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Form 990



Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

Information about Form 990 and its instructions is at [www.IRS.gov/form990](http://www.irs.gov/form990)

OMB No 1545-0047

2014

Open to Public Inspection

A For the 2014 calendar year, or tax year beginning 07-01-2014 , and ending 06-30-2015

B Check if applicable

☐ Address change

☐ Name change

☐ Initial return

☐ Final return/terminated

☐ Amended return

☐ Application pending

C Name of organization

BETHESDA HOSPITAL INC

Doing business as

Number and street (or P O box if mail is not delivered to street address)

Room/suite

619 OAK STREET - ACCOUNTING 3 WEST

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

CINCINNATI, OH 45206

F Name and address of principal officer

JOHN S PROUT

619 OAK STREET - ACCOUNTING 3 WEST

CINCINNATI, OH 45206

H(a) Is this a group return for subordinates?

☐ Yes

☒ No

H(b) Are all subordinates included?

☐ Yes

☐ No

If "No," attach a list (see instructions)

H(c) Group exemption number

I Tax-exempt status

☒ 501(c)(3)

☐ 501(c) ()

☐ (insert no)

☐ 4947(a)(1) or

☐ 527

J Website: WWW.TRIHEALTH.COM

K Form of organization

☒ Corporation

☐ Trust

☐ Association

☐ Other

L Year of formation 1896

M State of legal domicile OH

Part I	Summary																																									
Activities & Governance	<div><div>1</div><div>Briefly describe the organization's mission or most significant activities</div><div>TO IMPROVE THE HEALTH STATUS OF THE PEOPLE WE SERVE</div><div></div><div></div><div></div></div>																																									
	<div><div>2</div><div>Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets</div></div>																																									
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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

BRIAN KRAUSE VP FINANCE

Type or print name and title

2016-05-12

Date

Print/Type preparer's name

Preparer's signature

Date

Check ☐ if self-employed

PTIN P00961884

Firm's name BKD LLP

Firm's EIN 44-0160260

Phone no (513) 621-8300

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 (2014)

Part III

Statement of Program Service Accomplishments

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

1

Briefly describe the organization's mission

TO IMPROVE THE HEALTH STATUS OF THE PEOPLE WE SERVE THIS IS ACCOMPLISHED BY PROVIDING A FULL RANGE OF HEALTH RELATED SERVICES INCLUDING PREVENTION, WELLNESS AND EDUCATION

2

Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ?

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?

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 \$ 389,071,337 including grants of \$ 1,225,741) (Revenue \$ 523,399,218)

SEE SCHEDULE H

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 389,071,337

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 Yes	
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 Yes	
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 Yes	
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 Yes	
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	

Part IV

Checklist of Required Schedules (continued)

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? <i>If "Yes," complete Schedule I, Parts I and II</i>	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? <i>If "Yes," complete Schedule I, Parts I and III</i>	22		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>	24a		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		No
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	Yes	
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 Compliance

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

		Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable.	406	
1b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable.	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
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return.	2a	4,555
b. If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions).		2b	Yes
3a. Did the organization have unrelated business gross income of \$1,000 or more during the year?		3a	Yes
b. If "Yes," has it filed a Form 990-T for this year? <i>If "No" to line 3b, provide an explanation in Schedule O.</i>		3b	Yes
4a. At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?		4a	No
b. If "Yes," enter the name of the foreign country: See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).			
5a. Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		5a	No
b. Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		5b	No
c. If "Yes," to line 5a or 5b, did the organization file Form 8886-T?		5c	
6a. Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?		6a	No
b. If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		6b	
7. Organizations that may receive deductible contributions under section 170(c).			
a. Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?		7a	No
b. If "Yes," did the organization notify the donor of the value of the goods or services provided?		7b	
c. Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		7c	No
d. If "Yes," indicate the number of Forms 8282 filed during the year.		7d	
e. Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		7e	No
f. Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		7f	No
g. If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		7g	
h. If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		7h	
8. Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?		8	
9a. Did the sponsoring organization make any taxable distributions under section 4966?		9a	
b. Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?		9b	
10. Section 501(c)(7) organizations. Enter			
a. Initiation fees and capital contributions included on Part VIII, line 12.		10a	
b. Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities.		10b	
11. Section 501(c)(12) organizations. Enter			
a. Gross income from members or shareholders.		11a	
b. Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them).		11b	
12a. Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?		12a	
b. If "Yes," enter the amount of tax-exempt interest received or accrued during the year.		12b	
13. Section 501(c)(29) qualified nonprofit health insurance issuers.			
a. Is the organization licensed to issue qualified health plans in more than one state? Note. See the instructions for additional information the organization must report on Schedule O.		13a	
b. Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans.		13b	
c. Enter the amount of reserves on hand.		13c	
14a. Did the organization receive any payments for indoor tanning services during the tax year?		14a	No
b. If "Yes," has it filed a Form 720 to report these payments? <i>If "No," provide an explanation in Schedule O.</i>		14b	

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	12	
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			
1b	Enter the number of voting members included in line 1a, above, who are independent	8	
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	Yes
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	No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4	No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5	No
6	Did the organization have members or stockholders?	6	Yes
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a	Yes
7b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b	Yes
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following		
8a	The governing body?	8a	Yes
8b	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
10b	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	No
	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
12b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	Yes
12c	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?		
15a	The organization's CEO, Executive Director, or top management official	15a	Yes
15b	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
16b	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	No

Section C. Disclosure

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

18 Section 6104 requires an organization to make its Form 1023 (or 1024 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
BRIAN KRAUSE - VP FINANCE
619 OAK STREET - ACCOUNTING 3 WEST
CINCINNATI, OH 45206 (513) 569-5126

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

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

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

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

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

[illegible]

Part VII

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			

1b	Sub-Total			
c	Total from continuation sheets to Part VII, Section A			
d	Total (add lines 1b and 1c)	1,202,303	8,708,225	2,272,668

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization143

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
CATHOLIC HEALTH INITIATIVES 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112	CLINICAL ENGINEERING	6,018,840
AMERICAN NURSING CARE INC 1700 EDISON DRIVE SUITE 300 MILFORD, OH 45150	NURSE STAFFING	3,196,219
PATIENT TRANSPORT SERVICES INC 1700 EDISON DRIVE SUITE 300 MILFORD, OH 45150	PATIENT TRANSPORTATION	1,963,325
TRISTATE HEALTH CARE LAUNDRY 551 S LOOP RD EDGEWOOD, KY 41017	LAUNDRY SERVICES	1,621,597
PATHOLOGY ASSOCIATES MEDICAL LABS PO BOX 2720 SPOKANE, WA 99220	LABORATORY	1,598,718

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization49

Part VIII

Statement of Revenue

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514		
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns 1a	2,930,349					
	b	Membership dues 1b						
	c	Fundraising events 1c						
	d	Related organizations 1d					2,930,349	
	e	Government grants (contributions) 1e						
	f	All other contributions, gifts, grants, and similar amounts not included above 1f						
	g	Noncash contributions included in lines 1a-1f \$						
	h	Total. Add lines 1a-1f					2,930,349	
Program Service Revenue	2a PATIENT REVENUE		Business Code	535,231,284	533,668,496	1,562,788		
			621990					
	b JV REVENUE		900099	1,775,651	1,775,651			
	c AFFILIATED ORG RENTAL		532000	721,522			721,522	
	d MEDICAL RESEARCH		900099	444,127	444,127			
	e JOA REVENUE		900099	-15,592,358	-15,592,358			
	f All other program service revenue			312,267	312,267			
	g Total. Add lines 2a-2f		522,892,493					
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts)		5,762,866		39,473	5,723,393	
	4	Income from investment of tax-exempt bond proceeds						
	5	Royalties						
	6a	(i) Real		648,701			648,701	
		(ii) Personal						
		648,701						
		0						
	b	Less rental expenses						
	c	Rental income or (loss)						
	d	Net rental income or (loss)						
	7a	(i) Securities		8,596,064			8,596,064	
		(ii) Other						
		324,150,271						417,476
		315,920,798						50,885
	b	Less cost or other basis and sales expenses						
	c	Gain or (loss)						
	d	Net gain or (loss)						
	8a	Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18						
	a							
	b	Less direct expenses b						
	c	Net income or (loss) from fundraising events						
	9a	Gross income from gaming activities See Part IV, line 19						
	a							
	b	Less direct expenses b						
	c	Net income or (loss) from gaming activities						
	10a	Gross sales of inventory, less returns and allowances		241,749	241,749			
	a							
	b	Less cost of goods sold b						836,769
	c	Net income or (loss) from sales of inventory						595,020
	Miscellaneous Revenue		Business Code					
	11a	APOTHECARY		621990	6,097,466		2,480,922	3,616,544
	b	CAFETERIA		900099	2,181,126			2,181,126
	c	EHR MEANINGFUL USE		900099	1,445,948	1,445,948		
	d	All other revenue			1,103,338	1,103,338		
	e	Total. Add lines 11a-11d		10,827,878				
	12	Total revenue. See Instructions		551,900,100	523,399,218	4,083,183		21,487,350

Part IX

Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.		(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1	Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21	1,225,741	1,225,741		
2	Grants and other assistance to domestic individuals See Part IV, line 22				
3	Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, lines 15 and 16				
4	Benefits paid to or for members				
5	Compensation of current officers, directors, trustees, and key employees	4,152,765		4,152,765	
6	Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7	Other salaries and wages	193,599,523	160,051,009	33,548,514	
8	Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	6,793,747	3,467,423	3,326,324	
9	Other employee benefits	28,346,360	21,553,814	6,792,546	
10	Payroll taxes	14,447,335	11,670,475	2,776,860	
11	Fees for services (non-employees)				
a	Management	2,141,822	2,141,822		
b	Legal	2,095,328		2,095,328	
c	Accounting	325,234	2,250	322,984	
d	Lobbying				
e	Professional fundraising services See Part IV, line 17				
f	Investment management fees	934,458		934,458	
g	Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	26,015,830	20,436,461	5,579,369	
12	Advertising and promotion	4,014,282	49,162	3,965,120	
13	Office expenses	6,827,547	4,251,610	2,575,937	
14	Information technology	9,357,232	968,034	8,389,198	
15	Royalties				
16	Occupancy	13,735,117	11,814,942	1,920,175	
17	Travel	753,049	355,420	397,629	
18	Payments of travel or entertainment expenses for any federal, state, or local public officials				
19	Conferences, conventions, and meetings	417,898	223,611	194,287	
20	Interest	8,350,851	8,350,851		
21	Payments to affiliates				
22	Depreciation, depletion, and amortization	31,917,261	21,385,376	10,531,885	
23	Insurance	4,907,348	3,588,052	1,319,296	
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/DIETARY SUPPLY	98,362,391	98,074,737	287,654	
b	EQUIPMENT & REPAIRS	9,161,638	8,701,787	459,851	
c	OHIO HOSPITAL FEE	8,204,055	8,204,055		
d	OVERHEAD ALLOCATION	722,960	722,960		
e	All other expenses	3,496,863	1,831,745	1,665,118	
25	Total functional expenses. Add lines 1 through 24e	480,306,635	389,071,337	91,235,298	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 Sheet

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

				(A)		(B)
				Beginning of year		End of year
Assets	1	Cash—non-interest-bearing			1	
	2	Savings and temporary cash investments			2	
	3	Pledges and grants receivable, net			3	
	4	Accounts receivable, net		51,153,337	4	60,792,085
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L			5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L			6	
	7	Notes and loans receivable, net			7	
	8	Inventories for sale or use		2,582,531	8	3,037,754
	9	Prepaid expenses and deferred charges		1,906,667	9	1,906,667
	10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	10a	550,072,043		
	b	Less accumulated depreciation	10b	333,146,201	220,247,779	10c 216,925,842
	11	Investments—publicly traded securities		240,070,922	11	290,801,117
	12	Investments—other securities See Part IV, line 11		116,591,438	12	61,953,595
	13	Investments—program-related See Part IV, line 11		116,034,123	13	110,651,063
	14	Intangible assets		21,688,933	14	21,383,580
	15	Other assets See Part IV, line 11		22,519,094	15	20,010,565
	16	Total assets. Add lines 1 through 15 (must equal line 34)		792,794,824	16	787,462,268
Liabilities	17	Accounts payable and accrued expenses		41,994,678	17	45,835,986
	18	Grants payable			18	
	19	Deferred revenue		1,579,971	19	518,523
	20	Tax-exempt bond liabilities			20	
	21	Escrow or custodial account liability Complete Part IV of Schedule D			21	
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L			22	
	23	Secured mortgages and notes payable to unrelated third parties		198,336,915	23	188,333,156
	24	Unsecured notes and loans payable to unrelated third parties			24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24) Complete Part X of Schedule D		82,263,621	25	86,054,470
	26	Total liabilities. Add lines 17 through 25		324,175,185	26	320,742,135
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		455,869,344	27	454,303,569
	28	Temporarily restricted net assets		12,750,295	28	12,416,564
	29	Permanently restricted net assets			29	
	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		468,619,639	33	466,720,133
	34	Total liabilities and net assets/fund balances		792,794,824	34	787,462,268

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	551,900,100
2	Total expenses (must equal Part IX, column (A), line 25)	2	480,306,635
3	Revenue less expenses Subtract line 2 from line 1	3	71,593,465
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	468,619,639
5	Net unrealized gains (losses) on investments	5	-14,917,323
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	2,112,823
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-60,688,471
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	466,720,133

Part XII Financial Statements and Reporting

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

		Yes	No
1	Accounting method used to prepare the Form 990 <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	2a	No
2b	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	2b	Yes
2c	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	2c	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?	3a	No
3b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits	3b	

Additional Data

Software ID:

Software Version:

EIN: 31-0537122

Name: BETHESDA HOSPITAL INC

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			
(1) MICHAEL HAVERKAMP TRUSTEE	1 00 3 00	X						0	0	0
(1) JOHN PROUT CEO	15 00 45 00	X		X				0	1,899,621	469,213
(2) PAUL EDGETT III TRUSTEE	1 00 3 00	X						0	0	0
(3) MYRTIS POWELL TRUSTEE	1 00 3 00	X						0	0	0
(4) SR SALLY DUFFY TRUSTEE	1 00 3 00	X						0	0	0
(5) MICHAEL MCGRAW CHAIRMAN	1 00 3 00	X		X				0	0	0
(6) JOANN LOHR MD MED STAFF PRES-GOOD SAM	3 00 18 00	X						0	72,462	1,919
(7) ALAN ALTMAN MD MED STAFF PRES-BETHESDA	8 00 3 00	X						45,000	634,627	92,671
(8) CRAIG EISENTROUT MD TRUSTEE	1 00 3 00	X						0	513,309	48,728
(9) WAYNE SHIRCLIFF VICE CHAIRMAN/TREASURER	1 00 3 00	X		X				0	0	0
(10) RALPH S MICHAEL TRUSTEE	1 00 3 00	X						0	0	0
(11) ELLEN KATZ TRUSTEE (START 11/14)	1 00 3 00	X						0	0	0
(12) DONNA NIENABER ESQ SVP CORP COUNSEL/ASST SECR	15 00 45 00			X				0	559,897	164,078
(13) CRAIG RUCKER ASST TREASURER (END 8/14)	15 00 45 00			X				0	552,575	105,712
(14) MICHAEL CROFTON CFO/ASST TREASURER (START 9/14)	15 00 45 00			X				0	459,900	112,333
(15) MARK CLEMENT PRESIDENT (START 5/15)	15 00 45 00			X				0	0	0
(16) WILLIAM GRONEMAN EXEC VP SYSTEM DEVELOPMENT	15 00 45 00				X			0	655,598	194,358
(17) GERALD OLIPHANT EXEC VP & COO	15 00 45 00				X			0	722,085	162,794
(18) GEORGES FEGHALI MD CHIEF MEDICAL OFFICER (END 12/14)	15 00 45 00				X			0	650,293	186,696
(19) JOHN ROBINSON MD SVP-HOSPITAL OPERATIONS	25 00 35 00				X			0	425,790	104,283
(20) BARB BOYNE EXEC DIRECTOR-BETHESDA NORTH	60 00 0 00				X			0	239,666	95,585
(21) ROBERT COLLINS MD CHIEF MEDICAL OFFICER (START 1/15)	15 00 45 00				X			0	427,574	109,307
(22) CHARLES BROWN EXEC DIRECTOR-BETHESDA BUTLER	60 00 0 00				X			0	168,444	9,229
(23) RAYMOND HELLMANN MD PHYSICIAN	60 00 0 00					X		265,479	0	71,866
(24) RICHARD OKRAGLY MD PHYSICIAN	60 00 0 00					X		211,787	0	42,294

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			
(26) SAKUNTHALA NATARAJAN MD PHYSICIAN	60 00 0 00					X		240,923	0	101,232
(1) ROBERT KUNKEL MD PHYSICIAN	60 00 0 00					X		232,053	0	61,656
(2) LORRAINE STEPHENS MD PHYSICIAN	60 00 0 00					X		207,061	0	58,172
(3) SHER MCCLANAHAN FORMER	0 00 60 00						X	0	726,384	80,542

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.
▶ Information about Schedule A (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2014

Open to Public
Inspection

Name of the organization BETHESDA HOSPITAL INC	Employer identification number 31-0537122
---	--

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 11, 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)
- 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 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)
- 10

☐

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

☐

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 11a through 11d that describes the type of supporting organization and complete lines 11e, 11f, and 11g
- 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- 9 above or IRC section (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) and 170(b)(1)(A)(vi)
(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support						
Calendar year (or fiscal year beginning in) ▶	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 Public support. Subtract line 5 from line 4						

Section B. Total Support						
Calendar year (or fiscal year beginning in) ▶	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI)						
11 Total support Add lines 7 through 10						
12 Gross receipts from related activities, etc (see instructions)					12	
13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here						▶

Section C. Computation of Public Support Percentage						
14 Public support percentage for 2014 (line 6, column (f) divided by line 11, column (f))		14				
15 Public support percentage for 2013 Schedule A, Part II, line 14		15				
16a 33 1/3% support test—2014. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization						▶
b 33 1/3% support test—2013. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization						▶
17a 10%-facts-and-circumstances test—2014. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization						▶
b 10%-facts-and-circumstances test—2013. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization						▶
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions						▶

