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Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

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

OMB No. 1545-0047

2019

Open to Public Inspection

A For the 2019 calendar year, or tax year beginning 07-01-2019 , and ending 06-30-2020

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
625 EDEN PARK DRIVE 7TH FLOOR

City or town, state or province, country, and ZIP or foreign postal code
CINCINNATI, OH 45202

D Employer identification number
31-0537122

E Telephone number
(513) 569-6575

G Gross receipts $ 767,389,500

F Name and address of principal officer:
MARK CLEMENT
625 EDEN PARK DRIVE 7TH FLOOR
CINCINNATI, OH 45202

H(a) Is this a group return for subordinates? ☐ Yes ☑ No

H(b) Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

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

J Website: ▶ WWW.TRIHEALTH.COM

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

L Year of formation: 1896

M State of legal domicile: OH

Part I Summary

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)	**3**	13
4	Number of independent voting members of the governing body (Part VI, line 1b)	**4**	8
5	Total number of individuals employed in calendar year 2019 (Part V, line 2a)	**5**	3,909
6	Total number of volunteers (estimate if necessary)	**6**	535
7a	Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	1,370,794
b	Net unrelated business taxable income from Form 990-T, line 39	**7b**	0

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	945,906	3,371,557
9	Program service revenue (Part VIII, line 2g)	611,708,927	617,830,484
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	13,407,331	15,871,786
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	21,801,506	49,213,144
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	647,863,670	686,286,971
13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	315,064	707,533
14	Benefits paid to or for members (Part IX, column (A), line 4)	0	0
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	274,943,724	299,136,295
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶0		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	275,251,997	346,756,562
18	Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	550,510,785	646,600,390
19	Revenue less expenses. Subtract line 18 from line 12	97,352,885	39,686,581

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	1,076,223,195	1,219,368,332
21	Total liabilities (Part X, line 26)	504,942,942	682,046,006
22	Net assets or fund balances. Subtract line 21 from line 20	571,280,253	537,322,326

Part II Signature Block

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

Sign Here

Signature of officer — Date: 2021-05-13

MICHAEL CROFTON 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 SUITE 1900
CINCINNATI, OH 45202 — Phone no. (513) 784-7100

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

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:

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 $ 504,405,250 including grants of $ 707,533) (Revenue $ 663,713,681)

See Additional Data

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

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

4d Other program services (Describe in Schedule O.)

(Expenses $ including grants of $) (Revenue $)

4e **Total program service expenses** ▶ 504,405,250

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		No
c	Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c	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	Yes	
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	Yes	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f	Yes	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a		No
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	Yes	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		No
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		No
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b		No
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV*	15		No
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV*	16		No
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I* (see instructions)	17		No
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		No
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		No
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	Yes	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	Yes	
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21	Yes	

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
22	Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22		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? *If "Yes," complete Schedule J*	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? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a*	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? *If "Yes," complete Schedule L,* Part 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? *If "Yes," complete Schedule L,* Part I	25b		No
26	Did the organization report any amount on Part X, line 5 or 22 for receivables from or payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part II*	26		No
27	Did the organization provide a grant or other assistance to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or employee thereof, a grant selection committee member, or to a 35% controlled entity (including an employee thereof) or family member of any of these persons? *If "Yes," complete Schedule L,* Part III	27		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, key employee, creator or founder, or substantial contributor? *If "Yes," complete Schedule L, Part IV*	28a		No
b	A family member of any individual described in line 28a? *If "Yes," complete Schedule L, Part IV*	28b		No
c	A 35% controlled entity of one or more individuals and/or organizations described in lines 28a or 28b? *If "Yes," complete Schedule L, Part IV*	28c		No
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29		No
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		No
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		No
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		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? *If "Yes," complete Schedule R, Part I*	33		No
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	34	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)? *If "Yes," complete Schedule R, Part V, line 2*	35b	Yes	
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36	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? *If "Yes," complete Schedule R, Part VI*	37		No
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O.	38	Yes	

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	417		
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	

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

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**	3,909		
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**	
9	**Sponsoring organizations maintaining donor advised funds.**				
a	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**	
15	Is the organization subject to the section 4960 tax on payment(s) of more than $1,000,000 in remuneration or excess parachute payment(s) during the year? . . . . . If "Yes," see instructions and file Form 4720, Schedule N.			**15**	No
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? . . If "Yes," complete Form 4720, Schedule O.			**16**	No

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

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	**1a**	13		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.				
b	Enter the number of voting members included in line 1a, above, who are independent	**1b**	8		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?			**2**	Yes	
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?			**3**		No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?			**4**	Yes	
5	Did the organization become aware during the year of a significant diversion of the organization's assets?			**5**		No
6	Did the organization have members or stockholders?			**6**	Yes	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?			**7a**	Yes	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?			**7b**	Yes	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:					
a	The governing body?			**8a**	Yes	
b	Each committee with authority to act on behalf of the governing body?			**8b**	Yes	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*			**9**		No

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

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

Section C. Disclosure

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

18 Section 6104 requires an organization to make its Form 1023 (or 1024-A if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

☐ Own website ☐ Another's website ☑ Upon request ☐ Other (explain in Schedule O)

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

20 State the name, address, and telephone number of the person who possesses the organization's books and records:
▶MICHAEL CROFTON - VP FINANCE 625 EDEN PARK DRIVE 7TH FLOOR CINCINNATI, OH 45202 (513) 569-6577

Part VII **Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors**

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

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

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

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

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(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			
See Additional Data Table										

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
See Additional Data Table										
1b Sub-Total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶								1,341,504	10,081,313	2,384,421

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 ▶ 256

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
PREFERRED LAB PARTNERS LLC 1 MEDICAL VILLAGE DRIVE SUITE B EDGEWOOD, KY 41017	LABORATORY	13,696,411
CATHOLIC HEALTH INITIATIVES 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112	CLINICAL MAINTENANCE	6,452,100
AMERICAN NURSING CARE INC 1700 EDISON DRIVE SUITE 300 MILFORD, OH 45150	NURSE STAFFING	4,897,740
TRI-STATE HEALTHCARE LAUNDRY 551 S LOOP ROAD EDGEWOOD, KY 41017	LAUNDRY	1,674,048
DAVITA 2000 16TH ST DENVER, CO 80202	DIALYSIS SERVICES	1,454,809

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 59

Part VIII Statement of Revenue

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

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts					
1a Federated campaigns	1a				
b Membership dues	1b				
c Fundraising events	1c				
d Related organizations	1d	2,861,970			
e Government grants (contributions)	1e	80,397			
f All other contributions, gifts, grants, and similar amounts not included above	1f	429,190			
g Noncash contributions included in lines 1a - 1f: $	1g				
h **Total.** Add lines 1a-1f		3,371,557			
Program Service Revenue	Business Code				
2a PATIENT REVENUE	621990	602,072,091	601,495,819	576,272	
b AFFILIATED ORG. RENTAL	532000	8,403,546			8,403,546
c JOA REVENUE	900099	5,849,676	5,849,676		
d HATTON RESEARCH	900099	608,883	608,883		
e SENIOR HEALTH SERVICES	900099	339,992	339,992		
f All other program service revenue.		556,296	-238,226	794,522	
g **Total.** Add lines 2a–2f	617,830,484				
3 Investment income (including dividends, interest, and other similar amounts)		2,584,011			2,584,011
4 Income from investment of tax-exempt bond proceeds					
5 Royalties					

		(i) Real	(ii) Personal				
6a Gross rents	6a	950,705					
b Less: rental expenses	6b	0					
c Rental income or (loss)	6c	950,705					
d Net rental income or (loss)				950,705			950,705

		(i) Securities	(ii) Other				
7a Gross amount from sales of assets other than inventory	7a	93,425,864	98,525				
b Less: cost or other basis and sales expenses	7b	80,236,614	0				
c Gain or (loss)	7c	13,189,250	98,525				
d Net gain or (loss)				13,287,775			13,287,775
Other Revenue 8a Gross income from fundraising events (not including $ _____ of contributions reported on line 1c). See Part IV, line 18	8a						
b Less: direct expenses	8b						
c Net income or (loss) from fundraising events							
9a Gross income from gaming activities. See Part IV, line 19	9a						
b Less: direct expenses	9b						
c Net income or (loss) from gaming activities							
10a Gross sales of inventory, less returns and allowances	10a	1,098,847					
b Less: cost of goods sold	10b	865,915					
c Net income or (loss) from sales of inventory				232,932	232,932		
Miscellaneous Revenue	Business Code						
11a PHARMACY	621990	31,720,870	31,720,870				
b CARES ACT FUNDING	900099	13,457,424	13,457,424				
c CAFETERIA	900099	2,379,242					2,379,242
d All other revenue		471,971	471,971				
e **Total.** Add lines 11a–11d		48,029,507					
12 **Total revenue.** See instructions		686,286,971	653,939,341	1,370,794			27,605,279

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	707,533	707,533		
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16.				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	4,228,278		4,228,278	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	1,365,265		1,365,265	
7 Other salaries and wages	231,033,406	179,435,497	51,597,909	
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	15,857,023	11,146,643	4,710,380	
9 Other employee benefits	29,569,799	20,202,620	9,367,179	
10 Payroll taxes	17,082,524	12,888,443	4,194,081	
11 Fees for services (non-employees):				
a Management	16,298,332	16,298,332		
b Legal	3,338,289		3,338,289	
c Accounting	394,638		394,638	
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees	735,264		735,264	
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	36,387,876	22,718,877	13,668,999	
12 Advertising and promotion	8,567,832	93,746	8,474,086	
13 Office expenses	10,333,736	4,912,959	5,420,777	
14 Information technology	10,846,007	1,581,033	9,264,974	
15 Royalties				
16 Occupancy	16,829,789	14,384,494	2,445,295	
17 Travel	545,481	198,088	347,393	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	471,174	347,036	124,138	
20 Interest	13,584,970	13,333,353	251,617	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	51,993,278	32,594,674	19,398,604	
23 Insurance	3,126,640	3,126,640		
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	150,673,526	148,812,121	1,861,405	
b OHIO HOSPITAL FEE	11,965,126	11,965,126		
c EQUIPMENT & REPAIRS	8,866,043	8,801,465	64,578	
d DUES AND SUBSCRIPTIONS	286,092	286,092		
e All other expenses	1,512,469	570,478	941,991	
25 **Total functional expenses.** Add lines 1 through 24e	646,600,390	504,405,250	142,195,140	0
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720).				

Part X Balance Sheet

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

				(A) Beginning of year		(B) End of year
Assets	1	Cash–non-interest-bearing		60,922	1	74,345
	2	Savings and temporary cash investments			2	
	3	Pledges and grants receivable, net			3	
	4	Accounts receivable, net		72,547,523	4	66,763,771
	5	Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons			5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)			6	
	7	Notes and loans receivable, net			7	
	8	Inventories for sale or use		11,908,303	8	11,979,659
	9	Prepaid expenses and deferred charges		1,319,725	9	713,773
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 897,717,763			
	b	Less: accumulated depreciation	10b 440,557,903	382,315,960	10c	457,159,860
	11	Investments—publicly traded securities		297,537,350	11	339,322,584
	12	Investments—other securities. See Part IV, line 11		57,926,230	12	55,702,395
	13	Investments—program-related. See Part IV, line 11		184,511,909	13	191,277,602
	14	Intangible assets		37,702,879	14	33,773,623
	15	Other assets. See Part IV, line 11		30,392,394	15	62,600,720
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)		1,076,223,195	16	1,219,368,332
Liabilities	17	Accounts payable and accrued expenses		57,717,358	17	68,822,855
	18	Grants payable			18	
	19	Deferred revenue		34,821	19	125,782
	20	Tax-exempt bond liabilities		404,764,402	20	552,391,459
	21	Escrow or custodial account liability. Complete Part IV of Schedule D			21	
	22	Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons			22	
	23	Secured mortgages and notes payable to unrelated third parties		24,970,149	23	8,044,046
	24	Unsecured notes and loans payable to unrelated third parties			24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24). Complete Part X of Schedule D		17,456,212	25	52,661,864
	26	**Total liabilities.** Add lines 17 through 25		504,942,942	26	682,046,006
Net Assets or Fund Balances		**Organizations that follow FASB ASC 958, check here ▶ ☑ and complete lines 27, 28, 32, and 33.**				
	27	Net assets without donor restrictions		548,440,383	27	506,704,095
	28	Net assets with donor restrictions		22,839,870	28	30,618,231
		Organizations that do not follow FASB ASC 958, check here ▶ ☐ and complete lines 29 through 33.				
	29	Capital stock or trust principal, or current funds			29	
	30	Paid-in or capital surplus, or land, building or equipment fund			30	
	31	Retained earnings, endowment, accumulated income, or other funds			31	
	32	Total net assets or fund balances		571,280,253	32	537,322,326
	33	Total liabilities and net assets/fund balances		1,076,223,195	33	1,219,368,332

Part XI Reconcilliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	686,286,971
2	Total expenses (must equal Part IX, column (A), line 25)	2	646,600,390
3	Revenue less expenses. Subtract line 2 from line 1	3	39,686,581
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	571,280,253
5	Net unrealized gains (losses) on investments	5	6,117,518
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-79,762,026
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	537,322,326

Part XII Financial Statements and Reporting

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

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ Cash ☑ Accrual ☐ 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?	2a		No
	If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis			
b	Were the organization's financial statements audited by an independent accountant?	2b	Yes	
	If 'Yes,' check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: ☐ Separate basis ☑ Consolidated basis ☐ Both consolidated and separate basis			
c	If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?	2c	Yes	
	If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.			
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	3a		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.	3b		

Additional Data

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

Form 990 (2019)

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			
SR SALLY DUFFY SECRETARY	1.00 3.00	X		X				0	0	0
CRAIG EISENTROUT MD TRUSTEE (END 6/20)	1.00 60.00	X						0	304,084	51,011
RALPH MICHAEL CHAIR	1.00 3.00	X		X				0	0	0
ROBERT COLLINS MD TRUSTEE	1.00 3.00	X						0	127,616	0
MARK CLEMENT PRESIDENT/CEO	15.00 45.00	X		X				0	1,481,585	346,875
PHILLIP CASTELLINI TRUSTEE	1.00 3.00	X						0	0	0
KATHY KELLY TRUSTEE (START 7/19)	1.00 3.00	X						0	0	0
THEODORE TORBECK TREASURER	1.00 3.00	X		X				0	0	0
PHILIP FOSTER TRUSTEE	1.00 3.00	X						0	0	0
SCOTT FRIEDSTROM MD MED STAFF PRES-(END 12/19)	1.00 3.00	X						0	628,253	88,603

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 OBLINGER MD MED STAFF PRES-(END 12/19)	1.00 3.00	X						45,000	83,751	0
QUINT STUDER TRUSTEE	1.00 3.00	X						0	0	0
RANCE DUKE TRUSTEE (START 7/19)	1.00 3.00	X						0	0	0
DANNY FISCHER MD MED STAFF PRES-(START 1/20)	1.00 3.00	X						12,000	0	0
KURT KNOCHEL MD MED STAFF PRES-(START 1/20)	1.00 3.00	X						0	68,056	0
ANDREW DEVOE ASST. TREASURER/CFO	15.00 45.00			X				0	737,448	176,417
STEVE GRACEY ASST. SECRETARY/SVP LEGAL	15.00 45.00			X				0	534,649	141,312
STEFANIE NEWMAN VP-CNO BETHESDA (END 9/19)	60.00 0.00				X			0	527,004	69,717
DAVID COOK CHIEF HR OFFICER	15.00 45.00				X			0	475,894	104,412
LONDON QUICCI PRESIDENT-BETHESDA NORTH	60.00 0.00				X			0	392,928	81,172

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			
KEVIN JOSEPH MD CHIEF MEDICAL OFFICER	15.00 45.00				X			0	692,349	157,176
JENNY SKINNER CNE-TRIHEALTH	15.00 45.00				X			0	384,395	126,252
ROB CERCEK EVP POP HEALTH (END 10/19)	15.00 45.00				X			0	643,972	129,240
MICHAEL EVERETT PRESIDENT-BETHESDA BUTLER	30.00 30.00				X			0	172,152	23,213
JOHN WARD SVP-BETHESDA REGION	60.00 0.00				X			0	530,464	157,847
MICHAEL HOLBERT MD PHYSICIAN	60.00 0.00					X		266,080	91,782	44,302
RICHARD OKRAGLY MD PHYSICIAN	60.00 0.00					X		245,642	0	52,429
SAKUNTHALA NATARAJAN MD PHYSICIAN	60.00 0.00					X		236,539	0	47,089
ROBERT KUNKEL MD PHYSICIAN	60.00 0.00					X		284,145	0	50,450
SCOTT WOODS MD PHYSICIAN	60.00 0.00					X		252,098	0	59,143

