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	1,183,133,833	1,345,382,220
19 Revenue less expenses. Subtract line 18 from line 12	102,469,689	58,777,195

Net Assets or Fund Balances

	Beginning of Current Year	End of Year
20 Total assets (Part X, line 16)	962,297,096	1,126,496,791
21 Total liabilities (Part X, line 26)	150,650,591	180,766,013
22 Net assets or fund balances. Subtract line 21 from line 20	811,646,505	945,730,778

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

2021-04-29
Date

ANDREW BARROW CFO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date 2021-04-29	Check <input type="checkbox"/> if self-employed	PTIN P00960141
Firm's name ▶ PRICEWATERHOUSECOOPERS LLP	Firm's EIN ▶			
Firm's address ▶ 800 GREEN VALLEY RD STE 500 GREENSBORO, NC 27408	Phone no. (336) 665-2700			

May the IRS discuss this return with the preparer shown above? (see instructions)

☒ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate instructions.

Cat. No. 11282Y

Form 990 (2018)

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:

WE SERVE OUR COMMUNITIES BY PREVENTING ILLNESS, RESTORING HEALTH AND PROVIDING COMFORT, THROUGH EXCEPTIONAL PEOPLE DELIVERING EXCEPTIONAL CARE.

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 \$ 1,210,950,596 including grants of \$ 1,065,973) (Revenue \$ 1,384,781,686)
See Additional Data

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

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

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

4e Total program service expenses ► 1,210,950,596

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

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

Part V Statements Regarding Other IRS Filings and Tax ComplianceCheck 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 1,336	
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b 0	
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c Yes	

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

Section A. Governing Body and Management

		Yes	No
1a Enter the number of voting members of the governing body at the end of the tax year	1a 17		
If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.			
b Enter the number of voting members included in line 1a, above, who are independent	1b 14		
2 Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2		No
3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?	3	Yes	
4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4		No
5 Did the organization become aware during the year of a significant diversion of the organization's assets?	5		No
6 Did the organization have members or stockholders?	6		No
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		No
b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b		No
8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
a The governing body?	8a	Yes	
b Each committee with authority to act on behalf of the governing body?	8b	Yes	
9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O	9		No

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

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

Section C. Disclosure

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

18 Section 6104 requires an organization to make its Form 1023 (or 1024-A if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
☐ Own website ☒ Another's website ☒ Upon request ☐ Other (explain in Schedule O)

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

20 State the name, address, and telephone number of the person who possesses the organization's books and records:
▶ANDREW BARROW 1200 NORTH ELM STREET GREENSBORO, NC 27401 (336) 832-7000

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

• 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.

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

[illegible]

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

[illegible]

1b Sub-Total			
c Total from continuation sheets to Part VII, Section A			
d Total (add lines 1b and 1c)	9,629,140	7,027,444	1,742,257

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 ▶ 525

		Yes	No
3	Did the organization list any former officer, director or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i>	3 Yes	
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? <i>If "Yes," complete Schedule J for such individual</i>	4 Yes	
5	Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? <i>If "Yes," complete Schedule J for such person</i>	5	No

Section B. Independent Contractors

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

(A)	(B)	(C)
Name and business address	Description of services	Compensation
McKesson Plasma and Biologics LLC, 16578 Collections Center DR CHICAGO, IL 60693	Medical Services	48,201,030
Carefusion 303 Inc, 3750 Torrey View Court SAN DIEGO, CA 92130	Medical Services	4,140,003
Microsoft Licensing GP, 6100 Neil Rd RENO, NV 89511	IT Services	4,091,706
Laboratory Corp of America, PO BOX 12140 BURLINGTON, NC 27216	Medical services	3,000,227
Central Carolina Surgery PA, 1002 N Church St Suite 302 GREENSBORO, NC 27401	Medical services	3,496,664

<p>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 ► 190</p>	
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Part VIII

Statement of Revenue

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

Contributions, Gifts, Grants and Other Similar Amounts

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
1a	Federated campaigns . .	1a			
b	Membership dues . .	1b			
c	Fundraising events . .	1c			
d	Related organizations	1d	360,464		
e	Government grants (contributions)	1e			
f	All other contributions, gifts, grants, and similar amounts not included above	1f	3,946,874		
g	Noncash contributions included in lines 1a - 1f:\$ 131,142				
h	Total. Add lines 1a-1f		4,307,338		

Program Service Revenue

		Business Code				
2a	PATIENT REVENUE	621400	1,352,334,254	1,352,235,218	99,036	
b	SERVICES TO PATIENTS	621400	22,490,206	22,490,206		
c	SERVICES TO GOVERNMENTAL AGENCIES	621400	1,123,275	1,123,275		
d	SERVICES TO AFFILIATED ORGANIZATIONS	621400	2,649,930	2,649,930		
e	SERVICES TO NON-AFFILIATED ORGANIZATIONS	621400	6,142,623	6,142,623		
f	All other program service revenue.		41,398	41,398		
g	Total. Add lines 2a-2f		1,384,781,686			

Other Revenue

3	Investment income (including dividends, interest, and other similar amounts)		1,943,922			1,943,922
4	Income from investment of tax-exempt bond proceeds		0			
5	Royalties		0			
6a	Gross rents	(i) Real (ii) Personal				
		3,407,912 477,963				
b	Less: rental expenses	2,382,210 334,107				
c	Rental income or (loss)	1,025,702 143,856				
d	Net rental income or (loss)		1,169,558		1,169,558	
7a	Gross amount from sales of assets other than inventory	(i) Securities (ii) Other				
		109,124,010 24,988,880				
b	Less: cost or other basis and sales expenses	109,621,708 26,811,059				
c	Gain or (loss)	-497,698 -1,822,179				
d	Net gain or (loss)		-2,319,877			-2,319,877
8a	Gross income from fundraising events (not including \$ of contributions reported on line 1c). See Part IV, line 18	a 0				
b	Less: direct expenses	b 0				
c	Net income or (loss) from fundraising events		0			
9a	Gross income from gaming activities. See Part IV, line 19	a 0				
b	Less: direct expenses	b 0				
c	Net income or (loss) from gaming activities		0			
10a	Gross sales of inventory, less returns and allowances	a 0				
b	Less: cost of goods sold	b 0				
c	Net income or (loss) from sales of inventory		0			
Miscellaneous Revenue		Business Code				
11a	SERVICES TO EMPLOYEES	900099	6,111,785	6,111,785		
b	EQUITY SHARE INCOME FROM JOINT VENTURES	621400	8,104,525	8,104,525		
c	MEDICAL RECORDS	621400	57,533	57,533		
d	All other revenue		2,945	2,945		
e	Total. Add lines 11a-11d		14,276,788			
12	Total revenue. See Instructions.		1,404,159,415	1,398,959,438	1,268,594	-375,955

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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 ☐

	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.				
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	1,065,973	1,065,973		
2 Grants and other assistance to domestic individuals. See Part IV, line 22	0			
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.	0			
4 Benefits paid to or for members	0			
5 Compensation of current officers, directors, trustees, and key employees	7,477,351	6,729,616	747,735	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0			
7 Other salaries and wages	453,023,844	407,721,460	45,302,384	
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	100,721,244	90,649,120	10,072,124	
9 Other employee benefits	105,753,263	95,177,937	10,575,326	
10 Payroll taxes	37,558,668	33,802,801	3,755,867	
11 Fees for services (non-employees):				
a Management	49,661,439	44,695,295	4,966,144	
b Legal	3,118,942	2,807,048	311,894	
c Accounting	15,357,554	13,821,799	1,535,755	
d Lobbying	0			
e Professional fundraising services. See Part IV, line 17	0			
f Investment management fees	0			
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	28,468,621	25,621,759	2,846,862	
12 Advertising and promotion	4,777,922	4,300,130	477,792	
13 Office expenses	21,670,553	19,503,498	2,167,055	
14 Information technology	34,061,141	30,655,027	3,406,114	
15 Royalties	0			
16 Occupancy	44,225,394	39,802,855	4,422,539	
17 Travel	2,253,567	2,028,210	225,357	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19 Conferences, conventions, and meetings	0			
20 Interest	417,409	375,668	41,741	
21 Payments to affiliates	-99,636,332	-89,672,699	-9,963,633	
22 Depreciation, depletion, and amortization	65,205,269	58,684,742	6,520,527	
23 Insurance	11,501,887	10,351,698	1,150,189	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SERVICES & SUPPLIES	383,862,688	345,476,419	38,386,269	
b UTILITIES AND REPAIRS	33,683,982	30,315,584	3,368,398	
c RECRUITMENT-RETENTION & EDU	2,700,816	2,430,734	270,082	
d TAXES & LICENSURE	33,059,816	29,753,834	3,305,982	
e All other expenses	5,391,209	4,852,088	539,121	
25 Total functional expenses. Add lines 1 through 24e	1,345,382,220	1,210,950,596	134,431,624	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 <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

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

			(A) Beginning of year		(B) End of year
Assets	1	Cash—non-interest-bearing	19,462,261	1	-5,895,323
	2	Savings and temporary cash investments	77,776,460	2	63,532,712
	3	Pledges and grants receivable, net	0	3	0
	4	Accounts receivable, net	196,225,642	4	226,973,078
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L	0	5	0
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L	0	6	0
	7	Notes and loans receivable, net	375,244,603	7	523,904,255
	8	Inventories for sale or use	27,659,454	8	29,016,236
	9	Prepaid expenses and deferred charges	11,726,258	9	15,863,875
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	491,043,859		
	b	Less: accumulated depreciation	313,557,382		
			164,486,767	10c	177,486,477
	11	Investments—publicly traded securities	183,041	11	0
	12	Investments—other securities. See Part IV, line 11	52,786,399	12	55,861,789
	13	Investments—program-related. See Part IV, line 11	0	13	0
	14	Intangible assets	2,635,580	14	3,037,893
15	Other assets. See Part IV, line 11	34,110,631	15	36,715,799	
16	Total assets. Add lines 1 through 15 (must equal line 34)	962,297,096	16	1,126,496,791	
Liabilities	17	Accounts payable and accrued expenses	47,364,098	17	96,647,756
	18	Grants payable	74,167	18	114,167
	19	Deferred revenue	562,593	19	1,328,499
	20	Tax-exempt bond liabilities	0	20	0
	21	Escrow or custodial account liability. Complete Part IV of Schedule D	0	21	0
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L	0	22	0
	23	Secured mortgages and notes payable to unrelated third parties	0	23	0
	24	Unsecured notes and loans payable to unrelated third parties	0	24	0
	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	102,649,733	25	82,675,591
	26	Total liabilities. Add lines 17 through 25	150,650,591	26	180,766,013
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.				
	27	Unrestricted net assets	804,879,120	27	938,025,653
	28	Temporarily restricted net assets	6,767,385	28	7,705,125
	29	Permanently restricted net assets	0	29	0
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.				
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
33	Total net assets or fund balances	811,646,505	33	945,730,778	
34	Total liabilities and net assets/fund balances	962,297,096	34	1,126,496,791	

Part XI Reconciliation of Net AssetsCheck if Schedule O contains a response or note to any line in this Part XI ☒

1	Total revenue (must equal Part VIII, column (A), line 12)	1	1,404,159,415
2	Total expenses (must equal Part IX, column (A), line 25)	2	1,345,382,220
3	Revenue less expenses. Subtract line 2 from line 1	3	58,777,195
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	811,646,505
5	Net unrealized gains (losses) on investments	5	-1,473,857
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	76,780,935
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	945,730,778

Part XII Financial Statements and ReportingCheck if Schedule O contains a response or note to any line in this Part XII ☐

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

Additional Data

Software ID:

Software Version:

EIN: 58-1588823

Name: MOSES H CONE MEMORIAL HOSPITAL
OPERATING CORPORATION

Form 990 (2018)

Form 990, Part III, Line 4a:

PROVISION OF HEALTHCARE SERVICES: DURING THE FISCAL YEAR, MOSES H. CONE MEMORIAL OPERATING SYSTEM HAD A TOTAL OF 47,779 PATIENT DISCHARGES, 205,811 DAYS OF CARE, 752,481 TOTAL OUTPATIENT VISITS AND AN AVERAGE DAILY CENSUS OF 647.1.