Part IIISupport Schedule for Organizations Described in Section 509(a)(2)
(Complete only if you checked the box on line 9 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) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(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) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(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 2014 (line 8, column (f) divided by line 13, column (f))	15	
16 Public support percentage from 2013 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage		
17 Investment income percentage for 2014 (line 10c, column (f) divided by line 13, column (f))	17	
18 Investment income percentage from 2013 Schedule A, Part III, line 17	18	
19a 33 1/3% support tests—2014. 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—2013. 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 11 of Part I. If you checked 11a of Part I, complete Sections A and B. If you checked 11b of Part I, complete Sections A and C. If you checked 11c of Part I, complete Sections A, D, and E. If you checked 11d of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

	Yes	No
1 Are all of the organization's supported organizations listed by name in the organization's governing documents? If "No," describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.	1	
2 Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).	2	
3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? If "Yes," answer (b) and (c) below.	3a	
b Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? If "Yes," describe in Part VI when and how the organization made the determination.	3b	
c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? If "Yes," explain in Part VI what controls the organization put in place to ensure such use.	3c	
4a Was any supported organization not organized in the United States ("foreign supported organization")? If "Yes" and if you checked 11a or 11b in Part I, answer (b) and (c) below.	4a	
b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations. . . .	4b	
c Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.	4c	
5a Did the organization add, substitute, or remove any supported organizations during the tax year? If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in Part VI, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed, (ii) the reasons for each such action, (iii) the authority under the organization's organizing document authorizing such action, and (iv) how the action was accomplished (such as by amendment to the organizing document).	5a	
b Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document?	5b	
c Substitutions only. Was the substitution the result of an event beyond the organization's control?	5c	
6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (a) its supported organizations, (b) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (c) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? If "Yes," provide detail in Part VI .	6	
7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in IRC 4958(c)(3)(C)), a family member of a substantial contributor, or a 35-percent controlled entity with regard to a substantial contributor? If "Yes," complete Part I of Schedule L (Form 990) .	7	
8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? If "Yes," complete Part II of Schedule L (Form 990).	8	
9a Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? If "Yes," provide detail in Part VI .	9a	
b Did one or more disqualified persons (as defined in line 9(a)) hold a controlling interest in any entity in which the supporting organization had an interest? If "Yes," provide detail in Part VI .	9b	
c Did a disqualified person (as defined in line 9(a)) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? If "Yes," provide detail in Part VI .	9c	
10a Was the organization subject to the excess business holdings rules of IRC 4943 because of IRC 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? If "Yes," answer b below.	10a	
b Did the organization have any excess business holdings in the tax year? (Use Schedule C, Form 4720, to determine whether the organization had excess business holdings).	10b	
11 Has the organization accepted a gift or contribution from any of the following persons?		
a A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization?	11a	
b A family member of a person described in (a) above?	11b	
c A 35% controlled entity of a person described in (a) or (b) above? If "Yes" to a, b, or c, provide detail in Part VI.	11c	

Part IV

Supporting Organizations (continued)

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.		
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.		

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).		

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, (1) a written notice describing the type and amount of support provided during the prior tax year, (2) a copy of the Form 990 that was most recently filed as of the date of notification, and (3) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?		
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).		
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.		

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 <u>Activities Test</u> Answer (a) and (b) below.		Yes	No
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 <u>Parent of Supported Organizations</u> Answer (a) and (b) below.			
a Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? Provide details in Part VI.	3a		
b Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? If "Yes," describe in Part VI the role played by the organization in this regard.	3b		

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

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

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

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

Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1	
2	Enter 85% of line 1	2	
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3	
4	Enter greater of line 2 or line 3	4	
5	Income tax imposed in prior year	5	
6	Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	
7	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)		

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 2014 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-2014	(iii) Distributable Amount for 2014
1 Distributable amount for 2014 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2014 (reasonable cause required--see instructions)			
3 Excess distributions carryover, if any, to 2014			
a From 2009.			
b From 2010.			
c From 2011.			
d From 2012.			
e From 2013.			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2014 distributable amount			
i Carryover from 2009 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2014 from Section D, line 7 \$			
a Applied to underdistributions of prior years			
b Applied to 2014 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2014, if any Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions)			
6 Remaining underdistributions for 2014 Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions)			
7 Excess distributions carryover to 2015. Add lines 3j and 4c			
8 Breakdown of line 7			
a From 2010.			
b From 2011.			
c From 2012.			
d From 2013.			
e From 2014.			

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

Return Reference

Explanation

SCHEDULE C

(Form 990 or 990-EZ)

Department of the Treasury

Internal Revenue Service

Political Campaign and Lobbying Activities

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

▶ **Complete if the organization is described below. ▶ Attach to Form 990 or Form 990-EZ.**

▶ **Information about Schedule C (Form 990 or 990-EZ) and its instructions is at**

www.irs.gov/form990.

OMB No 1545-0047

2014

Open to Public Inspection

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

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

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

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

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

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

Name of the organization BETHESDA HOSPITAL INC	Employer identification number 31-0537122
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Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

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

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

1	Enter the amount of any excise tax incurred by the organization under section 4955	▶ \$
2	Enter the amount of any excise tax incurred by organization managers under section 4955	▶ \$
3	If the organization incurred a section 4955 tax, did it file Form 4720 for this year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4a	Was a correction made?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b	If "Yes," describe in Part IV	

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

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

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

Part II-A

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

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

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

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

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

Part II-B

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

For each "Yes" response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.		(a)		(b)
		Yes	No	Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
a	Volunteers?		No	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
c	Media advertisements?		No	
d	Mailings to members, legislators, or the public?		No	
e	Publications, or published or broadcast statements?		No	
f	Grants to other organizations for lobbying purposes?		No	
g	Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?	Yes		13,402
j	Total. Add lines 1c through 1i.			13,402
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

Part III-A

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

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

Part III-B

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

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

Part IV

Supplemental Information

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

Return Reference	Explanation
PART II-B, LINE 1	DURING THE TAX YEAR, BETHESDA HOSPITAL, INC ("HOSPITAL") PAID ANNUAL MEMBERSHIP DUES TO VARIOUS NATIONAL, STATE AND LOCAL ORGANIZATIONS, A PORTION (\$4,049) OF WHICH RELATED TO LOBBYING ACTIVITIES. IN ADDITION, TRIHEALTH, INC , A RELATED ORGANIZATION OF HOSPITAL, WHICH PROVIDES ADMINISTRATIVE SUPPORT SERVICES TO HOSPITAL, PAID ANNUAL MEMBERSHIP DUES TO VARIOUS NATIONAL, STATE AND LOCAL ORGANIZATIONS A PORTION OF WHICH RELATED TO LOBBYING ACTIVITIES. A PORTION OF THE AFOREMENTIONED ADMINISTRATIVE SUPPORT SERVICES ARE ALLOCATED TO HOSPITAL AND \$9,353 OF THE AMOUNT SHOWN ON LINE 1I REPRESENTS HOSPITAL'S SHARE OF THESE LOBBYING EXPENSES.

Part IV

Return Reference

Explanation

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

► Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
► Attach to Form 990.
Information about Schedule D (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization BETHESDA HOSPITAL INC	Employer identification number 31-0537122
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Part I

Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" to 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? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>	
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? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>	

Part II

Conservation Easements. Complete if the organization answered "Yes" to 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
b	Total acreage restricted by conservation easements
c	Number of conservation easements on a certified historic structure included in (a)
d	Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register

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, and enforcing conservation easements during the year ► _____

7

Amount of expenses incurred in monitoring, inspecting, 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" to 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 in 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 in Form 990, Part VIII, line 1

► \$ _____

b

Assets included in Form 990, Part X

► \$ _____

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

- 3

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

☐ Public exhibition

b

☐ Scholarly research

c

☐ Preservation for future generations

d

☐ Loan or exchange programs

e

☐ Other
- 4

Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII
- 5

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

☐ Yes

☐ No

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

- 1a

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

☐ Yes

☐ No
- b

If "Yes," explain the arrangement in Part XIII and complete the following table
- | | |
|----|--------|
| | Amount |
| 1c | |
| 1d | |
| 1e | |
| 1f | |

c

Beginning balance

d

Additions during the year

e

Distributions during the year

f

Ending balance
- 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" to Form 990, Part IV, line 10.

	(a)Current year	(b)Prior year	b (c)Two years back	(d)Three years back	(e)Four years back
1a Beginning of year balance	4,097,830	3,958,314	3,566,136	3,799,868	3,112,953
b Contributions			716	1,251	79,856
c Net investment earnings, gains, and losses	-131,484	285,534	415,730	-156,863	607,059
d Grants or scholarships					
e Other expenditures for facilities and programs	342,211	146,018	24,268	78,120	
f Administrative expenses					
g End of year balance	3,624,135	4,097,830	3,958,314	3,566,136	3,799,868

- 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

87 000 %

c

Temporarily restricted endowment

13 000 %

The percentages in 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

3a(i)

☐ Yes

☒ No

(ii) related organizations

3a(ii)

☒ Yes

☐

b

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

3b

☒ Yes

☐

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' to 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 | | 957,693 | | 957,693 |
| b Buildings | | 310,236,855 | 142,447,302 | 167,789,553 |
| c Leasehold improvements | | 1,951,479 | 1,545,204 | 406,275 |
| d Equipment | | 220,404,858 | 187,191,038 | 33,213,820 |
| e Other | | 16,521,158 | 1,962,657 | 14,558,501 |
| Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c).) | | | | 216,925,842 |
- Schedule D (Form 990) 2014

Part VII

Investments—Other Securities.

Complete if the organization answered 'Yes' to 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) PRIVATE EQUITY	10,891,057	F
(B) HEDGE FUNDS	16,006,737	F
(C) REAL ESTATE	26,355,627	F
(D) PRIVATE DEBT	8,700,174	F
Total. (Column (b) must equal Form 990, Part X, col (B) line 12)	61,953,595	

Part VIII

Investments—Program Related.

Complete if the organization answered 'Yes' to 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) INVESTMENT IN JOINT VENTURES	110,651,063	C
Total. (Column (b) must equal Form 990, Part X, col (B) line 13)	110,651,063	

Part IX

Other Assets.

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

(a) Description	(b) Book value
Total. (Column (b) must equal Form 990, Part X, col.(B) line 15.)

Part X

Other Liabilities.

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

1 (a) Description of liability	(b) Book value	
Federal income taxes		
THIRD PARTY SETTLEMENTS	3,934,681	
PENSION LIABILITY	7,907,347	
ACCRUED EIB	6,512,991	
MALPRACTICE INSURANCE/WORKERS COMPENATION LIABILITY	22,202,994	
ENVIRONMENTAL REMEDIATION LIABILITY	2,992,783	
DUE TO RELATED ORGANIZATIONS	42,503,674	
Total. (Column (b) must equal Form 990, Part X, col (B) line 25)	86,054,470	

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' to Form 990, Part IV, line 12a.

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

Part XII

Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.

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

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

Part XIII

Supplemental Information

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

Return Reference	Explanation
PART V, LINE 4	INVESTMENT PROCEEDS FROM ENDOWMENT FUNDS ARE USED TO SUPPORT BETHESDA HOSPITAL, INC PROGRAMS
PART X, LINE 2	THE FINANCIAL STATEMENTS OF BETHESDA HOSPITAL, INC ARE AUDITED AS PART OF TRIHEALTH AND ITS SUBSIDIARIES AND AFFILIATES ("TRIHEALTH") FOLLOWING IS THE TEXT OF THE FOOTNOTE TO THE AUDITED COMBINED FINANCIAL STATEMENTS OF TRIHEALTH THAT REPORTS ITS AND ITS SUBSIDIARIES AND AFFILIATES LIABILITY, IF APPLICABLE, FOR UNCERTAIN TAX POSITIONS UNDER ASC 740-10-25 TRIHEALTH PERFORMED AN ANALYSIS OF UNCERTAIN TAX POSITIONS IN ACCORDANCE WITH APPLICABLE ACCOUNTING GUIDANCE AT JUNE 30, 2015 AND 2014, AND DETERMINED NO AMOUNTS WERE REQUIRED TO BE RECOGNIZED IN THE COMBINED FINANCIAL STATEMENTS AT EITHER DATE IN ADDITION, THE FINANCIAL STATEMENTS OF BETHESDA HOSPITAL, INC ARE AUDITED AS PART OF ITS PARENT, BETHESDA, INC FOLLOWING IS THE TEXT OF THE FOOTNOTE TO THE AUDITED CONSOLIDATED FINANCIAL STATEMENTS OF BETHESDA, INC ("COMPANY") THAT REPORTS ITS AND ITS SUBSIDIARIES LIABILITY, IF APPLICABLE, FOR UNCERTAIN TAX POSITIONS UNDER ASC 740-10-25 THE COMPANY COMPLETED AN ANALYSIS OF UNCERTAIN TAX POSITIONS IN ACCORDANCE WITH APPLICABLE ACCOUNTING GUIDANCE AT JUNE 30, 2015 AND 2014, AND DETERMINED NO AMOUNTS WERE REQUIRED TO BE RECOGNIZED IN THE CONSOLIDATED FINANCIAL STATEMENTS AT JUNE 30, 2015 AND 2014

[illegible]

SCHEDULE H
(Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

► Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
► Attach to Form 990.
► Information about Schedule H (Form 990) and its instructions is at *www.irs.gov/form990*.

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization
BETHESDA HOSPITAL INC

Employer identification number
31-0537122

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 <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for <i>free</i> care <input checked="" type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input type="checkbox"/> Other _____ % b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input checked="" type="checkbox"/> 400% <input type="checkbox"/> Other _____ % 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	3a	Yes	
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	Yes	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	Yes	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		No
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		
6a	Did the organization prepare a community benefit report during the tax year?	6a	Yes	
b	If "Yes," did the organization make it available to the public?	6b	Yes	
	Complete the following table using the worksheets provided in the Schedule H instructions Do not submit these worksheets with the Schedule H			

7

Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			7,975,850	6,325,634	1,650,216	0 340 %
b Medicaid (from Worksheet 3, column a)			70,543,475	46,132,758	24,410,717	5 080 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			78,519,325	52,458,392	26,060,933	5 420 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			2,760,532	1,507,435	1,253,097	0 260 %
f Health professions education (from Worksheet 5)			8,473,260	6,507,855	1,965,405	0 410 %
g Subsidized health services (from Worksheet 6)			179,856	137,343	42,513	0 010 %
h Research (from Worksheet 7)			871,623	0	871,623	0 180 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)			135,000	0	135,000	0 030 %
j Total Other Benefits			12,420,271	8,152,633	4,267,638	0 890 %
k Total . Add lines 7d and 7j			90,939,596	60,611,025	30,328,571	6 310 %

Part IICommunity 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
1Physical improvements and housing						
2Economic development						
3Community support						
4Environmental improvements						
5Leadership development and training for community members						
6Coalition building						
7Community health improvement advocacy						
8Workforce development						
9Other						
10Total						

Part IIIBad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

1Did the organization report bad debt expense in accordance with Heathcare Financial Management Association Statement No 15?

1

No

2Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.

2

30,111,447

3Enter 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

0

4Provide 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

5Enter total revenue received from Medicare (including DSH and IME).

5

101,195,586

6Enter Medicare allowable costs of care relating to payments on line 5.

6

104,112,903

7Subtract line 6 from line 5. This is the surplus (or shortfall).

7

-2,917,317

8Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used.

☐ Cost accounting system

☒ Cost to charge ratio

☐ Other

Section C. Collection Practices

9aDid the organization have a written debt collection policy during the tax year?

9a

Yes

bIf "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 IVManagement 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				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

Part V

Facility Information

Section A. Hospital Facilities

(list in order of size from largest to smallest—see instructions)
How many hospital facilities did the organization operate during the tax year?