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 CROFTON FORMER OFFICER	0.00 60.00						X	0	366,377	113,843
WILLIAM GRONEMAN FORMER KEY EMPLOYEE	0.00 40.00						X	0	418,772	141,038
GAIL DONOVAN FORMER KEY EMPLOYEE	0.00 0.00						X	0	903,818	199,356
JASON NIEHAUS FORMER KEY EMPLOYEE	0.00 0.00						X	0	325,708	11,983
MARY IRVIN FORMER KEY EMPLOYEE	0.00 0.00						X	0	190,256	11,541

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SCHEDULE A (Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

▶ **Attach to Form 990 or Form 990-EZ.**

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
BETHESDA HOSPITAL INC

Employer identification number
31-0537122

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

The organization is not a private foundation because it is: (For lines 1 through 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 331/3% 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 331/3% 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? Yes	(iv) No	(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
Total						

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(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) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
7 Amounts from line 4. .						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . .						
9 Net income from unrelated business activities, whether or not the business is regularly carried on. .						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.). .						
11 **Total support.** Add lines 7 through 10						

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

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2019 (line 6, column (f) divided by line 11, column (f)) **14**

15 Public support percentage for 2018 Schedule A, Part II, line 14 . . . . . **15**

16a **33 1/3% support test—2019.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **33 1/3% support test—2018.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

17a **10%-facts-and-circumstances test—2019.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **10%-facts-and-circumstances test—2018.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

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

Part III **Support Schedule for Organizations Described in Section 509(a)(2)**
(Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(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) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(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 2019 (line 8, column (f) divided by line 13, column (f))	15	
16	Public support percentage from 2018 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2019** (line 10c, column (f) divided by line 13, column (f))	17	
18	Investment income percentage from **2018** Schedule A, Part III, line 17	18	

19a **33 1/3% support tests—2019.** 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—2018.** 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? *If "No," describe in* ***Part VI*** *how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.*	1		
2	Did the organization have any supported organization that does not have an IRS determination of status under section 509 (a)(1) or (2)? *If "Yes," explain in* ***Part VI*** *how the organization determined that the supported organization was described in section 509(a)(1) or (2).*	2		
3a	Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? *If "Yes," answer (b) and (c) below.*	3a		
b	Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? *If "Yes," describe in* ***Part VI*** *when and how the organization made the determination.*	3b		
c	Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? *If "Yes," explain in* ***Part VI*** *what controls the organization put in place to ensure such use.*	3c		
4a	Was any supported organization not organized in the United States ("foreign supported organization")? *If "Yes" and if you checked 12a or 12b in Part I, answer (b) and (c) below.*	4a		
b	Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? *If "Yes," describe in* ***Part VI*** *how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.*	4b		
c	Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? *If "Yes," explain in* ***Part VI*** *what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.*	4c		
5a	Did the organization add, substitute, or remove any supported organizations during the tax year? *If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in* ***Part VI,*** *including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).*	5a		
b	**Type I or Type II only.** Was any added or substituted supported organization part of a class already designated in the organization's organizing document?	5b		
c	**Substitutions only.** Was the substitution the result of an event beyond the organization's control?	5c		
6	Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? *If "Yes," provide detail in* ***Part VI.***	6		
7	Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? *If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ) .*	7		
8	Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? *If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).*	8		
9a	Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? *If "Yes," provide detail in* ***Part VI.***	9a		
b	Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? *If "Yes," provide detail in* ***Part VI.***	9b		
c	Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? *If "Yes," provide detail in* ***Part VI.***	9c		
10a	Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? *If "Yes," answer line 10b below.*	10a		
b	Did the organization have any excess business holdings in the tax year? *(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings).*	10b		

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

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

2 Activities Test. **Answer (a) and (b) below.**

			Yes	No
a	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? *If "Yes," then in* ***Part VI identify those supported organizations and explain*** *how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.*	**2a**		
b	Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? *If "Yes," explain in* ***Part VI*** *the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.*	**2b**		

3 Parent of Supported Organizations. **Answer (a) and (b) below.**

a	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? *Provide details in* ***Part VI.***	**3a**		
b	Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? *If "Yes," describe in* ***Part VI.*** *the role played by the organization in this regard.*	**3b**		

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

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

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

	Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):	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 ☐ 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 2019 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-2019**	**(iii) Distributable Amount for 2019**
1 Distributable amount for 2019 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2019 (reasonable cause required-- explain in **Part VI**). See instructions.			
3 Excess distributions carryover, if any, to 2019:			
a From 2014.			
b From 2015.			
c From 2016.			
d From 2017.			
e From 2018.			
f **Total** of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2019 distributable amount			
i Carryover from 2014 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4 Distributions for 2019 from Section D, line 7: $			
a Applied to underdistributions of prior years			
b Applied to 2019 distributable amount			
c Remainder. Subtract lines 4a and 4b from 4.			
5 Remaining underdistributions for years prior to 2019, if any. Subtract lines 3g and 4a from line 2. If the amount is greater than zero, explain in **Part VI**. See instructions.			
6 Remaining underdistributions for 2019. Subtract lines 3h and 4b from line 1. If the amount is greater than zero, explain in **Part VI**. See instructions.			
7 **Excess distributions carryover to 2020.** Add lines 3j and 4c.			
8 Breakdown of line 7:			
a Excess from 2015.			
b Excess from 2016.			
c Excess from 2017.			
d Excess from 2018.			
e Excess from 2019.			

Additional Data

Software ID:

Software Version:

EIN: 31-0537122

Name: BETHESDA HOSPITAL INC

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

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493133022671

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

OMB No. 1545-0047

2019

Open to Public Inspection

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

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

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

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

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

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

Name of the organization	Employer identification number
BETHESDA HOSPITAL INC	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 (see instructions for definition of "political campaign activities")

2 Political campaign activity expenditures (see instructions) ▶ $

3 Volunteer hours for political campaign activities (see instructions)

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

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

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

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

4a Was a correction made? ☐ Yes ☐ No

b If "Yes," describe in Part IV.

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

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

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

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

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

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

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

Part II-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)** 2016	**(b)** 2017	**(c)** 2018	**(d)** 2019	**(e)** Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.		(a) Yes	(a) No	(b) Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a	Volunteers?		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		15,577
j	Total. Add lines 1c through 1i			15,577
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:	1I) DURING THE TAX YEAR, BETHESDA HOSPITAL, INC. ("HOSPITAL") PAID ANNUAL MEMBERSHIP DUES TO VARIOUS NATIONAL, STATE AND LOCAL ORGANIZATIONS, A PORTION ($970) 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 $14,607 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.
▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2019

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.

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

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

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

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

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

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

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? ☐ Yes ☐ No

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

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

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

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

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

(i) Revenue included on Form 990, Part VIII, line 1 ▶ $ _____

(ii) Assets included in Form 990, Part X ▶ $ _____

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

a Revenue included on Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $ _____

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:

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

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

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

Part V Endowment Funds.

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	3,720,610	3,726,463	3,736,434	3,493,840	3,624,135
b Contributions	375	324,903	225		250
c Net investment earnings, gains, and losses	93,665	17,126	101,344	242,594	-58,206
d Grants or scholarships					
e Other expenditures for facilities and programs	72,493	347,882	111,540		72,339
f Administrative expenses					
g End of year balance	3,742,157	3,720,610	3,726,463	3,736,434	3,493,840

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

a Board designated or quasi-endowment ▶ .....

b Permanent endowment ▶ 94.570 %

c Temporarily restricted endowment ▶ 5.430 %

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

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

	Yes	No
3a(i) (i) unrelated organizations		No
3a(ii) (ii) related organizations	Yes	
3b b If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R?	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		4,480,479		4,480,479
b Buildings		538,622,561	193,624,234	344,998,327
c Leasehold improvements		3,529,170	2,170,311	1,358,859
d Equipment		299,256,279	240,996,060	58,260,219
e Other		51,829,274	3,767,298	48,061,976
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				457,159,860

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

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

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

(a) Description of investment	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)INVESTMENT IN JOINT VENTURES	191,277,602	C
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. *(Column (b) must equal Form 990, Part X, col.(B) line 13.)* ▶	191,277,602	

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

(a) Description	(b) Book value
(1)DUE FROM RELATED ORGANIZATIONS	52,078,774
(2)RIGHT OF USE ASSET - OPERATING LEASE	6,646,179
(3)INVESTMENT IN OUTSIDE ENTITIES	3,203,813
(4)MISCELLANEOUS ASSETS	671,954
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col.(B) line 15.)* ▶	62,600,720

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) THIRD PARTY SETTLEMENTS	2,011,714
(3) ACCRUED EIB	4,274,007
(4) MALPRACTICE INSURANCE/WORKERS COMP LIABILITY	5,218,089
(5) DUE TO RELATED ORGANIZATIONS	39,565,904
(6) MISCELLANEOUS	1,592,150
(7)	
(8)	
(9)	
(10)	
Total. *(Column (b) must equal Form 990, Part X, col.(B) line 25.)* ▶	52,661,864

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:	THE FINANCIAL STATEMENTS OF BETHESDA HOSPITAL, INC. ARE AUDITED AS PART OF TRIHEALTH AND I TS 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 COMPLETED AN ANALYSIS OF UNCERTAIN TAX POSITIONS AND DETERMINED THAT NO AMOUNTS WERE REQUIRED TO BE RECOGNIZED IN THE COMBINED FINANCIAL STATEMENTS AT JUNE 30, 2020 OR 20 19. IN ADDITION, THE FINANCIAL STATEMENTS OF BETHESDA HOSPITAL, INC. ARE AUDITED AS PART O F ITS PARENT, BETHESDA, INC. FOLLOWING IS THE TEXT OF THE FOOTNOTE TO THE AUDITED CONSOLID ATED FINANCIAL STATEMENTS OF BETHESDA, INC. ("COMPANY") THAT REPORTS ITS AND ITS SUBSIDIAR IES 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, 2020 OR 2019.

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SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
BETHESDA HOSPITAL INC

Employer identification number
31-0537122

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	Yes	
b	If "Yes," was it a written policy?	1b	Yes	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year.			
	☑ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☑ 150% ☐ 200% ☐ Other _____ %	3a	Yes	
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☑ 300% ☐ 350% ☐ 400% ☐ Other _____ %	3b	Yes	
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"?	4	Yes	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	Yes	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		No
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligibile for free or discounted care?	5c		
6a	Did the organization prepare a community benefit report during the tax year?	6a	Yes	
b	If "Yes," did the organization make it available to the public?	6b	Yes	
	Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.			

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			8,404,459	6,390,157	2,014,302	0.310 %
b Medicaid (from Worksheet 3, column a)			90,009,024	57,547,429	32,461,595	5.020 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			98,413,483	63,937,586	34,475,897	5.330 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4).			905,900	174,694	731,206	0.110 %
f Health professions education (from Worksheet 5)			11,327,857	9,000,063	2,327,794	0.360 %
g Subsidized health services (from Worksheet 6)			156,950	0	156,950	0.020 %
h Research (from Worksheet 7)			1,806,203	0	1,806,203	0.280 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)			281,695	0	281,695	0.040 %
j **Total.** Other Benefits			14,478,605	9,174,757	5,303,848	0.810 %
k **Total.** Add lines 7d and 7j			112,892,088	73,112,343	39,779,745	6.140 %

Part II Community Building Activities

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support						
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development						
9 Other			65,928	0	65,928	0.010 %
10 Total			65,928		65,928	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 46,716,359		
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	116,842,194
6	Enter Medicare allowable costs of care relating to payments on line 5	6	133,440,058
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-16,597,864
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:		

☐ Cost accounting system ☑ Cost to charge ratio ☐ Other

Section C. Collection Practices

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

Name of hospital facility or letter of facility reporting group BETHESDA NORTH HOSPITAL

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

			Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C.	2		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12.	3	Yes	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	☑ A definition of the community served by the hospital facility			
b	☑ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The significant health needs of the community			
f	☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 18			
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?	7	Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	☑ Hospital facility's website (list url): HTTPS://WWW.TRIHEALTH.COM/ABOUT-TRIHEALTH/COMMUNITY/			
b	☐ Other website (list url):			
c	☐ Made a paper copy available for public inspection without charge at the hospital facility			
d	☑ 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 18			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
a	If "Yes" (list url): HTTPS://WWW.TRIHEALTH.COM/ABOUT-TRIHEALTH/COMMUNITY/			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		No
b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

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?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP:			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150.000000000000 % and FPG family income limit for eligibility for discounted care of 300.000000000000 %			
b	☑ Income level other than FPG (describe in Section C)			
c	☐ Asset level			
d	☑ Medical indigency			
e	☑ Insurance status			
f	☑ Underinsurance discount			
g	☐ Residency			
h	☑ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	☑ The FAP was widely available on a website (list url): HTTPS://WWW.TRIHEALTH.COM/TOOLS/PAY-YOUR-BILL/FINANCIAL-ASSISTANCE/			
b	☑ The FAP application form was widely available on a website (list url): HTTP://WWW.TRIHEALTH.COM/TOOLS/PAY-YOUR-BILL/FINANCIAL-ASSISTANCE/			
c	☑ 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	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ 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	☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☐ 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 nonpayment?	17	Yes	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:			
a ☐ Reporting to credit agency(ies)			
b ☐ Selling an individual's debt to another party			
c ☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d ☐ Actions that require a legal or judicial process			
e ☐ Other similar actions (describe in Section C)			
f ☑ None of these actions or other similar actions were permitted			
19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	19		No
If "Yes," check all actions in which the hospital facility or a third party engaged:			
a ☐ Reporting to credit agency(ies)			
b ☐ Selling an individual's debt to another party			
c ☐ Deferring , denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d ☐ Actions that require a legal or judicial process			
e ☐ Other similar actions (describe in Section C)			
20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19. (check all that apply):			
a ☑ Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)			
b ☑ Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)			
c ☑ Processed incomplete and complete FAP applications (if not, describe in Section C)			
d ☑ Made presumptive eligibility determinations (if not, describe in Section C)			
e ☐ Other (describe in Section C)			
f ☐ None of these efforts were made			

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

BETHESDA NORTH HOSPITAL

Name of hospital facility or letter of facility reporting group

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

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group BETHESDA BUTLER HOSPITAL

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

			Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C.	2		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12.	3	Yes	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	☑ A definition of the community served by the hospital facility			
b	☑ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The significant health needs of the community			
f	☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 18			
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?	7	Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	☑ Hospital facility's website (list url): HTTPS://WWW.TRIHEALTH.COM/ABOUT-TRIHEALTH/COMMUNITY/			
b	☐ Other website (list url):			
c	☐ Made a paper copy available for public inspection without charge at the hospital facility			
d	☑ 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 18			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
a	If "Yes" (list url): HTTPS://WWW.TRIHEALTH.COM/ABOUT-TRIHEALTH/COMMUNITY/			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		No
b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

BETHESDA BUTLER 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?	**13**	Yes	
If "Yes," indicate the eligibility criteria explained in the FAP:			
a ☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150.000000000000 % and FPG family income limit for eligibility for discounted care of 300.000000000000 %			
b ☑ Income level other than FPG (describe in Section C)			
c ☐ Asset level			
d ☑ Medical indigency			
e ☑ Insurance status			
f ☑ Underinsurance discount			
g ☐ Residency			
h ☑ Other (describe in Section C)			
14 Explained the basis for calculating amounts charged to patients?	**14**	Yes	
15 Explained the method for applying for financial assistance?	**15**	Yes	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a ☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b ☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c ☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d ☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e ☐ Other (describe in Section C)			
16 Was widely publicized within the community served by the hospital facility?	**16**	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a ☑ The FAP was widely available on a website (list url): HTTPS://WWW.TRIHEALTH.COM/TOOLS/PAY-YOUR-BILL/FINANCIAL-ASSISTANCE/			
b ☑ The FAP application form was widely available on a website (list url): HTTP://WWW.TRIHEALTH.COM/TOOLS/PAY-YOUR-BILL/FINANCIAL-ASSISTANCE/			
c ☑ 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 ☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e ☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f ☑ 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 ☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h ☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i ☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j ☐ Other (describe in Section C)			

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

BETHESDA BUTLER HOSPITAL

Name of hospital facility or letter of facility reporting group

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

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

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

Form and Line Reference	Explanation
See Add'l Data	

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? **22**

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:	BETHESDA HOSPITAL, INC.'S FINANCIAL STATEMENTS ARE AUDITED AS PART OF THE TRIHEALTH AUDIT REPORT.PATIENT SERVICE REVENUE AND OTHER OPERATING REVENUE (PART OF FOOTNOTE B - PAGES 20-23)PLEASE NOTE THAT UNDER ACCOUNTING STANDARDS UPDATE NO. 2014-09, REVENUE FROM CONTRACTS WITH CUSTOMERS (TOPIC 606), WHICH TRIHEALTH ADOPTED DURING THE FISCAL YEAR, BAD DEBT IS CONSIDERED AN "IMPLICIT PRICE CONCESSION AND IS NOT DISTINGUISHED FROM A CONTRACTUAL ADJUSTMENT UNDER GENERALLY ACCEPTED ACCOUNTING PRINCIPLES (GAAP) AND THEREFORE THERE IS NO LONGER A SPECIFIC DISCLOSURE FOR BAD DEBT IN THE CURRENT YEAR AUDIT REPORT.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.