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
Akin Terrence President & CEO	0.0 40.0	X		X				0	2,293,636	153,300
Balsley III Jacob B Trustee	0.0 0.0	X						0	0	0
Boylston MD Yun Trustee	0.0 0.0	X						0	0	0
Campbell PhD Lenora R Trustee	0.0 0.0	X						0	0	0
Cone Edward Trustee	0.0 0.0	X						0	0	0
Davidson III Dwight M Vice Chair	0.0 0.0	X		X				0	0	0
Douglas Mae Trustee	0.0 0.0	X						0	0	0
Gant Jr Allen E Trustee	0.0 0.0	X						0	0	0
Hayes William B Trustee	0.0 0.0	X						0	0	0
Hornaday FD Chair	0.0 0.0	X		X				0	0	0

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
Keeling MD Wayne Trustee	0.0 40.0	X						0	298,087	30,814
Kitchen J Edward Trustee	0.0 0.0	X						0	0	0
Leeper David Trustee	0.0 0.0	X						0	0	0
Maxwell MD James Trustee	0.0 0.0	X						0	0	0
McAllister Lee Trustee	0.0 0.0	X						0	0	0
McQueen MD Chapman T Trustee	0.0 0.0	X						0	0	0
Simms Carole Trustee	0.0 0.0	X						0	0	0
Barrow Andrew Assistant Treasurer	40.0 0.0			X				436,756	0	49,206
Cagle MD Mary Jo Chief Operating Officer	0.0 40.0			X				0	1,148,770	88,486
Carter Robert VP & General Counsel	40.0 0.0			X				532,424	0	57,258

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
Eaton Mandy EVP & Assistant Secretary	40.0 0.0			X				329,933	0	35,073
Haywood Mehee Assistant Treasurer	0.0 40.0			X				0	142,483	48,405
Johnson Julie Assistant Treasurer	40.0 0.0			X				191,660	0	48,524
Jones Jeffrey CFO & Secretary	0.0 40.0			X				0	1,089,344	95,118
Kitzmiller David Assistant Treasurer	40.0 0.0			X				170,006	0	36,843
Miller John CIO & Treasurer	0.0 40.0			X				0	431,740	71,576
Rempher PhD Kenneth EVP & Assistant Secretary	0.0 40.0			X				0	651,459	63,105
Roskelly James EVP & Assistant Secretary	40.0 0.0			X				671,015	0	79,869
Simms Michael VP & Assistant Treasurer	40.0 0.0			X				331,085	0	41,209
Cunningham Deborah SVP & President Women's Health	40.0 0.0				X			380,924	0	43,211

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
Evans Joan	40.0				X			616,362	0	61,639
EVP Innovation & Transformatio	0.0				X					
Jeffrey Paul	40.0				X			504,415	0	49,307
President Wesley Long Hospital	0.0				X					
Swords Bruce	40.0				X			686,621	0	63,868
Chief Physician Executive	0.0				X					
Campbell MD John	40.0					X		487,992	0	57,763
Physician	0.0					X				
Kibbe Ike	40.0					X		454,024	0	63,340
SVP	0.0					X				
Kumar Archana	40.0					X		481,996	0	58,437
Physician	0.0					X				
Windham MD Toby	40.0					X		514,958	0	34,379
Physician	0.0					X				
Burt Noel	40.0						X	801,078	0	68,478
EVP & Assistant Secretary	0.0						X			
Clontz Timothy	40.0						X	500,166	0	77,117
SVP & Assistant Secretary	0.0						X			
Schanel Judith	0.0						X	0	971,925	88,783
Chief Operating Officer	40.0						X			

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
Street Rex VP & Assistant Treasurer	40.0 0.0						X	427,731	0	67,375
Wright Patrick Physician	40.0 0.0						X	494,728	0	62,895
Foster Mickey SVP & President - MHCMH	40.0 0.0						X	615,266	0	46,879

SCHEDULE A
(Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.
▶ Attach to Form 990 or Form 990-EZ.
▶ Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
MOSES H CONE MEMORIAL HOSPITAL
OPERATING CORPORATION

Employer identification number
58-1588823

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

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

- 1

☐

A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
- 2

☐

A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ).)
- 3

☒

A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- 4

☐

A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state: _____
- 5

☐

An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)
- 6

☐

A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- 7

☐

An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
- 8

☐

A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
- 9

☐

An agricultural research organization described in **170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture. See instructions. Enter the name, city, and state of the college or university: _____
- 10

☐

An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)
- 11

☐

An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**
- 12

☐

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

☐

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

☐

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

☐

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

☐

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

☐

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

Enter the number of supported organizations
- g

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

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

Part II

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

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

Section A. Public Support							
Calendar year (or fiscal year beginning in) ▶		(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
1	Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grant.") . . .						
2	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . . .						
3	The value of services or facilities furnished by a governmental unit to the organization without charge..						
4	Total. Add lines 1 through 3						
5	The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f). . .						
6	Public support. Subtract line 5 from line 4.						
Section B. Total Support							
Calendar year (or fiscal year beginning in) ▶		(a)2014	(b)2015	(c)2016	(d)2017	(e)2018	(f)Total
7	Amounts from line 4. . .						
8	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . . .						
9	Net income from unrelated business activities, whether or not the business is regularly carried on. . .						
10	Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.). . .						
11	Total support. Add lines 7 through 10						
12	Gross receipts from related activities, etc. (see instructions)					12	
13	First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here ▶ <input type="checkbox"/>						
Section C. Computation of Public Support Percentage							
14	Public support percentage for 2018 (line 6, column (f) divided by line 11, column (f))					14	
15	Public support percentage for 2017 Schedule A, Part II, line 14					15	
16a	33 1/3% support test—2018. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>						
b	33 1/3% support test—2017. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>						
17a	10%-facts-and-circumstances test—2018. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>						
b	10%-facts-and-circumstances test—2017. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>						
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 ▶ <input type="checkbox"/>						

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

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

Section A. Public Support

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

Section B. Total Support

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

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

Section C. Computation of Public Support Percentage

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

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2018 (line 10c, column (f) divided by line 13, column (f))	17	
18 Investment income percentage from 2017 Schedule A, Part III, line 17	18	

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

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

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

	Yes	No
1 Are all of the organization's supported organizations listed by name in the organization's governing documents? <i>If "No," describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.</i>		
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)? <i>If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).</i>		
2		
3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? <i>If "Yes," answer (b) and (c) below.</i>		
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)? <i>If "Yes," describe in Part VI when and how the organization made the determination.</i>		
3b		
c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? <i>If "Yes," explain in Part VI what controls the organization put in place to ensure such use.</i>		
3c		
4a Was any supported organization not organized in the United States ("foreign supported organization")? <i>If "Yes" and if you checked 12a or 12b in Part I, answer (b) and (c) below.</i>		
4a		
b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? <i>If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.</i>		
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)? <i>If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.</i>		
4c		
5a Did the organization add, substitute, or remove any supported organizations during the tax year? <i>If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in Part VI, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).</i>		
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? <i>If "Yes," provide detail in Part VI.</i>		
6		
7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ) .</i>		
7		
8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>		
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))? <i>If "Yes," provide detail in Part VI.</i>		
9a		
b Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? <i>If "Yes," provide detail in Part VI.</i>		
9b		
c Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? <i>If "Yes," provide detail in Part VI.</i>		
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)? <i>If "Yes," answer line 10b below.</i>		
10a		
b Did the organization have any excess business holdings in the tax year? <i>(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings).</i>		
10b		

Part IV

Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions):		
a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.		
b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions)		
2 Activities Test. Answer (a) and (b) below.		
a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.		
2a		
b Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.		
2b		
3 Parent of Supported Organizations. Answer (a) and (b) below.		
a Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? Provide details in Part VI.		
3a		
b Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? If "Yes," describe in Part VI the role played by the organization in this regard.		
3b		

Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations			
<div>1</div> <div><input type="checkbox"/></div> <div>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.</div>			
Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1	Net short-term capital gain	1	
2	Recoveries of prior-year distributions	2	
3	Other gross income (see instructions)	3	
4	Add lines 1 through 3	4	
5	Depreciation and depletion	5	
6	Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6	
7	Other expenses (see instructions)	7	
8	Adjusted Net Income (subtract lines 5, 6 and 7 from line 4)	8	
Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):	1	
a	Average monthly value of securities	1a	
b	Average monthly cash balances	1b	
c	Fair market value of other non-exempt-use assets	1c	
d	Total (add lines 1a, 1b, and 1c)	1d	
e	Discount claimed for blockage or other factors (explain in detail in Part VI):		
2	Acquisition indebtedness applicable to non-exempt use assets	2	
3	Subtract line 2 from line 1d	3	
4	Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions).	4	
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5	
6	Multiply line 5 by .035	6	
7	Recoveries of prior-year distributions	7	
8	Minimum Asset Amount (add line 7 to line 6)	8	
Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1	
2	Enter 85% of line 1	2	
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3	
4	Enter greater of line 2 or line 3	4	
5	Income tax imposed in prior year	5	
6	Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	
7	<div><input type="checkbox"/></div> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)		

Part V

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

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

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

Additional Data

Software ID:
Software Version:
EIN: 58-1588823
Name: MOSES H CONE MEMORIAL HOSPITAL
OPERATING CORPORATION

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

Facts And Circumstances Test

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
MOSES H CONE MEMORIAL HOSPITAL
OPERATING CORPORATION

Employer identification number
58-1588823

Part I

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

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

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

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?

☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?

☐ Yes ☐ No

Part II

Conservation Easements.

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

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

☐ Preservation of land for public use (e.g., recreation or education)

☐ Preservation of an historically important land area

☐ Protection of natural habitat

☐ Preservation of a certified historic structure

☐ Preservation of open space

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

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

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

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

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?

