

Form **990**

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

2017

Department of the Treasury
Internal Revenue Service

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

▶ Do not enter Social Security numbers on this form as it may be made public.

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

Open to Public Inspection

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

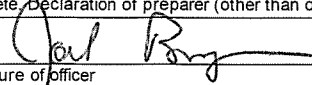
B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization MONTGOMERY GENERAL HOSPITAL, INC.			D Employer identification number 52-0646893		
	Doing Business As			E Telephone number (301) 774-8640		
	Number and street (or P.O. box if mail is not delivered to street address)		Room/suite			
	18101 PRINCE PHILIP DRIVE					
	City or town, state or province, country, and ZIP or foreign postal code OLNEY, MD 20832					
F Name and address of principal officer: THOMAS SENKER 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832			H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
			H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No			
			If "No," attach a list. (see instructions)			
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527			G Gross receipts \$ 173,639,871.			
J Website: WWW.MONTGOMERYGENERAL.ORG			H(c) Group exemption number ▶			
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶			L Year of formation: 2000 M State of legal domicile: MD			

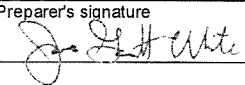
Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: MEDSTAR MONTGOMERY MEDICAL CENTER IS DEDICATED TO ENHANCING OUR COMMUNITY'S HEALTH BY OFFERING HIGH QUALITY, COMPASSIONATE AND PERSONALIZED CARE.	
	2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.	
	3 Number of voting members of the governing body (Part VI, line 1a)	3 19.
	4 Number of independent voting members of the governing body (Part VI, line 1b)	4 16.
	5 Total number of individuals employed in calendar year 2017 (Part V, line 2a)	5 1,078.
	6 Total number of volunteers (estimate if necessary)	6 346.
	7a Total unrelated business revenue from Part VIII, column (C), line 12	7a 907,571.
b Net unrelated business taxable income from Form 990-T, line 34	7b -218,611.	
Revenue	8 Contributions and grants (Part VIII, line 1h)	Prior Year 1,325,878. Current Year 2,376,556.
	9 Program service revenue (Part VIII, line 2g)	159,748,957. 169,042,964.
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	35,259. -204,528.
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	2,727,776. 2,424,879.
	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	163,837,870. 173,639,871.
	Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)
14 Benefits paid to or for members (Part IX, column (A), line 4)		0. 0.
15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)		74,462,305. 79,635,368.
16a Professional fundraising fees (Part IX, column (A), line 11e)		0. 0.
b Total fundraising expenses (Part IX, column (D), line 25) ▶ 0.		
17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)		86,208,343. 85,803,825.
18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	160,670,648. 165,439,193.	
19 Revenue less expenses. Subtract line 18 from line 12	3,167,222. 8,200,678.	
Net Assets or Fund Balances	20 Total assets (Part X, line 16)	Beginning of Current Year 104,824,605. End of Year 108,182,473.
	21 Total liabilities (Part X, line 26)	28,609,478. 29,197,122.
	22 Net assets or fund balances. Subtract line 21 from line 20.	76,215,127. 78,985,351.

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		05/09/19
	Signature of officer	Date
	JOEL BRYAN	VP/TREASURER / Chief Investment Officer
	Type or print name and title	

Paid Preparer Use Only	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
	JG WHITE		5/8/2019		P01498698
	Firm's name ▶ KPMG LLP	Firm's EIN ▶ 13-5565207			
	Firm's address ▶ 1676 INTERNATIONAL DRIVE MCLEAN, VA 22102	Phone no. 703-286-8000			

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

For Paperwork Reduction Act Notice, see the separate instructions.

Form **990** (2017)

Application for Automatic Extension of Time To File an Exempt Organization Return

▶ **File a separate application for each return.**
▶ Information about Form 8868 and its instructions is at www.irs.gov/form8868.

Electronic filing (e-file). You can electronically file Form 8868 to request a 6-month automatic extension of time to file any of the forms listed below with the exception of Form 8870, Information Return for Transfers Associated With Certain Personal Benefit Contracts, for which an extension request must be sent to the IRS in paper format (see instructions). For more details on the electronic filing of this form, visit www.irs.gov/efile, click on Charities & Non-Profits, and click on e-file for Charities and Non-Profits.

Automatic 6-Month Extension of Time. Only submit original (no copies needed).

All corporations required to file an income tax return other than Form 990-T (including 1120-C filers), partnerships, REMICs, and trusts must use Form 7004 to request an extension of time to file income tax returns.

Enter filer's identifying number, see instructions

Type or print File by the due date for filing your return. See instructions.	Name of exempt organization or other filer, see instructions. MONTGOMERY GENERAL HOSPITAL, INC.	Employer identification number (EIN) or 52-0646893
	Number, street, and room or suite no. If a P.O. box, see instructions. 18101 PRINCE PHILIP DRIVE	Social security number (SSN)
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. OLNEY, MD 20832	

Enter the Return Code for the return that this application is for (file a separate application for each return)

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01	Form 990-T (corporation)	07
Form 990-BL	02	Form 1041-A	08
Form 4720 (individual)	03	Form 4720 (other than individual)	09
Form 990-PF	04	Form 5227	10
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 6069	11
Form 990-T (trust other than above)	06	Form 8870	12

JOEL BRYAN

• The books are in the care of ▶ 10980 GRANTCHESTER WAY COLUMBIA MD 21044

Telephone No. ▶ 410 772-6721 Fax No. ▶

- If the organization does not have an office or place of business in the United States, check this box
- If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) If this is for the whole group, check this box . If it is for part of the group, check this box and attach a list with the names and EINs of all members the extension is for.

1 I request an automatic 6-month extension of time until 05/15, 2019, to file the exempt organization return for the organization named above. The extension is for the organization's return for:

- ▶ calendar year 20__ or
- ▶ tax year beginning 07/01, 2017, and ending 06/30, 2018.

2 If the tax year entered in line 1 is for less than 12 months, check reason: Initial return Final return Change in accounting period

3a If this application is for Forms 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	3a \$	0.
b If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit.	3b \$	0.
c Balance due. Subtract line 3b from line 3a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	3c \$	0.

Caution. If you are going to make an electronic funds withdrawal (direct debit) with this Form 8868, see Form 8453-EO and Form 8879-EO for payment instructions.