990 Schedule H, Supplemental Information

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.

990 Schedule H, Supplemental Information

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:	IN 1896, BETHESDA HOSPITAL, INC. ("BETHESDA") BEGAN AS A HOME VISITING MINISTRY OF THE MET HODIST DEACONESSES TO SERVE THE HEALTH NEEDS OF THE GERMAN IMMIGRANTS LIVING IN CINCINNATI . NOW THAT MINISTRY, ONCE LED BY DEACONESS LOUISE GOLDER AND HER BROTHER REV. CHRISTIAN GO LDER, HAS GROWN INTO SEVERAL HEALTH SERVICES FOR GREATER CINCINNATI. IN 1995, BETHESDA, IN C. AND GOOD SAMARITAN HOSPITAL FORMED A PARTNERSHIP TO CREATE A LOCAL HEALTH SYSTEM: TRIHE ALTH, INC. ("TRIHEALTH"). THE MISSION OF TRIHEALTH IS TO IMPROVE THE HEALTH STATUS OF THE COMMUNITY THROUGH A FULL RANGE OF HEALTH RELATED SERVICES- PREVENTION, WELLNESS AND EDUCATI ON AND THUS EXEMPLIFY THE FOUNDING SPIRIT OF THE BETHESDA DEACONESSES.THE SERVICES DESCRIB ED BELOW, AND OTHERS NOT LISTED, PROMOTE COMMUNITY HEALTH IN ACUTE ILLNESS, IN MANAGEMENT OF CHRONIC DISEASE, AND IN EDUCATION AND PREVENTION MEASURES. PROGRAMS SEEK TO REDUCE THE BURDENS ON THE GOVERNMENT. FOR EXAMPLE, IF BETHESDA DID NOT ADDRESS THE ROOT CAUSES OF LOW BIRTH WEIGHT AND PREMATURITY, THE BURDEN TO GOVERNMENT MEDICAL PROGRAMS SUCH AS MEDICAID WOULD BE EVEN GREATER. CHNAAS A FOLLOW UP TO THE 2016 CHNA, TRIHEALTH, INC. AND ITS HOSPIT ALS JOINED THIRTY-ONE (31) OTHER HOSPITALS IN THE GREATER CINCINNATI-DAYTON REGION TO SPON SOR AND FUND A COMPREHENSIVE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) REPORT ENTITLED "SW OHIO, N KENTUCKY, SE INDIANA COMMUNITY HEALTH NEEDS ASSESSMENT REPORT 2019". THE COMPREHEN SIVE CHNA SPANS TWENTY-FIVE (25) COUNTIES. THE REGIONAL CHNA REPORT COVERS GREATER DAYTON AND GREATER CINCINNATI, WHICH INCLUDES NORTHERN KENTUCKY AND SOUTHEASTERN INDIANA. THE 201 9 CHNA REPORT SHARES DATA FOR THE WHOLE REGION AS WELL AS DETAILED COUNTY-LEVEL DATA. IT A LSO ADDED THE VOICE OF THE SOUTHWEST OHIO MEMBERS OF THE ASSOCIATION OF OHIO HEALTH COMMIS SIONERS. DEVELOPING A BROAD CHNA HELPS FULFILL THE STATE OF OHIO'S REQUIREMENT MANDATING T HAT HEALTH DEPARTMENTS AND HOSPITALS ALIGN THEIR ASSESSMENTS.FROM THIS LARGER REPORT, TRIH EALTH DEVELOPED A CHNA AND ASSOCIATED IMPLEMENTATION STRATEGY FOR EACH OF ITS FACILITIES B ASED ON THE COUNTY BREAKDOWN AND DISCUSSION WITH TRIHEALTH LEADERS WITH EXPERTISE IN THE A REAS WHICH NEED TO BE ADDRESSED.PROGRAM SERVICE ACCOMPLISHMENTSFREE AND DISCOUNTED SERVICE S ARE PROVIDED FOR THOSE UNABLE TO PAY AND MEETING ELIGIBILITY CRITERIA. THROUGH THE HOSPI TAL CARE ASSURANCE PROGRAM (HCAP), BETHESDA SERVES PATIENTS MEETING CRITERIA SET FORTH BY THE OHIO DEPARTMENT OF JOBS AND FAMILY SERVICES. BETHESDA POLICY IS TO PROVIDE CHARITY CAR E ON A SLIDING SCALE DISCOUNTING WHEN THE FAMILY INCOME IS UP TO 300 PERCENT OF THE ANNUAL LY ESTABLISHED FEDERAL POVERTY GUIDELINE. IT OFFERS AN UNINSURED DISCOUNT FOR MEDICALLY NE CESSARY SERVICES FOR THOSE WHO HAVE NO INSURANCE AND WHO DO NOT QUALIFY FOR OTHER FINANCIA L ASSISTANCE OPTIONS. FINANCIAL COUNSELORS ASSIST PATIENTS IN COMPLETING THE FINANCIAL ASS ISTANCE APPLICATION WHICH IS AVAILABLE ON TRIHEALTH'S WEBSITE AND BROCHURES ABOUT FINANCIA L ASSISTANCE ARE VISIBLE AND AVAILABLE IN HOSPITAL REGISTRATION AND ADMITTING AREAS.DURING THE YEAR, BETHESDA PROVIDED COMMUNITY BENEFIT (INCLUDING UNCOMPENSATED CARE) AS SHOWN ON PART I, LINE 7A. THE AMOUNT OF BENEFIT FOR BOTH TRADITIONAL CHARITY CARE AND FOR THE UNPAI D COST OF MEDICAID IS ONE MANIFESTATION OF THE RISING RATES OF PERSONS WITHOUT HEALTH INSU RANCE. THE MEDICAID PUBLIC PROGRAM REIMBURSES HOSPITALS FOR SERVICES BUT PAYMENTS MAY NOT ALWAYS COVER THE TOTAL COST OF CARE AND MEDICATIONS. THE UNPAID COST OF MEDICARE IS NOT IN CLUDED IN TOTAL COMMUNITY BENEFIT. BETHESDA IS COMMITTED TO FULFILLING THE MISSION OF COMP ASSION TO THE VULNERABLE MEMBERS OF THE COMMUNITIES THEY SERVE.BETHESDA PARTICIPATES IN TH E REGIONAL TRAUMA SYSTEM THUS PROVIDING THE COMMUNITY WITH ACCESS TO TRAUMA CARE. THE TWO EMERGENCY ROOMS OF BETHESDA PROVIDE 24-HOUR EMERGENCY CARE TO COMMUNITY MEMBERS LIVING IN THE NORTHEAST CORRIDOR OF CINCINNATI AS WELL AS WARREN, BUTLER, AND CLERMONT COUNTIES. BET HESDA IS A LEVEL III TRAUMA CENTER AS VERIFIED BY THE COMMITTEE ON TRAUMA OF THE AMERICAN COLLEGE OF SURGEONS. ONE EXAMPLE OF ONGOING EFFORTS BY BETHESDA TO IMPROVE THE HEALTH OF T HE BROADER COMMUNITY ARE PROGRAMS TO ADDRESS THE IDENTIFIED HEALTH NEED OF DIABETES. DIABE TES EDUCATORS EXTEND THE EDUCATION TO THE COMMUNITY BY PROVIDING CLASSES TO A DIVERSE POPU LATION, FROM AREA INDUSTRIES AND FIREHOUSE GROUPS TO RETIREMENT CENTERS. A DIABETES SUPPOR T GROUP MEETS FOR CONTINUED EDUCATION IN CHRONIC DISEASE MANAGEMENT. THOUGH HEALTHY WOMEN HEALTHY LIVES WAS INSTITUTED IN JULY 2007 BY GOOD SAMARITAN HOSPITAL WOMEN'S SERVICES TO I MPROVE THE HEALTH OF THE GREATER CINCINNATI COMMUNITY, IT IS NOW FISCALLY SUPPORTED BY BET HESDA HOSPITAL AS WELL, MAKING IT A TRIHEALTH SYSTEM PROGRAM. HEALTHY WOMEN HEALTHY LIVES IS AN APPROACH BASED ON THE PREMISE THAT PREVENTION, 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 MENOPAU

Form and Line Reference	Explanation
PART VI, LINE 2:	SE. WELL ORGANIZED SCREENING AND EDUCATION EVENTS BRING THE SERVICES TO AT RISK POPULATION S OF AFRICAN AMERICAN, APPALACHIAN, HISPANIC, UNINSURED AND UNDERINSURED WOMEN FORTY YEARS OF AGE OR OLDER. SCREENING INCLUDES OSTEOPOROSIS, MAMMOGRAPHY, CHOLESTEROL, HYPERTENSION, AND OBESITY. EVERY WOMAN RECEIVES A NURSE CONSULTATION, A COPY OF THEIR RESULTS AND A WRI TTEN PRIMARY CARE REFERRAL. WOMEN WITH ABNORMAL RESULTS ARE CONTACTED AND ASSISTED IN ACCE SSING PRIMARY CARE. IN ADDITION, WOMEN NEEDING PREGNANCY AND GYNECOLOGIC CARE CAN ACCESS T HIS SERVICE AT THE OB/GYN CENTER AT BETHESDA NORTH HOSPITAL. CARE IS PROVIDED BY THE MEDIC AL RESIDENTS IN OBSTETRICS AND GYNECOLOGY, SUPERVISED BY FACULTY PHYSICIANS. FINANCIAL COU NSELORS AND CARE COORDINATORS ASSIST IN FINDING APPROPRIATE COVERAGE, PAYMENT PLANS AND FI NANCIAL AID. AS MANY OF THE WOMEN SERVED BY THE OB/GYN CENTER AT BETHESDA NORTH HOSPITAL H AVE LIMITED PROFICIENCY IN ENGLISH, QUALIFIED BILINGUAL STAFF ASSIST IN LANGUAGE INTERPRET ATION. THE TRIHEALTH THINK FIRST PROGRAM IS AN ESTABLISHED BETHESDA SERVICE FOCUSED ON INJ URY PREVENTION. THE THINK FIRST PROGRAM STAFF WORKS WITH COMMUNITY PARTNERS TO PROVIDE INJ URY 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. 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 MEDICA L OVERSIGHT. RESPITE HELPS PEOPLE WITHOUT HOMES TOWARD INDEPENDENT LIVING IN PERMANENT HOU SING. BETHESDA CONTINUES A COMMITMENT TO EDUCATING THE NEXT GENERATION OF HEALTH CARE PROV IDERS--PHYSICIANS AND ALLIED HEALTH PROFESSIONALS. COST IN EXCESS OF GOVERNMENTAL SUPPORT FOR MEDICAL EDUCATION PROGRAMS AS SHOWN ON PART I, LINE 7H.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 HOSPITA L CLINICAL ROTATIONS. BETHESDA, AS A PART OF TRIHEALTH, COLLABORATES WITH LOCAL AND REGION AL COLLEGES, UNIVERSITIES AND TRAINING CENTERS TO PROVIDE MENTORING, INTERNSHIPS, CLERKSHI PS, SUPERVISED EDUCATION AND CLINICAL ROTATIONS TO STUDENTS IN HEALTH FIELDS. THESE PARTNE RSHIPS HELP STUDENTS LEARN ABOUT AND PREPARE FOR PROFESSIONS IN NURSE PRACTITIONER, RESPIR ATORY THERAPY, RADIOLOGY TECHNOLOGY, STERILE PROCESSING, PHLEBOTOMY, MEDICAL LABORATORY, P HARMACY, SPEECH, AUDIOLOGY, PHYSICAL THERAPY, AND OCCUPATIONAL THERAPY. IN CONCLUSION, ASI DE FROM THE CHARITY CARE AND UNPAID COST OF MEDICARE PROGRAMS, BETHESDA PROVIDES THE COMMU NITY WITH HEALTH CARE SERVICES AND PROGRAMS, MEDICAL EDUCATION, AND CASH AND IN-KIND CONTR IBUTIONS FOR THE POOR AND THE BROADER COMMUNITY. THIS COMMITMENT TO COMMUNITY HEALTH REVEA LS 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.

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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.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 4:	WITH ONE HOSPITAL LOCATED IN MONTGOMERY, OHIO, A SUBURB OF CINCINNATI, AND ONE LOCATED NEAR HAMILTON, OHIO, BETHESDA HOSPITAL, INC. AND THE TRIHEALTH SYSTEM SERVE PRIMARILY HAMILTON, BUTLER, WARREN AND CLERMONT COUNTIES IN OHIO AS WELL AS SOME PERSONS FROM INDIANA AND KENTUCKY. BETHESDA NORTH HOSPITALHAMILTON COUNTY IS THE MOST POPULATED COUNTY IN THE REGION AND IS HOME TO THE LARGEST CITY, CINCINNATI. THE ESTIMATED POPULATION OF THE COUNTY IS 820,000 WITH APPROXIMATELY 15.5% IN POVERTY AND APPROXIMATELY 7% OF THE PEOPLE UNDER THE AGE OF 65 ARE WITHOUT HEALTH INSURANCE. BUTLER COUNTY HAS A MEDIAN INCOME OF APPROXIMATELY $52,500 WITH 90% OF THE POPULATION OVER THE AGE OF 24 HAVING A HIGH SCHOOL DIPLOMA OR HIGHER (36% BACHELOR'S DEGREE OR HIGHER) AND AN UNEMPLOYMENT RATE OF ABOUT 4%. APPROXIMATELY 15% OF THE POPULATION IS 65 YEARS AND OLDER, 65% IS WHITE, 27% IS AFRICAN-AMERICAN, 4% IS HISPANIC, 3% ASIAN AND 1% OTHER.CLERMONT COUNTY IS A LARGE COUNTY WHICH WAS ONCE MOSTLY RURAL BUT HAS BECOME MORE SUBURBAN AND IS ONE OF OHIO'S APPALACHIAN COUNTIES. THE ESTIMATED POPULATION OF THE COUNTY IS 205,000 WITH APPROXIMATELY 8.5% IN POVERTY AND APPROXIMATELY 6% OF THE PEOPLE UNDER THE AGE OF 65 ARE WITHOUT HEALTH INSURANCE. CLERMONT COUNTY HAS A MEDIAN INCOME OF APPROXIMATELY $64,000 WITH 90% OF THE POPULATION OVER THE AGE OF 24 HAVING A HIGH SCHOOL DIPLOMA OR HIGHER (28% BACHELOR'S DEGREE OR HIGHER) AND AN UNEMPLOYMENT RATE OF ABOUT 4%. APPROXIMATELY 16% OF THE POPULATION IS 65 YEARS AND OLDER, 93% IS WHITE, 2% IS AFRICAN-AMERICAN, 2% IS HISPANIC, 1.5% ASIAN AND 1.5% OTHER.WARREN COUNTY IS ONE OF THE FASTEST GROWING COUNTIES IN OHIO, BOTH IN RESIDENTIAL AND COMMERCIAL GROWTH. THE ESTIMATED POPULATION OF THE COUNTY IS 232,000 WITH APPROXIMATELY 5% IN POVERTY AND APPROXIMATELY 5% OF THE PEOPLE UNDER THE AGE OF 65 ARE WITHOUT HEALTH INSURANCE. CLERMONT COUNTY HAS A MEDIAN INCOME OF APPROXIMATELY $79,500 WITH 93% OF THE POPULATION OVER THE AGE OF 24 HAVING A HIGH SCHOOL DIPLOMA OR HIGHER (42% BACHELOR'S DEGREE OR HIGHER) AND AN UNEMPLOYMENT RATE OF ABOUT 3.5%. APPROXIMATELY 15% OF THE POPULATION IS 65 YEARS AND OLDER, 86% IS WHITE, 6% ASIAN, 4% IS AFRICAN-AMERICAN, 3% IS HISPANIC, AND 1% OTHER.BETHESDA BUTLERBUTLER COUNTY IS ONE OF THE MOST POPULATED COUNTIES IN THE REGION AND INCLUDES THE CITIES OF HAMILTON, MIDDLETOWN AND OXFORD. MANY OF THE CITIES IN THE COUNTY ARE EXPERIENCING GROWTH, AND ONLY ABOUT 9% IS CONSIDERED RURAL. THE ESTIMATED POPULATION OF THE COUNTY IS 385,000 WITH APPROXIMATELY 12.5% IN POVERTY AND APPROXIMATELY 7% OF THE PEOPLE UNDER THE AGE OF 65 ARE WITHOUT HEALTH INSURANCE. BUTLER COUNTY HAS A MEDIAN INCOME OF APPROXIMATELY $62,000 WITH 90% OF THE POPULATION OVER THE AGE OF 24 HAVING A HIGH SCHOOL DIPLOMA OR HIGHER (30% BACHELOR'S DEGREE OR HIGHER) AND AN UNEMPLOYMENT RATE OF ABOUT 4%. APPROXIMATELY 15% OF THE POPULATION IS 65 YEARS AND OLDER, 80% IS WHITE, 9% IS AFRICAN-AMERICAN, 5% IS HISPANIC, 4% ASIAN AND 2% OTHER.

