

Form **990**
Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)
Do not enter social security numbers on this form as it may be made public
Information about Form 990 and its instructions is at www.irs.gov/form990

OMB No 1545-0047
2017
Open to Public Inspection

A For the 2017 calendar year, or tax year beginning 07-01-2017, and ending 06-30-2018

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

C Name of organization
THE GOOD SAMARITAN HOSPITAL OF CINCINNATI OHIO

Doing business as

Number and street (or P.O. box if mail is not delivered to street address) Room/suite
625 EDEN PARK DRIVE 7TH FLOOR

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

D Employer identification number
31-0537486

E Telephone number
(513) 569-6575

G Gross receipts \$ 649,988,125

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

H(a) Is this a group return for subordinates? Yes No
H(b) Are all subordinates included? Yes No
If "No," attach a list (see instructions)
H(c) Group exemption number ▶ 0928

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

J Website: ▶ WWW.TRIHEALTH.COM

K Form of organization Corporation Trust Association Other ▶

L Year of formation 1852

M State of legal domicile OH

Part I Summary

1 Briefly describe the organization's mission or most significant activities
THE ORGANIZATION'S MISSION IS TO IMPROVE THE HEALTH STATUS OF THE COMMUNITY IT SERVES

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

3 Number of voting members of the governing body (Part VI, line 1a)	13
4 Number of independent voting members of the governing body (Part VI, line 1b)	8
5 Total number of individuals employed in calendar year 2017 (Part V, line 2a)	3,298
6 Total number of volunteers (estimate if necessary)	900
7a Total unrelated business revenue from Part VIII, column (C), line 12	-559,849
7b Net unrelated business taxable income from Form 990-T, line 34	-672,320

	Prior Year	Current Year
8 Contributions and grants (Part VIII, line 1h)	2,114,251	2,056,794
9 Program service revenue (Part VIII, line 2g)	561,848,144	612,350,546
10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	26,516,215	21,590,991
11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	10,246,551	13,237,921
12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	600,725,161	649,236,252
13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	3,358,854	2,931,475
14 Benefits paid to or for members (Part IX, column (A), line 4)	0	0
15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	266,163,716	270,986,494
16a Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b Total fundraising expenses (Part IX, column (D), line 25) ▶ 0		
17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	243,656,521	270,226,368
18 Total expenses Add lines 13-17 (must equal Part IX, column (A), line 25)	513,179,091	544,144,337
19 Revenue less expenses Subtract line 18 from line 12	87,546,070	105,091,915

	Beginning of Current Year	End of Year
20 Total assets (Part X, line 16)	859,742,464	913,439,877
21 Total liabilities (Part X, line 26)	160,520,283	147,475,987
22 Net assets or fund balances Subtract line 21 from line 20	699,222,181	765,963,890

Part II Signature Block

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

Sign Here
Signature of officer: MICHAEL CROFTON VP-FINANCE
Date: 2019-05-14
Type or print name and title

Paid Preparer Use Only
Print/Type preparer's name: ALICIA JANISCH
Preparer's signature: ALICIA JANISCH
Date: _____
Check if self-employed PTIN: P00741382
Firm's name: DELOITTE TAX LLP Firm's EIN: 86-1065772
Firm's address: 250 EAST FIFTH STREET SUITE 1900 CINCINNATI, OH 45202 Phone no: (513) 784-7100

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission

SEE SCHEDULE O

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 \$ 425,353,335 including grants of \$ 2,931,475) (Revenue \$ 608,832,315)
See Additional Data

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

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

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

4e Total program service expenses ▶ 425,353,335

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	Yes	
2 Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?	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		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	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		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		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		No
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III		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		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	Yes	
11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable		
a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI	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	Yes	
c Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII	Yes	
d Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part IX		No
e Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	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	Yes	
12a Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII		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	Yes	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E		No
14a Did the organization maintain an office, employees, or agents outside of the United States?		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		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		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		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)		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		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		No

Part IV Checklist of Required Schedules (continued)

		Yes	No
20a	Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	Yes	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	Yes	
21	Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i>	Yes	
22	Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i>		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>	Yes	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i>		No
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		
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?		
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		
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>		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>		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>		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>		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>		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>		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>		No
29	Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i>		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>		No
31	Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i>		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>		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>		No
34	Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i>	Yes	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	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>	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>	Yes	
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i>		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	Yes	

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Table with columns for question ID, question text, and Yes/No response boxes. Includes sections for backup withholding, employee reporting, foreign accounts, prohibited tax shelter transactions, deductible contributions, and 501(c)(7), (12), and (29) organizations.

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 [X]

Section A. Governing Body and Management

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

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

Table with 3 columns: Question, Yes, No. Rows include: 10a Did the organization have local chapters, branches, or affiliates? (No); 10b If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes? (No); 11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? (No); 11b Describe in Schedule O the process, if any, used by the organization to review this Form 990; 12a Did the organization have a written conflict of interest policy? If "No," go to line 13 (Yes); 12b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? (Yes); 12c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done (Yes); 13 Did the organization have a written whistleblower policy? (Yes); 14 Did the organization have a written document retention and destruction policy? (Yes); 15 Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision? 15a The organization's CEO, Executive Director, or top management official (No); 15b Other officers or key employees of the organization (No); If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions); 16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year? (Yes); 16b If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements? (No)

Section C. Disclosure

Table with 3 columns: Question, Yes, No. Rows include: 17 List the States with which a copy of this Form 990 is required to be filed; 18 Section 6104 requires an organization to make its Form 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply: [] Own website, [] Another's website, [X] Upon request, [] Other (explain in Schedule O); 19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year; 20 State the name, address, and telephone number of the person who possesses the organization's books and records: MICHAEL CROFTON - VP FINANCE 625 EDEN PARK DRIVE 7TH FLOOR CINCINNATI, OH 45202 (513) 569-6577

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

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

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

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

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

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			
See Additional Data Table										

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

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

1b Sub-Total									
1c Total from continuation sheets to Part VII, Section A									
1d Total (add lines 1b and 1c)							1,600,522	12,376,903	2,360,474

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 ▶ 161

	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
AMERICAN NURSING CARE INC 1700 EDISON DRIVE SUITE 300 MILFORD, OH 45150	NURSING	2,863,739
CATHOLIC HEALTH INITIATIVES 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112	CLINICAL ENGINEERING	2,060,208
TRISTATE HEALTH CARE LAUNDRY 551 S LOOP ROAD EDGEWOOD, KY 41017	LAUNDRY SERVICES	1,512,648
DAVITA 2000 16TH ST DENVER, CO 80202	RENAL SERVICES	710,288
MAYFIELD CLINIC 3825 EDWARDS ROAD SUITE 300 CINCINNATI, OH 45209	MEDICAL SERVICES	704,942

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 ▶ 37

Part VIII Statement of Revenue

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

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a			
	b Membership dues	1b			
	c Fundraising events	1c			
	d Related organizations	1d	1,981,855		
	e Government grants (contributions)	1e			
	f All other contributions, gifts, grants, and similar amounts not included above	1f	74,939		
	g Noncash contributions included in lines 1a-1f \$ _____				
	h Total. Add lines 1a-1f		2,056,794		

Program Service Revenue			Business Code				
	2a PATIENT SERVICES		621990	599,342,796	599,239,274	103,522	
b JOA REVENUE		990009	6,671,233	6,671,233			
c AFFILIATED ORG RENTAL		532000	4,845,397			4,845,397	
d MEDICAL RESEARCH		900099	990,975	990,975			
e MISCELLANEOUS		900099	500,145	1,241,233	-741,088		
f All other program service revenue							
g Total. Add lines 2a-2f			612,350,546				

Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)			7,630,541		77,717	7,552,824
	4 Income from investment of tax-exempt bond proceeds						
	5 Royalties						
	6a Gross rents	(i) Real	(ii) Personal				
		911,347					
	b Less rental expenses	370,660					
	c Rental income or (loss)	540,687					
	d Net rental income or (loss)			540,687			540,687
	7a Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other				
		13,961,124	49,480				
	b Less cost or other basis and sales expenses	0	50,154				
	c Gain or (loss)	13,961,124	-674				
	d Net gain or (loss)			13,960,450			13,960,450
	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	614,606					
b Less cost of goods sold	b	331,059					
c Net income or (loss) from sales of inventory			283,547			283,547	
Miscellaneous Revenue	Business Code						
11a PHARMACY	446110		8,678,165			8,678,165	
b CAFETERIA	722100		3,045,922			3,045,922	
c EHR INCENTIVE	900099		290,052	290,052			
d All other revenue			399,548	399,548			
e Total. Add lines 11a-11d			12,413,687				
12 Total revenue. See Instructions			649,236,252	608,832,315	-559,849	38,906,992	

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21	2,931,475	2,931,475		
2 Grants and other assistance to domestic individuals See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, line 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	4,596,331		4,596,331	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	734,872		734,872	
7 Other salaries and wages	210,006,988	166,805,175	43,201,813	
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	12,085,508	8,997,099	3,088,409	
9 Other employee benefits	27,857,464	17,438,253	10,419,211	
10 Payroll taxes	15,705,331	12,235,264	3,470,067	
11 Fees for services (non-employees)				
a Management	1,725,123	1,725,123		
b Legal	2,611,715		2,611,715	
c Accounting	358,509		358,509	
d Lobbying				
e Professional fundraising services See Part IV, line 17				
f Investment management fees	1,258,564		1,258,564	
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	26,323,865	15,235,947	11,087,918	
12 Advertising and promotion	5,234,858	57,986	5,176,872	
13 Office expenses	7,623,452	3,278,378	4,345,074	
14 Information technology	8,673,352	672,883	8,000,469	
15 Royalties				
16 Occupancy	16,284,318	14,074,488	2,209,830	
17 Travel	882,830	330,465	552,365	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	493,457	271,594	221,863	
20 Interest	2,671,929	2,521,423	150,506	
21 Payments to affiliates	6,105,372		6,105,372	
22 Depreciation, depletion, and amortization	29,957,470	21,635,322	8,322,148	
23 Insurance	3,186,567	3,186,567		
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL/DIETARY SUPPLY	133,896,684	133,581,644	315,040	
b OHIO HOSPITAL FEE	9,858,252	9,858,252		
c EQUIPMENT AND REPAIR	9,338,125	9,338,125		
d O&M COST TRACK FEES	756,400	756,400		
e All other expenses	2,985,526	421,472	2,564,054	
25 Total functional expenses. Add lines 1 through 24e	544,144,337	425,353,335	118,791,002	0
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year
Assets	1 Cash—non-interest-bearing	9,355	1	11,363
	2 Savings and temporary cash investments	25,542,864	2	
	3 Pledges and grants receivable, net		3	
	4 Accounts receivable, net	70,792,510	4	81,452,404
	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	6,046,933	8	6,849,651
	9 Prepaid expenses and deferred charges	219,831	9	512,137
	10a Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	628,595,521		
	b Less accumulated depreciation	457,415,120		
	11 Investments—publicly traded securities	8,517,349	11	4,950,526
	12 Investments—other securities See Part IV, line 11	364,078,024	12	388,717,077
	13 Investments—program-related See Part IV, line 11	142,050,333	13	203,187,933
	14 Intangible assets	17,192,256	14	17,104,256
	15 Other assets See Part IV, line 11	52,386,239	15	39,474,129
16 Total assets. Add lines 1 through 15 (must equal line 34)	859,742,464	16	913,439,877	
Liabilities	17 Accounts payable and accrued expenses	39,811,769	17	44,035,330
	18 Grants payable		18	
	19 Deferred revenue	976,683	19	967,575
	20 Tax-exempt bond liabilities		20	
	21 Escrow or custodial account liability Complete Part IV of Schedule D		21	
	22 Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L		22	
	23 Secured mortgages and notes payable to unrelated third parties		23	
	24 Unsecured notes and loans payable to unrelated third parties	919,588	24	408,725
	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	118,812,243	25	102,064,357
	26 Total liabilities. Add lines 17 through 25	160,520,283	26	147,475,987
Net Assets or Fund Balances	27 Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34. Unrestricted net assets	694,173,204	27	761,013,364
	28 Temporarily restricted net assets	5,048,977	28	4,950,526
	29 Permanently restricted net assets		29	
	30 Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34. 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	699,222,181	33	765,963,890
	34 Total liabilities and net assets/fund balances	859,742,464	34	913,439,877

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	649,236,252
2	Total expenses (must equal Part IX, column (A), line 25)	2	544,144,337
3	Revenue less expenses Subtract line 2 from line 1	3	105,091,915
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	699,222,181
5	Net unrealized gains (losses) on investments	5	1,888,658
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	-40,238,864
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	765,963,890

Part XII Financial Statements and Reporting

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

		Yes	No
<p>1 Accounting method used to prepare the Form 990 <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____</p> <p>If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O</p>			
<p>2a Were the organization's financial statements compiled or reviewed by an independent accountant?</p> <p>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</p> <p><input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis</p>	2a		No
<p>b Were the organization's financial statements audited by an independent accountant?</p> <p>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</p> <p><input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis</p>	2b	Yes	
<p>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?</p> <p>If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O</p>	2c	Yes	
<p>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?</p>	3a	Yes	
<p>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</p>	3b	Yes	

Additional Data

Software ID:

Software Version:

EIN: 31-0537486

Name: THE GOOD SAMARITAN HOSPITAL OF
CINCINNATI OHIO

Form 990 (2017)

Form 990, Part III, Line 4a:

SEE SCHEDULE H

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
MICHAEL HAVERKAMP TRUSTEE	1 00 3 00	X						0	0	0
PAUL EDGETT III TRUSTEE (END 7/17)	1 00 3 00	X						0	1,651,960	41,570
MYRTIS POWELL TRUSTEE	1 00 3 00	X						0	0	0
SR SALLY DUFFY SECRETARY	1 00 3 00	X		X				0	0	0
CRAIG EISENTROUT MD TRUSTEE	1 00 3 00	X						0	723,430	48,271
WAYNE SHIRCLIFF CHAIR	1 00 3 00	X		X				0	0	0
RALPH S MICHAEL VICE CHAIR/TREASURER	1 00 3 00	X		X				0	0	0
MARK CLEMENT PRESIDENT/CEO	15 00 45 00	X		X				0	1,443,430	315,687
MARK DELWORTH MD MED STAFF PRES-(END 12/17)	1 00 3 00	X						0	103,421	0
MARGARET LEMASTERS MD MED STAFF PRES-(END 12/17)	1 00 3 00	X						44,500	3,600	0

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
PHILLIP CASTELLINI TRUSTEE	1 00 3 00	X						0	0	0
LISA KNUTSON TRUSTEE	1 00 3 00	X						0	0	0
THEODORE TORBECK TRUSTEE	1 00 3 00	X						0	0	0
PHILIP FOSTER TRUSTEE (START 7/17)	1 00 3 00	X						0	840,975	42,107
SCOTT FRIEDSTROM MD MED STAFF PRES-GOOD SAM (START 1/18)	1 00 3 00	X						32,909	506,142	65,950
PHILLIP OBLINGER MD MED STAFF PRES-BETHESDA (START 1/18)	1 00 3 00	X						0	57,349	0
ANDREW DEVOE ASST TREASURER/CFO	15 00 45 00			X				0	804,513	132,225
STEVE GRACEY ASST SECRETARY/SVP LEGAL	15 00 45 00			X				0	382,265	90,360
WILLIAM GRONEMAN EXEC VP - (END 11/17)	15 00 45 00				X			0	774,497	221,077
JAIME EASTERLING EXEC DIRECTOR-GOOD SAM	60 00 0 00				X			0	282,841	43,888

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
ROBERT COLLINS MD CMO (END 12/17)	15 00 45 00				X			0	600,543	165,747
GAIL DONOVAN EXEC VP & COO	15 00 45 00				X			0	924,940	201,973
DAVID COOK CHIEF HR OFFICER	15 00 45 00				X			0	461,028	115,687
PAULA NIEDERBAUMER VP-CNO - GOOD SAM HOSPITAL	60 00 0 00				X			0	284,561	99,957
ROB CERCEK VP-GOOD SAM REGION (END 4/18)	60 00 0 00				X			0	504,445	130,947
MARY IRVIN CHIEF NURSE EXECUTIVE-TRIHEALTH	15 00 45 00				X			0	407,921	129,405
KEVIN JOSEPH MD CMO (START 1/18)	15 00 45 00				X			0	578,653	96,075
DAVID DHANRAJ MD PHYSICIAN	60 00 0 00					X		347,976	0	48,659
EDOUARD FEGHALI MD PHYSICIAN	60 00 0 00					X		294,666	0	71,911
SARAH HAWKINS MD PHYSICIAN	60 00 0 00					X		312,706	0	51,892

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
ANGEL MENA MD PHYSICIAN	60 00 0 00					X		247,081	0	37,990
MICHAEL HOLBERT MD PHYSICIAN	60 00 0 00					X		320,684	0	32,645
JOHN PROUT FORMER OFFICER	0 00 40 00						X	0	252,304	0
DONNA NIENABER ESQ FORMER OFFICER	0 00 0 00						X	0	394,836	59,278
MICHAEL CROFTON FORMER OFFICER	0 00 60 00						X	0	393,249	117,173

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.

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

2017

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
THE GOOD SAMARITAN HOSPITAL OF
CINCINNATI OHIO

Employer identification number

31-0537486

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) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(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) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
7	Amounts from line 4						
8	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9	Net income from unrelated business activities, whether or not the business is regularly carried on						
10	Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI)						
11	Total support. Add lines 7 through 10						
12	Gross receipts from related activities, etc (see instructions)					12	

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

Section C. Computation of Public Support Percentage

14	Public support percentage for 2017 (line 6, column (f) divided by line 11, column (f))	14	
15	Public support percentage for 2016 Schedule A, Part II, line 14	15	

- 16a 33 1/3% support test—2017.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ►
- b 33 1/3% support test—2016.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ►
- 17a 10%-facts-and-circumstances test—2017.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ►
- b 10%-facts-and-circumstances test—2016.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ►
- 18 Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ►

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ►		(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(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) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(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 2017 (line 8, column (f) divided by line 13, column (f))	15	
16	Public support percentage from 2016 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17	Investment income percentage for 2017 (line 10c, column (f) divided by line 13, column (f))	17	
18	Investment income percentage from 2016 Schedule A, Part III, line 17	18	

19a 33 1/3% support tests—2017. 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—2016. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ►

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

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?		
2	Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization (s) or (ii) serving on the governing body of a supported organization? <i>If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s).</i>		
3	By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? <i>If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.</i>		

Section E. Type III Functionally-Integrated Supporting Organizations

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

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

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

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

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

Section C - Distributable Amount		Current Year	
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1	
2	Enter 85% of line 1	2	
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3	
4	Enter greater of line 2 or line 3	4	
5	Income tax imposed in prior year	5	
6	Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	

- 7** Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions).