☐ Yes ☐ No

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

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

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?

☐ Yes ☐ No

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

Part III

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

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

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

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

(i) Revenue included on Form 990, Part VIII, line 1 ► \$

(ii) Assets included in Form 990, Part X ► \$

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

a Revenue included on Form 990, Part VIII, line 1 ► \$

b Assets included in Form 990, Part X ► \$

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

Cat. No. 52283D

Schedule D (Form 990) 2018

Part III

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

3

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

a

☐ Public exhibition

b

☐ Scholarly research

c

☐ Preservation for future generations

d

☐ Loan or exchange programs

e

☐ Other

4

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

5

During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? . . .

☐ Yes

☐ No

Part IV

Escrow and Custodial Arrangements.

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

1a

Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?

☐ Yes

☐ No

b

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

c

Beginning balance

d

Additions during the year

e

Distributions during the year

f

Ending balance

	Amount
1c	
1d	
1e	
1f	

2a

Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? . . .

☐ Yes

☐ No

b

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

☐

Part V

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

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

2

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

a

Board designated or quasi-endowment ▶

b

Permanent endowment ▶

c

Temporarily restricted endowment ▶

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

3a

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

(i) unrelated organizations

(ii) related organizations

b

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

	Yes	No
3a(i)		
3a(ii)		
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				
b Buildings				
c Leasehold improvements		4,356,729	1,736,089	2,620,640
d Equipment		462,544,565	311,821,293	150,723,272
e Other		24,142,565		24,142,565
Total. Add lines 1a through 1e.(Column (d) must equal Form 990, Part X, column (B), line 10(c).) . . . ▶				177,486,477

Schedule D (Form 990) 2018

Part VII

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

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

Part VIII

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

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

Part IX

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

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

Part X

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	0
DEFERRED COMPENSATION LIABILITY	23,571,210
SELF INSURANCE RESERVES	24,045,870
PENSION LIABILITY	838,269
CAPITAL LEASE OBLIGATION AND OTHER	34,205,623
OTHER CURRENT LIABILITIES	14,619
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col.(B) line 25.) ▶	82,675,591

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

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

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

1	Total revenue, gains, and other support per audited financial statements	1	1,330,903,927
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	-75,971,805
e	Add lines 2a through 2d	2e	-75,971,805
3	Subtract line 2e from line 1	3	1,406,875,732
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	-2,716,317
c	Add lines 4a and 4b	4c	-2,716,317
5	Total revenue. Add lines 3 and 4c . (This must equal Form 990, Part I, line 12.)	5	1,404,159,415

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	1,272,002,838
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	2,875,298
e	Add lines 2a through 2d	2e	2,875,298
3	Subtract line 2e from line 1	3	1,269,127,540
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	76,254,680
c	Add lines 4a and 4b	4c	76,254,680
5	Total expenses. Add lines 3 and 4c . (This must equal Form 990, Part I, line 18.)	5	1,345,382,220

Part XIII Supplemental Information

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

Return Reference	Explanation
See Additional Data Table	

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

Additional Data

Software ID:
Software Version:
EIN: 58-1588823
Name: MOSES H CONE MEMORIAL HOSPITAL
OPERATING CORPORATION

Supplemental Information

Return Reference	Explanation
TEXT OF FIN 48 (ASC 740) FOOTNOTE	FORM 990, SCHEDULE D, PART X, LINE 2 AS OF SEPTEMBER 30, 2019 AND 2018, THE HEALTH SYSTEM HAD NO UNCERTAIN TAX POSITIONS UNDER FINANCIAL ACCOUNTING STANDARDS BOARD (FASB) ASC 740, INCOME TAXES, REQUIRING ADJUSTMENTS TO ITS CONSOLIDATED FINANCIAL STATEMENTS. THE HEALTH S YSTEM DOES NOT EXPECT THAT UNRECOGNIZED TAX BENEFITS WILL MATERIALLY INCREASE WITHIN THE N EXT 12 MONTHS.

Supplemental Information

Return Reference	Explanation
Other Amounts Not on Return	SCHEDULE D, PART XI, LINE 2D Contribution Expense \$ (1,028,553) Grant Expense \$ (1,010) Pension Settlement Expense \$(75,225,117) Income Attributed to Annie Penn \$ 282,875 ----- -- Total \$ (75,971,805)

Supplemental Information	
Return Reference	Explanation
Other Amounts Not on Line 1	SCHEDULE D, PART XI, LINE 4B RENTAL EXPENSES TREATED AS NET RENTAL INCOME \$ (2,716,317)

Supplemental Information	
Return Reference	Explanation
Other Amounts Not on Return	SCHEDULE D, PART XII, LINE 2D Rental Expenses Treated as Net Rental Income \$ 2,716,317 Expense Attributed to Annie Penn \$ 158,981 ----- Total \$ 2,875,298

Supplemental Information	
Return Reference	Explanation
Other Amounts Not on Line 1	Schedule D, Part XII, Line 4B Contribution Expense \$ 1,028,553 Grant Expense \$ 1,010 Pensi on Settlement Expense \$75,225,117 ----- Total \$ 76,254,680

SCHEDULE H
(Form 990)

Department of the Treasury

Internal Revenue Service

Hospitals

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

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
MOSES H CONE MEMORIAL HOSPITAL
OPERATING CORPORATION

Employer identification number
58-1588823

Part I

Financial Assistance and Certain Other Community Benefits at Cost

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

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)			86,342,210		86,342,210	11.590 %
b Medicaid (from Worksheet 3, column a)			162,154,254	148,471,139	13,683,115	1.840 %
c Costs of other means-tested government programs (from Worksheet 3, column b)			493,181,570	423,101,632	70,079,938	9.410 %
d Total Financial Assistance and Means-Tested Government Programs			741,678,034	571,572,771	170,105,263	22.840 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4).			812,989		812,989	0.110 %
f Health professions education (from Worksheet 5)			1,702,433		1,702,433	0.230 %
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			786,801		786,801	0.110 %
j Total. Other Benefits			3,302,223		3,302,223	0.450 %
k Total. Add lines 7d and 7j			744,980,257	571,572,771	173,407,486	23.290 %

Part II

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

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

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	Yes
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	2	130,044,102
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3	26,991,874
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	423,101,632
6	Enter Medicare allowable costs of care relating to payments on line 5	6	493,181,570
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-70,079,938
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other		
Section C. Collection Practices			
9a	Did the organization have a written debt collection policy during the tax year?	9a	Yes
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b	Yes

Part IV

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

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1 Randolph Cancer Ctr	Provision of Cancer Care	40 %		
2 Guilf Adult Health	Care to Disadvantaged	50 %		
3 Advanced Homecare	Home Health Care	30 %		
4 Pace of GuilfordRoc	Home Health Care	20 %		
5 PACE of Southern Pie	Home Health Care	60 %		
6				
7				
8				
9				
10				
11				
12				
13				

Part V Facility Information

Section A. Hospital Facilities

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

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

5

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)

		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
	See Additional Data Table										

Part V Facility Information (continued)**Section B. Facility Policies and Practices**

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

A

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

	Yes	No
Community Health Needs Assessment		
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C.	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12. If "Yes," indicate what the CHNA report describes (check all that apply):	3	Yes
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>18</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
6 a 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	Yes
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	Yes
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply):	7	Yes
a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>www.conehealth.com</u>		
b <input type="checkbox"/> Other website (list url): _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11.	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>18</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url): <u>www.conehealth.com</u>	10	Yes
a		
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	No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V

Facility Information (continued)

Financial Assistance Policy (FAP)

		A		
Name of hospital facility or letter of facility reporting group			Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:				
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	13	Yes	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200. _____ % and FPG family income limit for eligibility for discounted care of 400. _____ %			
b	<input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)			
c	<input checked="" type="checkbox"/> Asset level			
d	<input checked="" type="checkbox"/> Medical indigency			
e	<input checked="" type="checkbox"/> Insurance status			
f	<input checked="" type="checkbox"/> Underinsurance discount			
g	<input type="checkbox"/> Residency			
h	<input type="checkbox"/> Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	15	Yes	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	<input type="checkbox"/> Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	16	Yes	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): www.conehealth.com			
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): www.conehealth.com			
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): www.conehealth.com			
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	<input type="checkbox"/> Other (describe in Section C)			

Part V Facility Information (continued)**Billing and Collections**

A

Name of hospital facility or letter of facility reporting group _____

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

A

Name of hospital facility or letter of facility reporting group _____

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

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

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

If "Yes," explain in Section C.

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

If "Yes," explain in Section C.

	Yes	No
22		
23		No
24		No

Part V Facility Information (continued)**Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**
(list in order of size, from largest to smallest)How many non-hospital health care facilities did the organization operate during the tax year? 5

Name and address	Type of Facility (describe)
1 Med Center High Point 2630 Willard Dairy Road High Point, NC 27265	Outpatient Services & ED
2 Med Center Kernersville 1635 NC 66 South Kernersville, NC 27284	Outpatient Services
3 Cone Health Cancer Center 501 North Elam Avenue Greensboro, NC 27403	Cancer Treatment Facility
4 Moses Cone Surgery Center 1127 N Church Street Greensboro, NC 27401	Outpatient Surgical Center
5 Wesley Long Surgery Center 509 North Elam Avenue Greensboro, NC 27403	Outpatient Surgical Center
6	
7	
8	
9	
10	

Part VI Supplemental Information

Provide the following information.