2
Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)

		Licensed hospital	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)

BETHESDA NORTH HOSPITAL

Name of hospital facility or letter of facility reporting group

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

1

	Yes	No
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 type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA 20 12		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	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) WWW.TRIHEALTH.COM		
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 12		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	No
a If "Yes" (list url)		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	Yes
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" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V

Facility Information (continued)

Name of hospital facility or letter of facility reporting group

BETHESDA NORTH HOSPITAL

		Yes	No
Financial Assistance Policy (FAP)			
13	Did the hospital facility have in place during the tax year a written financial assistance policy that 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 <u>100 000000000000</u> % and FPG family income limit for eligibility for discounted care of <u>400 000000000000</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input 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 checked="" 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?	15	Yes
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)		
a	<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 type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input 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	Included measures to publicize the policy within the community served by the hospital facility?	16	Yes
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)		
a	<input type="checkbox"/> The FAP was widely available on a website (list url) _____		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>HTTP //WWW.TRIHEALTH.COM/TOOLS/PAY-YOUR-BILL/</u>		
c	<input type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>HTTP //WWW.TRIHEALTH.COM/TOOLS/PAY-YOUR-BILL/</u>		
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 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 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 type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
h	<input 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"/> Other (describe in Section C)		
Billing and Collections			
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 non-payment?	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"/> Actions that require a legal or judicial process		
d	<input type="checkbox"/> Other similar actions (describe in Section C)		
e	<input type="checkbox"/> None of these actions or other similar actions were permitted		

Part V

Facility Information (continued)

BETHESDA NORTH HOSPITAL

Name of hospital facility or letter of facility reporting group			Yes	No
19	Did the hospital facility or other authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged	19		No
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"/> Actions that require a legal or judicial process			
d	<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 18 (check all that apply)			
a	<input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission			
b	<input checked="" type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge			
c	<input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills			
d	<input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy			
e	<input 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? If "No," indicate why	21	Yes	
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)			
Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)				
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	<input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged			
b	<input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged			
c	<input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged			
d	<input checked="" type="checkbox"/> Other (describe in Section C)			
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	23		No
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	24		No

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)

BETHESDA BUTLER HOSPITAL

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):

2

	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 type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA 20 13		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	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) WWW.TRIHEALTH.COM		
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 13		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	No
a If "Yes" (list url)		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	Yes
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" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V

Facility Information (continued)

Name of hospital facility or letter of facility reporting group

BETHESDA BUTLER HOSPITAL

		Yes	No
Financial Assistance Policy (FAP)			
13	Did the hospital facility have in place during the tax year a written financial assistance policy that 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 <u>100 000000000000</u> % and FPG family income limit for eligibility for discounted care of <u>400 000000000000</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input 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 checked="" 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?	15	Yes
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)		
a	<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 type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input 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	Included measures to publicize the policy within the community served by the hospital facility?	16	Yes
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)		
a	<input type="checkbox"/> The FAP was widely available on a website (list url) _____		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>HTTP //WWW.TRIHEALTH.COM/TOOLS/PAY-YOUR-BILL/</u>		
c	<input type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>HTTP //WWW.TRIHEALTH.COM/TOOLS/PAY-YOUR-BILL/</u>		
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 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 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 type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
h	<input 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"/> Other (describe in Section C)		
Billing and Collections			
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 non-payment?	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"/> Actions that require a legal or judicial process		
d	<input type="checkbox"/> Other similar actions (describe in Section C)		
e	<input type="checkbox"/> None of these actions or other similar actions were permitted		

Part V

Facility Information (continued)

Name of hospital facility or letter of facility reporting group		BETHESDA BUTLER HOSPITAL	
		Yes	No
19	Did the hospital facility or other authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged 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"/> Actions that require a legal or judicial process d <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 18 (check all that apply) a <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission b <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge c <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills d <input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy e <input type="checkbox"/> Other (describe in Section C) f <input type="checkbox"/> None of these efforts were made	19	No
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? 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)	21	Yes
Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)			
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 <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged b <input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged c <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged d <input checked="" type="checkbox"/> Other (describe in Section C) 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	23	No
		24	No

Part V

Facility Information *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

Form and Line Reference	Explanation
See Additional Data Table	

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? **17**

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

Part VI

Supplemental Information

Provide the following information

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

Form and Line Reference	Explanation
PART I, LINE 3C	BETHESDA HOSPITAL, INC UTILIZES THE FEDERAL POVERTY GUIDELINES ("FPG") IN DETERMINING CHARITY CARE ELIGIBILITY SEE THE RESPONSES TO PART I, LINES 3A AND 3B AN INDIVIDUAL'S INCOME UNDER FPG IS A SIGNIFICANT FACTOR IN DETERMINING ELIGIBILITY FOR CHARITY CARE ADDITIONALLY, AN INDIVIDUAL'S INCOME IN RELATION TO HIS/HER MEDICAL EXPENSES IS ALSO TAKEN INTO ACCOUNT AND SUCH A PATIENT MAY BE EXTENDED DISCOUNTED OR FREE CARE BASED UPON THE FACTS AND CIRCUMSTANCES

Form and Line Reference	Explanation
PART I, LINE 6A	IN 1995, THE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO AND BETHESDA HOSPITAL, INC FORMED A PARTNERSHIP CALLED TRIHEALTH TO CREATE AN INTEGRATED HEALTH DELIVERY SYSTEM WHOSE MISSION IS TO IMPROVE THE HEALTH OF THE PEOPLE THEY SERVE, WITH AN EMPHASIS ON PREVENTION, WELLNESS AND EDUCATION THE COMMUNITY BENEFIT PROVIDED BY BETHESDA HOSPITAL, INC IS TRACKED ON A STANDALONE BASIS, HOWEVER, ITS COMMUNITY BENEFIT IS REPORTED IN A REPORT PREPARED BY TRIHEALTH IN COMBINATION WITH ITS RELATED HOSPITALS - THE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO , MCCULLOUGH-HYDE MEMORIAL HOSPITAL AND TRIHEALTH HOSPITAL, INC

Form and Line Reference	Explanation
PART I, LINE 7	FOR THE AMOUNTS REPORTED AT COST, IN PART I, LINE 7, BETHESDA HOSPITAL, INC UTILIZED WORKSHEET 2 - RATIO OF PATIENT CARE COST-TO-CHARGES, WHICH WAS PROVIDED IN THE INSTRUCTIONS TO SCHEDULE H, TO CALCULATE THE COST-TO-CHARGE RATIO

Form and Line Reference	Explanation
PART I, LINE 7G	THE SUBSIDIZED HEALTH SERVICES COMMUNITY BENEFIT AMOUNT REPORTED IN PART I, LINE 7(G) DOES NOT INCLUDE COSTS ATTRIBUTABLE TO PHYSICIAN CLINICS

Form and Line Reference	Explanation
PART I, LN 7 COL(F)	BAD DEBT EXPENSE IS NOT INCLUDED ON FORM 990, PART IX, LINE 25 IT IS PRESENTED ON FORM 990, PART VIII, LINE 2 AS A DEDUCTION FROM PATIENT SERVICE REVENUE WHICH CORRESPONDS TO ITS FINANCIAL STATEMENT PRESENTATION SEE RESPONSE TO PART III, LINE 4 THEREFORE, NO ADJUSTMENT TO TOTAL EXPENSES SHOWN ON FORM 990, PART IX, LINE 25 IS NECESSARY

Form and Line Reference	Explanation
PART II, COMMUNITY BUILDING ACTIVITIES	BETHESDA HOSPITAL, INC DID NOT ENGAGE IN ANY COMMUNITY BUILDING ACTIVITIES DURING THE TAX YEAR

Form and Line Reference	Explanation
PART III, LINE 2	SEE THE RESPONSE TO PART III, LINE 4 AS SHOWN IN PART VI - SUPPLEMENTAL INFORMATION

Form and Line Reference	Explanation
PART III, LINE 4	<p>BETHESDA HOSPITAL, INC 'S FINANCIAL STATEMENTS ARE AUDITED AS PART OF THE TRIHEALTH AUDIT REPORT NET PATIENT ACCOUNTS RECEIVABLE (PART OF FOOTNOTE B) NET PATIENT ACCOUNTS RECEIVABLE AND NET PATIENT SERVICE REVENUE HAVE BEEN ADJUSTED TO THE ESTIMATED AMOUNTS EXPECTED TO BE COLLECTED THESE ESTIMATED AMOUNTS ARE SUBJECT TO FURTHER ADJUSTMENTS UPON REVIEW BY THIRD-PARTY PAYORS THE PROVISION FOR BAD DEBTS IS BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS CONSIDERING HISTORICAL BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN HEALTH CARE COVERAGE, AND OTHER COLLECTION INDICATORS MANAGEMENT PERIODICALLY ASSESSES THE ADEQUACY OF THE ALLOWANCES FOR UNCOLLECTIBLE ACCOUNTS BASED UPON HISTORICAL WRITE-OFF EXPERIENCE THE RESULTS OF THESE REVIEWS ARE USED TO MODIFY AS NECESSARY THE PROVISIONS FOR BAD DEBTS AND TO ESTABLISH APPROPRIATE ALLOWANCES FOR UNCOLLECTIBLE NET PATIENT ACCOUNTS RECEIVABLE SIGNIFICANT PROVISION IS MADE FOR SELF-PAY PATIENT ACCOUNTS RECEIVABLE IN THE PERIOD OF SERVICE BASED UPON HISTORICAL WRITE-OFF EXPERIENCE AFTER SATISFACTION OF AMOUNTS DUE FROM INSURANCE, TRIHEALTH FOLLOWS ESTABLISHED GUIDELINES FOR PLACING CERTAIN PATIENT BALANCES WITH COLLECTION AGENCIES, SUBJECT TO THE TERMS OF CERTAIN RESTRICTIONS ON COLLECTION EFFORTS AS DETERMINED BY TRIHEALTH DUE TO OHIO BEING A MEDICAID EXPANSION STATE, TRIHEALTH HAS EXPERIENCED A DECLINE IN SELF-PAY ACCOUNTS RECEIVABLE, WHICH HAS RESULTED IN A DECLINE IN WRITE-OFFS OF UNCOLLECTIBLE ACCOUNTS SINCE JUNE 30, 2014 TRIHEALTH HAS NOT EXPERIENCED SIGNIFICANT CHANGES IN WRITE-OFF TRENDS AND HAS NOT CHANGED ITS CHARITY CARE POLICY SINCE JUNE 30, 2014 THE OVERALL ALLOWANCE PERCENTAGE FOR UNCOLLECTIBLE ACCOUNTS INCREASED FROM 35% AT JUNE 30, 2014 TO 36% AT JUNE 30, 2015 AS A RESULT OF CHANGES IN PAYOR MIX DUE TO THE AFFORDABLE CARE ACT FINANCIAL INSTRUMENTS THAT POTENTIALLY SUBJECT TRIHEALTH TO CONCENTRATIONS OF CREDIT RISK CONSIST PRIMARILY OF NON-GOVERNMENTAL PATIENT ACCOUNTS RECEIVABLE TRIHEALTH GRANTS CREDIT WITHOUT COLLATERAL TO ITS PATIENTS, MOST OF WHOM ARE INSURED UNDER THIRD-PARTY PAYOR AGREEMENTS THE PERCENTAGES OF GROSS PATIENT ACCOUNTS RECEIVABLE FROM PATIENTS AND THIRD-PARTY PAYORS AT JUNE 30 APPROXIMATED THE FOLLOWING 2015 - MEDICARE 17%, MEDICAID 2%, MANAGED CARE 34%, SELF PAY 16%, COMMERCIAL AND OTHER 31% 2014 - MEDICARE 18%, MEDICAID 4%, MANAGED CARE 26%, SELF PAY 20%, COMMERCIAL AND OTHER 32% TRIHEALTH HAS AGREEMENTS WITH THIRD-PARTY PAYORS THAT PROVIDE FOR PAYMENTS AT AMOUNTS DIFFERENT FROM ITS ESTABLISHED RATES THE BASIS FOR PAYMENT UNDER THESE AGREEMENTS INCLUDES PROSPECTIVELY DETERMINED RATES, COST REIMBURSEMENT, NEGOTIATED DISCOUNTS FROM ESTABLISHED RATES, AND PER DIEM PAYMENTS PATIENT SERVICE REVENUE IS REPORTED AT THE ESTIMATED NET REALIZABLE AMOUNTS FROM PATIENTS, THIRD-PARTY PAYORS AND OTHERS FOR SERVICES RENDERED, INCLUDING ESTIMATED RETROACTIVE ADJUSTMENTS DUE TO FUTURE AUDITS, REVIEW AND INVESTIGATIONS THE DIFFERENCES BETWEEN THE ESTIMATED AND ACTUAL ADJUSTMENTS ARE RECORDED AS PART OF NET PATIENT SERVICE REVENUE IN FUTURE PERIODS, AS THE AMOUNTS BECOME KNOWN, OR AS YEARS ARE NO LONGER SUBJECT TO SUCH AUDITS, REVIEWS AND INVESTIGATIONS TRIHEALTH RECOGNIZES A SIGNIFICANT AMOUNT OF PATIENT SERVICE REVENUE AT THE TIME THE SERVICES ARE RENDERED EVEN THOUGH IT DOES NOT ASSESS THE PATIENT'S ABILITY TO PAY AS A RESULT, THE PROVISION FOR BAD DEBT IS PRESENTED AS A DEDUCTION FROM PATIENT SERVICE REVENUE NET OF CONTRACTUAL PROVISIONS AND DISCOUNTS AS FOR THE AMOUNT OF BAD DEBT THAT REASONABLY COULD BE ATTRIBUTABLE TO PATIENTS WHO LIKELY WOULD QUALIFY FOR FINANCIAL ASSISTANCE UNDER THE ORGANIZATION'S CHARITY CARE POLICY, BETHESDA HOSPITAL, INC DOES NOT REPORT ACTUAL BAD DEBT EXPENSE AS COMMUNITY BENEFIT IF UPON FURTHER RESEARCH, IT IS ULTIMATELY DETERMINED THAT A PORTION OF BAD DEBT EXPENSE IS ATTRIBUTABLE TO PATIENTS WHO WOULD LIKELY QUALIFY FOR FINANCIAL ASSISTANCE UNDER TRIHEALTH'S CHARITY CARE POLICY, THOSE COSTS WOULD BE RECLASSIFIED, AS APPROPRIATE, TO COMMUNITY BENEFIT AT THAT TIME PLEASE NOTE THAT BAD DEBT EXPENSE IS NOT DETERMINED UNTIL AFTER ALL DISCOUNTS AND ANY ASSOCIATED PAYMENTS ARE TAKEN INTO ACCOUNT IF ANY PAYMENTS ARE RECEIVED AFTER A PATIENT ACCOUNT IS DETERMINED TO BE BAD DEBT, THE ACCOUNT WILL BE ADJUSTED ACCORDINGLY AT THAT TIME</p>

Form and Line Reference	Explanation
PART III, LINE 8	BETHESDA HOSPITAL, INC USES THE "STEPDOWN METHODOLOGY" IN DETERMINING THE MEDICARE ALLOWABLE COSTS REPORTED ON THE MEDICARE COST REPORT THIS METHOD OF COST FINDING PROVIDES FOR THE ALLOCATION OF THE COST OF SERVICES RENDERED BY EACH GENERAL SERVICE COST CENTER TO OTHER COST CENTERS WHICH UTILIZE SUCH SERVICES ONCE THE COSTS OF A GENERAL SERVICE COST CENTER HAVE BEEN ALLOCATED, THAT COST CENTER IS CONSIDERED CLOSED ONCE CLOSED, IT DOES NOT RECEIVE ANY OF THE COSTS SUBSEQUENTLY ALLOCATED FROM THE REMAINING GENERAL SERVICE COST CENTERS BETHESDA HOSPITAL, INC DID NOT REPORT ANY MEDICARE SHORTFALL AS COMMUNITY BENEFIT IN PART III, LINE 7 OF THIS SCHEDULE

Form and Line Reference	Explanation
PART III, LINE 9B	AS OF THE FILING OF THIS RETURN, BETHESDA HOSPITAL, INC , AS PART OF TRIHEALTH, INC , MAINTAINS A WRITTEN DEBT COLLECTION POLICY TRIHEALTH, INC , WHO PERFORMS THE BILLING SERVICES FOR ALL AFFILIATED HOSPITALS, WILL NOT INITIATE COLLECTION PRACTICES ON PATIENTS WHO ARE KNOWN TO QUALIFY FOR CHARITY CARE OR FINANCIAL ASSISTANCE BEFORE COLLECTION ACTIONS ARE TAKEN, TRIHEALTH, INC WILL MAKE REASONABLE EFFORTS, GENERALLY AS EARLY IN THE BILLING PROCESS AS POSSIBLE, TO DETERMINE WHETHER A PATIENT IS ELIGIBLE FOR FINANCIAL ASSISTANCE AFTER SUCH EFFORTS HAVE BEEN MADE AND A BALANCE REMAINS THAT IS THE RESPONSIBILITY OF THE PATIENT OR GUARANTOR, TRIHEALTH, INC MAY PURSUE, IN ITS SOLE DISCRETION, WHATEVER ACTIONS IT MAY BE ENTITLED TO TAKE UNDER LAW