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

Section D - Distributions	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI) See instructions	
7 Total annual distributions. Add lines 1 through 6	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI) See instructions	
9 Distributable amount for 2017 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-2017	(iii) Distributable Amount for 2017
1 Distributable amount for 2017 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2017 (reasonable cause required-- explain in Part VI) See instructions			
3 Excess distributions carryover, if any, to 2017			
a			
b From 2013.			
c From 2014.			
d From 2015.			
e From 2016.			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2017 distributable amount			
i Carryover from 2012 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2017 from Section D, line 7			
\$			
a Applied to underdistributions of prior years			
b Applied to 2017 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2017, 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 2017 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 2018. Add lines 3j and 4c			
8 Breakdown of line 7			
a Excess from 2013.			
b Excess from 2014.			
c Excess from 2015.			
d Excess from 2016.			
e Excess from 2017.			

Additional Data

Software ID:

Software Version:

EIN: 31-0537486

Name: THE GOOD SAMARITAN HOSPITAL OF
CINCINNATI OHIO

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

Facts And Circumstances Test

SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities
For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶Complete if the organization is described below. ▶Attach to Form 990 or Form 990-EZ.
▶Information about Schedule C (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

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2017
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If the organization answered "Yes" on Form 990, Part IV, Line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then

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

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

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

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

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

Name of the organization THE GOOD SAMARITAN HOSPITAL OF CINCINNATI OHIO	Employer identification number 31-0537486
----------------------------------------------------------------------------	----------------------------------------------

Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

- 1 Provide a description of the organization's direct and indirect political campaign activities in Part IV (see instructions for definition of "political campaign activities")
- 2 Political campaign activity expenditures (see instructions) ▶ \$ _____
- 3 Volunteer hours for political campaign activities (see instructions) _____

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

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

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

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

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

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

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

Limits on Lobbying Expenditures
(The term "expenditures" means amounts paid or incurred.)

	(a) Filing organization's totals	(b) Affiliated group totals
--	----------------------------------	-----------------------------

- 1a** Total lobbying expenditures to influence public opinion (grass roots lobbying)
- b** Total lobbying expenditures to influence a legislative body (direct lobbying)
- c** Total lobbying expenditures (add lines 1a and 1b)
- d** Other exempt purpose expenditures
- e** Total exempt purpose expenditures (add lines 1c and 1d)
- f** Lobbying nontaxable amount Enter the amount from the following table in both columns

If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:
Not over \$500,000	20% of the amount on line 1e
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000
Over \$17,000,000	\$1,000,000

- g** Grassroots nontaxable amount (enter 25% of line 1f)
- h** Subtract line 1g from line 1a If zero or less, enter -0-
- i** Subtract line 1f from line 1c If zero or less, enter -0-
- j** If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?

Yes No

4-Year Averaging Period Under section 501(h)

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

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(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		21,463
j Total Add lines 1c through 1i			21,463
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).	2a	
a Current year	2b	
b Carryover from last year	2c	
c Total	3	
3 Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues		
4 If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?	4	
5 Taxable amount of lobbying and political expenditures (see instructions)	5	

Part IV Supplemental Information

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

Return Reference	Explanation
PART II-B, LINE 1	DURING THE TAX YEAR, THE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO ("HOSPITAL") PAID ANNUAL MEMBERSHIP DUES TO VARIOUS NATIONAL, STATE AND LOCAL ORGANIZATIONS, A PORTION (\$1,599) OF WHICH RELATED TO LOBBYING ACTIVITIES IN ADDITION, TRIHEALTH, INC , A RELATED ORGANIZATION OF HOSPITAL, WHICH PROVIDES ADMINISTRATIVE SUPPORT SERVICES TO HOSPITAL, PAID ANNUAL MEMBERSHIP DUES TO VARIOUS NATIONAL, STATE AND LOCAL ORGANIZATIONS A PORTION OF WHICH RELATED TO LOBBYING ACTIVITIES A PORTION OF THE AFOREMENTIONED ADMINISTRATIVE SUPPORT SERVICES ARE ALLOCATED TO HOSPITAL AND \$10,717 OF THE AMOUNT SHOWN ON LINE 1I REPRESENTS HOSPITAL'S SHARE OF THESE LOBBYING EXPENSES FINALLY, HOSPITAL'S CONTROLLING ORGANIZATION, CATHOLIC HEALTH INITIATIVES, PAYS ANNUAL DUES TO THE AMERICAN HOSPITAL ASSOCIATION ("AHA") AND CATHOLIC HOSPITAL ASSOCIATION ("CHA"), A PORTION OF WHICH IS ALLOCATED TO LOBBYING ACTIVITIES FOR THE TAX YEAR, THE AMOUNT SHOWN ON LINE 1I ABOVE REPRESENTS HOSPITAL'S SHARE OF ALLOCATED LOBBYING EXPENSES AHA \$4,873, CHA \$4,274

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

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

OMB No 1545-0047
2017
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Name of the organization
THE GOOD SAMARITAN HOSPITAL OF CINCINNATI OHIO

Employer identification number
31-0537486

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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

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

Preservation of land for public use (e g , recreation or education) Preservation of an historically important land area

Protection of natural habitat Preservation of a certified historic structure

Preservation of open space

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

	Held at the End of the Year	
a Total number of conservation easements	2a	
b Total acreage restricted by conservation easements	2b	
c Number of conservation easements on a certified historic structure included in (a)	2c	
d Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2d	

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 3** Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply)
- a** Public exhibition
 - b** Scholarly research
 - c** Preservation for future generations
 - d** Loan or exchange programs
 - e** Other
- 4** Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII
- 5** During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? Yes No

Part IV Escrow and Custodial Arrangements.

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

- 1a** Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? Yes No
- b** If "Yes," explain the arrangement in Part XIII and complete the following table
- | | Amount |
|----------------------------------------|--------|
| c Beginning balance | |
| d Additions during the year | |
| e Distributions during the year | |
| f Ending balance | |
- 2a** Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? Yes No
- b** If "Yes," explain the arrangement in Part XIII Check here if the explanation has been provided in Part XIII

Part V Endowment Funds. Complete if the organization answered "Yes" 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	11,468,848	11,300,912	10,965,414	12,711,099	11,117,985
b Contributions	21,193	1,302	150,278	44,769	75,468
c Net investment earnings, gains, and losses	651,269	658,571	565,536	396,525	1,989,550
d Grants or scholarships					
e Other expenditures for facilities and programs	658,061	491,937	380,316	2,186,979	471,904
f Administrative expenses					
g End of year balance	11,483,249	11,468,848	11,300,912	10,965,414	12,711,099

- 2** Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as
- a** Board designated or quasi-endowment ▶
 - b** Permanent endowment ▶ 94 330 %
 - c** Temporarily restricted endowment ▶ 5 670 %
- The percentages on lines 2a, 2b, and 2c should equal 100%
- 3a** Are there endowment funds not in the possession of the organization that are held and administered for the organization by
- | | | |
|--------------------------------------------------------------------------------------------------------|--------|-----|
| | Yes | No |
| (i) unrelated organizations | 3a(i) | No |
| (ii) related organizations | 3a(ii) | Yes |
| b If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R? | 3b | Yes |
- 4** Describe in Part XIII the intended uses of the organization's endowment funds

Part VI Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		11,366,329		11,366,329
b Buildings		341,548,540	246,663,714	94,884,826
c Leasehold improvements		4,651,986	4,073,922	578,064
d Equipment		234,403,691	201,806,079	32,597,612
e Other		36,624,975	4,871,405	31,753,570
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c)) . . . ▶				171,180,401

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) CHI OPERATING INVESTMENT PROGRAM	388,717,077	F
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 12.)	388,717,077	

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

(a) Description of investment	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1) INVESTMENT IN JOINT VENTURES	203,187,933	C
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 13.)	203,187,933	

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	
ENVIRONMENTAL REMEDIATION LIABILITY	496,843
MALPRACTICE INSURANCE/WORKERS COMP LIABILITY	14,007,368
ACCRUED EIB	5,800,000
THIRD PARTY SETTLEMENTS	2,539,113
DEBT PAYABLE TO RELATED ORGANIZATION	51,766,398
DUE TO RELATED ORGANIZATION	24,692,978
MISCELLANEOUS	2,761,657
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.)	102,064,357

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

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

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

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

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

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

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

Part XIII Supplemental Information

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

Return Reference	Explanation
See Additional Data Table	

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

Additional Data

Software ID:

Software Version:

EIN: 31-0537486

Name: THE GOOD SAMARITAN HOSPITAL OF
CINCINNATI OHIO

Supplemental Information

Return Reference	Explanation
PART V, LINE 4	INVESTMENT PROCEEDS FROM ENDOWMENT FUNDS ARE USED TO SUPPORT PROGRAMS AT THE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO

Supplemental Information

Return Reference	Explanation
PART X, LINE 2	<p>THE FINANCIAL STATEMENTS OF THE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO ARE AUDITED AS PART OF TRIHEALTH AND ITS SUBSIDIARIES AND AFFILIATES ("TRIHEALTH") FOLLOWING IS THE TEXT OF THE FOOTNOTE TO THE AUDITED COMBINED FINANCIAL STATEMENTS OF TRIHEALTH THAT REPORTS ITS AND ITS SUBSIDIARIES AND AFFILIATES LIABILITY, IF APPLICABLE, FOR UNCERTAIN TAX POSITIONS UNDER ASC 740-10-25 TRIHEALTH PERFORMED AN ANALYSIS OF UNCERTAIN TAX POSITIONS AND DETERMINED THAT NO AMOUNTS WERE REQUIRED TO BE RECOGNIZED IN THE COMBINED FINANCIAL STATEMENT</p> <p>S AT JUNE 30, 2018 AND 2017 IN ADDITION, HOSPITAL'S FINANCIAL INFORMATION IS INCLUDED IN THE CONSOLIDATED AUDITED FINANCIAL STATEMENTS OF CATHOLIC HEALTH INITIATIVES ("CHI"), A RELATED ORGANIZATION CHI'S FIN 48 (ASC 740) FOOTNOTE FOR THE YEAR ENDED JUNE 30, 2018 READS AS FOLLOWS CHI IS A TAX-EXEMPT COLORADO CORPORATION AND HAS BEEN GRANTED AN EXEMPTION FROM FEDERAL INCOME TAX UNDER SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE CHI OWNS CERTAIN TAXABLE SUBSIDIARIES AND ENGAGES IN CERTAIN ACTIVITIES THAT ARE UNRELATED TO ITS EXEMPT PURPOSE AND THEREFORE SUBJECT TO INCOME TAX AS OF JUNE 30, 2018, CHI HAS A DEFERRED TAX ASSET OF \$130.4 MILLION RELATED TO NET OPERATING LOSS (NOL) CARRYFORWARDS CHI BELIEVES THAT AT MOST OF THE NOL CARRYFORWARDS WILL EXPIRE UNUSED AND HAS ESTABLISHED A VALUATION ALLOWANCE OF \$127.0 MILLION AGAINST THE DEFERRED TAX ASSET ASSOCIATED WITH THESE NOL CARRYFORWARDS OF THE TOTAL DEFERRED TAX ASSET AND VALUATION ALLOWANCE AT JUNE 30, 2018, \$62.7 MILLION IS RELATED TO DISCONTINUED OPERATIONS MANAGEMENT REVIEWS ITS TAX POSITIONS ANNUALLY AND HAS DETERMINED THAT THERE ARE NO MATERIAL UNCERTAIN TAX POSITIONS THAT REQUIRE RECOGNITION IN THE ACCOMPANYING CONSOLIDATED FINANCIAL STATEMENTS</p>

**SCHEDULE H
(Form 990)**

Department of the Treasury
Internal Revenue Service
Name of the organization
THE GOOD SAMARITAN HOSPITAL OF CINCINNATI OHIO

Hospitals

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

Employer identification number
31-0537486

OMB No 1545-0047
2017
Open to Public Inspection

Part I Financial Assistance and Certain Other Community Benefits at Cost

	Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a Yes	
b If "Yes," was it a written policy?	1b Yes	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year		
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care <input type="checkbox"/> 100% <input checked="" type="checkbox"/> 150% <input type="checkbox"/> 200% <input type="checkbox"/> Other _____ %	3a Yes	
b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input checked="" type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %	3b Yes	
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care		
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4 Yes	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a Yes	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	No
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c	
6a Did the organization prepare a community benefit report during the tax year?	6a Yes	
b If "Yes," did the organization make it available to the public?	6b Yes	

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			7,171,383	8,612,385	0	0 %
b Medicaid (from Worksheet 3, column a)			110,589,392	83,136,055	27,453,337	5 050 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			117,760,775	91,748,440	27,453,337	5 050 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			1,379,307	0	1,379,307	0 250 %
f Health professions education (from Worksheet 5)			23,611,621	11,893,674	11,717,947	2 150 %
g Subsidized health services (from Worksheet 6)			2,299,614	1,582,760	716,854	0 130 %
h Research (from Worksheet 7)			4,373,249	0	4,373,249	0 800 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)			672,762	0	672,762	0 120 %
j Total. Other Benefits			32,336,553	13,476,434	18,860,119	3 450 %
k Total. Add lines 7d and 7j			150,097,328	105,224,874	46,313,456	8 500 %

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			290,000		290,000	0.050 %
3 Community support			47,150		47,150	0.010 %
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development						
9 Other						
10 Total			337,150		337,150	0.060 %

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 26,536,872	
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3 0	
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.		

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME).	5 105,402,227
6 Enter Medicare allowable costs of care relating to payments on line 5.	6 108,762,728
7 Subtract line 6 from line 5. This is the surplus (or shortfall).	7 -3,360,501
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other	

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures

(a) Name of entity (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

Part V Facility Information**Section A. Hospital Facilities**

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

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

1

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)

See Additional Data Table	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

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)
 GOOD SAMARITAN HOSPITAL

Name of hospital facility or letter of facility reporting group _____

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

		Yes	No
Community Health Needs Assessment			
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		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		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)	Yes	
a	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b	<input checked="" type="checkbox"/> Demographics of the community		
c	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input checked="" type="checkbox"/> How data was obtained		
e	<input checked="" type="checkbox"/> The significant health needs of the community		
f	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j	<input type="checkbox"/> Other (describe in Section C)		
4	Indicate the tax year the hospital facility last conducted a CHNA <u>20 15</u>		
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge 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	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	Yes	
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	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)	Yes	
a	<input checked="" type="checkbox"/> Hospital facility's website (list url) <u>HTTP //WWW TRIHEALTH COM/ABOUT-TRIHEALTH/COMMUNITY/</u>		
b	<input type="checkbox"/> Other website (list url) _____		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 15</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) _____		No
a			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	Yes	
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		No
b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
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)

GOOD SAMARITAN HOSPITAL

Name of hospital facility or letter of facility reporting group _____

		Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that		
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13 Yes	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>150 000000000000</u> % and FPG family income limit for eligibility for discounted care of <u>300 000000000000</u> %		
b	<input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance discount		
g	<input type="checkbox"/> Residency		
h	<input checked="" type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	14 Yes	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	15 Yes	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	16 Yes	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>HTTPS //WWW TRIHEALTH COM/TOOLS/PAY-YOUR-BILL/FINANCIAL-ASSISTANCE/</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>HTTP //WWW TRIHEALTH COM/TOOLS/PAY-YOUR-BILL/FINANCIAL-ASSISTANCE/</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>HTTP //WWW TRIHEALTH COM/TOOLS/PAY-YOUR-BILL/FINANCIAL-ASSISTANCE/</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input type="checkbox"/> Other (describe in Section C)		

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

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

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

Form and Line Reference	Explanation
See Add'l Data	

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

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

How many non-hospital health care facilities did the organization operate during the tax year? 11

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

Part VI Supplemental Information

Provide the following information

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

990 Schedule H, Supplemental Information

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

990 Schedule H, Supplemental Information

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

990 Schedule H, Supplemental Information

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

990 Schedule H, Supplemental Information

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

990 Schedule H, Supplemental Information

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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART II, COMMUNITY BUILDING ACTIVITIES	THE UPTOWN CONSORTIUM ("CONSORTIUM") IS RECOGNIZED BY THE INTERNAL REVENUE SERVICE AS EXEMPT FROM INCOME TAX UNDER INTERNAL REVENUE CODE SECTION 501(A) AS AN ORGANIZATION DESCRIBED IN INTERNAL REVENUE CODE SECTION 501(C)(3) IT IS MADE UP OF THE FIVE LARGEST EMPLOYERS OF CINCINNATI'S "UPTOWN" INCLUDING THE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO "UPTOWN" GENERALLY INCLUDES THE NEIGHBORHOODS OF AVONDALE, CLIFTON, CLIFTON HEIGHTS, CORRYVILLE, FAIRVIEW, MT AUBURN AND UNIVERSITY HEIGHTS THE CONSORTIUM IS DEDICATED TO BUILDING THE HUMAN, SOCIAL AND PHYSICAL IMPROVEMENT OF UPTOWN CINCINNATI IT WILL UNDERTAKE A VARIETY OF INVESTMENT AND PROGRAM ACTIVITIES IN UPTOWN TO HELP PROVIDE HOUSING, HEALTH CARE AND JOB OPPORTUNITIES ALSO, THE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO PROVIDED CASH DONATIONS TO VARIOUS CHARITABLE ORGANIZATIONS WITHIN THE COMMUNITY TO ADDRESS HOMELESSNESS, TO INCREASE EDUCATIONAL OPPORTUNITIES AND TO BUILD AN ECONOMIC INFRASTRUCTURE

