

Part III Statement of Program Service AccomplishmentsCheck if Schedule O contains a response or note to any line in this Part III ☒**1** Briefly describe the organization's mission

BINGHAM MEMORIAL HOSPITAL IS COMMITTED TO THE PURSUIT OF EXCELLENCE IN ITS ENDEAVOR TO PROVIDE A CONTINUUM OF QUALITY, COMPASSIONATE HEALTHCARE SERVICES FOR OUR RESIDENTS AND FOR VISITORS TO BINGHAM COUNTY, IN THE MOST EFFECTIVE AND COST EFFECTIVE MANNER POSSIBLE

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 \$ 63,844,673 including grants of \$ 211,039) (Revenue \$ 100,409,837) |
| | See Additional Data |

| | |
|-----------|---|
| 4b | (Code) (Expenses \$ 52,909,106 including grants of \$) (Revenue \$ 38,080,455) |
| | See Additional Data |

| | |
|-----------|---|
| 4c | (Code) (Expenses \$ 4,023,007 including grants of \$) (Revenue \$ 2,292,798) |
| | See Additional Data |

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

| | |
|-----------|---|
| 4e | Total program service expenses ▶ 120,776,786 |
|-----------|---|

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 | No |
| 11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable | | |
| a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI | 11a Yes | |
| b Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII | 11b | No |
| c Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII | 11c | No |
| d Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part IX | 11d | No |
| e Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X | 11e Yes | |
| f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part X | 11f Yes | |
| 12a Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII | 12a | No |
| b Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional | 12b Yes | |
| 13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E | 13 | No |
| 14a Did the organization maintain an office, employees, or agents outside of the United States? | 14a | No |
| b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV | 14b | No |
| 15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? If "Yes," complete Schedule F, Parts II and IV | 15 | No |
| 16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? If "Yes," complete Schedule F, Parts III and IV | 16 | No |
| 17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I (see instructions) | 17 | No |
| 18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II | 18 | No |
| 19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III | 19 | No |
| 20a Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H | 20a Yes | |
| b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? | 20b Yes | |
| 21 Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? If "Yes," complete Schedule I, Parts I and II | 21 Yes | |
| 22 Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? If "Yes," complete Schedule I, Parts I and III | 22 Yes | |

Part IV Checklist of Required Schedules (continued)

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

Part V Statements Regarding Other IRS Filings and Tax ComplianceCheck if Schedule O contains a response or note to any line in this Part V ☐

| | | Yes | No |
|-----------|--|-----|-----|
| 1a | Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable | 1a | 116 |
| b | Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable | 1b | 0 |
| c | Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? | 1c | Yes |

| | | | | | | |
|--|--|-----------|-------|------------|-----|----|
| 2a Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return | | 2a | 1,040 | 2b | Yes | |
| b If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions) | | | | 2b | Yes | |
| 3a Did the organization have unrelated business gross income of \$1,000 or more during the year? | | | | 3a | Yes | |
| b If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O | | | | 3b | Yes | |
| 4a At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? | | | | 4a | | No |
| b If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR) | | | | | | |
| 5a Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? | | | | 5a | | No |
| b Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? | | | | 5b | | No |
| c If "Yes," to line 5a or 5b, did the organization file Form 8886-T? | | | | 5c | | |
| 6a Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? | | | | 6a | | No |
| b If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? | | | | 6b | | |
| 7 Organizations that may receive deductible contributions under section 170(c). | | | | | | |
| a Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor? | | | | 7a | | No |
| b If "Yes," did the organization notify the donor of the value of the goods or services provided? | | | | 7b | | |
| c Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? | | | | 7c | | No |
| d If "Yes," indicate the number of Forms 8282 filed during the year | | | | 7d | | |
| e Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? | | | | 7e | | No |
| f Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? | | | | 7f | | No |
| g If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? | | | | 7g | | |
| h If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? | | | | 7h | | |
| 8 Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? | | | | 8 | | |
| 9a Did the sponsoring organization make any taxable distributions under section 4966? | | | | 9a | | |
| b Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? | | | | 9b | | |
| 10 Section 501(c)(7) organizations. Enter | | | | | | |
| a Initiation fees and capital contributions included on Part VIII, line 12 | | | | 10a | | |
| b Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities | | | | 10b | | |
| 11 Section 501(c)(12) organizations. Enter | | | | | | |
| a Gross income from members or shareholders | | | | 11a | | |
| b Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them) | | | | 11b | | |
| 12a Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041? | | | | 12a | | |
| b If "Yes," enter the amount of tax-exempt interest received or accrued during the year | | | | 12b | | |
| 13 Section 501(c)(29) qualified nonprofit health insurance issuers. | | | | | | |
| a Is the organization licensed to issue qualified health plans in more than one state? Note. See the instructions for additional information the organization must report on Schedule O | | | | 13a | | |
| b Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans | | | | 13b | | |
| c Enter the amount of reserves on hand | | | | 13c | | |
| 14a Did the organization receive any payments for indoor tanning services during the tax year? | | | | 14a | | No |
| b If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O | | | | 14b | | |
| 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 8 | | |
| 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 6 | | |
| 2 Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee? | 2 | | No |
| 3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? | 3 | | No |
| 4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? | 4 | | No |
| 5 Did the organization become aware during the year of a significant diversion of the organization's assets? | 5 | | No |
| 6 Did the organization have members or stockholders? | 6 | Yes | |
| 7a Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? | 7a | Yes | |
| 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 | Yes |
| b Describe in Schedule O the process, if any, used by the organization to review this Form 990. | | |
| 12a Did the organization have a written conflict of interest policy? If "No," go to line 13. | 12a | Yes |
| b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? | 12b | Yes |
| c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done. | 12c | Yes |
| 13 Did the organization have a written whistleblower policy? | 13 | Yes |
| 14 Did the organization have a written document retention and destruction policy? | 14 | Yes |
| 15 Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision? | | |
| a The organization's CEO, Executive Director, or top management official | 15a | Yes |
| b Other officers or key employees of the organization | 15b | Yes |
| If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions) | | |
| 16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year? | 16a | Yes |
| b If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements? | 16b | Yes |

Section C. Disclosure

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

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:
 JACOB ERICKSON 98 POPLAR STREET BLACKFOOT, ID 83221 (208) 785-4100

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.

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

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

| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W-2/1099-MISC) | (E) Reportable compensation from related organizations (W-2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|--|--|---|-----------------------|---------|--------------|------------------------------|--------|--|---|---|
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| (1) ADAM WRAY DIRECTOR/PHY | 70 00 | X | | | | | | 1,205,100 | 0 | 21,427 |
| (2) DAVID PETERSON DIRECTOR/PHY | 70 00 | X | | | | | | 871,470 | 0 | 12,477 |
| (3) WAYNE BROWER CHAIR | 10 00 | X | | X | | | | 0 | 0 | 0 |
| (4) GARY BAUMGARTNER VICE CHAIR | 10 00 | X | | X | | | | 0 | 0 | 0 |
| (5) T LAYNE VAN ORDEN TREASURER | 10 00 | X | | X | | | | 0 | 0 | 0 |
| (6) DEAN JONES DIRECTOR | 6 00 | X | | | | | | 0 | 0 | 0 |
| (7) LINDA VALENTINE DIRECTOR | 6 00 | X | | | | | | 0 | 0 | 0 |
| (8) BRYCE JOLLEY DIRECTOR | 6 00 | X | | | | | | 0 | 0 | 0 |
| (9) JACOB ERICKSON CEO | 70 00 | | | X | | | | 343,079 | 0 | 19,627 |
| (10) JOHN FULLMER CFO | 70 00 | | | X | | | | 220,021 | 0 | 17,545 |
| (11) DAVID LOWRY COO | 70 00 | | | | X | | | 247,455 | 0 | 14,121 |
| (12) CAROLYN HANSEN CNO | 70 00 | | | | X | | | 243,441 | 0 | 870 |
| (13) SCOTT HUNEYCUTT PHYSICIAN | 40 00 | | | | | X | | 1,109,105 | 0 | 17,617 |
| (14) ROBERT JOHNSON PHYSICIAN | 40 00 | | | | | X | | 767,241 | 0 | 17,617 |
| (15) NATHAN RICHARDSON PHYSICIAN | 40 00 | | | | | X | | 715,490 | 0 | 17,617 |
| (16) BALDWIN STUTTS PHYSICIAN | 40 00 | | | | | X | | 700,734 | 0 | 13,686 |
| (17) PRASHANTH MANJUNATH PHYSICIAN | 40 00 | | | | | X | | 689,013 | 0 | 17,617 |

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 | | | |
| (18) LOUIS KRAML FORMER CEO | | | | | | | X | 666,667 | 0 | 7,568 |
| (19) JEFFREY DANIELS FORMER CEO | | | | | | | X | 314,480 | 0 | 13,741 |
| (20) DAN COCHRAN FORMER COO | | | | | | | X | 258,926 | 0 | 0 |
| | | | | | | | | | | |
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| | | | | | | | | | | |
| 1b Sub-Total | | | | | | | | | | |
| c Total from continuation sheets to Part VII, Section A | | | | | | | | | | |
| d Total (add lines 1b and 1c) | | | | | | | | 8,352,222 | | 191,530 |

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 **▶ 14**

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

Section B. Independent Contractors

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

| (A) Name and business address | (B) Description of services | (C) Compensation |
|--|--------------------------------|---------------------|
| TD THERAPY SERVICES LLC 1757 LANCE DR POCATELLO, ID 83204 | THERAPY SERVICE | 2,525,723 |
| IDAHO PATHOLOGY LABORATORY 98 POPLAR BLACKFOOT, ID 83221 | PATHOLOGY LAB | 2,246,344 |
| HEALTHCARE ADMINISTRATIVE PARTNERS PO BOX 90 SALT LAKE CITY, UT 84110 | CODING SERVICES | 738,437 |
| GEBBS HEALTHCARE SOLUTIONS INC 600 CORPORATE POINTE SUITE 1250 CULVER CITY, CA 90230 | CODING SERVICES | 298,508 |
| IDAHO KIDNEY INSTITUTE 444 HOSPITAL WAY BLDG 2 POCATELLO, ID 83201 | IPC PRO FEES | 235,481 |

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 **▶ 17**

| | | | | | | | |
|--|---|--|--|---|--|-----------|-----------|
| Form 990 (2018) | | Page 9 | | | | | |
| Part VIII | | Statement of Revenue | | | | | |
| Check if Schedule O contains a response or note to any line in this Part VIII <input type="checkbox"/> | | | | | | | |
| | | (A) Total revenue | (B) Related or exempt function revenue | (C) Unrelated business revenue | (D) Revenue excluded from tax under sections 512 - 514 | | |
| Contributions, Gifts, Grants and Other Similar Amounts | 1a Federated campaigns | 1a | | | | | |
| | b Membership dues | 1b | | | | | |
| | c Fundraising events | 1c | | | | | |
| | d Related organizations | 1d | | | | | |
| | e Government grants (contributions) | 1e | 1,655,386 | | | | |
| | f All other contributions, gifts, grants, and similar amounts not included above | 1f | 158,737 | | | | |
| | g Noncash contributions included in lines 1a - 1f \$ | | | | | | |
| | h Total. Add lines 1a-1f ▶ | | 1,814,123 | | | | |
| Program Service Revenue | | | Business Code | | | | |
| | 2a NET PATIENT SERVICE REVENUE | | 621110 | 138,465,661 | 138,465,661 | | |
| | b PROGRAM RELATED INVESTMENTS | | 621110 | 2,254,198 | 2,254,198 | | |
| | c | | | | | | |
| | d | | | | | | |
| | e | | | | | | |
| | f All other program service revenue | | | | | | |
| | 9 Total. Add lines 2a-2f ▶ | | 140,719,859 | | | | |
| Other Revenue | 3 Investment income (including dividends, interest, and other similar amounts) ▶ | | 594,619 | | | | 594,619 |
| | 4 Income from investment of tax-exempt bond proceeds ▶ | | | | | | |
| | 5 Royalties ▶ | | | | | | |
| | 6a Gross rents | (i) Real | (ii) Personal | | | | |
| | | 118,311 | 103,229 | | | | |
| | | b Less rental expenses | 31,489 | | | | |
| | | c Rental income or (loss) | 86,822 | 103,229 | | | |
| | d Net rental income or (loss) ▶ | | 190,051 | | | 41,292 | 148,759 |
| | 7a Gross amount from sales of assets other than inventory | (i) Securities | (ii) Other | | | | |
| | | 12,897,941 | 18,000 | | | | |
| | | b Less cost or other basis and sales expenses | 12,510,678 | 82,428 | | | |
| | | c Gain or (loss) | 387,263 | -64,428 | | | |
| | d Net gain or (loss) ▶ | | 322,835 | | | | 322,835 |
| | 8a Gross income from fundraising events (not including \$ of contributions reported on line 1c) See Part IV, line 18 a | | | | | | |
| | b Less direct expenses b | | | | | | |
| | c Net income or (loss) from fundraising events ▶ | | | | | | |
| | 9a Gross income from gaming activities See Part IV, line 19 a | | | | | | |
| | b Less direct expenses b | | | | | | |
| | c Net income or (loss) from gaming activities ▶ | | | | | | |
| | 10a Gross sales of inventory, less returns and allowances a | | 2,822,216 | | | | |
| | b Less cost of goods sold b | | 601,700 | | | | |
| | c Net income or (loss) from sales of inventory ▶ | | 2,220,516 | | | | 2,220,516 |
| Miscellaneous Revenue | | Business Code | | | | | |
| 11a OTHER | | 561000 | 846,755 | | | 846,755 | |
| b CAFETERIA | | 722210 | 500,862 | | | 500,862 | |
| c HOSPITAL MANAGEMENT SERVICES | | 541610 | 462,331 | | | 462,331 | |
| d All other revenue | | | 314,607 | | 314,607 | | |
| e Total. Add lines 11a-11d ▶ | | 2,124,555 | | | | | |
| 12 Total revenue. See Instructions ▶ | | 147,986,558 | | 140,719,859 | 355,899 | 5,096,677 | |