Form and Line Reference	Explanation
PART VI, LINE 2	<p>IN 1896, BETHESDA HOSPITAL, INC ("BETHESDA") BEGAN AS A HOME VISITING MINISTRY OF THE MET HODIST DEACONESSES TO SERVE THE HEALTH NEEDS OF THE GERMAN IMMIGRANTS LIVING IN CINCINNATI NOW THAT MINISTRY, ONCE LED BY DEACONESS LOUISE GOLDER AND HER BROTHER REV CHRISTIAN GO LDER, HAS GROWN INTO SEVERAL HEALTH SERVICES FOR GREATER CINCINNATI IN 1995, BETHESDA, IN C AND GOOD SAMARITAN HOSPITAL FORMED A PARTNERSHIP TO CREATE A LOCAL HEALTH SYSTEM TRIHE ALTH, INC ("TRIHEALTH") THE MISSION OF TRIHEALTH IS TO IMPROVE THE HEALTH STATUS OF THE COMMUNITY THROUGH A FULL RANGE OF HEALTH RELATED SERVICES-PREVENTION, WELLNESS AND EDUCATI ON AND THUS EXEMPLIFY THE FOUNDING SPIRIT OF THE BETHESDA DEACONESSES THE SERVICES DESCRIB ED BELOW, AND OTHERS NOT LISTED, PROMOTE COMMUNITY HEALTH IN ACUTE ILLNESS, IN MANAGEMENT OF CHRONIC DISEASE, AND IN EDUCATION AND PREVENTION MEASURES PROGRAMS SEEK TO REDUCE THE BURDENS ON THE GOVERNMENT FOR EXAMPLE, IF BETHESDA DID NOT ADDRESS THE ROOT CAUSES OF LOW BIRTH WEIGHT AND PREMATURITY, THE BURDEN TO GOVERNMENT MEDICAL PROGRAMS SUCH AS MEDICAID WOULD BE EVEN GREATER IN 2011 AND 2012, BETHESDA, AS A PART OF TRIHEALTH, PARTICIPATED IN AND WAS A FUNDER OF THE WORK OF A COLLABORATIVE, REGIONAL EFFORT, THE A I M FOR BETTER H EALTH COMMUNITY HEALTH NEEDS ASSESSMENT ("A I M ") IN THE AREAS ASSESSED, THOSE SURVEYED WERE MORE OFTEN UNDERSERVED, INCLUDING THE UNINSURED, THE UNDERINSURED, THOSE IN LOW SOCIO ECONOMIC STATUS, MINORITIES, THOSE OVER THE AGE OF SIXTY-FIVE, OR THOSE WITH A DIAGNOSIS O F MENTAL ILLNESS THE A I M , PUBLISHED IN THE SPRING OF 2012, WAS THE BASIS FOR BETHESDA' S COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION PLAN ADOPTED IN FISCAL YEAR 2013 FREE AND DISCOUNTED SERVICES ARE PROVIDED FOR THOSE UNABLE TO PAY AND MEETING ELIGIBILITY C RITERIA THROUGH THE HOSPITAL CARE ASSURANCE PROGRAM (HCAP), BETHESDA SERVES PATIENTS MEET ING CRITERIA SET FORTH BY THE OHIO DEPARTMENT OF JOBS AND FAMILY SERVICES BETHESDA POLICY IS TO PROVIDE CHARITY CARE ON A SLIDING SCALE DISCOUNTING WHEN THE FAMILY INCOME IS UP TO 400 PERCENT OF THE ANNUALLY ESTABLISHED FEDERAL POVERTY GUIDELINE IT OFFERS AN UNINSURED DISCOUNT FOR MEDICALLY NECESSARY SERVICES FOR THOSE WHO HAVE NO INSURANCE AND WHO DO NOT QUALIFY FOR OTHER FINANCIAL ASSISTANCE OPTIONS FINANCIAL COUNSELORS ASSIST PATIENTS IN CO MPLETING THE FINANCIAL ASSISTANCE APPLICATION WHICH IS AVAILABLE ON TRIHEALTH'S WEBSITE AN D BROCHURES ABOUT FINANCIAL ASSISTANCE ARE VISIBLE AND AVAILABLE IN HOSPITAL REGISTRATION AND ADMITTING AREAS DURING THE YEAR, BETHESDA PROVIDED COMMUNITY BENEFIT (INCLUDING UNCOMP ENSATED CARE) AS SHOWN ON PART I, LINE 7 THE AMOUNT OF BENEFIT FOR BOTH TRADITIONAL CHARI TY CARE AND FOR THE UNPAID COST OF MEDICAID IS ONE MANIFESTATION OF THE RISING RATES OF PE RSONS WITHOUT HEALTH INSURANCE THE MEDICAID PUBLIC PROGRAM REIMBURSES HOSPITALS FOR SERVI CES BUT PAYMENTS MAY NOT ALWAYS COVER THE TOTAL COST OF CARE AND MEDICATIONS THE UNPAID C OST OF MEDICARE IS NOT INCLUDED IN TOTAL COMMUNITY BENEFIT BETHESDA IS COMMITTED TO FULFI LLING THE MISSION OF COMPASSION TO THE VULNERABLE MEMBERS OF THE COMMUNITIES THEY SERVE BE THESDA PARTICIPATES IN THE REGIONAL TRAUMA SYSTEM THUS PROVIDING THE COMMUNITY WITH ACCESS TO TRAUMA CARE THE TWO EMERGENCY ROOMS OF BETHESDA PROVIDE 24-HOUR EMERGENCY CARE TO COM MUNITY MEMBERS LIVING IN THE NORTHEAST CORRIDOR OF CINCINNATI AS WELL AS WARREN, BUTLER, A ND CLERMONT COUNTIES BETHESDA IS A LEVEL III TRAUMA CENTER AS VERIFIED BY THE COMMITTEE O N TRAUMA OF THE AMERICAN COLLEGE OF SURGEONS ONE EXAMPLE OF ONGOING EFFORTS BY BETHESDA T O IMPROVE THE HEALTH OF THE BROADER COMMUNITY ARE PROGRAMS TO ADDRESS THE IDENTIFIED HEALT H NEED OF DIABETES DIABETES EDUCATORS EXTEND THE EDUCATION TO THE COMMUNITY BY PROVIDING CLASSES TO A DIVERSE POPULATION, FROM AREA INDUSTRIES AND FIREHOUSE GROUPS TO RETIREMENT C ENTERS A DIABETES SUPPORT GROUP MEETS FOR CONTINUED EDUCATION IN CHRONIC DISEASE MANAGEME NT THOUGH HEALTHY WOMEN HEALTHY LIVES WAS INSTITUTED IN JULY 2007 BY GOOD SAMARITAN HOSPI TAL WOMEN'S SERVICES TO IMPROVE THE HEALTH OF THE GREATER CINCINNATI COMMUNITY, IT IS NOW FISCALLY SUPPORTED BY BETHESDA HOSPITAL AS WELL, MAKING IT A TRIHEALTH SYSTEM PROGRAM HEA LTHY WOMEN HEALTHY LIVES IS AN APPROACH BASED ON THE PREMISE THAT PREVENTION, EARLY DETECT ION, TREATMENT AND ACCESS TO HEALTH CARE SERVICES IMPROVE INDIVIDUAL AND COMMUNITY HEALTH OUTCOMES THE FOCUS IS ON HEALTH RISKS ASSOCIATED WITH THE ONSET OF MENOPAUSE WELL ORGANI ZED SCREENING AND EDUCATION EVENTS BRING THE SERVICES TO AT RISK POPULATIONS OF AFRICAN AM ERICAN, APPALACHIAN, HISPANIC, UNINSURED AND UNDERINSURED WOMEN FORTY YEARS OF AGE OR OLDE R SCREENING INCLUDES OSTEOPOROSIS, MAMMOGRAPHY, CHOLESTEROL, HYPERTENSION, AND OBESITY E VERY WOMAN RECEIVES A NURSE CONSULTATION, A COPY OF THEIR RESULTS AND A WRITTEN PRIMARY CA RE REFERRAL WOMEN WITH ABNORMAL RESULTS ARE CONTACTED AND ASSISTED IN ACCESSING PRIMARY C ARE IN ADDITION, WOMEN NEEDING PREGNANCY AND GYNE</p>

Form and Line Reference	Explanation
PART VI, LINE 2	<p>COLOGIC CARE CAN ACCESS THIS SERVICE AT THE OB/GYN CENTER AT BETHESDA NORTH HOSPITAL CARE IS PROVIDED BY THE MEDICAL RESIDENTS IN OBSTETRICS AND GYNECOLOGY, SUPERVISED BY FACULTY PHYSICIANS FINANCIAL COUNSELORS AND CARE COORDINATORS ASSIST IN FINDING APPROPRIATE COVER AGE, PAYMENT PLANS AND FINANCIAL AID AS MANY OF THE WOMEN SERVED BY THE OB/GYN CENTER AT BETHESDA NORTH HOSPITAL HAVE LIMITED PROFICIENCY IN ENGLISH, QUALIFIED BILINGUAL STAFF ASSIST IN LANGUAGE INTERPRETATION THE TRIHEALTH THINK FIRST PROGRAM IS AN ESTABLISHED BETHES DA SERVICE FOCUSED ON INJURY PREVENTION THE THINK FIRST PROGRAM STAFF WORKS WITH COMMUNIT Y PARTNERS TO PROVIDE INJURY PREVENTION PROGRAMS AND COMMUNITY AWARENESS EVENTS COLLABORA TING WITH THE EDUCATORS, THE MEDIA, CIVIC CLUBS AND CORPORATIONS, THINK FIRST TEACHES INJU RY PREVENTION TO ALL AGE GROUPS THE GREATER CINCINNATI COMMUNITY HAS IDENTIFIED A SIGNIFI CANT HEALTH NEED IN INFANT MORTALITY AND PREMATURETY TRIHEALTH HAS COMBINED EFFORTS WITH THE LARGER MEDICAL COMMUNITY, AGENCIES AND OTHER STAKEHOLDERS TO ADDRESS THIS ISSUE AS A SYSTEM, TRIHEALTH WORKS TO REDUCE ELECTIVE DELIVERIES BEFORE THE 39TH WEEK THE CARE MANAG EMENT PROVIDED TO MOTHERS BY BETHESDA PERINATAL SOCIAL WORKERS AND CARE COORDINATORS HELP IN THIS GOAL BETHESDA, WITH OTHER ORGANIZATIONS, PROVIDE SUPPORT TO THE RESPITE CENTER, SE RVING THE ADULT HOMELESS OF CINCINNATI THE RESPITE CENTER, WITH 14 BEDS AND 24 HOUR COVER AGE, PROVIDES FREE MEDICAL SERVICES AND ACCOMMODATIONS FOR HOMELESS PERSONS NEEDING SOME M EDICAL OVERSIGHT RESPITE HELPS PEOPLE WITHOUT HOMES TOWARD INDEPENDENT LIVING IN PERMANEN T HOUSING BETHESDA CONTINUES A COMMITMENT TO EDUCATING THE NEXT GENERATION OF HEALTH CARE PROVIDERS--PHYSICIANS AND ALLIED HEALTH PROFESSIONALS COST IN EXCESS OF GOVERNMENTAL SUP PORT FOR MEDICAL EDUCATION PROGRAMS AT BETHESDA TOTALED OVER \$1 5 MILLION IN FISCAL YEAR 2 015 BETHESDA, AS PART OF TRIHEALTH, SPONSORS MEDICAL RESIDENCIES THERE WERE 32 TOTAL RESI DENTS IN A JOINT OBSTETRICS AND GYNECOLOGY RESIDENCY AT TRIHEALTH HOSPITALS IN FISCAL YEAR 2015 WITH THREE GYNECOLOGY-UROLOGY FELLOWS ALSO, THE BETHESDA FAMILY PRACTICE RESIDENCY INCLUDED 19 RESIDENTS AND TWO BETHESDA SPORTS MEDICINE FELLOWS IN FISCAL YEAR 2015 THE BET HESDA PARAMEDIC TRAINING PROGRAM IS A HOSPITAL-BASED PROGRAM ACCREDITED BY THE OHIO DEPART MENT OF TRANSPORTATION THROUGH THIS TRAINING PROGRAM, CERTIFIED EMERGENCY MEDICAL TECHNIC IANS CAN ADVANCE TO THE PARAMEDIC LEVEL EDUCATION IS COMPRISED OF DIDACTIC SESSIONS, WITH LAB, FIELD, AND HOSPITAL CLINICAL ROTATIONS BETHESDA, AS A PART OF TRIHEALTH, COLLABORAT ES WITH LOCAL AND REGIONAL COLLEGES, UNIVERSITIES AND TRAINING CENTERS TO PROVIDE MENTORIN G, INTERNSHIPS, CLERKSHIPS, SUPERVISED EDUCATION AND CLINICAL ROTATIONS TO STUDENTS IN HEA LTH FIELDS THESE PARTNERSHIPS HELP STUDENTS LEARN ABOUT AND PREPARE FOR PROFESSIONS IN NU RSE PRACTITIONER, RESPIRATORY THERAPY, RADIOLOGY TECHNOLOGY, STERILE PROCESSING, PHLEBOTOM Y, MEDICAL LABORATORY, PHARMACY, SPEECH, AUDIOLOGY, PHYSICAL THERAPY, AND OCCUPATIONAL THE RAPY IN CONCLUSION, ASIDE FROM THE CHARITY CARE AND UNPAID COST OF MEDICARE PROGRAMS, BET HESDA PROVIDES THE COMMUNITY WITH HEALTH CARE SERVICES AND PROGRAMS, MEDICAL EDUCATION, AN D CASH AND IN- KIND CONTRIBUTIONS FOR THE POOR AND THE BROADER COMMUNITY THIS COMMITMENT T O COMMUNITY HEALTH REVEALS BETHESDA'S FOUNDING SPIRIT OF CONCERN FOR THE VULNERABLE IT AL SO REFLECTS THE ONGOING, TANGIBLE EFFORTS AND CONTRIBUTIONS OF COUNTLESS EMPLOYEES, PHYSIC IANS AND LEADERS LIVING THE CORE VALUES OF STEWARDSHIP AND RESPONSE TO COMMUNITY NEEDS</p>

Form and Line Reference	Explanation
PART VI, LINE 3	TRIHEALTH, INC PERFORMS THE BILLING SERVICES FOR ALL AFFILIATED HOSPITALS INCLUDING BETHESDA HOSPITAL, INC BROCHURES/APPLICATIONS, PROVIDED IN MULTIPLE LANGUAGES, ARE VISIBLE AND AVAILABLE IN THE REGISTRATION AND ADMITTING AREAS OF ALL TRIHEALTH AFFILIATED HOSPITALS IN ADDITION, THE APPLICATION IS PRINTED ON THE REVERSE SIDE OF A PATIENT'S BILL WITH INSTRUCTIONS ON HOW TO COMPLETE THE APPLICATION AS WELL AS HOW TO RETURN IT FINANCIAL COUNSELORS ASSIST PATIENTS IN COMPLETING THE FINANCIAL ASSISTANCE APPLICATION FINALLY, TRIHEALTH INC 'S WEBSITE CONTAINS INFORMATION REGARDING ITS CHARITY CARE AND FINANCIAL ASSISTANCE PROGRAMS WITH DIRECTIONS ON HOW TO CONTACT THE APPROPRIATE PERSONNEL TO INITIATE AN APPLICATION OR ASK QUESTIONS ABOUT THE PROCESS

Form and Line Reference	Explanation
PART VI, LINE 4	LOCATED IN CINCINNATI, OHIO, BETHESDA HOSPITAL, INC AND THE TRIHEALTH, INC SYSTEM SERVE HAMILTON, BUTLER, WARREN, CLINTON AND CLERMONT COUNTIES IN OHIO, AS WELL AS PERSONS FROM INDIANA AND KENTUCKY IN METROPOLITAN STATISTICAL AREAS, THE CINCINNATI-MIDDLETOWN REGION IS THE LARGEST IN OHIO THE ESTIMATED POPULATION FOR THIS AREA IS 2,150,000 THE POPULATION WITHIN THE FIVE OHIO COUNTIES SERVED BY BETHESDA HOSPITAL, INC AND TRIHEALTH, INC IS ESTIMATED TO BE 1,663,000

Form and Line Reference	Explanation
PART VI, LINE 5	<p>BETHESDA HOSPITAL, INC IS COMPRISED OF VARIOUS MEDICAL SERVICES INCLUDING BETHESDA NORTH HOSPITAL ("NORTH"), BETHESDA MEDICAL CENTER AT ARROW SPRINGS ("ARROW SPRINGS") AND BETHESDA BUTLER HOSPITAL ("HOSPITAL") ITS BOARD OF DIRECTORS IS COMPRISED OF INDEPENDENT COMMUNITY REPRESENTATIVES NORTH IS A 458-BED ACUTE TERTIARY TEACHING HOSPITAL NORTH PROVIDES A 24-HOUR EMERGENCY DEPARTMENT, INTENSIVE CARE UNITS AND A LEVEL II SPECIAL CARE NURSERY SERVICES ARE OPEN TO ALL INDIVIDUALS REGARDLESS OF ABILITY TO PAY IN ADDITION, NORTH HAS AN OPEN MEDICAL STAFF AND A HISTORY OF TRAINING AND EDUCATING MEDICAL RESIDENTS AND HEALTH CARE PROFESSIONALS FINALLY IN CONCERT WITH THE HATTON INSTITUTE AT THE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO, AN AFFILIATED HOSPITAL, NORTH CONDUCTS MEDICAL AND SCIENTIFIC RESEARCH PROGRAMS INCLUDING STUDIES THAT ARE NOT COMMERCIALY SPONSORED NORTH PARTICIPATES IN MEDICARE AND MEDICAID AND OTHER GOVERNMENT-SPONSORED HEALTH CARE PROGRAMS, AND HAS AN ACTIVE CHARITY CARE PROGRAM ARROW SPRINGS COMPRISES A FULLY STAFFED 24-HOUR EMERGENCY DEPARTMENT, PRIMARY CARE AND SPECIALIST PHYSICIANS, DIAGNOSTIC SERVICES, OCCUPATIONAL MEDICINE, PHYSICAL THERAPY AND A PHARMACY IT PROVIDES THE SAME HIGH-QUALITY, PATIENT-CENTERED CARE AND SERVICES THAT IS PROVIDED BY NORTH BUTLER IS A 10-BED SURGICAL HOSPITAL WITH EIGHT OPERATING ROOMS, THREE ENDOSCOPY SUITES, TWO PROCEDURE ROOMS AND A 24-HOUR EMERGENCY DEPARTMENT ALSO, BUTLER WILL BE OPENING, IN DECEMBER 2015, A 51,000 SQUARE FOOT EXPANSION ON ITS CAMPUS INCLUDING A 45,000 SQUARE FOOT, TWO STORY INPATIENT BUILDING THE BETHESDA HOSPITAL, INC SERVICES DESCRIBED ABOVE, AND OTHERS NOT LISTED, PROMOTE COMMUNITY HEALTH IN ACUTE ILLNESS, IN MANAGEMENT OF CHRONIC DISEASE, AND IN EDUCATION AND PREVENTION MEASURES WHICH SEEK TO REDUCE THE BURDENS ON THE GOVERNMENT SEE RESPONSE TO PART VI, LINE 2 FOR ADDITIONAL INFORMATION</p>

Form and Line Reference	Explanation
PART VI, LINE 6	IN 1995, THE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO AND BETHESDA HOSPITAL, INC FORMED A PARTNERSHIP CALLED TRIHEALTH IN ORDER TO CREATE AN INTEGRATED HEALTH DELIVERY SYSTEM WHOSE MISSION IS TO IMPROVE THE HEALTH OF THE PEOPLE THEY SERVE, WITH AN EMPHASIS ON PREVENTION, WELLNESS AND EDUCATION THROUGH FIVE (5) HOSPITALS, THREE (3) AMBULATORY LOCATIONS AND OVER 125 SITES OF CARE (EMPLOYING OVER 600 PHYSICIANS INCLUDING RESIDENTS), TRIHEALTH PROVIDES A WIDE RANGE OF CLINICAL, EDUCATIONAL, PREVENTIVE AND SOCIAL PROGRAMS TRIHEALTH'S NON-HOSPITAL SERVICES INCLUDE PHYSICIAN PRACTICE MANAGEMENT, FITNESS CENTERS AND FITNESS CENTER MANAGEMENT, OCCUPATIONAL HEALTH CENTERS, HOME HEALTH AND HOSPICE CARE