990 Schedule H, Supplemental Information

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

990 Schedule H, Supplemental Information

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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 4	<p>THE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO'S FINANCIAL STATEMENTS ARE AUDITED AS PART OF THE TRIHEALTH AUDIT REPORT NET PATIENT ACCOUNTS RECEIVABLE (PART OF FOOTNOTE B) NET PATIENT ACCOUNTS RECEIVABLE AND NET PATIENT SERVICE REVENUE HAVE BEEN ADJUSTED TO THE ESTIMATED AMOUNTS EXPECTED TO BE COLLECTED THESE ESTIMATED AMOUNTS ARE SUBJECT TO FURTHER ADJUSTMENTS UPON REVIEW BY THIRD-PARTY PAYORS THE PROVISION FOR BAD DEBT IS BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS, CONSIDERING HISTORICAL BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN HEALTH CARE COVERAGE, AND OTHER COLLECTION INDICATORS MANAGEMENT PERIODICALLY ASSESSES THE ADEQUACY OF THE ALLOWANCES FOR UNCOLLECTIBLE ACCOUNTS BASED UPON HISTORICAL WRITE-OFF EXPERIENCE THE RESULTS OF THESE REVIEWS ARE USED TO MODIFY AS NECESSARY THE PROVISIONS FOR BAD DEBT AND TO ESTABLISH APPROPRIATE ALLOWANCES FOR UNCOLLECTIBLE NET PATIENT ACCOUNTS RECEIVABLE SIGNIFICANT PROVISION IS MADE FOR SELF-PAY PATIENT ACCOUNTS RECEIVABLE IN THE PERIOD OF SERVICE BASED UPON HISTORICAL WRITE-OFF EXPERIENCE AFTER SATISFACTION OF AMOUNTS DUE FROM INSURANCE, TRIHEALTH FOLLOWS ESTABLISHED GUIDELINES FOR PLACING CERTAIN PATIENT BALANCES WITH COLLECTION AGENCIES, SUBJECT TO THE TERMS OF CERTAIN RESTRICTIONS ON COLLECTION EFFORTS AS DETERMINED BY TRIHEALTH THERE HAVE BEEN NO SIGNIFICANT CHANGES IN THE CURRENT YEAR TO THE UNDERLYING ASSUMPTIONS USED BY TRIHEALTH TO ESTIMATE THE ALLOWANCE FOR UNCOLLECTIBLE ACCOOUNTS FINANCIAL INSTRUMENTS THAT POTENTIALLY SUBJECT TRIHEALTH TO CONCENTRATIONS OF CREDIT RISK CONSIST PRIMARILY OF NONGOVERNMENTAL PATIENT ACCOUNTS RECEIVABLE TRIHEALTH GRANTS CREDIT WITHOUT COLLATERAL TO ITS PATIENTS, MOST OF WHOM ARE INSURED UNDER THIRD-PARTY PAYOR AGREEMENTS THE PERCENTAGES OF GROSS PATIENT ACCOUNTS RECEIVABLE FROM PATIENTS AND THIRD-PARTY PAYORS AT JUNE 30 APPROXIMATED THE FOLLOWING 2018 - MEDICARE 12%, MEDICAID 1%, MANAGED CARE 26%, SELF PAY 24%, COMMERCIAL AND OTHER 37% 2017 - MEDICARE 14%, MEDICAID 2%, MANAGED CARE 28%, SELF PAY 20%, COMMERCIAL AND OTHER 36% TRIHEALTH HAS AGREEMENTS WITH THIRD-PARTY PAYORS THAT PROVIDE FOR PAYMENTS AT AMOUNTS DIFFERENT FROM ITS ESTABLISHED RATES THE BASIS FOR PAYMENT UNDER THESE AGREEMENTS INCLUDES PROSPECTIVELY DETERMINED RATES, COST REIMBURSEMENT, NEGOTIATED DISCOUNTS FROM ESTABLISHED RATES, AND PER DIEM PAYMENTS PATIENT SERVICE REVENUE IS REPORTED AT THE ESTIMATED NET REALIZABLE AMOUNTS FROM PATIENTS, THIRD-PARTY PAYORS AND OTHERS FOR SERVICES RENDERED, INCLUDING ESTIMATED RETROACTIVE ADJUSTMENTS DUE TO FUTURE AUDITS, REVIEW AND INVESTIGATIONS THE DIFFERENCES BETWEEN THE ESTIMATED AND ACTUAL ADJUSTMENTS ARE RECORDED AS PART OF NET PATIENT SERVICE REVENUE IN FUTURE PERIODS, AS THE AMOUNTS BECOME KNOWN, OR AS YEARS ARE NO LONGER SUBJECT TO SUCH AUDITS, REVIEWS AND INVESTIGATIONS TRIHEALTH RECOGNIZES A SIGNIFICANT AMOUNT OF PATIENT SERVICE REVENUE AT THE TIME THE SERVICES ARE RENDERED EVEN THOUGH IT DOES NOT ASSESS THE PATIENT'S ABILITY TO PAY AS A RESULT, THE PROVISION FOR BAD DEBT IS PRESENTED AS A DEDUCTION FROM PATIENT SERVICE REVENUE NET OF CONTRACTUAL PROVISIONS AND DISCOUNTS AS FOR THE AMOUNT OF BAD DEBT THAT REASONABLY COULD BE ATTRIBUTABLE TO PATIENTS WHO LIKELY WOULD QUALIFY FOR FINANCIAL ASSISTANCE UNDER THE ORGANIZATION'S CHARITY CARE POLICY, THE GOOD SAMRITAN HOSPITAL OF CINCINNATI DOES NOT REPORT ACTUAL BAD DEBT EXPENSE AS COMMUNITY BENEFIT IF UPON FURTHER RESEARCH, IT IS ULTIMATELY DETERMINED THAT A PORTION OF BAD DEBT EXPENSE IS ATTRIBUTABLE TO PATIENTS WHO WOULD LIKELY QUALIFY FOR FINANCIAL ASSISTANCE UNDER TRIHEALTH'S CHARITY CARE POLICY, THOSE COSTS WOULD BE RECLASSIFIED, AS APPROPRIATE, TO COMMUNITY BENEFIT AT THAT TIME PLEASE NOTE THAT BAD DEBT EXPENSE IS NOT DETERMINED UNTIL AFTER ALL DISCOUNTS AND ANY ASSOCIATED PAYMENTS ARE TAKEN INTO ACCOUNT IF ANY PAYMENTS ARE RECEIVED AFTER A PATIENT ACCOUNT IS DETERMINED TO BE BAD DEBT, THE ACCOUNT WILL BE ADJUSTED ACCORDINGLY AT THAT TIME</p>

990 Schedule H, Supplemental Information

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

990 Schedule H, Supplemental Information

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

Form and Line Reference	Explanation
PART VI, LINE 2	<p>IN 1852, THE SISTERS OF CHARITY ESTABLISHED GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO ("GSH") IN AN EFFORT TO ADDRESS THE NEEDS OF THE GROWING CITY OF CINCINNATI. IN 1995, GSH & BETHESDA HOSPITAL, INC ("BETHESDA") FORMED A PARTNERSHIP TO CREATE A LOCAL HEALTH SYSTEM TRIHEALTH, INC ("TRIHEALTH"). TRIHEALTH'S MISSION IS TO IMPROVE THE HEALTH STATUS OF THE COMMUNITY THROUGH A FULL RANGE OF HEALTH RELATED SERVICES (E.G. PREVENTION, WELLNESS & EDUCATION) THE SERVICES DESCRIBED BELOW, & OTHERS NOT LISTED, PROMOTE A HEALTHY COMMUNITY AND SEEK TO REDUCE THE BURDENS ON THE GOVERNMENT. FOR EXAMPLE, IF GSH DID NOT ADDRESS THE ROOT CAUSES OF LOW BIRTH WEIGHT & PREMATUREITY, THE BURDEN TO GOVERNMENT MEDICAL PROGRAMS SUCH AS MEDICAID WOULD BE EVEN GREATER. GSH, AS PART OF TRIHEALTH, PARTICIPATED IN AND WAS A FINDER OF THE WORK OF A COLLABORATIVE, REGIONAL EFFORT, THE A I M FOR BETTER HEALTH COMMUNITY HEALTH NEEDS ASSESSMENT (A I M) IN THE AREAS ASSESSED THE POPULATIONS SURVEYED WERE MORE OFTEN UNDERSERVED, INCLUDING THE UNINSURED, UNDERINSURED, LOW SOCIOECONOMIC STATUS, MINORITIES, AND OVER AGE SIXTY-FIVE, OR WITH A DIAGNOSIS OF MENTAL ILLNESS. THE A I M, PUBLISHED IN THE SPRING OF 2012, WAS THE BASIS FOR THE DEVELOPMENT OF GSH' COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION PLAN THAT WAS APPROVED DURING FISCAL YEAR 2013. FREE & DISCOUNTED SERVICES ARE PROVIDED FOR THOSE UNABLE TO PAY & MEETING ELIGIBILITY CRITERIA THROUGH THE HOSPITAL CARE ASSURANCE PROGRAM (HCAP), GSH SERVES PATIENTS MEETING CRITERIA SET FORTH BY THE STATE OF OHIO. GSH POLICY IS TO PROVIDE CHARITY CARE ON A SLIDING SCALE DISCOUNTING WHEN THE FAMILY INCOME IS UP TO 400% OF THE ANNUALLY ESTABLISHED FEDERAL POVERTY GUIDELINE. IT OFFERS AN UNINSURED DISCOUNT FOR MEDICALLY NECESSARY SERVICES FOR THOSE WHO HAVE NO INSURANCE & WHO DO NOT QUALIFY FOR OTHER FINANCIAL ASSISTANCE OPTIONS. FINANCIAL COUNSELORS ASSIST PATIENTS IN COMPLETING THE FINANCIAL ASSISTANCE APPLICATION WHICH IS AVAILABLE ON TRIHEALTH'S WEBSITE & BROCHURES ABOUT FINANCIAL ASSISTANCE ARE VISIBLE & AVAILABLE IN HOSPITAL REGISTRATION & ADMITTING AREAS. GSH FUNDS THE TRIHEALTH OUTREACH MINISTRIES & COMMUNITY HEALTH WORKER PROGRAMS. THESE PROGRAMS PROVIDE, AT NO CHARGE, HOME VISITS TO LOW INCOME CLIENTS IN 9 NEIGHBORHOODS. CLIENTS INCLUDE SENIORS & FRAIL ELDERLY IN THEIR HOMES OR IN CONGREGATE SUBSIDIZED HOUSING, THE MENTALLY & PHYSICALLY HANDICAPPED LIVING ALONE OR IN GROUP HOMES, & MOTHERS WHO ARE PREGNANT OR WHO HAVE RECENTLY DELIVERED A BABY. REFERRALS COME FROM HOSPITAL CARE COORDINATORS, OTHER HOSPITALS & AGENCIES. THE TEAM PROVIDES HEALTH SCREENINGS, EDUCATION ON MANAGING CHRONIC ILLNESSES, & CONNECTIONS TO ASSISTANCE. HEALTHY WOMEN HEALTHY LIVES IS A PROGRAM BASED ON THE PREMISE THAT PREVENTION, EARLY DETECTION, TREATMENT & ACCESS TO HEALTH CARE SERVICES IMPROVE INDIVIDUAL & COMMUNITY HEALTH OUTCOMES. THE FOCUS IS ON HEALTH RISKS ASSOCIATED WITH THE ONSET OF MENOPAUSE. WELL ORGANIZED SCREENING & EDUCATION EVENTS BRING THE SERVICES TO AT RISK POPULATIONS OF AFRICAN AMERICAN, APPALACHIAN, HISPANIC, UNINSURED & UNDERINSURED WOMEN FORTY YEARS OF AGE OR OLDER. SCREENING INCLUDES OSTEOPOROSIS, MAMMOGRAPHY, CHOLESTEROL, HYPERTENSION, & OBESITY. EVERY WOMAN RECEIVES A NURSE CONSULTATION, A COPY OF THEIR RESULTS & A WRITTEN PRIMARY CARE REFERRAL. WOMEN WITH ABNORMAL RESULTS ARE CONTACTED & ASSISTED IN ACCESSING PRIMARY CARE. THIS PROGRAM SERVES AS AN ENTRY POINT TO HEALTH CARE SERVICES FOR MANY WOMEN IN THE COMMUNITY. HAMILTON COUNTY'S INFANT MORTALITY RATE IS THE HIGHEST IN OHIO AND HAS LED GSH TO FOCUS ON MATERNAL & INFANT HEALTH PROGRAMS. STRATEGIES INCLUDE INVESTIGATING THE ROOT CAUSES OF PREMATUREITY & LOW BIRTH WEIGHT. IN RESPONSE, GSH PROVIDES AND SUPPORTS A DIVERSITY OF PROGRAMS OF PERINATAL CARE FOR AT RISK MOTHERS. PERINATAL CARE COORDINATION NURSES & SOCIAL WORKERS FROM GSH ASSIST MOTHERS IN THE GSH FACILITY MEDICAL CENTER AND TRIHEALTH MIDWIVES LOCATIONS. THEY ALSO TRAVEL TO OUTSIDE CLINICS IN ORDER TO REACH OUT & HELP UNINSURED & UNDERINSURED MOTHERS ACCESS PUBLIC PROGRAMS, REFERRALS, EDUCATION, ASSESSMENT & RESOURCES. THE B4 (BEFORE, BETWEEN, AND BEYOND PREGNANCY FOR YOUR BABY AND YOU) IS A PREMATUREITY PREVENTION PROGRAM THAT PROVIDES INTERCONCEPTION HEALTH EDUCATION, TARGETED CASE MANAGEMENT, AND SUPPORT TO MOTHERS WHOSE INFANTS ARE BORN AT LESS THAN 32 COMPLETED WEEKS OF GESTATION AND RECEIVE CARE IN GSH'S NICU. THE GOAL OF THE PROGRAM IS TO PROMOTE A CONTINUUM OF WELLNESS CARE FOR WOMEN IN ORDER TO IMPROVE THEIR OWN HEALTH AND REDUCE THEIR RISK FOR RECURRING POOR BIRTH OUTCOMES, INCLUDING PREMATUREITY AND NEONATAL MORTALITY. ALSO, IN COLLABORATION WITH WINTON HILLS HEALTH CENTER, GSH FUNDS THE SALARIES OF AN OB/GYN PHYSICIAN AND A NURSE MIDWIFE AT THE CENTER AND ITS SATELLITE EXTENSION. THIS AFFORDS HEALTH CARE ACCESS TO WOMEN IN THE AREA SURROUNDING THE CENTER. GSH CONTINUES A COMMITMENT TO EDUCATING THE NEXT GENERATION OF HEALTH CARE PROVIDERS, PHYSICIANS & ALLIED HEALTH PRO.</p>

Form and Line Reference	Explanation
PART VI, LINE 2	<p>PROFESSIONALS GSH, AS PART OF TRIHEALTH, INC , SPONSORS MEDICAL RESIDENCIES THERE WERE 26 RESIDENTS IN INTERNAL MEDICINE & 21 GENERAL SURGERY RESIDENTS AT GSH 5 RESIDENTS/FELLOWS IN VASCULAR SURGERY RECEIVED EXTENDED LEARNING & PREPARATION AT GSH 32 TOTAL RESIDENTS IN OBSTETRICS & GYNECOLOGY LEARNED IN A JOINT RESIDENCY AT BOTH BETHESDA & GSH IN THE GSH FACULTY MEDICAL CENTER ("FMC"), A MULTI-SPECIALTY CENTER, MEDICAL RESIDENTS PROVIDE CARE TO PATIENTS UNDER THE GUIDANCE OF ATTENDING PHYSICIANS FMC SERVICES INCLUDE OBSTETRICS & GYNECOLOGY, INTERNAL MEDICINE, VASCULAR & GENERAL SURGERY, DYSPLASIA, HIGH-RISK PREGNANCY, URO-GYNECOLOGY & GASTRO-INTESTINAL THE FMC PHARMACIST HELPS ELIGIBLE CLIENTS COMPLETE THE MEDICATION ASSISTANCE PROGRAMS APPLICATIONS THE GSH ON-SITE PHARMACY PROVIDES PRESCRIPTIONS FOR THOSE IN NEED, AT REDUCED OR NO COST GSH FUNDS THE SALARIES OF STAFF SUPPORTING THE CLIENTS AND PHYSICIANS OF THE FACULTY MEDICAL CENTER THIS STAFF INCLUDES CARE COORDINATORS, SOCIAL WORKERS, DIETITIANS, PHARMACISTS, AND FINANCIAL COUNSELORS GSH COLLABORATES WITH LOCAL & REGIONAL COLLEGES, UNIVERSITIES & TRAINING CENTERS TO PROVIDE MENTORING, INTERNSHIPS, CLERKSHIPS, SUPERVISED EDUCATION & CLINICAL ROTATIONS TO STUDENTS IN HEALTH FIELDS THESE PARTNERSHIPS HELP STUDENTS LEARN ABOUT & PREPARE FOR PROFESSIONS IN NURSE PRACTITIONER, RESPIRATORY THERAPY, RADIOLOGY TECHNOLOGY, STERILE PROCESSING, PHLEBOTOMY, MEDICAL LABORATORY, CLINICAL DIETETICS, PHARMACY, SPEECH, AUDIOLOGY, PHYSICAL THERAPY, OCCUPATIONAL THERAPY, NURSE MIDWIFERY, & NEONATAL NURSE PRACTITIONER PASTORAL CARE OFFERS A CLINICAL PASTORAL EDUCATION PROGRAM EDUCATING CLERGY & OTHERS IN PASTORAL SKILLS TO MINISTER EFFECTIVELY TO THE SICK & THE DYING GSH'S RESEARCH PROGRAM MANAGES BASIC & APPLIED SCIENTIFIC STUDIES & SPONSORED CLINICAL TRIALS IT ALSO SUPPORTS THE EDUCATION ACTIVITIES OF STAFF PHYSICIANS & SURGEONS, TEACHING FACULTY, RESIDENTS, & ALLIED HEALTH PROFESSIONALS WHAT IS LEARNED THROUGH THE RESEARCH & EDUCATION PROGRAMS IS SHARED WITH THE LARGER COMMUNITY THE RESEARCH PROGRAM HELPS RESEARCHERS GIVE PROFESSIONAL PRESENTATIONS AT REGIONAL & NATIONAL MEETINGS AS HAVE STUDIES & ARTICLES PUBLISHED IN PEER-REVIEWED MEDICAL JOURNALS THROUGH THESE PROGRAMS, GSH CONTINUES ITS SPECIAL CONCERN FOR THE VULNERABLE EMPLOYEES, PHYSICIANS & LEADERS PROVIDING & GUIDING THESE PROGRAMS FOR COMMUNITY HEALTH ARE LIVING THE CORE VALUES OF STEWARDSHIP & RESPONSE TO COMMUNITY NEEDS</p>

