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Form 990

Return of Organization Exempt From Income Tax

OMB No 1545-0047

2016

Open to Public Inspection

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](#)

Department of the Treasury
Internal Revenue Service

A For the 2016 calendar year, or tax year beginning 07-01-2016 , and ending 06-30-2017

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

MARK CLEMENT

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

D Employer identification number

31-0537122

E Telephone number

(513) 569-6575

G Gross receipts \$ 653,724,555

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities

TO IMPROVE THE HEALTH STATUS OF THE PEOPLE WE SERVE

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

3 Number of voting members of the governing body (Part VI, line 1a)

4 Number of independent voting members of the governing body (Part VI, line 1b)

5 Total number of individuals employed in calendar year 2016 (Part V, line 2a)

6 Total number of volunteers (estimate if necessary)

7a Total unrelated business revenue from Part VIII, column (C), line 12

7b Net unrelated business taxable income from Form 990-T, line 34

Revenue

8 Contributions and grants (Part VIII, line 1h)

9 Program service revenue (Part VIII, line 2g)

10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)

11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)

12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)

Expenses

13 Grants and similar amounts paid (Part IX, column (A), lines 1–3)

14 Benefits paid to or for members (Part IX, column (A), line 4)

15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)

16a Professional fundraising fees (Part IX, column (A), line 11e)

b Total fundraising expenses (Part IX, column (D), line 25) ▶0

17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)

18 Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)

19 Revenue less expenses Subtract line 18 from line 12

Net Assets or Fund Balances

20 Total assets (Part X, line 16)

21 Total liabilities (Part X, line 26)

22 Net assets or fund balances Subtract line 21 from line 20

Prior Year

Current Year

763,5911,175,774

549,288,716567,029,288

11,441,76228,352,450

10,335,3069,975,676

571,829,375606,533,188

1,043,0901,105,297

00

261,615,419264,964,537

00

238,290,096259,663,092

500,948,605525,732,926

70,880,77080,800,262

Beginning of Current YearEnd of Year

817,420,2151,147,727,202

359,187,755639,176,390

458,232,460508,550,812

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

2018-05-10

Date

BRIAN KRAUSE VP FINANCE

Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name

Preparer's signature

Date

Check ☐ if self-employed

PTIN

P00741382

Firm's name ▶ DELOITTE TAX LLP

Firm's EIN ▶ 86-1065772

Firm's address ▶ 250 EAST FIFTH STREET

Phone no (513) 784-7100

CINCINNATI, OH 45202

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 (2016)

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? ☐ Yes ☒ No

If "Yes," describe these new services on Schedule O

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? ☐ Yes ☒ No

If "Yes," describe these changes on Schedule O

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a	(Code)	(Expenses \$ 423,057,714	including grants of \$ 1,105,297)	(Revenue \$ 561,654,874)
	See Additional Data			

4b	(Code)	(Expenses \$	including grants of \$	(Revenue \$)
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4c	(Code)	(Expenses \$	including grants of \$	(Revenue \$)
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4d	Other program services (Describe in Schedule O)	(Expenses \$	including grants of \$	(Revenue \$)
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4e	Total program service expenses ▶	423,057,714
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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

Part IV Checklist of Required Schedules (continued)

	Yes	No
20a Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	20a Yes	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b Yes	
21 Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <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 Yes	
b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b	No
c Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c	No
d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d	No
25a Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? <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 ComplianceCheck if Schedule O contains a response or note to any line in this Part V ☐

		Yes	No
1a	Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable	1a	396
b	Enter the number of Forms W-2G included in line 1a Enter -0- if not applicable	1b	0
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c	Yes
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	4,359
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? If "No" to line 3b, provide an explanation in Schedule O	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? If "No," provide an explanation in Schedule O	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		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O		
b	Enter the number of voting members included in line 1a, above, who are independent		
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?	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?		No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?		No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?		No
6	Did the organization have members or stockholders?	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?	Yes	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	Yes	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:		
a	The governing body?	Yes	
b	Each committee with authority to act on behalf of the governing body?	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.		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?		No
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?		
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?		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.	Yes	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	Yes	
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done.	Yes	
13	Did the organization have a written whistleblower policy?	Yes	
14	Did the organization have a written document retention and destruction policy?	Yes	
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?		
a	The organization's CEO, Executive Director, or top management official.		No
b	Other officers or key employees of the organization.		No
	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?	Yes	
b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?		No

Section C. Disclosure

17	List the States with which a copy of this Form 990 is required to be filed: BRIAN KRAUSE - VP FINANCE 619 OAK STREET - ACCOUNTING 3 WEST CINCINNATI, OH 45206 (513) 569-5126
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. <input type="checkbox"/> Own website <input type="checkbox"/> Another's website <input checked="" type="checkbox"/> Upon request <input type="checkbox"/> 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 ☐

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

Form **990** (2016)

[illegible]

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization ▶ 144

Section B. Independent Contractors

(A) Name and business address	(B) Description of services	(C) Compensation
CATHOLIC HEALTH INITIATIVES 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112	CLINICAL ENGINEERING	6,766,613
AMERICAN NURSING CARE INC 1700 EDISON DRIVE SUITE 300 MILFORD, OH 45150	NURSE STAFFING	1,976,367
PATHOLOGY ASSOCIATES MEDICAL LABS PO BOX 2720 SPOKANE, WA 99220	LABORATORY	1,743,286
MEDSPEED LLC 655 W GRAND AVENUE SUITE 320 ELMHURST, IL 60126	HEALTHCARE DELIVERY SVCS	1,502,580
REHAB RESOURCES INC 2315 N HEATHER HILL BLVD CINCINNATI, OH 45244	REHABILITATION SERVICES	1,448,140

Form 990 (2016)

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns . . .	1a				
	b Membership dues . . .	1b				
	c Fundraising events . . .	1c				
	d Related organizations	1d	1,087,865			
	e Government grants (contributions)	1e	78,650			
	f All other contributions, gifts, grants, and similar amounts not included above	1f	9,259			
	g Noncash contributions included in lines 1a-1f \$ _____					
	h Total. Add lines 1a-1f		1,175,774			
Program Service Revenue		Business Code				
	2a PATIENT REVENUE	621990	577,105,722	576,245,166	860,556	
	b AFFILIATED ORG. RENTAL	532000	6,646,565			6,646,565
	c JV REVENUE	900099	4,775,512	6,287,764	-1,512,252	
	d SENIOR HEALTH SERVICES	900099	661,078	661,078		
	e JOA REVENUE	900099	-22,435,114	-22,435,114		
	f All other program service revenue		275,525	275,525		
	g Total. Add lines 2a-2f		567,029,288			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		3,881,992			3,881,992
	4 Income from investment of tax-exempt bond proceeds					
	5 Royalties					
	6a Gross rents	(i) Real (ii) Personal				
		704,081				
	b Less rental expenses	0				
	c Rental income or (loss)	704,081				
	d Net rental income or (loss)		704,081			704,081
	7a Gross amount from sales of assets other than inventory	(i) Securities (ii) Other				
		68,154,165 2,923,535				
	b Less cost or other basis and sales expenses	42,538,343 4,068,899				
	c Gain or (loss)	25,615,822 -1,145,364				
	d Net gain or (loss)		24,470,458			24,470,458
	8a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18	a				
	b Less direct expenses	b				
	c Net income or (loss) from fundraising events					
	9a Gross income from gaming activities See Part IV, line 19	a				
	b Less direct expenses	b				
	c Net income or (loss) from gaming activities					
	10a Gross sales of inventory, less returns and allowances	a	850,882			
b Less cost of goods sold	b	584,125				
c Net income or (loss) from sales of inventory		266,757	266,757			
Miscellaneous Revenue		Business Code				
11a APOTHECARY	621990	6,110,429		2,045,142	4,065,287	
b CAFETERIA	900099	2,172,755			2,172,755	
c OUTSIDE LAB SERVICES	900099	367,956		367,956		
d All other revenue		353,698	353,698			
e Total. Add lines 11a-11d		9,004,838				
12 Total revenue. See Instructions		606,533,188	561,654,874	1,761,402	41,941,138	

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.	1,105,297	1,105,297		
2 Grants and other assistance to domestic individuals. See Part IV, line 22.				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.				
4 Benefits paid to or for members.				
5 Compensation of current officers, directors, trustees, and key employees.	3,415,076		3,415,076	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B).	3,755,794		3,755,794	
7 Other salaries and wages.	202,645,046	165,922,774	36,722,272	
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).	9,017,129	6,454,282	2,562,847	
9 Other employee benefits.	30,702,202	22,759,398	7,942,804	
10 Payroll taxes.	15,429,290	12,153,676	3,275,614	
11 Fees for services (non-employees):				
a Management.	2,816,225	2,816,225		
b Legal.	2,105,685		2,105,685	
c Accounting.	379,871		379,871	
d Lobbying.				
e Professional fundraising services. See Part IV, line 17.				
f Investment management fees.	819,445		819,445	
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	30,833,442	18,600,067	12,233,375	
12 Advertising and promotion.	4,664,076	42,111	4,621,965	
13 Office expenses.	8,559,678	5,486,761	3,072,917	
14 Information technology.	8,219,649	748,508	7,471,141	
15 Royalties.				
16 Occupancy.	16,138,963	14,164,092	1,974,871	
17 Travel.	727,482	246,878	480,604	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials.				
19 Conferences, conventions, and meetings.	565,795	318,063	247,732	
20 Interest.	10,531,600	10,531,600		
21 Payments to affiliates.				
22 Depreciation, depletion, and amortization.	37,119,060	27,995,771	9,123,289	
23 Insurance.	2,230,330	2,230,330		
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	112,008,546	111,687,269	321,277	
b EQUIPMENT & REPAIRS	9,514,077	9,122,963	391,114	
c OHIO HOSPITAL FEE	9,182,874	9,182,874		
d O&M COST TRACK FEES	793,815	793,815		
e All other expenses	2,452,479	694,960	1,757,519	
25 Total functional expenses. Add lines 1 through 24e.	525,732,926	423,057,714	102,675,212	0
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

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

				(A) Beginning of year		(B) End of year	
Assets	1	Cash—non-interest-bearing		64,710	1	44,869	
	2	Savings and temporary cash investments			2		
	3	Pledges and grants receivable, net			3		
	4	Accounts receivable, net		66,116,789	4	66,665,987	
	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		3,979,672	8	4,587,591	
	9	Prepaid expenses and deferred charges		2,104,612	9	1,543,516	
	10a	Land, buildings, and equipment—cost or other basis. Complete Part VI of Schedule D	10a	743,429,972			
	b	Less: accumulated depreciation	10b	371,373,481	271,514,500	10c	372,056,491
	11	Investments—publicly traded securities		248,818,071	11	461,552,651	
	12	Investments—other securities. See Part IV, line 11		63,158,699	12	63,641,619	
	13	Investments—program-related. See Part IV, line 11		117,957,750	13	104,735,439	
	14	Intangible assets		21,177,495	14	38,163,665	
	15	Other assets. See Part IV, line 11		22,527,917	15	34,735,374	
16	Total assets. Add lines 1 through 15 (must equal line 34)		817,420,215	16	1,147,727,202		
Liabilities	17	Accounts payable and accrued expenses		44,843,642	17	44,327,040	
	18	Grants payable			18		
	19	Deferred revenue		365,795	19	167,811	
	20	Tax-exempt bond liabilities			20	411,569,116	
	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		214,349,633	23	97,605,724	
	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		99,628,685	25	85,506,699	
	26	Total liabilities. Add lines 17 through 25		359,187,755	26	639,176,390	
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		444,172,298	27	483,768,820	
	28	Temporarily restricted net assets		14,060,162	28	24,781,992	
	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		458,232,460	33	508,550,812		
34	Total liabilities and net assets/fund balances		817,420,215	34	1,147,727,202		