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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
COSTING METHODOLOGY	FORM 990, SCHEDULE H, PART I, LINE 7 THE AMOUNTS REPORTED ON THIS SCHEDULE ARE REPORTED AT COST, COMPUTED USING THE COST TO CHARGE RATIO.
COMMUNITY BUILDING ACTIVITIES	FORM 990, SCHEDULE H, PART II OUR PROGRAMS TO IMPROVE COMMUNITY HEALTH ARE FOCUSED ON EDUCATION, ECONOMIC DEVELOPMENT, ACCESS TO HEALTHCARE, HEALTH SCREENINGS, AND WORKING WITH COMMUNITY PARTNERS TO IMPROVE THE SOCIAL DETERMINANTS OF HEALTH, ESPECIALLY HOUSING CONDITIONS AND NUTRITION. WE ARE ACTIVE IN THE UNION SQUARE PARTNERSHIP WITH NC A&T STATE UNIVERSITY AND UNC GREENSBORO TO SUPPORT THE IDENTIFICATION OF TALENTED HEALTH PROFESSIONALS AND SUPPORT THE DEVELOPMENT OF A DIVERSE HEALTHCARE WORKFORCE. WE SUPPORT THE GET READY GUILFORD INITIATIVE AND OTHER COLLECTIVE IMPACT MODELS THAT AIM TO DEVELOP POSITIVE SOCIAL, EMOTIONAL AND INTELLECTUAL GROWTH IN CHILDHOOD AND THE RESULTING POSITIVE OUTCOMES IN ADOLESCENCE AND ADULTHOOD. WE SUPPORT THE BUILD HEALTH CHALLENGE TO REDUCE THE IMPACT OF LOW HOUSING QUALITY ON ASTHMA AND OTHER RESPIRATORY ILLNESS, AS WELL AS OTHER INITIATIVES THAT SEEK TO IMPROVE HOUSING AND HEALTH SIMULTANEOUSLY. CONE HEALTH IS A LEADER IN THE STATEWIDE ADOPTION OF NCCARE360, THE NATION'S FIRST EMR-INTEGRATED STATEWIDE ELECTRONIC REFERRAL SERVICE LINKING HEALTH AND HUMAN SERVICES. CONE HEALTH'S CONGREGATIONAL NURSING PROGRAM AND VULNERABLE POPULATIONS DEPARTMENT SERVE NEW NORTH CAROLINIANS (IMMIGRANTS AND REFUGEES) AS WELL AS OUTREACH AND CARE FOR HOMELESS OR UNSTABLY HOUSED INDIVIDUALS. WE ARE ALSO HEAVILY ENGAGED IN COMMUNITY-WIDE EMERGENCY PREPAREDNESS PLANNING. WE ARE COMMITTED TO BEING A GOOD CORPORATE CITIZEN AND SERVE AND SUPPORT ORGANIZATIONS IN THE COMMUNITY THAT WORK TO IMPROVE ECONOMIC CONDITIONS AND ACCESS TO HEALTHCARE, SUCH AS THE UNITED WAY, GUILFORD COMMUNITY CARE NETWORK, THE CHAMBER OF COMMERCE. EMPLOYEES VOLUNTEER A SIGNIFICANT AMOUNT OF HOURS OF SERVICE ACROSS THE COMMUNITY IN A WIDE RANGE OF ORGANIZATIONS.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
BAD DEBT EXPENSE DESCRIPTION	FORM 990, SCHEDULE H, PART III, SECTION A, LINES 2-4 FOR OUR FINANCIAL STATEMENTS, THE DIFFERENCE BETWEEN GROSS CHARGES AND THE AMOUNT WE ESTIMATE WE WILL COLLECT IS CATEGORIZED AS CONTRACTUAL ADJUSTMENT, CHARITY OR BAD DEBT EXPENSE. THE DIFFERENCE BETWEEN GROSS AND THE PAYABLE AMOUNT PER THIRD-PARTY CONTRACTS OR GOVERNMENT PAYMENT FORMULAS IS CATEGORIZED AS CONTRACTUAL ADJUSTMENTS. THE AMOUNT OF CONTRACT ALLOWABLE THAT WE ESTIMATE WILL NOT BE COLLECTED IS DIVIDED BETWEEN CHARITY CARE AND BAD DEBT EXPENSE BASED ON THE DEMOGRAPHICS OF OUR PATIENT POPULATION AND OUR ESTIMATE FROM THESE DEMOGRAPHICS AS TO THE PORTION OF THIS UNCOLLECTED AMOUNT APPLICABLE TO INDIVIDUALS QUALIFYING FOR OUR CHARITY CARE POLICY. CONTRACTUAL ADJUSTMENTS, CHARITY CARE AND BAD DEBT EXPENSE ARE VALUED AT THE CHARGES FOR THE RELATED SERVICES.
MEDICARE SHORTFALL	FORM 990, SCHEDULE H, PART III, SECTION B, LINE 8 THE ENTIRE SHORTFALL IS REPORTED AS COMMUNITY BENEFIT. WE DO NOT RECEIVE ENOUGH IN MEDICARE REIMBURSEMENTS TO COVER OUR COSTS ASSOCIATED WITH THE CHALLENGES THAT CONTRIBUTE TO POOR HEALTH OUTCOMES WERE IDENTIFIED AND FROM THESE, MAJOR NEEDS AND PRIORITIES WERE DETERMINED. THESE INCLUDE ACCESS TO CLINICAL CARE FOR MINORITY POPULATIONS, INCREASED MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES, EFFORTS TO ENSURE HEALTHY PREGNANCIES AND EFFORTS TO REDUCE OBESITY. THE HEALTH SYSTEM IS CURRENTLY ENGAGED IN SEVERAL INITIATIVES TO ADDRESS THESE PRIORITIES.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
MEDICARE COSTING METHODOLOGY	FORM 990, SCHEDULE H, PART III, SECTION B, LINE 8 THE AMOUNT OF THE MEDICARE SHORTFALL INCLUDED AS COMMUNITY BENEFIT IS REPRESENTED AT COST AND IS COMPUTED USING COST TO CHARGE RATIO OF THE CHARGES BOOKED IN THE FINANCIAL STATEMENTS AS MEDICARE.
COLLECTION PRACTICES	FORM 990, SCHEDULE H, PART III, SECTION C, LINE 9B Cone Health will recognize each account turned over to an attorney, collection agency, or judgment taken as a bad debt. A patient's account will be considered a bad debt when the account is 120 days old. Exceptions to this are as follows: A. Account is in litigation B. Account is pending Insurance, Medicare or Medicaid for known reason. C. Authorized hospital personnel has other knowledge which makes keeping the account active. D. Authorized hospital personnel recognizes prior to 120 days that the account should go to an attorney, outside collection agency or judgment taken. E. Charges exceed \$10,000 and collection from a third party is doubtful, a judgment should be taken.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
NEEDS ASSESSMENT	FORM 990, SCHEDULE H, PART VI, Line 2 OUR BOARD INCLUDES REPRESENTATIVES FROM A WIDE RANGE OF STAKEHOLDERS IN THE COMMUNITY. WE ENGAGE OUR COMMUNITIES WITH INTEGRITY AND TRANSPARENCY AND WE EMBRACE OUR RESPONSIBILITY TO PROMOTE HEALTH AND WELL-BEING. TO THOSE ENDS, WE HAVE PARTNERED WITH THE GUILFORD COUNTY HEALTH DEPARTMENT AS WELL AS OTHER AREA HOSPITALS AND FOUNDATIONS TO CONDUCT A COMMUNITY HEALTH NEEDS ASSESSMENT. A NUMBER OF OVERARCHING SOCIO-ECONOMIC CHALLENGES THAT CONTRIBUTE TO POOR HEALTH OUTCOMES WERE IDENTIFIED AND FROM THESE MAJOR NEEDS AND PRIORITIES WERE DETERMINED. THESE INCLUDE ACCESS TO CLINICAL CARE, INCREASED MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES, EFFORTS TO REDUCE CHRONIC DISEASE, IMPROVE LIVING CONDITIONS AND REDUCE BIAS. THE HEALTH SYSTEM IS CURRENTLY ENGAGED IN SEVERAL INITIATIVES TO ADDRESS THESE PRIORITIES.
PATIENT EDUCATION	FORM 990, SCHEDULE H, PART VI, LINE 3 THE FINANCIAL ASSISTANCE POLICY IS COMMUNICATED TO ALL PATIENTS THROUGH MEANS WHICH INCLUDE, BUT ARE NOT LIMITED TO: POSTING ON THE HEALTH SYSTEM'S WEBSITE, INCLUSION WITH ALL BILLING STATEMENTS, POSTING AT CONSPICUOUS LOCATIONS THROUGHOUT THE FACILITY, DISCUSSIONS DURING FINANCIAL COUNSELOR PATIENT INTERVIEWS, AND DURING PATIENT ACCOUNTING CUSTOMER SERVICE PATIENT INTERACTIONS. AFTER RECEIVING A REQUEST FOR FINANCIAL ASSISTANCE AND ANY FINANCIAL INFORMATION OR OTHER DOCUMENTATION NEEDED TO DETERMINE ELIGIBILITY FOR FINANCIAL ASSISTANCE, THE PATIENT WILL BE NOTIFIED OF THEIR ELIGIBILITY DETERMINATION WITHIN A REASONABLE PERIOD OF TIME.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
COMMUNITY INFORMATION	FORM 990, SCHEDULE H, PART VI, LINE 4 THE POPULATION OF GUILFORD COUNTY IN THE 2010 CENSUS WAS 488,406 AND 87.3% OF THE POPULATION LIVES IN AN URBAN SETTING. ANNUAL GROWTH IS ESTIMATED TO BE JUST BELOW 1%. THE COUNTY WAS ONCE AN INDUSTRIAL-BASED CENTER, BUT HAS SEEN DECLINES IN THE MANUFACTURING OF TEXTILES, APPAREL AND FURNITURE. PRESENTLY, GUILFORD COUNTY SCHOOLS IS THE LARGEST EMPLOYER IN THE COUNTY, FOLLOWED BY CONE HEALTH SYSTEM AND THE CITY OF GREENSBORO. THE ESTIMATED MEDIAN FAMILY INCOME IS \$52,098. INDIVIDUALS AND FAMILY IN GUILFORD COUNTY ARE STILL DEALING WITH THE IMPACT OF THE ECONOMIC RECESSION. IN SEPTEMBER OF 2018, GUILFORD COUNTY UNEMPLOYMENT RATE WAS 3.6% AND 16.7% OF THE POPULATION HAD INCOME BELOW THE FEDERAL POVERTY LINE. TWENTY-SIX PERCENT OF THE POPULATION IS UNDER AGE OF 20, WHEREAS 19.9% IS AGE 60 OR ABOVE.
PROMOTION OF COMMUNITY HEALTH	FORM 990, SCHEDULE H, PART VI, LINE 5 CONE HEALTH'S SUPPORT FOR THE HEALTH AND WELL-BEING OF ITS COMMUNITIES GOES WELL BEYOND JUST ADDRESSING THE HEALTH CONCERNS IN THE COMMUNITY NEEDS ASSESSMENT. THE FOLLOWING ARE SOME OF THE PROGRAMS THAT WE PARTICIPATED IN DURING 2019: FREE CANCER SCREENINGS; SUPPORT FOR THE CLINICS OFFERING AFFORDABLE HEALTHCARE TO OUR UNINSURED RESIDENTS; CONGREGATIONAL NURSING; NETWORKS OF CARE FOR THE UNINSURED TO HAVE ACCESS TO PRIMARY, DENTAL AND SPECIALTY CARE; HOUSING IMPROVEMENTS TO SUPPORT HEALTH; TOBACCO-FREE PLACES; ACCESS TO HEALTH FOOD; TRAINING AND DEVELOPMENT OF STUDENTS SEEKING TO WORK IN HEALTHCARE PROFESSIONS; HEALTH RESEARCH.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
AFFILIATED HEALTH CARE SYSTEM	FORM 990, SCHEDULE H, PART VI, LINE 6 THE ORGANIZATION IS A MEMBER OF CONE HEALTH SYSTEM. IN ADDITION TO THE SERVICES PROVIDED UNDER THE MOSES H. CONE MEMORIAL HOSPITAL OPERATING CORPORATION, THE CONE HEALTH MEDICAL GROUP INCLUDES FOUR CORPORATE ENTITIES THAT OPERATE PHYSICIAN PRACTICES ACROSS THE COMMUNITY. THESE INCLUDE PROVIDERS OF BOTH PRIMARY CARE AND A WIDE RANGE OF SPECIALTIES. ALAMANCE REGIONAL MEDICAL CENTER AND ALAMANCE EXTENDED CARE PROVIDE HEALTH CARE SERVICES, INCLUDING OPERATION OF A LONG-TERM CARE FACILITY TO THE COMMUNITY IN ALAMANCE COUNTY. THE MOSES CONE-WESLEY LONG COMMUNITY FOUNDATION AND IMPACT ALAMANCE FOUNDATION FUNDS NUMEROUS COMMUNITY ORGANIZATIONS THAT ARE CONDUCTING ACTIVITIES THAT WILL ADDRESS THE PRIORITIES IDENTIFIED UNDER OUR COMMUNITY NEEDS ASSESSMENT.