990 Schedule H, Supplemental Information

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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 4	LOCATED IN CINCINNATI, OHIO, GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO AND THE TRIHEALTH SYSTEM SERVE HAMILTON, BUTLER, WARREN AND CLERMONT COUNTIES, AS WELL AS PERSONS FROM INDIANA AND KENTUCKY OHIO'S THIRD LARGEST CITY, CINCINNATI HAS AN ESTIMATED POPULATION OF 300,000 THE POPULATION WITHIN THE FOUR OHIO COUNTIES SERVED BY TRIHEALTH IS ESTIMATED TO BE 1,600,000 THE GEOGRAPHIC AREA SERVED BY THE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO IS PREDOMINANTLY URBAN WITH A LARGE SEGMENT OF ITS PATIENTS UNINSURED, UNDERINSURED OR MEDICAID RECIPIENTS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 5	THE ONGOING PURPOSE OF THE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO ("GSH") IS TO PROVIDE CARE WITH COMPASSION ITS MISSION IS TO IMPROVE THE HEALTH STATUS OF THE COMMUNITY THROUGH HEALTH RELATED SERVICES--PREVENTION, WELLNESS AND EDUCATION ITS BOARD OF DIRECTORS IS COMPRISED OF INDEPENDENT COMMUNITY REPRESENTATIVES GSH IS AN ACUTE TERTIARY TEACHING HOSPITAL AS PART OF TRIHEALTH A SYSTEM OF SERVICES SPANNING ACUTE CARE TO HOME CARE, BABIES TO SENIORS IT PROVIDES A 24-HOUR EMERGENCY ROOM, FOUR INTENSIVE CARE UNITS FOR NEONATES AND ADULTS, ADULT AND GERIATRIC INPATIENT PSYCHIATRIC CARE, AND AN ACCREDITED REHABILITATION MEDICINE PROGRAM SERVICES ARE OPEN TO ALL INDIVIDUALS REGARDLESS OF ABILITY TO PAY GSH HAS AN OPEN MEDICAL STAFF AND A HISTORY OF TRAINING AND EDUCATING MEDICAL RESIDENTS AND HEALTH CARE PROFESSIONALS ITS MEDICAL AND SCIENTIFIC RESEARCH PROGRAMS INCLUDE STUDIES THAT ARE NOT COMMERCIALY SPONSORED GSH PARTICIPATES IN MEDICARE AND MEDICAID AND OTHER GOVERNMENT-SPONSORED HEALTH CARE PROGRAMS, AND HAS AN ACTIVE CHARITY CARE PROGRAM SEE RESPONSE TO PART VI, LINE 2 FOR ADDITIONAL INFORMATION

990 Schedule H, Supplemental Information

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

Schedule H (Form 990) 2017

Additional Data**Software ID:****Software Version:****EIN:** 31-0537486**Name:** THE GOOD SAMARITAN HOSPITAL OF
CINCINNATI OHIO**Form 990 Schedule H, Part V Section A. Hospital Facilities**

Section A. Hospital Facilities		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (Describe)	Facility reporting group
(list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? <u>1</u>											
Name, address, primary website address, and state license number											
1	GOOD SAMARITAN HOSPITAL 375 DIXMYTH AVENUE CINCINNATI, OH 45220 WWW.TRIHEALTH.COM 1191	X	X		X		X	X			

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

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

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

Form and Line Reference	Explanation
GOOD SAMARITAN HOSPITAL	<p>BINATION OF THESE METHODS PROVIDED A WIDE-RANGE OF DATA COLLECTION OPPORTUNITIES ON WHICH THE CHNA COULD BE BASED CHNA COMMUNITY FOCUS GROUPS A TOTAL OF 156 INDIVIDUALS ATTENDED T HE 11 FOCUS GROUPS, 134 OF THE ATTENDEES REPRESENTED AN ORGANIZATION THE ORGANIZATIONS RE PRESENTED BY THESE ATTENDEES SERVE THE FOLLOWING POPULATIONS CHILDREN, ELDERLY, HOMELESS, LOW-INCOME, MEDICALLY UNDERSERVED, MINORITY, PEOPLE WITH MENTAL ILLNESS, AND VICTIMS OF D OMESTIC VIOLENCE FIFTEEN INDIVIDUALS, ALL REPRESENTING ORGANIZATIONS, ATTENDED THE BUTLER COUNTY FOCUS GROUP ON JULY 30, 2015 THREE INDIVIDUALS ATTENDED THE CLERMONT COUNTY FOCUS GROUP ON JULY 28, 2015 APPROXIMATELY 50 INDIVIDUALS ATTENDED MEETINGS ON BEHALF OF HAMIL TON COUNTY, THE MAJORITY REPRESENTED AN ORGANIZATION ON JULY 7, 2015, SIX INDIVIDUALS ATT ENDED THE WARREN COUNTY FOCUS GROUP AND REPRESENTED PREMIER HEALTH ATRIUM MEDICAL CENTER AND PREVENTIONFIRST OR CAME ON THEIR OWN BEHALF CHNA SURVEY IN AGGREGATE, 329 INDIVIDUAL S, 55 AGENCY REPRESENTATIVES, 52 LATINOS, AND 24 HEALTH DEPARTMENT REPRESENTATIVES COMPLET ED THE CHNA SURVEY THE CHNA TEAM, CHNA COMMITTEE, AND PARTNERS HELPED DISTRIBUTE THE SURV EY AT COMMUNITY MEETINGS, A HANDOUT PROVIDED THE SURVEY LINK, AND THE LINKS WERE WRITTEN ON AN EASEL PAD AT THE FRONT OF THE ROOM THROUGHOUT THE REGION, 381 INDIVIDUAL SURVEYS AN D 55 AGENCY SURVEYS WERE COMPLETED, INCLUDING RESPONSES FROM AGENCIES SUCH AS BUTLER COUNT Y UNITED WAY, CLERMONT COUNTY MENTAL HEALTH & RECOVERY BOARD, AND THE YMCA OF GREATER CINC INNATI IN BUTLER, CLERMONT, HAMILTON, AND WARREN COUNTIES, RESPONDENTS INCLUDED CONTACTS FROM LOCAL HEALTH DEPARTMENTS THE BUTLER COUNTY HEALTH DEPARTMENT, CITY OF HAMILTON HEALT H DEPARTMENT, THE MIDDLETOWN CITY HEALTH DISTRICT, THE CLERMONT COUNTY GENERAL HEALTH DIST RICT, HAMILTON COUNTY PUBLIC HEALTH, NORWOOD CITY HEALTH DISTRICT, SPRINGDALE CITY HEALTH DISTRICT, AND WARREN COUNTY COMBINED HEALTH DISTRICT OTHER ORGANIZATIONS THAT COMPLETED T HE SURVEY INCLUDED GOOD SAMARITAN FREE HEALTH CENTER, AND THE GREATER CINCINNATI FOUNDATIO N, ETC</p>

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

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 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
GOOD SAMARITAN HOSPITAL	PART V, SECTION B, LINE 6A ADAMS COUNTY REGIONAL MEDICAL CENTER, ATRIUM MEDICAL CENTER, DEARBORN COUNTY HOSPITAL, LINDNER CENTER OF HOPE, MARGARET MARY COMMUNITY HOSPITAL, MCCULLOUGH-HYDE MEMORIAL HOSPITAL, MERCY HEALTH, UC HEALTH, BETHESDA NORTH HOSPITAL, BETHESDA BUTLER COUNTY, THE CHRIST HOSPITAL, CINCINNATI CHILDREN'S HOSPITAL MEDICAL CENTER

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

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 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
GOOD SAMARITAN HOSPITAL	PART V, SECTION B, LINE 6B HEALTH COLLABORATIVE, CITY OF CINCINNATI HEALTH DEPARTMENT, HAMILTON COUNTY PUBLIC HEALTH, INTERACT FOR HEALTH, XAVIER UNIVERSITY DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

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

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

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

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 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
GOOD SAMARITAN HOSPITAL	PART V, SECTION B, LINE 13B SEE PART VI RESPONSE TO PART I, LINE 3C

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

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

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

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

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

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

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

Name and address	Type of Facility (describe)
1 1 - GOOD SAMARITAN MEDICAL CENTER 6949 GOOD SAMARITAN DRIVE CINCINNATI, OH 45247	EMERGENCY DEPARTMENT/OUTPATIENT SERVICES
1 2 - GOOD SAMARITAN PHYSICAL THERAPY 8748 UNION CENTRE DRIVE WEST CHESTER, OH 45069	PHYSICAL THERAPY
2 3 - GOOD SAMARITAN HOSPITAL OUTPATIENT CTR 6350 GLENWAY AVENUE CINCINNATI, OH 45211	OUTPATIENT PHYSICIAN CLINIC
3 4 - GOOD SAMARITAN HOSPITAL WEIGHT MGMT CTR 3219 CLIFTON AVENUE SUITE 225 CINCINNATI, OH 45220	WEIGHT MANAGEMENT SERVICES
4 5 - GOOD SAMARITAN HOSPITAL WOMEN'S CENTER 3219 CLIFTON AVENUE SUITE 100 CINCINNATI, OH 45220	WOMEN'S HEALTH SERVICES
5 6 - TRIHEALTH OUTPATIENT CENTER 7777 BEECHMONT AVE CINCINNATI, OH 45255	OUTPATIENT PHYSICIAN/PATIENT SERVICES
6 7 - TRIHEALTH INFUSION CENTER - WESTSIDE 5520 CHEVIOT RD SUITE A CINCINNATI, OH 45247	INFUSION CENTER
7 8 - TRIHEALTH INFUSION CENTER - NORTH 10550 MONTGOMERY RD STE 22 CINCINNATI, OH 45242	INFUSION CENTER/RADIATION THERAPY
8 9 - TRIHEALTH SLEEP MEDICINE 6350 GLENWAY AVENUE CINCINNATI, OH 45211	SLEEP MEDICINE
9 10 - GOOD SAMARITAN HOSPITAL WEIGHT MGMT CTR 6200 PFEIFFER ROAD CINCINNATI, OH 45242	WEIGHT MANAGEMENT SERVICES
10 11 - GOOD SAMARITAN ALCOHOL & DRUG TREATMENT 3219 CLIFTON AVENUE SUITE 305 CINCINNATI, OH 45220	OUTPATIENT ALCOHOL & DRUG TREATMENT

**Schedule I
(Form 990)**

Department of the Treasury
Internal Revenue Service

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

Complete if the organization answered "Yes," on Form 990, Part IV, line 21 or 22.
▶ Attach to Form 990.
▶ Information about Schedule I (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
THE GOOD SAMARITAN HOSPITAL OF CINCINNATI OHIO

Employer identification number
31-0537486

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 ▶ _____ 24

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

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

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

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

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

Additional Data

Software ID:
Software Version:
EIN: 31-0537486
Name: THE GOOD SAMARITAN HOSPITAL OF
CINCINNATI OHIO

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
GOOD SAMARITAN HOSPITAL FOUNDATION OF CINCINNATI INC 375 DIXMYTH AVE CINCINNATI, OH 45220	31-1206047	501(C)(3)	1,382,086				GENERAL PURPOSES
BETHESDA INC 625 EDEN PARK DRIVE CINCINNATI, OH 45202	31-1108895	501(C)(3)	718,359				GENERAL PURPOSES

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
UPTOWN CONSORTIUM INC 629 OAK STREET SUITE 306 CINCINNATI, OH 45206	20-0688727	501(C)(3)	169,645				GENERAL PURPOSES
AMERICAN HEART ASSOCIATION 5211 MADISON ROAD CINCINNATI, OH 45227	13-5613797	501(C)(3)	102,500				SPONSORSHIP

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
THE CENTER FOR CLOSING THE HEALTH GAP IN GREATER CINCINNATI 3120 BURNET AVE ROOM 201 CINCINNATI, OH 45229	20-0902286	501(C)(3)	100,000				GENERAL PURPOSES
UNITED WAY OF GREATER CINCINNATI 2400 READING ROAD CINCINNATI, OH 45202	31-0537502	501(C)(3)	60,359				GENERAL SUPPORT

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
HEALTHY MOMS & BABES INC 2270 BANNING ROAD NO 200 CINCINNATI, OH 45239	31-1155292	501(C)(3)	50,350				GENERAL SUPPORT
HEALTHY BEGINNINGS INC 47 E HOLLISTER CINCINNATI, OH 45219	31-1380939	501(C)(3)	40,000				GENERAL SUPPORT

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
GOOD SAMARITAN HOSPITAL FOUNDATION OF CINCINNATI INC 375 DIXMYTH AVE CINCINNATI, OH 45220	31-1206047	501(C)(3)	40,000				GENERAL SUPPORT
AMERICAN CANCER SOCIETY INC 250 WILLIAMS STREET NW SUITE 400 ATLANTA, GA 30303	13-1788491	501(C)(3)	26,375				SPONSORSHIP

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
UNITED SERVICE ORGANIZATIONS OF CENTRAL AND SOUTHERN OHIO INC 4200 HOOVER RD GROVE CITY, OH 43123	31-4401239	501(C)(3)	25,500				SPONSORSHIP
FRIARS CLUB INC 2316 HARRYWOOD COURT CINCINNATI, OH 45239	31-0537485	501(C)(3)	16,000				GENERAL SUPPORT

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
THE KAREN WELLINGTON MEMORIAL FOUNDATION FOR LIVING WITH BREAST CANCER 312 WALNUT ST NO 1800 CINCINNATI, OH 45202	26-3768567	501(C)(3)	14,000				SPONSORSHIP
THE MATT HAVERKAMP FOUNDATION 5870 DAY RD CINCINNATI, OH 45252	20-4155820	501(C)(3)	13,942				GENERAL SUPPORT

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
FREESTORE FOODBANK INC 1141 CENTRAL PARKWAY CINCINNATI, OH 45202	23-7122205	501(C)(3)	13,049				SPONSORSHIP & HURRICANE RELIEF
OVARIAN CANCER ALLIANCE OF GREATER CINCINNATI 4918 COOPER ROAD CINCINNATI, OH 45242	31-1287785	501(C)(3)	10,000				SPONSORSHIP

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CRAYONS TO COMPUTERS 1350 TENNESSEE AVE CINCINNATI, OH 45229	31-1507076	501(C)(3)	10,000				GENERAL SUPPORT
GAMEPLAN 09 LLC PO BOX 15025 CINCINNATI, OH 45215	27-0776556	501(C)(3)	10,000				SPONSORSHIP

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CLIFTON COOPERATIVE MARKET 319 LUDLOW AVE CINCINNATI, OH 45220	38-3925491		10,000				SPONSORSHIP
JDRF SOUTHWEST OHIO CHAPTER 8050 HOSBROOK RD SUITE 314 CINCINNATI, OH 45236	23-1907729	501(C)(3)	7,500				SPONSORSHIP

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
AMERICAN RED CROSS 431 18TH STREET NW WASHINGTON, DC 200065009	53-0196605	501(C)(3)	7,500				HURRICANE IRMA RELIEF
MATTHEW 25 MINISTRIES INC 11060 KENWOOD RD CINCINNATI, OH 45242	31-1348100	501(C)(3)	7,500				HURRICANE RELIEF

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
EASTER SEALS TRISTATE 2901 GILBERT AVE CINCINNATI, OH 45206	31-0873433	501(C)(3)	7,500				SPONSORSHIP
SWEET CHEEKS DIAPER BANK 1615 REPUBLIC STREET CINCINNATI, OH 45202	47-5175383	501(C)(3)	7,500				SPONSORSHIP

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
XAVIER UNIVERSITY 3800 VICTORY PARKWAY CINCINNATI, OH 452074531	31-0537516	501(C)(3)	5,060				SPONSORSHIP

Schedule J
(Form 990)

