

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

# Return of Organization Exempt From Income Tax

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

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

Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No 1545-0047  
**2018**  
Open to Public Inspection

**A For the 2019 calendar year, or tax year beginning 01-01-2018, and ending 12-31-2018**

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

**C** Name of organization: ATRIUM MEDICAL CENTER  
 % J MICHAEL SIMS  
 Doing business as

Number and street (or P O box if mail is not delivered to street address) Room/suite  
 110 N MAIN ST 500

City or town, state or province, country, and ZIP or foreign postal code  
 DAYTON, OH 45402

**D** Employer identification number: 31-1079309

**E** Telephone number: (937) 499-9942

**G** Gross receipts \$ 286,218,627

**F** Name and address of principal officer:  
 KEITH BRICKING MD  
 1 MEDICAL CENTER DR  
 MIDDLETOWN, OH 45005

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

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

**J** Website: ▶ WWW PREMIERHEALTH COM

**K** Form of organization:  Corporation  Trust  Association  Other ▶

**L** Year of formation 1983 **M** State of legal domicile OH

**Part I Summary**

**1** Briefly describe the organization's mission or most significant activities  
 WE WILL IMPROVE THE HEALTH OF THE COMMUNITIES WE SERVE WITH OTHERS WHO SHARE OUR COMMITMENT TO PROVIDE HIGH-QUALITY, COST-COMPETITIVE HEALTHCARE SERVICES

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

<b>3</b> Number of voting members of the governing body (Part VI, line 1a)	11
<b>4</b> Number of independent voting members of the governing body (Part VI, line 1b)	1
<b>5</b> Total number of individuals employed in calendar year 2018 (Part V, line 2a)	2,055
<b>6</b> Total number of volunteers (estimate if necessary)	281
<b>7a</b> Total unrelated business revenue from Part VIII, column (C), line 12	291,790
<b>7b</b> Net unrelated business taxable income from Form 990-T, line 34	

	Prior Year	Current Year
<b>8</b> Contributions and grants (Part VIII, line 1h)	192,851	589,494
<b>9</b> Program service revenue (Part VIII, line 2g)	229,244,406	223,424,893
<b>10</b> Investment income (Part VIII, column (A), lines 3, 4, and 7d)	3,908,083	3,275,698
<b>11</b> Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	2,295,948	6,174,302
<b>12</b> Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	235,641,288	233,464,387
<b>13</b> Grants and similar amounts paid (Part IX, column (A), lines 1-3)	441,869	449,165
<b>14</b> Benefits paid to or for members (Part IX, column (A), line 4)	0	0
<b>15</b> Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	104,802,971	101,729,336
<b>16a</b> Professional fundraising fees (Part IX, column (A), line 11e)	0	0
<b>b</b> Total fundraising expenses (Part IX, column (D), line 25) ▶0		
<b>17</b> Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	124,178,595	126,617,928
<b>18</b> Total expenses Add lines 13-17 (must equal Part IX, column (A), line 25)	229,423,435	228,796,429
<b>19</b> Revenue less expenses Subtract line 18 from line 12	6,217,853	4,667,958

	Beginning of Current Year	End of Year
<b>20</b> Total assets (Part X, line 16)	362,165,607	363,615,202
<b>21</b> Total liabilities (Part X, line 26)	241,907,431	253,985,972
<b>22</b> Net assets or fund balances Subtract line 21 from line 20	120,258,176	109,629,230

**Part II Signature Block**

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

**Sign Here**

Signature of officer: \_\_\_\_\_ Date: 2019-10-30

J MICHAEL SIMS VP TREAS, CONTROLLER  
 Type or print name and title

**Paid Preparer Use Only**

Print/Type preparer's name: \_\_\_\_\_ Preparer's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Check  if self-employed PTIN P01268401

Firm's name ▶ ERNST & YOUNG US LLP Firm's EIN ▶ \_\_\_\_\_

Firm's address ▶ 221 E 4TH STREET SUITE 2900 CINCINNATI, OH 45202 Phone no (513) 612-1400

**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

ATRIUM MEDICAL CENTER WILL IMPROVE THE HEALTH OF THE COMMUNITIES WE SERVE WITH OTHERS WHO SHARE OUR COMMITMENT TO PROVIDE HIGH-QUALITY, COST-COMPETITIVE HEALTHCARE SERVICES

**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 \$ 208,104,450 including grants of \$ 449,165 ) (Revenue \$ 223,424,893 )  
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 ▶ 208,104,450

Part IV Checklist of Required Schedules

Table with 3 columns: Question Number, Question Text, and Yes/No response. Rows include questions 1 through 22 regarding organizational requirements, lobbying, and financial reporting.

Part IV Checklist of Required Schedules (continued)

Table with 3 columns: Question ID, Question Text, Yes, No. Rows include questions 23 through 38 regarding compensation, bond issues, escrow accounts, 501(c)(3) organizations, and other IRS requirements.

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 3 columns: Question ID, Question Text, Yes, No. Rows include questions 1a, 1b, and 1c regarding Form 1096, Forms W-2G, and backup withholding rules.

<b>2a</b> Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return . . . . .		<b>2a</b>	2,055		
<b>b</b>	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? <b>Note.</b> If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	<b>2b</b>	Yes		
<b>3a</b>	Did the organization have unrelated business gross income of \$1,000 or more during the year? . . . . .	<b>3a</b>	Yes		
<b>b</b>	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O . . . . .	<b>3b</b>	Yes		
<b>4a</b>	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . . . . .	<b>4a</b>		No	
<b>b</b>	If "Yes," enter the name of the foreign country <b>▶</b> _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)				
<b>5a</b>	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . . . . .	<b>5a</b>		No	
<b>b</b>	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	<b>5b</b>		No	
<b>c</b>	If "Yes," to line 5a or 5b, did the organization file Form 8886-T? . . . . .	<b>5c</b>			
<b>6a</b>	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . . . .	<b>6a</b>		No	
<b>b</b>	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? . . . . .	<b>6b</b>			
<b>7 Organizations that may receive deductible contributions under section 170(c).</b>					
<b>a</b>	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor? . . . . .	<b>7a</b>		No	
<b>b</b>	If "Yes," did the organization notify the donor of the value of the goods or services provided? . . . . .	<b>7b</b>			
<b>c</b>	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? . . . . .	<b>7c</b>		No	
<b>d</b>	If "Yes," indicate the number of Forms 8282 filed during the year . . . . .	<b>7d</b>			
<b>e</b>	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	<b>7e</b>		No	
<b>f</b>	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . . . . .	<b>7f</b>		No	
<b>g</b>	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? . . . . .	<b>7g</b>			
<b>h</b>	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? . . . . .	<b>7h</b>			
<b>8 Sponsoring organizations maintaining donor advised funds.</b>					
	Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? . . . . .	<b>8</b>			
<b>9a</b>	Did the sponsoring organization make any taxable distributions under section 4966? . . . . .	<b>9a</b>			
<b>b</b>	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . . . .	<b>9b</b>			
<b>10 Section 501(c)(7) organizations.</b> Enter					
<b>a</b>	Initiation fees and capital contributions included on Part VIII, line 12 . . . . .	<b>10a</b>			
<b>b</b>	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	<b>10b</b>			
<b>11 Section 501(c)(12) organizations.</b> Enter					
<b>a</b>	Gross income from members or shareholders . . . . .	<b>11a</b>			
<b>b</b>	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them ) . . . . .	<b>11b</b>			
<b>12a Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?					
<b>b</b>	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	<b>12b</b>			
<b>13 Section 501(c)(29) qualified nonprofit health insurance issuers.</b>					
<b>a</b>	Is the organization licensed to issue qualified health plans in more than one state? <b>Note.</b> See the instructions for additional information the organization must report on Schedule O	<b>13a</b>			
<b>b</b>	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans . . . . .	<b>13b</b>			
<b>c</b>	Enter the amount of reserves on hand . . . . .	<b>13c</b>			
<b>14a</b>	Did the organization receive any payments for indoor tanning services during the tax year? . . . . .	<b>14a</b>		No	
<b>b</b>	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O . . . . .	<b>14b</b>			
<b>15</b>	Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see instructions and file Form 4720, Schedule N . . . . .	<b>15</b>		No	
<b>16</b>	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O . . . . .	<b>16</b>		No	

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



Section A. Governing Body and Management

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 (11); 1b Enter the number of voting members included in line 1a, above, who are independent (1); 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? (No); 3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? (Yes); 4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? (Yes); 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: a The governing body? (Yes); b Each committee with authority to act on behalf of the governing body? (Yes); 9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O (No)

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

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?; 11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? (Yes); 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? a The organization's CEO, Executive Director, or top management official (Yes); b Other officers or key employees of the organization (Yes); If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions); 16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year? (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? (Yes)

Section C. Disclosure

Table with 2 columns: Question, Answer. Rows include: 17 List the States with which a copy of this Form 990 is required to be filed (OH); 18 Section 6104 requires an organization to make its Form 1023 (or 1024-A if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection Indicate how you made these available Check all that apply: Own website, Another's website, Upon request, Other (explain in Schedule O); 19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year; 20 State the name, address, and telephone number of the person who possesses the organization's books and records: MICHAEL SIMS 110 N MAIN ST SUITE 500 DAYTON, OH 45402 (937) 499-9942

**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										
<b>1b Sub-Total</b>										
<b>1c Total from continuation sheets to Part VII, Section A</b>										
<b>1d Total (add lines 1b and 1c)</b>							2,850,220	13,378,294	1,518,232	

<b>2</b>	Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization ▶ 65			
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<b>3</b>	Did the organization list any <b>former</b> officer, director or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual . . . . .	<b>3</b>	Yes	No
<b>4</b>	For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? If "Yes," complete Schedule J for such individual . . . . .	<b>4</b>	Yes	No
<b>5</b>	Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? If "Yes," complete Schedule J for such person . . . . .	<b>5</b>		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
DAWSON HEALTHCARE, 1114 DUBLIN RD COLUMBUS, OH 43215	MEDICAL SERVICES	5,011,500
MIDDLETOWN ANESTHESIA, 3180 KETTERING BLVD DAYTON, OH 45439	MEDICAL SERVICES	2,001,326
EMERGENCY ACUTE CARE MED CO NE IN, 440 STEVENS AVE 150 SOLANA BEACH, CA 92075	MEDICAL SERVICES	1,917,703
COMPUNET CLINICAL LABORATORIES, 2308 SANDRIDGE DR DAYTON, OH 45349	CLINICAL LAB	1,361,873
MIAMI VALLEY EMERGENCY SPECIALISTS, 2400 MIAMI VALLEY WAY 220 CENTERVILLE, OH 45459	MEDICAL SERVICES	1,224,272

<b>2</b>	Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization ▶ 48
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**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
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<b>1a</b> Federated campaigns . . . . .	<b>1a</b>			
	<b>b</b> Membership dues . . . . .	<b>1b</b>			
	<b>c</b> Fundraising events . . . . .	<b>1c</b>			
	<b>d</b> Related organizations . . . . .	<b>1d</b>			
	<b>e</b> Government grants (contributions) . . . . .	<b>1e</b>			
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above . . . . .	<b>1f</b>	589,494		
	<b>g</b> Noncash contributions included in lines 1a - 1f \$ _____				
<b>h Total.</b> Add lines 1a-1f . . . . .		589,494			

<b>Program Service Revenue</b>			Business Code				
	<b>2a</b> NET PATIENT SERVICE REVENUE		900099	115,046,947	114,756,364	290,583	
	<b>b</b> MEDICARE/MEDICAID PAYMENTS		900099	104,928,095	104,928,095		
	<b>c</b> HOSPITAL FRANCHISE TAX RECOVERIES		900099	3,386,171	3,386,171		
	<b>d</b> MEDICAL RECORDS		900099	24,028	24,028		
	<b>e</b> MISCELLANEOUS		900099	39,652	39,652		
	<b>f</b> All other program service revenue						
<b>g Total.</b> Add lines 2a-2f . . . . .			223,424,893				

<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts) . . . . .			1,759,071			1,759,071
	<b>4</b> Income from investment of tax-exempt bond proceeds . . . . .			0			
	<b>5</b> Royalties . . . . .			0			
	<b>6a</b> Gross rents	(i) Real	(ii) Personal				
		2,271,976					
	<b>b</b> Less rental expenses	2,329,371					
	<b>c</b> Rental income or (loss)	-57,395	0				
	<b>d</b> Net rental income or (loss) . . . . .			-57,395			-57,395
	<b>7a</b> Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other				
		50,273,160	1,643,061				
	<b>b</b> Less cost or other basis and sales expenses	49,005,097	1,394,497				
	<b>c</b> Gain or (loss)	1,268,063	248,564				
	<b>d</b> Net gain or (loss) . . . . .			1,516,627			1,516,627
	<b>8a</b> Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18 . . . . .	<b>a</b>	0				
	<b>b</b> Less direct expenses . . . . .	<b>b</b>	0				
<b>c</b> Net income or (loss) from fundraising events . . . . .			0				
<b>9a</b> Gross income from gaming activities See Part IV, line 19 . . . . .	<b>a</b>	0					
<b>b</b> Less direct expenses . . . . .	<b>b</b>	0					
<b>c</b> Net income or (loss) from gaming activities . . . . .			0				
<b>10a</b> Gross sales of inventory, less returns and allowances . . . . .	<b>a</b>	19,636					
<b>b</b> Less cost of goods sold . . . . .	<b>b</b>	25,275					
<b>c</b> Net income or (loss) from sales of inventory . . . . .			-5,639			-5,639	
Miscellaneous Revenue	Business Code						
<b>11a</b> GAIN ON INTEREST SWAP ADJ	900099		4,862,081			4,862,081	
<b>b</b> CAFETERIA SALES	900099		970,438		1,207	969,231	
<b>c</b> ALL OTHER REVENUE	900099		404,817			404,817	
<b>d</b> All other revenue . . . . .							
<b>e Total.</b> Add lines 11a-11d . . . . .			6,237,336				
<b>12 Total revenue.</b> See Instructions . . . . .			233,464,387	223,134,310	291,790	9,448,793	