Additional Data

Software ID:
Software Version:
EIN: 58-1588823
Name: MOSES H CONE MEMORIAL HOSPITAL
OPERATING CORPORATION

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

Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? 5		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER—24 hours	ER—other	Other (Describe)	Facility reporting group
1	Moses H Cone Memorial Hospital 1200 North Elm Street Greensboro, NC 274011004 www.conehealth.com	X	X		X			X		General Service Hospital	A
2	Wesley Long Community Hospital 501 North Elam Avenue Greensboro, NC 274031118 www.conehealth.com	X	X		X			X		General Service Hospital	A
3	Women's Hospital of Greensboro 801 Green Valley Road Greensboro, NC 274087021 www.conehealth.com	X			X					Maternity and Infant Care	A
4	Annie Penn Hospital 618 South Main Street Reidsville, NC 273205020 www.conehealth.com	X	X		X			X		General Service Hospital	A
5	Behavioral Health Hospital 700 Walter Reed Drive Greensboro, NC 27403 www.conehealth.com	X								Psychiatric Care Hospital	A

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

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

Form and Line Reference	Explanation
COMMUNITY INPUT	FORM 990, SCH H, PT V, SEC B, LINE 5-FACILITY 1 THE HOSPITAL WORKED WITH EPIDEMIOLOGISTS AND HEALTH EDUCATORS AT THE GUILFORD COUNTY HEALTH DEPARTMENT, THE ALAMANCE COUNTY HEALTH DEPARTMENT, THE ROCKINGHAM COUNTY HEALTH DEPARTMENT, LEADERS AT UNC GREENSBORO, GUILFORD COMMUNITY CARE NETWORK AND ROCKINGHAM COUNTY HEALTH CARE ALLIANCE. IN ADDITION, DOOR-TO-DOOR SURVEYS WERE CONDUCTED IN ROCKINGHAM COUNTIES, FOCUS GROUPS IN ALAMANCE COUNTY AND GUILFORD COUNTY AS WELL AS COMMUNITY FORUMS OPEN TO THE PUBLIC.

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
JOINT CHNA DETAIL	FORM 990, SCH H, PT V, SEC B, LINE 6A-FACILITY 1 THE ASSESSMENT TEAM WAS COMPRISED OF REPRESENTATIVES FROM WAKE HEALTH HIGH POINT REGIONAL MEDICAL CENTER (HIGH POINT, NC), UNC ROCKINGHAM HOSPITAL(EDEN, NC), AND ALAMANCE REGIONAL MEDICAL CENTER (BURLINGTON, NC).

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

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

Form and Line Reference	Explanation
CHNA ONE OR MORE ORG	FORM 990, SCH H, PT V, SEC B, LINE 6B-FACILITY 1 HUMAN SERVICE LEADERS FROM CONE HEALTH FOUNDATION, FOUNDATION FOR A HEALTHY HIGH POINT, REIDSVILLE AREA FOUNDATION, GUILFORD COMMUNITY CARE NETWORK, ROCKINGHAM EDUCATION ALLIANCE, ROCKINGHAM COUNTY HEALTHCARE ALLIANCE, UNITED WAY OF HIGH POINT, UNITED WAY OF GREATER GREENSBORO, UNITED WAY OF ROCKINGHAM COUNTY AND ALCOHOL AND DRUG SERVICES OF GUILFORD.

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

Form and Line Reference	Explanation
CHNA SIGNIFICANT NEEDS	<p>FORM 990, SCH H, PT V, SEC B, LINE 11-FACILITY 1 CONE HEALTH WORKS WITH COMMUNITY PARTNERS IN ALAMANCE, GUILFORD AND ROCKINGHAM COUNTIES TO ASSESS THE SOCIAL, MEDICAL AND ECONOMIC HEALTH OF OUR COMMUNITIES. IN 2018-19, LOCAL TEAMS ANALYZED AVAILABLE DATA FROM TRUSTED SOURCES; COLLECTED NEW DATA THROUGH FOCUS GROUPS, SURVEYS (PHONE, DOOR-TO-DOOR AND ELECTRONIC) AND INTERVIEWS; AND CONDUCTED COMMUNITY FORUMS TO IDENTIFY PRIORITY HEALTH CONCERNS. INFORMATION IN THE 2019 CONE HEALTH NEEDS ASSESSMENT INCLUDES: - KEY FRAMEWORKS FOR UNDERSTANDING HEALTH OUTCOMES: A DESCRIPTION OF THE SCIENTIFIC BASIS FOR A "WHOLE PERSON" CONCEPT OF HEALTH THAT INCLUDES SOCIAL DRIVERS SUCH AS EDUCATION, INCOME, AND HOUSING, AND HOW THESE DRIVERS ARE VISIBLE IN THE HEALTH OUTCOMES IN OUR COMMUNITIES. - DEMOGRAPHICS AND POPULATION INFORMATION: IT IS IMPORTANT TO NOTE THAT MEDIAN INCOME IN ALAMANCE (\$47,900), GUILFORD (\$52,300) AND ROCKINGHAM (\$46,200) IS LOWER THAN THE STATE OF NC (\$52,800). HOUSEHOLD INCOME INFLUENCES MANY ISSUES THAT IMPACT HEALTH, SUCH AS INSURANCE COVERAGE, HOUSING AVAILABILITY, NUTRITIONAL PRACTICES, CHILDCARE OPTIONS AND EDUCATIONAL ATTAINMENT. ROCKINGHAM HAS THE LARGEST AGING POPULATION (20% OVER 65), AND GUILFORD HAS THE MOST RACIALLY AND ETHNICALLY DIVERSE (49.5%) RESIDENTS. - LIFE EXPECTANCY AND LEADING CAUSES OF DEATH: CANCER AND HEART DISEASE TOGETHER ACCOUNT FOR ALMOST 40% OF DEATHS IN OUR REGION. WE OBSERVE ALARMING DISPARITIES IN LIFE EXPECTANCY BY RACE AND GEOGRAPHY, EVIDENCE OF THE INFLUENCE OF SOCIAL DETERMINANTS OF HEALTH. INFANT MORTALITY IS IMPROVING IN ALAMANCE COUNTY, BUT HAS INCREASED IN GUILFORD (9.8/1000) AND THE DISPARITY IN BLACK (13.3/1000) AND WHITE (6.1/1000) RATES HAS GROWN. PRIORITY HEALTH CONCERNS IDENTIFIED IN THE COMMUNITY HEALTH NEEDS ASSESSMENT ARE SUMMARIZED BELOW</p> <p>PREVENTION OF CHRONIC DISEASE, ESPECIALLY DIABETES: CHRONIC DISEASE CONTRIBUTES TO LEADING CAUSES OF DEATH, INCREASES HEALTHCARE COSTS, AND SHORTENS LIVES. OUR REGION HAS A HIGH VOLUME OF CHRONIC DISEASE THAT MAY BE PREVENTABLE WITH LIFESTYLE CHANGES. WE ARE WORKING TO INCREASE ACCESS TO HEALTHY FOOD, WALKABLE COMMUNITIES, AND HEALTH EDUCATION. PREVENTION OF ADDICTION AND PROMOTING STRONG MENTAL HEALTH: BEHAVIORAL HEALTH AFFECTS PHYSICAL HEALTH AND A PERSON'S FUNDAMENTAL SENSE OF WELL-BEING. THE LAST DECADE HAS SEEN A DRAMATIC RISE IN DEPRESSION AND IN RATES OF ADDICTION, ESPECIALLY OPIOIDS. WE ARE INTEGRATING BEHAVIORAL HEALTH INTO PRIMARY CARE, AND USING A HARM REDUCTION APPROACH TO HELPING PEOPLE WITH ADDICTION. ACCESS TO HIGH QUALITY, AFFORDABLE HEALTHCARE: REGULAR CARE WITH TRUSTED PROVIDERS PREVENTS ILLNESS, IMPROVES LIFE EXPECTANCY, AND REDUCES COSTS. 12 % OF ADULTS UNDER 65 ARE UNINSURED, AND OUR REGION'S PROVIDER COVERAGE IS AT OR BELOW STATE AVERAGE. WE ARE OPENING NEW CLINICS IN AREAS WITH MEDICAL NEEDS AND STRENGTHENING OUR COMMUNITY'S SAFETY NET. CREATING THE LIVING CONDITIONS THAT NURTURE HEALTH: HUMANS FLOURISH IN SAFE, POLLUTION-FREE AND SU</p>

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

Form and Line Reference	Explanation
CHNA SIGNIFICANT NEEDS	PPORTIVE ENVIRONMENTS THAT PROMOTE HEALTH. GREENSBORO IS CONSIDERED THE NATION'S THIRD MOS T CHALLENGING CITY FOR PEOPLE WITH ASTHMA. WE ARE LINKING HEALTH AND HUMAN SERVICES PROVID ERS TO HELP PATIENTS; IMPROVING HOUSING AND NEIGHBORHOOD QUALITY. ELIMINATING BIAS AND DIS CRIMINATION IN HEALTHCARE: ELIMINATING BIAS REFLECTS OUR CORE VALUES OF CARING AND PROMOTE S EQUITABLE OPPORTUNITY IN OUR SOCIETY. DISEASE MORTALITY RATES, INFANT MORTALITY, AND RAT ES OF PREVENTIVE CARE REFLECT RACIAL/ETHNIC DISPARITIES. WE ARE IDENTIFYING THE ROOT CAUSE S OF UNEQUAL HEALTH OUTCOMES AND CHANGING PROTOCOLS TO IMPROVE HEALTH FOR ALL.