Additional Data

Software ID:
Software Version:
EIN: 31-0537122
Name: BETHESDA HOSPITAL INC

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
BETHESDA NORTH HOSPITAL	PART V, SECTION B, LINE 5 INPUT WAS RECEIVED FROM INDIVIDUALS REPRESENTING UNDERSERVED POPULATIONS USING THE THREE SURVEY APPROACHES DESCRIBED BELOW - CHNA GROUP LEVEL ASSESSMENTS (GLAS) THE UNIVERSITY OF CINCINNATI ACTION RESEARCH CENTER FACILITATED LARGE GROUP COMMUNITY DISCUSSIONS (GROUP LEVEL ASSESSMENTS) WITH SERVICE PROVIDERS IN EACH OF THE COUNTIES COVERED BY THE CHNA THE TOTAL NUMBER OF SERVICE PROVIDERS AT THE COUNTY GLAS RANGED FROM AS FEW AS NINE PEOPLE TO AS MANY AS 30 PEOPLE OVERALL, APPROXIMATELY 200 SERVICE PROVIDERS ACROSS THE COUNTIES PARTICIPATED THE RESULTS OF THE GLAS WERE PRESENTED BACK TO THE SERVICE PROVIDERS AND COMMUNITY AT LARGE THROUGH A SERIES OF PUBLIC PRESENTATIONS CHNA COMMUNITY HEALTH SURVEY THE ACTION RESEARCH CENTER ALSO SURVEYED POPULATIONS IN THE GREATER CINCINNATI REGION THAT ARE MORE OFTEN UNDERSERVED WITH A PARTICULAR FOCUS ON HEALTH CARE CONSUMERS WHO ARE UNINSURED, UNDERINSURED, LOW SOCIOECONOMIC STATUS, MINORITY, AGE 65 PLUS OR WHO HAVE BEEN DIAGNOSED WITH MENTAL ILLNESS SURVEYS WERE ADMINISTERED TO MORE THAN 1,000 COMMUNITY RESIDENTS ACROSS THE NINE COUNTIES WITH OVERSAMPLING OF VULNERABLE GROUPS INCLUDING MENTAL ILLNESS RESPONDENTS WHO REPORTED BEING DIAGNOSED WITH OR HAVING EXPERIENCE WITH MENTAL ILLNESS (214 RESPONDENTS)SENIORS THOSE 65 YEARS OF AGE OR OLDER (126 RESPONDENTS)HISPANIC/LATINOS THOSE OF LATIN AMERICAN ORIGIN (154 RESPONDENTS)AFRICAN IMMIGRANTS WEST AFRICAN AND CENTRAL AFRICAN IMMIGRANTS TO THE CINCINNATI AREA (48 RESPONDENTS)LOW INCOME RESPONDENTS REPORTING COMBINED HOUSEHOLD INCOME OF \$24,999 OR LESS (472 RESPONDENTS)FAMILIES AT RISK FAMILIES WITH CHILDREN UNDER THE AGE OF 18 LIVING IN THE HOUSE REPORTING A COMBINED HOUSEHOLD INCOME OF \$24,999 OR LESS(257 RESPONDENTS)THE INTERVIEW QUESTIONS WERE DRAFTED AND NARROWED TO A TOTAL OF 17 QUESTIONS IN FIVE CATEGORIES INCLUDING DEFINING HEALTH AND CONCERNS, ORGANIZATIONAL OPERATIONS PERTAINING TO COMMUNITY IMPROVEMENT, COLLABORATION AND ASSISTANCE, MEASUREMENT AND CLOSING QUESTIONS THE SURVEYS CONTAINED QUESTIONS REGARDING BARRIERS TO HEALTH CARE, USAGE OF HEALTH CARE, HEALTH CARE NEEDS AND DEMOGRAPHIC INFORMATION CHNA STAKEHOLDER INTERVIEWS WITH COUNTY LEADERS FURTHER INDIVIDUAL INPUT WAS OBTAINED THROUGH ONE-ON-ONE INTERVIEWS WITH COUNTY LEADERS LASTING 45-60 MINUTES EACH THIRTY INTERVIEWS WERE CONDUCTED IN PERSON, THREE OUT OF SIX REQUESTS TO COMPLETE THE ONLINE VERSION WERE FULFILLED, THREE INDIVIDUALS DECLINED, AND EIGHT INDIVIDUALS WERE UNABLE TO BE SCHEDULED DUE TO LACK OF RESPONSE FOLLOWING ARE ORGANIZATIONS AND GROUPS CONSULTED WHILE CONDUCTING THE CHNA GROUP LEVEL ASSESSMENTS REPRESENTATIONBUTLER COUNTY BUTLER 211, BUTLER COUNTY FAMILY CHILDREN FIRST COUNCIL, BUTLER COUNTY SUCCESS, EDUCATIONAL SERVICE CENTER - SUCCESS, FAIRFIELD CITY SCHOOLS, LIFESPAN, MIDDLETOWN HEALTH DEPARTMENT, PRIMARY HEALTH SOLUTIONS, SERVE CITY, TALAWANDA SCHOOL DISTRICT BOARD, BUTLER COUNTY HEALTH DEPARTMENT AND OXFORD COLLEGE CORNER FREE CLINICCLERMONT COUNTY AMERICAN CANCER SOCIETY, CHILD FOCUS, INC , CLERMONT COUNTY HEALTH DISTRICT, LIFEPOINT SOLUTIONS, MERCY CLERMONT, MERCY CLERMONT OUTREACH, SISTERS OF MERCY CLERMONTHAMILTON COUNTY CENTERPOINT HEALTH, CINCINNATI CHILDRENS HOSPITAL MEDICAL CENTER, CINCINNATI HEALTH DEPARTMENT, CROSSROAD HEALTH CENTER, EVERYBODY RIDES METRO, HAMILTON COUNTY PUBLIC HEALTH, HEALTH CARE ACCESS NOW, PRO SENIORS, INC, SINCERE HOME HEALTH CARE, SINCERE HOME HEALTH CARE, TALBERT HOUSE, THE GREATER CINCINNATI FOUNDATION, THE HEALTH FOUNDATION OF GREATER CINCINNATI, THE HEALTH COLLABORATIVE, THE HEALTHCARE CONNECTION, THE HEALTHCARE CONNECTION LINCOLN HEIGHTS, UNIVERSITY OF CINCINNATI FAMILY RESIDENCYWARREN COUNTY ABUSE RAPE CRISIS SHELTER, FAMILY & CHILDREN FIRST COUNCIL, HEALTH DISTRICT (HEALTH DEPARTMENT), OHIO STATE UNIVERSITY EXTENSION, TRIHEALTH, WARREN COUNTY CAREER CENTER, WARREN COUNTY COMMUNITY SERVICES, WARREN COUNTY UNITED WAYSTAKEHOLDER INTERVIEWS REPRESENTATIONALL COUNTIES CHATFIELD COLLEGE, GREATER CINCINNATI FOUNDATION, HEALTHSOURCE OF OHIO, SOUTHERN STATE COMMUNITY COLLEGE, UNIVERSITY OF CINCINNATI INSTITUTE FOR POLICY RESEARCHBUTLER COUNTY BUTLER COUNTY SUPPORTS TO ENCOURAGE LOW-INCOME FAMILIES, HAMILTON COMMUNITY FOUNDATION, MIDDLETOWN AREA UNITED WAY, MIDDLETOWN CITY HEALTH DEPARTMENT, MIDDLETOWN COMMUNITY FOUNDATIONCLERMONT COUNTY CLERMONT COUNTY COMMUNITY SERVICES, CLERMONT COUNTY MENTAL HEALTH AND RECOVERY BOARD, UNITED WAY OF GREATER CINCINNATIHAMILTON COUNTY CINCINNATI/HAMILTON COMMUNITY ACTION AGENCY, HAMILTON COUNTY MENTAL HEALTH AND RECOVERY SERVICES BOARD, HAMILTON COUNTY PUBLIC HEALTH, SANTA MARIA COMMUNITY SERVICES, UNITED WAY OF GREATER CINCINNATIWARREN COUNTY MENTAL HEALTH AND RETARDATION SERVICES OF WARREN AND CLINTON COUNTIES, WARREN COUNTY COMBINED HEALTH DISTRICT, WARREN COUNTY COMMUNITY SERVICES INC

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
BETHESDA BUTLER HOSPITAL	<p>PART V, SECTION B, LINE 5 INPUT WAS RECEIVED FROM INDIVIDUALS REPRESENTING UNDERSERVED POPULATIONS USING THE THREE SURVEY APPROACHES DESCRIBED BELOW</p> <p>CHNA GROUP LEVEL ASSESSMENTS (GLAS) THE UNIVERSITY OF CINCINNATIS ACTION RESEARCH CENTER FACILITATED LARGE GROUP COMMUNITY DISCUSSIONS (GROUP LEVEL ASSESSMENTS) WITH SERVICE PROVIDERS IN EACH OF THE COUNTIES COVERED BY THE CHNA THE TOTAL NUMBER OF SERVICE PROVIDERS AT THE COUNTY GLAS RANGED FROM AS FEW AS NINE PEOPLE TO AS MANY AS 30 PEOPLE OVERALL, APPROXIMATELY 200 SERVICE PROVIDERS ACROSS THE COUNTIES PARTICIPATED THE RESULTS OF THE GLAS WERE PRESENTED BACK TO THE SERVICE PROVIDERS AND COMMUNITY AT LARGE THROUGH A SERIES OF PUBLIC PRESENTATIONS CHNA COMMUNITY HEALTH SURVEY THE ACTION RESEARCH CENTER ALSO SURVEYED POPULATIONS IN THE GREATER CINCINNATI REGION THAT ARE MORE OFTEN UNDERSERVED WITH A PARTICULAR FOCUS ON HEALTH CARE CONSUMERS WHO ARE UNINSURED, UNDERINSURED, LOW SOCIOECONOMIC STATUS, MINORITY, AGE 65 PLUS OR WHO HAVE BEEN DIAGNOSED WITH MENTAL ILLNESS SURVEYS WERE ADMINISTERED TO MORE THAN 1,000 COMMUNITY RESIDENTS ACROSS THE NINE COUNTIES WITH OVERSAMPLING OF VULNERABLE GROUPS INCLUDING MENTAL ILLNESS RESPONDENTS WHO REPORTED BEING DIAGNOSED WITH OR HAVING EXPERIENCE WITH MENTAL ILLNESS (214 RESPONDENTS) SENIORS THOSE 65 YEARS OF AGE OR OLDER (126 RESPONDENTS) HISPANIC/LATINOS THOSE OF LATIN AMERICAN ORIGIN (154 RESPONDENTS) AFRICAN IMMIGRANTS WEST AFRICAN AND CENTRAL AFRICAN IMMIGRANTS TO THE CINCINNATI AREA (48 RESPONDENTS) LOW INCOME RESPONDENTS REPORTING COMBINED HOUSEHOLD INCOME OF \$24,999 OR LESS (472 RESPONDENTS) FAMILIES AT RISK FAMILIES WITH CHILDREN UNDER THE AGE OF 18 LIVING IN THE HOUSE REPORTING A COMBINED HOUSEHOLD INCOME OF \$24,999 OR LESS (257 RESPONDENTS) THE INTERVIEW QUESTIONS WERE DRAFTED AND NARROWED TO A TOTAL OF 17 QUESTIONS IN FIVE CATEGORIES INCLUDING DEFINING HEALTH AND CONCERNS, ORGANIZATIONAL OPERATIONS PERTAINING TO COMMUNITY IMPROVEMENT, COLLABORATION AND ASSISTANCE, MEASUREMENT AND CLOSING QUESTIONS THE SURVEYS CONTAINED QUESTIONS REGARDING BARRIERS TO HEALTH CARE, USAGE OF HEALTH CARE, HEALTH CARE NEEDS AND DEMOGRAPHIC INFORMATION CHNA STAKEHOLDER INTERVIEWS WITH COUNTY LEADERS FURTHER INDIVIDUAL INPUT WAS OBTAINED THROUGH ONE-ON-ONE INTERVIEWS WITH COUNTY LEADERS LASTING 45-60 MINUTES EACH THIRTY INTERVIEWS WERE CONDUCTED IN PERSON, THREE OUT OF SIX REQUESTS TO COMPLETE THE ONLINE VERSION WERE FULFILLED, THREE INDIVIDUALS DECLINED, AND EIGHT INDIVIDUALS WERE UNABLE TO BE SCHEDULED DUE TO LACK OF RESPONSE FOLLOWING ARE ORGANIZATIONS AND GROUPS CONSULTED WHILE CONDUCTING THE CHNA GROUP LEVEL ASSESSMENTS</p> <p>REPRESENTATION BUTLER COUNTY BUTLER 211, BUTLER COUNTY FAMILY CHILDREN FIRST COUNCIL, BUTLER COUNTY SUCCESS, EDUCATIONAL SERVICE CENTER - SUCCESS, FAIRFIELD CITY SCHOOLS, LIFESPAN, MIDDLETOWN HEALTH DEPARTMENT, PRIMARY HEALTH SOLUTIONS, SERVE CITY, TALAWANDA SCHOOL DISTRICT BOARD, BUTLER COUNTY HEALTH DEPARTMENT AND OXFORD COLLEGE CORNER FREE CLINIC CLERMONT COUNTY AMERICAN CANCER SOCIETY, CHILD FOCUS, INC, CLERMONT COUNTY HEALTH DISTRICT, LIFEPOINT SOLUTIONS, MERCY CLERMONT, MERCY CLERMONT OUTREACH, SISTERS OF MERCY CLERMONT HAMILTON COUNTY CENTERPOINT HEALTH, CINCINNATI CHILDRENS HOSPITAL MEDICAL CENTER, CINCINNATI HEALTH DEPARTMENT, CROSSROAD HEALTH CENTER, EVERYBODY RIDES METRO, HAMILTON COUNTY PUBLIC HEALTH, HEALTH CARE ACCESS NOW, PRO SENIORS, INC, SINCERE HOME HEALTH CARE, SINCERE HOME HEALTH CARE, TALBERT HOUSE, THE GREATER CINCINNATI FOUNDATION, THE HEALTH FOUNDATION OF GREATER CINCINNATI, THE HEALTH COLLABORATIVE, THE HEALTHCARE CONNECTION, THE HEALTHCARE CONNECTION LINCOLN HEIGHTS, UNIVERSITY OF CINCINNATI FAMILY RESIDENCY WARREN COUNTY ABUSE RAPE CRISIS SHELTER, FAMILY & CHILDREN FIRST COUNCIL, HEALTH DISTRICT (HEALTH DEPARTMENT), OHIO STATE UNIVERSITY EXTENSION, TRIHEALTH, WARREN COUNTY CAREER CENTER, WARREN COUNTY COMMUNITY SERVICES, WARREN COUNTY UNITED WAY STAKEHOLDER INTERVIEWS REPRESENTATION ALL COUNTIES CHATFIELD COLLEGE, GREATER CINCINNATI FOUNDATION, HEALTHSOURCE OF OHIO, SOUTHERN STATE COMMUNITY COLLEGE, UNIVERSITY OF CINCINNATI INSTITUTE FOR POLICY RESEARCH BUTLER COUNTY BUTLER COUNTY SUPPORTS TO ENCOURAGE LOW-INCOME FAMILIES, HAMILTON COMMUNITY FOUNDATION, MIDDLETOWN AREA UNITED WAY, MIDDLETOWN CITY HEALTH DEPARTMENT, MIDDLETOWN COMMUNITY FOUNDATION CLERMONT COUNTY CLERMONT COUNTY COMMUNITY SERVICES, CLERMONT COUNTY MENTAL HEALTH AND RECOVERY BOARD, UNITED WAY OF GREATER CINCINNATI HAMILTON COUNTY CINCINNATI/HAMILTON COMMUNITY ACTION AGENCY, HAMILTON COUNTY MENTAL HEALTH AND RECOVERY SERVICES BOARD, HAMILTON COUNTY PUBLIC HEALTH, SANTA MARIA COMMUNITY SERVICES, UNITED WAY OF GREATER CINCINNATI WARREN COUNTY MENTAL HEALTH AND RETARDATION SERVICES OF WARREN AND CLINTON COUNTIES, WARREN COUNTY COMBINED HEALTH DISTRICT, WARREN COUNTY COMMUNITY SERVICES INC</p>

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

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

Form and Line Reference	Explanation
BETHESDA NORTH HOSPITAL	PART V, SECTION B, LINE 6A ADAMS COUNTY REGIONAL MEDICAL CENTER, ATRIUM MEDICAL CENTER, DEARBORN COUNTY HOSPITAL, FORT HAMILTON HOSPITAL, LINDNER CENTER OF HOPE, MARGARET MARY COMMUNITY HOSPITAL, MCCULLOUGH-HYDE MEMORIAL HOSPITAL, MERCY HEALTH, UC HEALTH, GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO

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
BETHESDA BUTLER HOSPITAL	PART V, SECTION B, LINE 6A ADAMS COUNTY REGIONAL MEDICAL CENTER, ATRIUM MEDICAL CENTER, DEARBORN COUNTY HOSPITAL, FORT HAMILTON HOSPITAL, LINDNER CENTER OF HOPE, MARGARET MARY COMMUNITY HOSPITAL, MCCULLOUGH-HYDE MEMORIAL HOSPITAL, MERCY HEALTH, UC HEALTH, GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO

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
BETHESDA NORTH HOSPITAL	PART V, SECTION B, LINE 6B GREATER CINCINNATI FOUNDATION, GREATER CINCINNATI HEALTH COUNCIL, HAMILTON COUNTY PUBLIC HEALTH, HIGHLAND COUNTY HEALTH DEPARTMENT, MIDDLETOWN HEALTH DEPARTMENT, UNITED WAY OF GREATER CINCINNATI

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
BETHESDA BUTLER HOSPITAL	PART V, SECTION B, LINE 6B GREATER CINCINNATI FOUNDATION, GREATER CINCINNATI HEALTH COUNCIL, HAMILTON COUNTY PUBLIC HEALTH, HIGHLAND COUNTY HEALTH DEPARTMENT, MIDDLETOWN HEALTH DEPARTMENT, UNITED WAY OF GREATER CINCINNATI