**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
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21.	449,165	449,165		
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22.	0			
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.	0			
<b>4</b> Benefits paid to or for members.	0			
<b>5</b> Compensation of current officers, directors, trustees, and key employees.	1,859,509	1,035,080	824,429	0
<b>6</b> Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B).	0			
<b>7</b> Other salaries and wages.	81,153,647	71,897,110	9,256,537	
<b>8</b> Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions).	1,918,204	1,685,261	232,943	
<b>9</b> Other employee benefits.	10,977,381	8,649,802	2,327,579	
<b>10</b> Payroll taxes.	5,820,595	5,051,310	769,285	
<b>11</b> Fees for services (non-employees)				
<b>a</b> Management.	71,107	71,107		
<b>b</b> Legal.	224,653		224,653	
<b>c</b> Accounting.	133,138		133,138	
<b>d</b> Lobbying.	9,040		9,040	
<b>e</b> Professional fundraising services. See Part IV, line 17.	0			
<b>f</b> Investment management fees.	213,433		213,433	
<b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	20,488,149	18,643,492	1,844,657	
<b>12</b> Advertising and promotion.	2,030,528	2,030,528		
<b>13</b> Office expenses.	1,269,010	756,263	512,747	
<b>14</b> Information technology.	7,700,046	6,764,966	935,080	
<b>15</b> Royalties.	0			
<b>16</b> Occupancy.	3,690,844	3,335,145	355,699	
<b>17</b> Travel.	162,781	91,682	71,099	
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials.	0			
<b>19</b> Conferences, conventions, and meetings.	918	34	884	
<b>20</b> Interest.	8,342,677	8,342,677		
<b>21</b> Payments to affiliates.	0			
<b>22</b> Depreciation, depletion, and amortization.	21,361,711	21,361,711		
<b>23</b> Insurance.	540,593	379,164	161,429	
<b>24</b> 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.)				
<b>a</b> OPERATING SUPPLIES	41,491,105	41,491,105		
<b>b</b> PURCHASED SERVICES	11,424,514	9,083,343	2,341,171	
<b>c</b> HOSPITAL FRANCHISE TAX	4,059,609	4,059,609		
<b>d</b> ASSET IMPAIRMENT	961,513	961,513		
<b>e</b> All other expenses	2,442,559	1,964,383	478,176	
<b>25</b> Total functional expenses. Add lines 1 through 24e.	228,796,429	208,104,450	20,691,979	0
<b>26</b> 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
<b>Assets</b>	<b>1</b>	Cash—non-interest-bearing . . . . .	11,320	<b>1</b>	10,320
	<b>2</b>	Savings and temporary cash investments . . . . .	2,327,828	<b>2</b>	1,529,211
	<b>3</b>	Pledges and grants receivable, net . . . . .	0	<b>3</b>	0
	<b>4</b>	Accounts receivable, net . . . . .	35,401,385	<b>4</b>	31,448,952
	<b>5</b>	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L . . . . .	0	<b>5</b>	0
	<b>6</b>	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 . . . . .	0	<b>6</b>	0
	<b>7</b>	Notes and loans receivable, net . . . . .	12,020	<b>7</b>	63,748
	<b>8</b>	Inventories for sale or use . . . . .	1,794,439	<b>8</b>	2,227,768
	<b>9</b>	Prepaid expenses and deferred charges . . . . .	2,789,426	<b>9</b>	3,153,177
	<b>10a</b>	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	419,460,752		
	<b>b</b>	Less accumulated depreciation	224,160,024		
	<b>11</b>	Investments—publicly traded securities . . . . .	64,582,931	<b>11</b>	72,310,599
	<b>12</b>	Investments—other securities See Part IV, line 11 . . . . .	18,199,681	<b>12</b>	27,124,227
	<b>13</b>	Investments—program-related See Part IV, line 11 . . . . .	0	<b>13</b>	0
	<b>14</b>	Intangible assets . . . . .	9,199,143	<b>14</b>	8,874,147
	<b>15</b>	Other assets See Part IV, line 11 . . . . .	21,873,533	<b>15</b>	21,572,325
<b>16</b>	<b>Total assets.</b> Add lines 1 through 15 (must equal line 34) . . . . .	362,165,607	<b>16</b>	363,615,202	
<b>Liabilities</b>	<b>17</b>	Accounts payable and accrued expenses . . . . .	16,321,647	<b>17</b>	19,182,131
	<b>18</b>	Grants payable . . . . .	424,827	<b>18</b>	326,400
	<b>19</b>	Deferred revenue . . . . .	459,923	<b>19</b>	235,093
	<b>20</b>	Tax-exempt bond liabilities . . . . .	190,972,104	<b>20</b>	188,255,359
	<b>21</b>	Escrow or custodial account liability Complete Part IV of Schedule D . . . . .	0	<b>21</b>	0
	<b>22</b>	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 . . . . .	0	<b>22</b>	0
	<b>23</b>	Secured mortgages and notes payable to unrelated third parties . . . . .	17,207,018	<b>23</b>	16,909,516
	<b>24</b>	Unsecured notes and loans payable to unrelated third parties . . . . .	0	<b>24</b>	0
	<b>25</b>	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 . . . . .	16,521,912	<b>25</b>	29,077,473
	<b>26</b>	<b>Total liabilities.</b> Add lines 17 through 25 . . . . .	241,907,431	<b>26</b>	253,985,972
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.</b>				
	<b>27</b>	Unrestricted net assets	120,126,836	<b>27</b>	109,497,890
	<b>28</b>	Temporarily restricted net assets . . . . .	131,340	<b>28</b>	131,340
	<b>29</b>	Permanently restricted net assets	0	<b>29</b>	0
	<b>Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.</b>				
	<b>30</b>	Capital stock or trust principal, or current funds . . . . .		<b>30</b>	
	<b>31</b>	Paid-in or capital surplus, or land, building or equipment fund . . . . .		<b>31</b>	
	<b>32</b>	Retained earnings, endowment, accumulated income, or other funds		<b>32</b>	
<b>33</b>	<b>Total net assets or fund balances</b> . . . . .	120,258,176	<b>33</b>	109,629,230	
<b>34</b>	<b>Total liabilities and net assets/fund balances</b> . . . . .	362,165,607	<b>34</b>	363,615,202	

**Part XI Reconciliation of Net Assets**

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

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	233,464,387
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	228,796,429
<b>3</b>	Revenue less expenses Subtract line 2 from line 1	<b>3</b>	4,667,958
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	120,258,176
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	-6,867,925
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	-8,428,979
<b>10</b>	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	<b>10</b>	109,629,230

**Part XII Financial Statements and Reporting**

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

- 1** Accounting method used to prepare the Form 990  Cash  Accrual  Other \_\_\_\_\_  
 If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O
- 2a** Were the organization's financial statements compiled or reviewed by an independent accountant?  
 If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both  
 Separate basis  Consolidated basis  Both consolidated and separate basis
- b** Were the organization's financial statements audited by an independent accountant?  
 If 'Yes,' check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both  
 Separate basis  Consolidated basis  Both consolidated and separate basis
- c** If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?  
 If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O
- 3a** As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?
- 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

	Yes	No
<b>2a</b>		No
<b>2b</b>	Yes	
<b>2c</b>	Yes	
<b>3a</b>		No
<b>3b</b>		

## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 31-1079309

**Name:** ATRIUM MEDICAL CENTER

Form 990 (2018)

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**Form 990, Part III, Line 4a:**

THE PRIMARY EXEMPT PURPOSE OF ATRIUM MEDICAL CENTER IS TO PROVIDE COMPREHENSIVE INPATIENT, OUTPATIENT, AND EMERGENCY HEALTH CARE SERVICES TO THE RESIDENTS OF BUTLER AND WARREN COUNTIES THE HOSPITAL FURTHERS ITS TAX-EXEMPT PURPOSE BY PROMOTING THE HEALTH OF THE COMMUNITY IN MANY WAYS SEE SCHEDULE H FOR MORE INFORMATION

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**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	Insttutchnal Trustee	Officer	Key employee	Highest compensated employee	Former			
BARRY ROBERTSON MD ..... BOARD CHAIR	0 5 .....	X		X				0	0	0
MICHAEL R UHL ..... PRESIDENT	38 0 .....	X		X				591,930	0	48,840
MARQUITA L TURNER ..... COO & CNO	2 0 40 0 .....	X		X				345,287	0	19,082
BARBARA L STEEL MD ..... BOARD VICE-CHAIR	0 5 .....	X						0	0	0
WILLIAM ANDREW MD ..... TRUSTEE	0 0 0 5 .....	X						50,000	0	0
DALE J BLOCK MD ..... TRUSTEE	0 5 .....	X						0	265,739	40,951
MARY H BOOSALIS ..... TRUSTEE & PREMIER PRESIDENT	39 5 0 5 .....	X						0	1,877,611	40,298
JOHN M MILLER MD ..... TRUSTEE	0 5 .....	X						8,924	746,669	39,644
PERCY DAVID MITCHELL JR MD ..... TRUSTEE	39 5 0 5 .....	X						30,000	0	0
MATTHEW S REEVES DO ..... TRUSTEE / VP OPS AND CMO	0 0 40 0 .....	X						384,719	0	22,285

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			
RHONDA L SEIDENSCHMIDT ..... TRUSTEE / VP OPERATIONS	39 5 ..... 0 5	X						230,372	0	24,411
LYNDSEY A PITTMAN ..... BOARD TREAS / DIRECTOR-FINANCE	39 5 ..... 0 5			X				98,404	0	5,255
DALE E CREECH JR ..... SYS VP-CHF LGL OFFICER-TO JUL	8 0 ..... 32 0				X			0	712,176	198,521
THOMAS R CURTIN ..... VP REVENUE CYCLE	8 0 ..... 32 0				X			0	334,595	54,623
GARY G GINTER ..... VP &PREMIER CHIEF INFO OFFICER	8 0 ..... 32 0				X			0	554,305	50,289
JENNIFER J HAULER MD ..... VP MEDICAL AFFAIRS&PREMIER CMO	8 0 ..... 32 0				X			0	648,598	16,249
BARBARA A JOHNSON ..... SYS VP - HR OPERATIONS	8 0 ..... 32 0				X			0	575,983	25,035
RENEE M JOHNSON ..... SYS VP-MANAGED CARE (FROM APR)	8 0 ..... 32 0				X			0	185,662	20,889
MARGARET W MARK ..... VP NURSING SERVICE/PREMIER CNO	8 0 ..... 32 0				X			0	588,511	32,768
CRAIG SELF ..... CHF STRATEGY OFFICER (TO NOV)	8 0 ..... 32 0				X			0	787,777	360,014





**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			
JEFFREY S ZOLLETT MD ..... FORMER OFFICER	0 0 ..... 40 0						X	0	152,616	8,658
RENEE P GEORGE ..... FORMER KEY	0 0 ..... 40 0						X	0	571,367	37,650
TAMMY S LUNDSTROM MD ..... FORMER KEY	0 0 ..... 40 0						X	0	445,094	10,973
MICHAEL J MAIBERGER ..... FORMER KEY	0 0 ..... 40 0						X	0	1,208,794	48,670
MARK S SHAKER ..... FORMER KEY	0 0 ..... 0 0						X	0	814,710	25,970
THOMAS R PARKER ..... FORMER KEY	0 0 ..... 40 0						X	0	600,098	43,008

**SCHEDULE A**  
**(Form 990 or 990-EZ)**

**Public Charity Status and Public Support**

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.  
 Attach to Form 990 or Form 990-EZ.  
 Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

**2018**

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

Name of the organization  
ATRIUM MEDICAL CENTER

Employer identification number  
31-1079309

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

The organization is not a private foundation because it is (For lines 1 through 12, check only one box.)

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

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

**Part II Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv), 170(b)(1)(A)(vi), and 170(b)(1)(A)(ix)**

(Complete only if you checked the box on line 5, 7, 8, or 9 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ►		(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
<b>1</b>	Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant")						
<b>2</b>	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
<b>3</b>	The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>4</b>	<b>Total.</b> Add lines 1 through 3						
<b>5</b>	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)						
<b>6</b>	<b>Public support.</b> Subtract line 5 from line 4						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►		(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
<b>7</b>	Amounts from line 4						
<b>8</b>	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
<b>9</b>	Net income from unrelated business activities, whether or not the business is regularly carried on						
<b>10</b>	Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI )						
<b>11</b>	<b>Total support.</b> Add lines 7 through 10						
<b>12</b>	Gross receipts from related activities, etc (see instructions)					<b>12</b>	

**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**

<b>14</b>	Public support percentage for 2018 (line 6, column (f) divided by line 11, column (f))	<b>14</b>	
<b>15</b>	Public support percentage for 2017 Schedule A, Part II, line 14	<b>15</b>	

- 16a 33 1/3% support test—2018.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ►
- b 33 1/3% support test—2017.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ►
- 17a 10%-facts-and-circumstances test—2018.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ►
- b 10%-facts-and-circumstances test—2017.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ►
- 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) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
<b>1</b>	Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
<b>2</b>	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						
<b>3</b>	Gross receipts from activities that are not an unrelated trade or business under section 513						
<b>4</b>	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
<b>5</b>	The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>6</b>	<b>Total.</b> Add lines 1 through 5						
<b>7a</b>	Amounts included on lines 1, 2, and 3 received from disqualified persons						
<b>b</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						
<b>c</b>	Add lines 7a and 7b						
<b>8</b>	<b>Public support.</b> (Subtract line 7c from line 6)						

**Section B. Total Support**

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

<b>15</b>	Public support percentage for 2018 (line 8, column (f) divided by line 13, column (f))	<b>15</b>	
<b>16</b>	Public support percentage from 2017 Schedule A, Part III, line 15	<b>16</b>	

**Section D. Computation of Investment Income Percentage**

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

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

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

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

**Part IV Supporting Organizations**

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

**Section A. All Supporting Organizations**

		Yes	No
<b>1</b>	Are all of the organization's supported organizations listed by name in the organization's governing documents? If "No," describe in <b>Part VI</b> how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.		
	<b>1</b>		
<b>2</b>	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 <b>Part VI</b> how the organization determined that the supported organization was described in section 509(a)(1) or (2).		
	<b>2</b>		
<b>3a</b>	Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? If "Yes," answer (b) and (c) below.		
	<b>3a</b>		
<b>b</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 <b>Part VI</b> when and how the organization made the determination.		
	<b>3b</b>		
<b>c</b>	Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? If "Yes," explain in <b>Part VI</b> what controls the organization put in place to ensure such use.		
	<b>3c</b>		
<b>4a</b>	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.		
	<b>4a</b>		
<b>b</b>	Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? If "Yes," describe in <b>Part VI</b> how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.		
	<b>4b</b>		
<b>c</b>	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 <b>Part VI</b> 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.		
	<b>4c</b>		
<b>5a</b>	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 <b>Part VI</b> , 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).		
	<b>5a</b>		
<b>b</b>	<b>Type I or Type II only.</b> Was any added or substituted supported organization part of a class already designated in the organization's organizing document?		
	<b>5b</b>		
<b>c</b>	<b>Substitutions only.</b> Was the substitution the result of an event beyond the organization's control?		
	<b>5c</b>		
<b>6</b>	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 <b>Part VI</b> .		
	<b>6</b>		
<b>7</b>	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).		
	<b>7</b>		
<b>8</b>	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).		
	<b>8</b>		
<b>9a</b>	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 <b>Part VI</b> .		
	<b>9a</b>		
<b>b</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 <b>Part VI</b> .		
	<b>9b</b>		
<b>c</b>	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 <b>Part VI</b> .		
	<b>9c</b>		
<b>10a</b>	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.		
	<b>10a</b>		
<b>b</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.)		
	<b>10b</b>		

**Part IV Supporting Organizations** (continued)

		Yes	No
<b>11</b>	Has the organization accepted a gift or contribution from any of the following persons?		
<b>a</b>	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>b</b>	A family member of a person described in (a) above?		
<b>c</b>	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
<b>1</b>	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>		
<b>2</b>	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
<b>1</b>	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
<b>1</b>	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?		
<b>2</b>	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>		
<b>3</b>	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**

<b>1</b>	Check the box next to the method that the organization used to satisfy the Integral Part Test during the year ( <b>see instructions</b> )		
<b>a</b>	<input type="checkbox"/> The organization satisfied the Activities Test. Complete <b>line 2</b> below.		
<b>b</b>	<input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete <b>line 3</b> below.		
<b>c</b>	<input type="checkbox"/> The organization supported a governmental entity. Describe in <b>Part VI</b> how you supported a government entity (see instructions).		
<b>2</b>	Activities Test <b>Answer (a) and (b) below.</b>		
<b>a</b>	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>	Yes	No
<b>b</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>		
<b>3</b>	Parent of Supported Organizations <b>Answer (a) and (b) below.</b>		
<b>a</b>	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>b</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**

- 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.