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Form and Line Reference	Explanation
PART VI, LINE 5:	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 COMMERCIALLY 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.

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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, FIVE (5) 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.HTTPS://WWW.TRIHEALTH.COM/ABOUT-TRIHEALTH/

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 (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		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	**Other (Describe)**	**Facility reporting group**
1	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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
BETHESDA NORTH HOSPITAL	PART V, SECTION B, LINE 5: PRIMARY DATA SOURCES ALMOST 1,300 PEOPLE HAD AN OPPORTUNITY TO IDENTIFY AND PRIORITIZE HEALTH AND HEALTH-RELATED ISSUES AT A MEETING OR BY SURVEY. TWENTY -THREE (23) COUNTY- OR DISTRICT-LEVEL PUBLIC HEALTH DEPARTMENTS RESPONDED BY SURVEY, AND T HE CHNA TEAM ALSO RECEIVED SURVEY RESPONSES FROM 5 CITY-LEVEL HEALTH DEPARTMENTS. NINETY-S IX NONPROFIT ORGANIZATIONS COMPLETED SURVEYS, AND THEY SERVED RESIDENTS IN EVERY COUNTY. T OTAL RESPONSE FAR EXCEEDED THE LEVEL OF RESPONSE EXPERIENCED THREE YEARS EARLIER FOR THE 2 016 CHNAS IN CINCINNATI AND DAYTON. PRIMARY DATA WAS OBTAINED, WITH A UNIFORM SET OF QUEST IONS, VIA THE FOLLOWING: * THERE WERE 42 MEETINGS, HELD IN 23 COUNTIES DURING MAY THROUGH JULY 2018, WHICH ATTRACTED 463 REPRESENTATIVES OF COMMUNITY ORGANIZATIONS, THE GENERAL PUB LIC, AND/OR MEMBERS OF MEDICALLY UNDERSERVED AND VULNERABLE POPULATIONS TO IDENTIFY BARRIE RS TO CARE, GIVE INPUT FOR CURRENT NEEDS ASSESSMENT, PRIORITIZE ISSUES, AND IDENTIFY RESOU RCES TO ADDRESS HEALTH AND HEALTH-RELATED ISSUES. * ONLINE SURVEYS OF INDIVIDUALS (828), A GENCIES (96), AND PUBLIC HEALTH DEPARTMENTS (28) THROUGHOUT THE REGION FROM JUNE THROUGH A UGUST 2018. * THE REPORTING HOSPITAL DID NOT RECEIVE WRITTEN COMMENTS FROM THE PUBLIC REGA RDING THE 2016 CHNA OR ITS RELATED IMPLEMENTATION STRATEGY. COMMUNITY MEETINGSOUTREACH ANY INDIVIDUAL OR AGENCY REPRESENTATIVE WHO GAVE THEIR ADDRESS DURING THE 2013 OR 2016 CHNA P ROCESS WAS ADDED TO AN INVITE LIST, AND THE HEALTH COLLABORATIVE (THC) MAILED THEM AN INVI TATION TO THE MEETING SCHEDULED IN THEIR COUNTY. THE CONSULTANTS ADDED NONPROFIT ORGANIZAT IONS IN EACH COUNTY THAT HAD EITHER A PHONE NUMBER, STREET ADDRESS, OR EMAIL. THC SENT 544 EMAILS AND 376 LETTERS BY FIRST-CLASS MAIL. THE CONSULTANTS MADE PHONE CALLS TO AGENCIES THAT HAD NOT PREVIOUSLY ATTENDED A CHNA MEETING AS WELL AS TO STRATEGIC ORGANIZATIONS THAT SERVE VULNERABLE POPULATIONS AND/OR HAVE A BROAD REACH, E.G., UNITED WAY. THEY FOLLOWED U P WITH EMAILS. THC SENT FLYERS TO HOSPITALS AND TO MEETING HOST SITES FOR POSTING AND DIST RIBUTION. THE CONSULTANTS ALSO POSTED UPCOMING MEETINGS EVERY TWO WEEKS IN THE INTERACT FO R HEALTH E-NEWSLETTER: HEALTH WATCH, WHICH IS EMAILED ACROSS 20 COUNTIES. THE CONSULTANTS SENT FLYERS TO PUBLIC HEALTH DEPARTMENTS TO POST AND DISTRIBUTE. SOME HEALTH DEPARTMENTS P UBLICIZED MEETINGS ON THEIR SOCIAL MEDIA PAGES AND HELD ADDITIONAL MEETINGS. THERE WAS A 2 29% INCREASE IN MEETING ATTENDANCE, FROM 202 FOR THE 2016 CYCLE TO 463 FOR THE 2019 CYCLE. APPENDIX 1 OF THE CHNA, WHICH IS POSTED TO TRIHEALTH'S WEBSITE, INCLUDES A LIST OF MEETIN G ATTENDEES AND THE ORGANIZATIONS EACH REPRESENTS.PURPOSE OF MEETINGS THE PURPOSE OF THE M EETINGS WAS TO SOLICIT PUBLIC INPUT. THE DESIRE WAS TO ATTRACT INDIVIDUALS OR NONPROFIT OR GANIZATIONS WITH EXPERIENCE OR KNOWLEDGE TO SHARE, ESPECIALLY ON EMERGING ISSUES NOT CAPTU RED BY THE SECONDARY DATA AND FROM THE PERSPECTIVES OF MEDICALLY UNDERSERVED, MINORITY, AN D/OR LOW-INCOME POPULATIONS. T

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

Form and Line Reference	Explanation
BETHESDA NORTH HOSPITAL	HE OBJECTIVES WERE TO: * SHARE COUNTY-LEVEL HIGHLIGHTS FROM THE SECONDARY DATA (AND CITY-L EVEL FOR CINCINNATI HEALTH DEPARTMENT MEETINGS) * GATHER DIVERSE PEOPLE TO SHARE THEIR IDE AS -- GENERAL PUBLIC AND COMMUNITY LEADERS * RECEIVE INPUT FROM AGENCIES THAT REPRESENT VU LNERABLE POPULATIONS * HEAR CONCERNS AND QUESTIONS ABOUT EXISTING HEALTH/HEALTH-RELATED IS SUES * OBTAIN INFORMATION ABOUT FINANCIAL AND NON-FINANCIAL BARRIERS TO HEALTH CARE * IDEN TIFY RESOURCES AVAILABLE LOCALLY TO ADDRESS ISSUES * OBTAIN INSIGHT INTO LOCAL CONDITIONS FROM LOCAL PEOPLE * DISCOVER HEALTH AND HEALTH-RELATED PRIORITIES OF ATTENDEES MEETING FAC ILITATION A GROUP OF 2-3 CONSULTANTS WENT TO EACH MEETING, DEPENDING ON THE NUMBER OF RSVP S. EACH MEETING FOLLOWED THE SAME FORMAT AND AGENDA. REFRESHMENTS WERE SERVED, AND NAMETAG S WERE USED TO GENERATE A WELCOMING ATMOSPHERE. LOCATIONS WERE SELECTED FOR CONVENIENCE, A CCESS, AND TRUSTED REPUTATION IN THE COMMUNITY. THE FACILITATOR FIRST SHARED GENERAL TRIST ATE AND STATE-SPECIFIC HEALTH AND HEALTH-RELATED DATA TO PROVIDE CONTEXT. THE SURVEY QUEST IONS WERE USED, BUT THE FIRST QUESTION ABOUT MOST SERIOUS HEALTH ISSUES WAS ASKED SEPARATE LY. THIS TECHNIQUE WAS INTENDED TO CAPTURE FIRST THOUGHTS WITHOUT AN OPPORTUNITY TO BE INF LUENCED BY THE MORE SPECIFIC COUNTY-LEVEL DATA OR BY OTHER ATTENDEES. AFTER THE FIRST QUES TION, THE CONSULTANTS (A MEETING FACILITATOR AND AT LEAST ONE SCRIBE) SHARED A PROFILE OF THE COUNTY, INCLUDING A SUMMARY OF SECONDARY DATA. THE MEETINGS LASTED 90 MINUTES, OF WHIC H 60 MINUTES WAS DEVOTED TO THE GROUP'S BRAINSTORMING. AT THE END, EACH PERSON WAS GIVEN 3 COLORED DOTS. THEY PLACED THE DOTS NEXT TO ISSUES THEY PRIORITIZED AS MOST IMPORTANT HEAL TH CONDITIONS OR NEEDS OF THE COMMUNITY. THE AGENDA HANDOUT CONTAINED LINKS TO THE SURVEYS . SURVEYS THE CONSULTANTS DEVELOPED THREE TYPES OF SURVEYS: INDIVIDUAL CONSUMER; AGENCY; A ND HEALTH DEPARTMENT. THE QUESTIONS REMAINED THE SAME FOR EACH SURVEY. THE AGENCY SURVEYS WERE PUSHED OUT VIA EMAIL AS WELL AS THE LINK WAS SHARED AT THE COMMUNITY MEETINGS. THE HE ALTH DEPARTMENT VERSION ALSO REQUESTED THE QUALIFICATIONS OF THE RESPONDENTS. AS REQUIRED BY THE IRS, THE INDIVIDUAL CONSUMER SURVEY WAS ALSO TRANSLATED INTO SPANISH AND ADAPTED FO R MOBILE APPLICATION AT COMMUNITY EVENTS. THE CONSULTANTS USED SURVEYMONKEY TO COLLECT RES PONSES, TABULATE DATA, INTERPRET AND ANALYZE RESULTS, AND CREATE CATEGORIES TO TRACK KEY W ORDS AND PHRASES. PAPER COPIES (TRANSLATED) WERE USED WITH SPANISH-SPEAKING FAMILIES, REFU GEES FROM RWANDA, AND AT TREATMENT FACILITIES. BOTH TRIHEALTH OUTREACH MINISTRIES AND SANT A MARIA COMMUNITY SERVICES PROVIDED THE ANSWERS ALREADY TRANSLATED INTO ENGLISH FOR THE CO NSULTANTS. A TOTAL OF 113 IMMIGRANT SURVEYS WERE COMPLETED AND RETURNED. SEE APPENDIX 2 FO R THE SURVEY RESPONDENTS WHO IDENTIFIED THEMSELVES. APPENDIX 3 OF THE CHNA, WHICH IS POSTE D TO TRIHEALTH'S WEBSITE, HAS A LIST OF HEALTH DEPARTMENT RESPONDENTS WITH THEIR QUALIFICA TIONS.SECONDARY DATA SOURCES D

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

Form and Line Reference	Explanation
BETHESDA NORTH HOSPITAL	ATA COLLECTION COUNTY HEALTH RANKINGS (CHR) FORMED THE FOUNDATION FOR DATA COLLECTION WITH ITS COUNTY-LEVEL FOCUS ON HEALTH OUTCOMES, HEALTH FACTORS, HEALTH BEHAVIORS, QUALITY OF L IFE, CLINICAL CARE, PHYSICAL ENVIRONMENT, AND SOCIOECONOMIC FACTORS. ADDITIONAL SOURCES SU PPLEMENTED THE CHR DATA. PUBLICLY AVAILABLE HEALTH STATISTICS AND DEMOGRAPHICS WERE OBTAIN ED AT THE STATE AND COUNTY LEVEL. THE EPIDEMIOLOGISTS FOR PUBLIC HEALTH - DAYTON & MONTGOM ERY COUNTY (PHDMC) VOLUNTEERED TO COLLECT DATA FOR THE STATE OF OHIO AND ITS COUNTIES. THE Y INCLUDED DATA THROUGH 2016. OHIO'S 2017 DATA WAS NOT AVAILABLE IN TIME FOR THIS REPORT. THE NUMBER OF DATA MEASURES INCREASED BY 33%, FROM 106 IN 2016 TO 142 IN 2019. DATA SOURCE S THE STANDARDS FOR RESEARCHING AND INCLUDING DATA WERE: * COMPARABLE (MEASURES WITH BENCH MARKS SUCH AS HEALTHY PEOPLE 2020 OR STATE/NATIONAL RATES) * COUNTY-LEVEL DATA (ZIP CODE L EVEL PREFERRED BUT RARE) * FOCUS ON HEALTH OUTCOME DATA (PREFERRED OVER SUBJECTIVE SURVEY DATA WHEN BOTH WERE AVAILABLE) * REPRODUCIBLE (NEW UPDATE AVAILABLE WITHIN THREE YEARS OR AT 3-YEAR INTERVALS VS. ONE-TIME) * REPUTABLE SOURCE * TREND DATA AVAILABLE (MORE THAN ONE DATA POINT; 3-5 YEARS PREFERRED) THE CHR WAS AN EXCELLENT STARTING POINT, BUT THE CONSULT ANTS DISCOVERED ADDITIONAL SOURCES WITH MORE RECENT DATA AS WELL AS INDICATORS FOR MEASURE S NOT COLLECTED BY CHR. THE PREVALENCE OF CERTAIN CANCERS, THE RAPID INCREASE OF HEROIN OV ERDOSE DEATHS IN THE REGION, AND ADDITIONAL MORTALITY DATA ARE EXAMPLES OF SUPPLEMENTAL DA TA. MANY EXCELLENT SOURCES OF INFORMATION DID NOT HAVE A BREAKDOWN BELOW THE STATE LEVEL O R DID NOT INCLUDE THE ENTIRE REGION. THE CONSULTANTS CONTACTED STATE HEALTH DEPARTMENTS, L OCAL HEALTH DEPARTMENTS, AND LOCAL EXPERTS. THE BIGGEST CHANGE FROM THE PRIOR CYCLE IS THA T THE DEPARTMENT OF HEALTH AND HUMAN SERVICES NO LONGER MAINTAINS THE HEALTH INDICATORS WA REHOUSE AS AN ONLINE SOURCE, AND IT HAD PROVIDED DATA FOR EIGHT KEY MEASURES. PHDMC EPIDEM IOLOGISTS CONSULTED THE OHIO DATA FOR DATA RANGES ENDING WITH 2016 AND ONE PERIOD PRIOR. D UE TO CHARACTER LIMITATION IN THE SOFTWARE, THESE DATA SOURCES COULD NOT BE INCLUDED IN TH IS EXPLANATION. HOWEVER, THE DATA SOURCES AND DATES CAN BE FOUND ON PAGES 12 AND 13 OF THE CHNA POSTED ON TRIHEALTH'S WEBSITE.