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission: ATTACHMENT 1

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 [X] No

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

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 \$ 114,485,137. including grants of \$ 0.) (Revenue \$ 161,869,148.) ATTACHMENT 2

4b (Code:) (Expenses \$ 9,109,157. including grants of \$ 0.) (Revenue \$ 6,393,051.) MEDSTAR MONTGOMERY PROVIDED \$9.1M IN SUBSIDIZED (MISSION DRIVEN) HEALTH SERVICES IN FISCAL YEAR 2018. THESE CRITICAL SERVICES, WHICH ARE DRIVEN BY COMMUNITY NEEDS, OPERATE AT A LOSS. THEY ADDRESS PRIORITIES PRIMARILY THROUGH DISEASE PREVENTION AND IMPROVEMENT OF HEALTH STATUS. SERVICES PROVIDED INCLUDE PALLIATIVE CARE, WOMEN'S AND CHILDREN'S SERVICES, CONTINUING CARE.

4c (Code:) (Expenses \$ 2,007,432. including grants of \$ 0.) (Revenue \$ 0.) MEDSTAR MONTGOMERY PROVIDED \$2.0M IN CHARITY CARE SERVICES IN FISCAL YEAR 2018. CHARITY CARE IS PROVIDED PURSUANT TO MEDSTAR HEALTH'S FINANCIAL ASSISTANCE POLICY TO MEMBERS OF THE COMMUNITY WHOSE INCOME IS BELOW CERTAIN THRESHOLDS AND FOR WHICH THE HOSPITAL IS NOT COMPENSATED. UNDER MARYLAND'S UNIQUE PAYER SYSTEM, THE AMOUNT REPORTED REPRESENTS MEDSTAR MONTGOMERY'S CHARITY CARE EXPENSE AND REVENUES REPRESENT DIRECT PAYMENTS FROM THE STATE'S CHARITY CARE POOL. OTHER CHARITY CARE EXPENSES ARE INDIRECTLY REIMBURSED VIA THE STATE OF MARYLAND'S PAYMENT SYSTEM.

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

4e Total program service expenses 125,601,726.

Part IV Checklist of Required Schedules

	Yes	No
1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A.	X	
2 Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?	X	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I		X
4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II		X
5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? If "Yes," complete Schedule C, Part III.		X
6 Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes," complete Schedule D, Part I.		X
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II		X
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III		X
9 Did the organization report an amount in Part X, line 21, for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? If "Yes," complete Schedule D, Part IV		X
10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? If "Yes," complete Schedule D, Part V.		X
11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.		
a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI	X	
b Did the organization report an amount for investments-other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII		X
c Did the organization report an amount for investments-program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII.		X
d Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part IX		X
e Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	X	
f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part X	X	
12a Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII.		X
b Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional	X	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E.		X
14a Did the organization maintain an office, employees, or agents outside of the United States?		X
b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV	X	
15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? If "Yes," complete Schedule F, Parts II and IV	X	
16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? If "Yes," complete Schedule F, Parts III and IV	X	
17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I (see instructions).		X
18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II		X
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III		X

Part IV Checklist of Required Schedules (continued)

Table with columns for question number, question text, Yes, and No. Rows include questions 20a through 38 regarding hospital operations, financial statements, grants, compensation, tax-exempt bonds, and organizational transactions.

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

Main form grid with columns for line numbers, descriptions, and Yes/No checkboxes. Includes sections for backup withholding, employee reporting, foreign accounts, and charitable contributions.

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

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include 1a, 1b, 2, 3, 4, 5, 6, 7a, 7b, 8a, 8b, 9.

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, 10b, 11a, 11b, 12a, 12b, 12c, 13, 14, 15a, 15b, 16a, 16b.

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed MD
18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection.
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:

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, and highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former** directors or trustees that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) JOSEPH BELL CHAIR	1.00 0.	X					0.	0.	0.	
(2) KENNETH A. SAMET DIRECTOR	1.00 39.00	X					0.	6,538,888.	82,240.	
(3) RICHARD WEINSTEIN, M.D. DIRECTOR	1.00 0.	X					0.	0.	0.	
(4) JOHN FERGUSON DIRECTOR	1.00 0.	X					0.	0.	0.	
(5) WENDY WALKER, D.V.M. DIRECTOR	1.00 0.	X					0.	0.	0.	
(6) JAMES A. BONIFANT DIRECTOR	1.00 0.	X					0.	0.	0.	
(7) KATHERINE W. FARQUHAR, PH.D. VICE CHAIR	1.00 0.	X					0.	0.	0.	
(8) RICHARD KURNOT, M.D. DIRECTOR	1.00 0.	X					0.	0.	0.	
(9) CYNTHIA CHROSNIAK, M.D. DIRECTOR	1.00 0.	X					0.	0.	0.	
(10) CAROLE DERRICK DIRECTOR	1.00 0.	X					0.	0.	0.	
(11) DANIEL J. SCHRIDER DIRECTOR	1.00 0.	X					0.	0.	0.	
(12) STEVEN M. SHIMOURA, M.D. DIRECTOR	1.00 0.	X					0.	0.	0.	
(13) ANA E. MALDONADO, M.D. DIRECTOR	1.00 0.	X					0.	0.	0.	
(14) ALOK N. MATHUR, M.D. DIRECTOR	1.00 0.	X					0.	0.	0.	

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			
(15) THOMAS J. SENKER PRESIDENT/DIRECTOR	40.00 0.	X		X				572,153.	0.	33,717.
(16) RICHARD M. HOFFMAN DIRECTOR	1.00 0.	X						0.	0.	0.
(17) DEBORAH S. ELLINGHAUS DIRECTOR	1.00 0.	X						0.	0.	0.
(18) MARC KOZAM, M.D. DIRECTOR	1.00 0.	X						0.	0.	0.
(19) SUJITHRA JAYARAJ, MD DIRECTOR	40.00 0.	X						445,521.	0.	24,145.
(20) DAVID HAVRILLA CFO/TREASURER	40.00 0.			X				359,112.	0.	28,262.
(21) CAROLINA CHAVARRIA SECRETARY	40.00 0.			X				78,366.	0.	18,174.
(22) KEVIN MELL VP, OPERATIONS	40.00 0.				X			109,435.	126,643.	14,896.
(23) VIVIAN HSIA VP, HUMAN RESOURCES	40.00 0.					X		189,777.	0.	12,926.
(24) CONNIE STONE VP, PATIENT CARE SERVICES	40.00 0.					X		266,794.	0.	16,156.
(25) FREDERICK FINELLI VP, MEDICAL AFFAIRS	40.00 0.					X		721,574.	0.	27,836.
1b Sub-total								0.	6,538,888.	82,240.
c Total from continuation sheets to Part VII, Section A								3,064,061.	126,643.	199,648.
d Total (add lines 1b and 1c)								3,064,061.	6,665,531.	281,888.