<b>Section A - Adjusted Net Income</b>		(A) Prior Year	(B) Current Year (optional)
<b>1</b>	Net short-term capital gain	<b>1</b>	
<b>2</b>	Recoveries of prior-year distributions	<b>2</b>	
<b>3</b>	Other gross income (see instructions)	<b>3</b>	
<b>4</b>	Add lines 1 through 3	<b>4</b>	
<b>5</b>	Depreciation and depletion	<b>5</b>	
<b>6</b>	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)	<b>6</b>	
<b>7</b>	Other expenses (see instructions)	<b>7</b>	
<b>8</b>	<b>Adjusted Net Income</b> (subtract lines 5, 6 and 7 from line 4)	<b>8</b>	
<b>Section B - Minimum Asset Amount</b>		(A) Prior Year	(B) Current Year (optional)
<b>1</b>	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year)	<b>1</b>	
<b>a</b>	Average monthly value of securities	<b>1a</b>	
<b>b</b>	Average monthly cash balances	<b>1b</b>	
<b>c</b>	Fair market value of other non-exempt-use assets	<b>1c</b>	
<b>d</b>	<b>Total</b> (add lines 1a, 1b, and 1c)	<b>1d</b>	
<b>e</b>	<b>Discount</b> claimed for blockage or other factors (explain in detail in Part VI)		
<b>2</b>	Acquisition indebtedness applicable to non-exempt use assets	<b>2</b>	
<b>3</b>	Subtract line 2 from line 1d	<b>3</b>	
<b>4</b>	Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions)	<b>4</b>	
<b>5</b>	Net value of non-exempt-use assets (subtract line 4 from line 3)	<b>5</b>	
<b>6</b>	Multiply line 5 by .035	<b>6</b>	
<b>7</b>	Recoveries of prior-year distributions	<b>7</b>	
<b>8</b>	<b>Minimum Asset Amount</b> (add line 7 to line 6)	<b>8</b>	
<b>Section C - Distributable Amount</b>			Current Year
<b>1</b>	Adjusted net income for prior year (from Section A, line 8, Column A)	<b>1</b>	
<b>2</b>	Enter 85% of line 1	<b>2</b>	
<b>3</b>	Minimum asset amount for prior year (from Section B, line 8, Column A)	<b>3</b>	
<b>4</b>	Enter greater of line 2 or line 3	<b>4</b>	
<b>5</b>	Income tax imposed in prior year	<b>5</b>	
<b>6</b>	<b>Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	<b>6</b>	
<b>7</b>	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)		

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

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

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



## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 31-1079309

**Name:** ATRIUM MEDICAL CENTER

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

**Facts And Circumstances Test**

**SCHEDULE C**  
(Form 990 or 990-EZ)  
  
Department of the Treasury  
Internal Revenue Service

**Political Campaign and Lobbying Activities**  
For Organizations Exempt From Income Tax Under section 501(c) and section 527  
  
▶Complete if the organization is described below. ▶Attach to Form 990 or Form 990-EZ.  
▶Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No 1545-0047  
  
**2018**  
**Open to Public Inspection**

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

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

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

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

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

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

Name of the organization ATRIUM MEDICAL CENTER	Employer identification number 31-1079309
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**Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.**

- 1 Provide a description of the organization's direct and indirect political campaign activities in Part IV (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) 2015	(b) 2016	(c) 2017	(d) 2018	(e) Total
<b>2a</b> Lobbying nontaxable amount					
<b>b</b> Lobbying ceiling amount (150% of line 2a, column(e))					
<b>c</b> Total lobbying expenditures					
<b>d</b> Grassroots nontaxable amount					
<b>e</b> Grassroots ceiling amount (150% of line 2d, column (e))					
<b>f</b> 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
<b>1</b> 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			
<b>a</b> Volunteers?		No	
<b>b</b> Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
<b>c</b> Media advertisements?		No	
<b>d</b> Mailings to members, legislators, or the public?		No	
<b>e</b> Publications, or published or broadcast statements?		No	
<b>f</b> Grants to other organizations for lobbying purposes?	Yes		4,990
<b>g</b> Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
<b>h</b> Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
<b>i</b> Other activities?	Yes		4,050
<b>j</b> Total Add lines 1c through 1i			9,040
<b>2a</b> Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
<b>b</b> If "Yes," enter the amount of any tax incurred under section 4912			
<b>c</b> If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
<b>d</b> If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?		No	

**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
<b>1</b> Were substantially all (90% or more) dues received nondeductible by members?	<b>1</b>	
<b>2</b> Did the organization make only in-house lobbying expenditures of \$2,000 or less?	<b>2</b>	
<b>3</b> Did the organization agree to carry over lobbying and political expenditures from the prior year?	<b>3</b>	

**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."**

<b>1</b> Dues, assessments and similar amounts from members	<b>1</b>
<b>2</b> Section 162(e) nondeductible lobbying and political expenditures (do not include amounts of political expenses for which the section 527(f) tax was paid).	
<b>a</b> Current year	<b>2a</b>
<b>b</b> Carryover from last year	<b>2b</b>
<b>c</b> Total	<b>2c</b>
<b>3</b> Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	<b>3</b>
<b>4</b> 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?	<b>4</b>
<b>5</b> Taxable amount of lobbying and political expenditures (see instructions)	<b>5</b>

**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 1F	PAYMENTS FOR LOBBYING ACTIVITIES INCLUDE DUES PAID TO GREATER DAYTON AREA HOSPITAL ASSOCIATION, DAYTON DEVELOPMENT COALITION, AND OHIO HOSPITAL ASSOCIATION PART II-B, LINE 1I THE HOSPITAL CONTRACTS WITH A LOBBYIST FOR HEALTHCARE RELATED ISSUES

**SCHEDULE D**  
(Form 990)  
  
Department of the Treasury  
Internal Revenue Service

# Supplemental Financial Statements

OMB No 1545-0047  
**2018**  
**Open to Public Inspection**

▶ Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.  
▶ Attach to Form 990.  
▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

**Name of the organization**  
ATRIUM MEDICAL CENTER

**Employer identification number**  
31-1079309

**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 7/25/06, and not on a historic structure listed in the National Register	2d

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Part IV Escrow and Custodial Arrangements.**

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

- 1a** Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?  Yes  No
- b** If "Yes," explain the arrangement in Part XIII and complete the following table
- |   | Amount |
|---|--------|
| <b>1c</b> Beginning balance             |        |
| <b>1d</b> Additions during the year     |        |
| <b>1e</b> Distributions during the year |        |
| <b>1f</b> 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
<b>1a</b> Beginning of year balance . . . . .	131,340	131,340	133,659	132,575	133,055
<b>b</b> Contributions . . . . .			328	3,734	5,860
<b>c</b> Net investment earnings, gains, and losses					
<b>d</b> Grants or scholarships . . . . .					
<b>e</b> Other expenditures for facilities and programs . . . . .			2,647	2,650	6,340
<b>f</b> Administrative expenses . . . . .					
<b>g</b> End of year balance . . . . .	131,340	131,340	131,340	133,659	132,575

- 2** Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as
- a** Board designated or quasi-endowment ▶ 0 %
  - b** Permanent endowment ▶ 0 %
  - c** Temporarily restricted endowment ▶ 100 000 %
- 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 |
|--|-----|----|
| <b>(i)</b> unrelated organizations . . . . . | No  | No |
| <b>(ii)</b> related organizations . . . . .  | No  | No |
- b** If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R? . . . . .
- 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
<b>1a</b> Land . . . . .		25,472,332		25,472,332
<b>b</b> Buildings . . . . .		246,298,416	110,200,446	136,097,970
<b>c</b> Leasehold improvements		945,345	605,588	339,757
<b>d</b> Equipment . . . . .		138,312,716	113,353,990	24,958,726
<b>e</b> Other . . . . .		8,431,943		8,431,943
<b>Total.</b> Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c)) . . . ▶				195,300,728

**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) ALTERNATIVE INVESTMENTS	27,124,227	F
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
<b>Total.</b> (Column (b) must equal Form 990, Part X, col (B) line 12 )	27,124,227	

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

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

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

(a) Description	(b) Book value
(1) DUE FROM AFFILIATES	18,521,968
(2) REBATES RECEIVABLE	1,941,789
(3) DEFERRED COMPENSATION	675,420
(4) MISC AR	263,148
(5) DEPOSITS	140,000
(6) OTHER INVESTMENTS	30,000
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col (B) line 15 )	21,572,325

**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.

(a) Description of liability	(b) Book value
(1) Federal income taxes	0
PENSION OBLIGATION & DEFERRED	13,932,198
SWAP LIABILITY	6,430,077
SELF INSURANCE RESERVE	5,273,287
LEASE LIABILITIES	1,423,434
ACCRUED MANAGED CARE LIAB	1,204,383
MEDICAL STAFF FEES	298,440
WORKERS COMP RESERVE	199,278
OTHER	316,376
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col (B) line 25 )	29,077,473

**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.

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

**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.

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

**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:** 31-1079309  
**Name:** ATRIUM MEDICAL CENTER

### Form 990, Schedule D, Part X, - Other Liabilities

1 (a) Description of Liability	(b) Book Value
PENSION OBLIGATION & DEFERRED	13,932,198
SWAP LIABILITY	6,430,077
SELF INSURANCE RESERVE	5,273,287
LEASE LIABILITIES	1,423,434
ACCRUED MANAGED CARE LIAB	1,204,383
MEDICAL STAFF FEES	298,440
WORKERS COMP RESERVE	199,278
OTHER	316,376

**Supplemental Information**

Return Reference	Explanation
PART V, LINE 4	<p>THE ORGANIZATION'S ENDOWMENT FUNDS ARE DESIGNATED TO SUPPORT SPECIFIC HEALTHCARE SERVICES OR CAPITAL NEEDS SCHEDULE D, PART X, LINE 2 THE FOLLOWING FOOTNOTE IS FROM THE 2018 CONSOLIDATED AUDITED FINANCIAL STATEMENTS FOR PREMIER HEALTH (PHP) AND AFFILIATES PHP IS THE SOLE MEMBER OF ATRIUM MEDICAL CENTER (AMC) PHP has been determined by the Internal Revenue Service to be a tax-exempt nonprofit corporation under Section 501(c)(3) of the Internal Revenue Code As a tax-exempt organization, its income is exempt from federal income tax except to the extent of any unrelated business activities PHP consolidates certain subsidiaries, which are for-profit corporations subject to federal income taxes The Tax Cuts and Jobs Act (the Act) was enacted on December 22, 2017 For tax-exempt entities, the Act requires organizations to categorize certain fringe benefit expenses as a source of unrelated business income, pay an excise tax on remuneration above certain thresholds that is paid to executives by the organization, and report income or loss from unrelated business activities on an activity-by-activity basis, among other provisions Certain regulatory guidance provides for a measurement period of up to one year, during which the accounting for the tax effects of the Act may be completed PHP may record further adjustments in future periods upon obtaining, preparing, or analyzing additional information about facts and circumstances that existed as of the date of enactment PHP will continue to revise and refine the calculations as additional IRS guidance is issued, however, PHP does not anticipate any material impact to the consolidated financial statements Management annually reviews the tax positions and has determined that there are no material uncertain tax positions</p>

**SCHEDULE F  
(Form 990)**  
  
Department of the Treasury  
Internal Revenue Service

# Statement of Activities Outside the United States

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 14b, 15, or 16.  
▶ Attach to Form 990.  
▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No 1545-0047  
**2018**  
**Open to Public Inspection**

Name of the organization  
ATRIUM MEDICAL CENTER

**Employer identification number**  
31-1079309

**Part I** **General Information on Activities Outside the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 14b.

**1 For grantmakers.** Does the organization maintain records to substantiate the amount of its grants and other assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance?  Yes  No

**2 For grantmakers.** Describe in Part V the organization's procedures for monitoring the use of its grants and other assistance outside the United States

**3** Activities per Region (The following Part I, line 3 table can be duplicated if additional space is needed )

(a) Region	(b) Number of offices in the region	(c) Number of employees, agents, and independent contractors in region	(d) Activities conducted in region (by type) (e g , fundraising, program services, investments, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for and investments in region
See Add'l Data					
<b>3a</b> Sub-total					9,596,000
<b>b</b> Total from continuation sheets to Part I					
<b>c Totals</b> (add lines 3a and 3b)					9,596,000

**Part II Grants and Other Assistance to Organizations or Entities Outside the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 15, for any recipient who received more than \$5,000. Part II can be duplicated if additional space is needed.