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

Form and Line Reference	Explanation
BETHESDA BUTLER HOSPITAL	PART V, SECTION B, LINE 5: PRIMARY DATA SOURCES ALMOST 1,300 PEOPLE HAD AN OPPORTUNITY TO IDENTIFY AND PRIORITIZE HEALTH AND HEALTH-RELATED ISSUES AT A MEETING OR BY SURVEY. TWENTY -THREE (23) COUNTY- OR DISTRICT-LEVEL PUBLIC HEALTH DEPARTMENTS RESPONDED BY SURVEY, AND T HE CHNA TEAM ALSO RECEIVED SURVEY RESPONSES FROM 5 CITY-LEVEL HEALTH DEPARTMENTS. NINETY-S IX NONPROFIT ORGANIZATIONS COMPLETED SURVEYS, AND THEY SERVED RESIDENTS IN EVERY COUNTY. T OTAL RESPONSE FAR EXCEEDED THE LEVEL OF RESPONSE EXPERIENCED THREE YEARS EARLIER FOR THE 2 016 CHNAS IN CINCINNATI AND DAYTON. PRIMARY DATA WAS OBTAINED, WITH A UNIFORM SET OF QUEST IONS, VIA THE FOLLOWING: * THERE WERE 42 MEETINGS, HELD IN 23 COUNTIES DURING MAY THROUGH JULY 2018, WHICH ATTRACTED 463 REPRESENTATIVES OF COMMUNITY ORGANIZATIONS, THE GENERAL PUB LIC, AND/OR MEMBERS OF MEDICALLY UNDERSERVED AND VULNERABLE POPULATIONS TO IDENTIFY BARRIE RS TO CARE, GIVE INPUT FOR CURRENT NEEDS ASSESSMENT, PRIORITIZE ISSUES, AND IDENTIFY RESOU RCES TO ADDRESS HEALTH AND HEALTH-RELATED ISSUES. * ONLINE SURVEYS OF INDIVIDUALS (828), A GENCIES (96), AND PUBLIC HEALTH DEPARTMENTS (28) THROUGHOUT THE REGION FROM JUNE THROUGH A UGUST 2018. * THE REPORTING HOSPITAL DID NOT RECEIVE WRITTEN COMMENTS FROM THE PUBLIC REGA RDING THE 2016 CHNA OR ITS RELATED IMPLEMENTATION STRATEGY. COMMUNITY MEETINGSOUTREACH ANY INDIVIDUAL OR AGENCY REPRESENTATIVE WHO GAVE THEIR ADDRESS DURING THE 2013 OR 2016 CHNA P ROCESS WAS ADDED TO AN INVITE LIST, AND THE HEALTH COLLABORATIVE (THC) MAILED THEM AN INVI TATION TO THE MEETING SCHEDULED IN THEIR COUNTY. THE CONSULTANTS ADDED NONPROFIT ORGANIZAT IONS IN EACH COUNTY THAT HAD EITHER A PHONE NUMBER, STREET ADDRESS, OR EMAIL. THC SENT 544 EMAILS AND 376 LETTERS BY FIRST-CLASS MAIL. THE CONSULTANTS MADE PHONE CALLS TO AGENCIES THAT HAD NOT PREVIOUSLY ATTENDED A CHNA MEETING AS WELL AS TO STRATEGIC ORGANIZATIONS THAT SERVE VULNERABLE POPULATIONS AND/OR HAVE A BROAD REACH, E.G., UNITED WAY. THEY FOLLOWED U P WITH EMAILS. THC SENT FLYERS TO HOSPITALS AND TO MEETING HOST SITES FOR POSTING AND DIST RIBUTION. THE CONSULTANTS ALSO POSTED UPCOMING MEETINGS EVERY TWO WEEKS IN THE INTERACT FO R HEALTH E-NEWSLETTER: HEALTH WATCH, WHICH IS EMAILED ACROSS 20 COUNTIES. THE CONSULTANTS SENT FLYERS TO PUBLIC HEALTH DEPARTMENTS TO POST AND DISTRIBUTE. SOME HEALTH DEPARTMENTS P UBLICIZED MEETINGS ON THEIR SOCIAL MEDIA PAGES AND HELD ADDITIONAL MEETINGS. THERE WAS A 2 29% INCREASE IN MEETING ATTENDANCE, FROM 202 FOR THE 2016 CYCLE TO 463 FOR THE 2019 CYCLE. APPENDIX 1 OF THE CHNA, WHICH IS POSTED TO TRIHEALTH'S WEBSITE, INCLUDES A LIST OF MEETIN G ATTENDEES AND THE ORGANIZATIONS EACH REPRESENTS.PURPOSE OF MEETINGS THE PURPOSE OF THE M EETINGS WAS TO SOLICIT PUBLIC INPUT. THE DESIRE WAS TO ATTRACT INDIVIDUALS OR NONPROFIT OR GANIZATIONS WITH EXPERIENCE OR KNOWLEDGE TO SHARE, ESPECIALLY ON EMERGING ISSUES NOT CAPTU RED BY THE SECONDARY DATA AND FROM THE PERSPECTIVES OF MEDICALLY UNDERSERVED, MINORITY, AN D/OR LOW-INCOME POPULATIONS. T

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

Form and Line Reference	Explanation
BETHESDA BUTLER HOSPITAL	HE OBJECTIVES WERE TO: * SHARE COUNTY-LEVEL HIGHLIGHTS FROM THE SECONDARY DATA (AND CITY-L EVEL FOR CINCINNATI HEALTH DEPARTMENT MEETINGS) * GATHER DIVERSE PEOPLE TO SHARE THEIR IDE AS -- GENERAL PUBLIC AND COMMUNITY LEADERS * RECEIVE INPUT FROM AGENCIES THAT REPRESENT VU LNERABLE POPULATIONS * HEAR CONCERNS AND QUESTIONS ABOUT EXISTING HEALTH/HEALTH-RELATED IS SUES * OBTAIN INFORMATION ABOUT FINANCIAL AND NON-FINANCIAL BARRIERS TO HEALTH CARE * IDEN TIFY RESOURCES AVAILABLE LOCALLY TO ADDRESS ISSUES * OBTAIN INSIGHT INTO LOCAL CONDITIONS FROM LOCAL PEOPLE * DISCOVER HEALTH AND HEALTH-RELATED PRIORITIES OF ATTENDEES MEETING FAC ILITATION A GROUP OF 2-3 CONSULTANTS WENT TO EACH MEETING, DEPENDING ON THE NUMBER OF RSVP S. EACH MEETING FOLLOWED THE SAME FORMAT AND AGENDA. REFRESHMENTS WERE SERVED, AND NAMETAG S WERE USED TO GENERATE A WELCOMING ATMOSPHERE. LOCATIONS WERE SELECTED FOR CONVENIENCE, A CCESS, AND TRUSTED REPUTATION IN THE COMMUNITY. THE FACILITATOR FIRST SHARED GENERAL TRIST ATE AND STATE-SPECIFIC HEALTH AND HEALTH-RELATED DATA TO PROVIDE CONTEXT. THE SURVEY QUEST IONS WERE USED, BUT THE FIRST QUESTION ABOUT MOST SERIOUS HEALTH ISSUES WAS ASKED SEPARATE LY. THIS TECHNIQUE WAS INTENDED TO CAPTURE FIRST THOUGHTS WITHOUT AN OPPORTUNITY TO BE INF LUENCED BY THE MORE SPECIFIC COUNTY-LEVEL DATA OR BY OTHER ATTENDEES. AFTER THE FIRST QUES TION, THE CONSULTANTS (A MEETING FACILITATOR AND AT LEAST ONE SCRIBE) SHARED A PROFILE OF THE COUNTY, INCLUDING A SUMMARY OF SECONDARY DATA. THE MEETINGS LASTED 90 MINUTES, OF WHIC H 60 MINUTES WAS DEVOTED TO THE GROUP'S BRAINSTORMING. AT THE END, EACH PERSON WAS GIVEN 3 COLORED DOTS. THEY PLACED THE DOTS NEXT TO ISSUES THEY PRIORITIZED AS MOST IMPORTANT HEAL TH CONDITIONS OR NEEDS OF THE COMMUNITY. THE AGENDA HANDOUT CONTAINED LINKS TO THE SURVEYS . SURVEYS THE CONSULTANTS DEVELOPED THREE TYPES OF SURVEYS: INDIVIDUAL CONSUMER; AGENCY; A ND HEALTH DEPARTMENT. THE QUESTIONS REMAINED THE SAME FOR EACH SURVEY. THE AGENCY SURVEYS WERE PUSHED OUT VIA EMAIL AS WELL AS THE LINK WAS SHARED AT THE COMMUNITY MEETINGS. THE HE ALTH DEPARTMENT VERSION ALSO REQUESTED THE QUALIFICATIONS OF THE RESPONDENTS. AS REQUIRED BY THE IRS, THE INDIVIDUAL CONSUMER SURVEY WAS ALSO TRANSLATED INTO SPANISH AND ADAPTED FO R MOBILE APPLICATION AT COMMUNITY EVENTS. THE CONSULTANTS USED SURVEYMONKEY TO COLLECT RES PONSES, TABULATE DATA, INTERPRET AND ANALYZE RESULTS, AND CREATE CATEGORIES TO TRACK KEY W ORDS AND PHRASES. PAPER COPIES (TRANSLATED) WERE USED WITH SPANISH-SPEAKING FAMILIES, REFU GEES FROM RWANDA, AND AT TREATMENT FACILITIES. BOTH TRIHEALTH OUTREACH MINISTRIES AND SANT A MARIA COMMUNITY SERVICES PROVIDED THE ANSWERS ALREADY TRANSLATED INTO ENGLISH FOR THE CO NSULTANTS. A TOTAL OF 113 IMMIGRANT SURVEYS WERE COMPLETED AND RETURNED. SEE APPENDIX 2 FO R THE SURVEY RESPONDENTS WHO IDENTIFIED THEMSELVES. APPENDIX 3 OF THE CHNA, WHICH IS POSTE D TO TRIHEALTH'S WEBSITE, HAS A LIST OF HEALTH DEPARTMENT RESPONDENTS WITH THEIR QUALIFICA TIONS.SECONDARY DATA SOURCES D

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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 6A: * THE CHRIST HOSPITAL HEALTH NETWORK, * CINCINNATI CHILDREN'S HOSPITAL MEDICAL CENTER, * CLINTON MEMORIAL HOSPITAL,* HIGHPOINT HEALTH, * KETTERING HEALTH NETWORK (FORT HAMILTON HOSPITAL, GRANDVIEW MEDICAL CENTER, GREENE MEMORIAL HOSPITAL, KETTERING BEHAVIORAL MEDICINE CENTER, KETTERING MEDICAL CENTER, SOIN MEDICAL CENTER, SOUTHVIEW MEDICAL CENTER, SYCAMORE MEDICAL CENTER)* LINDNER CENTER OF HOPE* MERCY HEALTH-CINCINNATI REGION (MERCY HEALTH-ANDERSON HOSPITAL, MERCY HEALTH-CLERMONT HOSPITAL, MERCY HEALTH-FAIRFIELD HOSPITAL, MERCY HEALTH-WEST HOSPITAL, THE JEWISH HOSPITAL)* MERCY HEALTH-SPRINGFIELD REGION (MERCY HEALTH-URBANA HOSPITAL, SPRINGFIELD REGIONAL MEDICAL CENTER)* PREMIER HEALTH (ATRIUM MEDICAL CENTER, MIAMI VALLEY HOSPITAL NORTH, MIAMI VALLEY HOSPITAL SOUTH, UPPER VALLEY MEDICAL CENTER)* TRIHEALTH (BETHESDA BUTLER HOSPITAL, BETHESDA NORTH HOSPITAL, GOOD SAMARITAN HOSPITAL, MCCULLOUGH-HYDE MEMORIAL HOSPITAL, TRIHEALTH EVENDALE HOSPITAL)* UC HEALTH (DANIEL DRAKE CENTER FOR POST-ACUTE CARE, UNIVERSITY OF CINCINNATI MEDICAL CENTER, WEST CHESTER HOSPITAL)* WILSON HEALTH* WAYNE HEALTHCARE

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BETHESDA NORTH HOSPITAL	PART V, SECTION B, LINE 6B: * THE HEALTH COLLABORATIVE* GREATER DAYTON AREA HOSPITAL ASSOCIATION* ADAMS COUNTY HEALTH DEPARTMENT* BROWN COUNTY HEALTH DEPARTMENT* BUTLER COUNTY HEALTH DEPARTMENT* CHAMPAIGN-URBANA COUNTY HEALTH DEPARTMENT* CINCINNATI HEALTH DEPARTMENT* CITY OF HAMILTON HEALTH DEPARTMENT* CLARK COUNTY COMBINED HEALTH DEPARTMENT* CLERMONT COUNTY PUBLIC HEALTH* CLINTON COUNTY HEALTH DEPARTMENT* DARKE COUNTY GENERAL HEALTH DISTRICT* FAYETTE COUNTY PUBLIC HEALTH* GREENE COUNTY PUBLIC HEALTH* HAMILTON COUNTY PUBLIC HEALTH* HIGHLAND COUNTY HEALTH DEPARTMENT* MIAMI COUNTY PUBLIC HEALTH* MIDDLETOWN CITY HEALTH DISTRICT* NORWOOD HEALTH DEPARTMENT* PIQUA CITY HEALTH DEPARTMENT* PREBLE COUNTY PUBLIC HEALTH* PUBLIC HEALTH DAYTON & MONTGOMERY COUNTY* SIDNEY SHELBY COUNTY HEALTH DEPARTMENT* SPRINGFIELD HEALTH DEPARTMENT* WARREN COUNTY COMBINED HEALTH DISTRICT* NORTHERN KENTUCKY HEALTH DEPARTMENT

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Form and Line Reference	Explanation
BETHESDA NORTH HOSPITAL	PART V, SECTION B, LINE 7D: COPY AVAILABLE WITHOUT CHARGE.PLEASE CONTACT TRIHEALTH MISSION AND CULTURE, 625 EDEN PARK DRIVE, 9TH FLOOR, CINCINNATI, OHIO 45202