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	606,533,188
2	Total expenses (must equal Part IX, column (A), line 25)	2	525,732,926
3	Revenue less expenses Subtract line 2 from line 1	3	80,800,262
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	458,232,460
5	Net unrealized gains (losses) on investments	5	2,034,686
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	2,808,309
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-35,324,905
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	508,550,812

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

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

Additional Data

Software ID:

Software Version:

EIN: 31-0537122

Name: BETHESDA HOSPITAL INC

Form 990 (2016)

Form 990, Part III, Line 4a:

SEE SCHEDULE H

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			
MICHAEL HAVERKAMP TRUSTEE	1 00 3 00	X						0	0	0
PAUL EDGETT III TRUSTEE	1 00 3 00	X						0	0	0
MYRTIS POWELL TRUSTEE	1 00 3 00	X						0	0	0
DR SALLY DUFFY SECRETARY	1 00 3 00	X		X				0	0	0
CRAIG EISENTROUT MD TRUSTEE	1 00 60 00	X						0	658,651	37,912
WAYNE SHIRCLIFF CHAIR	1 00 3 00	X		X				0	0	0
RALPH S MICHAEL VICE CHAIR/TREASURER	1 00 3 00	X		X				0	0	0
MARK CLEMENT PRESIDENT/CEO	15 00 45 00	X		X				0	1,289,284	276,073
MARK DELWORTH MD MED STAFF PRES-BETHESDA	1 00 3 00	X						123,600	0	0
MARGARET LEMASTERS MD MED STAFF PRES-GOOD SAM	1 00 3 00	X						0	45,000	0

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors											
(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations	
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former				
PHILLIP CASTELLINI TRUSTEE	1 00 3 00	X						0	0	0	
LISA KNUTSON TRUSTEE	1 00 3 00	X						0	0	0	
THEODORE TORBECK TRUSTEE	1 00 3 00	X						0	0	0	
DONNA NIENABER ESQ ASST SECRETARY (END 7/16)	15 00 45 00			X				0	505,664	119,664	
MICHAEL CROFTON ASST TREASURER	15 00 45 00			X				0	533,255	130,762	
WILLIAM GRONEMAN EXEC VP SYSTEM DEVELOPMENT	15 00 45 00				X			0	759,158	202,031	
BARB BOYNE EXEC DIR-BETHESDA NORTH	60 00 0 00				X			0	256,494	47,452	
ROBERT COLLINS MD CHIEF MEDICAL OFFICER	15 00 45 00				X			0	568,916	141,265	
CHARLES BROWN EXEC DIR-BETHESDA BUTLER	60 00 0 00				X			0	245,282	11,851	
GAIL DONOVAN EXEC VP & COO	5 00 55 00				X			0	895,557	133,654	

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			
STEFANIE NEWMAN VP-CHIEF NURSING OFFICER	60 00 0 00				X			0	297,436	58,541
JASON NIEHAUS SVP-BETHESDA REGION	60 00 0 00				X			0	152,127	12,898
DAVID COOK CHIEF HUMAN RESOURCES OFFICER	15 00 45 00				X			0	290,612	41,569
ANDREW DEVOE CHIEF FINANCIAL OFFICER	15 00 45 00				X			0	570,000	0
RAYMOND HELLMANN MD PHYSICIAN	60 00 0 00					X		243,205	0	37,631
RICHARD OKRAGLY MD PHYSICIAN	60 00 0 00					X		212,962	0	34,042
SAKUNTHALA NATARAJAN MD PHYSICIAN	60 00 0 00					X		224,106	0	28,586
ROBERT KUNKEL MD PHYSICIAN	60 00 0 00					X		238,228	0	30,151
LORRAINE STEPHENS MD PHYSICIAN	50 00 10 00					X		210,416	22,962	47,025
JOHN PROUT FORMER OFFICER	0 00 60 00						X	0	1,389,908	24,109

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			
GERALD OLIPHANT FORMER KEY EMPLOYEE	0 00 0 00						X	0	558,601	16,915
JOHN ROBINSON MD FORMER KEY EMPLOYEE	0 00 0 00						X	0	264,258	39,921
SHER MCCLANAHAN FORMER KEY EMPLOYEE	0 00 0 00						X	0	631,769	0
GEORGES FEGHALI MD FORMER KEY EMPLOYEE	0 00 0 00						X	0	830,311	0

SCHEDULE A (Form 990 or 990-EZ)	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 2016 Open to Public Inspection
	Department of the Treasury Internal Revenue Service 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 12, check only one box)

- 1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i)**.
- 2 ☐ A school described in **section 170(b)(1)(A)(ii)**. (Attach Schedule E (Form 990 or 990-EZ))
- 3 ☒ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii)**.
- 4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii)**. Enter the hospital's name, city, and state _____
- 5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv)**. (Complete Part II)
- 6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v)**.
- 7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi)**. (Complete Part II)
- 8 ☐ A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II)
- 9 ☐ An agricultural research organization described in **170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture See instructions Enter the name, city, and state of the college or university _____
- 10 ☐ An organization that normally receives (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2)**. (Complete Part III)
- 11 ☐ An organization organized and operated exclusively to test for public safety See **section 509(a)(4)**.
- 12 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2)**. See **section 509(a)(3)**. Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g
- a ☐ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization **You must complete Part IV, Sections A and B.**
- b ☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s) **You must complete Part IV, Sections A and C.**
- c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions) **You must complete Part IV, Sections A, D, and E.**
- d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions) **You must complete Part IV, Sections A and D, and Part V.**
- e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization
- f Enter the number of supported organizations _____
- g Provide the following information about the supported organization(s) _____

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

Part II

Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)
(Complete only if you checked the box on line 5, 7, 8, or 9 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support						
Calendar year (or fiscal year beginning in) ▶	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 Public support. Subtract line 5 from line 4						
Section B. Total Support						
Calendar year (or fiscal year beginning in) ▶	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income (Do not include gain or loss from the sale of capital assets (Explain in Part VI.))						
11 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here ▶ <input type="checkbox"/>						
Section C. Computation of Public Support Percentage						
14 Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f))					14	
15 Public support percentage for 2015 Schedule A, Part II, line 14					15	
16a 33 1/3% support test—2016. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>						
b 33 1/3% support test—2015. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>						
17a 10%-facts-and-circumstances test—2016. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>						
b 10%-facts-and-circumstances test—2015. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>						
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ <input type="checkbox"/>						

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(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)2012	(b)2013	(c)2014	(d)2015	(e)2016	(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 2016 (line 8, column (f) divided by line 13, column (f))	15	
16 Public support percentage from 2015 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2016 (line 10c, column (f) divided by line 13, column (f))	17	
18 Investment income percentage from 2015 Schedule A, Part III, line 17	18	

19a 33 1/3% support tests—2016. 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—2015. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ☐

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

Part V

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

Section D - Distributions	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI) See instructions	
7 Total annual distributions. Add lines 1 through 6	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI) See instructions	
9 Distributable amount for 2016 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-2016	(iii) Distributable Amount for 2016
1 Distributable amount for 2016 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2016 (reasonable cause required--see instructions)			
3 Excess distributions carryover, if any, to 2016			
a			
b			
c From 2013.			
d From 2014.			
e From 2015.			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2016 distributable amount			
i Carryover from 2011 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2016 from Section D, line 7 \$			
a Applied to underdistributions of prior years			
b Applied to 2016 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2016, if any Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions)			
6 Remaining underdistributions for 2016 Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions)			
7 Excess distributions carryover to 2017. Add lines 3j and 4c			
8 Breakdown of line 7			
a			
b Excess from 2013.			
c Excess from 2014.			
d Excess from 2015.			
e Excess from 2016.			

Part VI **Supplemental Information.**

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

Facts And Circumstances Test

SCHEDULE 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

2016

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

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

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

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

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

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

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

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 7202 for this year? ☐ Yes ☐ No

4a Was a correction made? ☐ Yes ☐ No

b If "Yes," describe in Part IV

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

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

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

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

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

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

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

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

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?

☐ Yes ☐ No**4-Year Averaging Period Under section 501(h)**

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

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

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

		(a)		(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		12,045
j	Total. Add lines 1c through 1i			12,045
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 (\$2,645) 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 \$9,400 OF THE AMOUNT SHOWN ON LINE 1I REPRESENTS HOSPITAL'S SHARE OF THESE LOBBYING EXPENSES.

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SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
BETHESDA HOSPITAL INC

Employer identification number
31-0537122

Part I

Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.
Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

(a) Donor advised funds

(b) Funds and other accounts

1

Total number at end of year

2

Aggregate value of contributions to (during year)

3

Aggregate value of grants from (during year)

4

Aggregate value at end of year

5

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

☐ Yes

☐ No

6

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

☐ Yes

☐ No

Part II

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

1

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

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

☐ Preservation of an historically important land area

☐ Protection of natural habitat

☐ Preservation of a certified historic structure

☐ Preservation of open space

2

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

2a

Total number of conservation easements

2b

Total acreage restricted by conservation easements

2c

Number of conservation easements on a certified historic structure included in (a)

2d

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, handling of violations, and enforcing conservation easements during the year ►

7

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

8

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

☐ Yes

☐ No

9

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

Part III

Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.
Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

1a

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

b

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

(i)

Revenue included on Form 990, Part VIII, line 1

► \$

(ii)

Assets included in Form 990, Part X

► \$

2

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

a

Revenue included on Form 990, Part VIII, line 1

► \$

b

Assets included in Form 990, Part X

► \$

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Cat No 52283D

Schedule D (Form 990) 2016

Part III

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

3

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

a

☐ Public exhibition

b

☐ Scholarly research

c

☐ Preservation for future generations

d

☐ Loan or exchange programs

e

☐ Other

4

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

5

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

☐ Yes

☐ No

Part IV

Escrow and Custodial Arrangements.