1 (a) Name of organization	(b) IRS code section and EIN (if applicable)	(c) Region	(d) Purpose of grant	(e) Amount of cash grant	(f) Manner of cash disbursement	(g) Amount of non-cash assistance	(h) Description of non-cash assistance	(i) Method of valuation (book, FMV, appraisal, other)

- 2 Enter total number of recipient organizations listed above that are recognized as charities by the foreign country, recognized as tax-exempt by the IRS, or for which the grantee or counsel has provided a section 501(c)(3) equivalency letter . . . . . ▶ \_\_\_\_\_
- 3 Enter total number of other organizations or entities . . . . . ▶ \_\_\_\_\_

**Part III Grants and Other Assistance to Individuals Outside the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 16.

Part III can be duplicated if additional space is needed.

<b>(a)</b> Type of grant or assistance	<b>(b)</b> Region	<b>(c)</b> Number of recipients	<b>(d)</b> Amount of cash grant	<b>(e)</b> Manner of cash disbursement	<b>(f)</b> Amount of non-cash assistance	<b>(g)</b> Description of non-cash assistance	<b>(h)</b> Method of valuation (book, FMV, appraisal, other)

**Part IV Foreign Forms**

- 1 Was the organization a U S transferor of property to a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 926, Return by a U S Transferor of Property to a Foreign Corporation (see Instructions for Form 926)*  Yes  No
- 2 Did the organization have an interest in a foreign trust during the tax year? *If "Yes," the organization may be required to separately file Form 3520, Annual Return to Report Transactions with Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U S Owner (see Instructions for Forms 3520 and 3520-A, don't file with Form 990)*  Yes  No
- 3 Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U S Persons with Respect to Certain Foreign Corporations (see Instructions for Form 5471)*  Yes  No
- 4 Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? *If "Yes," the organization may be required to file Form 8621, Information Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund (see Instructions for Form 8621)*  Yes  No
- 5 Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U S Persons with Respect to Certain Foreign Partnerships (see Instructions for Form 8865)*  Yes  No
- 6 Did the organization have any operations in or related to any boycotting countries during the tax year? *If "Yes," the organization may be required to separately file Form 5713, International Boycott Report (see Instructions for Form 5713, don't file with Form 990)*  Yes  No

**Part V Supplemental Information**

Provide the information required by Part I, line 2 (monitoring of funds); Part I, line 3, column (f) (accounting method; amounts of investments vs. expenditures per region); Part II, line 1 (accounting method); Part III (accounting method); and Part III, column (c) (estimated number of recipients), as applicable. Also complete this part to provide any additional information (see instructions).

ReturnReference	Explanation



## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 31-1079309

**Name:** ATRIUM MEDICAL CENTER

### Form 990 Schedule F Part I - Activities Outside The United States

(a) Region	(b) Number of offices in the region	(c) Number of employees or agents in region	(d) Activities conducted in region (by type) (i.e., fundraising, program services, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for region
Central America and the Caribbean			Investments		9,569,000
Central America and the Caribbean			Program Services	INSURANCE	27,000

**SCHEDULE H (Form 990)**

**Hospitals**

OMB No 1545-0047

**2018**

**Open to Public Inspection**

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

Department of the Treasury  
 Internal Revenue Service

**Name of the organization**  
 ATRIUM MEDICAL CENTER

**Employer identification number**  
 31-1079309

**Part I Financial Assistance and Certain Other Community Benefits at Cost**

	Yes	No
<b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	Yes	
<b>1b</b> If "Yes," was it a written policy?	Yes	
<b>2</b> 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		
<b>3</b> 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		
<b>a</b> 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 type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %	Yes	
<b>b</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 _____ %	Yes	
<b>c</b> 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		
<b>4</b> Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	Yes	
<b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	Yes	
<b>b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	Yes	
<b>c</b> 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?		No
<b>6a</b> Did the organization prepare a community benefit report during the tax year?	Yes	
<b>b</b> If "Yes," did the organization make it available to the public?	Yes	

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

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

<b>Financial Assistance and Means-Tested Government Programs</b>	<b>(a) Number of activities or programs (optional)</b>	<b>(b) Persons served (optional)</b>	<b>(c) Total community benefit expense</b>	<b>(d) Direct offsetting revenue</b>	<b>(e) Net community benefit expense</b>	<b>(f) Percent of total expense</b>
<b>a</b> Financial Assistance at cost (from Worksheet 1)			5,484,000	3,890,000	1,594,000	0 700 %
<b>b</b> Medicaid (from Worksheet 3, column a)			47,974,171	29,072,171	18,902,000	8 260 %
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b)			3,116,000	2,412,000	704,000	0 310 %
<b>d Total</b> Financial Assistance and Means-Tested Government Programs			56,574,171	35,374,171	21,200,000	9 270 %
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4)			405,340	32,340	373,000	0 160 %
<b>f</b> Health professions education (from Worksheet 5)						
<b>g</b> Subsidized health services (from Worksheet 6)			9,142,000		9,142,000	4 000 %
<b>h</b> Research (from Worksheet 7)						
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8)			311,000		311,000	0 140 %
<b>j Total.</b> Other Benefits			9,858,340	32,340	9,826,000	4 300 %
<b>k Total.</b> Add lines 7d and 7j			66,432,511	35,406,511	31,026,000	13 570 %

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support						
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development			8,000		8,000	0 %
9 Other			2,000		2,000	0 %
<b>10 Total</b>			10,000		10,000	0 %

**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	7,633,462
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	50,252,000
6	Enter Medicare allowable costs of care relating to payments on line 5.	6	53,096,000
7	Subtract line 6 from line 5. This is the surplus (or shortfall).	7	-2,844,000
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 checked="" type="checkbox"/> Cost accounting system <input 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** (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

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

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

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

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

**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)

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

**Part V Facility Information** (continued)

**Section B. Facility Policies and Practices**

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

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
<b>Community Health Needs Assessment</b>			
<b>1</b>	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
<b>2</b>	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
<b>3</b>	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	
<b>a</b>	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b>	<input checked="" type="checkbox"/> Demographics of the community		
<b>c</b>	<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		
<b>d</b>	<input checked="" type="checkbox"/> How data was obtained		
<b>e</b>	<input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b>	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b>	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b>	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b>	<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)		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>4</b>	Indicate the tax year the hospital facility last conducted a CHNA <u>20 16</u>		
<b>5</b>	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	
<b>6 a</b>	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>b</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	
<b>7</b>	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	
<b>a</b>	<input checked="" type="checkbox"/> Hospital facility's website (list url) <u>SEE SCHED H, PART V, SECTION C</u>		
<b>b</b>	<input type="checkbox"/> Other website (list url) _____		
<b>c</b>	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>8</b>	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	
<b>9</b>	Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 17</u>		
<b>10</b>	Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url) <u>SEE SCHED H, PART V, SECTION C</u>	Yes	
<b>a</b>			
<b>b</b>	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .		
<b>11</b>	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		
<b>12a</b>	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>12b</b>	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .		
<b>c</b>	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)**

ATRIUM MEDICAL CENTER

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		
<b>13</b>	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	<b>13</b> Yes	
<b>a</b>	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>300</u> %		
<b>b</b>	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b>	<input type="checkbox"/> Asset level		
<b>d</b>	<input checked="" type="checkbox"/> Medical indigency		
<b>e</b>	<input type="checkbox"/> Insurance status		
<b>f</b>	<input checked="" type="checkbox"/> Underinsurance discount		
<b>g</b>	<input type="checkbox"/> Residency		
<b>h</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>14</b>	Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b> Yes	
<b>15</b>	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)	<b>15</b> Yes	
<b>a</b>	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</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		
<b>c</b>	<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		
<b>d</b>	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>16</b>	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)	<b>16</b> Yes	
<b>a</b>	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>SEE SCHED H, PART V, SECT C</u>		
<b>b</b>	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>SEE SCHED H, PART V, SECT C</u>		
<b>c</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>SEE SCHED H, PART V, SECT C</u>		
<b>d</b>	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b>	<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)		
<b>f</b>	<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)		
<b>g</b>	<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		
<b>h</b>	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b>	<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		
<b>j</b>	<input checked="" type="checkbox"/> Other (describe in Section C)		

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

ATRIUM MEDICAL CENTER

**Name of hospital facility or letter of facility reporting group**

		Yes	No	
<b>17</b>	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	
<b>18</b>	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			
<b>a</b>	<input type="checkbox"/> Reporting to credit agency(ies)			
<b>b</b>	<input type="checkbox"/> Selling an individual's debt to another party			
<b>c</b>	<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			
<b>d</b>	<input type="checkbox"/> Actions that require a legal or judicial process			
<b>e</b>	<input type="checkbox"/> Other similar actions (describe in Section C)			
<b>f</b>	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted			
<b>19</b>	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
<b>a</b>	<input type="checkbox"/> Reporting to credit agency(ies)			
<b>b</b>	<input type="checkbox"/> Selling an individual's debt to another party			
<b>c</b>	<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			
<b>d</b>	<input type="checkbox"/> Actions that require a legal or judicial process			
<b>e</b>	<input type="checkbox"/> Other similar actions (describe in Section C)			
<b>20</b>	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)			
<b>a</b>	<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>b</b>	<input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process			
<b>c</b>	<input checked="" type="checkbox"/> Processed incomplete and complete FAP applications			
<b>d</b>	<input checked="" type="checkbox"/> Made presumptive eligibility determinations			
<b>e</b>	<input type="checkbox"/> Other (describe in Section C)			
<b>f</b>	<input type="checkbox"/> None of these efforts were made			

**Policy Relating to Emergency Medical Care**

<b>21</b>	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	
<b>a</b>	<input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions			
<b>b</b>	<input type="checkbox"/> The hospital facility's policy was not in writing			
<b>c</b>	<input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
<b>d</b>	<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)**

ATRIUM MEDICAL CENTER

**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
<b>23</b>		No
<b>24</b>		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.

Table with 2 columns: Form and Line Reference, Explanation. Row 1: PART V, SECTION A, LINE 1. Explanation text describes Ohio hospital registration requirements and Atrium Medical Center's CHNA process, including data collection, stakeholder involvement, and community health needs assessment results.

**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? 3

Name and address	Type of Facility (describe)
<b>1</b> SOUTHWEST OHIO AMBULATORY SURGERY CENTER 295 N BREIEL BLVD MIDDLETOWN, OH 45042	GENERAL MEDICAL & SURGICAL OUTPATIENT FACILITY
<b>2</b> MASON EMERGENCY CENTER (TO JULY) 7450 Mason Montgomery Rd MASON, OH 45040	EMERGENCY CENTER
<b>3</b> ATRIUM HEALTH CENTER TRENTON 3590 BUSENBARK RD TRENTON, OH 45067	HEALTH CENTER
<b>4</b>	
<b>5</b>	
<b>6</b>	
<b>7</b>	
<b>8</b>	
<b>9</b>	
<b>10</b>	