Form 990 (2018)

Part IX Statement of Functional Expenses

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

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

| | (A) Total expenses | (B) Program service expenses | (C) Management and general expenses | (D) Fundraising expenses |
|---|-----------------------|---------------------------------|--|-----------------------------|
| Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII. | | | | |
| 1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21. | 201,164 | 201,164 | | |
| 2 Grants and other assistance to domestic individuals. See Part IV, line 22. | 9,875 | 9,875 | | |
| 3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16. | | | | |
| 4 Benefits paid to or for members. | | | | |
| 5 Compensation of current officers, directors, trustees, and key employees. | 3,217,575 | 2,354,785 | 862,790 | |
| 6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B). | | | | |
| 7 Other salaries and wages. | 60,504,053 | 53,987,880 | 6,516,173 | |
| 8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions). | 222,000 | 196,448 | 25,552 | |
| 9 Other employee benefits. | 8,969,490 | 5,813,175 | 3,156,315 | |
| 10 Payroll taxes. | 3,460,463 | 2,967,280 | 493,183 | |
| 11 Fees for services (non-employees): | | | | |
| a Management. | | | | |
| b Legal. | 201,244 | | 201,244 | |
| c Accounting. | 220,055 | | 220,055 | |
| d Lobbying. | | | | |
| e Professional fundraising services. See Part IV, line 17. | | | | |
| f Investment management fees. | 60,475 | | 60,475 | |
| g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O). | 15,275,937 | 10,836,833 | 4,439,104 | |
| 12 Advertising and promotion. | 1,687,877 | 540,966 | 1,144,120 | 2,791 |
| 13 Office expenses. | 4,966,870 | 3,327,268 | 1,638,233 | 1,369 |
| 14 Information technology. | 1,831,009 | | 1,831,009 | |
| 15 Royalties. | | | | |
| 16 Occupancy. | 3,789,700 | 1,818,277 | 1,971,423 | |
| 17 Travel. | 890,635 | 471,949 | 418,686 | |
| 18 Payments of travel or entertainment expenses for any federal, state, or local public officials. | | | | |
| 19 Conferences, conventions, and meetings. | 328,263 | 261,897 | 66,366 | |
| 20 Interest. | 1,246,622 | | 1,246,622 | |
| 21 Payments to affiliates. | | | | |
| 22 Depreciation, depletion, and amortization. | 3,951,982 | 3,560,265 | 391,717 | |
| 23 Insurance. | 810,238 | 797,048 | 13,190 | |
| 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 SUPPLIES & DRUGS | 26,643,062 | 26,643,062 | | |
| b BAD DEBT EXPENSE | 5,892,057 | 5,892,057 | | |
| c REPAIR AND MAINTENANCE | 1,055,559 | 641,271 | 414,288 | |
| d STATE ASSESSMENT | 222,687 | 222,687 | | |
| e All other expenses | 935,108 | 232,599 | 702,509 | |
| 25 Total functional expenses. Add lines 1 through 24e. | 146,594,000 | 120,776,786 | 25,813,054 | 4,160 |
| 26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720). | | | | |

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

| | | | (A) Beginning of year | | (B) End of year |
|------------------------------------|--|---|--------------------------|------------|--------------------|
| Assets | 1 | Cash—non-interest-bearing | 254,772 | 1 | 8,309,928 |
| | 2 | Savings and temporary cash investments | 2,253,177 | 2 | 36,209 |
| | 3 | Pledges and grants receivable, net | | 3 | |
| | 4 | Accounts receivable, net | 17,876,375 | 4 | 23,712,752 |
| | 5 | Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L | | 5 | |
| | 6 | Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L | | 6 | |
| | 7 | Notes and loans receivable, net | | 7 | |
| | 8 | Inventories for sale or use | 4,020,951 | 8 | 4,384,085 |
| | 9 | Prepaid expenses and deferred charges | 2,036,184 | 9 | 1,905,196 |
| | 10a | Land, buildings, and equipment—cost or other basis. Complete Part VI of Schedule D | 84,412,936 | | |
| | b | Less: accumulated depreciation | 52,462,138 | | |
| | | | 32,265,160 | 10c | 31,950,798 |
| | 11 | Investments—publicly traded securities | 20,713,672 | 11 | 16,945,737 |
| | 12 | Investments—other securities. See Part IV, line 11 | 3,161,651 | 12 | 4,144,807 |
| | 13 | Investments—program-related. See Part IV, line 11 | | 13 | |
| | 14 | Intangible assets | 131,000 | 14 | 5,809,557 |
| 15 | Other assets. See Part IV, line 11 | 3,787,588 | 15 | 2,358,019 | |
| 16 | Total assets. Add lines 1 through 15 (must equal line 34) | 86,500,530 | 16 | 99,557,088 | |
| Liabilities | 17 | Accounts payable and accrued expenses | 17,157,021 | 17 | 21,702,650 |
| | 18 | Grants payable | | 18 | |
| | 19 | Deferred revenue | | 19 | 46,937 |
| | 20 | Tax-exempt bond liabilities | 3,650,000 | 20 | 20,586,493 |
| | 21 | Escrow or custodial account liability. Complete Part IV of Schedule D | | 21 | |
| | 22 | Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L | | 22 | |
| | 23 | Secured mortgages and notes payable to unrelated third parties | 16,848,438 | 23 | 7,049,400 |
| | 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 | 4,115,252 | 25 | 5,659,797 |
| | 26 | Total liabilities. Add lines 17 through 25 | 41,770,711 | 26 | 55,045,277 |
| Net Assets or Fund Balances | Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34. | | | | |
| | 27 | Unrestricted net assets | 44,729,819 | 27 | 44,511,811 |
| | 28 | Temporarily restricted net assets | | 28 | |
| | 29 | Permanently restricted net assets | | 29 | |
| | Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34. | | | | |
| | 30 | Capital stock or trust principal, or current funds | | 30 | |
| | 31 | Paid-in or capital surplus, or land, building or equipment fund | | 31 | |
| | 32 | Retained earnings, endowment, accumulated income, or other funds | | 32 | |
| 33 | Total net assets or fund balances | 44,729,819 | 33 | 44,511,811 | |
| 34 | Total liabilities and net assets/fund balances | 86,500,530 | 34 | 99,557,088 | |

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

| | | | |
|-----------|---|-----------|-------------|
| 1 | Total revenue (must equal Part VIII, column (A), line 12) | 1 | 147,986,558 |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 146,594,000 |
| 3 | Revenue less expenses Subtract line 2 from line 1 | 3 | 1,392,558 |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | 44,729,819 |
| 5 | Net unrealized gains (losses) on investments | 5 | -1,610,566 |
| 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 | |
| 10 | Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 44,511,811 |

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

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

Additional Data

Software ID:
Software Version:
EIN: 20-5126945
Name: BMH INC

Form 990 (2018)

Form 990, Part III, Line 4a:

BMH OPERATES A 25-BED ACUTE CARE CRITICAL ACCESS HOSPITAL (CAH) FACILITY WHICH PROVIDES INPATIENT, OUTPATIENT, EMERGENCY CARE, AND SURGICAL SERVICES FOR RESIDENTS OF BINGHAM COUNTY AND SURROUNDING COUNTIES THE HOSPITAL PROVIDED SERVICES TO 2,313 INPATIENTS, 312 NEWBORN INFANTS, AND 9,679 EMERGENCY ROOM PATIENTS AS WELL AS PERFORMING 8,246 SURGERIES (INPATIENT AND OUTPATIENT) DURING THE YEAR THE HOSPITAL PROVIDES CARE TO PERSONS COVERED BY GOVERNMENTAL PROGRAMS AT OR BELOW COST AND TO INDIVIDUALS WHO ARE UNABLE TO PAY THE UNREIMBURSED CHARGES OF PROVIDING CARE TO THESE PATIENTS WAS 946,185 FOR CHARITY CARE, 71,675,022 FOR MEDICARE, 23,338,829 FOR MEDICAID, AND 72,999,101 FOR OTHER THIRD PARTY PAYORS FOR THE YEAR ENDED DECEMBER 31, 2018

Form 990, Part III, Line 4b:

BMH OPERATES SEVERAL CLINICS EMPLOYING AND CONTRACTING WITH PHYSICIANS TO PROVIDE MEDICAL CARE TO INDIVIDUALS IN THE COMMUNITY AND SERVICE AREA DURING THE YEAR, THESE PHYSICIANS PROVIDED 172,774 SEPARATE SERVICE ENCOUNTERS FOR INDIVIDUAL PATIENTS

Form 990, Part III, Line 4c:

BMH OPERATES A NURSING HOME WHICH AVERAGED 40 RESIDENTS PER DAY RECEIVING INPATIENT SERVICES (EITHER SHORT-TERM OR LONG-TERM SKILLED CARE)
DURING THE YEAR

| | | |
|--|---|---|
| SCHEDULE A (Form 990 or 990EZ) | Public Charity Status and Public Support Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust. ▶ Attach to Form 990 or Form 990-EZ. ▶ Go to www.irs.gov/Form990 for the latest information. | OMB No 1545-0047 2018 Open to Public Inspection |
| Department of the Treasury Internal Revenue Service Name of the organization BMH INC | | Employer identification number 20-5126945 |

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

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

Part II

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

| Section A. Public Support | | | | | | | |
|---------------------------|---|----------|----------|----------|----------|----------|-----------|
| | Calendar year (or fiscal year beginning in) ► | (a) 2014 | (b) 2015 | (c) 2016 | (d) 2017 | (e) 2018 | (f) Total |
| 1 | Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant ") | | | | | | |
| 2 | Tax revenues levied for the organization's benefit and either paid to or expended on its behalf | | | | | | |
| 3 | The value of services or facilities furnished by a governmental unit to the organization without charge | | | | | | |
| 4 | Total. Add lines 1 through 3 | | | | | | |
| 5 | The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f) | | | | | | |
| 6 | Public support. Subtract line 5 from line 4 | | | | | | |

| Section B. Total Support | | | | | | | |
|--|--|---------|---------|---------|---------|-----------|----------|
| Calendar year (or fiscal year beginning in) ► | | (a)2014 | (b)2015 | (c)2016 | (d)2017 | (e)2018 | (f)Total |
| 7 | Amounts from line 4 | | | | | | |
| 8 | Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources | | | | | | |
| 9 | Net income from unrelated business activities, whether or not the business is regularly carried on | | | | | | |
| 10 | Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI) | | | | | | |
| 11 | Total support. Add lines 7 through 10 | | | | | | |
| 12 | Gross receipts from related activities, etc (see instructions) | | | | | 12 | |
| 13 | First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here ► <input type="checkbox"/> | | | | | | |

| Section C. Computation of Public Support Percentage | | | | | | |
|---|--|--|--|--|--|----|
| 14 | Public support percentage for 2018 (line 6, column (f) divided by line 11, column (f)) | | | | | 14 |
| 15 | Public support percentage for 2017 Schedule A, Part II, line 14 | | | | | 15 |
| 16a | 33 1/3% support test—2018. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/> | | | | | |
| b | 33 1/3% support test—2017. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/> | | | | | |
| 17a | 10%-facts-and-circumstances test—2018. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/> | | | | | |
| b | 10%-facts-and-circumstances test—2017. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/> | | | | | |
| 18 | Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ <input type="checkbox"/> | | | | | |