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

1a

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

☐ Yes

☐ No

b

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

c

Beginning balance

d

Additions during the year

e

Distributions during the year

f

Ending balance

	Amount
1c	
1d	
1e	
1f	

2a

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

☐ Yes

☐ No

b

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

☐

Part V

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

	(a)Current year	(b)Prior year	(c)Two years back	(d)Three years back	(e)Four years back
1a Beginning of year balance	3,493,840	3,624,135	4,097,830	3,958,314	3,566,136
b Contributions	0	250			716
c Net investment earnings, gains, and losses	242,594	-58,206	-131,484	285,534	415,730
d Grants or scholarships					
e Other expenditures for facilities and programs	0	72,339	342,211	146,018	24,268
f Administrative expenses					
g End of year balance	3,736,434	3,493,840	3,624,135	4,097,830	3,958,314

2

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

a

Board designated or quasi-endowment

84 670 %

b

Permanent endowment

15 330 %

c

Temporarily restricted endowment

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

3a

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

(i) unrelated organizations

3a(i)

Yes

No

(ii) related organizations

3a(ii)

Yes

b

If "Yes" on 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' on Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		957,693		957,693
b Buildings		463,785,451	156,800,012	306,985,439
c Leasehold improvements		8,081,121	2,152,364	5,928,757
d Equipment		252,595,654	209,566,491	43,029,163
e Other		18,010,053	2,854,614	15,155,439
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c))				372,056,491

Part VII

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

(a) Description of security or category (including name of security)	(b)Book value	(c)Method of valuation Cost or end-of-year market value
(1)Financial derivatives		
(2)Closely-held equity interests		
(3)Other _____ (A) PRIVATE EQUITY	10,152,271	F
(B) HEDGE FUNDS	19,391,602	F
(C) REAL ESTATE	27,172,911	F
(D) PRIVATE DEBT	6,924,835	F
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Column (b) must equal Form 990, Part X, col (B) line 12) ▶	63,641,619	

Part VIII

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

(a) Description of investment	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1)INVESTMENT IN JOINT VENTURES	104,735,439	C
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. (Column (b) must equal Form 990, Part X, col (B) line 13) ▶	104,735,439	

Part IX

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

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

Part X

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
THIRD PARTY SETTLEMENTS	6,112,354
PENSION LIABILITY	15,563,957
ACCRUED EIB	5,900,000
MALPRACTICE INSURANCE/WORKERS COMPENATION LIABILITY	15,577,982
ENVIRONMENTAL REMEDIATION LIABILITY	2,874,395
DUE TO RELATED ORGANIZATIONS	36,651,917
MISCELLANEOUS	2,826,094
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 25) ▶	85,506,699

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

☒

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

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

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

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

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

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

Part XIII Supplemental Information

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

Return Reference	Explanation
See Additional Data Table	

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

Additional Data

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

Supplemental Information

Return Reference	Explanation
PART V, LINE 4	INVESTMENT PROCEEDS FROM ENDOWMENT FUNDS ARE USED TO SUPPORT BETHESDA HOSPITAL, INC PROGRAMS

Supplemental Information

Return Reference	Explanation
PART X, LINE 2	<p>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 AND DETERMINED THAT 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 AND DETERMINED NO AMOUNTS WERE REQUIRED TO BE RECOGNIZED IN THE CONSOLIDATED FINANCIAL STATEMENTS AT JUNE 30, 2017 AND 2016</p>

efile GRAPHIC print - DO NOT PROCESS		As Filed Data -		DLN: 93493130023128	
SCHEDULE H (Form 990)		Hospitals			OMB No 1545-0047
Department of the Treasury		► Complete if the organization answered "Yes" on Form 990, Part IV, question 20. ► Attach to Form 990.			2016 Open to Public Inspection
Internal Revenue Service		► Information about Schedule H (Form 990) and its instructions is at www.irs.gov/form990 .			
Name of the organization BETHESDA HOSPITAL INC				Employer identification number 31-0537122	

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

7	Financial Assistance and Certain Other Community Benefits at Cost
---	---

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)			7,895,697	10,265,977	0	0 %
b Medicaid (from Worksheet 3, column a)			76,732,161	50,500,827	26,231,334	4 990 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			84,627,858	60,766,804	26,231,334	4 990 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			2,639,398	1,399,971	1,239,427	0 240 %
f Health professions education (from Worksheet 5)			7,602,463	6,504,103	1,098,360	0 210 %
g Subsidized health services (from Worksheet 6)			119,045	0	119,045	0 020 %
h Research (from Worksheet 7)			824,758	0	824,758	0 160 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)			420,010	0	420,010	0 080 %
j Total. Other Benefits			11,605,674	7,904,074	3,701,600	0 710 %
k Total. Add lines 7d and 7j			96,233,532	68,670,878	29,932,934	5 700 %

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Cat No 50192T

Schedule H (Form 990) 2016

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support			63,393	0	63,393	0.010 %
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development						
9 Other						
10 Total			63,393		63,393	0.010 %

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

	Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	No
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2	32,042,600
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit	3	0
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements		

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME)	5	109,145,300
6 Enter Medicare allowable costs of care relating to payments on line 5	6	108,403,503
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	741,797
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other </div>		

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures

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

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1				
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

Community Health Needs Assessment

	Yes	No
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3	Yes
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C) _____		
4 Indicate the tax year the hospital facility last conducted a CHNA 20 <u>15</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	Yes
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>HTTPS //WWW.TRIHEALTH.COM/ABOUT-TRIHEALTH/COMMUNITY/</u>		
b <input type="checkbox"/> Other website (list url) _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> Other (describe in Section C) _____		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>15</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) _____	10	No
a _____		
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" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V

Facility Information (continued)

Financial Assistance Policy (FAP)

BETHESDA NORTH HOSPITAL

Name of hospital facility or letter of facility reporting group

	Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that		
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13 Yes	
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 100 000000000000 % and FPG family income limit for eligibility for discounted care of 300 000000000000 %		
b <input checked="" 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? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	15 Yes	
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e <input type="checkbox"/> Other (describe in Section C)		
16 Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	16 Yes	
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) HTTPS //WWW TRIHEALTH COM/TOOLS/PAY-YOUR-BILL/FINANCIAL-ASSISTANCE/		
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) HTTP //WWW TRIHEALTH COM/TOOLS/PAY-YOUR-BILL/FINANCIAL-ASSISTANCE/		
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) HTTP //WWW TRIHEALTH COM/TOOLS/PAY-YOUR-BILL/FINANCIAL-ASSISTANCE/		
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j <input type="checkbox"/> Other (describe in Section C)		

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

BETHESDA NORTH HOSPITAL

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

BETHESDA NORTH HOSPITAL

Name of hospital facility or letter of facility reporting group _____

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

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
22		
23		No
24		No

Part V Facility Information (continued)**Section 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

Community Health Needs Assessment

	Yes	No
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3	Yes
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C) _____		
4 Indicate the tax year the hospital facility last conducted a CHNA 20 <u>15</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	Yes
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>HTTPS //WWW.TRIHEALTH.COM/ABOUT-TRIHEALTH/COMMUNITY/</u>		
b <input type="checkbox"/> Other website (list url) _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> Other (describe in Section C) _____		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>15</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) _____	10	No
a _____		
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" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V

Facility Information (continued)

Financial Assistance Policy (FAP)

BETHESDA BUTLER HOSPITAL																																																																																								
Name of hospital facility or letter of facility reporting group																																																																																								
	<table><tr><td></td><td>Yes</td><td>No</td></tr><tr><td>Did the hospital facility have in place during the tax year a written financial assistance policy that</td><td></td><td></td></tr><tr><td>13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP</td><td>13 Yes</td><td></td></tr><tr><td>a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 100 000000000000 % and FPG family income limit for eligibility for discounted care of 300 000000000000 %</td><td></td><td></td></tr><tr><td>b <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)</td><td></td><td></td></tr><tr><td>c <input type="checkbox"/> Asset level</td><td></td><td></td></tr><tr><td>d <input checked="" type="checkbox"/> Medical indigency</td><td></td><td></td></tr><tr><td>e <input checked="" type="checkbox"/> Insurance status</td><td></td><td></td></tr><tr><td>f <input checked="" type="checkbox"/> Underinsurance discount</td><td></td><td></td></tr><tr><td>g <input type="checkbox"/> Residency</td><td></td><td></td></tr><tr><td>h <input checked="" type="checkbox"/> Other (describe in Section C)</td><td></td><td></td></tr><tr><td>14 Explained the basis for calculating amounts charged to patients?</td><td>14 Yes</td><td></td></tr><tr><td>15 Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)</td><td>15 Yes</td><td></td></tr><tr><td>a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application</td><td></td><td></td></tr><tr><td>b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application</td><td></td><td></td></tr><tr><td>c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process</td><td></td><td></td></tr><tr><td>d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications</td><td></td><td></td></tr><tr><td>e <input type="checkbox"/> Other (describe in Section C)</td><td></td><td></td></tr><tr><td>16 Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)</td><td>16 Yes</td><td></td></tr><tr><td>a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) HTTPS //WWW TRIHEALTH COM/TOOLS/PAY-YOUR-BILL/FINANCIAL-ASSISTANCE/</td><td></td><td></td></tr><tr><td>b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) HTTP //WWW TRIHEALTH COM/TOOLS/PAY-YOUR-BILL/FINANCIAL-ASSISTANCE/</td><td></td><td></td></tr><tr><td>c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) HTTP //WWW TRIHEALTH COM/TOOLS/PAY-YOUR-BILL/FINANCIAL-ASSISTANCE/</td><td></td><td></td></tr><tr><td>d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)</td><td></td><td></td></tr><tr><td>e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)</td><td></td><td></td></tr><tr><td>f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)</td><td></td><td></td></tr><tr><td>g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention</td><td></td><td></td></tr><tr><td>h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP</td><td></td><td></td></tr><tr><td>i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations</td><td></td><td></td></tr><tr><td>j <input type="checkbox"/> Other (describe in Section C)</td><td></td><td></td></tr></table>		Yes	No	Did the hospital facility have in place during the tax year a written financial assistance policy that			13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? 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Part V Facility Information (continued)**Billing and Collections**

BETHESDA BUTLER HOSPITAL

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

BETHESDA BUTLER HOSPITAL

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

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
22		
23		No
24		No

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

[illegible]

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

990 Schedule H, Supplemental Information

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

990 Schedule H, Supplemental Information

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

990 Schedule H, Supplemental Information

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

990 Schedule H, Supplemental Information

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

990 Schedule H, Supplemental Information

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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART II, COMMUNITY BUILDING ACTIVITIES	BETHESDA HOSPITAL, INC PROVIDED CASH DONATIONS TO VARIOUS CHARITABLE ORGANIZATIONS WITHIN THE COMMUNITY TO ADDRESS HOMELESSNESS, TO INCREASE EDUCATIONAL OPPORTUNITIES AND TO BUILD AN ECONOMIC INFRASTRUCTURE

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 2	SEE PART VI RESPONSE TO PART III, LINE 4

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 3	SEE PART VI RESPONSE TO PART III, LINE 4

990 Schedule H, 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 DEBT 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 DEBT 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 THERE HAVE BEEN NO SIGNIFICANT CHANGES IN THE CURRENT YEAR TO THE UNDERLYING ASSUMPTIONS USED BY TRIHEALTH TO ESTIMATE THE ALLOWANCE FOR UNCOLLECTABLE ACCOUNTS FINANCIAL INSTRUMENTS THAT POTENTIALLY SUBJECT TRIHEALTH TO CONCENTRATIONS OF CREDIT RISK CONSIST PRIMARILY OF NONGOVERNMENTAL 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 2017 - MEDICARE 14%, MEDICAID 2%, MANAGED CARE 28%, SELF PAY 20%, COMMERCIAL AND OTHER 36%2016 - MEDICARE 17%, MEDICAID 3%, MANAGED CARE 32%, SELF PAY 16%, 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 THE 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>