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization **79**

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

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
ATTACHMENT 3		

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization **33**

Part VIII Statement of Revenue

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

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514	
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a				
	b Membership dues	1b				
	c Fundraising events	1c				
	d Related organizations	1d				
	e Government grants (contributions) . .	1e	987,340.			
	f All other contributions, gifts, grants, and similar amounts not included above .	1f	1,389,216.			
	g Noncash contributions included in lines 1a-1f: \$					
	h Total. Add lines 1a-1f ▶		2,376,556.			
Program Service Revenue	2a PATIENT SERVICE REVENUE	Business Code 621300	168,206,723.	168,206,723.		
	b MEANINGFUL USE INCOME	621110	20,826.	20,826.		
	c PHYSICIAN BILLING REVENUE	621110	34,650.	34,650.		
	d PHARMACY REVENUE	900099	780,765.		780,765.	
	e					
	f All other program service revenue					
	g Total. Add lines 2a-2f ▶		169,042,964.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts). ▶		-209,779.		-209,779.	
	4 Income from investment of tax-exempt bond proceeds . ▶		0.			
	5 Royalties ▶		0.			
	6a Gross rents	(i) Real	448,307.			
		(ii) Personal				
		b Less: rental expenses				
	c Rental income or (loss)		448,307.			
	d Net rental income or (loss) ▶		448,307.		448,307.	
	7a Gross amount from sales of assets other than inventory	(i) Securities				
		(ii) Other		5,251.		
		b Less: cost or other basis and sales expenses				
		c Gain or (loss)		5,251.		
	d Net gain or (loss) ▶		5,251.		5,251.	
	8a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18	a				
		b Less: direct expenses	b			
c Net income or (loss) from fundraising events ▶			0.			
9a Gross income from gaming activities. See Part IV, line 19	a					
	b Less: direct expenses	b				
	c Net income or (loss) from gaming activities ▶		0.			
10a Gross sales of inventory, less returns and allowances	a					
	b Less: cost of goods sold	b				
	c Net income or (loss) from sales of inventory ▶		0.			
Miscellaneous Revenue		Business Code				
11a REBATE INCOME	525990	379,960.		379,960.		
b EQUITY INTEREST IN AFFILIATES	900099	177,363.		177,363.		
c OTHER REVENUE	900099	1,419,249.		126,806.		
d All other revenue						
e Total. Add lines 11a-11d ▶		1,976,572.				
12 Total revenue. See instructions. ▶		173,639,871.	168,262,199.	907,571.	2,093,545.	

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 X

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	0.			
2 Grants and other assistance to domestic individuals. See Part IV, line 22	0.			
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16	0.			
4 Benefits paid to or for members	0.			
5 Compensation of current officers, directors, trustees, and key employees	1,668,885.	1,411,267.	257,618.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0.			
7 Other salaries and wages	65,133,583.	55,096,264.	10,037,319.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	494,504.	405,831.	88,673.	
9 Other employee benefits	8,083,752.	6,804,162.	1,279,590.	
10 Payroll taxes	4,254,644.	3,454,689.	799,955.	
11 Fees for services (non-employees):				
a Management	13,691,932.		13,691,932.	
b Legal	0.			
c Accounting	0.			
d Lobbying	0.			
e Professional fundraising services. See Part IV, line 17.	0.			
f Investment management fees	1,523.		1,523.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.) ATCH 4	19,409,370.	17,905,168.	1,504,202.	
12 Advertising and promotion	550,331.	928.	549,403.	
13 Office expenses	376,029.	794,046.	-418,017.	
14 Information technology	0.			
15 Royalties	0.			
16 Occupancy	1,195,250.	851,748.	343,502.	
17 Travel	56,238.	34,753.	21,485.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0.			
19 Conferences, conventions, and meetings	72,402.	10,623.	61,779.	
20 Interest	1,194,846.		1,194,846.	
21 Payments to affiliates	0.			
22 Depreciation, depletion, and amortization	10,487,385.	6,414,900.	4,072,485.	
23 Insurance	1,186,419.	40,011.	1,146,408.	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a <u>MED/SURG SUPPLIES</u>	20,079,125.	20,159,115.	-79,990.	
b <u>MAINTENANCE</u>	5,792,665.	3,200,924.	2,591,741.	
c <u>IMPLANTS/PROSTHESES</u>	5,184,245.	5,184,245.		
d <u>UTILITIES</u>	2,517,946.	2,368,117.	149,829.	
e All other expenses _____	4,008,119.	1,464,935.	2,543,184.	
25 Total functional expenses. Add lines 1 through 24e	165,439,193.	125,601,726.	39,837,467.	
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)	0.			

Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year	
Assets	1	Cash - non-interest-bearing	15,966.	1	315.
	2	Savings and temporary cash investments	340,838.	2	384,285.
	3	Pledges and grants receivable, net	0.	3	0.
	4	Accounts receivable, net	18,562,734.	4	23,566,448.
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L	0.	5	0.
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L	0.	6	0.
	7	Notes and loans receivable, net	0.	7	0.
	8	Inventories for sale or use	3,334,650.	8	3,545,314.
	9	Prepaid expenses and deferred charges	1,399,032.	9	890,800.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 215,789,935.		
	b	Less: accumulated depreciation	10b 139,366,271.		
			81,171,385.	10c	76,423,664.
	11	Investments - publicly traded securities	0.	11	0.
	12	Investments - other securities. See Part IV, line 11	0.	12	2,702,904.
	13	Investments - program-related. See Part IV, line 11	0.	13	0.
	14	Intangible assets	0.	14	0.
15	Other assets. See Part IV, line 11	0.	15	668,743.	
16	Total assets. Add lines 1 through 15 (must equal line 34)	104,824,605.	16	108,182,473.	
Liabilities	17	Accounts payable and accrued expenses	9,394,740.	17	9,894,324.
	18	Grants payable	0.	18	0.
	19	Deferred revenue	3,437,029.	19	3,311,428.
	20	Tax-exempt bond liabilities	0.	20	0.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D	0.	21	0.
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L	0.	22	0.
	23	Secured mortgages and notes payable to unrelated third parties	0.	23	0.
	24	Unsecured notes and loans payable to unrelated third parties	0.	24	0.
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	15,777,709.	25	15,991,370.
	26	Total liabilities. Add lines 17 through 25	28,609,478.	26	29,197,122.
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.				
	27	Unrestricted net assets	76,215,127.	27	78,985,351.
	28	Temporarily restricted net assets	0.	28	0.
	29	Permanently restricted net assets	0.	29	0.
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.				
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
33	Total net assets or fund balances	76,215,127.	33	78,985,351.	
34	Total liabilities and net assets/fund balances	104,824,605.	34	108,182,473.	