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

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

Form and Line Reference	Explanation
PRE-COLLECTION PRACTICES	FORM 990, SCH H, PT V, SEC B, LINE 20E-FACILITY 1 THE HOSPITAL MAINTAINS A HARDSHIP SETTLEMENT POLICY WHICH PROVIDES AN OPPORTUNITY FOR PATIENTS TO REQUEST DISCOUNTS ON BALANCES DUE TO THE HOSPITAL IN EXCESS OF \$5,000. THE PURPOSE OF THIS POLICY IS TO RECOGNIZE THAT EVEN AFTER THE ADMINISTRATION OF THE HOSPITAL'S AUTOMATIC DISCOUNT FOR ALL UNINSURED PATIENTS, THERE STILL COULD BE SITUATIONS WHERE THE PATIENT IS EXPERIENCING A FINANCIAL HARDSHIP TO PAY THE BALANCE DUE IN FULL. A PATIENT MAY REQUEST A HARDSHIP SETTLEMENT. FINANCIAL NEED WILL BE DETERMINED BY COMPARING A PATIENT'S TOTAL HOUSEHOLD FINANCIAL RESOURCES AND ASSETS TO THE REMAINING BALANCE. IF IT IS DETERMINED THAT AFTER ALL THIRD PARTY REIMBURSEMENTS, THE REMAINING BALANCE IS GREATER THAN \$5,000 AND 20% OF THE PATIENT'S TOTAL FINANCIAL RESOURCES, THE PATIENT IS ELIGIBLE FOR A HARDSHIP SETTLEMENT. THE APPLICABLE DISCOUNT INCREASES FOR BALANCES THAT MAKE UP A GREATER PERCENTAGE OF THE PATIENT'S TOTAL HOUSEHOLD FINANCIAL RESOURCES. IF AFTER ALL EFFORTS TO QUALIFY THE PATIENT FOR FINANCIAL ASSISTANCE HAVE BEEN EXHAUSTED AND THE PATIENT REMAINS UNABLE TO PAY BALANCES GREATER THAN \$5,000, THE UNPAID PORTION OF THE BILL MAY BE TURNED OVER OT COLLECTIONS.

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
Financial Assistance Policy Eligibility Criteria	FORM 990, SCH H, PT V, SEC B, LINE 13B-FACILITY 1 PATIENTS WHO QUALIFY AND ARE RECEIVING BENEFITS FROM THE US DEPARTMENT OF AGRICULTURE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM AND COUNTY AND STATE RELIEF PROGRAM.

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

Schedule I
(Form 990)

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

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

▶ Attach to Form 990.

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

OMB No. 1545-0047

2018

Open to Public
Inspection

Department of the
Treasury
Internal Revenue Service

Name of the organization
MOSES H CONE MEMORIAL HOSPITAL
OPERATING CORPORATION

Employer identification number

58-1588823

Part I General Information on Grants and Assistance

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

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of noncash assistance	(h) Purpose of grant or assistance
(1) See Additional Data							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							

- 2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table ▶ 41
- 3 Enter total number of other organizations listed in the line 1 table ▶

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

Part III can be duplicated if additional space is needed.

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

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

Return Reference	Explanation
MONITORING PROCEDURES	FORM 990, SCHEDULE I, PART I, LINE 2 Requests for sponsorship to Cone Health are submitted in writing from the requesting organization. The requests are then evaluated online by a small group to determine whether the sponsorship request aligns with Cone Health's strategy. The group evaluating the requests typically includes the Executive Vice President for People & Corporate Services; the Senior Vice President - Marketing & Communications; the Director of Communications; and, as needed/appropriate, the CEO or his Administrative Assistant. Once a decision has been made, the requesting organization receives written confirmation from Cone Health on the outcome.

Additional Data

Software ID:
Software Version:
EIN: 58-1588823
Name: MOSES H CONE MEMORIAL HOSPITAL
OPERATING CORPORATION

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
ACTION GREENSBORO 122 N ELM STREET SUITE 110 GREENSBORO, NC 27401	56-2251250	501(c)(3)	9,500				CORPORATE PARTNERSHIP
ALAMANCE CHAMBER 610 LEXINGTON AVE PO BOX 450 BURLINGTON, NC 27215	56-0156970	501(c)(3)	8,000				SPONSOR 2020 WOMEN'S SYMPOSIUM

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
AMERICAN CANCER SOCIETY 7027 ALBERT PICK RD SUITE 104 GREENSBORO, NC 27409	13-1788491	501(c)(3)	17,000				SUPPORT OF THE COMMUNITY
AMERICAN HEART ASSOCIATION PO BOX 4002906 DESMOINES, IA 503402906	13-5613797	501(c)(3)	35,000				PROMOTION OF HEALTHY LIFESTYLES Smile of Carolinas

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
ANNIE PENN HOSPITAL FOUNDATION 618 S MAIN ST REIDSVILLE, NC 27320	58-1897269	501(c)(3)	6,200				2018 ENCHANTED EVENING ABRACADABRA SPONSORSHIP
ARTSGREENSBORO NC FOLK FESTIVAL PO BOX 877 GREENSBORO, NC 274020877	56-0746180	501(c)(3)	28,000				2019 NC FOLK FESTIVAL

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
BENNETT COLLEGE 900 E WASHINGTON ST GREENSBORO, NC 27401	52-1259840	501(c)(3)	25,000				SWB CAMPAIGN
BLUE RIDGE PARKWAY FOUNDATION 717 S MARSHALL ST SUITE 105B WINSTONSALEM, NC 271015865	31-1512730	501(c)(3)	7,500				CARETAKER SPONSOR OF THE DENIM BALL

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
BLUFORD HEALTHCARE LEADERSHIP INSTITUTE 7900 LEES SUMMIT ROAD KANSAS CITY, MO 64139	46-3328194	501(c)(3)	10,000				PROMOTION OF HEALTHY LIFESTYLES
CAROLINA THEATRE OF GREENSBORO INC - SETTING THE S 310 SOUTH GREENE STREET GREENSBORO, NC 27401	04-3781645	501(c)(3)	10,000				SUPPORT OF THE COMMUNITY

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
FAMILY SERVICE - GREENSBORO OYSTER ROAST 902 BONNER DRIVE JAMESTOWN, NC 27282	56-2061741	501(c)(3)	10,000				SUPPORT OF THE COMMUNITY
FREE CLINIC OF ROCKINGHAM 315 S MAIN ST REIDSVILLE, NC 27320	56-2003143	501(c)(3)	15,000				SUPPORT OF THE COMMUNITY

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
GIST HEALTHCARE LLC 2201 WISCONSIN AVE STE 200 WASHINGTON, DC 20007	82-3456008	501(c)(3)	23,000				SUPPORT OF THE COMMUNITY FIREWORKS
GREENSBORO CHAMBER OF COMMERCE PO BOX 3246 GREENSBORO, NC 27402	56-0245040	501(c)(3)	129,660				SUPPORT OF THE COMMUNITY

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
GREENSBORO CHILDREN'S MUSEUM 220 N CHURCH ST GREENSBORO, NC 27401	56-1959695	501(c)(3)	26,500				PROMOTION OF HEALTHY LIFESTYLES
GREENSBORO HOUSING COALITION 1031 SUMMIT AVE SUITE 1E-2 GREENSBORO, NC 27405	56-1727193	501(c)(3)	45,000				BUILD CONTRIBUTION DONATION

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
GREENSBORO MEDICAL SOCIETY PO BOX 2802 GREENSBORO, NC 27402	91-2047364	501(c)(3)	55,000				EDUCATION FOR HEALTH CARE PROVIDERS, 2019 YEARLY EN
GREENSBORO SCIENCE CENTER 4301 LAWDALE DRIVE GREENSBORO, NC 27455	56-0885727	501(c)(3)	20,000				SUPPORT OF THE COMMUNITY

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
HABITAT FOR HUMANITY 1031 SUMMIT AVE STE 2W-2 GREENSBORO, NC 27405	56-1586870	501(c)(3)	25,000				PROVIDE HOUSING IN COMMUNITY
HOSPICE AND PALLIATIVE CARE -CORKS FOR KIDS PATH 2500 SUMMIT AVENUE GREENSBORO, NC 27405	56-1249146	501(c)(3)	10,100				CORKS FOR KIDS PATH SPONSORSHIP

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
INTERNATIONAL CIVIL RIGHTS 134 S ELM STREET GREENSBORO, NC 27401	56-1856093	501(c)(3)	12,500				MUSEUM
JDRF - JUVENILE DIABETES RESEARCH FOUNDATION 216 W MARKET ST SUITE B GREENSBORO, NC 27401	23-1907729	501(c)(3)	25,000				PROMOTION OF HEALTHY LIFESTYLES

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MEDASSIST OF MECKLENBURG 4428 TAGGART CREEK RD SUITE 101 CHARLOTTE, NC 28208	99-9117017	501(c)(3)	7,500				SPONSOR MOBILE FREE PHARMACY
NAT GREENE KIWANIS FOUNDATION PO BOX 10487 GREENSBORO, NC 27404	26-1079240	501(c)(3)	10,000				POSTGRADUATE SCHOLARSHIP AWARDS LUNCHEON

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
NC BUSINESS LEADERS FOR EDUCATION 100SAS CAMPUS DR BUILDING T CARY, NC 27513	46-2988453	501(c)(3)	10,000				EDUCATION AND ADVOCACY
NC TRIAD FUSION INC 118 SOUTH HERRY ST SUITE B KERNERSVILLE, NC 27284	83-0887947	501(c)(3)	25,000				TWO YEAR JERSY SPONSORSHIP

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
NCCJ PIEDMONT TRIAD 713 NORTH GREENE STREET GREENSBORO, NC 27401	06-1753756	501(c)(3)	15,000				SUPPORT OF THE COMMUNITY
NCHA PO Box 4449 CARY, NC 275194449	56-0641290	501(c)(3)	225,074				EDUCATION AND ADVOCACY

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
OPERATION SMILE 502 E CORNWALLIS DR SUITE L GREENSBORO, NC 27405	54-1460147	501(c)(3)	5,500				SALSA SPONSORSHIP DANCING WITH CAROLINA STARS
PIEDMONT TRIAD PARTNERSHIP PO BOX 2672 HIGH POINT, NC 27261	56-1750279	501(c)(3)	25,000				2018 INVESTMENT FOR ECONOMIC DEVELOPMENT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
READING CONNECTIONS INC 122 N ELM STREET SUITE 920 GREENSBORO, NC 27401	56-1726754	501(c)(3)	10,000				2019 SPONSORSHIP LITERACY SUPPORT
READY FOR SCHOOL READY FOR LIFE 1416 YANCEYVILLE ST SUITE A GREENSBORO, NC 27405	82-3893055	501(c)(3)	35,000				PROMOTION OF HEALTHY LIFESTYLES

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
REIDSVILLE CHAMBER OF COMMERCE PO BOX 1020 REIDSVILLE, NC 27323	56-0735425	501(c)(3)	9,602				TRIPLE DIAMOND CHAMBER CHAMPION
REDISVILLE DOWNTOWN CORP 230 WEST MOREHEAD ST REIDSVILLE, NC 27320	51-0223082	501(c)(3)	7,000				SUPPORT OF THE COMMUNITY

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
ROCKINGHAM COUNTY STUDENT HEALTH CENTER 117 EAST KINGS HIGHWAY EDEN, NC 27253	56-6001527	501(c)(3)	50,000				PROMOTION OF HEALTHY LIFESTYLES
UNITED WAY OF GREATER GREENSBORO 1500 YANCEYVILLE STREET GREENSBORO, NC 27405	56-0668555	501(c)(3)	12,225				SUPPORT OF COMMUNITY NON- PROFIT ORGANIZATIONS