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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

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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 DEACONESSSES 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 TRIHEALTH, 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 DEACONESSSES 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 PREMATUREITY, THE BURDEN TO GOVERNMENT MEDICAL PROGRAMS SUCH AS MEDICAID WOULD BE EVEN GREATER 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 HEALTH COMMUNITY HE ALTH NEEDS ASSESSMENT ("A I M ") IN THE AREAS ASSESSED, THOSE SURVEYED WERE MORE OFTEN UN DERSEVED, INCLUDING THE UNINSURED, THE UNDERINSURED, THOSE IN LOW SOCIOECONOMIC STATUS, M INORITIES, THOSE OVER THE AGE OF SIXTY-FIVE, OR THOSE WITH A DIAGNOSIS OF MENTAL ILLNESS THE A I M WAS THE BASIS FOR BETHESDA'S COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATI ON PLAN ADOPTED FREE AND DISCOUNTED SERVICES ARE PROVIDED FOR THOSE UNABLE TO PAY AND MEE TING ELIGIBILITY CRITERIA THROUGH THE HOSPITAL CARE ASSURANCE PROGRAM (HCAP), BETHESDA SE RVES PATIENTS MEETING CRITERIA SET FORTH BY THE OHIO DEPARTMENT OF JOBS AND FAMILY SERVICE S BETHESDA POLICY IS TO PROVIDE CHARITY CARE ON A SLIDING SCALE DISCOUNTING WHEN THE FAMI LY INCOME IS UP TO 400 PERCENT OF THE ANNUALLY ESTABLISHED FEDERAL POVERTY GUIDELINE IT O FFERS AN UNINSURED DISCOUNT FOR MEDICALLY NECESSARY SERVICES FOR THOSE WHO HAVE NO INSURAN CE AND WHO DO NOT QUALIFY FOR OTHER FINANCIAL ASSISTANCE OPTIONS FINANCIAL COUNSELORS ASS IST PATIENTS IN COMPLETING THE FINANCIAL ASSISTANCE APPLICATION WHICH IS AVAILABLE ON TRIH EALTH'S WEBSITE AND BROCHURES ABOUT FINANCIAL ASSISTANCE ARE VISIBLE AND AVAILABLE IN HOSP ITAL REGISTRATION AND ADMITTING AREAS DURING THE YEAR, BETHESDA PROVIDED COMMUNITY BENEFIT (INCLUDING UNCOMPENSATED CARE) AS SHOWN ON PART I, LINE 7 THE AMOUNT OF BENEFIT FOR BOTH TRADITIONAL CHARITY CARE AND FOR THE UNPAID COST OF MEDICAID IS ONE MANIFESTATION OF THE RISING RATES OF PERSONS WITHOUT HEALTH INSURANCE THE MEDICAID PUBLIC PROGRAM REIMBURSES H OSPITALS FOR SERVICES BUT PAYMENTS MAY NOT ALWAYS COVER THE TOTAL COST OF CARE AND MEDICAT IONS THE UNPAID COST OF MEDICARE IS NOT INCLUDED IN TOTAL COMMUNITY BENEFIT BETHESDA IS COMMITTED TO FULFILLING THE MISSION OF COMPASSION TO THE VULNERABLE MEMBERS OF THE COMMUNI TIES THEY SERVE BETHESDA PARTICIPATES IN THE REGIONAL TRAUMA SYSTEM THUS PROVIDING THE COM MUNITY WITH ACCESS TO TRAUMA CARE THE TWO EMERGENCY ROOMS OF BETHESDA PROVIDE 24-HOUR EME RGENCY CARE TO COMMUNITY MEMBERS LIVING IN THE NORTHEAST CORRIDOR OF CINCINNATI AS WELL AS WARREN, BUTLER, AND CLERMONT COUNTIES BETHESDA IS A LEVEL III TRAUMA CENTER AS VERIFIED BY THE COMMITTEE ON TRAUMA OF THE AMERICAN COLLEGE OF SURGEONS ONE EXAMPLE OF ONGOING EFF ORTS BY BETHESDA TO IMPROVE THE HEALTH OF THE BROADER COMMUNITY ARE PROGRAMS TO ADDRESS TH E IDENTIFIED HEALTH NEED OF DIABETES DIABETES EDUCATORS EXTEND THE EDUCATION TO THE COMMU NITY BY PROVIDING CLASSES TO A DIVERSE POPULATION, FROM AREA INDUSTRIES AND FIREHOUSE GROU PS TO RETIREMENT CENTERS A DIABETES SUPPORT GROUP MEETS FOR CONTINUED EDUCATION IN CHRONI C DISEASE MANAGEMENT THOUGH HEALTHY WOMEN HEALTHY LIVES WAS INSTITUTED IN JULY 2007 BY GO OD SAMARITAN HOSPITAL WOMEN'S SERVICES TO IMPROVE THE HEALTH OF THE GREATER CINCINNATI COM MUNITY, IT IS NOW FISCALLY SUPPORTED BY BETHESDA HOSPITAL AS WELL, MAKING IT A TRIHEALTH S YSTEM PROGRAM HEALTHY WOMEN HEALTHY LIVES IS AN APPROACH BASED ON THE PREMISE THAT PREVEN TION, EARLY DETECTION, TREATMENT AND ACCESS TO HEALTH CARE SERVICES IMPROVE INDIVIDUAL AND COMMUNITY HEALTH OUTCOMES THE FOCUS IS ON HEALTH RISKS ASSOCIATED WITH THE ONSET OF MENO PAUSE WELL ORGANIZED SCREENING AND EDUCATION EVENTS BRING THE SERVICES TO AT RISK POPULAT IONS OF AFRICAN AMERICAN, APPALACHIAN, HISPANIC, UNINSURED AND UNDERINSURED WOMEN FORTY YE ARS OF AGE OR OLDER SCREENING INCLUDES OSTEOPOROSIS, MAMMOGRAPHY, CHOLESTEROL, HYPERTENSI ON, AND OBESITY EVERY WOMAN RECEIVES A NURSE CONSULTATION, A COPY OF THEIR RESULTS AND A WRITTEN PRIMARY CARE REFERRAL WOMEN WITH ABNORMAL RESULTS ARE CONTACTED AND ASSISTED IN A CCESSING PRIMARY CARE IN ADDITION, WOMEN NEEDING PREGNANCY AND GYNECOLOGIC CARE CAN ACCES S THIS SERVICE AT THE OB/GYN CENTER AT BETHESDA NO</p>

Form and Line Reference	Explanation
PART VI, LINE 2	<p>RTH 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 COVERAGE, 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 BETHESDA SERVICE FOCUSED ON INJURY PREVENTION. THE THINK FIRST PROGRAM STAFF WORKS WITH COMMUNITY PARTNERS TO PROVIDE INJURY PREVENTION PROGRAMS AND COMMUNITY AWARENESS EVENTS. COLLABORATING WITH THE EDUCATORS, THE MEDIA, CIVIC CLUBS AND CORPORATIONS, THINK FIRST TEACHES INJURY PREVENTION TO ALL AGE GROUPS. THE GREATER CINCINNATI COMMUNITY HAS IDENTIFIED A SIGNIFICANT HEALTH NEED IN INFANT MORTALITY AND PREMATURITY. 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 MANAGEMENT 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, SERVING THE ADULT HOMELESS OF CINCINNATI. THE RESPITE CENTER, WITH 14 BEDS AND 24 HOUR COVERAGE, PROVIDES FREE MEDICAL SERVICES AND ACCOMMODATIONS FOR HOMELESS PERSONS NEEDING SOME MEDICAL OVERSIGHT. RESPITE HELPS PEOPLE WITHOUT HOMES TOWARD INDEPENDENT LIVING IN PERMANENT HOUSING. BETHESDA CONTINUES A COMMITMENT TO EDUCATING THE NEXT GENERATION OF HEALTH CARE PROVIDERS--PHYSICIANS AND ALLIED HEALTH PROFESSIONALS. COST IN EXCESS OF GOVERNMENTAL SUPPORT FOR MEDICAL EDUCATION PROGRAMS AT BETHESDA TOTALLED OVER \$1.5 MILLION IN FISCAL YEAR 2015. BETHESDA, AS PART OF TRIHEALTH, SPONSORS MEDICAL RESIDENCIES. THERE WERE 32 TOTAL RESIDENTS 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 BETHESDA PARAMEDIC TRAINING PROGRAM IS A HOSPITAL-BASED PROGRAM ACCREDITED BY THE OHIO DEPARTMENT OF TRANSPORTATION. THROUGH THIS TRAINING PROGRAM, CERTIFIED EMERGENCY MEDICAL TECHNICIANS 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, COLLABORATES WITH LOCAL AND REGIONAL COLLEGES, UNIVERSITIES AND TRAINING CENTERS TO PROVIDE MENTORING, INTERNSHIPS, CLERKSHIPS, SUPERVISED EDUCATION AND CLINICAL ROTATIONS TO STUDENTS IN HEALTH FIELDS. THESE PARTNERSHIPS HELP STUDENTS LEARN ABOUT AND PREPARE FOR PROFESSIONS IN NURSE PRACTITIONER, RESPIRATORY THERAPY, RADIOLOGY TECHNOLOGY, STERILE PROCESSING, PHLEBOTOMY, MEDICAL LABORATORY, PHARMACY, SPEECH, AUDIOLOGY, PHYSICAL THERAPY, AND OCCUPATIONAL THERAPY. IN CONCLUSION, ASIDE FROM THE CHARITY CARE AND UNPAID COST OF MEDICAL CARE PROGRAMS, BETHESDA PROVIDES THE COMMUNITY WITH HEALTH CARE SERVICES AND PROGRAMS, MEDICAL EDUCATION, AND CASH AND IN-KIND CONTRIBUTIONS FOR THE POOR AND THE BROADER COMMUNITY. THIS COMMITMENT TO COMMUNITY HEALTH REVEALS BETHESDA'S FOUNDING SPIRIT OF CONCERN FOR THE VULNERABLE. IT ALSO REFLECTS THE ONGOING, TANGIBLE EFFORTS AND CONTRIBUTIONS OF COUNTLESS EMPLOYEES, PHYSICIANS AND LEADERS LIVING THE CORE VALUES OF STEWARDSHIP AND RESPONSE TO COMMUNITY NEEDS.</p>

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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

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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

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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 AN OVER 50-BED SURGICAL HOSPITAL LOCATED NEAR HAMILTON, OHIO IT PROVIDES EVERYTHING FROM SURGERY, CARDIOLOGY AND IMAGING TO PHYSICAL THERAPY AND SLEEP STUDIES WITH EIGHT OPERATING ROOMS, THREE ENDOSCOPY SUITES, TWO PROCEDURE ROOMS AND A FULL-SERVICE 24-HOUR EMERGENCY DEPARTMENT, THE HOSPITAL IS COMPLEMENTED BY ADDITIONAL SERVICES AND PHYSICIAN OFFICES FOR PRIMARY CARE, PEDIATRICS AND SPECIALTY CARE ON CAMPUS 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>

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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 Schedule H, Part V Section A. Hospital Facilities