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

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

Section A. Public Support

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

Section B. Total Support

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

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

Section C. Computation of Public Support Percentage

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

Section D. Computation of Investment Income Percentage

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

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

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

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV

Supporting Organizations (continued)

| | Yes | No |
|---|-----|----|
| 11 Has the organization accepted a gift or contribution from any of the following persons? | | |
| a A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization? | | |
| 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 <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below | | |
| b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below | | |
| c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions) | | |
| 2 Activities Test. Answer (a) and (b) below. | 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 | | | |
| <div>1</div> <div><input type="checkbox"/></div> <div>Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970 (explain in Part VI). See instructions. All other Type III non-functionally integrated supporting organizations must complete Sections A through E.</div> | | | |
| Section A - Adjusted Net Income | | (A) Prior Year | (B) Current Year (optional) |
| 1 | Net short-term capital gain | 1 | |
| 2 | Recoveries of prior-year distributions | 2 | |
| 3 | Other gross income (see instructions) | 3 | |
| 4 | Add lines 1 through 3 | 4 | |
| 5 | Depreciation and depletion | 5 | |
| 6 | Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions) | 6 | |
| 7 | Other expenses (see instructions) | 7 | |
| 8 | Adjusted Net Income (subtract lines 5, 6 and 7 from line 4) | 8 | |
| Section B - Minimum Asset Amount | | (A) Prior Year | (B) Current Year (optional) |
| 1 | Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year) | 1 | |
| a | Average monthly value of securities | 1a | |
| b | Average monthly cash balances | 1b | |
| c | Fair market value of other non-exempt-use assets | 1c | |
| d | Total (add lines 1a, 1b, and 1c) | 1d | |
| e | Discount claimed for blockage or other factors (explain in detail in Part VI) | | |
| 2 | Acquisition indebtedness applicable to non-exempt use assets | 2 | |
| 3 | Subtract line 2 from line 1d | 3 | |
| 4 | Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions) | 4 | |
| 5 | Net value of non-exempt-use assets (subtract line 4 from line 3) | 5 | |
| 6 | Multiply line 5 by .035 | 6 | |
| 7 | Recoveries of prior-year distributions | 7 | |
| 8 | Minimum Asset Amount (add line 7 to line 6) | 8 | |
| Section C - Distributable Amount | | | Current Year |
| 1 | Adjusted net income for prior year (from Section A, line 8, Column A) | 1 | |
| 2 | Enter 85% of line 1 | 2 | |
| 3 | Minimum asset amount for prior year (from Section B, line 8, Column A) | 3 | |
| 4 | Enter greater of line 2 or line 3 | 4 | |
| 5 | Income tax imposed in prior year | 5 | |
| 6 | Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions) | 6 | |
| 7 | <div><input type="checkbox"/></div> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions) | | |

Part V

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

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

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

Additional Data

Software ID:
Software Version:
EIN: 20-5126945
Name: BMH 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

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

2018

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 BMH INC | Employer identification number 20-5126945 |
|-------------------------------------|--|

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? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4a | Was a correction made? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b | If "Yes," describe in Part IV | |

Part I-C

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

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

| (a) Name | (b) Address | (c) EIN | (d) Amount paid from filing organization's funds If none, enter -0- | (e) Amount of political contributions received and promptly and directly delivered to a separate political organization If none, enter -0- |
|----------|-------------|---------|---|--|
| 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 | | | | | | | | | | | | | | |
| <table><thead><tr><th>If the amount on line 1e, column (a) or (b) is:</th><th>The lobbying nontaxable amount is:</th></tr></thead><tbody><tr><td>Not over \$500,000</td><td>20% of the amount on line 1e</td></tr><tr><td>Over \$500,000 but not over \$1,000,000</td><td>\$100,000 plus 15% of the excess over \$500,000</td></tr><tr><td>Over \$1,000,000 but not over \$1,500,000</td><td>\$175,000 plus 10% of the excess over \$1,000,000</td></tr><tr><td>Over \$1,500,000 but not over \$17,000,000</td><td>\$225,000 plus 5% of the excess over \$1,500,000</td></tr><tr><td>Over \$17,000,000</td><td>\$1,000,000</td></tr></tbody></table> | If the amount on line 1e, column (a) or (b) is: | The lobbying nontaxable amount is: | Not over \$500,000 | 20% of the amount on line 1e | Over \$500,000 but not over \$1,000,000 | \$100,000 plus 15% of the excess over \$500,000 | Over \$1,000,000 but not over \$1,500,000 | \$175,000 plus 10% of the excess over \$1,000,000 | Over \$1,500,000 but not over \$17,000,000 | \$225,000 plus 5% of the excess over \$1,500,000 | Over \$17,000,000 | \$1,000,000 | | |
| If the amount on line 1e, column (a) or (b) is: | The lobbying nontaxable amount is: | | | | | | | | | | | | | |
| Not over \$500,000 | 20% of the amount on line 1e | | | | | | | | | | | | | |
| Over \$500,000 but not over \$1,000,000 | \$100,000 plus 15% of the excess over \$500,000 | | | | | | | | | | | | | |
| Over \$1,000,000 but not over \$1,500,000 | \$175,000 plus 10% of the excess over \$1,000,000 | | | | | | | | | | | | | |
| Over \$1,500,000 but not over \$17,000,000 | \$225,000 plus 5% of the excess over \$1,500,000 | | | | | | | | | | | | | |
| Over \$17,000,000 | \$1,000,000 | | | | | | | | | | | | | |
| g Grassroots nontaxable amount (enter 25% of line 1f) | | | | | | | | | | | | | | |
| h Subtract line 1g from line 1a If zero or less, enter -0- | | | | | | | | | | | | | | |
| i Subtract line 1f from line 1c If zero or less, enter -0- | | | | | | | | | | | | | | |
| j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | |

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

| Lobbying Expenditures During 4-Year Averaging Period | | | | | |
|---|----------|----------|----------|----------|-----------|
| Calendar year (or fiscal year beginning in) | (a) 2015 | (b) 2016 | (c) 2017 | (d) 2018 | (e) Total |
| 2a Lobbying nontaxable amount | | | | | |
| b Lobbying ceiling amount (150% of line 2a, column(e)) | | | | | |
| c Total lobbying expenditures | | | | | |
| d Grassroots nontaxable amount | | | | | |
| e Grassroots ceiling amount (150% of line 2d, column (e)) | | | | | |
| f Grassroots lobbying expenditures | | | | | |

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

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

| | | (a) | | (b) |
|-----------|--|-----|----|--------|
| | | Yes | No | Amount |
| 1 | During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of | | | |
| a | Volunteers? | | No | |
| b | Paid staff or management (include compensation in expenses reported on lines 1c through 1i)? | | No | |
| c | Media advertisements? | | No | |
| d | Mailings to members, legislators, or the public? | | No | |
| e | Publications, or published or broadcast statements? | | No | |
| f | Grants to other organizations for lobbying purposes? | | No | |
| g | Direct contact with legislators, their staffs, government officials, or a legislative body? | | No | |
| h | Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means? | | No | |
| i | Other activities? | Yes | | 5,344 |
| j | Total. Add lines 1c through 1i | | | 5,344 |
| 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 |
|-------------------------------|--|
| SCHEDULE C, PART II-B, LINE 1 | THE HOSPITAL DOES NOT DIRECTLY PERFORM ANY LOBBYING ACTIVITIES. THE HOSPITAL PAYS MEMBERSHIP DUES TO STATE AND NATIONAL HOSPITAL ASSOCIATIONS. THE ASSOCIATIONS ALLOCATE A PORTION OF SUCH DUES TO LOBBYING ACTIVITIES BASED ON STUDIES CONDUCTED BY THE RESPECTIVE ASSOCIATION. |

| | | | | | |
|---|--|--|--|--|--|
| efile GRAPHIC print - DO NOT PROCESS | | As Filed Data - | | DLN: 93493319077979 | |
| <div>SCHEDULE D (Form 990)</div> <div>Department of the Treasury Internal Revenue Service</div> | | <div>Supplemental Financial Statements</div> <div>► Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b. ► Attach to Form 990. ► Go to www.irs.gov/Form990 for the latest information.</div> | | | <div>OMB No 1545-0047</div> <div>2018</div> <div>Open to Public Inspection</div> |
| Name of the organization BMH INC | | | | Employer identification number 20-5126945 | |
| 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? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div> | | | |
| 6 | | Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div> | | | |
| Part II Conservation Easements. Complete if the organization answered "Yes" on Form 990, Part IV, line 7. | | | | | |
| 1 Purpose(s) of conservation easements held by the organization (check all that apply) <div><input type="checkbox"/> Preservation of land for public use (e g , recreation or education) <input type="checkbox"/> Preservation of an historically important land area <input type="checkbox"/> Protection of natural habitat <input type="checkbox"/> Preservation of a certified historic structure <input type="checkbox"/> Preservation of open space</div> | | | | | |
| 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? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div> | | | | | |
| 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)? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div> | | | | | |
| 9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements | | | | | |
| Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets. Complete if the organization answered "Yes" on Form 990, Part IV, line 8. | | | | | |
| 1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items | | | | | |
| b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items | | | | | |
| (i) Revenue included on Form 990, Part VIII, line 1 ► \$ | | | | | |
| (ii) Assets included in Form 990, Part X ► \$ | | | | | |
| 2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items | | | | | |
| a Revenue included on Form 990, Part VIII, line 1 ► \$ | | | | | |
| b Assets included in Form 990, Part X ► \$ | | | | | |
| For Paperwork Reduction Act Notice, see the Instructions for Form 990. | | | | | |
| | | Cat No 52283D | | Schedule D (Form 990) 2018 | |

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

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

- a** ☐ Public exhibition
- b** ☐ Scholarly research
- c** ☐ Preservation for future generations
- d** ☐ Loan or exchange programs
- e** ☐ Other

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

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

Part IV Escrow and Custodial Arrangements.

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

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

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

c Beginning balance

d Additions during the year

e Distributions during the year

f Ending balance

| | Amount |
|-----------|--------|
| 1c | |
| 1d | |
| 1e | |
| 1f | |

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

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

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

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

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

a Board designated or quasi-endowment ▶

b Permanent endowment ▶

c Temporarily restricted endowment ▶

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

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

(i) unrelated organizations

(ii) related organizations

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

| | Yes | No |
|---------------|-----|----|
| 3a(i) | | |
| 3a(ii) | | |
| 3b | | |

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

Part VI Land, Buildings, and Equipment.