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	173,639,871.
2	Total expenses (must equal Part IX, column (A), line 25)	2	165,439,193.
3	Revenue less expenses. Subtract line 2 from line 1	3	8,200,678.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	76,215,127.
5	Net unrealized gains (losses) on investments	5	-50,899.
6	Donated services and use of facilities	6	0.
7	Investment expenses	7	0.
8	Prior period adjustments	8	0.
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-5,379,555.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	78,985,351.

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
2a		X
2b	X	
2c	X	
3a		X
3b		

Form **990** (2017)

SCHEDULE A
(Form 990 or 990-EZ)

Public Charity Status and Public Support

OMB No. 1545-0047

2017

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

▶ Attach to Form 990 or Form 990-EZ.

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

Name of the organization MONTGOMERY GENERAL HOSPITAL, INC.	Employer identification number 52-0646893
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Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.

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

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

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

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

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

Section A. Public Support

Table with 7 columns: Calendar year (or fiscal year beginning in), (a) 2013, (b) 2014, (c) 2015, (d) 2016, (e) 2017, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Tax revenues levied for the organization's benefit; 3 The value of services or facilities furnished by a governmental unit; 4 Total. Add lines 1 through 3; 5 The portion of total contributions by each person; 6 Public support. Subtract line 5 from line 4.

Section B. Total Support

Table with 7 columns: Calendar year (or fiscal year beginning in), (a) 2013, (b) 2014, (c) 2015, (d) 2016, (e) 2017, (f) Total. Rows include: 7 Amounts from line 4; 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources; 9 Net income from unrelated business activities; 10 Other income. Do not include gain or loss from the sale of capital assets; 11 Total support. Add lines 7 through 10; 12 Gross receipts from related activities, etc. (see instructions); 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

Table with 2 columns: Line number, Description. Rows include: 14 Public support percentage for 2017 (line 6, column (f) divided by line 11, column (f)); 15 Public support percentage from 2016 Schedule A, Part II, line 14; 16a 33 1/3% support test - 2017; b 33 1/3% support test - 2016; 17a 10%-facts-and-circumstances test - 2017; b 10%-facts-and-circumstances test - 2016; 18 Private foundation.

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

Table with 7 columns: (a) 2013, (b) 2014, (c) 2015, (d) 2016, (e) 2017, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Gross receipts from admissions, merchandise sold or services performed; 3 Gross receipts from activities that are not an unrelated trade or business; 4 Tax revenues levied for the organization's benefit; 5 The value of services or facilities furnished by a governmental unit; 6 Total; 7a Amounts included on lines 1, 2, and 3 received from disqualified persons; 7b Amounts included on lines 2 and 3 received from other than disqualified persons; 7c Add lines 7a and 7b; 8 Public support.

Section B. Total Support

Table with 7 columns: (a) 2013, (b) 2014, (c) 2015, (d) 2016, (e) 2017, (f) Total. Rows include: 9 Amounts from line 6; 10a Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources; 10b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975; 10c Add lines 10a and 10b; 11 Net income from unrelated business activities not included in line 10b; 12 Other income; 13 Total support; 14 First five years.

Section C. Computation of Public Support Percentage

Table with 3 columns: Description, Value, Percentage. Row 15: Public support percentage for 2017; Row 16: Public support percentage from 2016 Schedule A, Part III, line 15.

Section D. Computation of Investment Income Percentage

Table with 3 columns: Description, Value, Percentage. Row 17: Investment income percentage for 2017; Row 18: Investment income percentage from 2016 Schedule A, Part III, line 17.

19a 33 1/3% support tests - 2017. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and stop here. The organization qualifies as a publicly supported organization.

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

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

Table with 3 columns: Question, Yes, No. Row 11: Has the organization accepted a gift or contribution from any of the following persons? Sub-rows 11a, 11b, 11c.

Section B. Type I Supporting Organizations

Table with 3 columns: Question, Yes, No. Row 1: Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? Row 2: Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization?

Section C. Type II Supporting Organizations

Table with 3 columns: Question, Yes, No. Row 1: Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)?

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally Integrated Supporting Organizations

Table with 3 columns: Question, Yes, No. Row 1: Check the box next to the method that the organization used to satisfy the Integral Part Test during the year. Sub-rows a, b, c. Row 2: Activities Test. Answer (a) and (b) below. Sub-rows a, b. Row 3: Parent of Supported Organizations. Answer (a) and (b) below. Sub-rows a, b.

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

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

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

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

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

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

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

Section D - Distributions	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI). See instructions.	
7 Total annual distributions. Add lines 1 through 6.	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions.	
9 Distributable amount for 2017 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2017	(iii) Distributable Amount for 2017
1 Distributable amount for 2017 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2017 (reasonable cause required-explain in Part VI). See instructions.			
3 Excess distributions carryover, if any, to 2017			
a			
b From 2013			
c From 2014			
d From 2015			
e From 2016			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2017 distributable amount			
i Carryover from 2012 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4 Distributions for 2017 from Section D, line 7: \$			
a Applied to underdistributions of prior years			
b Applied to 2017 distributable amount			
c Remainder. Subtract lines 4a and 4b from 4.			
5 Remaining underdistributions for years prior to 2017, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, explain in Part VI. See instructions.			
6 Remaining underdistributions for 2017. Subtract lines 3h and 4b from line 1. For result greater than zero, explain in Part VI. See instructions.			
7 Excess distributions carryover to 2018. Add lines 3j and 4c.			
8 Breakdown of line 7:			
a Excess from 2013			
b Excess from 2014			
c Excess from 2015			
d Excess from 2016			
e Excess from 2017			

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.)

Schedule of Contributors

2017

▶ Attach to Form 990, Form 990-EZ, or Form 990-PF.
 ▶ Go to www.irs.gov/Form990 for the latest information.

Name of the organization MONTGOMERY GENERAL HOSPITAL, INC.	Employer identification number 52-0646893
---	--

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

501(c)(3) (enter number) organization

4947(a)(1) nonexempt charitable trust not treated as a private foundation

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

4947(a)(1) nonexempt charitable trust treated as a private foundation

501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule**.

Note: Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, contributions totaling \$5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.

Special Rules

For an organization described in section 501(c)(3) filing Form 990 or 990-EZ that met the 33 1/3 % support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), that checked Schedule A (Form 990 or 990-EZ), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions of the greater of (1) \$5,000; or (2) 2% of the amount on (i) Form 990, Part VIII, line 1h; or (ii) Form 990-EZ, line 1. Complete Parts I and II.

For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than \$1,000 *exclusively* for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals. Complete Parts I, II, and III.