Section A. Hospital Facilities		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER—24 hours	ER—other	Other (Describe)	Facility reporting group
(list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? 2											
Name, address, primary website address, and state license number											
1	BETHESDA NORTH HOSPITAL 10500 MONTGOMERY ROAD CINCINNATI, OH 45242 WWW.TRIHEALTH.COM 1024	X	X		X		X	X			
2	BETHESDA BUTLER HOSPITAL 3125 HAMILTON-MASON ROAD HAMILTON, OH 45011 WWW.TRIHEALTH.COM 1457	X	X					X			

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

Form and Line Reference	Explanation
BETHESDA NORTH HOSPITAL	<p>PART V, SECTION B, LINE 5 PRIMARY RESEARCHCHNA COMMUNITY FOCUS GROUPS/PUBLIC MEETINGS TH E FOCUS GROUPS WERE CONDUCTED BY AN ASSIGNED FACILITATOR AND SCRIBES THE FACILITATOR INTR ODUCE THE ATTENDEES TO THE COUNTY SNAPSHOT AND THE CNI MAP AFTER A PERIOD OF QUESTIONS A ND BRAINSTORMING, EACH ATTENDEE WAS ASKED TO INDICATE WHICH ISSUES WERE MOST IMPORTANT TH E ATTENDEES INCLUDED MEMBERS OF THE COMMUNITY AND REPRESENTATIVES OF ORGANIZATIONS SERVING THE COMMUNITY, INCLUDING COMMUNITY ADVOCATES AND REPRESENTATIVES FROM FAITH-BASED ORGANIZ ATIONS, PUBLIC HEALTH DEPARTMENTS, AND COMMUNITY-BASED HEALTH CENTERS THE PURPOSE OF THE MEETINGS WAS TO SOLICIT PUBLIC INPUT THE RESULTS OF THE COMMUNITY FOCUS GROUPS WERE SUMMA RIZED BY COUNTY THIS DOCUMENT REFERS TO THE COMMUNITY HEALTH NEEDS ASSESSMENT COMMUNITY FOCUS GROUPS AS "COMMUNITY FOCUS GROUPS OR "FOCUS GROUPS" CHNA COMMUNITY HEALTH SURVEYS TH E SURVEY WAS CUSTOMIZED FOR THREE DIFFERENT RESPONDENTS CONSUMERS, AGENCIES, AND HEALTH D EPARTMENTS A SPANISH LANGUAGE SURVEY WAS ALSO CREATED WITH THE HELP OF COMMUNITY HEALTH W ORKERS THE SURVEY CONTAINED QUESTIONS ABOUT THE HEALTH ISSUES FACING THE COMMUNITY, IF HE ALTH ISSUES WERE BEING ADDRESSED, AND WHAT BARRIERS THE COMMUNITY WAS EXPERIENCING SOME P ARTICIPANTS PREFERRED TO RESPOND IN-PERSON OR OVER THE PHONE, THESE RESPONSES WERE TRANSCR IBED INTO THE SURVEY TOOL THIS DOCUMENT REFERS TO THE COMMUNITY HEALTH NEEDS ASSESSMENT C OMMUNITY SURVEYS AS "SURVEYS" SECONDARY RESEARCHSECONDARY RESEARCH CONSISTED OF GATHERING AVAILABLE HEALTH-RELATED DATA FOR A COLLECTION OF TWENTY-THREE COUNTIES, INCLUDING BUTLER, CLERMONT, HAMILTON, AND WARREN COUNTIES BECAUSE THE TARGETED REGION SPANNED THREE STATES , CONSISTENT DATA WERE NOT ALWAYS AVAILABLE, AND NOT ALL DATA WERE AVAILABLE FOR THE ENTIR E REGION WHENEVER POSSIBLE, DATA WERE COLLECTED AT THE COUNTY LEVEL SUB-COUNTY LEVEL DAT A WERE NOT A FOCUS OF THIS RESEARCH THE COUNTY HEALTH RANKINGS (CHR) FORMED THE FOUNDATIO N FOR DATA COLLECTION WITH ITS COUNTY-LEVEL FOCUS ON HEALTH OUTCOMES, HEALTH FACTORS, HEAL TH BEHAVIORS, QUALITY OF LIFE, CLINICAL CARE, PHYSICAL ENVIRONMENT, AND SOCIOECONOMIC FACT ORS DATA WAS VERIFIED AND FORMATTED CONSISTENTLY, SUPPLEMENTAL DATA WAS ALSO IDENTIFIED A ND COLLECTED THE INTERACTIVE TOOL ON THE CNI (COMMUNITY NEED INDEX) WAS ACCESSED TO CREAT E COUNTY-LEVEL MAPS AND ZIP CODE TABLES THE CHR AND CNI WEBSITES WERE MONITORED FOR PERIO DIC DATA UPDATES AND DATA WORKSHEETS WERE REVISED UNTIL SEPTEMBER 2015 STANDARDS FOR RESEA RCHING AND INCLUDING THE DATA WERE ESTABLISHED AND INCLUDED THE FOLLOWING CHARACTERISTICS COMPARABLE, COUNTY-LEVEL, FOCUSED ON HEALTH OUTCOMES, REPRODUCIBLE, REPUTABLE, AND TRENDE D THE CHR SERVED AS A STARTING POINT BUT RESOURCES WITH MORE RECENT DATA AND ADDITIONAL M EASURES WERE ALSO IDENTIFIED INPUT FROM A BROAD RANGE OF REPRESENTATIVESINPUT WAS RECEIVED FROM INDIVIDUALS REPRESENTING UNDERSERVED POPULATIONS USING, PRIMARILY THE TWO SURVEY APP ROACHES DESCRIBED ABOVE THE C</p>

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

Form and Line Reference	Explanation
BETHESDA NORTH HOSPITAL	<p>OMBINATION OF THESE METHODS PROVIDED A WIDE-RANGE OF DATA COLLECTION OPPORTUNITIES ON WHIC H THE CHNA COULD BE BASED CHNA COMMUNITY FOCUS GROUPS A TOTAL OF 156 INDIVIDUALS ATTENDED THE 11 FOCUS GROUPS, 134 OF THE ATTENDEES REPRESENTED AN ORGANIZATION THE ORGANIZATIONS REPRESENTED BY THESE ATTENDEES SERVE THE FOLLOWING POPULATIONS CHILDREN, ELDERLY, HOMELES S, LOW-INCOME, MEDICALLY UNDERSERVED, MINORITY, PEOPLE WITH MENTAL ILLNESS, AND VICTIMS OF DOMESTIC VIOLENCE FIFTEEN INDIVIDUALS, ALL REPRESENTING ORGANIZATIONS, ATTENDED THE BUTL ER COUNTY FOCUS GROUP ON JULY 30, 2015 THREE INDIVIDUALS ATTENDED THE CLERMONT COUNTY FOC US GROUP ON JULY 28, 2015 APPROXIMATELY 50 INDIVIDUALS ATTENDED MEETINGS ON BEHALF OF HAM ILTON COUNTY, THE MAJORITY REPRESENTED AN ORGANIZATION ON JULY 7, 2015, SIX INDIVIDUALS A TTENDED THE WARREN COUNTY FOCUS GROUP AND REPRESENTED PREMIER HEALTH ATRIUM MEDICAL CEN TE R AND PREVENTIONFIRST OR CAME ON THEIR OWN BEHALF CHNA SURVEY IN AGGREGATE, 329 INDIVIDU ALS, 55 AGENCY REPRESENTATIVES, 52 LATINOS, AND 24 HEALTH DEPARTMENT REPRESENTATIVES COMPL ETED THE CHNA SURVEY THE CHNA TEAM, CHNA COMMITTEE, AND PARTNERS HELPED DISTRIBUTE THE SU RVEY AT COMMUNITY MEETINGS, A HANDOUT PROVIDED THE SURVEY LINK, AND THE LINKS WERE WRITTE N ON AN EASEL PAD AT THE FRONT OF THE ROOM THROUGHOUT THE REGION, 381 INDIVIDUAL SURVEYS AND 55 AGENCY SURVEYS WERE COMPLETED, INCLUDING RESPONSES FROM AGENCIES SUCH AS BUTLER COU NTY UNITED WAY, CLERMONT COUNTY MENTAL HEALTH & RECOVERY BOARD, AND THE YMCA OF GREATER CI NCINNATI IN BUTLER, CLERMONT, HAMILTON, AND WARREN COUNTIES, RESPONDENTS INCLUDED CONTACT S FROM LOCAL HEALTH DEPARTMENTS THE BUTLER COUNTY HEALTH DEPARTMENT, CITY OF HAMILTON HEA LTH DEPARTMENT, THE MIDDLETOWN CITY HEALTH DISTRICT, THE CLERMONT COUNTY GENERAL HEALTH DI STRICT, HAMILTON COUNTY PUBLIC HEALTH, NORWOOD CITY HEALTH DISTRICT, SPRINGDALE CITY HEALT H DISTRICT, AND WARREN COUNTY COMBINED HEALTH DISTRICT OTHER ORGANIZATIONS THAT COMPLETED THE SURVEY INCLUDED GOOD SAMARITAN FREE HEALTH CENTER, AND THE GREATER CINCINNATI FOUNDAT ION, ETC</p>