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

| Description of property | (a) Cost or other basis (investment) | (b) Cost or other basis (other) | (c) Accumulated depreciation | (d) Book value |
|--|--------------------------------------|---------------------------------|------------------------------|----------------|
| 1a Land | | 3,131,594 | | 3,131,594 |
| b Buildings | | 39,733,247 | 23,209,978 | 16,523,269 |
| c Leasehold improvements | | 3,576,473 | 1,817,864 | 1,758,609 |
| d Equipment | | 36,912,143 | 27,434,296 | 9,477,847 |
| e Other | | 1,059,479 | | 1,059,479 |
| Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c)) . . . ▶ | | | | 31,950,798 |

Part VII

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

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

Part VIII

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

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

Part IX

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

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

Part X

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

| 1. (a) Description of liability | (b) Book value |
|---|----------------|
| (1) Federal income taxes | |
| LINE OF CREDIT | 2,981,114 |
| CAPITAL LEASE OBLIGATIONS | 2,418,683 |
| MALPRACTICE INSURANCE LIABILITY | 260,000 |
| (4) | |
| (5) | |
| (6) | |
| (7) | |
| (8) | |
| (9) | |
| Total. (Column (b) must equal Form 990, Part X, col (B) line 25) ▶ | 5,659,797 |

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 |
|------------------|-------------|
| | |
| | |
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| | |

Additional Data

Software ID:
Software Version:
EIN: 20-5126945
Name: BMH INC

Supplemental Information

| Return Reference | Explanation |
|----------------------------|--|
| SCHEDULE D, PAGE 3, PART X | THE ORGANIZATION IS A NON-FOR-PROFIT CORPORATION AND HAS BEEN RECOGNIZED AS TAX EXEMPT PURSUANT TO SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE (IRC) THE ORGANIZATION IS EXEMPT FROM FEDERAL INCOME TAX UNSEER SECTION 501(C)(3) OF THE IRC EXCEPT TO THE EXTENT OF UNRELAT ED BUSINESS TAXABLE INCOME AS DEFINED UNDER IRC SECTION 511 THROUGH 515 THE ORGANIZATION HAS ADOPTED ACCOUNTING FOR UNCERTAIN TAX POSITIONS THE ACCOUNTING STANDARD PRESCRIBES A R ECOGNITION THRESHOLD AND MEASUREMENT PROCESS FOR UNCERTAIN TAX POSITIONS THE ORGANIZATION HAD NO UNCERTAIN TAX POSITIONS AS OF DECEMBER 31, 2018 OR 2017 |

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SCHEDULE H
(Form 990)

Hospitals

OMB No 1545-0047

2018

Open to Public Inspection

Department of the Treasury

Internal Revenue Service

Name of the organization

BMH INC

Employer identification number

20-5126945

► 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.

Part I

Financial Assistance and Certain Other Community Benefits at Cost

1a

Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a

1a

Yes

No

b

If "Yes," was it a written policy?

1b

Yes

No

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

3a

Yes

No

☐ 100%

☒ 150%

☐ 200%

☐ Other

%

b

Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care

3b

Yes

No

☒ 200%

☐ 250%

☐ 300%

☐ 350%

☐ 400%

☐ Other

%

c

If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care

4

Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?

4

Yes

No

5a

Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?

5a

Yes

No

b

If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?

5b

No

Yes

c

If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?

5c

No

Yes

6a

Did the organization prepare a community benefit report during the tax year?

6a

No

Yes

b

If "Yes," did the organization make it available to the public?

6b

No

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) | | | 489,115 | | 489,115 | 0 350 % |
| b Medicaid (from Worksheet 3, column a) | | | 16,958,675 | 14,637,551 | 2,321,124 | 1 650 % |
| c Costs of other means-tested government programs (from Worksheet 3, column b) | | | 173,670 | | 173,670 | 0 120 % |
| d Total Financial Assistance and Means-Tested Government Programs | | | 17,621,460 | 14,637,551 | 2,983,909 | 2 120 % |
| Other Benefits | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4) | | 35,253 | 1,119,954 | 42,500 | 1,077,454 | 0 770 % |
| f Health professions education (from Worksheet 5) | | | 2,168,874 | 1,709,386 | 459,488 | 0 330 % |
| g Subsidized health services (from Worksheet 6) | | | | | | |
| h Research (from Worksheet 7) | | | 53,087 | 53,087 | | |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | | | 327,764 | | 327,764 | 0 230 % |
| j Total. Other Benefits | | 35,253 | 3,669,679 | 1,804,973 | 1,864,706 | 1 330 % |
| k Total. Add lines 7d and 7j | | 35,253 | 21,291,139 | 16,442,524 | 4,848,615 | 3 450 % |

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

Cat No 50192T

Schedule H (Form 990) 2018

Part III

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

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

Part III

Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

| | | Yes | No |
|--|----------|------------|-----------|
| 1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? | 1 | Yes | |
| 2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount. | 2 | 5,955,306 | |
| 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 | 1,488,827 | |
| 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 | 29,821,214 | |
| 6 Enter Medicare allowable costs of care relating to payments on line 5. | 6 | 32,416,012 | |
| 7 Subtract line 6 from line 5. This is the surplus (or shortfall). | 7 | -2,594,798 | |
| 8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used. | | | |
| <input type="checkbox"/> Cost accounting system | <input type="checkbox"/> Cost to charge ratio | <input checked="" type="checkbox"/> Other | |

Section C. Collection Practices

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

Part IV

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

| (a) Name of entity | (b) Description of primary activity of entity | (c) Organization's profit % or stock ownership % | (d) Officers, directors, trustees, or key employees' profit % or stock ownership % | (e) Physicians' profit % or stock ownership % |
|-------------------------------|---|--|--|---|
| 1 BMH PHYSICIANS CLINI | RENTAL REAL ESTATE | 59 000 % | | 41 000 % |
| 2 IDAHO PATHOLOGY LAB | PATHOLOGY SERVICES | 55 000 % | | 45 000 % |
| 3 DOCTORS & HOSPITAL | SURGICAL SERVICES | 100 000 % | | |
| 4 CMRGO LLC | RENTAL REAL ESTATE | 100 000 % | | |
| 5 BBH INVESTMENTS | SURGICAL SERVICES | 22 000 % | | 78 000 % |
| 6 CRESTWOOD ENTERPRISE | RENTAL REAL ESTATE | 21 000 % | 25 000 % | |
| 7 SKYLINE SURGERY CENT | SURGICAL SERVICES | 21 000 % | | 46 000 % |
| 8 ORANGE LLC | MEDICAL SERVICES | 100 000 % | | |
| 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)

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

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

1

Community Health Needs Assessment

| | Yes | No |
|---|---------------|----|
| 1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? | 1 | No |
| 2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C | 2 | No |
| 3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply) | 3 Yes | |
| a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility | | |
| b <input checked="" type="checkbox"/> Demographics of the community | | |
| c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | |
| d <input checked="" type="checkbox"/> How data was obtained | | |
| e <input checked="" type="checkbox"/> The significant health needs of the community | | |
| f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | |
| g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs | | |
| h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests | | |
| i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s) | | |
| j <input checked="" type="checkbox"/> Other (describe in Section C) | | |
| 4 Indicate the tax year the hospital facility last conducted a CHNA 20 <u>16</u> | | |
| 5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted | 5 Yes | |
| 6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | 6a | No |
| b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C | 6b Yes | |
| 7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply) | 7 Yes | |
| a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>WWW.BINGHAMMEMORIAL.ORG</u> | | |
| b <input type="checkbox"/> Other website (list url) _____ | | |
| c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility | | |
| d <input type="checkbox"/> Other (describe in Section C) | | |
| 8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 | 8 Yes | |
| 9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u> | | |
| 10 Is the hospital facility's most recently adopted implementation strategy posted on a website? | 10 Yes | |
| a If "Yes" (list url) <u>WWW.BINGHAMMEMORIAL.ORG/ABOUT-BMH/COMM</u> | | |
| b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? | 10b | No |
| 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)

| | | | |
|--|---|----|-----|
| BINGHAM MEMORIAL HOSPITAL | | | |
| Name of hospital facility or letter of facility reporting group | | | |
| Did the hospital facility have in place during the tax year a written financial assistance policy that | | | |
| 13 | Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP | 13 | Yes |
| a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150 000000000000 % and FPG family income limit for eligibility for discounted care of 200 000000000000 % | | | |
| b <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C) | | | |
| c <input checked="" type="checkbox"/> Asset level | | | |
| d <input checked="" type="checkbox"/> Medical indigency | | | |
| e <input checked="" type="checkbox"/> Insurance status | | | |
| f <input type="checkbox"/> Underinsurance discount | | | |
| g <input type="checkbox"/> Residency | | | |
| h <input checked="" type="checkbox"/> Other (describe in Section C) | | | |
| 14 | Explained the basis for calculating amounts charged to patients? | 14 | Yes |
| 15 | Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply) | 15 | Yes |
| a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application | | | |
| b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | | |
| c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | | |
| d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | | |
| e <input type="checkbox"/> Other (describe in Section C) | | | |
| 16 | Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply) | 16 | Yes |
| a <input type="checkbox"/> The FAP was widely available on a website (list url) | | | |
| b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) SEE PART V, PAGE 8 | | | |
| c <input type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) | | | |
| d <input type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| e <input type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| f <input type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| g <input type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention | | | |
| h <input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP | | | |
| i <input type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations | | | |
| j <input checked="" type="checkbox"/> Other (describe in Section C) | | | |

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

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

Policy Relating to Emergency Medical Care

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

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

BINGHAM MEMORIAL HOSPITAL

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

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

| | Yes | No |
|-----------|-----|----|
| | | |
| 23 | | No |
| 24 | | No |

Part V Facility Information (continued)**Section B. Facility Policies and Practices**(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)
IDAHO DOCTORS HOSPITAL**Name of hospital facility or letter of facility reporting group** _____**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** _____

2

Community Health Needs Assessment

| | Yes | No |
|---|--------------|----|
| 1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? | 1 | No |
| 2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C | 2 Yes | |
| 3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply) | 3 | No |
| a <input type="checkbox"/> A definition of the community served by the hospital facility | | |
| b <input type="checkbox"/> Demographics of the community | | |
| c <input type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | |
| d <input type="checkbox"/> How data was obtained | | |
| e <input type="checkbox"/> The significant health needs of the community | | |
| f <input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | |
| g <input type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs | | |
| h <input type="checkbox"/> The process for consulting with persons representing the community's interests | | |
| i <input type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s) | | |
| j <input type="checkbox"/> Other (describe in Section C) | | |
| 4 Indicate the tax year the hospital facility last conducted a CHNA 20 ____ | | |
| 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 | |
| 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 | |
| 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 | |
| 7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply) | 7 | |
| a <input type="checkbox"/> Hospital facility's website (list url) _____ | | |
| b <input type="checkbox"/> Other website (list url) _____ | | |
| c <input type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility | | |
| d <input type="checkbox"/> Other (describe in Section C) | | |
| 8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 | 8 | |
| 9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 ____ | | |
| 10 Is the hospital facility's most recently adopted implementation strategy posted on a website? | 10 | |
| a If "Yes" (list url) _____ | | |
| 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)

| | | | |
|--|--|----|-----|
| IDAHO DOCTORS HOSPITAL | | | |
| Name of hospital facility or letter of facility reporting group | | | |
| Did the hospital facility have in place during the tax year a written financial assistance policy that | | | |
| 13 | Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP | 13 | Yes |
| a | <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150 000000000000 % and FPG family income limit for eligibility for discounted care of 200 000000000000 % | | |
| b | <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C) | | |
| c | <input checked="" type="checkbox"/> Asset level | | |
| d | <input checked="" type="checkbox"/> Medical indigency | | |
| e | <input checked="" type="checkbox"/> Insurance status | | |
| f | <input type="checkbox"/> Underinsurance discount | | |
| g | <input type="checkbox"/> Residency | | |
| h | <input checked="" type="checkbox"/> Other (describe in Section C) | | |
| 14 | Explained the basis for calculating amounts charged to patients? | 14 | Yes |
| 15 | Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply) | 15 | Yes |
| a | <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application | | |
| b | <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | |
| c | <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | |
| d | <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | |
| e | <input checked="" type="checkbox"/> Other (describe in Section C) | | |
| 16 | Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply) | 16 | Yes |
| a | <input type="checkbox"/> The FAP was widely available on a website (list url) | | |
| b | <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) SEE PART V, PAGE 8 | | |
| c | <input type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) | | |
| d | <input type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| e | <input type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| f | <input type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| g | <input type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention | | |
| h | <input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP | | |
| i | <input type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations | | |
| j | <input checked="" type="checkbox"/> Other (describe in Section C) | | |

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

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

Policy Relating to Emergency Medical Care

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

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

IDAHO DOCTORS HOSPITAL

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

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

| | Yes | No |
|-----------|-----|----|
| 22 | | |
| 23 | | No |
| 24 | | No |

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

[illegible]

Part V Facility Information *(continued)***Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