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
BETHESDA NORTH HOSPITAL	PART V, SECTION B, LINE 11 OBESITY - BETHESDA NORTH HOSPITAL WILL ADDRESS THIS NEED IN HAMILTON AND BUTLER COUNTIES, HOWEVER, IT WILL NOT, AT THIS TIME, ENTER INTO SPECIFIC PROGRAMS IN WARREN AND CLERMONT COUNTIES THESE COUNTIES HAVE POPULATIONS THAT ARE SIGNIFICANTLY SMALLER AND LESS DENSE THAN HAMILTON AND BUTLER COUNTIES, THEREBY PRESENTING ADDITIONAL CHALLENGES FOR AN EFFECTIVE AND COMPREHENSIVE STRATEGY SUBSTANCE ABUSE/MENTAL HEALTH - THIS NEED WILL NOT BE ADDRESSED BY BETHESDA NORTH HOSPITAL AS ITS AFFILIATED HOSPITAL IN THE TRIHEALTH, INC SYSTEM, THE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO PROVIDES THIS CARE THROUGH ITS GERIATRIC AND ADULT BEHAVIORAL HEALTH PATIENT UNITS IT WILL NOT ADDRESS MENTAL HEALTH NEEDS OTHERWISE AS THERE IS A COMPREHENSIVE OUTPATIENT PROGRAM FOR SUBSTANCE ABUSE ELSEWHERE IN THE TRIHEALTH, INC SYSTEM, TO WHICH GOOD SAMARITAN HOSPITAL BELONGS BETHESDA NORTH HOSPITAL BELIEVES THAT IT CAN LEVERAGE THE TRIHEALTH NETWORK TO ASSIST IN ADDRESSING PORTIONS OF THIS SIGNIFICANT NEED, THEREBY PERMITTING IT TO ALLOCATE RESOURCES TO OTHER SIGNIFICANT NEEDS

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
BETHESDA BUTLER HOSPITAL	PART V, SECTION B, LINE 11 SUBSTANCE ABUSE/MENTAL HEALTH - THIS NEED WILL NOT BE ADDRESSED BY BETHESDA BUTLER HOSPITAL AS IT HAS A SISTER HOSPITAL, GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO, WHICH IS IN THE TRIHEALTH, INC SYSTEM, PROVIDING THIS CARE IT WILL NOT ADDRESS MENTAL HEALTH NEEDS OTHERWISE AS THERE IS A COMPREHENSIVE OUTPATIENT PROGRAM FOR SUBSTANCE ABUSE ELSEWHERE IN THE TRIHEALTH, INC SYSTEM SERVING THE BROAD COMMUNITY THAT INCLUDES BUTLER COUNTY ACCESS TO DENTAL HEALTH SERVICES - THIS NEED WILL NOT BE ADDRESSED BY BETHESDA BUTLER AS DENTAL SERVICES ARE NOT A CORE HOSPITAL COMPETENCY AND BETHESDA BUTLER HOSPITAL DOES NOT HAVE THE CAPACITY TO SERVE THIS NEED IN BUTLER COUNTY THE TRIHEALTH SYSTEM OPERATES A FREE DENTAL CLINIC IN HAMILTON COUNTY, WHICH CAN SERVE BUTLER COUNTY RESIDENTS HOMELESSNESS - THIS NEED WILL NOT BE ADDRESSED BY BETHESDA BUTLER HOSPITAL BECAUSE IT IS NOT A CORE HOSPITAL COMPETENCY AND BETHESDA BUTLER HOSPITAL DOES NOT HAVE THE CAPACITY TO SERVE THIS HEALTH NEED IN BUTLER COUNTY

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
BETHESDA NORTH HOSPITAL	PART V, SECTION B, LINE 13B SEE PART VI RESPONSE TO PART I, LINE 3C

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
BETHESDA BUTLER HOSPITAL	PART V, SECTION B, LINE 13B SEE PART VI RESPONSE TO PART I, LINE 3C

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
BETHESDA NORTH HOSPITAL	PART V, SECTION B, LINE 13H SEE PART VI RESPONSE TO PART I, LINE 3C

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
BETHESDA BUTLER HOSPITAL	PART V, SECTION B, LINE 13H SEE PART VI RESPONSE TO PART I, LINE 3C

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
BETHESDA NORTH HOSPITAL	PART V, SECTION B, LINE 16I BETHESDA NORTH HOSPITAL DOES NOT PROVIDE A DETAILED COPY OF ITS FINANCIAL ASSISTANCE POLICY TO PATIENTS HOWEVER IT DOES PROVIDE A SUMMARY OF THE POLICY IN A MANNER LISTED IN LINES 13A-13E IN ADDITION, SUCH INFORMATION SHALL BE PROVIDED IN LANGUAGES CONSIDERED TO BE COMMONLY SPOKEN BY THE POPULATION BETHESDA NORTH HOSPITAL SERVES IF TRANSLATION OR OTHER ASSISTANCE IS NEEDED TO FACILITATE COMPLETION AND/OR UNDERSTANDING OF THE FINANCIAL ASSISTANCE POLICY AND/OR APPLICATION TRANSLATION AND OTHER REASONABLE REQUESTS FOR ASSISTANCE WILL BE PROVIDED

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
BETHESDA BUTLER HOSPITAL	PART V, SECTION B, LINE 16I BETHESDA BUTLER COUNTY MEDICAL CENTER DOES NOT PROVIDE A DETAILED COPY OF ITS FINANCIAL ASSISTANCE POLICY TO PATIENTS HOWEVER IT DOES PROVIDE A SUMMARY OF THE POLICY IN A MANNER LISTED IN LINES 13A-13E IN ADDITION, SUCH INFORMATION SHALL BE PROVIDED IN LANGUAGES CONSIDERED TO BE COMMONLY SPOKEN BY THE POPULATION BETHESDA BUTLER COUNTY MEDICAL CENTER SERVES IF TRANSLATION OR OTHER ASSISTANCE IS NEEDED TO FACILITATE COMPLETION AND/OR UNDERSTANDING OF THE FINANCIAL ASSISTANCE POLICY AND/OR APPLICATION TRANSLATION AND OTHER REASONABLE REQUESTS FOR ASSISTANCE WILL BE PROVIDED

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
BETHESDA NORTH HOSPITAL	PART V, SECTION B, LINE 22D BETHESDA NORTH HOSPITAL ("BNH") ISSUES A BILLING STATEMENT TO ALL FAP-ELIGIBLE INDIVIDUALS THAT STATE GROSS CHARGES FOR THE CARE RECEIVED AS THE STARTING POINT FOR APPLYING THE DISCOUNTS AND DEDUCTIONS THE FAP-ELIGIBLE INDIVIDUAL IS ENTITLED TO UNDER ITS FAP, SUCH THAT THE AMOUNT THAT A FAP-ELIGIBLE IS REQUIRED TO PAY IS (I) LESS THAN THE GROSS CHARGES FOR SUCH CARE AND (II) TYPICALLY LESS THAN THE AMOUNTS GENERALLY BILLED TO PERSONS WITH INSURANCE CURRENTLY, AS PART OF THE TRIHEALTH SYSTEM, BNH PROVIDES FREE CARE TO PATIENTS WHOSE INCOME FALLS BELOW 100% OF THE FEDERAL POVERTY GUIDELINES IN ADDITION, IT PROVIDES DISCOUNTED CARE ON A SLIDING SCALE TO PATIENTS WITH INCOMES ALL THE WAY UP TO 400% OF THE FEDERAL POVERTY GUIDELINES ANY UNINSURED PATIENT THAT FILLS OUT A FINANCIAL ASSISTANCE FORM AUTOMATICALLY RECEIVES A 40% DISCOUNT REGARDLESS OF INCOME WHILE OTHER PATIENTS RECEIVE A 45% DISCOUNT (INCOME BETWEEN 300% AND 400% OF POVERTY GUIDELINES), 60% DISCOUNT (INCOME BETWEEN 200% AND 300% OF POVERTY GUIDELINES), OR AN 80% DISCOUNT (INCOME BETWEEN 100% AND 200% OF POVERTY GUIDELINES) THE CURRENT AVERAGE DISCOUNT WITH COMMERCIAL INSURANCE COMPANIES IS 65% SO VIRTUALLY ALL PATIENTS QUALIFYING FOR FINANCIAL ASSISTANCE WITH INCOME UP TO 300% OF THE POVERTY GUIDELINES ARE RECEIVING DISCOUNTS EQUAL TO OR GREATER THAN THE AVERAGE COMMERCIAL INSURANCE DISCOUNT IN ADDITION, BNH BELIEVES THE TRIHEALTH FINANCIAL ASSISTANCE POLICY IS GENEROUS AS MANY HOSPITALS DO NOT OFFER ANY FINANCIAL ASSISTANCE TO PATIENTS WITH INCOME OVER 300% OF THE POVERTY GUIDELINE HOWEVER, IT PREFERS TO EXTEND DISCOUNTS TO SUCH INDIVIDUALS RATHER THAN DENY THEM ELIGIBILITY UNDER THE POLICY SO THAT SUCH INDIVIDUALS RECEIVE SOME FINANCIAL ASSISTANCE RATHER THAN NONE

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
BETHESDA BUTLER HOSPITAL	PART V, SECTION B, LINE 22D BETHESDA BUTLER HOSPITAL ("BBH") ISSUES A BILLING STATEMENT TO ALL FAP-ELIGIBLE INDIVIDUALS THAT STATES GROSS CHARGES FOR THE CARE RECEIVED AS THE STARTING POINT FOR APPLYING THE DISCOUNTS AND DEDUCTIONS THE FAP-ELIGIBLE INDIVIDUAL IS ENTITLED TO UNDER ITS FAP, SUCH THAT THE AMOUNT THAT AN FAP-ELIGIBLE INDIVIDUAL IS REQUIRED TO PAY IS (I) LESS THAN THE GROSS CHARGES FOR SUCH CARE, AND (II) TYPICALLY LESS THAN THE AMOUNTS GENERALLY BILLED TO PERSONS WITH INSURANCE CURRENTLY, AS PART OF THE TRIHEALTH SYSTEM, BBH PROVIDES FREE CARE TO PATIENTS WHOSE INCOME FALLS BELOW 100% OF THE FEDERAL POVERTY GUIDELINES IN ADDITION, IT PROVIDES DISCOUNTED CARE ON A SLIDING SCALE TO PATIENTS WITH INCOMES ALL THE WAY UP TO 400% OF THE FEDERAL POVERTY GUIDELINES ANY UNINSURED PATIENT THAT FILLS OUT A FINANCIAL ASSISTANCE FORM AUTOMATICALLY RECEIVES A 40% DISCOUNT REGARDLESS OF INCOME WHILE OTHER PATIENTS RECEIVE A 45% DISCOUNT (INCOME BETWEEN 300% AND 400% OF POVERTY GUIDELINES), 60% DISCOUNT (INCOME BETWEEN 200% AND 300% OF POVERTY GUIDELINES), OR AN 80% DISCOUNT (INCOME BETWEEN 100% AND 200% OF POVERTY GUIDELINES) THE CURRENT AVERAGE DISCOUNT WITH COMMERCIAL INSURANCE COMPANIES IS 65% SO VIRTUALLY ALL PATIENTS QUALIFYING FOR FINANCIAL ASSISTANCE WITH INCOME UP TO 300% OF THE POVERTY GUIDELINES ARE RECEIVING DISCOUNTS EQUAL TO OR GREATER THAN THE AVERAGE COMMERCIAL INSURANCE DISCOUNT IN ADDITION, BBH BELIEVES THE TRIHEALTH FINANCIAL ASSISTANCE POLICY IS GENEROUS AS MANY HOSPITALS DO NOT OFFER ANY FINANCIAL ASSISTANCE TO PATIENTS WITH INCOME OVER 300% OF THE POVERTY GUIDELINE HOWEVER, IT PREFERES TO EXTEND DISCOUNTS TO SUCH INDIVIDUALS RATHER THAN DENY THEM ELIGIBILITY UNDER THE POLICY SO THAT SUCH INDIVIDUALS RECEIVE SOME FINANCIAL ASSISTANCE RATHER THAN NONE

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
PART V, SECTION B, LINE 16	FINANCIAL ASSISTANCE POLICY WEBSITE AVAILABILITY

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
BETHESDA NORTH HOSPITAL PART V, SECTION B, LINE 16B WEBSITE	HTTP //WWW.TRIHEALTH.COM/TOOLS/PAY-YOUR-BILL/

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
BETHESDA BUTLER HOSPITAL PART V, SECTION B, LINE 16B WEBSITE	HTTP //WWW.TRIHEALTH.COM/TOOLS/PAY-YOUR-BILL/

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

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

Name and address	Type of Facility (describe)
BETHESDA MEDICAL CENTER-ARROW SPRINGS 100 ARROW SPRINGS BLVD LEBANON, OH 45036	24-HOUR EMERGENCY ROOM AND COMPREHENSIVE OUTPATIENT SERVICES
BETHESDA NORTH OBGYN CLINIC 10498 MONTGOMERY ROAD CINCINNATI, OH 45242	24-HOUR EMERGENCY ROOM AND COMPREHENSIVE OUTPATIENT SERVICES
BETHESDA OAK CAMPUS 619 OAK STREET CINCINNATI, OH 45206	24-HOUR EMERGENCY ROOM AND COMPREHENSIVE OUTPATIENT SERVICES
BNH AMBULATORY TREATMENT CENTER 10506 MONTGOMERY ROAD CINCINNATI, OH 45242	24-HOUR EMERGENCY ROOM AND COMPREHENSIVE OUTPATIENT SERVICES
TRIHEALTH SLEEP MEDICINE 10475 MONTGOMERY ROAD CINCINNATI, OH 45242	24-HOUR EMERGENCY ROOM AND COMPREHENSIVE OUTPATIENT SERVICES
NORTH AMBULATORY SURGERY CENTER 10506 MONTGOMERY ROAD CINCINNATI, OH 45242	24-HOUR EMERGENCY ROOM AND COMPREHENSIVE OUTPATIENT SERVICES
BETHESDA NORTH OUTPATIENT IMAGING CTR 10494 MONTGOMERY ROAD CINCINNATI, OH 45242	24-HOUR EMERGENCY ROOM AND COMPREHENSIVE OUTPATIENT SERVICES
TRIHEALTH NURSE MIDWIVES 3440 BURNET AVENUE 120 CINCINNATI, OH 45229	24-HOUR EMERGENCY ROOM AND COMPREHENSIVE OUTPATIENT SERVICES
BETHESDA SURGERY CENTER 10615 MONTGOMERY ROAD 300 CINCINNATI, OH 45242	24-HOUR EMERGENCY ROOM AND COMPREHENSIVE OUTPATIENT SERVICES
BETHESDA HAND REHABILITATION 10700 MONTGOMERY ROAD CINCINNATI, OH 45242	24-HOUR EMERGENCY ROOM AND COMPREHENSIVE OUTPATIENT SERVICES
BETHESDA LOVELAND PHYSICAL THERAPY 10675 LOVELAND-MADERIA ROAD LOVELAND, OH 45140	24-HOUR EMERGENCY ROOM AND COMPREHENSIVE OUTPATIENT SERVICES
BETHESDA FAMILY PRACTICE CENTER 1775 LEXINGTON AVE CINCINNATI, OH 45212	24-HOUR EMERGENCY ROOM AND COMPREHENSIVE OUTPATIENT SERVICES
BETHESDA ALCOHOLDRUG TREATMENT 11305 REED HARTMAN HWY CINCINNATI, OH 45242	24-HOUR EMERGENCY ROOM AND COMPREHENSIVE OUTPATIENT SERVICES
BETHESDA BUTLER PHYSICAL THERAPY 3035 HAMILTON-MASON ROAD HAMILTON, OH 45011	24-HOUR EMERGENCY ROOM AND COMPREHENSIVE OUTPATIENT SERVICES
BETHESDA BUTLER IMAGING CENTER 3075 HAMILTON-MASON ROAD HAMILTON, OH 45011	24-HOUR EMERGENCY ROOM AND COMPREHENSIVE OUTPATIENT SERVICES

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

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

Name and address	Type of Facility (describe)
TRIHEALTH SLEEP MEDICINE 3055 HAMILTON-MASON ROAD HAMILTON,OH 45011	24-HOUR EMERGENCY ROOM AND COMPREHENSIVE OUTPATIENT SERVICES
BETHESDA MASON PHYSICAL THERAPY 6020 MASON MONTGOMERY RD MASON,OH 45040	24-HOUR EMERGENCY ROOM AND COMPREHENSIVE OUTPATIENT SERVICES

Schedule I
(Form 990)

Department of the Treasury
Internal Revenue Service

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

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

▶ Information about Schedule I (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2014

Open to Public
Inspection

Name of the organization
BETHESDA HOSPITAL INC

Employer identification number
31-0537122

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" to 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 non-cash assistance	(h) Purpose of grant or assistance
See Additional Data Table							

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table 22

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

Part III

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

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

Return Reference	Explanation
PART I, LINE 2	BETHESDA HOSPITAL, INC ("HOSPITAL") PROVIDES GRANTS TO OTHER ORGANIZATIONS DIRECTLY ON A VERY LIMITED BASIS IN THOSE INSTANCES, THE DEPARTMENT GRANTING THE FUNDS IS RESPONSIBLE FOR OBTAINING AND STORING ALL NECESSARY INFORMATION FROM THE OTHER ORGANIZATION RELATIVE TO HOW THE FUNDS WILL BE SPENT. GENERALLY, GRANTS ARE PROVIDED, ON BEHALF OF HOSPITAL THROUGH TRIHEALTH, INC ("TRIHEALTH"), A SUPPORTING ORGANIZATION OF HOSPITAL, WHICH PROVIDES ADMINISTRATIVE SUPPORT SERVICES TO HOSPITAL. AS SUCH, TRIHEALTH IS RESPONSIBLE FOR MONITORING THE USE OF HOW THE FUNDS WILL BE SPENT.