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

Form and Line Reference	Explanation
BETHESDA BUTLER HOSPITAL	<p>PART V, SECTION B, LINE 5 PRIMARY RESEARCHCHNA COMMUNITY FOCUS GROUPS/PUBLIC MEETINGS TH E FOCUS GROUPS WERE CONDUCTED BY AN ASSIGNED FACILITATOR AND SCRIBES THE FACILITATOR INTR ODUCE THE ATTENDEES TO THE COUNTY SNAPSHOT AND THE CNI MAP AFTER A PERIOD OF QUESTIONS A ND BRAINSTORMING, EACH ATTENDEE WAS ASKED TO INDICATE WHICH ISSUES WERE MOST IMPORTANT TH E ATTENDEES INCLUDED MEMBERS OF THE COMMUNITY AND REPRESENTATIVES OF ORGANIZATIONS SERVING THE COMMUNITY, INCLUDING COMMUNITY ADVOCATES AND REPRESENTATIVES FROM FAITH-BASED ORGANIZ ATIONS, PUBLIC HEALTH DEPARTMENTS, AND COMMUNITY-BASED HEALTH CENTERS THE PURPOSE OF THE MEETINGS WAS TO SOLICIT PUBLIC INPUT THE RESULTS OF THE COMMUNITY FOCUS GROUPS WERE SUMMA RIZED BY COUNTY THIS DOCUMENT REFERS TO THE COMMUNITY HEALTH NEEDS ASSESSMENT COMMUNITY FOCUS GROUPS AS "COMMUNITY FOCUS GROUPS OR "FOCUS GROUPS" CHNA COMMUNITY HEALTH SURVEYS TH E SURVEY WAS CUSTOMIZED FOR THREE DIFFERENT RESPONDENTS CONSUMERS, AGENCIES, AND HEALTH D EPARTMENTS A SPANISH LANGUAGE SURVEY WAS ALSO CREATED WITH THE HELP OF COMMUNITY HEALTH W ORKERS THE SURVEY CONTAINED QUESTIONS ABOUT THE HEALTH ISSUES FACING THE COMMUNITY, IF HE ALTH ISSUES WERE BEING ADDRESSED, AND WHAT BARRIERS THE COMMUNITY WAS EXPERIENCING SOME P ARTICIPANTS PREFERRED TO RESPOND IN-PERSON OR OVER THE PHONE, THESE RESPONSES WERE TRANSCR IBED INTO THE SURVEY TOOL THIS DOCUMENT REFERS TO THE COMMUNITY HEALTH NEEDS ASSESSMENT C OMMUNITY SURVEYS AS "SURVEYS" SECONDARY RESEARCHSECONDARY RESEARCH CONSISTED OF GATHERING AVAILABLE HEALTH-RELATED DATA FOR A COLLECTION OF TWENTY-THREE COUNTIES, INCLUDING BUTLER, CLERMONT, HAMILTON, AND WARREN COUNTIES BECAUSE THE TARGETED REGION SPANNED THREE STATES , CONSISTENT DATA WERE NOT ALWAYS AVAILABLE, AND NOT ALL DATA WERE AVAILABLE FOR THE ENTIR E REGION WHENEVER POSSIBLE, DATA WERE COLLECTED AT THE COUNTY LEVEL SUB-COUNTY LEVEL DAT A WERE NOT A FOCUS OF THIS RESEARCH THE COUNTY HEALTH RANKINGS (CHR) FORMED THE FOUNDATIO N FOR DATA COLLECTION WITH ITS COUNTY-LEVEL FOCUS ON HEALTH OUTCOMES, HEALTH FACTORS, HEAL TH BEHAVIORS, QUALITY OF LIFE, CLINICAL CARE, PHYSICAL ENVIRONMENT, AND SOCIOECONOMIC FACT ORS DATA WAS VERIFIED AND FORMATTED CONSISTENTLY, SUPPLEMENTAL DATA WAS ALSO IDENTIFIED A ND COLLECTED THE INTERACTIVE TOOL ON THE CNI (COMMUNITY NEED INDEX) WAS ACCESSSED TO CREAT E COUNTY-LEVEL MAPS AND ZIP CODE TABLES THE CHR AND CNI WEBSITES WERE MONITORED FOR PERIO DIC DATA UPDATES AND DATA WORKSHEETS WERE REVISED UNTIL SEPTEMBER 2015 STANDARDS FOR RESEA RCHING AND INCLUDING THE DATA WERE ESTABLISHED AND INCLUDED THE FOLLOWING CHARACTERISTICS COMPARABLE, COUNTY-LEVEL, FOCUSED ON HEALTH OUTCOMES, REPRODUCIBLE, REPUTABLE, AND TRENDE D THE CHR SERVED AS A STARTING POINT BUT RESOURCES WITH MORE RECENT DATA AND ADDITIONAL M EASURES WERE ALSO IDENTIFIED INPUT FROM A BROAD RANGE OF REPRESENTATIVESINPUT WAS RECEIVED FROM INDIVIDUALS REPRESENTING UNDERSERVED POPULATIONS USING, PRIMARILY THE TWO SURVEY APP ROACHES DESCRIBED ABOVE THE C</p>

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

Form and Line Reference	Explanation
BETHESDA BUTLER HOSPITAL	<p>OMBINATION OF THESE METHODS PROVIDED A WIDE-RANGE OF DATA COLLECTION OPPORTUNITIES ON WHIC H THE CHNA COULD BE BASED CHNA COMMUNITY FOCUS GROUPS A TOTAL OF 156 INDIVIDUALS ATTENDED THE 11 FOCUS GROUPS, 134 OF THE ATTENDEES REPRESENTED AN ORGANIZATION THE ORGANIZATIONS REPRESENTED BY THESE ATTENDEES SERVE THE FOLLOWING POPULATIONS CHILDREN, ELDERLY, HOMELES S, LOW-INCOME, MEDICALLY UNDERSERVED, MINORITY, PEOPLE WITH MENTAL ILLNESS, AND VICTIMS OF DOMESTIC VIOLENCE FIFTEEN INDIVIDUALS, ALL REPRESENTING ORGANIZATIONS, ATTENDED THE BUTL ER COUNTY FOCUS GROUP ON JULY 30, 2015 THREE INDIVIDUALS ATTENDED THE CLERMONT COUNTY FOC US GROUP ON JULY 28, 2015 APPROXIMATELY 50 INDIVIDUALS ATTENDED MEETINGS ON BEHALF OF HAM ILTON COUNTY, THE MAJORITY REPRESENTED AN ORGANIZATION ON JULY 7, 2015, SIX INDIVIDUALS A TTENDED THE WARREN COUNTY FOCUS GROUP AND REPRESENTED PREMIER HEALTH ATRIUM MEDICAL CEN TE R AND PREVENTIONFIRST OR CAME ON THEIR OWN BEHALF CHNA SURVEY IN AGGREGATE, 329 INDIVIDU ALS, 55 AGENCY REPRESENTATIVES, 52 LATINOS, AND 24 HEALTH DEPARTMENT REPRESENTATIVES COMPL ETED THE CHNA SURVEY THE CHNA TEAM, CHNA COMMITTEE, AND PARTNERS HELPED DISTRIBUTE THE SU RVEY AT COMMUNITY MEETINGS, A HANDOUT PROVIDED THE SURVEY LINK, AND THE LINKS WERE WRITTE N ON AN EASEL PAD AT THE FRONT OF THE ROOM THROUGHOUT THE REGION, 381 INDIVIDUAL SURVEYS AND 55 AGENCY SURVEYS WERE COMPLETED, INCLUDING RESPONSES FROM AGENCIES SUCH AS BUTLER COU NTY UNITED WAY, CLERMONT COUNTY MENTAL HEALTH & RECOVERY BOARD, AND THE YMCA OF GREATER CI NCINNATI IN BUTLER, CLERMONT, HAMILTON, AND WARREN COUNTIES, RESPONDENTS INCLUDED CONTACT S FROM LOCAL HEALTH DEPARTMENTS THE BUTLER COUNTY HEALTH DEPARTMENT, CITY OF HAMILTON HEA LTH DEPARTMENT, THE MIDDLETOWN CITY HEALTH DISTRICT, THE CLERMONT COUNTY GENERAL HEALTH DI STRICT, HAMILTON COUNTY PUBLIC HEALTH, NORWOOD CITY HEALTH DISTRICT, SPRINGDALE CITY HEALT H DISTRICT, AND WARREN COUNTY COMBINED HEALTH DISTRICT OTHER ORGANIZATIONS THAT COMPLETED THE SURVEY INCLUDED GOOD SAMARITAN FREE HEALTH CENTER, AND THE GREATER CINCINNATI FOUNDAT ION, ETC</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 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

Form and Line Reference	Explanation
BETHESDA NORTH HOSPITAL	PART V, SECTION B, LINE 6A ADAMS COUNTY REGIONAL MEDICAL CENTER, ATRIUM MEDICAL CENTER, DEARBORN COUNTY HOSPITAL, LINDNER CENTER OF HOPE, MARGARET MARY COMMUNITY HOSPITAL, MCCULLOUGH-HYDE MEMORIAL HOSPITAL, MERCY HEALTH, UC HEALTH, BETHESDA NORTH HOSPITAL, BETHESDA BUTLER COUNTY, THE CHRIST HOSPITAL, CINCINNATI CHILDREN'S HOSPITAL MEDICAL CENTER

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

Form and Line Reference	Explanation
BETHESDA BUTLER HOSPITAL	PART V, SECTION B, LINE 6A ADAMS COUNTY REGIONAL MEDICAL CENTER, ATRIUM MEDICAL CENTER, DEARBORN COUNTY HOSPITAL, LINDNER CENTER OF HOPE, MARGARET MARY COMMUNITY HOSPITAL, MCCULLOUGH-HYDE MEMORIAL HOSPITAL, MERCY HEALTH, UC HEALTH, BETHESDA NORTH HOSPITAL, BETHESDA BUTLER COUNTY, THE CHRIST HOSPITAL, CINCINNATI CHILDREN'S HOSPITAL MEDICAL CENTER

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

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Form and Line Reference	Explanation
BETHESDA NORTH HOSPITAL	PART V, SECTION B, LINE 6B HEALTH COLLABORATIVE, CITY OF CINCINNATI HEALTH DEPARTMENT, HAMILTON COUNTY PUBLIC HEALTH, INTERACT FOR HEALTH, XAVIER UNIVERSITY DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

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

Form and Line Reference	Explanation
BETHESDA BUTLER HOSPITAL	PART V, SECTION B, LINE 6B HEALTH COLLABORATIVE, CITY OF CINCINNATI HEALTH DEPARTMENT, HAMILTON COUNTY PUBLIC HEALTH, INTERACT FOR HEALTH, XAVIER UNIVERSITY DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

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

Form and Line Reference	Explanation
BETHESDA NORTH HOSPITAL	PART V, SECTION B, LINE 11 CHILD HEALTH/INFANT MORTALITY - BETHESDA NORTH WILL CONTINUE ITS FOCUS ON THIS HEALTH NEED THROUGH ITS HEALTH SYSTEM'S SPONSORSHIP OF MULTIPLE PROGRAMS IN ITS FOUR COUNTY SERVICE AREA IN COLLABORATION WITH OTHER EXISTING COMMUNITY SERVICE ORGANIZATIONS BETHESDA NORTH IS AN ACTIVE PARTICIPANT IN CRADLE CINCINNATI OBESITY - BETHESDA NORTH WILL ADDRESS THIS NEED IN THE FOUR COUNTY SERVICE AREAS BETHESDA NORTH WILL ALSO PARTNER WITH THE COLLECTIVE IMPACT ON HEALTH (PART OF THE HEALTH COLLABORATIVE) TO MAKE THIS A REGION WIDE PRIORITY FOR HEALTH SYSTEMS AND COMMUNITY ORGANIZATIONS SUBSTANCE ABUSE/MENTAL HEALTH - BETHESDA NORTH WILL ADDRESS THIS NEED BY OUR CONTINUED RELATIONSHIP WITH THE HOPE PROGRAM, HEALTHY MOMS AND BABES, SOJOURNERS, COMMUNITY PARTNERS (NATIONAL ALLIANCE ON MENTAL ILLNESS) AND BY EXTENDING OUR BETHESDA ALCOHOL AND DRUG PROGRAM OUTREACH PROGRAMS CANCER - BETHESDA NORTH WILL ADDRESS THIS NEED BY CONTINUING TO UTILIZE THE OUTREACH MINISTRIES PROGRAM (FORMERLY NAMED PARISH NURSE PROGRAM) AT BETHESDA NORTH, WHERE THERE IS A CONCENTRATION OF THIS UNDERSERVED POPULATION