How many non-hospital health care facilities did the organization operate during the tax year? **21**

| 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 7, COLUMN (F) - EXCLUSIONS FROM PERCENT OF TOTAL EXPENSE | THE BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 24, BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGE IN THIS COLUMN IS 5,892,057 |
| PART I, LINE 7 - COSTING METHODOLOGY EXPLANATION | THE COSTING METHODOLOGY USED TO DETERMINE THE FINANCIAL ASSISTANCE IS THE COST TO CHARGE RATIO |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|---|--|
| PART III, LINE 2 - BAD DEBT EXPENSE METHODOLOGY | THE COSTING METHODOLOGY USED TO DETERMINE BAD DEBT EXPENSE IS THE COST TO CHARGE RATIO |
| PART III, LINE 3 BAD DEBT EXPENSE, PATIENTS ELIGIBLE FOR ASSISTANCE | <p>PATIENTS ARE NOTIFIED OF THE FINANCIAL ASSISTANCE PROGRAM VIA APPOINTMENTS WITH PATIENT FINANCIAL COUNSELORS, CALLS WITH PATIENT FINANCIAL ADVOCATES AND BROCHURES AVAILABLE IN THE ADMISSION AND BUSINESS OFFICE AREAS OF THE HOSPITAL EVEN THOUGH THERE ARE MULTIPLE AVENUES USED TO EDUCATE AND ASSIST PATIENTS IN APPLYING FOR THE FINANCIAL ASSISTANCE PROGRAM, SOME PATIENTS ARE RELUCTANT TO SPEND THE TIME GOING THROUGH THE QUALIFICATION PROCESS THERE ARE ALSO THOSE PATIENTS THAT APPLY FOR THE PROGRAM BUT FAIL TO PROVIDE THE NECESSARY PAPERWORK TO SUPPORT THE APPLICATION THIS PREVENTS ACCURATELY IDENTIFYING THEIR FINANCIAL NEEDS MANY PATIENTS IN THE AREA HAVE A STEADY INCOME PROVIDED TO THEM BY THE GOVERNMENT AND HAVE NO NEED FOR A HEALTHY CREDIT SCORE THERE ARE ALSO PATIENTS THAT ARE WELL ABOVE THE FINANCIAL GUIDELINES FOR FINANCIAL ASSISTANCE THAT ALLOW THEIR ACCOUNTS TO GO TO A BAD DEBT AGENCY IN ADDITION, THERE ARE THOSE PATIENTS THAT DO NOT PLACE A HIGH IMPORTANCE ON PAYING MEDICAL BILLS AND BELIEVE THAT CREDITORS DO NOT FAULT THEM FOR HAVING MEDICAL BAD DEBT FOR THE ABOVE REASONS IT IS ESTIMATED THAT THE PERCENTAGE OF THE BAD DEBT EXPENSE THAT WOULD QUALIFY AS CHARITY UNDER OUR FINANCIAL ASSISTANCE PROGRAM IS 25%</p> |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|---|---|
| BAD DEBT EXPENSE FOOTNOTE TO FINANCIAL STATEMENTS | THE PATIENT ACCOUNTS RECEIVABLE FOOTNOTE OF THE AUDITED FINANCIAL STATEMENTS IS FOUND IN FOOTNOTE 2 ON PAGE 8 OF THE AUDITED FINANCIAL STATEMENTS THE PROVISION FOR BAD DEBTS IS ALSO INCLUDED IN FOOTNOTE 2 OF THE AUDITED FINANCIAL STATEMENTS |
| PART III, LINE 8 - MEDICARE EXPLANATION | THE SHORTFALL IN MEDICARE UNREIMBURSED COST SHOULD BE INCLUDED AS COMMUNITY BENEFIT AS SERVICES ARE RENDERED TO ALL INDIVIDUALS REGARDLESS OF ABILITY TO PAY AND/OR THE REIMBURSEMENT EXPECTED TO BE RECEIVED FROM MEDICARE, MEDICAID OR OTHER PAYERS THE COSTING METHODOLOGY USED TO DETERMINE MEDICARE COSTS IS THE COST OF CHARGE RATIO BINGHAM MEMORIAL IS DESIGNATED A CRITICAL ACCESS HOSPITAL AS SUCH, A PORTION OF ITS MEDICARE CHARGES IS PAID UNDER A COST BASED REIMBURSEMENT SYSTEM ONLY THAT PORTION OF THE TOTAL MEDICARE REVENUE EARNED AND THE ASSOCIATED ALLOWABLE COSTS INCURRED BY THE ORGANIZATION IS REPORTED ON ITS MEDICARE COST REPORT PER THE SCHEDULE H INSTRUCTIONS THE AMOUNTS REPORTED IN PART III LINES 5-7 ARE FROM OUR MEDICARE COST REPORT THE RESULTANT SHORTFALL ON LINE 7 IS 2,594,798 THERE IS SIGNIFICANT DIFFERENCE, HOWEVER, BETWEEN OUR TOTAL MEDICARE PROGRAM SERVICES AND THE SUBSET OF THE TOTAL WHICH IS ACCOUNTED FOR ON THE COST REPORT IN ORDER TO CLEARLY AND FULLY DESCRIBE THESE SERVICES, MANAGEMENT HAS MADE INTERNAL CALCULATIONS, WHICH TAKE INTO CONSIDERATION OUR MEDICARE SERVICES IN ITS ENTIRETY BINGHAM MEMORIAL OPERATES 20 CLINICS (BOTH PRIMARY CARE AND SPECIALTY) BINGHAM HAS RECRUITED AND EMPLOYS 43 PHYSICIANS AND 13 MID-LEVEL PROFESSIONALS, PROVIDING VITAL CARE FOR OUR COMMUNITY'S CITIZENS MUCH OF THESE ARE REIMBURSED USING FEE SCHEDULE RATES THAT ARE (IN THE AGGREGATE) BELOW THE COST OF PROVIDING THAT CARE IN ORDER TO SUPPORT THE DELIVERY OF THESE HEALTH SERVICES, THE HOSPITAL INCURS OTHER ASSOCIATED COSTS, LIKE DIRECT SUPPORT STAFF, INFRASTRUCTURE, SUPPORTING DEPARTMENTS (ACCOUNTING, PATIENT FINANCIAL SERVICES, INFORMATION TECHNOLOGY, HUMAN RESOURCES, ETC) AND EXECUTIVE LEADERSHIP IF NOT FOR TAX EXEMPT AND CRITICAL ACCESS HOSPITALS, SUCH AS BINGHAM MEMORIAL, ABSORBING THE DEFICIT ATTACHED TO PROVIDING THESE VITAL SERVICES TO MEDICARE RECIPIENTS, THE CENTERS FOR MEDICARE AND MEDICAID SERVICES WOULD BEAR THE FINANCIAL BURDEN OF THESE CITIZENS' CARE |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|--|--|
| PART III, LINE 9B - COLLECTION PRACTICES EXPLANATION | ONCE A PATIENT APPLIES FOR FINANCIAL ASSISTANCE, WE HOLD ALL COLLECTIONS EFFORTS UNTIL A DETERMINATION IS MADE WE SEND THE PATIENT A LETTER NOTIFYING THEM OF APPROVAL OR DENIAL OF FINANCIAL ASSISTANCE APPROVED FINANCIAL ASSISTANCE IS GOOD FOR 3 MONTHS UNLESS FINANCIAL SITUATION HAS CHANGED, AND THEN A PATIENT MUST REAPPLY FOR ASSISTANCE ANY NON-EMERGENCY SERVICES REQUIRE A NEW APPLICATION |
| PART VI, LINE 2 - NEEDS ASSESSMENT | BINGHAM MEMORIAL HOSPITAL'S DEPARTMENT OF PUBLIC RELATIONS UTILIZES A COMMUNITY SURVEY TO IDENTIFY THE HEALTHCARE NEEDS OF OUR COMMUNITY SURVEYS ARE MAILED TO APPROXIMATELY 25% OF OUR COUNTY POPULATION ON-SITE SURVEYS ARE ALSO DISTRIBUTED AT HOSPITAL EVENTS SURVEYS ASK WHICH SERVICES AND EDUCATION PROGRAMS COMMUNITY MEMBERS ARE INTERESTED IN THE RESULTS ARE SHARED WITH ADMINISTRATION, AFTER WHICH, COMMUNITY EVENTS AND OUTREACH EFFORTS ARE PLANNED ACCORDINGLY THE HOSPITAL ALSO RECEIVES A VARIETY OF DIRECT REQUESTS FROM COMMUNITY ORGANIZATIONS AND MEMBERS TO PROVIDE SERVICES AND EDUCATION EXAMPLES INCLUDE DISCOUNTED FLU CLINICS, DISCOUNTED LAB TESTING, FREE HEALTH EDUCATION CLASSES AND SEMINARS RELATED TO JOINT PAIN, ARTHRITIS PAIN, WEIGHT LOSS, AND BACK PAIN WE PERFORM FREE PHYSICAL EXAMS FOR STUDENT ATHLETES, PLACE AN ATHLETIC TRAINER FREE OF CHARGE AT HIGH SCHOOL SPORTING EVENTS, AND PROVIDE FREE EXAMS FOR STUDENT ATHLETES INJURED AT A SPORTING EVENT BY PROVIDING THESE SERVICES WITHIN OUR COMMUNITY WE ARE REDUCING TRAVEL COSTS FOR COMMUNITY MEMBERS MANAGEMENT, HOSPITAL DEPARTMENT STAFF AND MANAGERS, AND THE BOARD OF DIRECTORS ARE COMPRISED OF MEMBERS WITHIN THE COMMUNITY THEY ARE ABLE TO GATHER AND COMMUNICATE THE HEALTH CARE NEEDS OF THE COMMUNITY IT SERVES AND CONTINUALLY ADDRESS THEM AT STAFF AND BOARD MEETINGS THE MOST RECENTLY ADOPTED IMPLEMENTATION STRATEGY AND COMMUNITY HEALTH NEEDS ASSESSMENT CAN BE FOUND AT THE FOLLOWING URL HTTPS //WWW BINGHAMMEMORIAL ORG/ABOUT-BMH/COMMUNITY-HEALTH-NEEDS-ASSESSMENT |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|---|---|
| PART VI, LINE 3 - PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE | WE NOTIFY PATIENTS VERBALLY PRIOR TO ADMISSIONS VIA THE FRONT OFFICE, PATIENT FINANCIAL COUNSELOR OR ADMISSION CLERK WHEN THEY PRESENT FOR SERVICES, WE SCREEN FOR INSURANCE COVERAGE AND, IF APPROPRIATE, WE GET THEM AN APPOINTMENT WITH A FINANCIAL COUNSELOR AFTER THE SERVICES, WHEN WE CALL THEM FOR PAYMENTS, WE EXPLAIN THE PROCESS AGAIN TO ANY APPLICABLE PATIENTS IF THEY ARE HAVING TROUBLE MEETING THEIR OBLIGATIONS, OR IF THEY EXPRESS NEED, WE SEND THEM OUT A LETTER EXPLAINING THE PROCESS AGAIN AND PROVIDE AN APPLICATION FOR THEIR COMPLETION THE FAP APPLICATION CAN BE FOUND ON OUR WEBSITE AT THE FOLLOWING URL BINGHAMMEMORIAL ORG/UPLOADS/FINANCIAL%20STATEMENT%20APPLICATION%20FORM PDF |
| PART VI, LINE 4 - COMMUNITY INFORMATION | BMH, INC SERVES THE 45,000 RESIDENTS OF BINGHAM COUNTY WITH MEDICAL SERVICES LOCATED BETWEEN THE FOURTH AND FIFTH LARGEST CITIES IN IDAHO, BINGHAM COUNTY INCORPORATES JUST OVER 2,000 SQUARE MILES THE COUNTY POPULATION CONSISTS MOSTLY OF YOUNGER FAMILIES WITH CHILDREN WITH A MEDIAN AGE OF 30 THE COUNTY'S POPULATION AGE BREAKDOWN IS AS FOLLOWS 32% AGE 0-18, 10% AGE 18-25, 12% AGE 25-35, 12% AGE 35-45, 11% AGE 45-55, 8% AGE 55-65, AND 15% OVER AGE 65 BINGHAM COUNTY'S RURAL COMMUNITIES HAVE OVER 1,300 UNINSURED INDIVIDUALS (2 9% OF POPULATION) AND IT IS ESTIMATED TO HAVE AN EVEN GREATER PERCENTAGE OF UNDERINSURED INDIVIDUALS IN BINGHAM COUNTY'S AGRICULTURAL BASED ECONOMY, THE MEDIAN HOUSEHOLD INCOME, 50,155 (US CENSUS BUREAU 2015), IS 12% LOWER THAN THE NATIONAL AVERAGE OF 57,230 (US CENSUS BUREAU 2015) ADDITIONALLY, BMH SERVES THE FORT HALL INDIAN RESERVATION AND ITS 3,000 INHABITANTS, AS WELL AS A NUMBER OF BANNOCK AND BONNEVILLE RESIDENTS |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|---|--|
| PART VI, LINE 5 - PROMOTION OF COMMUNITY HEALTH | THE COMMUNITY BOARD STEERS THE ORGANIZATIONAL GOALS AND MISSION TOWARDS PROVIDING THE BEST HEALTHCARE FOR THE COMMUNITY BMH SUPPORTS A MULTITUDE OF PHYSICIAN SPECIALISTS IN THEIR EFFORTS TO PROVIDE CARE TO THE COMMUNITY ON A REGULAR SCHEDULE WITH THIS ASSISTANCE, AND AN OPEN MEDICAL STAFF, NUMEROUS PHYSICIANS ARE ABLE TO PROVIDE OUR COMMUNITY WITH SPECIALIZED MEDICAL CARE, FROM NEUROLOGY TO PODIATRY OUR FINANCIAL ASSISTANCE POLICIES AND PROTOCOLS ALLOW THOSE COMMUNITY MEMBERS WHO MAY HAVE LESS ABILITY TO PAY RECEIVE THE MEDICAL ATTENTION THEY NEED TO LIVE A HEALTHY LIFE THE VARIOUS SEMINARS, CLASSES AND EVENTS WE PROVIDE TO THE COMMUNITY FREE OF CHARGE GIVES THE COMMUNITY OPPORTUNITIES TO EDUCATE THEMSELVES ABOUT SOME OF THE MAJOR HEALTH CONCERNS PEOPLE HAVE |
| PART VI, LINE 6 - AFFILIATED HEALTH CARE SYSTEM | N/A |