Additional Data

Software ID:
Software Version:
EIN: 31-0537122
Name: BETHESDA HOSPITAL INC

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 Code 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
UPTOWN CONSORTIUM INC629 OAK STREET SUITE 306 CINCINNATI,OH 45206	20-0688727	501(C)(3)	146,292				GENERAL PURPOSES
AMERICAN HEART ASSOCIATION7272 GREENVILLE AVE DALLAS,TX 75231	13-5613797	501(C)(3)	7,350				SPONSORSHIP
GOOD SAMARITAN HOSPITAL FOUNDATION OF CINCINNATI INC619 OAK STREET CINCINNATI,OH 45206	31-1206047	501(C)(3)	64,680				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 Code 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
BETHESDA FOUNDATION INC619 OAK STREET CINCINNATI,OH 45206	23-7374129	501(C)(3)	64,680				SPONSORSHIP
THE HEALTH COLLABORATIVE2649 ERIE AVENUE 2ND FLOOR CINCINNATI,OH 45208	31-1449807	501(C)(3)	34,300				GENERAL PURPOSES
THE CHILDREN'S THEATER 5020 OAKLAWN DRSUITE 2000 CINCINNATI,OH 45227	31-6026285	501(C)(3)	9,800				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 Code 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
FRIARS CLUB INC2316 HARRYWOOD COURT CINCINNATI,OH 45239	31-0537485	501(C)(3)	9,800				SPONSORSHIP
MARVIN LEWIS COMMUNITY FUND700 WEST PETE ROSE WAY NO 37 CINCINNATI,OH 45203	20-2704690	501(C)(3)	17,456				SPONSORSHIP
CINCINNATI LANDMARK PRODUCTION4990 GLENWAY AVE CINCINNATI,OH 45238	20-2814659	501(C)(3)	9,800				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 Code 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
CINCINNATI ZOO AND BOTANICAL GARDENS 3400 VINE STREET CINCINNATI,OH 45220	31-0537171	501(C)(3)	21,641				SPONSORSHIP
CINCINNATI USA REGIONAL CHAMBER441 VINE STREET NO 300 CINCINNATI,OH 45202	31-0239310	501(C)(6)	5,145				SPONSORSHIP
HEALTHY BEGINNINGS INC 47 E HOLLISTER CINCINNATI,OH 45219	31-1380939	501(C)(3)	39,200				GENERAL SUPPORT

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 Code 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 INC250 WILLIAMS STREET NW SUITE 400 ATLANTA,GA 30303	13-1788491	501(C)(3)	6,125				SPONSORSHIP
HEALTHY MOMS & BABES INC2270 BANNING ROAD NO 200 CINCINNATI,OH 45239	31-1155292	501(C)(3)	49,000				GENERAL PURPOSES
ARTHRITIS FOUNDATION GREAT LAKES REGION INC 3740 RIDGE MILL DR HILLIARD,OH 43026	27-4014550	501(C)(3)	9,800				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 Code 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
FREESTORE FOODBANK INC1141 CENTRAL PARKWAY CINCINNATI,OH 45202	23-7122205	501(C)(3)	27,140				SPONSORSHIP
CINCINNATI ARTS ASSOCIATION650 WALNUT STREET CINCINNATI,OH 45202	31-1310256	501(C)(3)	19,600				SPONSORSHIP
THE CENTER FOR CLOSING THE HEALTH GAP IN GREATER CINCINNATI 3120 BURNET AVE ROOM 201 CINCINNATI,OH 45229	20-0902286	501(C)(3)	98,000				GENERAL PURPOSES

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 Code 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 SERVICE ORGANIZATIONS INC2111 WILSON BLVD SUITE 1200 ARLINGTON,VA 22201	13-1610451	501(C)(3)	7,350				SPONSORSHIP
CINCINNATI STATE STEM ACADEMY INC3520 CENTRAL PKY CINCINNATI,OH 45223	90-0867170	501(C)(3)	10,365				GENERAL PURPOSE
THE CINCINNATI BALLET COMPANY INC1555 CENTRAL PARKWAY CINCINNATI,OH 45214	31-6050354	501(C)(3)	7,350				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 Code 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
THE SPIRIT OF CINCINNATUS INC4138 LINDEN AVE DEER PARK, OH 45236	80-0352850	501(C)(3)	22,050				SPONSORSHIP
PATTY BRISBEN FOUNDATION FOR WOMEN'S SEXUAL HEALTH 655 PLUM STREET CINCINNATI, OH 45202	20-4277190	501(C)(3)	7,350				SPONSORSHIP

Schedule J
(Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees
▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 23.
▶ Attach to Form 990.
▶ Information about Schedule J (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization
BETHESDA HOSPITAL INC

Employer identification number
31-0537122

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 in 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"/> Housing allowance or residence for personal use</div><div><input type="checkbox"/> Travel for companions</div><div><input type="checkbox"/> Payments for business use of personal residence</div><div><input type="checkbox"/> Tax idemnification and gross-up payments</div><div><input type="checkbox"/> Health or social club dues or initiation fees</div><div><input type="checkbox"/> Discretionary spending account</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 type="checkbox"/> Compensation committee</div><div><input type="checkbox"/> Written employment contract</div><div><input type="checkbox"/> Independent compensation consultant</div><div><input type="checkbox"/> Compensation survey or study</div><div><input type="checkbox"/> Form 990 of other organizations</div><div><input type="checkbox"/> Approval by the board or compensation committee</div></div>			
4	During the year, did any person listed in Form 990, Part VII, Section A, line 1a with respect to the filing organization or a related organization:			
a	Receive a severance payment or change-of-control payment?	4a	Yes	
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b	Yes	
c	Participate in, or receive payment from, an equity-based compensation arrangement? If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.	4c		No
	Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.			
5	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:			
a	The organization?	5a		No
b	Any related organization? If "Yes," to line 5a or 5b, describe in Part III.	5b		No
6	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a	The organization?	6a		No
b	Any related organization? If "Yes," to line 6a or 6b, describe in Part III.	6b		No
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III.	7		No
8	Were any amounts reported in 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" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9		

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

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

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

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column(B) reported as deferred in prior Form 990
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
See Additional Data Table							

Part III Supplemental Information

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

Return Reference	Explanation
PART I, LINES 4A-B	ELIGIBLE EXECUTIVES (GENERALLY VICE PRESIDENTS AND ABOVE) PARTICIPATE IN A PROGRAM THAT PROVIDES FOR SUPPLEMENTAL RETIREMENT BENEFITS. THE PAYMENT OF BENEFITS UNDER THE PROGRAM, IF ANY, IS ENTIRELY DEPENDENT UPON THE FACTS AND CIRCUMSTANCES UNDER WHICH THE EXECUTIVE TERMINATES EMPLOYMENT WITH THE ORGANIZATION. BENEFITS UNDER THE PROGRAM ARE UNFUNDED AND NON-VESTED. DUE TO THE SUBSTANTIAL RISK OF FORFEITURE PROVISION, THERE IS NO GUARANTEE THAT THESE EXECUTIVES WILL EVER RECEIVE ANY BENEFIT UNDER THE PROGRAM. ANY AMOUNT ULTIMATELY PAID UNDER THE PROGRAM TO THE EXECUTIVE IS REPORTED AS COMPENSATION ON FORM 990, SCHEDULE J, PART II, COLUMN B IN THE YEAR PAID. TRIHEALTH, INC., THE RELATED ORGANIZATION THAT PAID THE SALARIES OF THE FOLLOWING INDIVIDUALS LISTED IN SCHEDULE J, PART II, CONTRIBUTED, ON BEHALF OF THE FOLLOWING INDIVIDUALS, TO A SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN IN THE AMOUNTS AS NOTED: JOHN PROUT - \$401,161; DONNA NIENABER, ESQ. - \$84,330; MICHAEL CROFTON - \$56,175; CRAIG RUCKER - \$55,867; SHER MCCLANAHAN - \$44,286; WILLIAM GRONEMAN - \$102,992; GERALD OLIPHANT - \$110,403; GEORGES FEGHALI, MD - \$107,373; JOHN ROBINSON, MD - \$52,178; ROBERT COLLINS, MD - \$41,161. IN ADDITION, THE FOLLOWING INDIVIDUAL LISTED IN SCHEDULE J, PART II, RECEIVED A PAYMENT FROM A SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN WHICH WAS TREATED AS TAXABLE COMPENSATION BY TRIHEALTH, INC.: JOHN PROUT - \$858,502; WILLIAM GRONEMAN - \$22,635.
PART I, LINE 3	TRIHEALTH, INC., A RELATED ORGANIZATION OF BETHESDA HOSPITAL, INC., USES THE FOLLOWING TO ESTABLISH THE COMPENSATION OF THE ORGANIZATION'S CEO/EXECUTIVE DIRECTOR: COMPENSATION COMMITTEE, INDEPENDENT COMPENSATION CONSULTANT, WRITTEN EMPLOYMENT CONTRACT, COMPENSATION SURVEY OR STUDY, AND APPROVAL BY THE BOARD/COMPENSATION COMMITTEE.
PART I, LINE 4A	THE REPORTABLE INDIVIDUALS OF BETHESDA HOSPITAL, INC. ARE PAID BY TRIHEALTH, INC., A RELATED ORGANIZATION, RECOGNIZED BY THE INTERNAL REVENUE SERVICE AS EXEMPT FROM FEDERAL INCOME TAX UNDER INTERNAL REVENUE CODE SECTION 501(A) AS AN ORGANIZATION DESCRIBED IN INTERNAL REVENUE CODE SECTION 501(C)(3). TRIHEALTH, INC. HAS A STANDARD EMPLOYEE SEVERANCE PACKAGE. GENERAL SEVERANCE PAY IS BASED ON LENGTH OF SERVICE. IN ADDITION, NOTICE PAY, IF APPLICABLE UNDER TRIHEALTH, INC. POLICY, MAY BE ADDED TO THE SEVERANCE PACKAGE AND THE AMOUNT OF NOTICE PAY WILL BE DETERMINED BY HUMAN RESOURCES IN ACCORDANCE WITH TRIHEALTH, INC. POLICY. PAYMENTS OF SEVERANCE ARE CONDITIONED UPON SIGNING A SEPARATION AND RELEASE AGREEMENT. DURING THE 2014 CALENDAR YEAR, THE FOLLOWING REPORTABLE INDIVIDUALS RECEIVED SEVERANCE PAYMENTS FROM TRIHEALTH, INC.: SHER MCCLANAHAN - \$216,296.

Additional Data

Software ID:
Software Version:
EIN: 31-0537122
Name: BETHESDA HOSPITAL INC

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

(A) Name and Title	(B) Breakdown of W-2 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 in prior Form 990
	(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
JOHN PROUT, CEO	(i)	0	0	0	0	0	0
	(ii)	999,918	0	899,703	459,406	9,807	2,368,834
ALAN ALTMAN MD, MED STAFF PRES-BETHESDA	(i)	0	0	45,000	0	45,000	0
	(ii)	632,590	0	2,037	68,008	24,663	727,298
CRAIG EISENTROUT MD, TRUSTEE	(i)	0	0	0	0	0	0
	(ii)	509,121	0	4,188	26,268	22,460	562,037
DONNA NIENABER ESQ, SVP CORP COUNSEL/ASST SECR	(i)	0	0	0	0	0	0
	(ii)	367,879	159,406	32,612	149,191	14,887	723,975
CRAIG RUCKER, ASST TREASURER (END 8/14)	(i)	0	0	0	0	0	0
	(ii)	320,089	174,532	57,954	96,120	9,592	658,287
MICHAEL CROFTON, CFO/ASST TREASURER (START 9/14)	(i)	0	0	0	0	0	0
	(ii)	297,044	136,647	26,209	87,580	24,753	572,233
WILLIAM GRONEMAN, EXEC VP SYSTEM DEVELOPMENT	(i)	0	0	0	0	0	0
	(ii)	429,983	152,937	72,678	167,030	27,328	849,956
GERALD OLIPHANT, EXEC VP & COO	(i)	0	0	0	0	0	0
	(ii)	522,235	180,186	19,664	137,358	25,436	884,879
GEORGES FEGHALI MD, CHIEF MEDICAL OFFICER (END 12/14)	(i)	0	0	0	0	0	0
	(ii)	436,528	174,577	39,188	164,261	22,435	836,989
JOHN ROBINSON MD, SVP-HOSPITAL OPERATIONS	(i)	0	0	0	0	0	0
	(ii)	314,943	95,378	15,469	79,160	25,123	530,073
BARB BOYNE, EXEC DIRECTOR-BETHESDA NORTH	(i)	0	0	0	0	0	0
	(ii)	189,320	49,425	921	75,653	19,932	335,251
ROBERT COLLINS MD, CHIEF MEDICAL OFFICER (START 1/15)	(i)	0	0	0	0	0	0
	(ii)	325,380	81,722	20,472	94,905	14,402	536,881
CHARLES BROWN, EXEC DIRECTOR-BETHESDA BUTLER	(i)	0	0	0	0	0	0
	(ii)	143,247	25,023	174	9,159	70	177,673
RAYMOND HELLMANN MD, PHYSICIAN	(i)	261,842	100	3,537	57,524	14,342	337,345
	(ii)	0	0	0	0	0	0
RICHARD OKRAGLY MD, PHYSICIAN	(i)	203,865	752	7,170	20,913	21,381	254,081
	(ii)	0	0	0	0	0	0
SAKUNTHALA NATARAJAN MD, PHYSICIAN	(i)	235,789	0	5,134	100,134	1,098	342,155
	(ii)	0	0	0	0	0	0
ROBERT KUNKEL MD, PHYSICIAN	(i)	230,376	0	1,677	41,005	20,651	293,709
	(ii)	0	0	0	0	0	0
LORRAINE STEPHENS MD, PHYSICIAN	(i)	206,028	0	1,033	36,232	21,940	265,233
	(ii)	0	0	0	0	0	0
SHER MCCLANAHAN, FORMER	(i)	0	0	0	0	0	0
	(ii)	416,010	0	310,374	76,339	4,203	806,926

SCHEDULE O
(Form 990 or 990-EZ)Department of the Treasury
Internal Revenue Service**Supplemental Information to Form 990 or 990-EZ****Complete to provide information for responses to specific questions on
Form 990 or 990-EZ or to provide any additional information.****▶ Attach to Form 990 or 990-EZ.****▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at
www.irs.gov/form990.**

OMB No 1545-0047

2014**Open to Public
Inspection**Name of the organization
BETHESDA HOSPITAL INC**Employer identification number**

31-0537122

**Return
Reference****Explanation**FORM 990,
PART VI,
SECTION A,
LINE 2

THE OFFICERS, DIRECTORS AND TRUSTEES OF BETHESDA HOSPITAL, INC LISTED IN PART VII, SECTION A HAVE A "BUSINESS RELATIONSHIP" WITH EACH OTHER BY VIRTUE OF SITTING ON THE BOARDS OF TRIHEALTH, INC , TRIHEALTH HOSPITAL, INC AND THE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO, ALL AFFILIATED ENTITIES OF BETHESDA HOSPITAL, INC WAYNE SHIRCLIFF, ELLEN KATZ, CRAIG EISENTROUT, MD, ALAN ALTMAN, MD, MICHAEL HAVERKAMP, AND MYRTIS POWELL HAVE A "BUSINESS RELATIONSHIP" WITH EACH OTHER BY VIRTUE OF SITTING ON THE BOARD OF BETHESDA, INC , THE SINGLE CORPORATE MEMBER OF BETHESDA HOSPITAL, INC JOHN PROUT AND CRAIG EISENTROUT, MD HAVE A "BUSINESS RELATIONSHIP" WITH EACH OTHER BY VIRTUE OF SITTING ON THE BOARD OF BETHESDA FOUNDATION, INC , A RELATED ENTITY OF BETHESDA HOSPITAL, INC JOHN PROUT AND MYRTIS POWELL HAVE A "BUSINESS RELATIONSHIP" WITH EACH OTHER BY VIRTUE OF SITTING ON THE BOARD OF THE GOOD SAMARITAN COLLEGE OF NURSING AND HEALTH SCIENCE, AN AFFILIATED ENTITY OF BETHESDA HOSPITAL, INC JOHN PROUT, MARK CLEMENT, DONNA NIENABER, ESQ , MICHAEL CROFTON, CRAIG RUCKER, WILLIAM GRONEMAN, GERALD OLIPHANT, ALAN ALTMAN, MD, ROBERT COLLINS, MD, GEORGES FEGHALI, MD, JOHN ROBINSON, MD, AND BARB BOYNE HAVE A "BUSINESS RELATIONSHIP" WITH EACH OTHER BY VIRTUE OF SITTING ON RELATED ENTITY BOARDS OF TRIHEALTH, INC AND ITS SUBSIDIARIES AND AFFILIATES AS WELL AS BEING EMPLOYED BY TRIHEALTH, INC SR SALLY DUFFY AND MICHAEL MCGRAW HAVE A "BUSINESS RELATIONSHIP" WITH EACH OTHER VIA AN UNRELATED TAX-EXEMPT ORGANIZATION

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 6	BETHESDA HOSPITAL, INC HAS TWO CORPORATE MEMBERS - BETHESDA, INC (VOTING MEMBER) AND TRIHEALTH, INC (NON-VOTING MEMBER)

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7A	BETHESDA, INC HAS THE ABILITY TO ELECT MEMBERS TO THE GOVERNING BODY OF BETHESDA HOSPITAL, INC

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B	BETHESDA, INC MUST APPROVE CERTAIN FINANCIAL TRANSACTIONS, AMENDMENTS TO BETHESDA HOSPITAL, INC 'S GOVERNING DOCUMENTS AND THOSE MATTERS RESERVED BY OHIO LAW

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11	MEMBERS OF THE BOARD ARE PROVIDED AN ELECTRONIC COPY OF THIS FORM 990 PRIOR TO FILING. HOWEVER, FOR THE PROTECTION OF DONOR PRIVACY, SCHEDULE B - SCHEDULE OF CONTRIBUTORS WAS REMOVED FROM THE COPY PROVIDED TO THE BOARD. SUBSEQUENT TO PRESENTATION TO THE BOARD, THE ORGANIZATION FILES THE RETURN MAKING ANY NON-SUBSTANTIVE CHANGES NECESSARY TO EFFECT E-FILING. ANY SUCH NON-SUBSTANTIVE CHANGES ARE NOT SUBMITTED TO THE BOARD.