**Part VI Supplemental Information**

Provide the following information

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

Form and Line Reference	Explanation
PART I, LINE 6A	<p>THE COMMUNITY BENEFIT REPORT FOR ATRIUM MEDICAL CENTER IS PART OF THE PREMIER HEALTH (PREMIER) REPORT (EIN# 31-1446699) PART I, LINE 7 A COST TO CHARGE RATIO WAS USED TO CALCULATE THIS FINANCIAL ASSISTANCE AT COST THIS CALCULATION TAKES TOTAL OPERATING EXPENSES LESS OTHER OPERATING REVENUES DIVIDED BY TOTAL GROSS REVENUES UNREIMBURSED MEDICAID AND OTHER MEANS-TESTED GOVERNMENTAL PROGRAMS WERE CALCULATED USING A COST ACCOUNTING SYSTEM THIS SYSTEM ADDRESSES ALL PATIENT SEGMENTS AND INCLUDES FULLY LOADED COSTS FOR THE REMAINING ITEMS THE ORGANIZATION USED SPECIFIC NUMBERS FOR EXPENSE PAID DIRECTLY FOR THESE SERVICES PART I, LINE 7G ATRIUM MEDICAL CENTER (AMC) PROVIDES SUBSIDIZED EMERGENCY SERVICES BY OPERATING A 24-HOUR EMERGENCY ROOM 365 DAYS PER YEAR THIS EMERGENCY ROOM IS OPEN TO ALL INDIVIDUALS REGARDLESS OF THEIR ABILITY TO PAY THE HOSPITAL INCURS EXPENSES RELATED TO CALL TIME AND PHYSICIAN SUBSIDIES DUE TO THE LARGE NUMBER OF INDIGENT PATIENTS COMING THROUGH THE EMERGENCY ROOM FOR 2018, THE AMOUNT PAID FOR CALL AND SUBSIDIES WAS \$9,142,000 PART II ----- ATRIUM MEDICAL CENTER (AMC) IS COMMITTED TO IMPROVING THE HEALTH OF THE COMMUNITIES IT SERVES THROUGH A VARIETY OF PREVENTION, HEALTH IMPROVEMENT AND ENGAGEMENT PROGRAMS AS PART OF ITS OVERALL COMMITMENT TO THE COMMUNITY, AMC FOCUSES ON FOUR AREAS OF SERVICE --INVESTING IN THE COMMUNITY --PREVENTION AND WELLNESS --COMMITMENT TO THE UNDER-SERVED --COMMUNITY ENGAGEMENT SOME OF THE PROGRAMS SUPPORTED BY AMC DURING 2018 INCLUDE 1) FUNDING OF \$7,500 WAS CONTRIBUTED TO ASSIST THOSE LIVING IN POVERTY TO WORK TOWARDS ECONOMIC SELF-SUFFICIENCY THROUGH EMPLOYMENT 2) \$2,000 WAS DONATED TO ASSIST IN RECOVERY FROM NATURAL DISASTERS PART III, LINES 2 &amp; 3 BAD DEBT EXPENSE IS INCURRED WHEN AN ACCOUNT IS TAKEN OUT OF ACCOUNTS RECEIVABLE AND TURNED OVER TO A COLLECTION AGENCY THIS ACTION MAY OCCUR IF A PATIENT REFUSES PAYMENT ARRANGEMENTS, REFUSES TO APPLY FOR FINANCIAL ASSISTANCE, AND THE REASON IS NOT AN INSURANCE BALANCE BEING CONTENDED AN ACCOUNT IS WRITTEN OFF TO BAD DEBT AFTER 130 DAYS IF AN ATTEMPT TO COLLECT FROM THE PATIENT IS MADE WITHIN OUR COLLECTION POLICY THE COLLECTION AGENCY ATTEMPTS TO COLLECT THE ACCOUNT IN ACCORDANCE WITH ESTABLISHED GUIDELINES COLLECTION ATTEMPTS ARE CEASED AND THE ACCOUNT RETURNED TO THE ORGANIZATION IF THE PATIENT APPLIES FOR FINANCIAL ASSISTANCE ANY AMOUNTS COLLECTED FROM THESE ACCOUNTS ARE CREDITED BACK AGAINST BAD DEBT EXPENSE THE ORGANIZATION RECOGNIZES THERE ARE ACCOUNTS WRITTEN OFF TO BAD DEBT THAT MAY HAVE QUALIFIED FOR CHARITY CARE IF THE PATIENT HAD PROVIDED THE NECESSARY FINANCIAL INFORMATION TO RESOLVE THIS, THE ORGANIZATION HAS ENGAGED A THIRD-PARTY VENDOR TO ANALYZE DATA BASED ON CREDIT SCORES TO REALLOCATE SOME OF THIS EXPENSE TO CHARITY CARE A REPRESENTATIVE SAMPLE OF THESE ACCOUNTS IS THEN SENT TO OUR THIRD-PARTY VENDOR WHO GATHERS EXTERNAL CREDIT DATA THAT PRESENTS THE ACCOUNT AS LESS THAN 100% FEDERAL POVERTY LEVEL OR NOT ENOUGH INFORMATION (TYPICALLY INDICATIVE OF INDIGENT) THESE ACCOUNTS ARE RECLASSIFIED FROM BAD DEBT EXPENSE TO CHARITY EXPENSE ON OUR INCOME STATEMENT ANY CREDIT SCORE THAT PRESENTS THE ACCOUNTS AS GREATER THAN 100% FEDERAL POVERTY LEVEL REMAINS IN BAD DEBT EXPENSE DUE TO THIS PROCESS, THE ORGANIZATION HAS USED BEST EFFORTS TO NOT REPORT BAD DEBT EXPENSE FOR PATIENTS ELIGIBLE UNDER THE ORGANIZATION'S CHARITY CARE POLICY PART III, LINE 4 THE ORGANIZATION DOES NOT HAVE A FOOTNOTE IN THE AUDITED FINANCIAL STATEMENTS WHICH DISCUSSES THIS CALCULATION PART III, SECTION B, LINES 5, 6, AND 7 THE AMOUNTS REPORTED ON LINES 5, 6, AND 7 DO NOT INCLUDE CERTAIN MEDICARE PROGRAM REVENUES AND COSTS, AND THUS DO NOT REFLECT ALL OF THE ORGANIZATION'S REVENUES AND COSTS ASSOCIATED WITH ITS PARTICIPATION IN MEDICARE PROGRAMS IN ADDITION TO THE AMOUNTS REPORTED ON LINE 5, 6, AND 7, THE ORGANIZATION RECEIVED REVENUE OF \$41,912,000 AND INCURRED COST OF \$34,603,000, FOR AN ADDITIONAL NET SHORTFALL OF \$15,409,000 ASSOCIATED WITH THESE PROGRAMS BELOW IS A RECONCILIATION OF THE AMOUNTS ASSOCIATED WITH MEDICARE PROGRAMS ALLOWABLE MEDICARE REVENUE PER MEDICARE COST REPORT IN PART III, SECTION B \$50,252,000 MEDICARE REVENUE NOT REPORTED IN PART III, SECTION B \$41,912,000 TOTAL MEDICARE ASSOCIATED REVENUE \$92,164,000 ALLOWABLE MEDICARE COST PER MEDICARE COST REPORT IN PART III, SECTION B \$53,096,000 MEDICARE COST NOT REPORTED IN PART III, SECTION B \$57,321,000 TOTAL MEDICARE ASSOCIATED COST \$110,417,000 ALLOWABLE MEDICARE SHORTFALL IN PART III, SECTION B \$2,844,000 ADDITIONAL SHORTFALL NOT INCLUDED IN PART III, SECTION B \$15,409,000 TOTAL MEDICARE SHORTFALL \$18,253,000 PART III, LINE 8 THE ORGANIZATION'S SHORTFALL SHOULD BE CONSIDERED CHARITY CARE BECAUSE IT IS PROVIDING HIGH-QUALITY CARE IN EXCESS OF THE COST TO OUR COMMUNITY RESIDENTS THAT NEED CARE THE MEDICARE POPULATION AT THE ORGANIZATION IS IN EXCESS OF 51% OF NET PATIENT REVENUE THE ORGANIZATION USED A COST ACCOUNTING SYSTEM TO CALCULATE</p>

Form and Line Reference	Explanation
PART I, LINE 6A	<p>THE MEDICARE ALLOWABLE COSTS PART III, LINE 9B THE ORGANIZATION MAKES REASONABLE EFFORTS TO DETERMINE WHETHER OR NOT AN INDIVIDUAL IS ELIGIBLE FOR ASSISTANCE UNDER THE STATE OR HOSPITAL FINANCIAL ASSISTANCE POLICY BEFORE ENGAGING IN EXTRAORDINARY COLLECTIVE ACTIONS AGAINST THAT INDIVIDUAL PATIENTS WHO ARE KNOWN TO QUALIFY FOR FINANCIAL ASSISTANCE ARE OFFERED REASONABLE PAYMENT PLAN ARRANGEMENTS FOR ANY REMAINING BALANCES ANY THIRD-PARTY COLLECTING SELF-PAY RECEIVABLES ON OUR BEHALF IS REQUIRED TO MAKE REASONABLE EFFORTS TO DETERMINE IF THE INDIVIDUAL MEETS THE QUALIFICATIONS OF THE STATE OR OF OUR HOSPITAL FINANCIAL ASSISTANCE PROGRAMS REASONABLE EFFORTS INCLUDE A VALIDATING THAT THE PATIENT OWES THE UNPAID BILLS AND THAT ALL SOURCES OF THIRD-PARTY PAYMENT HAVE BEEN IDENTIFIED AND BILLED BY THE HOSPITAL B DOCUMENTING THAT THE ORGANIZATION HAS OR HAS ATTEMPTED TO OFFER THE PATIENT THE OPPORTUNITY TO APPLY FOR CHARITY CARE UNDER ITS FINANCIAL ASSISTANCE POLICY C DOCUMENT THAT THE PATIENT DOES NOT QUALIFY FOR FINANCIAL ASSISTANCE D DOCUMENT THAT THE PATIENT HAS BEEN OFFERED AND ACCEPTED TERMS FOR A PAYMENT PLAN BUT HAS NOT HONORED THE TERMS OF THAT PLAN THE FINANCIAL COUNSELORS MEET WITH INPATIENT, OUTPATIENT, SELF-PAY, AND OTHER PATIENTS UPON REQUEST WHO MAY NEED FINANCIAL ASSISTANCE IN ADDITION TO ASSISTING PATIENTS WHO WANT TO APPLY FOR ASSISTANCE THROUGH THE MEDICAID PROGRAM, THE FINANCIAL COUNSELOR WILL PROVIDE THE PATIENT WITH A FINANCIAL ASSISTANCE APPLICATION PART VI, LINE 2 THE ORGANIZATION WORKS WITH THE COMMUNITY ON PROGRAMS THAT ADDRESS THE UNDERLYING CAUSES OF PERSISTENT HEALTH PROBLEMS AS PART OF A COMPREHENSIVE STRATEGY TO IMPROVE THE HEALTH STATUS AND QUALITY OF LIFE FOR IDENTIFIED MEMBERS OF THE COMMUNITY WHO ARE ECONOMICALLY DISADVANTAGED, DISENFRANCHISED AND/OR WHO HAVE DISPROPORTIONATE UNMET HEALTH NEEDS THE ORGANIZATION STRIVES TO WORK WITH PREMIER, THE HOSPITAL BOARD OF TRUSTEES, EXECUTIVE MANAGEMENT, MANAGERS, STAFF MEMBERS, COMMUNITY GROUPS, AND INDIVIDUALS TO PROVIDE A COLLABORATIVE APPROACH TO THE GOVERNANCE AND MANAGEMENT OF COMMUNITY BENEFIT ACTIVITIES PART VI, LINE 3 THERE ARE SEVERAL WAYS IN WHICH OUR ORGANIZATION INFORMS AND EDUCATES PATIENTS WHO MAY BE BILLED FOR SERVICES ABOUT ELIGIBILITY FOR ASSISTANCE UNDER FEDERAL, STATE, OR LOCAL GOVERNMENT PROGRAMS, OR UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY FIRST, NOTIFICATION OF SUCH AVAILABLE ASSISTANCE IS CLEARLY POSTED IN REGISTRATION AREAS, AS WELL AS MATERNITY AND EMERGENCY DEPARTMENTS NEXT, PATIENT ADVOCATES, PATIENT ACCESS STAFF MEMBERS, AND FINANCIAL COUNSELORS IN THE INPATIENT AND EMERGENCY DEPARTMENTS MEET WITH UNINSURED AND UNDERINSURED PATIENTS, AND THOSE WITH ONLY MEDICARE COVERAGE TO DISCUSS ELIGIBILITY FOR ASSISTANCE FINANCIAL COUNSELORS ALSO DISCUSS OPTIONS TO RESOLVE UNPAID ACCOUNT BALANCES WITH UNINSURED AND UNDERINSURED PATIENTS THE FINANCIAL ASSISTANCE POLICY IS POSTED ON THE HOSPITAL'S WEBSITE, ALONG WITH INFORMATION ON HOW TO OBTAIN AN APPLICATION WHEN A PATIENT RECEIVES A BILL, THE REVERSE SIDE OF THE BILL CONTAINS INFORMATION ABOUT THE STATE OF OHIO FREE CARE PROGRAM (CARE ASSURANCE) AND A FINANCIAL ASSISTANCE APPLICATION THE BILLING STATEMENTS OFFER THE FINANCIAL ASSISTANCE OPTIONS AVAILABLE, AND THE CONTACT INFORMATION FOR ASSISTANCE PART VI, LINE 4 ATRIUM MEDICAL CENTER IS LOCATED IN MIDDLETOWN OHIO, SERVICING BUTLER AND WARREN COUNTIES THE POPULATION OF ATRIUM MEDICAL CENTERS SERVICE AREA IS APPROXIMATELY 581,000 PEOPLE THE MEDIAN HOUSEHOLD INCOME OF WARREN COUNTY IS JUST BELOW \$79,400 PER YEAR, WITH APPROXIMATELY 4.7% OF ITS CITIZENS LIVING BELOW THE FEDERAL POVERTY LEVEL THE MEDIAN HOUSEHOLD INCOME OF BUTLER COUNTY IS JUST BELOW \$62,200 PER YEAR, WITH APPROXIMATELY 10.7% OF ITS CITIZENS LIVING BELOW THE FEDERAL POVERTY LEVEL FOR 2018, MEDICARE PATIENTS REPRESENTED 51.2% OF GROSS PATIENT REVENUE AND MEDICAID REPRESENTED 19.5% OF GROSS PATIENT REVENUE PART VI, LINE 5 ATRIUM MEDICAL CENT</p>

**Additional Data****Software ID:****Software Version:****EIN:** 31-1079309**Name:** ATRIUM MEDICAL CENTER**Form 990 Schedule H, Part V Section A. Hospital Facilities**

<b>Section A. Hospital Facilities</b>		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? <b>1</b>											
Name, address, primary website address, and state license number											
1	ATRIUM MEDICAL CENTER ONE MEDICAL CENTER DRIVE MIDDLETOWN, OH 45044 WWW PREMIERHEALTH COM SEE PART V SEC C	X	X					X			A

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

**Schedule I  
(Form 990)**

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

OMB No 1545-0047

**2018**

**Open to Public  
Inspection**

Department of the  
Treasury  
Internal Revenue Service

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

▶ Attach to Form 990.

▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

Name of the organization  
ATRIUM MEDICAL CENTER

Employer identification number  
31-1079309

**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 ▶ 14

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

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

Part III can be duplicated if additional space is needed

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

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

Return Reference	Explanation
SCHEDULE I, PART I, LINE 2	1) DISBURSEMENTS ARE ANALYZED MONTHLY THROUGH VARIOUS REPORTS AND COMMITTEE MEETINGS 2) INVOICES ARE RECEIVED IN ACCOUNTS PAYABLE AND APPROVED AND DISBURSED PER ORGANIZATIONAL POLICY 3) GRANT SPENDING IS MONITORED AGAINST BUDGETED AMOUNTS ON AN ONGOING BASIS



**Additional Data**

**Software ID:**  
**Software Version:**  
**EIN:** 31-1079309  
**Name:** ATRIUM MEDICAL CENTER

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

<b>(a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section if applicable	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of non-cash assistance	<b>(h)</b> Purpose of grant or assistance
MIDDLETOWN TRANSIT SYSTEM 3045 MOSER CT HAMILTON, OH 45011	31-6000139	GOVT	75,248				TRAVEL ASSISTANCE
ATRIUM MEDICAL CENTER FOUNDATION 110 N MAIN ST 500 DAYTON, OH 45402	31-1079213	501(C)(3)	70,019				SUPPORT

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

<b>(a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section if applicable	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of non-cash assistance	<b>(h)</b> Purpose of grant or assistance
REACH OUT MONTGOMERY COUNTY 25 E FORAKER ST DAYTON, OH 45409	31-1434282	501(C)(3)	40,863				RX ASSIST FOR INDIGENT
MIAMI VALLEY HOSPITAL 110 N MAIN ST 500 DAYTON, OH 45402	31-0537504	501(C)(3)	31,596				AFRICAN AMERICAN WOMEN'S HEALTH PROGRAM & BRIDGE PROGRAMS

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

<b>(a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section if applicable	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of non-cash assistance	<b>(h)</b> Purpose of grant or assistance
UNITED WAY OF GREATER DAYTON AREA 33 W FIRST ST 500 DAYTON, OH 45402	31-0536658	501(C)(3)	12,000				SUPPORT
DAYTON FOUNDATION 40 N MAIN ST 500 DAYTON, OH 45423	31-6027287	501(C)(3)	11,640				SUPPORT