Compensation Information

OMB No 1545-0047

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

2017

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
THE GOOD SAMARITAN HOSPITAL OF
CINCINNATI OHIO

Employer identification number
31-0537486

Part I Questions Regarding Compensation

	Yes	No								
<p>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.</p> <table border="0"> <tr> <td><input type="checkbox"/> First-class or charter travel</td> <td><input type="checkbox"/> Housing allowance or residence for personal use</td> </tr> <tr> <td><input type="checkbox"/> Travel for companions</td> <td><input type="checkbox"/> Payments for business use of personal residence</td> </tr> <tr> <td><input type="checkbox"/> Tax indemnification and gross-up payments</td> <td><input type="checkbox"/> Health or social club dues or initiation fees</td> </tr> <tr> <td><input type="checkbox"/> Discretionary spending account</td> <td><input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)</td> </tr> </table>	<input type="checkbox"/> First-class or charter travel	<input type="checkbox"/> Housing allowance or residence for personal use	<input 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)		
<input type="checkbox"/> First-class or charter travel	<input type="checkbox"/> Housing allowance or residence for personal use									
<input 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)									
<p>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.</p>	1b									
<p>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?</p>	2									
<p>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.</p> <table border="0"> <tr> <td><input type="checkbox"/> Compensation committee</td> <td><input type="checkbox"/> Written employment contract</td> </tr> <tr> <td><input type="checkbox"/> Independent compensation consultant</td> <td><input type="checkbox"/> Compensation survey or study</td> </tr> <tr> <td><input type="checkbox"/> Form 990 of other organizations</td> <td><input type="checkbox"/> Approval by the board or compensation committee</td> </tr> </table>	<input type="checkbox"/> Compensation committee	<input type="checkbox"/> Written employment contract	<input type="checkbox"/> Independent compensation consultant	<input type="checkbox"/> Compensation survey or study	<input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Approval by the board or compensation committee				
<input type="checkbox"/> Compensation committee	<input type="checkbox"/> Written employment contract									
<input type="checkbox"/> Independent compensation consultant	<input type="checkbox"/> Compensation survey or study									
<input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Approval by the board or compensation committee									
<p>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:</p> <p>a Receive a severance payment or change-of-control payment?</p> <p>b Participate in, or receive payment from, a supplemental nonqualified retirement plan?</p> <p>c Participate in, or receive payment from, an equity-based compensation arrangement?</p> <p>If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.</p>	4a	Yes								
	4b	Yes								
	4c	No								
<p>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</p> <p>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:</p> <p>a The organization?</p> <p>b Any related organization?</p> <p>If "Yes," on line 5a or 5b, describe in Part III.</p>	5a	No								
	5b	No								
<p>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:</p> <p>a The organization?</p> <p>b Any related organization?</p> <p>If "Yes," on line 6a or 6b, describe in Part III.</p>	6a	No								
	6b	No								
<p>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.</p>	7	Yes								
<p>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.</p>	8	No								
<p>9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?</p>	9									

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

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

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

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

Part III Supplemental Information

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

Return Reference	Explanation
PART I, LINES 4A-B	ELIGIBLE EXECUTIVES (GENERALLY VICE PRESIDENTS AND ABOVE) PARTICIPATE IN A PROGRAM THAT PROVIDES FOR SUPPLEMENTAL RETIREMENT BENEFITS. THE PAYMENT OF BENEFITS UNDER THE PROGRAM, IF ANY, IS ENTIRELY DEPENDENT UPON THE FACTS AND CIRCUMSTANCES UNDER WHICH THE EXECUTIVE TERMINATES EMPLOYMENT WITH THE ORGANIZATION. BENEFITS UNDER THE PROGRAM ARE UNFUNDED AND NON-VESTED. DUE TO THE SUBSTANTIAL RISK OF FORFEITURE PROVISION, THERE IS NO GUARANTEE THAT THESE EXECUTIVES WILL EVER RECEIVE ANY BENEFIT UNDER THE PROGRAM. ANY AMOUNT ULTIMATELY PAID UNDER THE PROGRAM TO THE EXECUTIVE IS REPORTED AS COMPENSATION ON FORM 990, SCHEDULE J, PART II, COLUMN B IN THE YEAR PAID. THE FOLLOWING INDIVIDUALS LISTED IN SCHEDULE J, PART II, RECEIVED A PAYMENT FROM A SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN WHICH WAS TREATED AS TAXABLE COMPENSATION BY THEIR RESPECTIVE EMPLOYERS: JOHN PROUT - \$12,304 WILLIAM GRONEMAN - \$31,401
PART I, LINE 7	A PHYSICIAN HAS A BASE SALARY BUT IS ALSO ELIGIBLE FOR A BONUS. THE BONUS IS CONTINGENT ON THE PROFITABILITY OF HIS OR HER PRACTICE. ESSENTIALLY, THE PROFITABILITY OF HIS OR HER PRACTICE GETS PAID TO THE PHYSICIAN AS A BONUS UP TO A MAXIMUM OF \$100,000.
PART I, LINE 3	TRIHEALTH, INC., A RELATED ORGANIZATION OF THE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO, WHO PAID THE INDIVIDUAL, USES THE FOLLOWING TO ESTABLISH THE COMPENSATION OF THE FILING ORGANIZATION'S CEO/EXECUTIVE DIRECTOR: * COMPENSATION COMMITTEE, * INDEPENDENT COMPENSATION CONSULTANT, * COMPENSATION SURVEY OR STUDY, AND * APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE.
PART I, LINE 4A	THE REPORTABLE INDIVIDUALS OF THE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO ARE PAID BY TRIHEALTH, INC., A RELATED ORGANIZATION, RECOGNIZED BY THE INTERNAL REVENUE SERVICE AS EXEMPT FROM FEDERAL INCOME TAX UNDER INTERNAL REVENUE CODE SECTION 501(A) AS AN ORGANIZATION DESCRIBED IN INTERNAL REVENUE CODE SECTION 501(C)(3). TRIHEALTH, INC. HAS A STANDARD EMPLOYEE SEVERANCE PACKAGE. GENERAL SEVERANCE PAY IS BASED ON LENGTH OF SERVICE. IN ADDITION, NOTICE PAY, IF APPLICABLE UNDER TRIHEALTH, INC. POLICY, MAY BE ADDED TO THE SEVERANCE PACKAGE AND THE AMOUNT OF NOTICE PAY WILL BE DETERMINED BY HUMAN RESOURCES IN ACCORDANCE WITH TRIHEALTH, INC. POLICY. PAYMENTS OF SEVERANCE ARE CONDITIONED UPON SIGNING A SEPARATION AND RELEASE AGREEMENT. DURING THE 2017 CALENDAR YEAR, THE FOLLOWING REPORTABLE INDIVIDUAL(S) RECEIVED SEVERANCE PAYMENTS FROM TRIHEALTH, INC.: DONNA NIENABER - \$190,415

Additional Data

Software ID:

Software Version:

EIN: 31-0537486

Name: THE GOOD SAMARITAN HOSPITAL OF CINCINNATI OHIO

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				
1 PAUL EDGETT III TRUSTEE (END 7/17)	(i)	0	0	0	0	0	0	0
	(ii)	662,879	823,271	165,810	15,900	25,670	1,693,530	0
1 CRAIG EISENTROUT MD TRUSTEE	(i)	0	0	0	0	0	0	0
	(ii)	706,605	10,000	6,825	24,338	23,933	771,701	0
2 MARK CLEMENT PRESIDENT/CEO	(i)	0	0	0	0	0	0	0
	(ii)	1,064,319	361,237	17,874	297,460	18,227	1,759,117	0
3 PHILIP FOSTER TRUSTEE (START 7/17)	(i)	0	0	0	0	0	0	0
	(ii)	442,331	331,981	66,663	16,075	26,032	883,082	0
4 SCOTT FRIEDSTROM MD MED STAFF PRES-GOOD SAM (START 1/18)	(i)	20,909	0	12,000	0	0	32,909	0
	(ii)	467,385	31,795	6,962	37,414	28,536	572,092	0
5 ANDREW DEVOE ASST TREASURER/CFO	(i)	0	0	0	0	0	0	0
	(ii)	406,729	184,778	213,006	109,621	22,604	936,738	0
6 STEVE GRACEY ASST SECRETARY/SVP LEGAL	(i)	0	0	0	0	0	0	0
	(ii)	278,422	76,895	26,948	63,155	27,205	472,625	0
7 WILLIAM GRONEMAN EXEC VP - (END 11/17)	(i)	0	0	0	0	0	0	0
	(ii)	531,685	159,221	83,591	191,245	29,832	995,574	31,401
8 JAIME EASTERLING EXEC DIRECTOR-GOOD SAM	(i)	0	0	0	0	0	0	0
	(ii)	226,033	48,831	7,977	27,422	16,466	326,729	0
9 ROBERT COLLINS MD CMO (END 12/17)	(i)	0	0	0	0	0	0	0
	(ii)	442,689	132,072	25,782	148,839	16,908	766,290	0
10 GAIL DONOVAN EXEC VP & COO	(i)	0	0	0	0	0	0	0
	(ii)	692,100	215,255	17,585	192,834	9,139	1,126,913	0
11 DAVID COOK CHIEF HR OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	355,022	92,932	13,074	93,645	22,042	576,715	0
12 PAULA NIEDERBAUMER VP-CNO - GOOD SAM HOSPITAL	(i)	0	0	0	0	0	0	0
	(ii)	223,998	48,066	12,497	76,598	23,359	384,518	0
13 ROB CERCEK VP-GOOD SAM REGION (END 4/18)	(i)	0	0	0	0	0	0	0
	(ii)	395,675	91,458	17,312	105,691	25,256	635,392	0
14 MARY IRVIN CHIEF NURSE EXECUTIVE- TRIHEALTH	(i)	0	0	0	0	0	0	0
	(ii)	311,686	81,251	14,984	110,157	19,248	537,326	0
15 KEVIN JOSEPH MD CMO (START 1/18)	(i)	0	0	0	0	0	0	0
	(ii)	398,878	166,718	13,057	69,998	26,077	674,728	0
16 DAVID DHANRAJ MD PHYSICIAN	(i)	343,942	3,127	907	27,289	21,370	396,635	0
	(ii)	0	0	0	0	0	0	0
17 EDOUARD FEHALI MD PHYSICIAN	(i)	287,535	2,521	4,610	53,831	18,080	366,577	0
	(ii)	0	0	0	0	0	0	0
18 SARAH HAWKINS MD PHYSICIAN	(i)	310,423	1,725	558	18,965	32,927	364,598	0
	(ii)	0	0	0	0	0	0	0
19 ANGEL MENA MD PHYSICIAN	(i)	246,793	0	288	14,673	23,317	285,071	0
	(ii)	0	0	0	0	0	0	0

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
21 MICHAEL HOLBERT MD PHYSICIAN	(i)	319,650	0	1,034	24,797	7,848	353,329	0
		-----	-----	-----	-----	-----	-----	-----
	(ii)	0	0	0	0	0	0	0
1 JOHN PROUT FORMER OFFICER	(i)	0	0	0	0	0	0	0
		-----	-----	-----	-----	-----	-----	-----
	(ii)	0	0	252,304	0	0	252,304	12,304
2 DONNA NIENABER ESQ FORMER OFFICER	(i)	0	0	0	0	0	0	0
		-----	-----	-----	-----	-----	-----	-----
	(ii)	188,415	0	206,421	53,218	6,060	454,114	0
3 MICHAEL CROFTON FORMER OFFICER	(i)	0	0	0	0	0	0	0
		-----	-----	-----	-----	-----	-----	-----
	(ii)	302,565	64,965	25,719	88,719	28,454	510,422	0

SCHEDULE O
(Form 990 or 990-EZ)

Supplemental Information to Form 990 or 990-EZ

OMB No 1545-0047

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

▶ Attach to Form 990 or 990-EZ.

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

2017

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
THE GOOD SAMARITAN HOSPITAL OF
CINCINNATI OHIO

Employer identification number

31-0537486

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III, LINE 1	THE ORGANIZATION'S MISSION IS TO NURTURE THE HEALING MINISTRY OF THE CHURCH BY BRINGING IT NEW LIFE, ENERGY AND VIABILITY IN THE 21ST CENTURY FIDELITY TO THE GOSPEL URGES US TO EMPHASIZE HUMAN DIGNITY AND SOCIAL JUSTICE AS WE MOVE TOWARD THE CREATION OF HEALTHIER COMMUNITIES

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 2	<p>THE OFFICERS, DIRECTORS AND TRUSTEES OF THE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO LISTED IN PART VII, SECTION A HAVE A "BUSINESS RELATIONSHIP" WITH EACH OTHER BY VIRTUE OF SITTING ON THE BOARDS OF BETHESDA HOSPITAL, INC , TRIHEALTH, INC AND TRIHEALTH HOSPITAL, INC , ALL RELATED/AFFILIATED ENTITIES MICHAEL CROFTON, GAIL DONOVAN, ROBERT COLLINS, MD, MARK CLEMENT, AND MYRTIS POWELL HAVE A "BUSINESS RELATIONSHIP" WITH EACH OTHER BY VIRTUE OF SITTING ON THE BOARD OF THE MCCULLOUGH-HYDE MEMORIAL HOSPITAL, AN AFFILIATED ENTITY OF GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO WAYNE SHIRCLIFF, LISA KNUTSON, MARK DELWORTH, MD, MICHAEL HAVERKAMP, CRAIG EISENTROUT, MD AND MYRTIS POWELL HAVE A "BUSINESS RELATIONSHIP" WITH EACH OTHER BY VIRTUE OF SITTING ON THE BOARD OF BETHESDA, INC , THE SINGLE CORPORATE MEMBER OF BETHESDA HOSPITAL, INC , AN AFFILIATED ENTITY MARK CLEMENT AND MYRTIS POWELL HAVE A "BUSINESS RELATIONSHIP" WITH EACH OTHER BY VIRTUE OF SITTING ON THE BOARD OF THE GOOD SAMARITAN COLLEGE OF NURSING AND HEALTH SCIENCE, A RELATED ENTITY MARK CLEMENT, MYRTIS POWELL AND CRAIG EISENTROUT, MD HAVE A "BUSINESS RELATIONSHIP" WITH EACH OTHER BY VIRTUE OF SITTING ON THE BOARD OF BETHESDA FOUNDATION, INC , AN AFFILIATED ENTITY MARK CLEMENT, GAIL DONOVAN, STEVE GRACEY, ANDREW DEVOE, MICHAEL CROFTON, ROB CERCEK, WILLIAM GRONEMAN, MARY IRVIN, DAVID COOK, KEVIN JOSEPH, MD, ROBERT COLLINS, MD, CRAIG EISENTROUT, MD, JAMIE EASLERLING, PHILLIP OBLINGER, MD, SCOTT FRIEDSTROM, MD, AND PAULA NIEDERBAUMER HAVE A "BUSINESS RELATIONSHIP" WITH EACH OTHER BY VIRTUE OF SITTING ON RELATED ENTITY BOARDS OF TRIHEALTH, INC AND ITS SUBSIDIARIES AND AFFILIATES AS WELL AS BEING EMPLOYED BY TRIHEALTH, INC OR ITS AFFILIATES/SUBSIDIARIES</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 6	THE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO HAS TWO (2) CORPORATE MEMBERS CATHOLIC HEALTH INITIATIVES, A COLORADO NON-PROFIT CORPORATION, IS THE SOLE VOTING MEMBER AND TRIHEALTH, INC , AN OHIO NON-PROFIT CORPORATION, IS THE SOLE NON-VOTING MEMBER

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7A	IN ACCORDANCE WITH THE CORPORATE BYLAWS OF THE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO ("HOSPITAL"), THE TRUSTEES OF THE HOSPITAL (OTHER THAN THE CHIEF EXECUTIVE OFFICER AND THE PRESIDENTS OF THE MEDICAL STAFFS OF GOOD SAMARITAN HOSPITAL AND BETHESDA NORTH HOSPITAL WHO SERVE BY VIRTUE OF THEIR OFFICES) SHALL BE NOMINATED AND ELECTED BY THE VOTING MEMBER NO LATER THAN JUNE 30 OF EACH YEAR IN THE MANNER PROVIDED IN THE NETWORK AFFILIATION AGREEMENT

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B	CATHOLIC HEALTH INITIATIVES ("CHI") IS THE SOLE CORPORATE VOTING MEMBER OF THE GOOD SAMARI TAN HOSPITAL OF CINCINNATI, OHIO ("HOSPITAL") PURSUANT TO SECTION 5 4 2 OF THE HOSPITAL'S BYLAWS AND THE NETWORK AFFILIATION AGREEMENT, THE VOTING MEMBER SHALL HAVE THE SPECIFIC RIGHTS SET FORTH IN THE GOVERNANCE MATRIX PURSUANT TO THE GOVERNANCE MATRIX, THE FOLLOWING RIGHTS ARE RESERVED TO THE CHI BOARD DIRECTLY OR THROUGH POWERS DELEGATED TO THE CHI CHIEF EXECUTIVE OFFICER * SUBSTANTIAL CHANGE IN THE MISSION OR PHILOSOPHY OF THE HOSPITAL, * A MENDMENT OF THE CORPORATE DOCUMENTS OF THE HOSPITAL, * APPROVAL OF MEMBERS OF THE HOSPITAL 'S BOARD, * REMOVAL OF A MEMBER OF THE GOVERNING BODY OF THE HOSPITAL, * APPROVAL OF ISSUA NCE OF DEBT BY THE HOSPITAL, * APPROVAL OF PARTICIPATION OF THE HOSPITAL IN A JOINT VENTUR E, * APPROVAL OF FORMATION OF A NEW CORPORATION BY THE HOSPITAL, * APPROVAL OF A MERGER IN VOLVING THE HOSPITAL, * APPROVAL OF THE SALE OF ALL OR SUBSTANTIALLY ALL OF THE ASSETS OF THE HOSPITAL, * AUTHORITY TO REQUIRE THE TRANSFER OF ASSETS BY THE HOSPITAL TO CHI TO ACCO MPLISH CHI'S GOALS AND OBJECTIVES, AND TO SATISFY CHI DEBTS, AND * ADOPTION OF LONG RANGE AND STRATEGIC PLANS FOR THE HOSPITAL PURSUANT TO SECTION 5 5 2 OF THE HOSPITAL'S BYLAWS A ND THE NETWORK AFFILATION AGREEMENT, CHI MAY, IN EXERCISE OF ITS APPROVAL POWERS, GRANT OR WITHHOLD APPROVAL IN WHOLE OR IN PART, OR MAY, IN ITS COMPLETE DISCRETION, AFTER CONSULTA TION WITH THE BOARD AND THE PRESIDENT AND CHIEF EXECUTIVE OFFICER OF THE HOSPITAL, RECOMME ND SUCH OTHER OR DIFFERENT ACTIONS AS IT DEEMS APPROPRIATE