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

Form and Line Reference	Explanation
BETHESDA BUTLER HOSPITAL	PART V, SECTION B, LINE 11 CHILD HEALTH/INFANT MORTALITY - BETHESDA BUTLER WILL CONTINUE ITS FOCUS ON THIS HEALTH NEED THROUGH ITS HEALTH SYSTEM'S SPONSORSHIP OF MULTIPLE PROGRAMS IN ITS SERVICE AREA IN COLLABORATION WITH OTHER EXISTING COMMUNITY SERVICE ORGANIZATIONS BETHESDA BUTLER IS AN ACTIVE PARTICIPANT IN CRADLE CINCINNATI OBESITY - BETHESDA BUTLER WILL ADDRESS THIS NEED IN THE BUTLER COUNTY AREA BETHESDA BUTLER WILL ALSO PARTNER WITH THE COLLECTIVE IMPACT ON HEALTH (PART OF THE HEALTH COLLABORATIVE) TO MAKE THIS A REGION WIDE PRIORITY FOR HEALTH SYSTEMS AND COMMUNITY ORGANIZATIONS SUBSTANCE ABUSE - BETHESDA BUTLER WILL ADDRESS THIS NEED BY ITS CONTINUED RELATIONSHIP WITH THE HOPE PROGRAM, HEALTHY MOMS AND BABES AND BY EXTENDING THE BETHESDA HOSPITAL, INC ALCOHOL AND DRUG PROGRAM OUTREACH PROGRAMS CANCER - BETHESDA BUTLER WILL ADDRESS THIS NEED BY CONTINUING TO UTILIZE THE OUTREACH MINISTRIES PROGRAM (FORMERLY NAMED PARISH NURSE PROGRAM) AT BETHESDA BUTLER, WHERE THERE IS A CONCENTRATION OF THIS UNDERSERVED POPULATION

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

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

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

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

Form and Line Reference	Explanation
BETHESDA BUTLER HOSPITAL	PART V, SECTION B, LINE 13H SEE PART VI RESPONSE TO PART I, LINE 3C

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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

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

Name and address	Type of Facility (describe)
1 - BETHESDA MEDICAL CENTER-ARROW SPRINGS 100 ARROW SPRINGS BLVD LEBANON, OH 45036	24-HOUR EMERGENCY ROOM AND COMPREHENSIVE OUTPATIENT SERVICES
2 - BETHESDA NORTH OBGYN CLINIC 10498 MONTGOMERY ROAD CINCINNATI, OH 45242	WOMEN'S HEALTH
3 - BETHESDA OAK CAMPUS 619 OAK STREET CINCINNATI, OH 45206	LAB, PHARMACY AND OUTPATIENT DRUG/ALCOHOL TREATMENT
4 - BNH AMBULATORY TREATMENT CENTER 10506 MONTGOMERY ROAD CINCINNATI, OH 45242	OUTPATIENT INFUSION AND CHEMOTHERAPY TREATMENT
5 - TRIHEALTH SLEEP MEDICINE 10475 MONTGOMERY ROAD CINCINNATI, OH 45242	SLEEP CENTER
6 - NORTH AMBULATORY SURGERY CENTER 10506 MONTGOMERY ROAD CINCINNATI, OH 45242	OUTPATIENT SURGICAL CENTER
7 - BETHESDA NORTH OUTPATIENT IMAGING CTR 10494 MONTGOMERY ROAD CINCINNATI, OH 45242	OUTPATIENT IMAGING AND COMPREHENSIVE BREAST CARE CENTER
8 - TRIHEALTH NURSE MIDWIVES 3440 BURNET AVENUE 120 CINCINNATI, OH 45229	OUTPATIENT WOMEN'S HEALTH CLINIC
9 - BETHESDA SURGERY CENTER 10615 MONTGOMERY ROAD 300 CINCINNATI, OH 45242	OUTPATIENT SURGICAL CENTER
10 - BETHESDA HAND REHABILITATION 10700 MONTGOMERY ROAD CINCINNATI, OH 45242	PHYSICAL THERAPY
11 - BETHESDA LOVELAND PHYSICAL THERAPY 10675 LOVELAND-MADERIA ROAD LOVELAND, OH 45140	PHYSICAL THERAPY
12 - BETHESDA FAMILY PRACTICE CENTER 1775 LEXINGTON AVE CINCINNATI, OH 45212	FAMILY MEDICINE CLINIC
13 - BETHESDA ALCOHOLDRUG TREATMENT 11305 REED HARTMAN HWY CINCINNATI, OH 45242	OUTPATIENT ALCOHOL AND DRUG TREATMENT
14 - BETHESDA BUTLER PHYSICAL THERAPY 3035 HAMILTON-MASON ROAD HAMILTON, OH 45011	PHYSICAL THERAPY
15 - BETHESDA BUTLER IMAGING CENTER 3075 HAMILTON-MASON ROAD HAMILTON, OH 45011	MEDICAL IMAGING

Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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)
16 - TRIHEALTH SLEEP MEDICINE 3055 HAMILTON-MASON ROAD HAMILTON, OH 45011	SLEEP MEDICINE CENTER
17 - BETHESDA MASON PHYSICAL THERAPY 6020 MASON MONTGOMERY RD MASON, OH 45040	PHYSICAL THERAPY

efile GRAPHIC print - DO NOT PROCESS

As Filed Data -

DLN: 93493130023128

Schedule I
(Form 990)

OMB No 1545-0047

2016

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

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

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

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" on Form 990, Part IV, line 21, for any recipient that received more than \$5,000. Part II can be duplicated if additional space is needed.

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

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table 18

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

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

Part III can be duplicated if additional space is needed

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

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

Return Reference	Explanation
PART I, LINE 2	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 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 INC 629 OAK STREET SUITE 306 CINCINNATI, OH 45206	20-0688727	501(C)(3)	144,808				GENERAL PURPOSES
FRIARS CLUB INC 2316 HARRYWOOD COURT CINCINNATI, OH 45239	31-0537485	501(C)(3)	15,680				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 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
HEALTHY BEGINNINGS INC 47 E HOLLISTER CINCINNATI, OH 45219	31-1380939	501(C)(3)	29,400				GENERAL SUPPORT
AMERICAN CANCER SOCIETY INC 250 WILLIAMS STREET NW SUITE 400 ATLANTA, GA 30303	13-1788491	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 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
HEALTHY MOMS & BABES INC 2270 BANNING ROAD NO 200 CINCINNATI, OH 45239	31-1155292	501(C)(3)	45,212				GENERAL PURPOSES
FREESTORE FOODBANK INC 1141 CENTRAL PARKWAY CINCINNATI, OH 45202	23-7122205	501(C)(3)	76,073				SPONSORSHIP

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
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
JDRF SOUTHWEST OHIO CHAPTER 8050 HOSBROOK RD SUITE 314 CINCINNATI, OH 45236	23-1907729	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 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
CENTER FOR RESPITE CARE INC PO BOX 141301 CINCINNATI, OH 45250	20-2544994	501(C)(3)	24,500				GENERAL PURPOSES
OVARIAN CANCER ALLIANCE OF GREATER CINCINNATI 4918 COOPER ROAD CINCINNATI, OH 45242	31-1287785	501(C)(3)	12,863				SPONSORSHIP

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
ARTHRITIS FOUNDATION 7124 MIAMI AVE CINCINNATI, OH 45243	27-4014550	501(C)(3)	9,800				SPONSORSHIP
MARCH OF DIMES 10806 KENWOOD ROAD CINCINNATI, OH 45242	13-1846366	501(C)(3)	11,270				SPONSORSHIP

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
OHIO CANCER RESEARCH 50 W BROAD STREET STE 1132 COLUMBUS, OH 43215	31-1038309	501(C)(3)	7,350				SPONSORSHIP
AMERICAN HEART ASSOCIATION 5211 MADISON ROAD CINCINNATI, OH 45227	13-5613797	501(C)(3)	68,600				SPONSORSHIP

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
BETHESDA FOUNDATION INC 10500 MONTGOMERY ROAD CINCINNATI, OH 45242	23-7374129	501(C)(3)	39,298				SPONSORSHIP
MONTESSORI CENTER ROOM INC 2505 RIVERSIDE DRIVE CINCINNATI, OH 45202	31-0731908	501(C)(3)	7,350				OUTDOOR CLASSROOM SHADE STRUCTURE AND FALL SURFACE

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CRAYONS TO COMPUTERS 1350 TENNESSEE AVE CINCINNATI, OH 45229	31-1507076	501(C)(3)	9,800				GENERAL SUPPORT
THE MATT HAVERKAMP FOUNDATION 5870 DAY RD CINCINNATI, OH 45252	20-4155820	501(C)(3)	9,813				GENERAL SUPPORT

Schedule J
(Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

OMB No 1545-0047

2015

Open to Public Inspection

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

Questions Regarding Compensation

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

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

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

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

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column(B) reported as deferred on prior Form 990
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
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. 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 - \$200,215; WILLIAM GRONEMAN - \$28,092; GEORGES FEGHALI M D - \$828,637; SHER MCCLANAHAN - \$631,769.
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, 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 2016 CALENDAR YEAR, THE FOLLOWING REPORTABLE INDIVIDUALS RECEIVED SEVERANCE PAYMENTS FROM TRIHEALTH, INC.: GERALD OLIPHANT - \$485,193.

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 on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1CRAIG EISENTROUT MD TRUSTEE	(i)	0	0	0	0	0	0	0
	(ii)	652,461	0	6,190	9,912	-	-	0
						28,000	696,563	
1MARK CLEMENT PRESIDENT/CEO	(i)	0	0	0	0	0	0	0
	(ii)	955,818	296,481	36,985	254,562	-	-	0
						21,511	1,565,357	
2DONNA NIENABER ESQ ASST SECRETARY (END 7/16)	(i)	0	0	0	0	0	0	0
	(ii)	376,676	91,104	37,884	108,889	-	-	0
						10,775	625,328	
3MICHAEL CROFTON ASST TREASURER	(i)	0	0	0	0	0	0	0
	(ii)	379,000	123,542	30,713	102,850	-	-	0
						27,912	664,017	
4WILLIAM GRONEMAN EXEC VP SYSTEM DEVELOPMENT	(i)	0	0	0	0	0	0	0
	(ii)	513,167	152,266	93,725	173,074	-	-	28,092
						28,957	961,189	
5BARB BOYNE EXEC DIR-BETHESDA NORTH	(i)	0	0	0	0	0	0	0
	(ii)	204,223	43,088	9,183	24,893	-	-	0
						22,559	303,946	
6ROBERT COLLINS MD CHIEF MEDICAL OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	427,064	119,473	22,379	124,996	-	-	0
						16,269	710,181	
7CHARLES BROWN EXEC DIR-BETHESDA BUTLER	(i)	0	0	0	0	0	0	0
	(ii)	207,054	37,869	359	8,762	-	-	0
						3,089	257,133	
8GAIL DONOVAN EXEC VP & COO	(i)	0	0	0	0	0	0	0
	(ii)	644,732	193,447	57,378	126,278	-	-	0
						7,376	1,029,211	
9STEFANIE NEWMAN VP-CHIEF NURSING OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	227,005	46,066	24,365	35,929	-	-	0
						22,612	355,977	
10JASON NIEHAUS SVP-BETHESDA REGION	(i)	0	0	0	0	0	0	0
	(ii)	152,068	0	59	5,556	-	-	0
						7,342	165,025	
11DAVID COOK CHIEF HUMAN RESOURCES OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	224,097	44,247	22,268	32,287	-	-	0
						9,282	332,181	
12ANDREW DEVOE CHIEF FINANCIAL OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	0	0	570,000	0	-	-	0
						0	570,000	
13RAYMOND HELLMANN MD PHYSICIAN	(i)	236,230	0	6,975	16,127	21,504	280,836	0
	(ii)	0	0	0	0	-	-	0
						0	0	
14RICHARD OKRAGLY MD PHYSICIAN	(i)	205,768	0	7,194	10,461	23,581	247,004	0
	(ii)	0	0	0	0	-	-	0
						0	0	
15SAKUNTHALA NATARAJAN MD PHYSICIAN	(i)	216,087	0	8,019	27,458	1,128	252,692	0
	(ii)	0	0	0	0	-	-	0
						0	0	
16ROBERT KUNKEL MD PHYSICIAN	(i)	229,245	0	8,983	7,527	22,624	268,379	0
	(ii)	0	0	0	0	-	-	0
						0	0	
17LORRAINE STEPHENS MD PHYSICIAN	(i)	208,556	0	1,860	19,854	24,737	255,007	0
	(ii)	22,962	0	0	0	-	-	0
						2,434	25,396	
18JOHN PROUT FORMER OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	541,905	308,973	539,030	18,967	-	-	200,215
						5,142	1,414,017	
19GERALD OLIPHANT FORMER KEY EMPLOYEE	(i)	0	0	0	0	0	0	0
	(ii)	0	0	558,601	7,250	-	-	0
						9,665	575,516	

Schedule K
(Form 990)

Department of the Treasury
Internal Revenue Service

Name of the organization
BETHESDA HOSPITAL INC

Supplemental Information on Tax Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990.