For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc., purposes, but no such contributions totaled more than \$1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Don't complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions totaling \$5,000 or more during the year ▶ \$ _____

Caution: An organization that isn't covered by the General Rule and/or the Special Rules doesn't file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on its Form 990-PF, Part I, line 2, to certify that it doesn't meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization MONTGOMERY GENERAL HOSPITAL, INC.	Employer identification number 52-0646893
---	---

Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	_____ _____ _____	\$ 109,602.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization **MONTGOMERY GENERAL HOSPITAL, INC.**

Employer identification number
52-0646893

Part II **Noncash Property** (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____

Name of organization MONTGOMERY GENERAL HOSPITAL, INC.

Employer identification number

52-0646893

Part III *Exclusively religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than \$1,000 for the year from any one contributor.* Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of **\$1,000 or less** for the year. (Enter this information once. See instructions.) ▶ \$ _____
 Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
_____	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
_____		_____	
_____		_____	
_____		_____	
_____	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
_____		_____	
_____		_____	
_____		_____	
_____	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
_____		_____	
_____		_____	
_____		_____	
_____	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
_____		_____	
_____		_____	
_____		_____	

SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No. 1545-0047

2017

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 for instructions and the latest information.

Department of the Treasury Internal Revenue Service

Name of the organization

MONTGOMERY GENERAL HOSPITAL, INC.

Employer identification number

52-0646893

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.

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows include: Total number at end of year, Aggregate value of contributions to (during year), Aggregate value of grants from (during year), Aggregate value at end of year, 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?, 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?

Part II Conservation Easements.

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

Form with multiple sections: Purpose(s) of conservation easements held by the organization (check all that apply), 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. (Includes sub-sections a, b, c, d with table for Held at the End of the Tax Year), Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year, Number of states where property subject to conservation easement is located, Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?, Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year, Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year, 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)?, 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.

Form with sections: 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. 1b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items: (i) Revenue included on Form 990, Part VIII, line 1. (ii) Assets included in Form 990, Part X. 2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items: a Revenue included on Form 990, Part VIII, line 1. b Assets included in Form 990, Part X.

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

Schedule D (Form 990) 2017

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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?

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?
b If "Yes," explain the arrangement in Part XIII and complete the following table:
Table with columns: Amount, rows: 1c Beginning balance, 1d Additions during the year, 1e Distributions during the year, 1f Ending balance
2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability?
b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided on Part XIII

Part V Endowment Funds.

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

- Table with columns: (a) Current year, (b) Prior year, (c) Two years back, (d) Three years back, (e) Four years back. Rows: 1a-1g (Balance, Contributions, Net investment earnings, Grants, Other expenditures, Administrative expenses, End of year balance)
2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
a Board designated or quasi-endowment %
b Permanent endowment %
c Temporarily restricted endowment %
3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
(i) unrelated organizations
(ii) related organizations
b If "Yes" on line 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.

Table with columns: Description of property, (a) Cost or other basis (investment), (b) Cost or other basis (other), (c) Accumulated depreciation, (d) Book value. Rows: 1a Land, b Buildings, c Leasehold improvements, d Equipment, e Other, Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)

Part VII Investments - Other Securities.

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

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

Part VIII Investments - Program Related.

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

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

Part IX Other Assets.

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

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

Part X Other Liabilities.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) MOB LIABILITY	7,877,865.
(3) ADVANCE HEALTH INSURANCE	5,165,979.
(4) WORKERS COMPENSATION	1,023,858.
(5) CREDIT BALANCES PATIENT AR	516,726.
(6) GBR LIABILITY	298,554.
(7) OTHER SHORT TERM LIABILITIES	510,947.
(8) OTHER LONG TERM LIABILITIES	485,459.
(9) UCC POOL LIABILITY	111,982.
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	15,991,370.

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 XIII Supplemental Information (continued)

FIN 48 FOOTNOTE

SCHEDULE D, PART X

INCOME TAXES ARE ACCOUNTED FOR UNDER THE ASSET AND LIABILITY METHOD. DEFERRED TAX ASSETS AND LIABILITIES ARE RECOGNIZED FOR THE FUTURE TAX CONSEQUENCES ATTRIBUTABLE TO DIFFERENCES BETWEEN THE FINANCIAL STATEMENT CARRYING AMOUNTS OF EXISTING ASSETS AND LIABILITIES AND THEIR RESPECTIVE TAX BASES AND OPERATING LOSS AND TAX CREDIT CARRYFORWARDS. DEFERRED TAX ASSETS AND LIABILITIES ARE MEASURED USING ENACTED TAX RATES EXPECTED TO APPLY TO TAXABLE INCOME IN THE YEARS IN WHICH THOSE TEMPORARY DIFFERENCES ARE EXPECTED TO BE RECOVERED OR SETTLED. THE EFFECT ON DEFERRED TAX ASSETS AND LIABILITIES OF A CHANGE IN TAX RATES IS RECOGNIZED IN THE PERIOD THAT INCLUDES THE ENACTMENT DATE. ANY CHANGES TO THE VALUATION ALLOWANCE ON THE DEFERRED TAX ASSET ARE REFLECTED IN THE YEAR OF CHANGE. THE CORPORATION ACCOUNTS FOR UNCERTAIN TAX POSITIONS IN ACCORDANCE WITH THE FASB ACCOUNTING STANDARDS CODIFICATION (ASC) TOPIC 740, INCOME TAXES. THERE WAS NO LIABILITY RECORDED FOR UNCERTAIN TAX POSITIONS AS OF JUNE 30, 2018.

**SCHEDULE F
(Form 990)**

Statement of Activities Outside the United States

OMB No. 1545-0047

2017

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 14b, 15, or 16.
▶ Attach to Form 990.

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

Name of the organization

MONTGOMERY GENERAL HOSPITAL, INC.

Employer identification number

52-0646893

Part I **General Information on Activities Outside the United States.** Complete if the organization answered "Yes" on 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 the region	(d) Activities conducted in the region (by type) (such as, 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 the region	(f) Total expenditures for and investments in the region
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					
(11)					
(12)					
(13)					
(14)					
(15)					
(16)					
(17)					
3a Sub-total					
b Total from continuation sheets to Part I					
c Totals (add lines 3a and 3b)					

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

Schedule F (Form 990) 2017

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Part II Grants and Other Assistance to Organizations or Entities Outside the United States. Complete if the organization answered "Yes" on 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. X

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)
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									
(8)									
(9)									
(10)									
(11)									
(12)									
(13)									
(14)									
(15)									
(16)									

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" on Form 990, Part IV, line 16. Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Region	(c) Number of recipients	(d) Amount of cash grant	(e) Manner of cash disbursement	(f) Amount of non-cash assistance	(g) Description of non-cash assistance	(h) Method of valuation (book, FMV, appraisal, other)
(1)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							
(13)							
(14)							
(15)							
(16)							
(17)							
(18)							

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).