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	ALL BOARD MEMBERS ARE REQUIRED TO ANNUALLY DISCLOSE CERTAIN FINANCIAL INTERESTS AND FIDUCIARY RELATIONSHIPS THE EXECUTIVE COMMITTEE AND CORPORATE COUNSEL REVIEW RESPONSES, CONDUCT FURTHER INVESTIGATION, IF NECESSARY, AND DETERMINE WHEN A CONFLICT EXISTS WITH RESPECT TO A CERTAIN TRANSACTION IF A CONFLICT EXISTS, THE TRANSACTION IS NOT TO BE ENTERED INTO UNLESS ALTERNATIVES ARE FULLY INVESTIGATED AND, IN THEIR ABSENCE, THE BOARD, WITHOUT PARTICIPATION OF THE INTERESTED MEMBER(S), DETERMINES THAT THE TRANSACTION IS IN THE BEST INTEREST OF THE ORGANIZATION PLANS TO MANAGE THE CONFLICT DURING THE RELATIONSHIP ARE IMPLEMENTED ALL DISCUSSIONS ARE APPROPRIATELY DOCUMENTED

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	THE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO'S GOVERNING DOCUMENTS, CONFLICTS OF INTEREST POLICY AND FINANCIAL STATEMENTS ARE AVAILABLE UPON REQUEST IN ADDITION, THE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO'S FINANCIAL STATEMENTS ARE INCLUDED IN THE CATHOLIC HEALTH INITIATIVES' CONSOLIDATED AUDITED FINANCIAL STATEMENTS THAT ARE AVAILABLE AT WWW CATHOLICHEALTHINT ORG OR AT HTTP //WWW DACBOND COM

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9	LOSS ON UNCONSOLIDATED ORGANIZATIONS -53,275,542 GAIN ON UPTOWN (NMTC) LOAN UNWIND 3,950, 103 CHANGE PENSION PLAN/SERP FUNDED STATUS 15,565,799 TRANSFER TO CHI CAPITAL RESOURCE P OOL -1,426,152 TRANSFER TO GOOD SAMARITAN HOSPITAL FOUNDATION OF CINCINNATI, INC -5,000, 000 MISCELLANEOUS ADJUSTMENT -53,072

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART I, LINE 6	DURING THE TAX YEAR, THE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO WAS ASSISTED BY AN ESTIMATED 900 VOLUNTEERS WHO DONATED OVER APPROXIMATELY 32,000 HOURS

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, LINE 1	PURSUANT TO ARTICLE SECTION 8 1 1 OF THE BYLAWS OF THE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO ("HOSPITAL"), THE BOARD OF TRUSTEES MAY ESTABLISH AN THE EXECUTIVE COMMITTEE WHICH MAY EXERCISE SUCH POWER AND AUTHORITY OF THE BOARD OF TRUSTEES IN INTERVALS BETWEEN MEETINGS OF THE BOARD AS AUTHORIZED BY THE BOARD THE EXECUTIVE COMMITTEE IS COMPOSED OF THE BOARD CHAIR, THE BOARD VICE CHAIR, THE PRESIDENT AND THE CHIEF EXECUTIVE OFFICER, THE SECRETARY AND TWO OTHER BOARD MEMBERS IN ACCORDANCE WITH THE NETWORK AFFILIATION AGREEMENT PURSUANT TO SECTION 8 1 5 OF THE HOSPITAL'S BYLAWS, COMMITTEES, SUCH AS THE EXECUTIVE COMMITTEE, THAT ARE GRANTED THE AUTHORITY TO ACT ON BEHALF OF THE BOARD OF DIRECTORS SHALL CONSIST OF AT LEAST THREE MEMBERS OF THE BOARD OF TRUSTEES FURTHER, PURSUANT TO SECTION 8 1 1 OF THE HOSPITAL'S BYLAWS, FOUR MEMBERS OF THE EXECUTIVE COMMITTEE SHALL CONSTITUTE A QUORUM FOR THE TRANSACTIONS OF BUSINESS AND THE ACT OF THE FOUR OF THEM SHALL CONSTITUTE THE ACT OF THE COMMITTEE

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, LINE 16B	THE GOOD SAMARITAN HOSPITAL OF CINCINNATI, OHIO HAS NOT FORMALLY ADOPTED A WRITTEN POLICY OR PROCEDURE REGARDING JOINT VENTURES HOWEVER, CATHOLIC HEALTH INITIATIVES, A RELATED ORGANIZATION, HAS A SYSTEM-WIDE JOINT VENTURE MODEL OPERATING AGREEMENT WHICH INCORPORATES CONTROLS OVER THE VENTURE SUFFICIENT TO ENSURE THAT (1) THE EXEMPT ORGANIZATION AT ALL TIMES RETAINS CONTROL OVER THE VENTURE SUFFICIENT TO ENSURE THAT THE PARTNERSHIP FURTHERS THE EXEMPT PURPOSE OF THE ORGANIZATION, (2) IN ANY PARTNERSHIP IN WHICH THE EXEMPT ORGANIZATION IS A PARTNER, ACHIEVEMENT OF EXEMPT PURPOSES IS PRIORITIZED OVER MAXIMIZATION OF PROFITS FOR THE PARTNERS, (3) THE PARTNERSHIP DOES NOT ENGAGE IN ANY ACTIVITIES THAT WOULD JEOPARDIZE THE EXEMPT ORGANIZATION'S EXEMPTION, (4) RETURNS OF CAPITAL, ALLOCATIONS, AND DISTRIBUTIONS MUST BE MADE IN PROPORTION TO THE PARTNERS' RESPECTIVE OWNERSHIP INTERESTS, AND (5) ALL CONTRACTS ENTERED INTO BY THE PARTNERSHIP WITH THE EXEMPT ORGANIZATION MUST BE AT ARM'S-LENGTH, WITH PRICES SET AT FAIR MARKET VALUE ANY JOINT VENTURE AGREEMENTS THAT DO NOT CONFORM TO THE MODEL AGREEMENT ARE GENERALLY REVIEWED BY COUNSEL

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No 1545-0047

2017

**Open to Public
Inspection**

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.**
▶ **Attach to Form 990.**
▶ **Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.**

Department of the Treasury
Internal Revenue Service

Name of the organization
THE GOOD SAMARITAN HOSPITAL OF
CINCINNATI OHIO

Employer identification number

31-0537486

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

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

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

See Additional Data Table

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

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

See Additional Data Table

(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	

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
See Additional Data Table									

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

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

	Yes	No
1 During the tax year, did the 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	1a Yes	
b Gift, grant, or capital contribution to related organization(s)	1b Yes	
c Gift, grant, or capital contribution from related organization(s)	1c Yes	
d Loans or loan guarantees to or for related organization(s)	1d	No
e Loans or loan guarantees by related organization(s)	1e Yes	
f Dividends from related organization(s)	1f	No
g Sale of assets to related organization(s)	1g	No
h Purchase of assets from related organization(s)	1h	No
i Exchange of assets with related organization(s)	1i	No
j Lease of facilities, equipment, or other assets to related organization(s)	1j	No
k Lease of facilities, equipment, or other assets from related organization(s)	1k Yes	
l Performance of services or membership or fundraising solicitations for related organization(s)	1l Yes	
m Performance of services or membership or fundraising solicitations by related organization(s)	1m Yes	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n	No
o Sharing of paid employees with related organization(s)	1o Yes	
p Reimbursement paid to related organization(s) for expenses	1p Yes	
q Reimbursement paid by related organization(s) for expenses	1q	No
r Other transfer of cash or property to related organization(s)	1r Yes	
s Other transfer of cash or property from related organization(s)	1s Yes	

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

See Additional Data Table

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

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

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

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

Part VII **Supplemental Information**

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

Additional Data

Software ID:

Software Version:

EIN: 31-0537486

Name: THE GOOD SAMARITAN HOSPITAL OF CINCINNATI OHIO

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
12809 W DODGE RD OMAHA, NE 68154 47-0765154	HEALTHCARE	NE	501(C)(3)	3	ACH	Yes	
12809 W DODGE RD OMAHA, NE 68154 47-0757164	HEALTHCARE	NE	501(C)(3)	3	CHI NEBRASKA	Yes	
12809 W DODGE RD OMAHA, NE 68154 47-0648586	FUNDRAISING	NE	501(C)(3)	7	ACH	Yes	
7500 MERCY RD OMAHA, NE 68124 47-0484764	HEALTHCARE	NE	501(C)(3)	3	CHI NEBRASKA	Yes	
631 N 8TH ST MISSOURI VALLEY, IA 51555 42-0776568	HEALTHCARE	IA	501(C)(3)	3	CHI NEBRASKA	Yes	
6901 N 72ND ST OMAHA, NE 68122 47-0376615	HEALTHCARE	NE	501(C)(3)	3	CHI NEBRASKA	Yes	
104 W 17TH ST SCHUYLER, NE 68661 47-0399853	HEALTHCARE	NE	501(C)(3)	3	CHI NEBRASKA	Yes	
PO BOX 368 CORNING, IA 50841 42-0782518	HEALTHCARE	IA	501(C)(3)	3	CHI NEBRASKA	Yes	
300 SE 8TH AVE LITTLE FALLS, MN 56345 41-1351177	LTERM CARE	MN	501(C)(3)	10	CHI	Yes	
601 OAK ST BRECKENRIDGE, MN 56520 41-1850500	SENIOR LIVING	MN	501(C)(3)	10	SFH	Yes	
17200 ST LUKES WAY STE 170 THE WOODLANDS, TX 77384 27-4499340	PHYSICIANS	TX	501(C)(3)	12A	SLCHS	Yes	
6624 FANNIN ST STE 1100 HOUSTON, TX 77030 76-0458535	PHYSICIANS	TX	501(C)(3)	3	SLHS	Yes	
2801 FRANCISCAN DRIVE BRYAN, TX 77802 27-4005511	HEALTHCARE	TX	501(C)(3)	3	SHSC	Yes	
5837 WINWOOD DR JOHNSTON, IA 50311 42-0725196	LTERM CARE	IA	501(C)(3)	10	CHI-IA CORP	Yes	
198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 23-2187242	HEALTHCARE	PA	501(C)(3)	12A	CHI	Yes	
1 WEST WAY CT LAKE JACKSON, TX 77566 76-0080110	FUNDRAISING	TX	501(C)(3)	12A	BRHS	Yes	
100 MEDICAL DRIVE LAKE JACKSON, TX 77566 80-0240261	HEALTHCARE	TX	501(C)(3)	3	BRHS	Yes	
2801 FRANCISCAN DRIVE BRYAN, TX 77802 74-2759890	HEALTHCARE	TX	501(C)(3)	3	SJSC	Yes	
2801 FRANCISCAN DRIVE BRYAN, TX 77802 74-2913931	HEALTHCARE	TX	501(C)(3)	10	SJSC	Yes	
800 N 4TH ST CARRINGTON, ND 58421 45-0227311	HEALTHCARE	ND	501(C)(3)	3	CHI	Yes	

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations							
(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 47-0617373	HEALTHCARE	CO	501(C)(3)	12A	N/A	Yes	
9100 EAST MINERAL CIRCLE CENTENNIAL, CO 80112 84-0405257	HEALTHCARE	CO	501(C)(3)	3	CHI	Yes	
1111 6TH AVE DES MOINES, IA 50314 42-0680448	HEALTHCARE	IA	501(C)(3)	3	CHI	Yes	
1150 KELLY JOHNSON BLVD 204 COLORADO SPRINGS, CO 80920 84-0902211	FUNDRAISING	CO	501(C)(3)	7	CHIC	Yes	
1150 KELLY JOHNSON BLVD 204 COLORADO SPRINGS, CO 80920 27-0930004	FUNDRAISING	CO	501(C)(3)	12A	CHI	Yes	
198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 46-0992796	HEALTHCARE	CO	501(C)(3)	12A	CHINS	Yes	
2700 STEWART PKWY ROSEBURG, OR 97471 26-3946191	PHYSICIANS	OR	501(C)(3)	10	MMC	Yes	
3515 BROADWAY GREAT BEND, KS 67530 48-0543724	SURGERY CENTER	KS	501(C)(3)	3	CHI	Yes	
9100 E MINERAL CIRCLE CENTENNIAL, CO 80112 84-1335382	HOLDING CO	CO	501(C)(3)	12A	N/A	Yes	
4816 AMBER VALLEY PKWY S FARGO, ND 58104 27-1966847	HEALTHCARE	MN	501(C)(3)	10	CHI	Yes	
198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 27-1050565	HEALTHCARE	CO	501(C)(3)	12A	CHI	Yes	
3900 OLYMPIC BLVD STE 400 ERLANGER, KY 41018 20-2741651	HEALTHCARE	KY	501(C)(3)	12A	CHI	Yes	
5942 RENAISSANCE PLACE STE A TOLEDO, OH 43623 34-1892096	HEALTHCARE	OH	501(C)(3)	12B	SFH	Yes	
100 GROSS CRESCENT CIRCLE FORT OGLETHORPE, GA 30742 82-2748395	HEALTHCARE	GA	501(C)(3)	3	MHCS	Yes	
198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 45-1261716	HEALTHCARE	CO	501(C)(3)	10	CHI NS	Yes	
198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 45-2532084	HEALTHCARE	CO	501(C)(3)	12A	CHI	Yes	
12809 W DODGE RD OMAHA, NE 68510 36-3233121	HEALTHCARE	NE	501(C)(3)	12A	CHI	Yes	
1929 LINCOLN HWY E STE 150 LANCASTER, PA 17602 23-2342997	HEALTHCARE	PA	501(C)(3)	12A	CHI	Yes	
1516 5TH ST NW ALBUQUERQUE, NM 87102 71-0897107	COMMUNITY	NM	501(C)(3)	12A	CHI	Yes	
6624 FANNIN ST 1100 HOUSTON, TX 77030 74-1161938	HEALTHCARE	TX	501(C)(3)	3	SLHS	Yes	

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations							
(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
300 WERNER ST HOT SPRINGS, AR 71913 71-0236913	HEALTHCARE	AR	501(C)(3)	3	CHISVHS	Yes	
300 WERNER ST HOT SPRINGS, AR 71913 26-1125064	HOLDING CO	AR	501(C)(3)	12B	SVIMC	Yes	
300 WERNER ST HOT SPRINGS, AR 71913 26-1125131	HEALTHCARE	AR	501(C)(3)	3	CHISVHS	Yes	
325 EDEN PARK DRIVE 7TH FLOOR CINCINNATI, OH 45202 23-7419853	HOLDING CO	OH	501(C)(2)		GSH	Yes	
631 N 8TH ST MISSOURI VALLEY, IA 51555 42-1294399	FUNDRAISING	IA	501(C)(3)	12A	AH-CMHMV	Yes	
ONE SAINT JOSEPH DRIVE LEXINGTON, KY 40504 61-1400619	LT ACH	KY	501(C)(3)	3	SJHS	Yes	
2801 VIA FORTUNA SUITE 500 AUSTIN, TX 78746 45-4736213	HEALTHCARE	TX	501(C)(3)	12A	MHSET	Yes	
1450 BATTERSBY AVE ENUMCLAW, WA 98022 91-0715805	HEALTHCARE	WA	501(C)(3)	3	FHS	Yes	
4305 NEW SHEPHERDSVILLE RD BARDSTOWN, KY 40004 61-1345363	HEALTHCARE	KY	501(C)(3)	3	KOH	Yes	
4305 NEW SHEPHERDSVILLE RD BARDSTOWN, KY 40004 56-2351341	FUNDRAISING	KY	501(C)(3)	12A	FH	Yes	
4111 N HOOLAND-SYLVANIA RD TOLEDO, OH 43623 34-1931806	HEALTHCARE	OH	501(C)(3)	10	FLC	Yes	
1717 SOUTH J ST TACOMA, WA 98405 91-1145592	FUNDRAISING	WA	501(C)(3)	10	FHS	Yes	
1717 SOUTH J ST TACOMA, WA 98405 91-0564491	HEALTHCARE	WA	501(C)(3)	3	CHI	Yes	
TACOMA FNC CTR BLDG 1145 BROADWAY TACOMA, WA 98402 43-1882377	PHYSICIANS	MO	501(C)(3)	10	CHI	Yes	
1313 BROADWAY STE 200 TACOMA, WA 98402 91-1939739	HEALTHCARE	WA	501(C)(3)	10	FHS	Yes	
3601 S CHICAGO AVE SOUTH MILWAUKEE, WI 53172 39-1093829	HEALTHCARE	WI	501(C)(3)	10	CHI	Yes	
407 THIRD AVENUE SOUTHEAST GARRISON, ND 58540 45-0227752	HEALTHCARE	ND	501(C)(3)	3	SAMC	Yes	
198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 20-1536108	MINISTRIES	CO	501(C)(3)	12A	CHI	Yes	
625 EDEN PARK DR 7TH FLOOR CINCINNATI, OH 45202 31-1778403	EDUCATION	OH	501(C)(3)	2	GSH	Yes	
625 EDEN PARK DR 7TH FLOOR CINCINNATI, OH 45202 31-1206047	FUNDRAISING	OH	501(C)(3)	12A	GSH	Yes	