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

<b>(a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section if applicable	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of non-cash assistance	<b>(h)</b> Purpose of grant or assistance
MIAMI VALLEY HOSPITAL FOUNDATION 110 N MAIN ST 500 DAYTON, OH 45402	31-1040231	501(C)(3)	10,280				SUPPORT
EAST END COMMUNITY SERVICES 624 XENIA AVE DAYTON, OH 45410	31-1508554	501(C)(3)	10,000				SUPPORT

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

<b>(a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section if applicable	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of non-cash assistance	<b>(h)</b> Purpose of grant or assistance
GALA OF HOPE FOUNDATION 3500 PENTAGON BLVD 500 BEAVERCREEK, OH 45431	46-4277044	501(C)(3)	10,000				SUPPORT
COMMUNITY BUILDING INSTITUTE 800 LAFAYETTE AVE MIDDLETOWN, OH 45044	46-5205808	501(C)(3)	10,000				SUPPORT

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

<b>(a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section if applicable	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of non-cash assistance	<b>(h)</b> Purpose of grant or assistance
ELIZABETHS NEW LIFE CENTER INC 2201 N MAIN ST DAYTON, OH 45405	31-1381901	501(C)(3)	8,000				SUPPORT
UNITED WAY GREATER CINCINNATI 2400 READING RD CINCINNATI, OH 45202	31-0537502	501(C)(3)	7,000				SUPPORT

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

<b>(a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section if applicable	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of non-cash assistance	<b>(h)</b> Purpose of grant or assistance
DAYTON ART INSTITUTE 456 BELMONTE PARK N DAYTON, OH 45405	31-0537480	501(C)(3)	6,119				SUPPORT
WESLEY COMMUNITY CENTER 3730 DELPHOS AVE DAYTON, OH 45417	30-0203259	501(C)(3)	6,000				SUPPORT

**Schedule J**  
(Form 990)

Department of the Treasury  
Internal Revenue Service

## Compensation Information

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

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 23.**  
▶ **Attach to Form 990.**  
▶ **Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.**

OMB No 1545-0047

# 2018

**Open to Public Inspection**

Name of the organization  
ATRIUM MEDICAL CENTER

Employer identification number  
31-1079309

**Part I Questions Regarding Compensation**

		Yes	No		
<p><b>1a</b> 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 style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> First-class or charter travel  <input type="checkbox"/> Travel for companions  <input type="checkbox"/> Tax indemnification and gross-up payments  <input type="checkbox"/> Discretionary spending account                 </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Housing allowance or residence for personal use  <input type="checkbox"/> Payments for business use of personal residence  <input type="checkbox"/> Health or social club dues or initiation fees  <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)                 </td> </tr> </table>	<input type="checkbox"/> First-class or charter travel <input type="checkbox"/> Travel for companions <input type="checkbox"/> Tax indemnification and gross-up payments <input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Housing allowance or residence for personal use <input type="checkbox"/> Payments for business use of personal residence <input type="checkbox"/> Health or social club dues or initiation fees <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)			
<input type="checkbox"/> First-class or charter travel <input type="checkbox"/> Travel for companions <input type="checkbox"/> Tax indemnification and gross-up payments <input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Housing allowance or residence for personal use <input type="checkbox"/> Payments for business use of personal residence <input type="checkbox"/> Health or social club dues or initiation fees <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)				
<p><b>b</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>	<b>1b</b>				
<p><b>2</b> 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>	<b>2</b>				
<p><b>3</b> 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 style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input checked="" type="checkbox"/> Compensation committee  <input checked="" type="checkbox"/> Independent compensation consultant  <input type="checkbox"/> Form 990 of other organizations                 </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Written employment contract  <input checked="" type="checkbox"/> Compensation survey or study  <input checked="" type="checkbox"/> Approval by the board or compensation committee                 </td> </tr> </table>	<input checked="" type="checkbox"/> Compensation committee <input checked="" type="checkbox"/> Independent compensation consultant <input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Written employment contract <input checked="" type="checkbox"/> Compensation survey or study <input checked="" type="checkbox"/> Approval by the board or compensation committee			
<input checked="" type="checkbox"/> Compensation committee <input checked="" type="checkbox"/> Independent compensation consultant <input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Written employment contract <input checked="" type="checkbox"/> Compensation survey or study <input checked="" type="checkbox"/> Approval by the board or compensation committee				
<p><b>4</b> 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><b>a</b> Receive a severance payment or change-of-control payment?</p>	<b>4a</b>	Yes			
<p><b>b</b> Participate in, or receive payment from, a supplemental nonqualified retirement plan?</p>	<b>4b</b>	Yes			
<p><b>c</b> Participate in, or receive payment from, an equity-based compensation arrangement? If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III</p>	<b>4c</b>		No		
<p><b>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</b></p>					
<p><b>5</b> 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><b>a</b> The organization?</p>	<b>5a</b>		No		
<p><b>b</b> Any related organization? If "Yes," on line 5a or 5b, describe in Part III</p>	<b>5b</b>		No		
<p><b>6</b> 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><b>a</b> The organization?</p>	<b>6a</b>		No		
<p><b>b</b> Any related organization? If "Yes," on line 6a or 6b, describe in Part III</p>	<b>6b</b>		No		
<p><b>7</b> 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>	<b>7</b>		No		
<p><b>8</b> 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>	<b>8</b>		No		
<p><b>9</b> If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?</p>	<b>9</b>				



**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, LINE 4A	<p>THE FOLLOWING INDIVIDUALS RECEIVED A SEVERANCE PAYMENT CRAIG SELF RECEIVED \$16,230 IN 2018 AND WILL RECEIVE \$381,414 IN 2019, MARK SHAKER RECEIVED \$583,003 IN 2018 AND WILL RECEIVE \$11,212 IN 2019 THE FOLLOWING INDIVIDUALS WERE SELECTED TO PARTICIPATE IN A VOLUNTARY RETIREMENT PROGRAM AND RECEIVED THE FOLLOWING PAYMENTS IN 2018 DALE CREECH JR \$205,770, MARK SHAW \$247,000 PART I, LINE 4B DUE TO RESTRICTIONS IMPOSED BY THE INTERNAL REVENUE CODE, CERTAIN PERSONS ARE LIMITED IN THE AMOUNT OF BENEFIT THAT CAN BE EARNED UNDER A QUALIFIED RETIREMENT PLAN LIKE MANY EMPLOYERS, ATRIUM MEDICAL CENTER (AMC) AND ITS AFFILIATED ORGANIZATIONS COMPENSATE FOR THIS LIMITATION AND SUPPLEMENT THE AFFECTED EXECUTIVES' QUALIFIED PENSION THROUGH CERTAIN NONQUALIFIED PLANS AMC SUPPLEMENTS THE AFFECTED EXECUTIVES THROUGH A PENSION RESTORATION PLAN AND A SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN (SERP) THE BENEFITS UNDER THESE SUPPLEMENTAL NONQUALIFIED PLANS ARE SUBJECT TO MULTI-YEAR VESTING AND A PARTICIPANT CAN FORFEIT BENEFITS EARNED IF VESTING REQUIREMENTS ARE NOT SATISFIED UNDER THE TERMS OF THE SUPPLEMENTAL PLANS, AND BECAUSE OF TAX RULES PERTAINING TO TAXATION OF THE EARNED BENEFITS UPON VESTING, CERTAIN INDIVIDUALS RECEIVED A PAYOUT OF THE CUMULATIVE VESTED BENEFITS UNDER THEIR SUPPLEMENTAL PLAN DURING 2018 THE INDIVIDUALS LISTED BELOW HAVE MET THE MULTI-YEAR VESTING REQUIREMENT UNDER THE PENSION RESTORATION PLAN AND RECEIVED THE ASSOCIATED PAYMENT IN 2018 DALE CREECH, JR \$112,018, BARBARA JOHNSON \$23,417, MARGARET MARK \$1,276, MARK SHAKER \$134,793, MARK SHAW \$173,140, SCOTT SHELTON \$40,846, MICHAEL SIMS \$15,913, GEOFFREY WALKER \$17,073 THERE WERE NO INDIVIDUALS WHO HAVE MET THE MULTI-YEAR VESTING REQUIREMENT UNDER THE SERP AND RECEIVED THE ASSOCIATED PLAN PAYMENT IN 2018 IN ADDITION, THE FOLLOWING SERP AMOUNTS WERE DEFERRED ON THE PARTICIPANTS' BEHALF DURING THE YEAR AND WILL BE HELD UNTIL THE INCREMENTAL AMOUNTS ARE VESTED AND PAID TO THE SERP PARTICIPANTS THOMAS CURTIN \$2,634, RENEE GEORGE \$13,523, JENNIFER HAULER, M D \$6,140, BARBARA JOHNSON \$(1,815), TAMMY LUNDSTROM, M D \$877, MARGARET MARK \$3,852, THOMAS PARKER \$12,494, CRAIG SELF \$22,957, MARQUITA TURNER \$2,207, MICHAEL UHL \$10,312 BASED ON THE GUIDANCE PROVIDED IN THE INSTRUCTIONS TO THE FORM 990, ANY PAYMENTS TO THE PARTICIPANTS RELATED TO THESE PLANS THAT WERE MADE WITHIN 2-1/2 MONTHS AFTER THE END OF THE ORGANIZATION'S TAX YEAR ARE NOT TREATED AS DEFERRED COMPENSATION FOR PURPOSES OF SCHEDULE J SUCH AMOUNTS ARE PROPERLY REPORTED AS COMPENSATION FOR FORM 990 PURPOSES WHEN INCLUDED IN THE PARTICIPANTS' FORM W-2 WAGES ANY PAYMENTS MADE AFTER THE 2-1/2 MONTHS WERE PROPERLY REPORTED ON PRIOR YEARS' FILED IRS FORM 990 RETURNS, DISCLOSING COMPENSATION EARNED BY THESE INDIVIDUALS UNDER THE PLANS FOR EACH SUCH YEAR</p>



**Additional Data**

**Software ID:**  
**Software Version:**  
**EIN:** 31-1079309  
**Name:** ATRIUM MEDICAL CENTER

**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				
MICHAEL R UHL PRESIDENT	(i)	380,420	192,099	19,411	19,594	29,246	640,770	0
	(ii)	0	0	0	0	0	0	0
MARQUITA L TURNER COO & CNO	(i)	278,028	65,842	1,417	14,218	4,864	364,369	0
	(ii)	0	0	0	0	0	0	0
DALE J BLOCK MD TRUSTEE	(i)	0	0	0	0	0	0	0
	(ii)	242,678	20,640	2,421	8,424	32,527	306,690	0
MARY H BOOSALIS TRUSTEE & PREMIER PRESIDENT	(i)	0	0	0	0	0	0	0
	(ii)	1,098,492	744,674	34,445	24,572	15,726	1,917,909	0
JOHN M MILLER MD TRUSTEE	(i)	8,924	0	0	0	0	8,924	0
	(ii)	690,016	35,553	21,100	10,736	28,908	786,313	0
MATTHEW S REEVES DO TRUSTEE / VP OPS AND CMO	(i)	302,923	61,588	20,208	2,183	20,102	407,004	0
	(ii)	0	0	0	0	0	0	0
RHONDA L SEIDENSCHMIDT TRUSTEE / VP OPERATIONS	(i)	160,095	68,867	1,410	7,372	17,039	254,783	0
	(ii)	0	0	0	0	0	0	0
DALE E CREECH JR SYS VP-CHF LGL OFFICER- TO JUL	(i)	0	0	0	0	0	0	0
	(ii)	226,848	163,898	321,430	173,749	24,772	910,697	0
THOMAS R CURTIN VP REVENUE CYCLE	(i)	0	0	0	0	0	0	0
	(ii)	255,614	72,332	6,649	21,583	33,040	389,218	0
GARY G GINTER VP & PREMIER CHIEF INFO OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	397,507	152,860	3,938	23,309	26,980	604,594	0
JENNIFER J HAULER MD VP MEDICAL AFFAIRS&PREMIER CMO	(i)	0	0	0	0	0	0	0
	(ii)	518,950	127,987	1,661	13,812	2,437	664,847	0
BARBARA A JOHNSON SYS VP - HR OPERATIONS	(i)	0	0	0	0	0	0	0
	(ii)	387,494	159,514	28,975	14,183	10,852	601,018	0
RENEE M JOHNSON SYS VP-MANAGED CARE (FROM APR)	(i)	0	0	0	0	0	0	0
	(ii)	157,107	27,452	1,103	12,055	8,834	206,551	0
MARGARET W MARK VP NURSING SERVICE/PREMIER CNO	(i)	0	0	0	0	0	0	0
	(ii)	362,886	216,282	9,343	12,540	20,228	621,279	0
CRAIG SELF CHF STRATEGY OFFICER (TO NOV)	(i)	0	0	0	0	0	0	0
	(ii)	385,642	369,777	32,358	332,468	27,546	1,147,791	0
MARK W SHAW SYS VP - MANAGED CARE (TO APR)	(i)	0	0	0	0	0	0	0
	(ii)	124,054	136,382	423,240	59,456	24,387	767,519	0
SCOTT A SHELTON SYS VP CPO-TO JUL/ PREMIER CFO	(i)	0	0	0	0	0	0	0
	(ii)	360,128	122,854	45,012	15,941	5,131	549,066	0
J MICHAEL SIMS SYS VP-TREAS & CORP CONTROLLER	(i)	0	0	0	0	0	0	0
	(ii)	288,061	74,913	38,875	23,763	29,347	454,959	0
KIM K STRAHL SYS VP & CPO (FROM JUL)	(i)	0	0	0	0	0	0	0
	(ii)	187,401	78,137	2,631	22,405	11,625	302,199	0
GEOFFREY P WALKER SYS VP-CHF LGL OFFICER- FRM JUL	(i)	0	0	0	0	0	0	0
	(ii)	317,976	88,247	20,078	22,722	25,725	474,748	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				
DONNA L BANKS VP OPERATIONS	(i)	236,033	84,515	2,236	10,959	10,355	344,098	0
	(ii)	0	0	0	0	0	0	0
JOANNE R MORGAN SYSTEM VP - PHARMACY OPS	(i)	195,172	34,715	21,477	11,970	11,365	274,699	0
	(ii)	0	0	0	0	0	0	0
DOROTHY C PERRY DIRECTOR HUMAN RESOURCES	(i)	158,210	24,694	1,474	5,978	2,613	192,969	0
	(ii)	0	0	0	0	0	0	0
ROBYN S MYERS DEPARTMENT DIRECTOR	(i)	150,648	19,898	6,081	7,384	22,122	206,133	0
	(ii)	0	0	0	0	0	0	0
JAN E SCHUSTER SYSTEM DIRECTOR-LAB	(i)	149,396	24,029	2,006	6,912	13,989	196,332	0
	(ii)	0	0	0	0	0	0	0
RENEE P GEORGE FORMER KEY	(i)	0	0	0	0	0	0	0
	(ii)	383,206	186,870	1,291	24,090	13,560	609,017	0
TAMMY S LUNDSTROM MD FORMER KEY	(i)	0	0	0	0	0	0	0
	(ii)	215,866	227,220	2,008	10,115	858	456,067	0
MICHAEL J MAIBERGER FORMER KEY	(i)	0	0	0	0	0	0	0
	(ii)	827,405	361,953	19,436	16,296	32,374	1,257,464	0
MARK S SHAKER FORMER KEY	(i)	0	0	0	0	0	0	0
	(ii)	0	97,534	717,176	23,763	2,207	840,680	0
JEFFREY S ZOLLETT MD FORMER OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	150,836	0	1,780	6,080	2,578	161,274	0
THOMAS R PARKER FORMER KEY	(i)	0	0	0	0	0	0	0
	(ii)	419,601	152,940	27,557	36,092	6,916	643,106	0

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

**Schedule K (Form 990)**

**Supplemental Information on Tax-Exempt Bonds**

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

▶ Attach to Form 990.

▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No 1545-0047

**2018**

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

Name of the organization  
ATRIUM MEDICAL CENTER

Employer identification number

31-1079309

**Part I Bond Issues**

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pool financing	
							Yes	No	Yes	No	Yes	No
<b>A</b>	CITY OF MIDDLETOWN OH	31-6000139	597146AH2	11-21-2008	111,000,000	REFUND SERIES 2007 A & B		X		X		X
<b>B</b>	CITY OF MIDDLETOWN OH	31-6000139	597146AP4	08-31-2016	86,392,792	REFUND SERIES 2010		X		X		X

**Part II Proceeds**

	A	B	C	D				
<b>1</b> Amount of bonds retired . . . . .	28,450,000	3,452,792						
<b>2</b> Amount of bonds legally defeased . . . . .	0	0						
<b>3</b> Total proceeds of issue . . . . .	111,000,000	86,392,792						
<b>4</b> Gross proceeds in reserve funds . . . . .	0	0						
<b>5</b> Capitalized interest from proceeds . . . . .	0	0						
<b>6</b> Proceeds in refunding escrows . . . . .	0	0						
<b>7</b> Issuance costs from proceeds . . . . .	1,513,169	400,067						
<b>8</b> Credit enhancement from proceeds . . . . .	0	0						
<b>9</b> Working capital expenditures from proceeds . . . . .	0	0						
<b>10</b> Capital expenditures from proceeds . . . . .	0	0						
<b>11</b> Other spent proceeds . . . . .	109,486,832	85,992,725						
<b>12</b> Other unspent proceeds . . . . .	0	0						
<b>13</b> Year of substantial completion . . . . .	2008	2010						
	Yes	No	Yes	No	Yes	No	Yes	No
<b>14</b> Were the bonds issued as part of a current refunding issue? . . . . .	X		X					
<b>15</b> Were the bonds issued as part of an advance refunding issue? . . . . .		X		X				
<b>16</b> Has the final allocation of proceeds been made? . . . . .	X		X					
<b>17</b> Does the organization maintain adequate books and records to support the final allocation of proceeds? . . . . .	X		X					

**Part III Private Business Use**

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

**Part III Private Business Use** (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
<b>3a</b> Are there any management or service contracts that may result in private business use of bond-financed property? . . . . .		X		X				
<b>b</b> If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
<b>c</b> Are there any research agreements that may result in private business use of bond-financed property? . . . . .	X		X					
<b>d</b> If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?	X		X					
<b>4</b> Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government . . . . . ▶	0 045 %		0 045 %					
<b>5</b> Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government . . . . . ▶	0 163 %		0 163 %					
<b>6</b> Total of lines 4 and 5 . . . . .	0 209 %		0 209 %					
<b>7</b> Does the bond issue meet the private security or payment test? . . . . .		X		X				
<b>8a</b> Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued? . . . . .		X		X				
<b>b</b> If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of . . . . .								
<b>c</b> If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1 141-12 and 1 145-2? . . . . .		X		X				
<b>9</b> Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1 141-12 and 1 145-2? . . . . .	X		X					

**Part IV Arbitrage**

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
<b>1</b> Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate? . . . . .		X		X				
<b>2</b> If "No" to line 1, did the following apply? . . . . .								
<b>a</b> Rebate not due yet? . . . . .		X	X					
<b>b</b> Exception to rebate? . . . . .		X						
<b>c</b> No rebate due? . . . . .	X			X				
If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed . . . . .								
<b>3</b> Is the bond issue a variable rate issue? . . . . .	X			X				
<b>4a</b> Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?	X		X					
<b>b</b> Name of provider . . . . .	MERRYL LYNCH		BARCLAYS					
<b>c</b> Term of hedge . . . . .	2090 %		2690 %					
<b>d</b> Was the hedge superintegrated? . . . . .	X			X				
<b>e</b> Was the hedge terminated? . . . . .		X		X				

**Part IV Arbitrage** (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
<b>5a</b> Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X				
<b>b</b> Name of provider . . . . .	0		0					
<b>c</b> Term of GIC . . . . .								
<b>d</b> Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied? . . . . .								
<b>6</b> Were any gross proceeds invested beyond an available temporary period?		X		X				
<b>7</b> Has the organization established written procedures to monitor the requirements of section 148? . . . . .	X		X					

**Part V Procedures To Undertake Corrective Action**

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

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

Return Reference	Explanation
PART IV ARBITRAGE - LINE 2C	Computation date is November 13, 2018 for the series 2008 A&B



## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 31-1079309

**Name:** ATRIUM MEDICAL CENTER

Return Reference	Explanation
PART IV ARBITRAGE - LINE 2C	Computation date is November 13, 2018 for the series 2008 A&B

**Schedule L**  
(Form 990 or 990-EZ)

**Transactions with Interested Persons**

OMB No 1545-0047

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, lines 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.**  
 ▶ **Attach to Form 990 or Form 990-EZ.**  
 ▶ **Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.**

**2018**

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

Name of the organization  
ATRIUM MEDICAL CENTER

Employer identification number  
31-1079309

**Part I Excess Benefit Transactions** (section 501(c)(3), section 501(c)(4), and 501(c)(29) organizations only)  
 Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b

1	(a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected?	
				Yes	No

2 Enter the amount of tax incurred by organization managers or disqualified persons during the year under section 4958 . . . . . ▶ \$ \_\_\_\_\_  
 3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization . . . . . ▶ \$ \_\_\_\_\_

**Part II Loans to and/or From Interested Persons.**  
 Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a, or Form 990, Part IV, line 26, or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization?		(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?		(i) Written agreement?	
			To	From			Yes	No	Yes	No	Yes	No
Total						▶ \$						

**Part III Grants or Assistance Benefiting Interested Persons.**  
 Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance

**Part IV Business Transactions Involving Interested Persons.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) BARBARA STEEL MD	TRUSTEE	296,025	APPLIED BLOOD MANAGEMENT, LLC		No

**Part V Supplemental Information**

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

Return Reference	Explanation

**SCHEDULE O**  
**(Form 990 or 990-EZ)**

Department of the Treasury

Name of the organization  
ATRIUM MEDICAL CENTER

**Supplemental Information to Form 990 or 990-EZ**

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

▶ Attach to Form 990 or 990-EZ.

▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No 1545-0047

**2018**

**Open to Public Inspection**

Employer identification number

31-1079309

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
<p>FORM 990, PART VI, SECTION A, LINE 3</p>	<p>PREMIER HEALTH (PREMIER) AS THE OPERATOR OF ATRIUM MEDICAL CENTER (AMC) DEVELOPS AND OVERS EES THE IMPLEMENTATION OF THE STRATEGIC PLAN FOR AMC, WHICH INCLUDES (BUT IS NOT LIMITED T O) SUCH MATTERS AS LOCATION OF CLINICAL AND ADMINISTRATIVE EXPENSES AND THE CONSOLIDATION OF SUCH SERVICES AMC SHALL COMPLY WITH AND IMPLEMENT THIS PLAN AND SHALL NOT TAKE ANY ACT ION THAT MATERIALLY DEPARTS FROM THIS PLAN WITHOUT PREMIER'S APPROVAL AMC SHALL IMPLEMENT ANY CAPITAL AND OPERATING BUDGET SO APPROVED AND/OR REVISED FOR IT BY PREMIER AMC SHALL IMPLEMENT THE BUSINESS PLAN APPROVED BY PREMIER PREMIER IS THE SOLE AGENT TO NEGOTIATE AL L RELATIONSHIPS WITH PAYORS ON BEHALF OF AMC WITH ALL THIRD-PARTY PAYORS AND ALTERNATIVE D ELIVERY SYSTEMS INCLUDING, BUT NOT LIMITED TO INSURERS AMC MUST HAVE APPROVAL FROM PREMIER TO BORROW IN ANY FISCAL YEAR, GUARANTEE IN ANY YEAR, OR INCUR ANY LIEN OR OTHER ENCUMBRA NCE ON ANY PROPERTY IN AN AMOUNT EQUAL TO OR GREATER THAN \$1,000,000 AMC MUST SEEK PREMIER'S APPROVAL FOR ANY ACQUISITIONS, SALE OR TRANSFER OF ANY MATERIAL ASSET USED IN PREMIER' S ACTIVITIES FORM 990, PART VI, SECTION A, LINE 4 IN 2018, ATRIUM MEDICAL CENTERS (AMC) CODE OF REGULATIONS WERE MODIFIED LISTED BELOW ARE THE SIGNIFICANT CHANGES * THE SOLE ME MBER OF THE CORPORATION SHALL BE PREMIER, WHICH SHALL BE AN OHIO NONPROFIT CORPORATION * IN THE EVENT OF DISSOLUTION OF THE CORPORATION, THE BOARD OF TRUSTEES AFTER PAYING OR MAKI NG PROVISION FOR THE PAYMENT OF ALL OF THE LIABILITIES OF THE CORPORATION, SHALL DISTRIBUT E, IN ANY PROPORTIONS CONSIDERED PRUDENT, ALL OF THE ASSETS OF THE CORPORATION TO PREMIER, IF THEN IN EXISTENCE AND IF QUALIFIED UNDER SECTION 501(C)(3) OF THE INTERNAL REVENUE COD E FORM 990, PART VI, SECTION A, LINE 6 ATRIUM MEDICAL CENTER HAS ONE CORPORATE MEMBER, P REMIER, AN OHIO NON-PROFIT CORPORATION FORM 990, PART VI, SECTION A, LINES 7A &amp; 7B PREMIER HAS THE SOLE AUTHORITY TO ELECT THE BOARD OF TRUSTEES FOR ATRIUM MEDICAL CENTER (AMC) PREMIER HAS THE AUTHORITY TO REMOVE SUCH TRUSTEES AT ANY REGULAR OR SPECIAL MEETING OR BY WRITTEN CONSENT FORM 990, PART VI, SECTION B, LINE 11B THIS 990 FILING AND ATTACHED SCHE DULES (THE RETURN) ARE PREPARED BY A STAFF MEMBER IN THE TAX DEPARTMENT OF PREMIER, OF WHI CH ATRIUM MEDICAL CENTER IS AN AFFILIATE THE RETURN IS REVIEWED BY THE TAX MANAGER AND DI RECTOR OF TAX COMPLIANCE OF PREMIER THE RETURN IS CONCURRENTLY SENT TO ERNST &amp; YOUNG U S LLP FOR THEIR REVIEW AFTER ALL CHANGES FROM THE ABOVE GROUPS ARE MADE, THE RETURN IS REV IEWED BY THE VICE PRESIDENT/CONTROLLER OF PREMIER AND THE CHIEF FINANCIAL OFFICER OF THIS ENTITY A FINAL VERSION OF THE RETURN IS SENT TO ERNST &amp; YOUNG U S LLP FOR A FINAL REVIEW AND THEN PROVIDED TO THE BOARD OF TRUSTEES FOR REVIEW AT A BOARD OF TRUSTEES MEETING, TH E VICE PRESIDENT/CONTROLLER OF PREMIER (OR DESIGNEE) SHARES DETAILED INFORMATION ON COMPEN SATION AND OTHER KEY AREAS, AS WELL AS ADDRESSES ANY OTHER QUESTIONS FROM THE BOARD OF TRU STEES, PENDING THEIR REVIEW T</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
<p>FORM 990, PART VI, SECTION A, LINE 3</p>	<p>THE 990 FILING IS ALSO SHARED WITH THE AUDIT COMMITTEE OF PREMIER FORM 990, PART VI, SECTION B, LINE 12C PREMIER, WITH WHICH ATRIUM MEDICAL CENTER IS AN AFFILIATE, REQUIRES ALL BOARD MEMBERS, BOARD COMMITTEE MEMBERS, MEDICAL DIRECTORS, SUPPLY CHAIN DIVISION MEMBERS, AUTHORIZED SIGNERS, DIRECTORS, EXECUTIVES, MEDICAL EXECUTIVE COMMITTEE MEMBERS, MEDICAL DEPARTMENT AND SECTION CHAIRS, PHYSICIAN PARTNERSHIP COMMITTEE MEMBERS, PHYSICIAN GUIDANCE GROUP MEMBERS, AND ALL EMPLOYED PHYSICIANS TO ANNUALLY REVIEW THE PREMIER COMPREHENSIVE CONFLICT OF INTEREST STATEMENT, AN EXPLANATORY MEMORANDUM, THE ANTITRUST COMPLIANCE POLICY, AND COMPLETE AN INDIVIDUAL QUESTIONNAIRE DISCLOSING ANY POTENTIAL CONFLICTS AS DEFINED IN THE CONFLICT OF INTEREST POLICY THIS IS ACCOMPLISHED EITHER BY WAY OF AN ELECTRONIC COMMUNICATION SENT OUT DIRECTLY BY THE CORPORATE COMPLIANCE DEPARTMENT OR BY WAY OF A MEMO SENT OUT FROM THE CHAIRMAN OF THE BOARD AND CHIEF EXECUTIVE OFFICER OF PREMIER IT ALSO INCLUDES AN EXPLANATORY MEMORANDUM OF SPECIFIC ACTIVITIES THAT MIGHT GIVE CAUSE TO A CONFLICT AND AN INDIVIDUAL QUESTIONNAIRE TO DISCLOSE ALL SUCH ACTIVITIES THIS QUESTIONNAIRE MUST BE COMPLETED AND SIGNED BY THE INDIVIDUAL THIS CORRESPONDENCE INCLUDES A COPY OF THE ANTITRUST COMPLIANCE POLICY THAT MUST BE SIGNED BY THE INDIVIDUAL ALL OF THESE DOCUMENTS ARE SENT TO THE CORPORATE COMPLIANCE DEPARTMENT THE CORPORATE COMPLIANCE DEPARTMENT ENSURES ALL FORMS ARE RETURNED AND RETAINS THE DOCUMENTS FOR FIVE YEARS IN ADDITION, AT EACH MEETING OF THE BOARD OR ANY BOARD COMMITTEE, FOLLOWING APPROVAL OF THE PREVIOUS MEETING'S MINUTES, THE BOARD OR COMMITTEE CHAIR SHALL REQUEST ANY BOARD MEMBER WHO PERCEIVES A POTENTIAL CONFLICT OF INTEREST ON ANY OF THE MEETING'S AGENDA ITEMS TO DISCLOSE THE POTENTIAL CONFLICT ADDITIONALLY, AT ANY BOARD OR BOARD COMMITTEE MEETING WHERE THE SUBJECT OF CONFLICT OF INTEREST IS DISCUSSED, THE MINUTES SHALL CONTAIN THE NAME OF THE PARTY DISCUSSING A POTENTIAL CONFLICT OF INTEREST, THE NATURE OF THE POTENTIAL CONFLICT OF INTEREST AND WHETHER A CONFLICT OF INTEREST WAS FOUND TO EXIST IF A CONFLICT OF INTEREST IS DETERMINED BY THE BOARD TO EXIST, THE MEMBER WILL BE EXCUSED FROM PARTICIPATING IN ANY DISCUSSION OR VOTING ON THE PARTICULAR AGENDA ITEM THE CHIEF COMPLIANCE AND ENTERPRISE RISK OFFICER REPORTS THE RESULTS OF THE PREMIER CONFLICT OF INTEREST QUESTIONNAIRES NO LESS THAN ANNUALLY TO THE BOARD OF TRUSTEES BY WAY OF THE COMPLIANCE AND AUDIT COMMITTEE THIS REVIEW IS DOCUMENTED IN THE MINUTES OF THE MEETING PERIODICALLY, THE INTERNAL AUDIT DEPARTMENT WILL REVIEW A SAMPLE OF COMPLETED CONFLICT OF INTEREST QUESTIONNAIRES AND REPORT THE RESULTS TO THE COMPLIANCE AND AUDIT COMMITTEE THE ANNUAL CONFLICT OF INTEREST QUESTIONNAIRES ARE INDIVIDUALLY SUMMARIZED IN A DOCUMENT AND SENT ELECTRONICALLY TO THE FINANCE DEPARTMENT FOR ANY NECESSARY DISCLOSURES REQUIRED ON THE 990 FILING FORM 990, PART VI, SECTION B, LINES 15A AND 15B COMPLETION FOR ATRIUM MEDICAL CENTER</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 3	<p>TER'S (AMC) CEO IS REVIEWED AND APPROVED BY PREMIER, WITH WHICH AMC IS AN AFFILIATE, ON AN ANNUAL BASIS THE REVIEW PROCESS PERFORMED BY PREMIER FOLLOWS A MARKET BASED COMPENSATION PHILOSOPHY DESIGNED TO ATTRACT AND RETAIN THE EXECUTIVE TALENT REQUIRED TO MEET THE HIGH- PERFORMANCE STANDARDS OF OUR BOARD AND OUR COMMUNITY PREMIER ANNUALLY REVIEWS EXECUTIVE C OMPENSATION SURVEY DATA FOR A REGIONAL PEER GROUP OF SYSTEMS AND HOSPITALS THAT ARE SIMILA R IN SIZE AND COMPLEXITY TO PREMIER AND ITS AFFILIATES THE DATA FOR THE SURVEY IS PROVIDE D BY A THIRD-PARTY CONSULTANT GROUP THAT IS INDEPENDENT OF PREMIER THIS REPORT INCLUDES C OMPARABILITY FOR KEY EXECUTIVES, VICE PRESIDENTS, AND DIRECTOR LEVEL POSITIONS THE INDEPE NDENT COMPARABILITY DATA IS REVIEWED BY THE EXECUTIVE COMPENSATION COMMITTEE ON AN ANNUAL BASIS THIS COMMITTEE IS COMPRISED OF THREE MEMBERS, ALL OF WHOM ARE INDEPENDENT THIS COM MITTEE REVIEWS IN DETAIL THE COMPENSATION FOR THE PREMIER CEO, COO, CFO, CHIEF INTEGRATION OFFICER, CHIEF STRATEGY OFFICER, AND THE HOSPITAL CEOS OTHER POSITIONS ARE REVIEWED AT A HIGH LEVEL FOR REASONABLENESS ALL THE MEETING MINUTES ARE DOCUMENTED AND KEPT ON FILE AL ONG WITH ANY COMPARABILITY DATA AND THE CONSULTANT REPORT AFTER THE COMPENSATION COMMITTE E REVIEWS AND APPROVES THE COMPENSATION ACTIONS, THE PROCESS IS AUDITED BY THE INTERNAL AU DIT DEPARTMENT THE EXECUTIVE COMPENSATION COMMITTEE PRESENTS THE COMPENSATION ACTIONS TO THE PREMIER BOARD ANNUALLY FORM 990, PART VI, SECTION C, LINE 19 THE GOVERNING DOCUMENTS AND FINANCIAL STATEMENTS ARE MADE AVAILABLE TO THE PUBLIC WHEN REQUIRED BY LAW OR FOR ACC REDITATION PURPOSES THE CONFLICT OF INTEREST POLICY IS AVAILABLE UPON REQUEST FORM 990, PART XI, LINE 9 PENSION FASB 158 ADJUSTMENT (23,438,670) FOUNDATION ADJUSTMENT (589,494) TRANSFER FROM AFFILIATE 183,587 EQUITY TRANSFERS TO AFFILIATES 15,415,598 ----- TOT AL (8,428,979)</p>