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2017

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/Form990 for instructions and the latest information.

Department of the Treasury
Internal Revenue Service

Name of the organization

MONTGOMERY GENERAL HOSPITAL, INC.

Employer identification number

52-0646893

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			2,007,432.		2,007,432.	1.21
b Medicaid (from Worksheet 3, column a)						
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			2,007,432.		2,007,432.	1.21
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			649,618.	18,465.	631,153.	.38
f Health professions education (from Worksheet 5)			238,890.		238,890.	.14
g Subsidized health services (from Worksheet 6)			9,109,157.	6,393,051.	2,716,106.	1.64
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			168,703.		168,703.	.10
j Total. Other Benefits			10,166,368.	6,411,516.	3,754,852.	2.26
k Total. Add lines 7d and 7j.			12,173,800.	6,411,516.	5,762,284.	3.47

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			53,372.		53,372.	.03
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building			21,966.		21,966.	.01
7 Community health improvement advocacy			26,385.		26,385.	.02
8 Workforce development			13,610.		13,610.	.01
9 Other						
10 Total			115,333.		115,333.	.07

Part III Bad Debt, Medicare, & Collection Practices

		Yes	No
Section A. Bad Debt Expense			
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	X	
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.		
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		
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)		
6	Enter Medicare allowable costs of care relating to payments on line 5		
7	Subtract line 6 from line 5. This is the surplus (or shortfall)		
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other		
Section C. Collection Practices			
9a	Did the organization have a written debt collection policy during the tax year?	X	
9b	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	X	

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 (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group MONTGOMERY GENERAL HOSPITAL

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

Community Health Needs Assessment

Table with 3 columns: Question ID, Yes, No. Rows 1-12b with 'X' marks in various cells.

- 1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year?
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)?
a A definition of the community served by the hospital facility
b Demographics of the community
c Existing health care facilities and resources within the community that are available to respond to the health needs of the community
d How data was obtained
e The significant health needs of the community
f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups
g The process for identifying and prioritizing community health needs and services to meet the community health needs
h The process for consulting with persons representing the community's interests
i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)
j Other (describe in Section C)
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 17
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health?
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities?
6b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?
7 Did the hospital facility make its CHNA report widely available to the public?
a Hospital facility's website (list url): HTTP://WWW.MEDSTARMONTGOMERY.ORG/
b Other website (list url):
c Made a paper copy available for public inspection without charge at the hospital facility
d Other (describe in Section C)
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA?
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 2017
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?
a If "Yes," (list url): HTTP://WWW.MEDSTARMONTGOMERY.ORG/
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?
c If "Yes" to 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)

Name of hospital facility or letter of facility reporting group MONTGOMERY GENERAL HOSPITAL

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	X	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200.0000</u> % and FPG family income limit for eligibility for discounted care of <u>400.0000</u> %		
b	<input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input checked="" type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance status		
g	<input checked="" type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	X	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	X	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	X	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>HTTP://WWW.MEDSTARMONTGOMERY.ORG/</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>HTTP://WWW.MEDSTARMONTGOMERY.ORG/</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>HTTP://WWW.MEDSTARMONTGOMERY</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input type="checkbox"/> Other (describe in Section C)		

Part V Facility Information (continued)

Billing and Collections

Name of hospital facility or letter of facility reporting group MONTGOMERY GENERAL HOSPITAL

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

Name of hospital facility or letter of facility reporting group MONTGOMERY GENERAL HOSPITAL

		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a	<input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b	<input type="checkbox"/> 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	<input type="checkbox"/> 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	<input checked="" type="checkbox"/> 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.		X
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.		X

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.

CHNA INPUT PART V, SECTION B, LINE 5

HOSPITAL LEAD

ROLE DESCRIPTION

THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) HOSPITAL LEAD SERVES AS THE COORDINATOR OF ALL ASPECTS OF THE COMMUNITY HEALTH ASSESSMENT PROCESS. HE/SHE HELPS ESTABLISH AND COORDINATE THE ACTIVITIES OF THE ADVISORY TASK FORCE. THE LEAD ALSO HELPS PRODUCE THE HOSPITAL'S COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION STRATEGY. HE/SHE WORKS COLLABORATIVELY WITH REPRESENTATIVES FROM THE CORPORATE COMMUNITY HEALTH DEPARTMENT AND GEORGETOWN UNIVERSITY. THE LEAD ALSO WORKS CLOSELY WITH THE WRITER. HE/SHE REVIEWS ALL NARRATIVES PRIOR TO PUBLICATION.

NAME OF HOSPITAL LEAD: DAIRY MARROQUIN AND DIANA SALADINI

EXECUTIVE SPONSOR

ROLE DESCRIPTION

THE EXECUTIVE SPONSOR SERVES AS THE CONDUIT BETWEEN THE ADVISORY TASK FORCE AND THE SENIOR MANAGEMENT TEAM. THE SPONSOR IS AN ACTIVE PARTICIPANT OF THE ADVISORY TASK FORCE AND HE/SHE COMMUNICATES THE HOSPITAL'S CLINICAL STRENGTHS AND PROGRAM PRIORITIES TO DIVERSE AUDIENCES.

NAME OF EXECUTIVE SPONSOR: FREDERICK FINELLI, MD

ADVISORY TASK FORCE ROLE DESCRIPTION THE ADVISORY TASK FORCE (ATF) REVIEWS PRIMARY/SECONDARY DATA AND LOCAL/STATE/FEDERAL COMMUNITY HEALTH GOALS. BASED ON FINDINGS, THE ATF PROVIDES INPUT INTO THE HOSPITAL'S THREE-YEAR IMPLEMENTATION STRATEGY. AS AMBASSADORS FOR THE CHNA PROCESS,

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.

THE ATF MEMBERS SUPPORT EFFORTS TO OPTIMIZE COMMUNITY PARTICIPATION.NOTE:

THE ATF SHOULD BE A COMBINATION OF COMMUNITY REPRESENTATIVES AND STAFF.

COMMUNITY REPRESENTATIVES SHOULD MAKEUP AT LEAST 50% OF TOTAL

PARTICIPANTS.