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

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Form and Line Reference	Explanation
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Form and Line Reference	Explanation
BETHESDA NORTH HOSPITAL	PART V, SECTION B, LINE 11: DUE TO THE PROXIMITY OF TRIHEALTH EVENDALE HOSPITAL (TEH) AND BETHESDA NORTH HOSPITAL (BNH) (LESS THAN 5 MILES) AS WELL AS TEH BEING ONLY A SURGERY CENT ER, THESE TWO HOSPITALS WILL WORK TOGETHER IN ADDRESSING THE SIGNIFICANT NEEDS OF THE AREA WITH BNH BEING THE LEADER AS IT IS ONE OF THE FLAGSHIP HOSPITALS OF THE TRIHEALTH SYSTEM. 1) SUBSTANCE ABUSE/MENTAL HEALTH - IN RESPONSE TO THE ESCALATING OPIOID ADDICTION EPIDEMIC IN THE MARKET SERVED, A RELATED HOSPITAL, GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO (GS H) AND THE TRIHEALTH SYSTEM ENGAGED THE COMMUNITY IN AN ORGANIZED AND FOCUSED SET OF TACTI CS TO ADDRESS THIS. SINCE OCTOBER 2017, THE TRIHEALTH OPIATE STEERING COMMITTEE AND THE GS H OPIATE PILOT CONTINUES TO FOCUS ON FIVE KEY AREAS: PREVENTION, TREATMENT, FUNDING, COMMU NITY PARTNERSHIPS AND TEAM MEMBER SUPPORT. THE FOCUS ON KEY AREAS HAS HELPED BUILD THE INF RASTRUCTURE NECESSARY TO PROVIDE TREATMENT NOT ONLY AT GSH BUT TO EXPAND KEY INITIATIVES T O OTHER TRIHEALTH HOSPITALS. PREVENTION* NARCAN DISTRIBUTION: NARCAN SERVES TO BLOCK THE E FFECTS OF OPIOIDS IN CASE OF AN ACCIDENTAL OVERDOSE. NARCAN WILL CONTINUE TO BE PROVIDED T O ALL ER PATIENTS WHO NEED IT WITHOUT COST TO THE PATIENT, AND GSH WILL CONTINUE ITS EDUCA TION OF FIRST RESPONDERS AS NEW INFORMATION ARISES AND NEW RESPONDERS ARE TRAINED. TREATME NT * SUBSTANCE USE TREATMENT COORDINATORS (SUTC): BY JULY 2019, TRIHEALTH WILL HAVE A RESP ONSE TO A GRANT PROPOSAL IT SUBMITTED TO BETHESDA FOUNDATION TO EXPAND THE SUTC ROLE TO BE THESDA NORTH HOSPITAL AS A PLATFORM FOR UTILIZING TELEHEALTH FOR FURTHER EXPANSION TO BETH ESDA ARROW SPRINGS AMBULATORY CENTER AND MCCULLOUGH HYDE MEMORIAL HOSPITAL. SUTC HAS SPECI FIC SUBSTANCE USE TRAINING, CERTIFICATION AND EXPERIENCE IN SUBSTANCE USE DISORDERS (ALCOH OL, OPIATES ETC.). THE ROLE OF THE SUTC IS TO ENGAGE, ASSESS AND PROVIDE AN APPOINTMENT TO A TREATMENT PROGRAM WITHIN 24-48 HOURS AFTER DISCHARGE. * IN COLLABORATION WITH COMMUNITY PARTNERS BNH/TEH WILL CONTINUE TO TEST THE EFFICACY OF THIS ROLE AND EFFECTIVENESS AT MEE TING THESE TARGETS. * IF THE PEER RECOVERY SPECIALIST IDENTIFIED IN THE GOOD SAMARITAN HOS PITAL PROGRESS REPORT RE: 2016 PRIORITIES IS EFFECTIVE IN REACHING OUT TO PATIENTS THAT MI GHT OTHERWISE BE RELUCTANT TO ENTER INTO RECOVERY, THIS FUNCTION WILL BE EVALUATED FOR EXP ANSION TO OTHER TRIHEALTH ERS. * TRACKING OUTCOMES: THE TASK FORCE WILL BE MONITORING AN O PIOID DASHBOARD TO TRACK OUTCOMES SUCH AS UTILIZATION OF SUBSTANCE USE WITHDRAWAL MANAGEME NT ORDER SETS, BUPRENORPHINE INDUCTION (MEDICATION USED TO TREAT OPIATE ADDICTION), NARCAN DISPENSING ETC. THIS ALLOWS US TO MONITOR THE EFFECTIVENESS OF OUR INITIATIVES.2). INFANT MORTALITY - BNH PROVIDES OBSTETRIC ("OB") AND GYNECOLOGICAL SERVICES TO ALL COMERS VIA IT S OB CLINICS. THE OB CLINICS HAVE ADOPTED AN INNOVATIVE WOMAN CENTERED MEDICAL HOME MODEL MEANT TO REINFORCE COMPLIANCE WITH PREGNANT PATIENT OFFICE VISITS AND FOLLOW UP CARE. TRIH EALTH PROVIDES A BREASTFEEDING

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

Form and Line Reference	Explanation
BETHESDA NORTH HOSPITAL	SUPPORT LINE FREE TO THE COMMUNITY, WHICH INCLUDES THE BNH/TEH SERVICE AREA.BNH AND TEH, THROUGH TRIHEALTH, WILL ALSO CONTINUE ITS LONG-TIME PARTNERSHIP WITH AND FUNDING OF SEVERA L ORGANIZATIONS (PROVIDING FUNDING AND HUMAN/CLINICAL RESOURCES) THAT TARGET INFANT MORTAL ITY AND CHILD HEALTH CONCERNS, INCLUDING; * CRADLE CINCINNATI - AN ORGANIZATION AIMED AT R EDUCING INFANT MORTALITY THROUGH EDUCATION AND AWARENESS. CRADLE CINCINNATI'S GOALS ARE TO PREVENT PREMATURE BIRTHS, REDUCING TOBACCO USE AND SUBSTANCE ABUSE, AND PROMOTING SAFE SL EEP FOR BABIES THROUGH THREE APPROACHES: COMMUNICATIONS, MEDICAL, AND COMMUNITY. * HEALTHY BEGINNINGS, WHICH PROVIDES COMPREHENSIVE PRE-NATAL CARE TO THE UNDERSERVED. * HEALTHY MOM S AND BABES, WHICH PROVIDES HOME SERVICES FOR BOTH PRE-NATAL AND POST-DELIVERY SUPPORT FOR UNDERSERVED POPULATIONS. * TRIHEALTH'S THINK FIRST FOR YOUR BABY IS AN INJURY PREVENTION PROGRAM WITH A GOAL TO REDUCE UNINTENTIONAL INJURIES IN INFANTS UNDER THE AGE OF ONE YEAR THROUGH PRENATAL EDUCATION AND POST-PARTUM FOLLOW-UP. * OTHER PARTNERS INCLUDE MARCH OF DI MES AND SWEET CHEEKS DIAPER BANK. FINALLY, BNH AND TEH, THROUGH TRIHEALTH, WILL ALSO PROVI DE FINANCIAL SUPPORT TO OTHER ORGANIZATIONS THAT FOCUS RESOURCES ON INFANT MORTALITY AND M ATERNAL HEALTH: * URBAN HEALTH PROJECT (OFFICE SPACE) * OB CLINICS * OB WOMAN CENTERED MED ICAL HOME MODEL * FUNDING FOR CRADLE CINCINNATI NEIGHBORHOOD BASED WOMAN CENTERED MEDICAL HOME * GOOD SAMARITAN FREE HEALTH CLINIC * HEALTHY BEGINNINGS * HEALTHY MOMS AND BABES * T HINK FIRST FOR YOUR BABY * START STRONG * MARCH OF DIMES * SWEET CHEEKS DIAPER BANK3. CANC ER - BNH, TEH AND TRIHEALTH CANCER INSTITUTE WILL CONTINUE THE TARGETED (MELANOMA, LUNG) F REE SCREENINGS AND FOLLOW UPS. THERE IS A MOBILE MAMMOGRAPHY UNIT THAT WILL CONTINUE TO DO SCREENING IN HIGH NEED AREAS WITHIN HAMILTON COUNTY E.G. AVONDALE, AND THE CITY OF HAMILT ON IN BUTLER COUNTY. PATIENTS WITH POSITIVE RESULTS IDENTIFIED AT THE GOOD SAMARITAN FREE HEALTH CENTER WILL CONTINUE TO BE REFERRED TO BNH CLINIC PROVIDERS AND OBTAIN COVERAGE FRO M STATE FUNDED BREAST AND CERVICAL CANCER PREVENTION (BCCP) FUNDING. BNH AND TEH THROUGH T RIHEALTH JUST BEGAN A PARTNERSHIP WITH THE ERICA HOLLOMAN FOUNDATION TO SCREEN PRIMARILY A FRICAN AMERICAN WOMEN AT RISK FOR A SPECIFIC KIND OF BREAST CANCER. BNH'S AND TEH'S FOCUS ON PREVENTION WILL CONTINUE TO DEMONSTRATE ITS COMMITMENT VIA IN KIND AND FINANCIAL SUPPOR T OF OHIO CANCER RESEARCH, WHICH IS AN INDEPENDENT, STATEWIDE, NONPROFIT ORGANIZATION DEDI CATED TO THE CURE AND PREVENTION OF THE MANY FORMS OF CANCER AND THE REDUCTION OF ITS DEBI LITATING EFFECTS THROUGH AGGRESSIVE BASIC SEED MONEY RESEARCH, CANCER INFORMATION, AND AWA RENESS. THE HOSPITALS PLAN TO CONTINUE FINANCIAL SUPPORT TO THE AMERICAN CANCER SOCIETY AN D AMERICAN LUNG ASSOCIATION. 4. ACCESS TO CARE - THIS PRIORITY APPLIES ONLY TO BNH DUE TO THE NATURE OF TEH. CURRENTLY, BNH PROVIDES TRANSPORTATION FOR NEEDY PATIENTS WITH BUS TOKE NS AND PAID UBER RIDES. GSH/TR

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

Form and Line Reference	Explanation
BETHESDA NORTH HOSPITAL	IHEALTH WILL SEEK NEW PARTNERS AND IDENTIFY OTHER AVENUES TO EXPAND THIS TYPE OF SERVICE. IT IS NOT SOMETHING THAT HAS A NATURAL CONNECTION TO A HOSPITAL OR HEALTH SYSTEM LIKE THE OTHER THREE PRIORITIES. IF SPECIFIC ACTIONS THAT ARE WITHIN BNH AREAS OF EXPERTISE ARE NOT FOUND, BNH AND TEH WILL FOCUS ON 1-3 ABOVE.

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

Form and Line Reference	Explanation
BETHESDA BUTLER HOSPITAL	PART V, SECTION B, LINE 11: 1. SUBSTANCE ABUSE/MENTAL HEALTH - IN RESPONSE TO THE ESCALATI NG OPIOID ADDICTION EPIDEMIC IN THE MARKET SERVED, A RELATED HOSPITAL, THE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO (GSH) AND THE TRIHEALTH SYSTEM ENGAGED THE COMMUNITY IN AN OR GANIZED AND FOCUSED SET OF TACTICS TO ADDRESS THIS. SINCE OCTOBER 2017, THE TRIHEALTH OPIA TE STEERING COMMITTEE AND THE GSH OPIATE PILOT CONTINUES TO FOCUS ON FIVE KEY AREAS: PREVE NTION, TREATMENT, FUNDING, COMMUNITY PARTNERSHIPS AND TEAM MEMBER SUPPORT. THE FOCUS ON KE Y AREAS HAS HELPED BUILD THE INFRASTRUCTURE NECESSARY TO PROVIDE TREATMENT NOT ONLY AT GSH BUT TO EXPAND KEY INITIATIVES TO OTHER TRIHEALTH HOSPITALS, INCLUDING BETHESDA BUTLER HOS PITAL (BBH). PREVENTION * NARCAN DISTRIBUTION: NARCAN SERVES TO BLOCK THE EFFECTS OF OPIOI DS IN CASE OF AN ACCIDENTAL OVERDOSE. NARCAN WILL CONTINUE TO BE PROVIDED TO ALL ER PATIEN TS WHO NEED IT WITHOUT COST TO THE PATIENT, AND BBH WILL CONTINUE ITS EDUCATION OF FIRST R ESPONDERS AS NEW INFORMATION ARISES AND NEW RESPONDERS ARE TRAINED. TREATMENT * SUBSTANCE USE TREATMENT COORDINATORS (SUTC): IN DECEMBER 2018, TRIHEALTH EXPANDED THE ROLE OF THE SU BSTANCE USE TREATMENT COORDINATOR ("SUTC") TO BBH THROUGH A STATE GRANT. THE ROLE OF THE S UTC IS TO ENGAGE, ASSESS AND PROVIDE AN APPOINTMENT TO A TREATMENT PROGRAM WITHIN 24-48 HO URS AFTER DISCHARGE. IN COLLABORATION WITH COMMUNITY PARTNERS SUCH AS THE ADDICTION SERVIC ES COUNCIL, BRIGHTVIEW, TALBERT HOUSE ENGAGEMENT CENTER, TRIHEALTH AND BBH WILL CONTINUE T O TEST THE EFFICACY OF THIS ROLE AND EFFECTIVENESS AT MEETING THESE TARGETS. *BY JULY 2019 , TRIHEALTH WILL HAVE A RESPONSE TO A GRANT PROPOSAL IT SUBMITTED TO BETHESDA FOUNDATION T O EXPAND THE SUTC ROLE TO BETHESDA NORTH HOSPITAL AS A PLATFORM FOR UTILIZING TELEHEALTH F OR FURTHER EXPANSION TO ARROW SPRINGS AND MCCULLOUGH HYDE MEMORIAL HOSPITAL (MHMH), A RELA TED HOSPITAL. MHMH ALSO SERVES THE BUTLER COUNTY POPULATION. * IF THE PEER RECOVERY SPECIA LIST IDENTIFIED IN THE PROGRESS REPORT RE: 2016 PRIORITIES IS EFFECTIVE IN REACHING OUT TO PATIENTS THAT MIGHT OTHERWISE BE RELUCTANT TO ENTER INTO RECOVERY, THIS FUNCTION WILL BE EVALUATED FOR EXPANSION TO BBH. * TRACKING OUTCOMES: THE TASK FORCE WILL BE MONITORING AN OPIOID DASHBOARD TO TRACK OUTCOMES SUCH AS UTILIZATION OF SUBSTANCE USE WITHDRAWAL MANAGEM ENT ORDER SETS, BUPRENORPHINE INDUCTION (MEDICATION USED TO TREAT OPIATE ADDICTION), NARCA N DISPENSING ETC. THIS ALLOWS US TO MONITOR THE EFFECTIVENESS OF OUR INITIATIVES. BBH PART ICIPATES IN THE TRIHEALTH BEHAVIORAL HEALTH INTAKE, DESIGNED TO GET PATIENTS TO PROPER TRE ATMENT SETTINGS AND LOCATIONS EARLY ONCE THEY ARE IN ONE OF THE TRIHEALTH EMERGENCY DEPART MENTS. EXPANDED TO 24 HR/7-DAY OPERATION * RESPONSIVE TO ALL EMERGENCY DEPARTMENTS WITHIN TRIHEALTH BBH THROUGH TRIHEALTH ALSO PLANS TO CONTINUE ITS SUPPORT FOR: * URBAN HEALTH PRO JECT * UNITED WAY, WHICH FUNDS A NUMBER OF AGENCIES THAT AIM TO GET SUBSTANCE ABUSERS BACK ON THEIR FEET IN SOCIETY * NA

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

Form and Line Reference	Explanation
BETHESDA BUTLER HOSPITAL	MI SOUTHWEST OHIO * CAT FEST, HOSTED BY THE CENTER FOR ADDICTION TREATMENT (MAJOR SPONSOR ALCOHOL AND DRUG ADDICTION PROGRAM) 2. INFANT MORTALITY - BBH PARTNERS DIRECTLY WITH AN AR EA FEDERALLY QUALIFIED HEALTH CENTER ("FQHC") CALLED PRIMARY HEALTH SOLUTIONS ON A PROGRAM CALLED PRIM (PARTNERSHIP TO REDUCE INFANT MORTALITY), OBTAINING AN OBSTETRICIAN/GYNECOLOG IST FOR PATIENTS THAT SHOW UP IN BBH'S EMERGENCY DEPARTMENT PREGNANT AND WITHOUT PRENATAL CARE. IN PARTNERSHIP WITH MIAMI UNIVERSITY SCHOOL OF NURSING, BBH WILL CONTINUE SCREENING OF ER PATIENTS FOR UNDERLYING SOCIAL DETERMINANTS OF HEALTH ISSUES AND REFER THEM TO PRIMA RY HEALTH SOLUTIONS AND/OR COMMUNITY AGENCIES THAT CAN HELP WITH THE UNDERLYING SOCIAL ISS UES. FINALLY, BBH THROUGH TRIHEALTH ALSO PROVIDES FINANCIAL SUPPORT TO OTHER ORGANIZATIONS THAT FOCUS RESOURCES ON INFANT MORTALITY AND MATERNAL HEALTH: * GOOD SAMARITAN FREE HEALT H CLINIC * MARCH OF DIMES * SWEET CHEEKS DIAPER BANK 3. CANCER - BBH AND TRIHEALTH CANCER INSTITUTE WILL CONTINUE THE TARGETED (MELANOMA, LUNG) FREE SCREENINGS AND FOLLOW UPS. THER E IS A MOBILE MAMMOGRAPHY UNIT THAT WILL CONTINUE TO DO SCREENING IN HIGH NEED AREAS WITHI N THE CITY OF HAMILTON IN BUTLER COUNTY. BBH'S AND TRIHEALTH'S FOCUS ON PREVENTION WILL CO NTINUE TO DEMONSTRATE ITS COMMITMENT VIA IN KIND AND FINANCIAL SUPPORT OF OHIO CANCER RESE ARCH, WHICH IS AN INDEPENDENT, STATEWIDE, NONPROFIT ORGANIZATION DEDICATED TO THE CURE AND PREVENTION OF THE MANY FORMS OF CANCER AND THE REDUCTION OF ITS DEBILITATING EFFECTS THRO UGH AGGRESSIVE BASIC SEED MONEY RESEARCH, CANCER INFORMATION, AND AWARENESS. THE HOSPITAL PLANS TO CONTINUE FINANCIAL SUPPORT TO THE AMERICAN CANCER SOCIETY AND AMERICAN LUNG ASSOC IATION. 4. ACCESS TO CARE - CURRENTLY, BBH PROVIDES TRANSPORTATION FOR NEEDY PATIENTS WITH BUS TOKENS AND PAID UBER RIDES. BBH/TRIHEALTH WILL SEEK NEW PARTNERS AND IDENTIFY OTHER A VENUES TO EXPAND THIS TYPE OF SERVICE. IT IS NOT SOMETHING THAT HAS A NATURAL CONNECTION T O A HOSPITAL OR HEALTH SYSTEM LIKE THE OTHER THREE PRIORITIES. IF SPECIFIC ACTIONS THAT AR E WITHIN BBH AREAS OF EXPERTISE ARE NOT FOUND, BBH WILL FOCUS ON 1-3 ABOVE, PARTICULARLY O N SUBSTANCE ABUSE.