Additional Data

Software ID:
Software Version:
EIN: 20-5126945
Name: BMH 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 | | 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 | BINGHAM MEMORIAL HOSPITAL 98 POPLAR STREET BLACKFOOT, ID 832211799 WWW.BINGHAMMEMORIAL.ORG 36 | X | X | | | X | X | X | X | | |
| 2 | IDAHO DOCTORS HOSPITAL 98 POPLAR STREET BLACKFOOT, ID 832211799 IDAHO DOCTORS HOSPITAL 66 | X | X | | | | | X | | | |

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 |
|---|--|
| FACILITY 1, BINGHAM MEMORIAL HOSPITAL - PART V, LINE 3E | IDENTIFICATION AND PRIORITIZATION OF HEALTH NEEDS ARE ADDRESSED IN PART TWO - PAGES 17-49, OF THE CHNA LOCATED ON THE HOSPITAL'S WEBSITE |
| FACILITY 1, BINGHAM MEMORIAL HOSPITAL - PART V, LINE 5 | BINGHAM MEMORIAL HOSPITAL (BINGHAM), LOCATED IN BLACKFOOT ID, CONDUCTED A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) BETWEEN MAY 2016 AND OCTOBER 2016 BINGHAM CONTRACTED WITH LAMPROPHONY ENTERPRISES, LLC (LE) TO FACILITATE AND CONDUCT THIS CHNA LE PROVIDES SUPPORT TO NON-PROFIT HOSPITALS AND OTHER COMMUNITY GROUPS TO CONDUCT NEEDS ASSESSMENTS AND PLANNING ACTIVITIES TO IMPROVE HEALTH AND INCREASE HEALTH EQUITY THE CHNA INCLUDED COMPILATION AND ANALYSIS OF EXISTING SECONDARY DATA FROM A VARIETY OF SOURCES INCLUDING STATE AND FEDERAL AGENCIES, SUCH AS THE PUBLIC HEALTH DEPARTMENT, AS WELL AS NATIONAL FOUNDATIONS IN ORDER TO CREATE A COMMUNITY HEALTH PROFILE FOR BINGHAM'S SERVICE AREA THE PROCESS ALSO INCLUDED COMMUNITY INPUT VIA KEY STAKEHOLDER INTERVIEWS, AN ONLINE SURVEY, AND REGIONAL COMMUNITY HEALTH NEEDS ASSESSMENTS PRIORITY HEALTH ISSUES WERE IDENTIFIED BY BINGHAM STAFF IN PARTNERSHIP WITH LE BY LOOKING AT FINDINGS FROM ACROSS ALL DATA AND PERSPECTIVES |

Form 990 Part V 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 |
|---|---|
| FACILITY 1, BINGHAM MEMORIAL HOSPITAL - PART V, LINE 6B | THE HOSPITAL FACILITY'S CHNA WAS CONDUCTED WITH LAMPROPHONY ENTERPRISES, LLC |
| FACILITY 1, BINGHAM MEMORIAL HOSPITAL - PART V, LINE 11 | ANALYSIS AND COMPARISONS OF THE PRIMARY (INTERVIEWS AND SURVEYS) AND SECONDARY (PUBLIC DATABASES) SOURCES OF DATA FACILITATED THE IDENTIFICATION OF HEALTH NEEDS IN BINGHAM'S SERVICE AREA THE TOP EIGHT CAUSES OF DEATH, WHICH ARE THE SAME IN BOTH BINGHAM AND BANNOCK COUNTIES, WERE INCLUDED AS IDENTIFIED NEEDS HEALTH RISK FACTORS WITH HIGHER RATES AND CLINICAL CARE FACTORS THAT LEAD TO WORSE HEALTH OUTCOMES IN BINGHAM COUNTY WHEN COMPARED WITH THE STATE OF IDAHO WERE ALSO INCLUDED AS IDENTIFIED NEEDS THE FOLLOWING WERE IDENTIFIED AS THE 10 MOST HIGHLY PRIORITIZED HEALTH NEEDS, AND ADDRESSED IN THE FOLLOWING MANNER 1 - HIGH COST OF CARE BMH RURAL CLINICS, A LOW INCOME SLIDING FEE SCHEDULE IS ALSO OFFERED 2 - UNINSURED/UNDERINSURED AN INSURANCE BENEFITS COMMUNITY CLASS HAS BEEN PROPOSED FOR UNINSURED OR UNDERINSURED PATIENTS 3 - DIABETES BMH OPERATES A DIABETES AND OSTEOPOROSIS CENTER IN POCATELLO THAT OFFERS HYPERBARIC, AND WOULD OSTOMY TREATMENT A CERTIFIED DIABETES EDUCATION PROGRAM IS IN DEVELOPMENT OVER THE NEXT THREE YEARS WHICH WILL RESULT IN A DIABETES SELF-MANAGEMENT PROGRAM THE CURRENT DIABETES PREVENTION PROGRAM IS TRANSITIONING TO A PATIENT 4 - HEALTHY LIFESTYLE CHOICES A TOBACCO CESSATION CLASS IS OFFERED TO HELP INDIVIDUALS STOP SMOKING 5 - OBESITY A DIABETES PREVENTION PROGRAM IS OFFERED AS WELL AS WEIGHT LOSS SEMINARS TO PREVENT OBESITY A COOKING MATTERS CLASS IS PROPOSED TO BE OFFERED AS A WAY TO TEACH INDIVIDUALS TO EAT HEALTHIER DIETS 6 - MENTAL HEALTH SERVICES ANGER MANAGEMENT, LOVE AND LOGIC CLASSES, AND COUNSELING SERVICES ARE CURRENTLY OFFERED LOCAL MENTAL HEALTH SPECIALISTS ARE PROPOSED TO BE PROVIDED TO ADDRESS MENTAL HEALTH ISSUES 7 - HEART DISEASE CARDIOLOGY SERVICES ARE OFFERED TO HELP PREVENT HEART DISEASE 8 - LIMITED HEALTH KNOWLEDGE HEART HEALTH SCREENINGS AND A DIABETES PREVENTION PROGRAM ARE OFFERED TO INCREASE HEALTH KNOWLEDGE A DIABETES SELF-MANAGEMENT PROGRAM IS PROPOSED TO BE OFFERED SPANISH INTERPRETERS, HEALTH FAIRS, AND WEIGHT LOSS SEMINARS ARE ALSO PROVIDED AND DESIGNED TO HELP EDUCATE PATIENTS 9 - DRUG/ALCOHOL ABUSE A PATIENT CENTERED MEDICAL HOME MODEL IS PROPOSED TO BE OFFERED TO WORK WITH PATIENTS' PRIMARY PHYSICIANS TO ENSURE THAT THEY RECEIVE PROPER CARE 10 - HEALTH SCREENING FREE WELLNESS SCREENINGS, BUMPS AND BRUISES CLINICS, HEALTH FAIRS, AND WEIGHT LOSS SEMINARS ARE ALL OFFERED AS A WAY TO HELP PATIENTS MONITOR THEIR HEALTH BMH'S DESIRE TO EXCEED EXPECTATIONS MEANS THAT IT IS CONTINUALLY IMPROVING ON THESE AREAS OF NEEDS THROUGH NEW PROGRAMS AND AFFILIATIONS WHILE ALL SIGNIFICANT NEEDS OF THE COMMUNITY ARE BEING MET, SOME OF THE INITIAL PLANS TO MEET THOSE NEEDS HAVE CHANGED DUE TO NEW HEALTHCARE PROVIDERS, GRANTS, AND PROGRAMS |

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 |
|--|---|
| FACILITY 1, BINGHAM MEMORIAL HOSPITAL - PART V, LINE 13B | CONSIDERATIONS ARE GIVEN TO INCOME LEVEL IN COMBINATION WITH OTHER LISTED FACTORS |
| FACILITY 1, BINGHAM MEMORIAL HOSPITAL - PART V, LINE 13H | CONSIDERATIONS ARE GIVEN TO MEDICAID/MEDICARE AND HOMELESS |

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 |
|--|--|
| FACILITY 1, BINGHAM MEMORIAL HOSPITAL - PART V, LINE 16J | ABRIDGED BROCHURE WITH POLICY HIGHLIGHTS WAS MADE AVAILABLE IN THE ER, ADMISSIONS, AND PATIENT FINANCIAL SERVICES THE FAP APPLICATION FORM CAN BE FOUND ON THE WEBSITE AT THE FOLLOWING URL BINGHAMMEMORIAL.ORG/UPLOADS/FINANCIAL%20STATEMENT%20APPLICATION%20FORM.PDF |
| FACILITY 2, IDAHO DOCTORS HOSPITAL - PART V, LINE 2 | SIXTY PERCENT OF IDAHO DOCTOR'S HOSPITAL WAS ACQUIRED IN 2016 AND THE REMAINING SHARES WERE ACQUIRED IN 2018 |

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 |
|--|---|
| FACILITY 2, IDAHO DOCTORS HOSPITAL - PART V, LINE 13B | CONSIDERATIONS ARE GIVEN TO INCOME LEVEL IN COMBINATION WITH OTHER LISTED FACTORS |
| FACILITY 2, IDAHO DOCTORS HOSPITAL - PART V, LINE 13H | CONSIDERATIONS ARE GIVEN TO MEDICAID/MEDICARE AND HOMELESS |

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 |
|---|--|
| FACILITY 2, IDAHO DOCTORS HOSPITAL - PART V, LINE 15E | CONSIDERATIONS ARE GIVEN TO INCOME LEVEL, MEDICAL INDIGENCE, INSURANCE STATUS, UNINSURED DISCOUNT, MEDICAID/MEDICARE, ASSET LEVEL, AND HOMELESSNESS |
| FACILITY 2, IDAHO DOCTORS HOSPITAL - PART V, LINE 16J | ABRIDGED BROCHURE WITH POLICY HIGHLIGHTS WAS MADE AVAILABLE IN THE ER, ADMISSIONS, AND PATIENT FINANCIAL SERVICES THE FAP APPLICATION FORM CAN BE FOUND ON THE WEBSITE AT THE FOLLOWING URL BINGHAMMEMORIAL.ORG/UPLOADS/FINANCIAL%20STATEMENT%20APPLICATION%20FORM.PDF |