NAME:	TITLE/AFFILIATION	NAME OF ORGANIZATION
	WITH HOSPITAL	
AMY SHIELDS WILSON	VICE PRESIDENT OF OPERATIONS	MINDOULA HEALTH
DAIRY MARROQUIN (LEAD)	COMMUNITY OUTREACH COORDINATOR	MMMC
DEB OTANI	CANCER NURSE NAVIGATOR	MMMC
DEBBIE ELLINGHAUS	MANAGING DIRECTOR	OLNEY THEATRE
DIANA SALADINI	DIRECTOR, POPULATION HEALTH	MMMC
EDITH WILLIAMS	COMMUNITY MEMBER	MILLIAN UNITED METHODIST CHURCH
FREDERICK FINELLI, MD	EXECUTIVE SPONSOR VP MEDICAL AFFAIRS	MMMC
JAQUELINE HUBBARD -WILLIAMS	HEALTH CENTER DIRECTOR	HOLY CROSS HEALTHCENTER- ASPEN HILL
JOE PODSON	EXECUTIVE DIRECTOR	HOMECREST HOUSE
KAREN THOMPKINS	SR. PLANNING SPECIALIST	HEALTHY MONTGOMERY/ MONTGOMERY COUNTY

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.

		HEALTH DEPARTMENT
LYNDA SUH	DIRECTOR, QUALITY & RISK	MMMC
MARSHA BATISTA	RESIDENT COUNSELOR III	HOUSING OPPORTUNITIES
		COMMISSION
MARY JANE JOSEPH	PROJECT MANAGER	PRIMARY CARE COALITION
SHARON RISER	CASE MANAGER EMERGENCY	MMMC
	DEPARTMENT	
SUSAN MONTGOMERY	DIRECTOR OF SOCIAL SERVICES	LEISURE WORLD SENIOR
		COMMUNITY
THOMAS BRUNETTO (OHFL)	CHAIR	OLNEY HOME FOR LIFE

IMPLEMENTATION STRATEGIES

PART V, SECTION B, LINE 11

THE IMPLEMENTATION STRATEGIES SERVE AS A ROADMAP FOR HOW COMMUNITY BENEFIT RESOURCES WILL BE ALLOCATED AND DEPLOYED. MEDSTAR'S HOSPITALS WILL BE ABLE TO MEASURE OUR CONTRIBUTION TO IMPROVING THE HEALTH OF UNDERSERVED AND VULNERABLE POPULATIONS IN THE REGIONS WE SERVE. THREE-YEAR IMPLEMENTATION STRATEGIES WITH MEASURABLE OBJECTIVES WERE DEVELOPED FOR EACH HOSPITAL'S COMMUNITY BENEFIT SERVICE AREA - A SPECIFIC COMMUNITY OR TARGET POPULATION OF FOCUS. PRIORITIES WERE BASED ON COMMUNITY NEED AS DETERMINED BY QUANTITATIVE DATA AND COMMUNITY INPUT, AS WELL AS ON HOSPITAL EXPERTISE, RESOURCES, STRENGTHS OF EXISTING

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.

PROGRAMMING AND PARTNERSHIPS, AND ALIGNMENT WITH NATIONAL, STATE, AND LOCAL HEALTH GOALS. THE MEDSTAR HEALTH CORPORATE COMMUNITY HEALTH DEPARTMENT WILL PROVIDE SYSTEM-WIDE COORDINATION AND OVERSIGHT OF COMMUNITY BENEFIT PROGRAMMING.

HOSPITAL ADVISORY TASK FORCES CONVENE AT LEAST ANNUALLY TO MONITOR PROGRESS OF STRATEGY EXECUTION AND TO PROVIDE ONGOING RECOMMENDATIONS RELATED TO OUTCOMES ACHIEVEMENT, PROGRAM DEVELOPMENT, PARTNERSHIP APPROACHES, AND OVERALL IMPLEMENTATION IMPROVEMENT.

FOR SIGNIFICANT NEEDS IDENTIFIED IN THE CHNA THAT THE HOSPITAL HAS NOT PRIORITIZED AS FOCUS AREAS THROUGH ITS IMPLEMENTATION STRATEGY, THESE NEEDS WILL BE ADDRESSED BY COLLABORATING WITH OTHER LEADING ORGANIZATIONS, AND BY TAKING A SUPPORTER ROLE ON IDENTIFIED NEEDS THAT ARE BEYOND THE SCOPE OF THE HOSPITAL'S STRENGTHS.

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? _____

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

Part VI Supplemental Information

Provide the following information.

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

CHARITY CARE AT COST

PART I, LINE 7A

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC), DETERMINES PAYMENT THROUGH A RATE-SETTING PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL. MARYLAND'S UNIQUE ALL-PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED CARE IN EACH PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE.

UNREIMBURSED MEDICAID

PART I, LINE 7B

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC), DETERMINES PAYMENT THROUGH A RATE-SETTING PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL. MARYLAND'S

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.

UNIQUE ALL-PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED CARE IN EACH PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE. COMMUNITY BENEFIT EXPENSES ARE EQUAL TO MEDICAID REVENUES IN MARYLAND, AS SUCH, THE NET EFFECT IS ZERO. THE EXCEPTION TO THIS IS THE IMPACT ON THE HOSPITAL OF ITS SHARE OF THE MEDICAID ASSESSMENT. IN RECENT YEARS, THE STATE OF MARYLAND HAS CLOSED FISCAL GAPS IN THE STATE MEDICAID BUDGET BY ASSESSING HOSPITALS THROUGH THE RATE-SETTING SYSTEM.

BAD DEBT

PART III, LINES 2 & 4

MEDSTAR HEALTH AND ITS AFFILIATED ORGANIZATIONS REPORT BAD DEBT EXPENSE IN ACCORDANCE WITH ASU 2011-07, WHICH REQUIRES CERTAIN HEALTHCARE ENTITIES TO CHANGE THE PRESENTATION OF THEIR STATEMENT OF OPERATIONS BY RECLASSIFYING THE PROVISION FOR BAD DEBTS ASSOCIATED WITH PATIENT SERVICE REVENUE FROM AN OPERATING EXPENSE TO A DEDUCTION FROM PATIENT SERVICE REVENUE (NET OF CONTRACTUAL ALLOWANCES AND DISCOUNTS). HOWEVER, MEDSTAR AND ITS AFFILIATED ENTITIES DO NOT MAKE A DETERMINATION AS TO WHETHER

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.

SELF PAY AMOUNTS ARE COLLECTIBLE IN DETERMINING REVENUE RECOGNITION.

RESERVE MODELS, WHICH HAVE BEEN DEVELOPED BASED ON HISTORICAL COLLECTION RESULTS AND WHICH ARE ADJUSTED PERIODICALLY BASED ON ACTUAL COLLECTIONS EXPERIENCE, ARE USED TO ESTIMATE UNCOLLECTIBLE AMOUNTS ACROSS ALL PAYORS INCLUDING SELF PAY. BAD DEBT DETERMINATIONS ARE MADE ONLY AFTER SUFFICIENT EVIDENCE IS OBTAINED TO SUPPORT THAT AN AMOUNT IS NOT COLLECTIBLE.