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

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

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

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

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

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

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

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

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

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

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

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

Form 990 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)
1	1 - BETHESDA MEDICAL CENTER-ARROW SPRINGS 100 ARROW SPRINGS BLVD LEBANON, OH 45036	24-HOUR EMERGENCY ROOM AND COMPREHENSIVE OUTPATIENT SERVICES
1	2 - BETHESDA OBGYN CENTER RESIDENT CLINIC 10495 MONTGOMERY ROAD CINCINNATI, OH 45242	WOMEN'S HEALTH
2	3 - BNH AMBULATORY TREATMENT CENTER 10506 MONTGOMERY ROAD CINCINNATI, OH 45242	OUTPATIENT INFUSION AND CHEMOTHERAPY TREATMENT
3	4 - TRIHEALTH SLEEP MEDICINE 10475 MONTGOMERY ROAD CINCINNATI, OH 45242	SLEEP CENTER
4	5 - B NORTH MINIMALLY INVASIVE SURGERY CTR 10506 MONTGOMERY ROAD CINCINNATI, OH 45242	OUTPATIENT SURGICAL CENTER
5	6 - BETHESDA NORTH OUTPATIENT IMAGING CTR 10494 MONTGOMERY ROAD CINCINNATI, OH 45242	OUTPATIENT IMAGING AND COMPREHENSIVE BREAST CARE CENTER
6	7 - BETHESDA HAND REHABILITATION 10700 MONTGOMERY ROAD CINCINNATI, OH 45242	PHYSICAL THERAPY
7	8 - BETHESDA HAND REHABILITATION 538 OAK STREET CINCINNATI, OH 45206	PHYSICAL THERAPY
8	9 - BETHESDA LOVELAND PHYSICAL THERAPY 10675 LOVELAND-MADERIA ROAD LOVELAND, OH 45140	PHYSICAL THERAPY
9	10 - BETHESDA FAMILY PRACTICE CENTER 1775 LEXINGTON AVE CINCINNATI, OH 45212	FAMILY MEDICINE CLINIC
10	11 - BETHESDA ALCOHOLDRUG TREATMENT 4410 CARVER WOODS DRIVE CINCINNATI, OH 45242	OUTPATIENT ALCOHOL AND DRUG TREATMENT
11	12 - BETHESDA BUTLER PHYSICAL THERAPY 3035 HAMILTON-MASON ROAD HAMILTON, OH 45011	PHYSICAL THERAPY
12	13 - BETHESDA BUTLER IMAGING CENTER 3075 HAMILTON-MASON ROAD HAMILTON, OH 45011	MEDICAL IMAGING
13	14 - TRIHEALTH SLEEP MEDICINE 3055 HAMILTON-MASON ROAD HAMILTON, OH 45011	SLEEP MEDICINE CENTER
14	15 - BETHESDA SURGERY CENTER 10615 MONTGOMERY ROAD 300 CINCINNATI, OH 45242	OUTPATIENT SURGICAL CENTER

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	16 - BETHESDA MONTGOMERY CARDIAC TESTING 10525 MONTGOMERY ROAD CINCINNATI, OH 45242	OUTPATIENT CARDIAC TESTING
1	17 - BETHESDA MONTGOMERY SLEEP CENTER 10535 MONTGOMERY ROAD CINCINNATI, OH 45242	SLEEP CENTER
2	18 - BETHESDA MRI KENWOOD 8311 MOTGOMERY ROAD CINCINNATI, OH 45236	MEDICAL IMAGING
3	19 - BETHESDA MRI WEST CHESTER 4900 WUNNENBERG WAY WEST CHESTER, OH 45069	MEDICAL IMAGING
4	20 - MEDICENTER RADIATION THERAPY 10550 MONTGOMERY ROAD CINCINNATI, OH 45242	RADIATION THERAPY
5	21 - TRIHEALTH KENWOOD 8240 NORTHCREEK DRIVE CINCINNATI, OH 45236	INTEGRATED OUTPATIENT CENTER
6	22 - THOMAS COMPREHENSIVE CARE CENTER 10506A MONTGOMERY RD CINCINNATI, OH 45242	SPECIALTY SERVICES

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Schedule I (Form 990)

Department of the Treasury
Internal Revenue Service

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

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

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
BETHESDA HOSPITAL INC

Employer identification number
31-0537122

Part I General Information on Grants and Assistance

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

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

Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments.

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

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

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

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 noncash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of noncash assistance
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					

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

Return Reference	Explanation
PART I, LINE 2:	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 619 OAK STREET SUITE 1100 CINCINNATI, OH 45206	20-0688727	501(C)(3)	185,310				GENERAL PURPOSES
UNITED WAY 2400 READING ROAD CINCINNATI, OH 45202	31-0537502	501(C)(3)	77,932				GENERAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
AMERICAN HEART ASSOCIATION 7272 GREENVILLE AVENUE DALLAS, TX 75231	13-5613797	501(C)(3)	63,900				SPONSORSHIP
LEGAL AID SOCIETY OF CINCINNATI 215 EAST NINTH STREET SUITE 200 CINCINNATI, OH 45202	31-0536673	501(C)(3)	57,510				M-HELP PROGRAM FUNDING

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)	53,676				GENERAL SUPPORT
GREATER CINCINNATI FOUNDATION 720 E PETE ROSE WAY SUITE 120 CINCINNATI, OH 45202	31-0669700	501(C)(3)	51,120				PROJECT LIFT FUNDING

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
FREESTORE FOODBANK INC 1141 CENTRAL PARKWAY CINCINNATI, OH 45202	23-7122205	501(C)(3)	37,851				SPONSORSHIP
AMERICAN CANCER SOCIETY INC 250 WILLIAMS STREET NW SUITE 400 ATLANTA, GA 30303	13-1788491	501(C)(3)	24,793				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)	20,448				GENERAL SUPPORT
SWEET CHEEKS DIAPER BANK 1615 REPUBLIC STREET CINCINNATI, OH 45202	47-5175383	501(C)(3)	20,448				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
JDRF INTERNATIONAL 200 VESEY STREET 28TH FLOOR NEW YORK, NY 10281	23-1907729	501(C)(3)	15,336				SPONSORSHIP
KAREN WELLINGTON MEMORIAL FOUNDATION FOR LIVING W BREAST CANCER 312 WALNUT ST NO 1800 CINCINNATI, OH 45202	26-3768567	501(C)(3)	12,780				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
OVARIAN CANCER ALLIANCE OF GREATER CINCINNATI 4918 COOPER ROAD CINCINNATI, OH 45242	31-1287785	501(C)(3)	10,224				SPONSORSHIP
FRIARS CLUB INC 4300 VINE STREET CINCINNATI, OH 45217	31-0537485	501(C)(3)	10,224				PROGRAM SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC 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
NAMI OF SOUTHWEST OHIO 4055 EXECUTIVE PARK DRIVE SUITE 450 450 CINCINNATI, OH 45241	31-0998076	501(C)(3)	10,224				SPONSORSHIP
LEUKEMIA & LYMPHOMA SOCIETY INC 3 INTERNATIONAL DRIVE RYE BROOK, NY 10573	13-5644916	501(C)(3)	7,668				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
EPISCOPAL RETIREMENT HOMES INC 3870 VIRGINA AVE CINCINNATI, OH 45227	31-0554071	501(C)(3)	5,112				SPONSORSHIP
MARCH OF DIMES 10806 KENWOOD ROAD CINCINNATI, OH 45242	13-1846366	501(C)(3)	5,112				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
INTERFAITH HOSPITALITY NETWORK OF GREATER CINCINNATI 990 NASSAU STREET CINCINNATI, OH 45206	31-1335474	501(C)(3)	5,112				DIRECT SERVICES TO HOMELESS FAMILIES
OHIO CANCER RESEARCH ASSOCIATES 85 EAST GAY STREET SUITE 700 COLUMBUS, OH 43215	31-1038309	501(C)(3)	5,112				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
DOWN SYNDROME ASSOCIATION OF GREATER CINCINNATI 4623 WESLEY AVENUE CINCINNATI, OH 45212	31-1051378	501(C)(3)	5,112				SPONSORSHIP
TENDER MERCIES INC 27 WEST 12TH STREET CINCINNATI, OH 45202	31-1137270	501(C)(3)	5,112				GENERAL SUPPORT

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Schedule J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 23.**

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
BETHESDA HOSPITAL INC

Employer identification number
31-0537122

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropiate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax idemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (e.g., maid, chauffeur, chef)		
b	If any of the boxes on Line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	**1b**		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked on 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.			
	☐ Compensation committee	☐ Written employment contract		
	☐ Independent compensation consultant	☐ Compensation survey or study		
	☐ Form 990 of other organizations	☐ Approval by the board or compensation committee		
4	During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a	Receive a severance payment or change-of-control payment?	**4a**	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?	**4c**		No
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	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?	**5b**		No
	If "Yes," on line 5a or 5b, describe in Part III.			
6	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a	The organization?	**6a**		No
b	Any related organization?	**6b**		No
	If "Yes," on line 6a or 6b, describe in Part III.			
7	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described 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 accured 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(S) LISTED IN SCHEDULE J, PART II, RECEIVED A PAYMENT FROM A SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN WHICH WAS TREATED AS TAXABLE COMPENSATION BY TRIHEALTH, INC.: WILLIAM GRONEMAN - $27,729
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 2019 CALENDAR YEAR, THE FOLLOWING REPORTABLE INDIVIDUAL(S) RECEIVED SEVERANCE PAYMENTS FROM TRIHEALTH, INC.: STEFANIE NEWMAN - $254,509 JASON NIEHAUS - $262,423

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 (END 6/20)	(i)	0	0	0	0	0	0	0
	(ii)	299,737	0	4,347	25,410	25,601	355,095	0
1MARK CLEMENT PRESIDENT/CEO	(i)	0	0	0	0	0	0	0
	(ii)	1,158,232	264,531	58,822	329,321	17,554	1,828,460	0
2SCOTT FRIEDSTROM MD MED STAFF PRES-(END 12/19)	(i)	0	0	0	0	0	0	0
	(ii)	543,036	31,795	53,422	55,677	32,926	716,856	0
3ANDREW DEVOE ASST. TREASURER/CFO	(i)	0	0	0	0	0	0	0
	(ii)	579,546	140,404	17,498	144,652	31,765	913,865	0
4STEVE GRACEY ASST. SECRETARY/SVP LEGAL	(i)	0	0	0	0	0	0	0
	(ii)	429,210	86,917	18,522	109,962	31,350	675,961	0
5STEFANIE NEWMAN VP-CNO BETHESDA (END 9/19)	(i)	0	0	0	0	0	0	0
	(ii)	153,704	80,594	292,706	49,037	20,680	596,721	0
6DAVID COOK CHIEF HR OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	391,458	81,103	3,333	79,254	25,158	580,306	0
7LONDON QUICCI PRESIDENT-BETHESDA NORTH	(i)	0	0	0	0	0	0	0
	(ii)	339,189	51,838	1,901	69,781	11,391	474,100	0
8KEVIN JOSEPH MD CHIEF MEDICAL OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	535,110	124,151	33,088	125,353	31,823	849,525	0
9JENNY SKINNER CNE-TRIHEALTH	(i)	0	0	0	0	0	0	0
	(ii)	309,470	58,382	16,543	108,609	17,643	510,647	0
10ROB CERCEK EVP POP HEALTH (END 10/19)	(i)	0	0	0	0	0	0	0
	(ii)	455,459	118,061	70,452	106,374	22,866	773,212	0
11MICHAEL EVERETT PRESIDENT-BETHESDA BUTLER	(i)	0	0	0	0	0	0	0
	(ii)	142,071	20,000	10,081	11,129	12,084	195,365	0
12JOHN WARD SVP-BETHESDA REGION	(i)	0	0	0	0	0	0	0
	(ii)	416,123	84,343	29,998	131,884	25,963	688,311	0
13MICHAEL HOLBERT MD PHYSICIAN	(i)	265,050	0	1,030	35,067	6,900	308,047	0
	(ii)	91,539	0	243	0	2,335	94,117	0
14RICHARD OKRAGLY MD PHYSICIAN	(i)	232,403	3,695	9,544	21,621	30,808	298,071	0
	(ii)	0	0	0	0	0	0	0
15 SAKUNTHALA NATARAJAN MD PHYSICIAN	(i)	203,453	29,691	3,395	46,199	890	283,628	0
	(ii)	0	0	0	0	0	0	0
16ROBERT KUNKEL MD PHYSICIAN	(i)	251,512	18,982	13,651	32,045	18,405	334,595	0
	(ii)	0	0	0	0	0	0	0
17SCOTT WOODS MD PHYSICIAN	(i)	235,993	4,896	11,209	32,156	26,987	311,241	0
	(ii)	0	0	0	0	0	0	0
18MICHAEL CROFTON FORMER OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	312,830	47,263	6,284	88,322	25,521	480,220	0
19WILLIAM GRONEMAN FORMER KEY EMPLOYEE	(i)	0	0	0	0	0	0	0
	(ii)	305,676	39,310	73,786	114,176	26,862	559,810	27,729

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				
21GAIL DONOVAN FORMER KEY EMPLOYEE	(i)	0	0	0	0	0	0	0
	(ii)	740,011	155,885	7,922	189,660	9,696	1,103,174	0
1JASON NIEHAUS FORMER KEY EMPLOYEE	(i)	0	0	0	0	0	0	0
	(ii)	0	0	325,708	0	11,983	337,691	0
2MARY IRVIN FORMER KEY EMPLOYEE	(i)	0	0	0	0	0	0	0
	(ii)	13,497	38,113	138,646	9,902	1,639	201,797	0

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Schedule K (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part VI, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990.
▶ Go to *www.irs.gov/Form990* for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
BETHESDA HOSPITAL INC

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
C	COUNTY OF HAMILTON OHIO	31-6000063	000000000	05-14-2020	148,454,656	BUILDINGS, STRUCTURES & REFUND OF TAXABLE & TAX-EXEMPT BONDS ISSUED 9/29/15		X		X		X

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	1,170,000	11,270,000		
2	Amount of bonds legally defeased				
3	Total proceeds of issue	318,770,291	102,490,423	148,460,751	
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	1,811,516	
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds	314,505,586	90,049,192	9,434,692	
11	Other spent proceeds			36,938,431	
12	Other unspent proceeds	290,111	12,096,228	100,276,112	
13	Year of substantial completion				

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)?		X		X	X			
15	Were the bonds issued as part of an advance refunding issue of taxable bonds (or, if issued prior to 2018, an advance refunding issue)?		X		X	X			
16	Has the final allocation of proceeds been made?		X		X		X		
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		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		X		
2	Are there any lease arrangements that may result in private business use of bond-financed property?	X		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			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		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 ▶		1.510 %		1.970 %		0 %		
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 ▶								
6	Total of lines 4 and 5		1.510 %		1.970 %		0 %		
7	Does the bond issue meet the private security or payment test?		X		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		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		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		X		
2	If "No" to line 1, did the following apply?								
a	Rebate not due yet?	X		X		X			
b	Exception to rebate?		X		X		X		
c	No rebate due?		X		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			X		
4a	Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X		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		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			X		
7	Has the organization established written procedures to monitor the requirements of section 148? . . .	X		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		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, COLUMN B AND COLUMN C	TOTAL PROCEEDS SHOWN ARE NOT IDENTICAL TO THE ISSUE PRICE LISTED IN PART I, COLUMN (E) DUE TO THE INVESTMENT EARNINGS.