**SCHEDULE R  
(Form 990)**

**Related Organizations and Unrelated Partnerships**

OMB No 1545-0047

**2018**

**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.**  
▶ **Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.**

Department of the Treasury  
Internal Revenue Service

Name of the organization  
ATRIUM MEDICAL CENTER

**Employer identification number**

31-1079309

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

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

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

See Additional Data Table

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



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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
<b>(1)</b> Premier Plaza LLC 110 N Main St 500 DAYTON, OH 45402 80-0708185	HOLDING CO	OH	MAHS	EXCLUDED	0	0		No	0		No	0 %
<b>(2)</b> SW OHIO NEONATAL COLLABORATIVE LLC 110 N Main St 500 DAYTON, OH 45402 46-3231330	NEONATOLOGY	OH	MVH	RELATED	0	0		No	0		No	0 %
<b>(3)</b> Samaritan North Surgery Center 9000 N Main St DAYTON, OH 45415 31-1618587	O/P SURGERY	OH	GSH	RELATED	0	0		No	0		No	0 %
<b>(4)</b> Compunet Clinical Laboratories LLC 2308 Sandridge Dr MORAIN, OH 45439 31-1258010	MEDICAL LABS	OH	MVHE INC	RELATED	0	0		No	0		No	0 %
<b>(5)</b> Sweitzer Street LLC 110 N Main St 1250 DAYTON, OH 45402 45-4700417	REAL ESTATE	OH	MVHE INC	EXCLUDED	0	0		No	0		No	0 %
<b>(6)</b> Sweitzer MOB LLC 110 N Main St 1250 DAYTON, OH 45402 47-4554657	REAL ESTATE	OH	MVHE INC	EXCLUDED	0	0		No	0		No	0 %

**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.

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) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No

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

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

	Yes	No
<b>1</b> 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?		
<b>a</b> Receipt of <b>(i)</b> interest, <b>(ii)</b> annuities, <b>(iii)</b> royalties, or <b>(iv)</b> rent from a controlled entity . . . . .		No
<b>b</b> Gift, grant, or capital contribution to related organization(s) . . . . .	Yes	
<b>c</b> Gift, grant, or capital contribution from related organization(s) . . . . .	Yes	
<b>d</b> Loans or loan guarantees to or for related organization(s) . . . . .		No
<b>e</b> Loans or loan guarantees by related organization(s) . . . . .		No
<b>f</b> Dividends from related organization(s) . . . . .		No
<b>g</b> Sale of assets to related organization(s) . . . . .		No
<b>h</b> Purchase of assets from related organization(s) . . . . .		No
<b>i</b> Exchange of assets with related organization(s) . . . . .		No
<b>j</b> Lease of facilities, equipment, or other assets to related organization(s) . . . . .	Yes	
<b>k</b> Lease of facilities, equipment, or other assets from related organization(s) . . . . .		No
<b>l</b> Performance of services or membership or fundraising solicitations for related organization(s) . . . . .		No
<b>m</b> Performance of services or membership or fundraising solicitations by related organization(s) . . . . .		No
<b>n</b> Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) . . . . .		No
<b>o</b> Sharing of paid employees with related organization(s) . . . . .		No
<b>p</b> Reimbursement paid to related organization(s) for expenses . . . . .	Yes	
<b>q</b> Reimbursement paid by related organization(s) for expenses . . . . .	Yes	
<b>r</b> Other transfer of cash or property to related organization(s) . . . . .	Yes	
<b>s</b> Other transfer of cash or property from related organization(s) . . . . .	Yes	

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

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

**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)

<b>Return Reference</b>	<b>Explanation</b>

**Additional Data**

**Software ID:**  
**Software Version:**  
**EIN:** 31-1079309  
**Name:** ATRIUM MEDICAL CENTER

**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 500 DAYTON, OH 45402 31-1446699	PARENT	OH	501(C)(3)	12B	NA		No
110 N MAIN ST 500 DAYTON, OH 45402 31-0537492	SUPPORT ORG	OH	501(C)(3)	12B	NA		No
110 N MAIN ST 500 DAYTON, OH 45402 31-1040228	SUPPORT ORG	OH	501(C)(3)	12B	NA		No
110 N MAIN ST 500 DAYTON, OH 45402 31-0537504	HOSPITAL	OH	501(C)(3)	3	PREMIER		No
110 N Main St 500 DAYTON, OH 45402 31-1040231	FOUNDATION	OH	501(C)(3)	7	PREMIER		No
110 N MAIN ST 500 DAYTON, OH 45402 31-1075381	HOME HEALTH	OH	501(C)(3)	10	PREMIER		No
110 N MAIN ST 500 DAYTON, OH 45402 31-1122883	HEALTH EDUCAT	OH	501(C)(3)	10	FHC		No
110 N Main St 500 DAYTON, OH 45402 31-1107411	SUPPORT ORG	OH	501(C)(3)	12B	PREMIER		No
110 N Main St 500 DAYTON, OH 45402 31-0536981	HOSPITAL	OH	501(C)(3)	3	PREMIER		No
110 N Main St 500 DAYTON, OH 45402 23-7296923	FOUNDATION	OH	501(C)(3)	7	PREMIER		No
110 N Main St 500 DAYTON, OH 45402 30-0502367	EDUCATION	OH	501(C)(3)	10	PREMIER		No
110 N Main St 500 DAYTON, OH 45402 02-0633634	BEHAVORIAL HE	OH	501(C)(3)	7	PREMIER		No
110 N Main St 500 DAYTON, OH 45402 34-1850683	SUPPORT ORG	OH	501(C)(3)	12B	NA		No
110 N Main St 500 DAYTON, OH 45402 31-0537095	HOSPITAL	OH	501(C)(3)	3	PREMIER		No
110 N Main St 500 DAYTON, OH 45402 31-1400963	HEALTH CARE	OH	501(C)(3)	10	PREMIER		No
110 N Main St 500 DAYTON, OH 45402 20-3687536	HEALTH CARE	OH	501(C)(3)	10	UVPC		No
110 N Main St 500 DAYTON, OH 45402 31-1224064	NURSING HOME	OH	501(C)(3)	10	PREMIER		No

**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
(1) MVHE INC 110 N Main St 400 DAYTON, OH 45402 31-1185270	PHYSICIAN SVCS	OH	PREMIER HOLDING	C CORP	0	0	0 %		No
(1) Premier Health Specialists 110 N Main St 400 DAYTON, OH 45402 06-1744704	PHYSICIAN SVCS	OH	PREMIER HOLDING	C CORP	0	0	0 %		No
(2) Samaritan Family Care 110 N Main St 400 DAYTON, OH 45402 31-1299450	PHYSICIAN SVCS	OH	PREMIER HOLDING	C CORP	0	0	0 %		No
(3) After Hours Family Care 110 N Main St 500 DAYTON, OH 45402 31-1269483	HEALTH CARE	OH	UVPC	C CORP	0	0	0 %		No
(4) UVMC Management Corp 110 N Main St 500 DAYTON, OH 45402 31-1360489	MANAGEMENT CO	OH	PREMIER	C CORP	0	0	0 %		No
(5) Premier Health Urgent Care Inc 110 N Main St 900 DAYTON, OH 45402 82-2079409	URGENT CARE	OH	PREMIER HOLDING	C CORP	0	0	0 %		No
(6) Premier Health Plan Inc 110 N Main St 500 DAYTON, OH 45402 46-3024049	HEALTH INSURANCE	OH	PHIC	C CORP	0	0	0 %		No
(7) Premier Health ACO of Ohio 110 N Main St 500 DAYTON, OH 45402 47-4049773	MEDICARE ACO	OH	PREMIER	C CORP	0	0	0 %		No
(8) Premier Health Holding (premier holding) 110 N Main St 400 DAYTON, OH 45402 81-2419110	HOLDING CO	OH	PREMIER	C CORP	0	0	0 %		No
(9) Premier Health Insuring Co (PHIC) 110 N Main St 500 DAYTON, OH 45402 46-4766841	HEALTH INSURANCE	OH	PREMIER	C CORP	0	0	0 %		No