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	ALL BOARD MEMBERS ARE REQUIRED TO ANNUALLY DISCLOSE CERTAIN FINANCIAL INTERESTS AND FIDUCIARY RELATIONSHIPS. THE EXECUTIVE COMMITTEE AND CORPORATE COUNSEL REVIEW RESPONSES, CONDUCT FURTHER INVESTIGATION (IF NECESSARY), AND DETERMINE WHEN A CONFLICT EXISTS WITH RESPECT TO A CERTAIN TRANSACTION. IF A CONFLICT EXISTS, THE TRANSACTION IS NOT TO BE ENTERED INTO UNLESS ALTERNATIVES ARE FULLY INVESTIGATED, AND IN THEIR ABSENCE, THE BOARD, WITHOUT THE PARTICIPATION OF THE INTERESTED MEMBER(S), DETERMINES THAT THE TRANSACTION IS IN THE BEST INTEREST OF THE ORGANIZATION. PLANS TO MANAGE THE CONFLICT DURING THE RELATIONSHIP ARE IMPLEMENTED. ALL DISCUSSIONS ARE APPROPRIATELY DOCUMENTED. ALL DIRECTORS AND MANAGERS, WHICH INCLUDE OFFICERS AND KEY EMPLOYEES, ARE REQUIRED TO ANNUALLY DISCLOSE ANY CIRCUMSTANCES, INCLUDING FAMILY AND BUSINESS RELATIONSHIPS, THAT MAY CREATE A CONFLICT OF INTEREST FOR THE ORGANIZATION. THESE RESPONSES ARE REVIEWED AND ACTED UPON BY A CONFLICT OF INTEREST COMMITTEE.

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15	IN DETERMINING COMPENSATION OF THE BETHESDA HOSPITAL, INC 'S OFFICERS AND KEY EMPLOYEES, THE ANNUAL PROCESS PERFORMED BY TRIHEALTH, INC (A RELATED ORGANIZATION WHO PAID THE INDIVIDUALS), INCLUDED COMPENSATION COMMITTEE, INDEPENDENT COMPENSATION CONSULTANT, COMPENSATION SURVEY OR STUDY, AND APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE. ADDITIONALLY, ALL DISCUSSIONS AND DECISIONS ARE CONTEMPORANEOUSLY DOCUMENTED

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	BETHESDA HOSPITAL, INC 'S GOVERNING DOCUMENTS, CONFLICTS OF INTEREST POLICY AND FINANCIAL STATEMENTS ARE AVAILABLE UPON REQUEST

Return Reference	Explanation
FORM 990, PART XI, LINE 9	CONTRIBUTED CAPITAL TO PARENT -10,000,000 RETURN OF CAPITAL 3,081,531 LOSS ON UNCONSOLIDATED ORGANIZATIONS -31,702,718 ELIMINATION OF INVESTMENT IN DIRECT SUBSIDIARY -4,909,502 CHANGE IN PENSION PLAN/SERP FUNDED STATUS -16,824,051 CHANGE IN TEMPORARILY RESTRICTED NET ASSETS HELD AT FOUNDATION -301,715 MISCELLANEOUS -32,016

Return Reference	Explanation
FORM 990, PART I, LINE 6	DURING THE TAX YEAR, BETHESDA HOSPITAL, INC WAS ASSISTED BY 1,050 VOLUNTEERS WHO DONATED APPROXIMATELY 127,600 HOURS

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 1A	THE BOARD OF TRUSTEES OF BETHESDA HOSPITAL, INC ("THE CORPORATION"), ESTABLISHED AN EXECUTIVE COMMITTEE WHICH MAY EXERCISE SUCH POWER AND AUTHORITY OF THE BOARD OF TRUSTEES IN INTERVALS BETWEEN MEETINGS OF THE BOARD AS AUTHORIZED BY THE BOARD THE EXECUTIVE COMMITTEE IS COMPOSED OF THE BOARD CHAIR, THE BOARD VICE CHAIR, THE PRESIDENT & CEO, THE SECRETARY AND TWO OTHER BOARD MEMBERS ALL IN ACCORDANCE WITH THE NETWORK AFFILIATION AGREEMENT

Return Reference	Explanation
FORM 990, PART XII, LINE 2C	THE FINANCIAL STATEMENTS OF BETHESDA HOSPITAL, INC ("HOSPITAL") ARE AUDITED AS PART OF TRIHEALTH, INC AND ITS SUBSIDIARIES AND AFFILIATES ("TRIHEALTH") TRIHEALTH HAS A COMMITTEE THAT ASSUMES THE RESPONSIBILITY FOR OVERSIGHT OF THE AUDIT OF BOTH ITS AND ITS SUBSIDIARIES AND AFFILIATES FINANCIAL STATEMENTS AS WELL AS THE SELECTION OF THE INDEPENDENT AUDITOR IN ADDITION, HOSPITAL'S FINANCIAL STATEMENTS ARE AUDITED WITH BETHESDA, INC , THE PARENT ORGANIZATION OF HOSPITAL BETHESDA, INC HAS A COMMITTEE THAT ASSUMES THE RESPONSIBILITY FOR OVERSIGHT OF THE AUDIT OF BOTH ITS AND ITS SUBSIDIARIES FINANCIAL STATEMENTS AS WELL AS THE SELECTION OF THE INDEPENDENT AUDITOR DURING THE TAX YEAR, THERE WAS NOT A CHANGE IN THE PROCESS OF AUDIT OVERSIGHT AND/OR SELECTION OF AN INDEPENDENT AUDITOR BY EITHER TRIHEALTH OR BETHESDA, INC

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 16B	DURING THE YEAR, BETHESDA HOSPITAL, INC PARTICIPATED IN A JOINT VENTURE WITH ONE OR MORE TAXABLE PERSONS AND/OR ORGANIZATIONS AS OF THE END OF THE FISCAL YEAR, BETHESDA HOSPITAL, INC HAD NOT ADOPTED A WRITTEN POLICY OR PROCEDURE THAT REQUIRES THE ORGANIZATION TO NEGOTIATE, IN ITS TRANSACTIONS AND ARRANGEMENTS WITH OTHER MEMBERS OF THE VENTURE OR ARRANGEMENT, SUCH TERMS AND SAFEGUARDS AS ARE ADEQUATE TO ENSURE THAT THE ORGANIZATION'S EXEMPT STATUS IS PROTECTED HOWEVER, ALL JOINT VENTURES, WHEN ENTERED INTO, HAVE OUTSIDE LEGAL COUNSEL REVIEW OF THE OPERATING AGREEMENT OR OTHER ORGANIZATIONAL DOCUMENTS TO ENSURE THAT THE ORGANIZATION'S EXEMPT STATUS IS PROTECTED PRIOR TO THE COMMENCEMENT OF THE JOINT VENTURE ONCE THE JOINT VENTURE COMMENCES, BETHESDA HOSPITAL, INC PERSONNEL MONITORS ITS ACTIVITITES TO ENSURE THE ORGANIZATION'S EXEMPT STATUS IS PROTECTED

Return Reference	Explanation
FORM 990, PART VII, SECTION A - AVERAGE HOURS PER WEEK	<p>THE OFFICERS AND DIRECTORS FOR BETHESDA HOSPITAL, INC THAT SHOW AT LEAST 60 HOURS PER WEEK PROVIDE SERVICES TO TRIHEALTH, INC (A RELATED ORGANIZATION WHO PAID THE INDIVIDUALS) AND ITS SUBSIDIARIES/AFFILIATES ("TRIHEALTH") AS AN ENTIRE SYSTEM. HOURS WORKED, INCLUDING THEIR DUTIES AS OFFICERS AND DIRECTORS OF THE FILING ORGANIZATION, ARE NOT TRACKED ON AN ENTITY BY ENTITY BASIS, THUS THE AVERAGE HOURS PER WEEK DISCLOSED ARE ESTIMATES TO SHOW THAT THE TIME SPENT BY THESE INDIVIDUALS RELATE TO THEM FULFILLING THEIR DUTIES AS FULL-TIME, 60 HOURS-PER-WEEK EMPLOYEES OF TRIHEALTH VERSUS THEIR DUTIES AS OFFICERS AND DIRECTORS OF THE FILING ORGANIZATION. IN ADDITION, THE COMPENSATION REPORTED ON FORM 990, PART VII WAS PAID TO THESE INDIVIDUALS IN FULFILLMENT OF THEIR DUTIES AS EMPLOYEES OF TRIHEALTH. DIRECTORS (AS NOTED WITH A "MED STAFF PRES" REFERENCE) FOR BETHESDA HOSPITAL, INC SERVE ON THE BOARD IN THEIR CAPACITY AS MEDICAL STAFF PRESIDENT FOR EITHER BETHESDA HOSPITAL, INC OR THE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO. IN ADDITION, THESE INDIVIDUALS PROVIDE SERVICES AS EMPLOYEES OF VARIOUS RELATED ENTITIES FOR WHICH THEY RECEIVE COMPENSATION. NONE OF THE COMPENSATION SHOWN IS FOR SERVING AS A DIRECTOR.</p>

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.
▶ Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization BETHESDA HOSPITAL INC	Employer identification number 31-0537122
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Part I

Identification of Disregarded Entities

Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

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

Part II

Identification of Related Tax-Exempt Organizations

Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.

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

Part IIIdentification 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) Disproporionate 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) 10600 MONTGOMERY LLC 619 OAK STREET-ACCOUNTING 3 WEST CINCINNATI, OH 45206 26-1964995	PROPERTY MANAGEMENT	OH	N/A									

Part IVIdentification 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) TJ CUBEDMONTGOMERY INC 619 OAK STREET- ACCOUNTING 3 WEST CINCINNATI, OH 45206 26-1964885	HOLDING COMPANY	OH	N/A	S				Yes	
(2) TRIHEALTH PHYSICIANS OF INDIANA INC 619 OAK STREET- ACCOUNTING 3 WEST CINCINNATI, OH 45206 46-1125130	PHYSICIAN PRACTICES	OH	N/A	C				Yes	
(3) TRIHEALTH PHYSICIAN SOLUTIONS INC 619 OAK STREET- ACCOUNTING 3 WEST CINCINNATI, OH 45206 31-1444353	CLAIMS ADMINISTRATION	OH	N/A	C				Yes	
(4) TRIHEALTH CIPHO INC 619 OAK STREET- ACCOUNTING 3 WEST CINCINNATI, OH 45206 46-3294306	PHYSICIAN HEALTH ORGANIZATION	OH	N/A	C				Yes	

Part V

Transactions With Related Organizations

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

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

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 Yes

1b Yes

1c Yes

1d

1e

1f

1g

1h

1i

1j

1k Yes

1l Yes

1m Yes

1n

1o Yes

1p Yes

1q

1r

1s Yes

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

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

Schedule R (Form 990) 2014

Part VI **Unrelated Organizations Taxable as a Partnership** Complete if the organization answered "Yes" on Form 990, Part IV, line 37.
Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization See instructions regarding exclusion for certain investment partnerships

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

Part VII

Supplemental Information

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

Return Reference	Explanation
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Additional Data

Software ID:

Software Version:

EIN: 31-0537122

Name: BETHESDA HOSPITAL INC

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c) 3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
(1) BETHESDA INC 619 OAK STREET-ACCOUNTING 3 WEST CINCINNATI, OH 45206 31-1108895	INVESTMENT MANAGEMENT	OH	SECTION 501 (C)(3)	SCHEDULE A, LINE 11C	N/A		No
(1) BETHESDA FOUNDATION INC 619 OAK STREET-ACCOUNTING 3 WEST CINCINNATI, OH 45206 23-7374129	FUNDRAISING	OH	SECTION 501 (C)(3)	SCHEDULE A, LINE 7	BETHESDA INC	Yes	
(2) BETHESDA HEALTHCARE INC 619 OAK STREET-ACCOUNTING 3 WEST CINCINNATI, OH 45206 31-1027660	HEALTHCARE SERVICES	OH	SECTION 501 (C)(3)	SCHEDULE A, LINE 11B	BETHESDA INC	Yes	
(3) BETHESDA FAMILY PRACTICE CENTER 619 OAK STREET-ACCOUNTING 3 WEST CINCINNATI, OH 45206 31-1242442	HEALTHCARE SERVICES	OH	SECTION 501 (C)(3)	SCHEDULE A, LINE 11A	BETHESDA HOSPITAL INC	Yes	
(4) BETHESDA PROPERTIES INC 619 OAK STREET-ACCOUNTING 3 WEST CINCINNATI, OH 45206 31-1352694	PROPERTY MANAGEMENT	OH	SECTION 501 (C)(2)		BETHESDA HOSPITAL INC	Yes	
(5) HOSPICE OF CINCINNATI INCORPORATED 619 OAK STREET-ACCOUNTING 3 WEST CINCINNATI, OH 45206 31-0917155	HOSPICE SERVICES	OH	SECTION 501 (C)(3)	SCHEDULE A, LINE 9	BETHESDA HOSPITAL INC	Yes	
(6) FERNSIDE INC A CENTER FOR GRIEVING CHILDREN 619 OAK STREET-ACCOUNTING 3 WEST CINCINNATI, OH 45206 31-1179234	COUNSELING TO GRIEVING CHILDREN	OH	SECTION 501 (C)(3)	SCHEDULE A, LINE 7	HOSPICE OF CINCINNATI INCORPORATED	Yes	
(7) TRIHEALTH INC 619 OAK STREET-ACCOUNTING 3 WEST CINCINNATI, OH 45206 31-1438846	SUPPORT AFFILIATED HOSPITALS	OH	SECTION 501 (C)(3)	SCHEDULE A, LINE 11B	N/A	Yes	
(8) THE GOOD SAMARITAN HOSPITAL OF CINCINNATI OHIO 619 OAK STREET-ACCOUNTING 3 WEST CINCINNATI, OH 45206 31-0537486	INPATIENT AND OUTPATIENT SERVICES	OH	SECTION 501 (C)(3)	SCHEDULE A, LINE 3	TRIHEALTH INC	Yes	
(9) GOOD SAMARITAN COLLEGE OF NURSING AND HEALTH SCIENCE 619 OAK STREET-ACCOUNTING 3 WEST CINCINNATI, OH 45206 31-1778403	EDUCATION	OH	SECTION 501 (C)(3)	SCHEDULE A, LINE 2	THE GOOD SAMARITAN HOSPITAL OF CINCINNATI OHIO	Yes	
(10) COMMUNITY LIMITED CARE DIALYSIS CENTER 619 OAK STREET-ACCOUNTING 3 WEST CINCINNATI, OH 45206 23-7419853	DIALYSIS	OH	SECTION 501 (C)(2)		THE GOOD SAMARITAN HOSPITAL OF CINCINNATI OHIO	Yes	
(11) GOOD SAMARITAN HOSPITAL FREE CLINIC 619 OAK STREET-ACCOUNTING 3 WEST CINCINNATI, OH 45206 27-3893817	HEALTHCARE SERVICES	OH	SECTION 501 (C)(3)	SCHEDULE A, LINE 7	TRIHEALTH INC	Yes	
(12) TRIHEALTH HOSPITALINC 619 OAK STREET-ACCOUNTING 3 WEST CINCINNATI, OH 45206 46-1393755	INPATIENT AND OUTPATIENT SERVICES	OH	SECTION 501 (C)(3)	SCHEDULE A, LINE 3	TRIHEALTH INC	Yes	
(13) TRIHEALTH PHYSICIAN ENTERPRISE CORP 619 OAK STREET-ACCOUNTING 3 WEST CINCINNATI, OH 45206 31-1383365	PHYSICIAN PRACTICES	OH	SECTION 501 (C)(3)	SCHEDULE A, LINE 9	TRIHEALTH INC	Yes	
(14) TRIHEALTH PHYSICIAN INSTITUTE 619 OAK STREET-ACCOUNTING 3 WEST CINCINNATI, OH 45206 31-1074519	PHYSICIAN PRACTICES	OH	SECTION 501 (C)(3)	SCHEDULE A, LINE 9	TRIHEALTH INC	Yes	
(15) MCCULLOUGH HYDE MEMORIAL HOSPITAL INC 110 N POPLAR STREET OXFORD, OH 45056 31-0650283	INPATIENT AND OUTPATIENT SERVICES	OH	SECTION 501 (C)(3)	SCHEDULE A, LINE 3	TRIHEALTH INC	Yes	

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
TRIHEALTH PHYSICIAN ENTERPRISE CORP	A	394,485	FMV
TRIHEALTH PHYSICIAN INSTITUTE	A	280,416	FMV
BETHESDA HEALTHCARE INC	A	32,454	FMV
TRIHEALTH INC	B	38,033,172	CASH
BETHESDA INC	B	10,000,000	CASH
BETHESDA FOUNDATION INC	B	64,680	CASH
BETHESDA INC	C	944,440	CASH
BETHESDA FOUNDATION INC	C	1,939,691	CASH
GOOD SAMARITAN HOSPITAL OF CINCINNATI OHIO	K	11,440	FMV
BETHESDA PROPERTIES INC	K	1,768,693	FMV
BETHESDA HEALTHCARE INC	K	428,464	FMV
TRIHEALTH PHYSICIAN ENTERPRISE CORP	K	8,400	FMV
TRIHEALTH INC	K	5,923	FMV
TRIHEALTH INC	M	181,142	FMV
TRIHEALTH PHYSICIAN SOLUTIONS INC	M	77,717	FMV
TRIHEALTH INC	M	91,526,083	COST
TRIHEALTH INC	P	191,919,393	COST
HOSPICE OF CINCINNATI INCORPORATED	O	32,762,165	FMV
BETHESDA INC	O	1,938,637	FMV
FERNSIDE INC A CENTER FOR GRIEVING CHILDREN	O	396,053	FMV
BETHESDA FOUNDATION INC	O	916,331	FMV
BETHESDA PROPERTIES INC	O	187,274	FMV
BETHESDA PROPERTIES INC	S	4,575,339	CASH