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
UNITED WAY OF GREATER HIGH POINT PO BOX 601318 CHARLOTTE, NC 282601318	56-0847486	501(c)(3)	20,000				SUPPORT OF COMMUNITY NON-PROFIT ORGANIZATIONS
UNITED WAY OF ROCKINGHAM COUNTY INC PO BOX 317 WENTWORTH, NC 27375	56-0649247	501(c)(3)	10,250				SUPPORT OF COMMUNITY NON-PROFIT ORGANIZATIONS

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
US FIGURE SKATING CHAMPIONSHIPS-2020 MAJOR EVENTS 401 HARRISON OAKS BLVD STE 210 CARY, NC 27513	84-0768715	501(c)(3)	50,000				SUPPORT OF THE COMMUNITY
VINE CATERING 2025 Watersone Lane HIGH POINT, NC 27265	56-2046838	501(c)(3)	35,000				SUPPORT OF COMMUNITY

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
YMCA OF GREENSBORO 620 GREEN VALLEY ROAD SUITE 210 GREENSBORO, NC 27408	56-0543243	501(c)(3)	12,000				PROMOTION OF HEALTHY LIFESTYLES

Schedule J (Form 990)	Compensation Information	OMB No. 1545-0047
		2018
Department of the Treasury Internal Revenue Service	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.	
Name of the organization MOSES H CONE MEMORIAL HOSPITAL OPERATING CORPORATION		Employer identification number 58-1588823

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

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

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

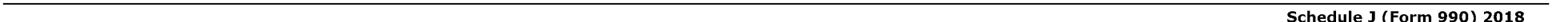
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Part III Supplemental Information

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

Return Reference	Explanation
EARNINGS CONTINGENT COMP	FORM 990, SCHEDULE J, PART I, LINE 6 OFFICERS ARE PAID BY MOSES H. CONE MEMORIAL HOSPITAL OPERATING CORPORATION, INC. AND PARTICIPATE IN THE MANAGEMENT INCENTIVE COMPENSATION PROGRAM. UNDER THIS PROGRAM, A PORTION OF THE SALARY OF THOSE AT A LEVEL OF DEPARTMENT DIRECTOR AND HIGHER IS SET ASIDE AND IS CONTINGENT UPON THE HEALTH SYSTEM'S PERFORMANCE ON SEVERAL MEASURES, INCLUDING NET EARNINGS. NOTE: IF THESE MEASURES ARE NOT MET, THEIR COMPENSATION WILL BE BELOW THE MARKET LEVEL FOR THEIR JOB.

Return Reference	Explanation
Severance and Other Payments	Form 990, Schedule J, Part I, Line 4 Former SVP & Assistant Secretary Timothy Clontz - \$206,931 Former Physician Patrick Wright - \$306,923



Additional Data

Software ID:
Software Version:
EIN: 58-1588823
Name: MOSES H CONE MEMORIAL HOSPITAL
OPERATING CORPORATION

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
Akin Terrence President & CEO	(i)	0	0	0	0	0	0	0
	(ii)	1,242,356	784,839	266,441	125,160	28,140	2,446,936	0
Barrow Andrew Assistant Treasurer	(i)	331,709	82,962	22,085	37,137	12,069	485,962	0
	(ii)	0	0	0	0	0	0	0
Burt Noel EVP & Assistant Secretary	(i)	383,398	349,757	67,923	54,887	13,591	869,556	0
	(ii)	0	0	0	0	0	0	0
Cagle MD Mary Jo Chief Operating Officer	(i)	0	0	0	0	0	0	0
	(ii)	691,497	307,940	149,333	65,186	23,300	1,237,256	0
Campbell MD John Physician	(i)	349,133	84,438	54,421	49,647	8,116	545,755	0
	(ii)	0	0	0	0	0	0	0
Carter Robert VP & General Counsel	(i)	398,387	105,409	28,628	44,824	12,434	589,682	0
	(ii)	0	0	0	0	0	0	0
Clontz Timothy SVP & Assistant Secretary	(i)	188,136	174,032	137,998	69,087	8,030	577,283	0
	(ii)	0	0	0	0	0	0	0
Cunningham Deborah SVP & President Women's Health	(i)	262,959	71,647	46,318	34,716	8,495	424,135	0
	(ii)	0	0	0	0	0	0	0
Eaton Mandy EVP & Assistant Secretary	(i)	247,468	61,240	21,225	30,750	4,323	365,006	0
	(ii)	0	0	0	0	0	0	0
Evans Joan EVP Innovation & Transformatio	(i)	291,697	265,591	59,074	54,887	6,752	678,001	0
	(ii)	0	0	0	0	0	0	0
Foster Mickey SVP & President - MHCMH	(i)	371,020	198,448	45,798	37,003	9,876	662,145	0
	(ii)	0	0	0	0	0	0	0
Haywood Mehee Assistant Treasurer	(i)	0	0	0	0	0	0	0
	(ii)	117,497	23,493	1,493	44,493	3,912	190,888	0
Jeffrey Paul President Wesley Long Hospital	(i)	342,344	112,391	49,680	41,005	8,302	553,722	0
	(ii)	0	0	0	0	0	0	0
Johnson Julie Assistant Treasurer	(i)	158,277	30,611	2,772	45,772	2,752	240,184	0
	(ii)	0	0	0	0	0	0	0
Jones Jeffrey CFO & Secretary	(i)	0	0	0	0	0	0	0
	(ii)	628,945	326,003	134,396	60,972	34,146	1,184,462	0
Keeling MD Wayne Trustee	(i)	0	0	0	0	0	0	0
	(ii)	254,949	36,408	6,730	29,834	980	328,901	0
Kibbe Ike SVP	(i)	299,095	103,556	51,373	53,912	9,428	517,364	0
	(ii)	0	0	0	0	0	0	0
Kitzmiller David Assistant Treasurer	(i)	142,192	26,137	1,677	26,177	10,666	206,849	0
	(ii)	0	0	0	0	0	0	0
Kumar Archana Physician	(i)	248,679	228,766	4,551	43,966	14,471	540,433	0
	(ii)	0	0	0	0	0	0	0
Miller John CIO & Treasurer	(i)	0	0	0	0	0	0	0
	(ii)	300,725	84,917	46,098	67,271	4,305	503,316	0

Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees								
(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
Rempher PhD Kenneth EVP & Assistant Secretary	(i)	0	0	0	0	0	0	0
	(ii)	486,750	151,479	13,230	45,014	18,091	714,564	0
Roskelly James EVP & Assistant Secretary	(i)	287,176	310,479	73,360	69,161	10,708	750,884	0
	(ii)	0	0	0	0	0	0	0
Schanel Judith Chief Operating Officer	(i)	0	0	0	0	0	0	0
	(ii)	626,266	277,146	68,513	60,404	28,379	1,060,708	0
Simms Michael VP & Assistant Treasurer	(i)	238,954	66,536	25,595	33,367	7,842	372,294	0
	(ii)	0	0	0	0	0	0	0
Street Rex VP & Assistant Treasurer	(i)	302,444	92,136	33,151	54,887	12,488	495,106	0
	(ii)	0	0	0	0	0	0	0
Swords Bruce Chief Physician Executive	(i)	450,326	172,012	64,283	49,505	14,363	750,489	0
	(ii)	0	0	0	0	0	0	0
Windham MD Toby Physician	(i)	161,381	77,130	276,447	26,324	8,055	549,337	0
	(ii)	0	0	0	0	0	0	0
Wright Patrick Physician	(i)	351,142	107,275	36,311	54,084	8,811	557,623	0
	(ii)	0	0	0	0	0	0	0

SCHEDULE M
(Form 990)

Department of the Treasury
Internal Revenue Service

Noncash Contributions

►Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.
► Attach to Form 990.
►Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
MOSES H CONE MEMORIAL HOSPITAL
OPERATING CORPORATION

Employer identification number
58-1588823

Part I

Types of Property

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art—Works of art				
2 Art—Historical treasures				
3 Art—Fractional interests				
4 Books and publications				
5 Clothing and household goods				
6 Cars and other vehicles				
7 Boats and planes				
8 Intellectual property				
9 Securities—Publicly traded	X	1,164	131,142	PROCEEDS LESS FEES
10 Securities—Closely held stock				
11 Securities—Partnership, LLC, or trust interests				
12 Securities—Miscellaneous				
13 Qualified conservation contribution—Historic structures				
14 Qualified conservation contribution—Other				
15 Real estate—Residential				
16 Real estate—Commercial				
17 Real estate—Other				
18 Collectibles				
19 Food inventory				
20 Drugs and medical supplies				
21 Taxidermy				
22 Historical artifacts				
23 Scientific specimens				
24 Archeological artifacts				
25 Other ► ()				
26 Other ► ()				
27 Other ► ()				
28 Other ► ()				

29

Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement

29

30a

During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 28, that it must hold for at least three years from the date of the initial contribution, and which is not required to be used for exempt purposes for the entire holding period?

30a

Yes

No

b

If "Yes," describe the arrangement in Part II.

31

Does the organization have a gift acceptance policy that requires the review of any nonstandard contributions?

31

Yes

32a

Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions?

32a

No

b

If "Yes," describe in Part II.

33

If the organization did not report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II.

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

Cat. No. 51227J

Schedule M (Form 990) (2018)

Part II**Supplemental Information.**

Provide the information required by Part I, lines 30b, 32b, and 33, and whether the organization is reporting in Part I, column (b), the number of contributions, the number of items received, or a combination of both. Also complete this part for any additional information.

Return Reference

Explanation

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury

Internal Revenue Service

Name of the organization
MOSES H CONE MEMORIAL HOSPITAL
OPERATING CORPORATION

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on
Form 990 or 990-EZ or to provide any additional information.

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2018

**Open to Public
Inspection**

Employer identification number

58-1588823

990 Schedule O, Supplemental Information

Return Reference	Explanation
GOVERNING DOCUMENTS	FORM 990, PART VI, SECTION C, LINE 19 These documents are proprietary and are not made available to the public.

990 Schedule O, Supplemental Information

Return Reference	Explanation
COMPENSATION REVIEW PROCESS	FORM 990, PART VI, SECTION B, LINE 15 THE FOLLOWING METHODS ARE USED TO ESTABLISH COMPENSA TION OF OFFICERS: COMPENSATION COMMITTEE; INDEPENDENT COMPENSATION CONSULTANT; WRITTEN EMP LOYEMENT CONTRACT; COMPENSATION SURVEY OR STUDY AND APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE.