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

OMB No 1545-0047

2016

Open to Public Inspection

Employer identification number
31-0537122

Part I Bond Issues											
(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pool financing	
						Yes	No	Yes	No	Yes	No
A COUNTY OF HAMILTON OHIO	31-6000063	407272V59	04-12-2017	316,011,223	BUILDINGS AND STRUCTURES		X		X		X
B COUNTY OF HAMILTON OHIO	31-6000063	000000000	04-19-2017	100,000,000	BUILDINGS AND STRUCTURES		X		X		X

Part II		Proceeds							
		A		B		C		D	
1	Amount of bonds retired								
2	Amount of bonds legally defeased								
3	Total proceeds of issue	316,122,658		100,188,238					
4	Gross proceeds in reserve funds								
5	Capitalized interest from proceeds								
6	Proceeds in refunding escrows								
7	Issuance costs from proceeds	3,974,594		345,003					
8	Credit enhancement from proceeds								
9	Working capital expenditures from proceeds								
10	Capital expenditures from proceeds	228,751,732		50,590,000					
11	Other spent proceeds								
12	Other unspent proceeds	83,396,332		49,253,235					
13	Year of substantial completion								
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue?		X		X				
15	Were the bonds issued as part of an advance refunding issue?		X		X				
16	Has the final allocation of proceeds been made?		X		X				
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X					

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

Part III Private Business Use (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?	X		X					
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?	X		X					
c Are there any research agreements that may result in private business use of bond-financed property?		X		X				
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government	1 160 %		3 840 %					
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government	0 %		0 %					
6 Total of lines 4 and 5	1 160 %		3 840 %					
7 Does the bond issue meet the private security or payment test?		X		X				
8a Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?		X		X				
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of . . .								
c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1 141-12 and 1 145-2?								
9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1 141-12 and 1 145-2?	X		X					

Part IV Arbitrage

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

Part IV Arbitrage (Continued)

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

Part V Procedures To Undertake Corrective Action

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

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

Return Reference	Explanation
PART II, LINE 3, COLUMN A AND COLUMN B	TOTAL PROCEEDS SHOWN ARE NOT IDENTICAL TO THE ISSUE PRICE LISTED IN PART I, COLUMN (E) DUE TO THE AMOUNT OF INVESTMENT EARNINGS FOR THE FISCAL YEAR OF \$111,435 AND \$188,238 RESPECTIVELY

SCHEDULE O (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service
Name of the organization
BETHESDA HOSPITAL INC

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

2016

Open to Public Inspection

Employer identification number

31-0537122

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 2	<p>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, OH IO, ALL AFFILIATED ENTITIES OF BETHESDA HOSPITAL, INC MICHAEL CROFTON, GAIL DONOVAN, ROBERT COLLINS, MD, MARK CLEMENT AND MYRTIS POWELL HAVE A "BUSINESS RELATIONSHIP" WITH EACH OTHER BY VIRTUE OF SITTING ON THE BOARD OF THE MCCULLOUGH-HYDE MEMORIAL HOSPITAL, AN AFFILIATED ENTITY OF BETHESDA HOSPITAL, INC WAYNE SHIRCLIFF, LISA KNUTSON, CRAIG EISENTROUT, MD, MARK DELWORTH, 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 MARK CLEMENT, MYRTIS POWELL 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 MARK CLEMENT 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 MARK CLEMENT, DONNA NIENABER, ESQ , MICHAEL CROFTON, WILLIAM GRONEMAN, GAIL DONOVAN, ROBERT COLLINS, MD, CRAIG EISENTROUT, MD, STEFANIE NEWMAN 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</p>

990 Schedule O, Supplemental Information

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)

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	MEMBERS OF THE BOARD ARE PROVIDED AN ELECTRONIC COPY OF THIS FORM 990 PRIOR TO FILING AFTER REVIEW BY THE FINANCE AND AUDIT COMMITTEE OF THE BOARD, ALONG WITH THE COMMITTEE'S SUMMARY OF THE FORM 990. 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.

990 Schedule O, Supplemental Information

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.

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9	CONTRIBUTED CAPITAL TO PARENT -10,000,000 RETURN OF CAPITAL 2,230,942 LOSS ON UNCONSOLIDATED ORGANIZATIONS -49,263,592 CHANGE IN PENSION PLAN/SERP FUNDED STATUS 22,572,822 CHANGE IN TEMPORARILY RESTRICTED NET ASSETS HELD AT FOUNDATION 10,983,812 PENSION SETTLEMENT CHARGE -11,586,908 MISCELLANEOUS -261,981

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART I, LINE 6	DURING THE TAX YEAR, BETHESDA HOSPITAL, INC WAS ASSISTED BY 724 VOLUNTEERS WHO DONATED OVER 106,600 HOURS

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

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 ACTIVITIES TO ENSURE THE ORGANIZATION'S EXEMPT STATUS IS PROTECTED

990 Schedule O, Supplemental Information

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

Name of the organization
BETHESDA HOSPITAL INC

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

2016

Open to Public Inspection

Name of the organization
BETHESDA HOSPITAL INC

Employer identification number
31-0537122

Part I

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

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

Part II

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

See Additional Data Table

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512- 514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) 10600 MONTGOMERY LLC 619 OAK STREET-ACCOUNTING 3 WEST CINCINNATI, OH 45206 26-1964995	PROPERTY MANAGEMENT	OH	N/A									
(2) HEALTHCARE SOLUTIONS NETWORK LLC 619 OAK STREET-ACCOUNTING 3 WEST CINCINNATI, OH 45206 47-2103334	PHYSICIAN HOSPITAL ORGANIZATION	OH	N/A									

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of- year assets	(h) Percentage ownership	(i) Section 512(b) (13) controlled entity?	
								Yes	No
(1) 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		No
1e		No
1f		No
1g		No
1h		No
1i		No
1j		No
1k	Yes	
1l	Yes	
1m	Yes	
1n		No
1o	Yes	
1p	Yes	
1q		No
1r		No
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

See Additional Data Table

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

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

[illegible]

Part VII **Supplemental Information**

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

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) 619 OAK STREET-ACCOUNTING 3 WEST CINCINNATI, OH 45206 31-1108895	POPULATION HEALTH	OH	SECTION 501(C)(3)	SCHEDULE A, LINE 12C	N/A		No
(1) 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) 619 OAK STREET-ACCOUNTING 3 WEST CINCINNATI, OH 45206 31-1027660	HEALTHCARE SERVICES	OH	SECTION 501(C)(3)	SCHEDULE A, LINE 12B	BETHESDA INC	Yes	
(3) 619 OAK STREET-ACCOUNTING 3 WEST CINCINNATI, OH 45206 31-1242442	HEALTHCARE SERVICES	OH	SECTION 501(C)(3)	SCHEDULE A, LINE 12A	BETHESDA HOSPITAL INC	Yes	
(4) 619 OAK STREET-ACCOUNTING 3 WEST CINCINNATI, OH 45206 31-1352694	PROPERTY MANAGEMENT	OH	SECTION 501(C)(2)		BETHESDA HOSPITAL INC	Yes	
(5) 619 OAK STREET-ACCOUNTING 3 WEST CINCINNATI, OH 45206 31-0917155	HOSPICE SERVICES	OH	SECTION 501(C)(3)	SCHEDULE A, LINE 10	BETHESDA HOSPITAL INC	Yes	
(6) 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) 619 OAK STREET-ACCOUNTING 3 WEST CINCINNATI, OH 45206 31-1438846	SUPPORT AFFILIATED HOSPITALS	OH	SECTION 501(C)(3)	SCHEDULE A, LINE 12B	N/A	Yes	
(8) 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) 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) 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) 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) 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) 619 OAK STREET-ACCOUNTING 3 WEST CINCINNATI, OH 45206 31-1383365	PHYSICIAN PRACTICES	OH	SECTION 501(C)(3)	SCHEDULE A, LINE 10	TRIHEALTH INC	Yes	
(14) 619 OAK STREET-ACCOUNTING 3 WEST CINCINNATI, OH 45206 31-1074519	PHYSICIAN PRACTICES	OH	SECTION 501(C)(3)	SCHEDULE A, LINE 10	TRIHEALTH INC	Yes	
(15) 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
(1)	TRIHEALTH PHYSICIAN ENTERPRISE CORP	A	4,802,725	FMV
(1)	GOOD SAMARITAN HOSPITAL OF CINCINNATI OHIO	A	1,811,381	FMV
(2)	BETHESDA HEALTHCARE INC	A	32,459	FMV
(3)	TRIHEALTH INC	B	47,758,667	CASH
(4)	BETHESDA INC	B	10,000,000	CASH
(5)	BETHESDA FOUNDATION INC	B	39,298	CASH
(6)	BETHESDA FOUNDATION INC	C	1,087,865	CASH
(7)	BETHESDA INC	K	2,802	FMV
(8)	BETHESDA PROPERTIES INC	K	1,677,543	FMV
(9)	BETHESDA HEALTHCARE INC	K	432,197	FMV
(10)	TRIHEALTH PHYSICIAN ENTERPRISE CORP	K	8,400	FMV
(11)	TRIHEALTH INC	K	6,212	FMV
(12)	TRIHEALTH INC	M	102,961,068	COST
(13)	TRIHEALTH INC	P	215,481,730	COST
(14)	HOSPICE OF CINCINNATI INCORPORATED	O	36,247,412	FMV
(15)	BETHESDA INC	O	2,045,772	FMV
(16)	FERNESIDE INC A CENTER FOR GRIEVING CHILDREN	O	434,876	FMV
(17)	BETHESDA FOUNDATION INC	O	1,110,664	FMV
(18)	BETHESDA PROPERTIES INC	S	3,054,849	CASH