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 BINGHAM MEMORIAL SKILLED NURSING & 98 POPLAR STREET BLACKFOOT, ID 83221 | SKILLED NURSING FACILITY |
| 1 BINGHAM MEMORIAL HOSPITAL SLEEP LAB 53 POPLAR STREET BLACKFOOT, ID 83274 | HOSPITAL OFFICES |
| 2 BINGHAM MEMORIAL FAMILY MEDICINE 1 353 N 4TH AVE SUITE 102 POCATELLO, ID 83201 | PHYSICIAN OFFICES |
| 3 BINGHAM MEMORIAL FAMILY MEDICINE 2 1595 BANNOCK HWY POCATELLO, ID 83204 | PHYSICIAN OFFICES |
| 4 BINGHAM MEMORIAL FAMILY MEDICINE 3 315 W IDAHO STREET BLACKFOOT, ID 83221 | PHYSICIAN OFFICES |
| 5 BINGHAM MEMORIAL FAMILY MEDICINE 4 1740 E 17TH STREET IDAHO FALLS, ID 83404 | PHYSICIAN OFFICES |
| 6 BMH PHYSICIANS 98 POPLAR STREET BLACKFOOT, ID 83221 | PHYSICIAN OFFICES |
| 7 BINGHAM MEMORIAL SPECIALTY PLAZA 326 POPLAR STREET BLACKFOOT, ID 83221 | PHYSICIAN OFFICES |
| 8 DIABETES INTERNAL MEDICINE ARTHRI 2302 E TERRY STREET POCATELLO, ID 83201 | PHYSICIAN OFFICES |
| 9 FIRST CHOICE URGENT CARE 1350 PARKWAY DRIVE BLACKFOOT, ID 83221 | PHYSICIAN OFFICES |
| 10 PHYSICIANS & SURGEONS CLINIC OF IDA 2375 SUNNYSIDE ROAD IDAHO FALLS, ID 83404 | PHYSICIAN OFFICES |
| 11 PHYSICIANS & SURGEONS CLINIC OF POC 1151 HOSPITAL WAY BLDG D POCATELLO, ID 83201 | PHYSICIAN OFFICES |
| 12 PHYSICIANS & SURGEONS CLINIC OF SHE 275 W LOCUST SHELLEY, ID 83274 | PHYSICIAN OFFICES |
| 13 GRADUATE MEDICAL STUDENTS 310 W IDAHO STREET BLACKFOOT, ID 83221 | HOSPITAL OFFICES |
| 14 BINGHAM MEMORIAL FAMILY MEDICINE 353 N 4TH AVE SUITE 110 POCATELLO, ID 83201 | PHYSICIAN OFFICES |

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 BINGHAM SPECIALTY CLINIC 235 POPLAR STREET BLACKFOOT, ID 83221 | PHYSICIAN OFFICES |
| 1 BINGHAM SPECIALTY CLINIC 285 VISTA DR SUITE E POCATELLO, ID 83201 | PHYSICIAN OFFICES |
| 2 BINGHAM SPECIALTY CLINIC 3760 WASHINGTON PARKWAY IDAHO FALLS, ID 83404 | PHYSICIAN OFFICES |
| 3 HEALTH & WELLNESS SLEEP INSTITUTE 1553 E CENTER STREET POCATELLO, ID 83201 | PHYSICIAN OFFICES |
| 4 IDAHO ORTHOPEDIC & SPORTS CLINIC 560 MEMORIAL DR POCATELLO, ID 83201 | PHYSICIAN OFFICES |
| 5 BINGHAM SPECIALTY CLINIC 1975 MARTHA AVENUE IDAHO FALLS, ID 83404 | PHYSICIAN OFFICES |

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

Schedule I
(Form 990)

Department of the Treasury
Internal Revenue Service

Name of the organization
BMH INC

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

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

OMB No 1545-0047

2018

Open to Public Inspection

Employer identification number
20-5126945

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 4

3 Enter total number of other organizations listed in the line 1 table 2

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) SCHOLARSHIPS | 16 | 9,875 | | | |
| (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 |
|------------------------------------|--|
| SCHEDULE I, PAGE 1, PART I, LINE 2 | THE RECIPIENTS OF GRANTS ARE REQUIRED TO MAKE SOME KIND OF PUBLIC RECOGNITION OF THE FUNDS GIVEN |

Additional Data

Software ID:
Software Version:
EIN: 20-5126945
Name: BMH 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 |
|---|------------|-------------------------------|--------------------------|-----------------------------------|---|--|------------------------------------|
| ISU FOUNDATION 921 S 8TH AVENUE POCATELLO, ID 83209 | 82-6013543 | 501C3 | 25,000 | | | | BUSINESS SCHOLARSHIP |
| IDAHO STATE UNIVERSITY 921 S 8TH AVENUE POCATELLO, ID 83209 | 82-6000924 | GOV | 25,000 | | | | BUSINESS SCHOLARSHIP |

| 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 |
| EASTERN IDAHO STATE FAIR PO BOX 250 BLACKFOOT, ID 83221 | 82-6001069 | GOV | 20,000 | | | | COMMUNITY EVENT |
| POST REGISTER 333 NORTHGATE MILE IDAHO FALLS, ID 83401 | 30-0873123 | | 7,500 | | | | COMMUNITY EVENT |

| 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 |
| BENGAL SPORTS PROPERTIES 505 HOBBS ROAD JEFFERSON CITY, MO 65109 | 47-0911648 | | 7,500 | | | | SPORTS DONATION |
| HIGHLAND HIGH SCHOOL 1800 BENCH ROAD POCATELLO, ID 83202 | 82-6000591 | GOV | 5,414 | | | | SPORTS DONATION |

| | | |
|--------------------------|---|---------------------------|
| Schedule J (Form 990) | <div>Compensation Information</div> <div>For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees</div> <div>▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23. ▶ Attach to Form 990.</div> <div>▶ Go to www.irs.gov/Form990 for instructions and the latest information.</div> | OMB No 1545-0047 |
| | | 2018 |
| | | Open to Public Inspection |

| | | |
|--|-------------------------------------|--|
| Department of the Treasury Internal Revenue Service | Name of the organization BMH INC | Employer identification number 20-5126945 |
|--|-------------------------------------|--|

| Part I Questions Regarding Compensation | | Yes | No |
|--|---|-----------|-----|
| 1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items. | | | |
| <input type="checkbox"/> First-class or charter travel | <input type="checkbox"/> Housing allowance or residence for personal use | | |
| <input checked="" type="checkbox"/> Travel for companions | <input type="checkbox"/> Payments for business use of personal residence | | |
| <input type="checkbox"/> Tax indemnification and gross-up payments | <input type="checkbox"/> Health or social club dues or initiation fees | | |
| <input type="checkbox"/> Discretionary spending account | <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef) | | |
| b If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain. | | 1b | Yes |
| 2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a? | | 2 | Yes |
| 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. | | | |
| <input checked="" type="checkbox"/> Compensation committee | <input type="checkbox"/> Written employment contract | | |
| <input checked="" type="checkbox"/> Independent compensation consultant | <input checked="" type="checkbox"/> Compensation survey or study | | |
| <input type="checkbox"/> Form 990 of other organizations | <input checked="" type="checkbox"/> 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 | No |
| 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 | Yes |
| 8 Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III. | | 8 | No |
| 9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)? | | 9 | |

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

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

See Additional Data Table

Schedule J (Form 990) 2018

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 |
|-------------------------------------|--|
| SCHEDULE J, PAGE 1, PART I, LINE 1A | IT IS ESTIMATED THAT 5 EXECUTIVES ARE ACCOMPANIED BY SPOUSES ON APPROXIMATELY 3-4 BUSINESS TRIPS PER YEAR FOR A TOTAL OF APPROXIMATELY 10 COMPANION-TRIPS PER YEAR. COSTS INCLUDE ECONOMY-CLASS AIRFARE, MEALS, AND SHARED LODGING. SUCH COSTS ARE INCLUDED IN EXECUTIVE COMPENSATION AS APPLICABLE. |

| Return Reference | Explanation |
|------------------------------------|-------------------------|
| SCHEDULE J, PAGE 1, PART I, LINE 4 | LOUIS KRAML 666,667 0 0 |

| Return Reference | Explanation |
|------------------------------------|---|
| SCHEDULE J, PAGE 1, PART I, LINE 7 | SOME PERFORMANCE-BASED BONUSES ARE PAID TO EXECUTIVES THOSE BONUSES ARE TIED TO PERFORMED WORK DUTIES AND ARE DETERMINED ON AN AD-HOC BASIS BY THE CEO AND THE BOARD OF DIRECTORS |

| Return Reference | Explanation |
|----------------------|---|
| SCHEDULE J, PART III | A 457(F) PLAN IS AVAILABLE TO HIGHLY COMPENSATED AND CERTAIN MANAGEMENT EMPLOYEES IN WHICH THEY ARE ALLOWED TO DEFER COMPENSATION THIS PLAN IS FUNDED BUT THE ASSETS REMAIN PART OF BMH, INC UNTIL SUCH TIME AS AN APPROPRIATE ELECTION IS MADE BY THE PARTICIPANT TO HAVE THE FUNDS PAID TO THE PARTICIPANT BMH IS PHASING THIS PLAN OUT |



Additional Data

Software ID:
Software Version:
EIN: 20-5126945
Name: BMH 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 | | | | |
| ADAM WRAY DIRECTOR/PHYSICIAN | (i) | 339,129 | 822,524 | 43,447 | | 21,427 | 1,226,527 | |
| | (ii) | | | | | | | |
| DAVID PETERSON DIRECTOR/PHYSICIAN | (i) | 488,947 | 381,794 | 729 | | 12,477 | 883,947 | |
| | (ii) | | | | | | | |
| JACOB ERICKSON CEO | (i) | 269,087 | 65,000 | 8,992 | | 19,627 | 362,706 | |
| | (ii) | | | | | | | |
| JOHN FULLMER CFO | (i) | 190,369 | 10,251 | 19,401 | | 17,545 | 237,566 | |
| | (ii) | | | | | | | |
| DAVID LOWRY COO | (i) | 204,349 | 37,154 | 5,952 | | 14,121 | 261,576 | |
| | (ii) | | | | | | | |
| CAROLYN HANSEN CNO | (i) | 195,240 | 39,000 | 9,201 | | 870 | 244,311 | |
| | (ii) | | | | | | | |
| SCOTT HUNEYCUTT PHYSICIAN | (i) | 1,108,376 | | 729 | | 17,617 | 1,126,722 | |
| | (ii) | | | | | | | |
| ROBERT JOHNSON PHYSICIAN | (i) | 743,171 | | 24,070 | | 17,617 | 784,858 | |
| | (ii) | | | | | | | |
| NATHAN RICHARDSON PHYSICIAN | (i) | 707,838 | | 7,652 | | 17,617 | 733,107 | |
| | (ii) | | | | | | | |
| BALDWIN STUTTS PHYSICIAN | (i) | 689,641 | | 11,093 | | 13,686 | 714,420 | |
| | (ii) | | | | | | | |
| PRASHANTH MANJUNATH PHYSICIAN | (i) | 526,952 | 116,546 | 45,515 | | 17,617 | 706,630 | |
| | (ii) | | | | | | | |
| LOUIS KRAML FORMER CEO | (i) | | | 666,667 | | 7,568 | 674,235 | |
| | (ii) | | | | | | | |
| JEFFREY DANIELS FORMER CEO | (i) | 276,757 | | 37,723 | | 13,741 | 328,221 | |
| | (ii) | | | | | | | |
| DAN COCHRAN FORMER COO | (i) | | | 258,926 | | | 258,926 | |
| | (ii) | | | | | | | |