990 Schedule O, Supplemental Information

Return Reference	Explanation
INFORMATION REGARDING DELEGATION	FORM 990, PART VI, SECTION A, LINE 3 CONE HEALTH SYSTEM HAS CONTRACTED WITH ATRIUM HEALTH TO PERFORM THE FOLLOWING MANAGEMENT DUTIES: (1) PROVIDE EXECUTIVE STAFF; (2) MANAGED CARE CONTRACTING; (3) BEST PRACTICES CONSULTING FOR OPERATIONS ACROSS THE HEALTH SYSTEM; (4) PROVIDE ACCESS TO ITS PURCHASING CONTRACTS; AND (5) COLLABORATION OF QUALITY DATA ANALYSIS THAT WILL ALLOW THEM TO BETTER MANAGE THE CONVERSION OF REIMBURSEMENT FROM VOLUME-BASED MODELS TO VALUE-BASED MODELS AS IS REQUIRED UNDER THE AFFORDABLE CARE ACT. THE FOLLOWING OFFICERS WERE COMPENSATED BY ATRIUM HEALTH DURING THE CALENDAR YEAR ENDING WITHIN THE COMPANY'S TAX YEAR: TERRENCE AKIN, CHIEF EXECUTIVE OFFICER: \$2,446,936 JEFFREY JONES, CHIEF FINANCIAL OFFICER: \$1,184,462 JUDITH SCHANEL, CHIEF OPERATING OFFICER: \$1,060,708 KENNETH REMPHER, EXECUTIVE VICE PRESIDENT: \$714,564 MARY JO CAGLE, CHIEF OPERATING OFFICER: \$1,237,256

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990 REVIEW PROCESS	FORM 990, PART VI, SECTION B, LINE 11B AN ELECTRONIC VERSION OF THE RETURN will be made available on the board portal to all board members in advance of the filing date. Representatives of the finance staff from the health system will be available to respond to any questions or address any issues.

990 Schedule O, Supplemental Information

Return Reference	Explanation
CONFLICT OF INTEREST POLICY	FORM 990, PART VI, SECTION B, LINE 12C BEFORE EVERY BOARD meeting OR COMMITTEE MEETING, TH E CHAIR WILL ASK EVERY MEMBER TO REVIEW THE AGENDA AND TO DISCLOSE ANY AREA where they may have CONFLICT so that THE DISCLOSURE IS COMPLETE PRIOR TO the DISCUSSION.

990 Schedule O, Supplemental Information

Return Reference	Explanation
OTHER CHANGES IN NET ASSETS	FORM 990, PART XI, LINE 9 OTHER COMPREHENSIVE INCOME \$ 75,225,117 OTHER CHANGES IN NET ASSETS \$ 13,617 INCREASE IN UNRESTRICTED FUNDS \$ 604,461 INCREASE IN TEMP RESTRICTED FUNDS \$ 937,740 ----- TOTAL CHANGE IN NET ASSETS OR FUND BALANCE \$ 76,780,935

990 Schedule O, Supplemental Information

Return Reference	Explanation
AMENDED RETURN REASON	THIS AMENDED RETURN IS BEING FILED TO CORRECT THE FOLLOWING QUESTIONS: FORM 990: PART V LINE 15 - UPDATED ANSWER TO "NO" PART V LINE 16 - UPDATED ANSWER TO "NO" SCHEDULE H: PART V LINE 12a - UPDATED ANSWER TO "NO" PART V LINE 12b - REMOVED "YES" ANSWER DUE TO CHANGE TO QUESTION 12a PART V LINE 12c - REMOVED AMOUNT AS THE TOTAL AMOUNT OF SECTION 4959 EXCISE TAX IS \$0 PART V LINE 16b - UPDATED ANSWER TO "YES" ADDED "WWW.CONEHEALTH.COM" PART V LINE 16c - UPDATED ANSWER TO "YES" ADDED "WWW.CONEHEALTH.COM" PART V LINE 16h - UPDATED ANSWER TO "YES" PART V LINE 16i - UPDATED ANSWER TO "YES" PART V LINE 18a - REMOVED CHECK PART V LINE 18d - REMOVED CHECK PART V LINE 18f - ADDED CHECK AS NONE OF THESE ACTIONS OR OTHER SIMILAR ACTIONS WERE PERMITTED PART V LINE 19 - UPDATED ANSWER TO "NO" PART V LINE 19a - REMOVED CHECK DUE TO CHANGE TO QUESTION 19 PART V LINE 19d - REMOVED CHECK DUE TO CHANGE TO QUESTION 19 PART V LINE 22b - ADDED CHECK PART V LINE 22d - REMOVED CHECK

SCHEDULE R
(Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
MOSES H CONE MEMORIAL HOSPITAL
OPERATING CORPORATION

Employer identification number
58-1588823

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.

See Additional Data Table

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512- 514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) NSC GREENSBORO WEST LLC 3000 Riverchase Galleria Birmingham, AL 35244 47-2847536	PHYSICIANS	NC	MC MED SVCS	N/A				No			No	
(2) CONE HEALTH CONNECTED CARE LLC 1200 N Elm St Greensboro, NC 27401 81-4880456	For Profit HC SER	NC	WLCHS	N/A				No			No	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of- year assets	(h) Percentage ownership	(i) Section 512(b) (13) controlled entity?	
								Yes	No
(1) Wesley Long Community Health Services 1200 North Elm Street Greensboro, NC 27401 56-1441377	MEDICAL SERVICES	NC	MC PARENT	C				Yes	
(2) Care-N-Care of North Carolina 1200 North Elm Street Greensboro, NC 27401 47-2847536	INSURANCE	NC	WLCHS	C				Yes	
(3) Wellsmith Inc 9011 Mountain Ridge Drive Ste 210 Austin, TX 78759 82-3045731	Software	TX	WLCHS	C				Yes	
(4) INSURANCE CASUALTY AND RISK ENTERPRISE PO BOX 1159 GRAND CAYMAN KY1-1102 CJ 98-1491204	SELF-INSURANCE	CJ	MC PARENT	C				Yes	

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

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

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

b Gift, grant, or capital contribution to related organization(s)

c Gift, grant, or capital contribution from related organization(s)

d Loans or loan guarantees to or for related organization(s)

e Loans or loan guarantees by related organization(s)

f Dividends from related organization(s)

g Sale of assets to related organization(s)

h Purchase of assets from related organization(s)

i Exchange of assets with related organization(s)

j Lease of facilities, equipment, or other assets to related organization(s)

k Lease of facilities, equipment, or other assets from related organization(s)

l Performance of services or membership or fundraising solicitations for related organization(s)

m Performance of services or membership or fundraising solicitations by related organization(s)

n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)

o Sharing of paid employees with related organization(s)

p Reimbursement paid to related organization(s) for expenses

q Reimbursement paid by related organization(s) for expenses

r Other transfer of cash or property to related organization(s)

s Other transfer of cash or property from related organization(s)

Yes

No

1a

No

1b

No

1c

Yes

1d

No

1e

No

1f

No

1g

No

1h

No

1i

No

1j

Yes

1k

Yes

1l

No

1m

No

1n

No

1o

Yes

1p

Yes

1q

Yes

1r

No

1s

No

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved

Schedule R (Form 990) 2018

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.

[illegible]

Part VII

Supplemental Information

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

Return Reference	Explanation

Additional Data

Software ID:
Software Version:
EIN: 58-1588823
Name: MOSES H CONE MEMORIAL HOSPITAL
OPERATING CORPORATION

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
1200 North Elm Street Greensboro, NC 27401 56-0532302	Parent	NC	501(C)(3)	12.b	NA		No
1200 North Elm Street Greensboro, NC 27401 56-1714318	PHYSICIANS	NC	501(C)(3)	3	MC PARENT	Yes	
1200 North Elm Street Greensboro, NC 27401 80-0249057	PHYSICIANS	NC	501(C)(3)	3	MC PARENT	Yes	
1200 North Elm Street Greensboro, NC 27401 30-0554775	PHYSICIANS	NC	501(C)(3)	3	MC PARENT	Yes	
1200 North Elm Street Greensboro, NC 27401 80-0217430	PHYSICIANS	NC	501(C)(3)	3	MC AFFIL PHY	Yes	
618 S Main Street Reidsville, NC 27320 58-1897269	FUNDING	NC	501(C)(3)	7	NA		No
1200 North Elm Street Greensboro, NC 27401 58-1681363	OPERATIONS	NC	501(C)(3)	3	MC PARENT	Yes	
1200 North Elm Street Greensboro, NC 27401 56-0529994	OPERATIONS	NC	501(C)(3)	3	ARMC HC	Yes	
1200 North Elm Street Greensboro, NC 27401 58-1681364	L-T CARE	NC	501(C)(3)	10	ARMC HC	Yes	
1200 North Elm Street Greensboro, NC 27401 56-1681560	FUNDING	NC	501(C)(3)	12.b	ARMC HC	Yes	
1200 North Elm Street Greensboro, NC 27401 27-4683614	OPERATIONS	NC	501(C)(3)	3	MC OPERATING	Yes	
1200 North Elm Street Greensboro, NC 27401 56-2095382	physicians	NC	501(C)(3)	3	ARMC HC	Yes	
1200 North Elm Street Greensboro, NC 27401 46-2505818	FUNDING	NC	501(C)(3)	12.b	MC PARENT	Yes	
1200 North Elm Street Greensboro, NC 27401 56-2001399	FUNDING	NC	501(C)(3)	12.b	MC PARENT		No

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

(a) Name of related organization		(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
(1)	MOSES CONE PHYSICIAN SERVICES INC	p	285,723	ACCRUAL
(1)	MOSES CONE MEDICAL SERVICES INC	q	1,279,756	Accrual
(2)	MOSES CONE PHYSICIAN SERVICES INC	q	7,092,277	ACCRUAL
(3)	MOSES CONE AFFILIATED PHYSICIANS INC	q	165,653	ACCRUAL
(4)	ALAMANCE REGIONAL MEDICAL CENTER INC	q	59,418,171	ACCRUAL
(5)	ALAMANCE EXTENDED CARE INC	q	1,075,700	ACCRUAL
(6)	ALAMANCE EXTENDED CARE INC	p	30,764	ACCRUAL
(7)	ALAMANCE PHYSICIANS INC	q	1,130,964	ACCRUAL
(8)	THE MOSES H CONE MEMORIAL HOSPITAL INC	j	663,847	ACCRUAL
(9)	THE MOSES H CONE MEMORIAL HOSPITAL INC	k	2,504,397	ACCRUAL
(10)	THE MOSES H CONE MEMORIAL HOSPITAL INC	q	12,468,958	ACCRUAL
(11)	MOSES CONE MEDICAL SERVICES INC	p	162,500	ACCRUAL
(12)	ALAMANCE EXTENED CARE INC	j	120,250	ACCRUAL
(13)	ALAMANCE REGIONAL MEDICAL CENTER INC	j	2,048,315	ACCRUAL
(14)	MOSES CONE AFFILIATED PHYSICIANS INC	j	1,476,807	ACCRUAL
(15)	MOSES CONE PHYSICIAN SERVICES INC	j	16,010,736	ACCRUAL
(16)	MOSES CONE MEDICAL SERVICES INC	j	2,028,978	Accrual