Return Reference	Explanation
PART II, LINE 11, COLUMN C	THE AMOUNT SHOWN HERE CONSISTS OF $36,646,925 SPENT TO RETIRE PRINCIPAL AND INTEREST OF PRIOR BONDS, PLUS $291,506 FOR A SWAP TERMINATION FEE PAID WITH RESPECT TO THE RETIRED TAX-EXEMPT DEBT. THE REFUNDING CONSISTED OF PRIOR TAX-EXEMPT BONDS ($9,324,915) AND PRIOR TAXABLE BONDS ($27,322,010) OF MCCULLOUGH-HYDE MEMORIAL HOSPITAL, A RELATED IRC SECTION 501(C)(3) ORGANIZATION OF BETHESDA HOSPITAL, INC.

Return Reference	Explanation
PART IV, LINE 6, COLUMNS A AND B	SUCH AMOUNTS WERE APPROPRIATELY YIELD RESTRICTED.

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SCHEDULE O (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.
▶ **Attach to Form 990 or 990-EZ.**
▶ **Go to *www.irs.gov/Form990* for the latest information.**

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
BETHESDA HOSPITAL INC

Employer identification number
31-0537122

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 2	THE OFFICERS, DIRECTORS AND TRUSTEES OF BETHESDA HOSPITAL, INC. LISTED IN PART VII, SECTIO N A HAVE A "BUSINESS RELATIONSHIP" WITH EACH OTHER BY VIRTUE OF SITTING ON THE BOARDS OF T RIHEALTH, INC., TRIHEALTH HOSPITAL, INC. AND THE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OH IO, ALL AFFILIATED ENTITIES OF BETHESDA HOSPITAL, INC. MICHAEL EVERETT, KEVIN JOSEPH, MD, MARK CLEMENT, ROB CERCEK, JOHN WARD AND STEVE GRACEY HAVE A "BUSINESS RELATIONSHIP" WITH E ACH OTHER BY VIRTUE OF SITTING ON THE BOARD OF THE MCCULLOUGH-HYDE MEMORIAL HOSPITAL, AN A FFILIATED ENTITY OF BETHESDA HOSPITAL, INC. KATHY KELLY, RANCE DUKE, CRAIG EISENTROUT, MD, DANNY FISCHER, MD, PHILLIP OBLINGER, MD, BOB COLLINS, MD AND QUINT STUDER HAVE A "BUSINES S RELATIONSHIP" WITH EACH OTHER BY VIRTUE OF SITTING ON THE BOARD OF BETHESDA, INC., THE S INGLE CORPORATE MEMBER OF BETHESDA HOSPITAL, INC. MARK CLEMENT AND CRAIG EISENTROUT, MD HA VE 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, JENNY SKINNER AND SR. SALLY DUFFY HAVE A "BUSINESS RELATIONSHIP" WITH EACH OTHER BY VIRTUE OF SITTING O N THE BOARD OF THE GOOD SAMARITAN COLLEGE OF NURSING AND HEALTH SCIENCE, A RELATED ENTITY. MARK CLEMENT, ANDREW DEVOE, ROB CERCEK, STEVE GRACEY, JENNIFER SKINNER, DAVID COOK, LONDO N QUICCI, CRAIG EISENTROUT, MD, STEFANIE NEWMAN, PHILLIP OBLINGER, MD, SCOTT FRIEDSTROM, M D, MICHAEL EVERETT AND KEVIN JOSEPH, MD HAVE A "BUSINESS RELATIONSHIP" WITH EACH OTHER BY VIRTUE OF SITTING ON RELATED ENTITY BOARDS OF TRIHEALTH, INC. AND ITS SUBSIDIARIES AND AFF ILIATES AS WELL AS BEING EMPLOYED BY TRIHEALTH, INC.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 4	THE CODE OF REGULATIONS BETHESDA HOSPITAL, INC. HAVE BEEN UPDATED TO PERMIT EACH SPONSORIN G ORGANIZATION TO HAVE A TRUSTEE SERVE AN UNLIMITED NUMBER OF TERMS.

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 HOSPITA L, 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 AFTE R REVIEW BY THE FINANCE AND AUDIT COMMITTEE OF THE BOARD, ALONG WITH THE COMMITTEE'S SUMMA RY 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 NECESSA RY 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 FIDUCI ARY RELATIONSHIPS. THE EXECUTIVE COMMITTEE AND CORPORATE COUNSEL REVIEW RESPONSES, CONDUCT FURTHER INVESTIGATION (IF NECESSARY), AND DETERMINE WHEN A CONFLICT EXISTS WITH RESPECT T O A CERTAIN TRANSACTION. IF A CONFLICT EXISTS, THE TRANSACTION IS NOT TO BE ENTERED INTO U NLESS ALTERNATIVES ARE FULLY INVESTIGATED, AND IN THEIR ABSENCE, THE BOARD, WITHOUT THE PA RTICIPATION OF THE INTERESTED MEMBER(S), DETERMINES THAT THE TRANSACTION IS IN THE BEST IN TEREST OF THE ORGANIZATION. PLANS TO MANAGE THE CONFLICT DURING THE RELATIONSHIP ARE IMPLE MENTED. ALL DISCUSSIONS ARE APPROPRIATELY DOCUMENTED. ALL DIRECTORS AND MANAGERS, WHICH IN CLUDE OFFICERS AND KEY EMPLOYEES, ARE REQUIRED TO ANNUALLY DISCLOSE ANY CIRCUMSTANCES, INC LUDING FAMILY AND BUSINESS RELATIONSHIPS, THAT MAY CREATE A CONFLICT OF INTEREST FOR THE O RGANIZATION. THESE RESPONSES ARE REVIEWED AND ACTED UPON BY A CONFLICT OF INTEREST COMMITT EE.

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. LOSS ON UNCONSOLIDATED ORGANIZATIONS -86,429,92 2. CHANGE IN PENSION PLAN/SERP FUNDED STATUS 3,963,662. CHANGE IN TEMPORARILY RESTRICTED N ET ASSETS HELD AT FOUNDATION 744,831. INSURANCE RATE VALUATION CORRECTION 3,007,109. REMOV AL OF PRIOR YEAR INVESTMENT LAG AMOUNT -3,984,714. NET SPECIAL FUNDS ACTIVITY 13,056,457. MISCELLANEOUS -119,449.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART I, LINE 6	DURING THE TAX YEAR, BETHESDA HOSPITAL, INC. WAS ASSISTED BY 535 VOLUNTEERS WHO DONATED AP PROXIMATELY 56,000 HOURS. UNFORTUNATELY, THE COVID-19 PANDEMIC LIMITED THE IMPACT OF THESE INDIVIDUALS FROM MARCH THROUGH JUNE DUE TO THE SUSPENSION OF VOLUNTEER ACTIVITIES.

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 TR IHEALTH, 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 SUBSIDIARI ES 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 A S 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 TRIHE ALTH 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 NEGO TIATE, IN ITS TRANSACTIONS AND ARRANGEMENTS WITH OTHER MEMBERS OF THE VENTURE OR ARRANGEME NT, SUCH TERMS AND SAFEGUARDS AS ARE ADEQUATE TO ENSURE THAT THE ORGANIZATION'S EXEMPT STA TUS IS PROTECTED. HOWEVER, ALL JOINT VENTURES, WHEN ENTERED INTO, HAVE OUTSIDE LEGAL COUNS EL 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 ACTIVITIE S 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	THE OFFICERS AND DIRECTORS FOR BETHESDA HOSPITAL, INC. THAT SHOW AT LEAST 60 HOURS PER WEE K PROVIDE SERVICES TO TRIHEALTH, INC. (A RELATED ORGANIZATION WHO PAID THE INDIVIDUALS) AN D ITS SUBSIDIARIES/AFFILIATES ("TRIHEALTH") AS AN ENTIRE SYSTEM. HOURS WORKED, INCLUDING T HEIR DUTIES AS OFFICERS AND DIRECTORS OF THE FILING ORGANIZATION, ARE NOT TRACKED ON AN EN TITY 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. DIRECT ORS (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 T HE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO. IN ADDITION, THESE INDIVIDUALS PROVIDE SER VICES AS EMPLOYEES OF VARIOUS RELATED ENTITIES FOR WHICH THEY RECEIVE COMPENSATION. NONE O F THE COMPENSATION SHOWN IS FOR SERVING AS A DIRECTOR.

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SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No. 1545-0047

2019

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	(g) Section 512(b)(13) controlled entity? 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) Disproprtionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1) 10600 MONTGOMERY LLC 625 EDEN PARK DRIVE 7TH FLOOR CINCINNATI, OH 45202 26-1964995	PROPERTY MANAGEMENT	OH	N/A									
(2) HEALTHCARE SOLUTIONS NETWORK LLC 625 EDEN PARK DRIVE 7TH FLOOR CINCINNATI, OH 45202 47-2103334	PHYSICIAN HOSPITAL ORGANIZATION	OH	N/A									
(3) PREFERRED LAB PARTNERS LLC ONE MEDICAL VILLAGE DRIVE SUITE B EDGEWOOD, KY 41017 82-4758763	LABORATORY SERVICES	KY	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	(i) No
(1)TJ CUBEDMONTGOMERY INC 625 EDEN PARK DRIVE 7TH FLOOR CINCINNATI, OH 45202 26-1964885	HOLDING COMPANY	OH	N/A	S				Yes	
(2)TRIHEALTH PHYSICIANS OF INDIANA INC 625 EDEN PARK DRIVE 7TH FLOOR CINCINNATI, OH 45202 46-1125130	PHYSICIAN PRACTICES	OH	N/A	C				Yes	
(3)TRIHEALTH PHYSICIAN SOLUTIONS INC 625 EDEN PARK DRIVE 7TH FLOOR CINCINNATI, OH 45202 31-1444353	CLAIMS ADMINISTRATION	OH	N/A	C				Yes	
(4)TRIHEALTH CIPHO INC 625 EDEN PARK DRIVE 7TH FLOOR CINCINNATI, OH 45202 46-3294306	PHYSICIAN HEALTH ORGANIZATION	OH	N/A	C				Yes	
(5)PREMIERE MEDICAL OWNERS ASSOCIATION 625 EDEN PARK DRIVE 7TH FLOOR CINCINNATI, OH 45202 14-1913019	CONDO ASSOCIATION	OH	BETHESDA HOSPITAL INC	C		113,454	100.000 %	Yes	
(6)SERVE INSURANCE LTD PO BOX 69 CAMANA BAY, GRAND CAYMAN CJ 98-1529310	ALTERNATIVE RISK FINANCING	CJ	N/A	C				Yes	

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

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

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

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

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

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

Part VII Supplemental Information

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

Return Reference	Explanation

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
625 EDEN PARK DRIVE 7TH FLOOR CINCINNATI, OH 45202 31-1108895	POPULATION HEALTH	OH	SECTION 501(C)(3)	SCHEDULE A, LINE 12C	N/A		No
625 EDEN PARK DRIVE 7TH FLOOR CINCINNATI, OH 45202 23-7374129	FUNDRAISING	OH	SECTION 501(C)(3)	SCHEDULE A, LINE 7	BETHESDA INC	Yes	
625 EDEN PARK DRIVE 7TH FLOOR CINCINNATI, OH 45202 31-1027660	HEALTHCARE SERVICES	OH	SECTION 501(C)(3)	SCHEDULE A, LINE 12B	BETHESDA INC	Yes	
625 EDEN PARK DRIVE 7TH FLOOR CINCINNATI, OH 45202 31-1242442	HEALTHCARE SERVICES	OH	SECTION 501(C)(3)	SCHEDULE A, LINE 12A	BETHESDA HOSPITAL INC	Yes	
625 EDEN PARK DRIVE 7TH FLOOR CINCINNATI, OH 45202 31-1352694	PROPERTY MANAGEMENT	OH	SECTION 501(C)(2)		BETHESDA HOSPITAL INC	Yes	
625 EDEN PARK DRIVE 7TH FLOOR CINCINNATI, OH 45202 31-0917155	HOSPICE SERVICES	OH	SECTION 501(C)(3)	SCHEDULE A, LINE 10	BETHESDA HOSPITAL INC	Yes	
625 EDEN PARK DRIVE 7TH FLOOR CINCINNATI, OH 45202 31-1179234	COUNSELING TO GRIEVING CHILDREN	OH	SECTION 501(C)(3)	SCHEDULE A, LINE 7	HOSPICE OF CINCINNATI INCORPORATED	Yes	
625 EDEN PARK DRIVE 7TH FLOOR CINCINNATI, OH 45202 31-1438846	SUPPORT AFFILIATED HOSPITALS	OH	SECTION 501(C)(3)	SCHEDULE A, LINE 12B	N/A	Yes	
625 EDEN PARK DRIVE 7TH FLOOR CINCINNATI, OH 45202 31-0537486	INPATIENT AND OUTPATIENT SERVICES	OH	SECTION 501(C)(3)	SCHEDULE A, LINE 3	TRIHEALTH INC	Yes	
625 EDEN PARK DRIVE 7TH FLOOR CINCINNATI, OH 45202 31-1778403	EDUCATION	OH	SECTION 501(C)(3)	SCHEDULE A, LINE 2	THE GOOD SAMARITAN HOSPITAL OF CINCINNATI OHIO	Yes	
625 EDEN PARK DRIVE 7TH FLOOR CINCINNATI, OH 45202 23-7419853	DIALYSIS	OH	SECTION 501(C)(2)		THE GOOD SAMARITAN HOSPITAL OF CINCINNATI OHIO	Yes	
625 EDEN PARK DRIVE 7TH FLOOR CINCINNATI, OH 45202 27-3893817	HEALTHCARE SERVICES	OH	SECTION 501(C)(3)	SCHEDULE A, LINE 7	TRIHEALTH INC	Yes	
625 EDEN PARK DRIVE 7TH FLOOR CINCINNATI, OH 45202 46-1393755	INPATIENT AND OUTPATIENT SERVICES	OH	SECTION 501(C)(3)	SCHEDULE A, LINE 3	TRIHEALTH INC	Yes	
625 EDEN PARK DRIVE 7TH FLOOR CINCINNATI, OH 45202 31-1383365	PHYSICIAN PRACTICES	OH	SECTION 501(C)(3)	SCHEDULE A, LINE 10	TRIHEALTH INC	Yes	
625 EDEN PARK DRIVE 7TH FLOOR CINCINNATI, OH 45202 31-1074519	PHYSICIAN PRACTICES	OH	SECTION 501(C)(3)	SCHEDULE A, LINE 10	TRIHEALTH INC	Yes	
625 EDEN PARK DRIVE 7TH FLOOR CINCINNATI, OH 45202 31-0650283	INPATIENT AND OUTPATIENT SERVICES	OH	SECTION 501(C)(3)	SCHEDULE A, LINE 3	TRIHEALTH INC	Yes	

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

(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
TRIHEALTH PHYSICIAN ENTERPRISE CORP	A	3,215,197	FMV
GOOD SAMARITAN HOSPITAL OF CINCINNATI OHIO	A	5,155,890	FMV
BETHESDA HEALTHCARE INC	A	32,459	FMV
TRIHEALTH INC	B	88,817,098	CASH
BETHESDA INC	B	10,000,000	CASH
BETHESDA FOUNDATION INC	C	2,861,970	CASH
BETHESDA PROPERTIES INC	K	2,215,948	FMV
BETHESDA HEALTHCARE INC	K	452,013	FMV
TRIHEALTH PHYSICIAN ENTERPRISE CORP	K	29,191	FMV
TRIHEALTH INC	K	544,484	FMV
TRIHEALTH INC	M	142,393,542	COST
TRIHEALTH INC	P	280,533,648	COST
HOSPICE OF CINCINNATI INCORPORATED	O	39,707,977	FMV
BETHESDA INC	O	3,260,154	FMV
FERNSIDE INC A CENTER FOR GRIEVING CHILDREN	O	486,167	FMV
BETHESDA FOUNDATION INC	O	1,317,850	FMV
BETHESDA PROPERTIES INC	S	2,510,260	CASH