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury

Name of the organization
BMH INC

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No 1545-0047

2018

Open to Public Inspection

Employer identification number

20-5126945

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|-----------------------------------|---|
| FORM 990 - ORGANIZATION'S MISSION | BINGHAM MEMORIAL HOSPITAL IS COMMITTED TO THE PURSUIT OF EXCELLENCE IN ITS ENDEAVOR TO PROVIDE A CONTINUUM OF QUALITY, COMPASSIONATE HEALTHCARE SERVICES FOR OUR RESIDENTS AND FOR VISITORS TO BINGHAM COUNTY, IN THE MOST EFFECTIVE AND COST EFFECTIVE MANNER POSSIBLE |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|--|
| FORM 990, PAGE 2, PART III, LINE 4A | BMH OPERATES A 25-BED ACUTE CARE CRITICAL ACCESS HOSPITAL (CAH) FACILITY WHICH PROVIDES INPATIENT, OUTPATIENT, EMERGENCY CARE, AND SURGICAL SERVICES FOR RESIDENTS OF BINGHAM COUNTY AND SURROUNDING COUNTIES THE HOSPITAL PROVIDED SERVICES TO 2,313 INPATIENTS, 312 NEWBORN INFANTS, AND 9,679 EMERGENCY ROOM PATIENTS AS WELL AS PERFORMING 8,246 SURGERIES (INPATIENT AND OUTPATIENT) DURING THE YEAR THE HOSPITAL PROVIDES CARE TO PERSONS COVERED BY GOVERNMENTAL PROGRAMS AT OR BELOW COST AND TO INDIVIDUALS WHO ARE UNABLE TO PAY THE UNREIMBURSED CHARGES OF PROVIDING CARE TO THESE PATIENTS WAS 946,185 FOR CHARITY CARE, 71,675,022 FOR MEDICARE, 23,338,829 FOR MEDICAID, AND 72,999,101 FOR OTHER THIRD PARTY PAYORS FOR THE YEAR ENDED DECEMBER 31, 2018 |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|---|
| FORM 990, PAGE 6, PART VI, LINE 6 | THE MEMBERS OF THE HOSPITAL CONSIST OF A BROAD REPRESENTATION OF THE CITIZENS OF BINGHAM C OUNTY, IDAHO, INCLUDING AT LEASE ONE RESIDENT OF EACH INCORPORATED CITY IN BINGHAM COUNTY, IDAHO AND THE UNINCORPORATED AREA OF BINGHAM COUNTY |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|--|
| FORM 990, PAGE 6, PART VI, LINE 7A | DIRECTORS ARE ELECTED BY A MAJORITY OF THE VOTES CAST BY THE MEMBERS ENTITLED TO VOTE IN T HE ELECTION AT THE MEETING AT WHICH A QUORUM OF MEMBERS IS PRESENT |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|--|
| FORM 990, PAGE 6, PART VI, LINE 7B | EACH MEMBER OF RECORD OF THE HOSPITAL IS ENTITLED TO VOTE AT THE MEETINGS AN AFFIRMATIVE VOTE OF A MAJORITY OF THE MEMBERS AT A MEETING IN WHICH A QUORUM WAS PRESENT IS AN ACT OF THE MEMBERS |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|---|
| FORM 990, PAGE 6, PART VI, LINE 11B | A COPY OF THE 990 IS PROVIDED TO THE CFO AND CEO WHO REVIEWS THE FORM, SCHEDULES AND RELATED ATTACHMENTS A FINAL DRAFT IS REVIEWED BY THE BOARD OF DIRECTORS WHO THEN APPROVE THE 990 ONCE MANAGEMENT IS SATISFIED WITH THE 990, THE CEO SIGNS THE FORM 8879-EO AUTHORIZING THE PREPARER TO E-FILE THE RETURN |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|--|
| FORM 990, PAGE 6, PART VI, LINE 12C | HOSPITAL BOARD MEMBERS ANNUALLY SIGN A STATEMENT WHICH AFFIRMS SUCH PERSON HAS RECEIVED A COPY OF THE CONFLICT OF INTEREST POLICY, READ AND UNDERSTANDS THE POLICY, AND AGREES TO COMPLY PER THE CONFLICT OF INTEREST POLICY, A BOARD MEMBER MUST DISCLOSE AN ACTUAL OR POTENTIAL CONFLICT AFTER DISCLOSURE, THE INTERESTED PERSON SHALL LEAVE THE MEETING WHILE THE DETERMINATION OF A CONFLICT ON INTEREST IS DISCUSSED AND VOTED UPON THE REMAINING BOARD OR COMMITTEE MEMBERS SHALL DECIDE IF A CONFLICT OF INTEREST EXISTS IF NONE EXISTS, AN INTERESTED PERSON MAY MAKE A PRESENTATION TO THE BOARD OR COMMITTEE BUT MUST LEAVE THE MEETING DURING THE DISCUSSION OF AN VOTE ON THE TRANSACTION OR ARRANGEMENT INVOLVING THE POSSIBLE CONFLICT OF INTEREST |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|---|
| FORM 990, PAGE 6, PART VI, LINE 15A | INTEGRATED HEALTHCARE STRATEGIES, A NATIONALLY RECOGNIZED EXECUTIVE COMPENSATION FIRM EVALUATES ALL EXECUTIVE POSITIONS FOR COMPENSATION. IN ADDITION, AN EXECUTIVE COMPENSATION REVIEW COMMITTEE REVIEWS COMPENSATION. THE BOARD OF DIRECTORS ESTABLISHES THE CEO COMPENSATION AND THE CEO ESTABLISHES THE OTHER EXECUTIVES' COMPENSATION WITH THE APPROVAL OF THE BOARD OF DIRECTORS. THESE PROCEDURES ARE COMPLETED EVERY TWO TO THREE YEARS, AND THE PROCEDURES WERE COMPLETED IN 2016. |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|---------------------------------|
| FORM 990, PAGE 6, PART VI, LINE 15B | SEE FORM 990, PART VI, LINE 15A |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PAGE 6, PART VI, LINE 19 | BMH MAKES ITS CONFLICT OF INTEREST POLICY, FORM 990, FORM 1023, FINANCIAL STATEMENTS AND OTHER GOVERNANCE DOCUMENTS AVAILABLE UPON REQUEST BY CONTACTING JOHN FULLMER, CFO, AT 98 PO PLAR ST, BLACKFOOT, ID 83221 THE ORGANIZATIONS' AUDITED, CONSOLIDATED FINANCIAL STATEMENTS ARE PUBLICALLY AVAILABLE THROUGH THE MUNICIPAL SECURITIES RULEMAKING BOARD AT HTTP //EMMAMSRBORG/DEFAULT.ASPX |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|-----------------------------------|------------------------|
| FORM 990, PART IX, LINE 11G | 10,836,833 4,439,104 0 |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---------------------------------|--|
| FORM 990, PART XI, LINE 9 | INVENTORY EXPENSE 601,700 RENTAL EXPENSES 31,489 BAD DEBT EXPENSE -5,892,057 INVENTORY EXP ENSE -601,700 RENTAL EXPENSES -31,489 BAD DEBT EXPENSE 5,892,057 |

SCHEDULE R
(Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
BMH INC

Employer identification number
20-5126945

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 |
|---|-------------------------|--|---------------------|---------------------------|---|
| (1) BINGHAM LAND LLC 98 POPLAR STREET BLACKFOOT, ID 83221 71-1035721 | REAL ESTAT | ID | 288,446 | 542,127 | BMH INC |
| (2) CMRGO LLC 350 N MERIDIAN BLACKFOOT, ID 83221 47-0917145 | REAL ESTAT | ID | 297,167 | 1,819,016 | BMH INC |
| (3) CRCA MANAGEMENT COMPANY LLC 98 POPLAR STREET BLACKFOOT, ID 83221 36-4873992 | PHYSICIANS | ID | -1,364,710 | -1,689,125 | BMH INC |
| (4) FERRIS HOLDINGS LLC 98 POPLAR STREET BLACKFOOT, ID 83221 20-5126945 | INVESTMENT | ID | | 1,500 | BMH INC |
| (5) MOUNTAIN RIVER BIRTHING & SURGERY CENTER 98 POPLAR STREET BLACKFOOT, ID 83221 47-0917144 | BIRTH/SURG | ID | | | DOCTORS & HOSPITAL HEALTH SYSTEM OF IDAHO |
| | | | | | |

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

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

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Predominant income(related, unrelated, excluded from tax under sections 512- 514) | (f) Share of total income | (g) Share of end- of-year assets | (h) Disproportionate allocations? | | (i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065) | (j) General or managing partner? | | (k) Percentage ownership |
|--|-------------------------|---|--|--|---------------------------------|---|---|----|--|---|----|--------------------------------|
| | | | | | | | Yes | No | | Yes | No | |
| (1) DOCTORS & HOSPITAL HEALTH SYSTEM OF IDAHO LLC 98 POPLAR STREET BLACKFOOT, ID 83221 20-8167113 | SURGICAL | ID | BMH INC | RELATED | -779,771 | 2,786,063 | | No | | Yes | | 100 000 % |
| (2) IDAHO PATHOLOGY LABORATORY LLC 98 POPLAR STREET BLACKFOOT, ID 83221 45-0956263 | PATHOLOGY | ID | BMH INC | RELATED | 1,053,864 | 456,346 | | No | | Yes | | 55 000 % |
| (3) HEALTH & WELLNESS SLEEP INSTITUTE OF POCATELLO PLLC 1553 E CENTER STREET POCATELLO, ID 83201 37-1529937 | SLEEP CTR | ID | BMH INC | RELATED | | | | No | | Yes | | 100 000 % |
| (4) BMH PHYSICIANS CLINIC LLC 98 POPLAR STREET BLACKFOOT, ID 83221 26-3952823 | REAL RENTA | ID | BINGHAM LAND LLC | RELATED | 130,451 | 5,355,226 | | No | | Yes | | 58 720 % |
| (5) ORANGE LLC 98 POPLAR STREET BLACKFOOT, ID 83221 47-5046728 | MEDICAL | ID | BMH INC | RELATED | -52,101 | | | No | | Yes | | 100 000 % |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |

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

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

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

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

1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?

a Receipt of (i) interest, (ii)annuities, (iii) royalties, or(iv) rent from a controlled entity

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

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

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

e Loans or loan guarantees by related organization(s)

f Dividends from related organization(s)

g Sale of assets to related organization(s)

h Purchase of assets from related organization(s)

i Exchange of assets with related organization(s)

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

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

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

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

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

o Sharing of paid employees with related organization(s)

p Reimbursement paid to related organization(s) for expenses

q Reimbursement paid by related organization(s) for expenses

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

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

Yes

No

1a Yes

1b No

1c No

1d Yes

1e Yes

1f No

1g No

1h No

1i No

1j No

1k Yes

1l Yes

1m Yes

1n No

1o No

1p No

1q No

1r No

1s Yes

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

See Additional Data Table

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

Schedule R (Form 990) 2018

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

[illegible]

Part VII **Supplemental Information**

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

| Return Reference | Explanation |
|------------------|-------------|
| | |

Additional Data

Software ID:
Software Version:
EIN: 20-5126945
Name: BMH INC

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

| (a) Name of related organization | | (b) Transaction type(a-s) | (c) Amount Involved | (d) Method of determining amount involved |
|-------------------------------------|-----------------------------------|---------------------------------|------------------------|--|
| (1) | IDAHO PATHOLOGY LABORATORY LLC | D | 237,124 | GAAP ACCOUNTING |
| (1) | BMH PHYSICIANS CLINIC LLC | D | 441,496 | GAAP ACCOUNTING |
| (2) | HEALTH & WELLNESS SLEEP INSTITUTE | D | 117,107 | GAAP ACCOUNTING |
| (3) | ORANGE LLC | D | 162,264 | GAAP ACCOUNTING |
| (4) | IDAHO PATHOLOGY LABORATORY LLC | E | 1,249,733 | GAAP ACCOUNTING |
| (5) | BMH PHYSICIANS CLINIC LLC | K | 1,007,318 | GAAP ACCOUNTING |
| (6) | IDAHO PATHOLOGY LABORATORY LLC | L | 250,571 | GAAP ACCOUNTING |
| (7) | IDAHO PATHOLOGY LABORATORY LLC | M | 2,718,148 | GAAP ACCOUNTING |
| (8) | IDAHO PATHOLOGY LABORATORY LLC | S | 1,012,000 | CASH DISTRIBUTIONS |