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations							
(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
110 N MAIN ST STE 500 DAYTON, OH 45402 31-0536981	HEALTHCARE	OH	501(C)(3)	3	SHP	Yes	
PO BOX 1990 KEARNEY, NE 68848 47-0379755	HEALTHCARE	NE	501(C)(3)	3	CHI NEBRASKA	Yes	
111 W 31ST ST KEARNEY, NE 68847 47-0659443	FUNDRAISING	NE	501(C)(3)	7	GSH	Yes	
110 N MAIN ST STE 500 DAYTON, OH 45402 23-7296923	FUNDRAISING	OH	501(C)(3)	7	SHP	Yes	
2520 CHERRY AVE BREMERTON, WA 98310 91-0565546	HEALTHCARE	WA	501(C)(3)	3	FHS	Yes	
2520 CHERRY AVE BREMERTON, WA 98310 91-1197626	FUNDRAISING	WA	501(C)(3)	7	HMC	Yes	
2400 ST FRANCIS DR BRECKENRIDGE, MN 56520 76-0761782	FUNDRAISING	MN	501(C)(3)	12A	SFMC	Yes	
16251 SYLVESTER RD SW BURIEN, WA 98166 91-0712166	HEALTHCARE	WA	501(C)(3)	3	FHS	Yes	
1111 6TH AVE DES MOINES, IA 50314 42-1323808	SHELTER	IA	501(C)(3)	7	CHI-IA CORP	Yes	
250 E LIBERTY ST STE 500 LOUISVILLE, KY 40202 61-1029768	HEALTHCARE	KY	501(C)(3)	3	KOH	Yes	
100 E LIBERTY ST STE 800 LOUISVILLE, KY 40202 61-1352729	HEALTHCARE	KY	501(C)(3)	10	JHSMH	Yes	
200 ABRAHAM FLEXNER WAY LOUISVILLE, KY 40202 61-1029769	HEALTHCARE	KY	501(C)(3)	10	CHI	Yes	
600 MAIN AVE S BAUDETTE, MN 56623 41-0758434	HEALTHCARE	MN	501(C)(3)	3	CHI	Yes	
600 MAIN AVE S BAUDETTE, MN 56623 41-1893795	FUNDRAISING	ND	501(C)(3)	7	LHC	Yes	
2700 STEWART PKWY ROSEBURG, OR 97471 93-0821381	SENIOR LIVING	OR	501(C)(3)	10	MMC	Yes	
905 MAIN ST LISBON, ND 58054 82-0558836	HEALTHCARE	ND	501(C)(3)	3	CHI	Yes	
PO BOX 1447 LUFKIN, TX 75901 82-0563768	PROPERTY MGMT	TX	501(C)(3)	12A	MHSET	Yes	
2801 FRANCISCAN DRIVE BRYAN, TX 77802 74-2761145	HEALTHCARE	TX	501(C)(3)	3	SJSC	Yes	
2344 AMSTERDAM RD VILLA HILLS, KY 51017 61-0654635	LIVING ASSIST	KY	501(C)(3)	10	FLC	Yes	
2525 DE SALES AVE CHATTANOOGA, TN 37404 62-1839548	FUNDRAISING	TN	501(C)(3)	7	MHCS	Yes	

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations							
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						Yes	No
2525 DE SALES AVE CHATTANOOGA, TN 37404 62-0532345	HEALTHCARE	TN	501(C)(3)	3	CHI	Yes	
5600 BRAINERD RD STE 500 CHATTANOOGA, TN 37411 03-0417049	HEALTHCARE	TN	501(C)(3)	10	MHCS	Yes	
PO BOX 1447 LUFKIN, TX 75902 75-0755367	HEALTHCARE	TX	501(C)(3)	3	CHI	Yes	
PO BOX 1447 LUFKIN, TX 75902 76-0436439	HEALTHCARE	TX	501(C)(3)	3	MHSET	Yes	
PO BOX 1447 LUFKIN, TX 75902 75-2663904	HEALTHCARE	TX	501(C)(3)	3	MHSET	Yes	
1201 FRANK AVE LUFKIN, TX 95904 75-2721155	PHYSICIANS	TX	501(C)(3)	12A	MHSET	Yes	
PO BOX 1447 LUFKIN, TX 95902 75-2492741	HEALTHCARE	TX	501(C)(3)	3	MHSET	Yes	
1111 6TH AVE DES MOINES, IA 50314 42-6076069	AUXILIARY	IA	501(C)(3)	12A	MF-DM IA	Yes	
1111 6TH AVE DES MOINES, IA 50314 42-1193699	PHYSICIANS	IA	501(C)(3)	10	CHI-IA CORP	Yes	
1111 6TH AVE DES MOINES, IA 50314 42-1511682	EDUCATION	IA	501(C)(3)	2	CHI-IA CORP	Yes	
1111 6TH AVE DES MOINES, IA 50314 23-7358794	FUNDRAISING	IA	501(C)(3)	7	CHI-IA CORP	Yes	
2700 STEWART PKWY ROSEBURG, OR 97471 93-6088946	FUNDRAISING	OR	501(C)(3)	7	MMC	Yes	
PO BOX 368 CORNING, IA 50841 42-1461064	FUNDRAISING	IA	501(C)(3)	12A	AHMH-CORNING	Yes	
570 CHAUTAUQUA BLVD VALLEY CITY, ND 58072 45-0435338	FUNDRAISING	ND	501(C)(3)	12A	MHVC	Yes	
800 MERCY DR COUNCIL BLUFFS, IA 51503 42-1178204	FUNDRAISING	IA	501(C)(3)	12A	AHBMHS	Yes	
1031 7TH ST NE DEVILS LAKE, ND 58301 45-0227012	HEALTHCARE	ND	501(C)(3)	3	CHI	Yes	
1031 7TH ST NE DEVILS LAKE, ND 58301 35-2367360	FUNDRAISING	ND	501(C)(3)	7	MHDL	Yes	
570 CHAUTAUQUA BLVD VALLEY CITY, ND 58072 45-0226553	HEALTHCARE	ND	501(C)(3)	3	CHI	Yes	
1301 15TH AVE WEST WILLISTON, ND 58801 45-0231183	HEALTHCARE	ND	501(C)(3)	3	CHI	Yes	
ONE ST JOSEPHS DRIVE CENTERVILLE, IA 52544 42-0680308	HEALTHCARE	IA	501(C)(3)	3	CHI-IA CORP	Yes	

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations							
(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
204 N 4TH AVE E NEWTON, IA 50314 42-1470935	PHYSICIANS	IA	501(C)(3)	3	CHI-IA CORP	Yes	
2700 STEWART PKWY ROSEBURG, OR 97471 93-0386868	HEALTHCARE	OR	501(C)(3)	3	CHI	Yes	
1301 15TH AVE WEST WILLISTON, ND 58801 45-0381803	FUNDRAISING	ND	501(C)(3)	12A	MMC	Yes	
7500 S 91ST ST LINCOLN, NE 68526 39-2031968	HEALTHCARE	NE	501(C)(3)	3	CHI NEBRASKA	Yes	
401 N 9TH ST BISMARCK, ND 58501 45-0439894	HEALTHCARE	ND	501(C)(3)	8	NHCA	Yes	
1200 N 7TH ST OAKES, ND 58474 45-0231675	HEALTHCARE	ND	501(C)(3)	3	CHI	Yes	
1200 N 7TH ST OAKES, ND 58474 71-0966606	FUNDRAISING	ND	501(C)(3)	12A	OCH	Yes	
PO BOX 1447 LUFKIN, TX 75902 75-2493116	PROPERTY MGMT	TX	501(C)(3)	12A	MHSET	Yes	
2025 HAYNES AVENUE SANDUSKY, OH 44870 34-1658625	HEALTHCARE	OH	501(C)(3)	10	FLC	Yes	
2025 HAYNES AVENUE SANDUSKY, OH 44870 34-1826099	HOLDING CO	OH	501(C)(3)	12B	FLC	Yes	
5055 PROVIDENCE DRIVE SANDUSKY, OH 44870 34-1896807	LIVING COMMUNITY	OH	501(C)(3)	10	FLC	Yes	
1925 E ORMAN AVE STE G52 PUEBLO, CO 81004 84-1234295	COMMUNITY	CO	501(C)(3)	7	CHIC	Yes	
16251 SYLVESTER ROAD SW BURIEN, WA 98166 91-1170040	HEALTHCARE	WA	501(C)(3)	3	FHS	Yes	
9100 E MINERAL CIRCLE CENTENNIAL, CO 80112 84-1183335	LTERM CARE	CO	501(C)(3)	7	CHIC	Yes	
25 POCONO RD DENVER, NJ 07834 22-2876836	HEALTHCARE	NJ	501(C)(3)	10	SCHS	Yes	
25 POCONO RD DENVER, NJ 07834 22-2502997	FUNDRAISING	NJ	501(C)(3)	6	SCHS	Yes	
25 POCONO RD DENVER, NJ 07834 22-3639733	MANAGEMENT	NJ	501(C)(3)	10	CHI	Yes	
25 POCONO RD DENVER, NJ 07834 22-3319886	HEALTHCARE	NJ	501(C)(3)	2	SCHS	Yes	
555 S 70TH ST LINCOLN, NE 68510 47-0625523	FUNDRAISING	NE	501(C)(3)	7	SERMC	Yes	
555 S 70TH ST LINCOLN, NE 68510 36-3233120	HEALTHCARE	NE	501(C)(3)	3	SERMC	Yes	

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations							
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						Yes	No
555 S 70TH ST LINCOLN, NE 68510 47-0379836	HEALTHCARE	NE	501(C)(3)	3	CHI NEBRASKA	Yes	
2620 W FAIDLEY GRAND ISLAND, NE 68803 47-0376601	HEALTHCARE	NE	501(C)(3)	3	CHI NEBRASKA	Yes	
PO BOX 9804 GRAND ISLAND, NE 68802 47-0630267	FUNDRAISING	NE	501(C)(3)	7	SFMC	Yes	
305 ESTILL ST BEREA, KY 40403 26-0152877	FUNDRAISING	KY	501(C)(3)	7	SJHS	Yes	
200 ABRAHAM FLEXNER WAY LOUISVILLE, KY 40202 61-1334601	HEALTHCARE	KY	501(C)(3)	3	KOH	Yes	
701 BOB OLINK DR 200 LEXINGTON, KY 40504 61-1159649	FUNDRAISING	KY	501(C)(3)	12A	SJHS	Yes	
1001 SAINT JOSEPH LANE LONDON, KY 40741 26-0438748	FUNDRAISING	KY	501(C)(3)	7	SJHS	Yes	
225 FALCON DR MOUNT STERLING, KY 40353 27-2884584	FUNDRAISING	KY	501(C)(3)	7	SJHS	Yes	
2500 FAIRWAY STREET DICKINSON, ND 58601 36-3418207	FUNDRAISING	ND	501(C)(3)	12A	SJHHC	Yes	
110 N MAIN ST STE 500 DAYTON, OH 45402 02-0633634	HEALTHCARE	OH	501(C)(3)	7	SHP	Yes	
110 N MAIN ST STE 500 DAYTON, OH 45402 31-1107411	HEALTHCARE	OH	501(C)(3)	12A	CHI	Yes	
104 W 17TH ST SCHUYLER, NE 68661 36-3630014	FUNDRAISING	NE	501(C)(3)	12A	AHMHS	Yes	
198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 44-0545809	HEALTHCARE	MO	501(C)(3)	3	CHI	Yes	
900 EAST BROADWAY AVENUE BISMARCK, ND 58501 45-0226711	HEALTHCARE	ND	501(C)(3)	3	CHI	Yes	
2801 ST ANTHONY WAY PENDLETON, OR 97801 93-0391614	HEALTHCARE	OR	501(C)(3)	3	CHI	Yes	
2801 ST ANTHONY WAY PENDLETON, OR 97801 93-0992727	FUNDRAISING	OR	501(C)(3)	12A	SAH	Yes	
FOUR HOSPITAL DR MORRILTON, AR 72110 71-0245507	HEALTHCARE	AR	501(C)(3)	3	SVIMC	Yes	
401 EAST SPRUCE ST GARDEN CITY, KS 67846 48-0543721	HEALTHCARE	KS	501(C)(3)	3	CHI	Yes	
401 EAST SPRUCE ST GARDEN CITY, KS 67846 20-0598702	FUNDRAISING	KS	501(C)(3)	12A	SCH	Yes	
12469 FIVE POINT ROAD TOLEDO, OH 43551 27-0163752	LIVING COMMUNITY	OH	501(C)(3)	10	FLC	Yes	

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						Yes	No
198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 93-0433692	HEALTHCARE	OR	501(C)(2)		CHI	Yes	
2400 ST FRANCIS DR BRECKENRIDGE, MN 56520 41-0729978	LTERM CARE	MN	501(C)(3)	10	CHI	Yes	
19 POCONO RD DENVER, NJ 07834 22-2536017	ELDERLY CARE	NJ	501(C)(3)	8	SCHS	Yes	
2400 ST FRANCIS DR BRECKENRIDGE, MN 56520 41-0695598	HEALTHCARE	MN	501(C)(3)	3	CHI	Yes	
2801 FRANCISCAN DRIVE BRYAN, TX 77802 74-2351158	FUNDRAISING	TX	501(C)(3)	12B	SJSC	Yes	
2801 FRANCISCAN DRIVE BRYAN, TX 77802 74-2847594	HEALTHCARE	TX	501(C)(3)	10	SJSC	Yes	
201 INTERNATIONAL CIRCLE STE 212 HUNT VALLEY, MD 21030 52-0591461	HEALTHCARE	MD	501(C)(3)	3	CHI	Yes	
2801 FRANCISCAN DRIVE BRYAN, TX 77802 20-3159302	HEALTHCARE	TX	501(C)(3)	3	SJSC	Yes	
201 INTERNATIONAL CIRCLE STE 212 HUNT VALLEY, MD 21030 52-1311775	PHYSICIANS	MD	501(C)(3)	12A	SJMC	Yes	
2801 FRANCISCAN DRIVE BRYAN, TX 77802 74-1282696	HEALTHCARE	TX	501(C)(3)	3	SJSC	Yes	
2801 FRANCISCAN DRIVE BRYAN, TX 77802 45-4088170	HEALTHCARE	TX	501(C)(3)	3	SJSC	Yes	
2801 FRANCISCAN DRIVE BRYAN, TX 77802 46-3265423	HEALTHCARE	TX	501(C)(3)	10	SJSC	Yes	
2801 FRANCISCAN DRIVE BRYAN, TX 77802 74-2455161	MANAGEMENT	TX	501(C)(3)	12A	SFH	Yes	
600 PLEASANT AVE PARK RAPIDS, MN 56470 41-0695603	HEALTHCARE	MN	501(C)(3)	3	CHI	Yes	
2500 FAIRWAY ST DICKINSON, ND 58601 45-0226429	HEALTHCARE	ND	501(C)(3)	3	CHI	Yes	
8100 CLYO ROAD CENTERVILLE, OH 45458 34-1940863	LIVING COMMUNITY	OH	501(C)(3)	10	FLC	Yes	
6624 FANNIN ST STE 2505 HOUSTON, TX 77030 27-3733278	HEALTHCARE	TX	501(C)(3)	3	SLCDC	Yes	
6624 FANNIN ST STE 2505 HOUSTON, TX 77030 26-1947374	HEALTHCARE	TX	501(C)(3)	3	SLHS	Yes	
6624 FANNIN ST STE 2505 HOUSTON, TX 77030 26-0335902	HEALTHCARE	TX	501(C)(3)	3	SLCDC	Yes	
6624 FANNIN ST STE 1100 HOUSTON, TX 77030 76-0536234	HEALTHCARE	TX	501(C)(3)	3	SLHS	Yes	

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						Yes	No
1213 HERMANN DRIVE STE 855 HOUSTON, TX 77004 45-3811485	FUNDRAISING	TX	501(C)(3)	7	SLHS	Yes	
PO BOX 20269 HOUSTON, TX 77225 76-0536232	MANAGEMENT	TX	501(C)(3)	12A	CHI	Yes	
6624 FANNIN ST STE 2505 HOUSTON, TX 77030 26-3734606	HEALTHCARE	TX	501(C)(3)	3	SLHS	Yes	
6624 FANNIN ST STE 1100 HOUSTON, TX 77030 76-0531713	PROPERTY MGMT	TX	501(C)(3)	12A	CHI-SLH	Yes	
1213 HERMANN DRIVE STE 855 HOUSTON, TX 77004 76-0531716	PROPERTY MGMT	TX	501(C)(3)	12A	SLHS	Yes	
6624 FANNIN ST STE 2505 HOUSTON, TX 77030 45-4120549	PROPERTY MGMT	TX	501(C)(3)	12A	SLCDC-SL	Yes	
1301 GRUNDMAN BOULEVARD NEBRASKA CITY, NE 68410 47-0443636	HEALTHCARE	NE	501(C)(3)	3	CHI NEBRASKA	Yes	
1314 3RD AVE NEBRASKA CITY, NE 68410 47-0707604	FUNDRAISING	NE	501(C)(3)	7	SMCH	Yes	
TWO ST VINCENT CIRCLE LITTLE ROCK, AR 72205 51-0169537	FUNDRAISING	AR	501(C)(3)	12A	SVIMC	Yes	
TWO ST VINCENT CIRCLE LITTLE ROCK, AR 72205 71-0236917	HEALTHCARE	AR	501(C)(3)	3	CHI	Yes	
TWO ST VINCENT CIRCLE LITTLE ROCK, AR 72205 71-0830696	HEALTHCARE	AR	501(C)(3)	10	SVIMC	Yes	
1715 INDIAN WOOD CIR 200 MAUMEE, OH 43537 34-1412964	HEALTHCARE	OH	501(C)(3)	12A	CHI	Yes	
1715 INDIAN WOOD CIR 200 MAUMEE, OH 43537 45-5357161	FUNDRAISING	OH	501(C)(3)	12A	FLC	Yes	
5000 PROVIDENCE DRIVE SANDUSKY, OH 44870 34-1826097	LIVING ASSIST	OH	501(C)(3)	10	FLC	Yes	
100 MEDICAL DRIVE LAKE JACKSON, TX 77566 74-1385192	HEALTHCARE	TX	501(C)(3)	3	SLHS	Yes	
110 N MAIN ST STE 500 DAYTON, OH 45402 30-0502367	HEALTHCARE	OH	501(C)(3)	10	CHS	Yes	
2000 Q ST STE 500 LINCOLN, NE 68503 47-0780857	PHYSICIANS	NE	501(C)(3)	12A	CHI NEBRASKA	Yes	
9100 E MINERAL CIRCLE CENTENNIAL, CO 80112 84-0927232	HEALTHCARE	CO	501(C)(3)	3	CHIC	Yes	
380 SUMMIT AVENUE STEBENVILLE, OH 43952 31-1329423	FUNDRAISING	OH	501(C)(3)	12A	THS	Yes	
380 SUMMIT AVENUE STEBENVILLE, OH 43952 34-1818681	HEALTHCARE	OH	501(C)(3)	12A	SFH	Yes	

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						Yes	No
380 SUMMIT AVENUE STEUBENVILLE, OH 43952 30-0752920	HEALTHCARE	OH	501(C)(3)	12B	THS	Yes	
819 NORTH FIRST STREET DENNISON, OH 44621 27-5401105	HEALTHCARE	OH	501(C)(3)	3	SFH	Yes	
ONE ROSS PARK BLVD STEUBENVILLE, OH 43952 34-1522484	ASSIST LIVING	OH	501(C)(3)	7	THS	Yes	
815 SE 2ND ST LITTLE FALLS, MN 56345 41-0721642	HEALTHCARE	MN	501(C)(3)	3	CHI	Yes	
801 PAGE DR FARGO, ND 58103 45-0226714	LTERM CARE	ND	501(C)(3)	10	CHI	Yes	
191 WOODPORT RD SPARTA, NJ 07871 22-1768334	HOME HEALTH	NJ	501(C)(3)	10	SCHS	Yes	
625 EDEN PARK DR 7TH FLOOR CINCINNATI, OH 45202 31-1438846	SUPPORT AFFILIATED HOSPITALS	OH	501(C)(3)	12B	N/A	Yes	
625 EDEN PARK DR 7TH FLOOR CINCINNATI, OH 45202 46-1393755	INPATIENT AND OUTPATIENT SERVICES	OH	501(C)(3)	3	TRIHEALTH INC	Yes	
625 EDEN PARK DR 7TH FLOOR CINCINNATI, OH 45202 27-3893817	FREE CLINIC	OH	501(C)(3)	7	TRIHEALTH INC	Yes	
625 EDEN PARK DR 7TH FLOOR CINCINNATI, OH 45202 31-1383365	PHYSICIAN PRACTICES	OH	501(C)(3)	10	TRIHEALTH INC	Yes	
625 EDEN PARK DR 7TH FLOOR CINCINNATI, OH 45202 31-1074519	PHYSICIAN PRACTICES	OH	501(C)(3)	10	TRIHEALTH INC	Yes	
625 EDEN PARK DR 7TH FLOOR CINCINNATI, OH 45202 31-0537122	INPATIENT AND OUTPATIENT SERVICES	OH	501(C)(3)	3	TRIHEALTH INC	Yes	
625 EDEN PARK DR 7TH FLOOR CINCINNATI, OH 45202 31-1027660	HEALTHCARE SERVICES	OH	501(C)(3)	12B	TRIHEALTH INC	Yes	
625 EDEN PARK DR 7TH FLOOR CINCINNATI, OH 45202 31-1352694	PROPERTY MGMT	OH	501(C)(2)		BETHESDA HOSPITAL INC	Yes	
625 EDEN PARK DR 7TH FLOOR CINCINNATI, OH 45202 31-1242442	HEALTHCARE SERVICES	OH	501(C)(3)	12A	BETHESDA HOSPITAL INC	Yes	
625 EDEN PARK DR 7TH FLOOR CINCINNATI, OH 45202 31-0917155	HOSPICE SERVICES	OH	501(C)(3)	10	BETHESDA HOSPITAL INC	Yes	
625 EDEN PARK DR 7TH FLOOR CINCINNATI, OH 45202 31-1179234	COUNSELING TO GRIEVING CHILDREN	OH	501(C)(3)	7	HOSPICE OF CINCINNATI INC	Yes	
375 DIXMYTH AVE CINCINNATI, OH 45220 31-6056217	SUPPORT AFFILIATED HOSPITAL	OH	501(C)(3)	12A	N/A	Yes	
110 NORTH POPLAR STREET OXFORD, OH 45056 31-0650283	INPATIENT AND OUTPATIENT SERVICES	OH	501(C)(3)	3	TRIHEALTH INC	Yes	

Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust									
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								Yes	No
ALEGENT HEALTHCARE ST JOSEPH MANAGED CARE SERVICES INC 12809 WEST DODGE RD OMAHA, NE 68154 47-0802396	MANAGED CARE	NE	N/A	C				Yes	
ALL SAINTS INSURANCE COMPANY SPC LTD PO BOX 10073 APO GEORGETOWN, GRAND CAYMAN CJ 98-0556913	INSURANCE	CJ	N/A	C				Yes	
ALLIANCE HEALTH PROVIDERS OF BRAZOS VALLEY INC 2801 FRANCISCAN DRIVE BRYAN, TX 77802 74-2466914	HEALTHCARE	TX	N/A	C				Yes	
ALTERNATIVE INSURANCE MANAGEMENT SERVICE INC 3900 OLYMPIC BLVD STE 400 ERLANGER, KY 41018 84-1112049	MANAGEMENT SERVICES	CO	N/A	C				Yes	
AMERICAN NURSING CARE INC 1700 EDISON DR MILFORD, OH 45150 31-1085414	HOME HEALTH	OH	N/A	C				Yes	
AMERIMED INC 1700 EDISON DR MILFORD, OH 45150 31-1158699	HOME HEALTH	OH	N/A	C				Yes	
BC HOLDING COMPANY INC 1850 BLUEGRASS AVE LOUISVILLE, KY 40215 31-1542851	FITNESS CLUB	KY	N/A	C				Yes	
BRAZOSPORT HEALTH ALLIANCE 1 WEST WAY COURT LAKE JACKSON, TX 77566 76-0518376	HEALTH CARE	TX	N/A	C				Yes	
CADUCEUS MEDICAL ASSOCIATES INC 5600 BRAINERD ROAD STE 500 CHATTANOOGA, TN 37411 62-1570736	HEALTHCARE	TN	N/A	C				Yes	
CAPTIVE MANAGEMENT INITIATIVES LTD PO BOX 10073 APO GEORGETOWN, GRAND CAYMAN CJ 98-0663022	CAPTIVE MANAGEMENT	CJ	N/A	C				Yes	
CARMONA-DESOTO BUILDING HORIZONTAL PROPERTY REGIME INC 300 WERNER ST HOT SPRINGS, AR 71913 71-0771076	HEALTHCARE	AR	N/A	C				Yes	
CATHOLIC HEALTH INITIATIVES CENTER FOR TRANSLATIONAL RESEARCH 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 27-2269511	RESEARCH	CO	N/A	C				Yes	
CHI ST LUKE'S HEALTH BAYLOR COLLEGE OF MEDICINE CONDO ASSOC 6624 FANNIN STE 1100 HOUSTON, TX 77030 46-5079545	CONDO ASSOC	TX	N/A	C				Yes	
CLEARRIVER HEALTH 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 46-4495960	INSURANCE	TN	N/A	C				Yes	
COMCARE SERVICES INC 5570 DTC PARKWAY ENGLEWOOD, CO 80111 84-0904813	INACTIVE	CO	N/A	C				Yes	

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								Yes	No
CONSOLIDATED HEALTH SERVICES 1700 EDISON DR MILFORD, OH 45150 31-1378212	HOME HEALTH	OH	N/A	C				Yes	
DES MOINES MEDICAL CENTER INC 1111 6TH AVE DES MOINES, IA 50314 42-0837382	REAL ESTATE	IA	N/A	C				Yes	
DIVERSIFIED HEALTH RESOURCES INC 100 MEDICAL DRIVE LAKE JACKSON, TX 77566 76-0222679	HEALTH CARE	TX	N/A	C				Yes	
FIRST INITIATIVES INSURANCE LTD PO BOX 10073 APO GEORGETOWN, GRAND CAYMAN CJ 98-0203038	INSURANCE	CJ	N/A	C				Yes	
FRANCISCAN CITY URGENT CARE SERVICES PS DBA CITY MD-FRANCISCAN URGENT CARE 1345 AVE OF THE AMERICAS NEW YORK, NY 10105 81-2174959	HEALTHCARE	NY	N/A	C				Yes	
FRANCISCAN SERVICES INC 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 23-2487967	HEALTHCARE	CO	N/A	C				Yes	
GOOD SAMARITAN OUTREACH SERVICES PO BOX 1990 KEARNEY, NE 68848 47-0659440	MEDICAL CLINIC	NE	N/A	C				Yes	
HARVESTPLAINS HEALTH OF IOWA 32129 WEYERHAEUSER WAY S STE 201 FEDERAL WAY, WA 98001 47-3451750	INSURANCE	WA	N/A	C				Yes	
HEALTH SYSTEMS ENTERPRISES INC PO BOX 1990 KEARNEY, NE 68848 47-0664558	MGMT	NE	N/A	C				Yes	
HEALTHCARE MGMT SERVICES ORGANIZATION INC 1149 MARKET ST TACOMA, WA 98402 91-1865474	HEALTH ORG	WA	N/A	C				Yes	
HEARTLANDPLAINS HEALTH 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 46-4368223	INSURANCE	NE	N/A	C				Yes	
HIGHLINE MEDICAL GROUP 1717 S J STREET TACOMA, WA 98405 91-1586438	MEDICAL SERVICES	WA	N/A	C				Yes	
MEDICAL OFFICE BUILDING HORIZONTAL PROPERTY REGIME INC 300 WERNER ST HOT SPRINGS, AR 71913 71-0720429	REAL ESTATE	AR	N/A	C				Yes	
MEDQUEST 1301 15TH AVENUE WEST WILLISTON, ND 58801 45-0392137	SALE OF DME	ND	N/A	C				Yes	
MEMORIAL CV SERVICE LINE MANAGEMENT COMPANY LLC 1201 W FRANK AVE LUFKIN, TX 75904 46-3622849	HEATH CARE	TX	N/A	C				Yes	

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								Yes	No
MERCY PARK APARTMENTS LTD 1111 6TH AVE DES MOINES, IA 50314 42-1202422	HOUSING	IA	N/A	C				Yes	
MERCY SERVICES CORP 2700 STEWART PARKWAY ROSEBURG, OR 97471 93-0824308	RETAIL SALES	OR	N/A	C				Yes	
MHI CLINICAL SERVICES 1201 W FRANK AVE LUFKIN, TX 75904 46-1967952	HEALTHCARE	TX	N/A	C				Yes	
MOUNTAIN MANAGEMENT SERVICES INC 6028 SHALLOWFORD RD CHATTANOOGA, TN 37421 62-1570739	MGMT SVC ORG	TN	N/A	C				Yes	
PATIENT TRANSPORT SERVICES INC 1700 EDISON DR MILFORD, OH 45150 31-1100798	HOME HEALTH	OH	N/A	C				Yes	
QCA HEALTH PLAN INC 12615 CHENAL PARKWAY STE 300 LITTLE ROCK, AR 72211 71-0794605	INSURANCE	AR	N/A	C				Yes	
QUALCHOICE ADVANTAGE 32129 WEYERHAEUSER WAY S STE 201 FEDERAL WAY, WA 98001 47-3433912	INSURANCE	WA	N/A	C				Yes	
QUALCHOICE HEALTH PLAN SERVICES INC 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 46-1224037	ADMIN SERVICES	CO	N/A	C				Yes	
QUALCHOICE HEALTH INC 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 46-1222808	HOLDING CO	CO	N/A	C				Yes	
QUALCHOICE HOLDINGS INC 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 27-4075520	HOLDING CO	AR	N/A	C				Yes	
QUALCHOICE LIFE AND HEALTH INSURANCE COMPANY INC 12615 CHENAL PARKWAY STE 300 LITTLE ROCK, AR 72211 71-0386640	INSURANCE	AR	N/A	C				Yes	
QUALCHOICE OF NEBRASKA 2401 S 73RD ST OMAHA, NE 68124 81-0738827	INSURANCE	NE	N/A	C				Yes	
RIVERLINK HEALTH 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 46-4380824	INSURANCE	OH	N/A	C				Yes	
RIVERLINK HEALTH OF KENTUCKY INC 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 46-4828332	INSURANCE	KY	N/A	C				Yes	
ROSS PARK PHARMACY INC 380 SUMMIT AVE STEBENVILLE, OH 43952 34-1832654	PHARMACY	OH	N/A	C				Yes	

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								Yes	No
SAINT CLARE'S PRIMARY CARE INC 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 22-2441202	BILLING SERVICES	NJ	N/A	C				Yes	
SAMARITAN FAMILY CARE INC 40 W FOURTH ST STE 1700 DAYTON, OH 45402 31-1299450	HEALTHCARE	OH	N/A	C				Yes	
SJH SERVICES CORPORATION 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 23-2307408	HEALTHCARE	CO	N/A	C				Yes	
SJL PHYSICIAN MANAGEMENT SERVICES INC 424 LEWIS HARGETT CR STE 160 LEXINGTON, KY 40503 27-0164198	MGMT	KY	N/A	C				Yes	
SOUNDPATH HEALTH INC 32129 WEYERHAEUSER WAY S STE 201 FEDERAL WAY, WA 98001 42-1720801	INSURANCE	WA	N/A	C				Yes	
ST ALEXIS HEALTH SERVICES INC 900 EAST BROADWAY AVE BISMARCK, ND 58501 45-0402812	HEALTHCARE	ND	N/A	C				Yes	
ST ANTHONY DEVELOPMENT COMPANY 1415 SOUTHGATE PENDLETON, OR 97801 93-1216943	ATHLETIC CLUB	OR	N/A	C				Yes	
ST JOSEPH DEVELOPMENT COMPANY INC 1717 SOUTH J ST TACOMA, WA 98405 91-1480569	RENTAL	WA	N/A	C				Yes	
ST LUKE'S EPISCOPAL HOSPITAL PHO INC 6720 BERTNER MC4-262 HOUSTON, TX 77030 76-0377932	PHO	TX	N/A	C				Yes	
ST LUKE'S HEALTH SYSTEM HOLDINGS INC 6624 FANNIN STE 800 HOUSTON, TX 77030 76-0637138	HOLDING CO	TX	N/A	C				Yes	
ST VINCENT COMMUNITY HEALTH SERVICES INC TWO ST VINCENT CIRCLE LITTLE ROCK, AR 72205 71-0710785	HEALTHCARE	AR	N/A	C				Yes	
STABLEVIEW HEALTH INC 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 46-4373713	INSURANCE	KY	N/A	C				Yes	
STE HOLDINGS 1317 LAKE POINT PARKWAY SUGAR LAND, TX 77478 45-4270163	MEDICAL CLINIC	TX	N/A	C				Yes	
SUGAR LAND DOCTOR GROUP 1317 LAKE POINTE PARKWAY SUGAR LAND, TX 77478 45-4270163	MEDICAL CLINIC	TX	N/A	C				Yes	
TEXAS HEART INST-ST LUKE'S EPISCOPAL HOSP COOLEY CONDO ASSOC 6624 FANNIN STE 1100 HOUSTON, TX 77030 90-0064009	CONDO ASSOC	TX	N/A	C				Yes	

Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust

(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
TOWSON MANAGEMENT INC 7601 OSLER DR TOWSON, MD 21204 52-1710750	MGMT SERVICES	MD	N/A	C				Yes	
TRINITY MANAGEMENT SERVICES ORGANIZATION 380 SUMMIT AVE STEUBENVILLE, OH 43952 34-1471026	MGMT SERVICES	OH	N/A	C				Yes	
TRIHEALTH PHYSICIAN SOLUTIONS INC 625 EDEN PARK DR 7TH FLOOR CINCINNATI, OH 45202 31-1444353	CLAIMS ADMINISTRATION	OH	N/A	C				Yes	
TRIHEALTH PHYSICIANS OF INDIANA INC 625 EDEN PARK DR 7TH FLOOR CINCINNATI, OH 45202 46-1125130	PHYSICIAN PRACTICES	OH	N/A	C				Yes	
TRIHEALTH CIPHO INC 625 EDEN PARK DR 7TH FLOOR CINCINNATI, OH 45202 46-3294306	PHO	OH	N/A	C				Yes	
PREMIERE MEDICAL OWNERS ASSOCIATION 625 EDEN PARK DR 7TH FLOOR CINCINNATI, OH 45202 14-1913019	CONDO ASSOC	OH	N/A	C				Yes	

Form 990, Schedule R, Part V - Transactions With Related Organizations			
(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
TRIHEALTH PHYSICIAN ENTERPRISE CORP	A	4,836,563	FMV
TRIHEALTH INC	A	2,897	FMV
GOOD SAMARITAN HOSPITAL FOUNDATION OF CINCINNATI	B	6,382,086	CASH
TRIHEALTH INC	B	110,317,917	CASH
GOOD SAMARITAN HOSPITAL FOUNDATION OF CINCINNATI	C	1,981,855	CASH
CATHOLIC HEALTH INITIATIVES	E	5,024,522	FMV
BETHESDA HOSPITAL INC	K	6,016,140	FMV
BETHESDA PROPERTIES INC	K	17,488	FMV
BETHESDA HEALTHCARE INC	K	29,046	FMV
TRIHEALTH INC	K	272,599	FMV
TRIHEALTH PHYSICIAN ENTERPRISE CORP	K	103,428	FMV
AMERICAN NURSING CARE INC	M	2,863,739	FMV
PATIENT TRANSPORT SERVICES INC	M	701,783	FMV
CATHOLIC HEALTH INITIATIVES	M	11,905,229	FMV
GOOD SAMARITAN HOSPITAL FOUNDATION OF CINCINNATI	O	721,220	FMV
GOOD SAMARITAN COLLEGE OF NURSING & HEALTH SCIENCE	O	5,560,255	FMV
TRIHEALTH INC	M	112,258,096	COST
TRIHEALTH INC	P	231,410,451	COST
CATHOLIC HEALTH INITIATIVES	P	4,834,918	COST
GOOD SAMARITAN HOSPITAL FOUNDATION OF CINCINNATI	R	5,000,000	CASH
COMMUNITY LIMITED CARE DIALYSIS CENTER	S	2,502,719	CASH