MEDICARE

PART III, LINE 8

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC) DETERMINES PAYMENT THROUGH A RATE-SETTING PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL. MARYLAND'S UNIQUE ALL-PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED CARE IN EACH PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE. AS SUCH,

Part VI Supplemental Information

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- 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.

THE NET EFFECT FOR MEDICARE EXPENSES AND REVENUES IN MARYLAND IS ZERO.

PART III, LINE 9B

IF IT IS DETERMINED THAT A PATIENT MAY POTENTIALLY QUALIFY FOR A CHARITABLE/FINANCIAL PROGRAM, A HOLD IS PLACED ON THE ACCOUNT TO PREVENT IT FROM BEING REPORTED AS BAD DEBT UNTIL PROGRAM APPROVALS HAVE BEEN OBTAINED. IF IT IS APPROVED, THE ACCOUNT IS DOCUMENTED AND THE NECESSARY ADJUSTMENTS ARE MADE TO CLOSE THE ACCOUNT.

NEEDS ASSESSMENT

PART VI, LINE 2

IN FY18, MEDSTAR MONTGOMERY MEDICAL CENTER (MMC) CONDUCTED A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) IN ACCORDANCE WITH THE GUIDELINES ESTABLISHED BY THE PATIENT PROTECTION AND AFFORDABLE CARE ACT AND THE INTERNAL REVENUE SERVICE.

A 16 MEMBER ADVISORY TASK FORCE (ATF) LED THE MMC CHNA PROCESS. THE ATF INCLUDED A DIVERSE GROUP OF INDIVIDUALS, INCLUDING HOSPITAL LEADERS,

Part VI Supplemental Information

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GRASSROOTS ACTIVISTS, COMMUNITY RESIDENTS, FAITH-BASED LEADERS, HOSPITAL REPRESENTATIVES, PUBLIC HEALTH LEADERS AND OTHER STAKEHOLDER ORGANIZATIONS, SUCH AS REPRESENTATIVES FROM LOCAL HEALTH DEPARTMENTS.

THE ATF REVIEWED NATIONAL, STATE, AND LOCAL HEALTH AND DISPARITY DATA, PUBLIC HEALTH PRIORITIES AND COMMUNITY HEALTH IMPROVEMENT PLANS AS WELL AS COUNTY-LEVEL ZIP CODE AND NEIGHBORHOOD LEVEL DATA (WHEN AVAILABLE). BASED ON THEIR FINDINGS, ATF MEMBERS DESIGNED A CHNA SURVEY TOOL CONSISTING OF OPEN AND CLOSED-ENDED QUESTIONS ABOUT HEALTHCARE ACCESS, HEALTH EQUITY, HEALTH CONDITION CONCERNS, SOCIAL DETERMINANTS AND COMMUNITY STRENGTHS AND ASSETS. COMMUNITY MEMBERS RESPONDED TO THE SURVEY BY ATTENDING A COMMUNITY INPUT SESSION OR COMPLETING IT ONLINE OR VIA HARDCOPY.

BASED ON THE ATF'S RECOMMENDATION, THE HOSPITAL IDENTIFIED ASPEN HILL AND BEL PRE AS ITS COMMUNITY BENEFIT SERVICE AREA (CBSA), WHICH INCLUDES RESIDENTS LIVING IN ZIP CODES 20906 AND 20853. THE HOSPITAL SELECTED THIS GEOGRAPHIC AREA BASED ON HOSPITAL UTILIZATION AND SECONDARY PUBLIC HEALTH

Part VI Supplemental Information

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DATA AS WELL AS ITS CLOSE PROXIMITY TO THE HOSPITAL, COUPLED WITH A HIGH DENSITY OF LOW-INCOME RESIDENTS.

THE ATF USED POPULATION-LEVEL DATA, COMMUNITY HEALTH NEEDS SURVEY FINDINGS AND FEEDBACK FROM COMMUNITY INPUT SESSIONS TO CREATE RECOMMENDATIONS FOR THE HOSPITAL'S HEALTH PRIORITIES, POTENTIAL IMPLEMENTATION STRATEGIES, AND TO IDENTIFY KEY PARTNERS. BASED ON THE ATF'S RECOMMENDATION, THE HOSPITAL HEALTH PRIORITIES FOR THE CBSA INCLUDE HEALTH AND WELLNESS (CHRONIC DISEASE PREVENTION AND MANAGEMENT, BEHAVIORAL HEALTH), ACCESS TO CARE AND SERVICES (EMERGENCY AND PRIMARY CARE, MENTAL HEALTH SERVICES, TRANSPORTATION, MEDICATION ADHERENCE) AND SOCIAL DETERMINANTS OF HEALTH (EMPLOYMENT, HOUSING).

THE HOSPITAL'S FY18 CHNA AND THREE-YEAR IMPLEMENTATION STRATEGIES WERE ENDORSED BY MMC BOARD OF DIRECTORS AND APPROVED BY THE MEDSTAR HEALTH BOARD OF DIRECTORS. THE DOCUMENT BECAME AVAILABLE ON THE HOSPITAL'S WEBSITE ON JUNE 30, 2018.

Part VI Supplemental Information

Provide the following information.

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AS A PROUD MEMBER OF MEDSTAR HEALTH, REPRESENTATIVES FROM MMMC ROUTINELY PARTICIPATE IN THE MEDSTAR HEALTH COMMUNITY BENEFIT WORKGROUP. THE WORKGROUP IS COMPRISED OF COMMUNITY HEALTH PROFESSIONALS WHO REPRESENT ALL TEN MEDSTAR HOSPITALS. THE TEAM ANALYZES LOCAL AND REGIONAL COMMUNITY HEALTH DATA, ESTABLISHES SYSTEM-WIDE COMMUNITY HEALTH PROGRAMMING PERFORMANCE AND EVALUATION MEASURES AND SHARES BEST PRACTICES.

PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE
PART VI, LINE 3

AS ONE OF THE REGION'S LEADING NOT-FOR-PROFIT HEALTHCARE SYSTEMS, MEDSTAR HEALTH IS COMMITTED TO ENSURING THAT UNINSURED PATIENTS AND UNDERINSURED PATIENTS MEETING MEDICAL HARDSHIP CRITERIA WITHIN THE COMMUNITIES WE SERVE WHO LACK FINANCIAL RESOURCES HAVE ACCESS TO EMERGENCY AND MEDICALLY NECESSARY HOSPITAL SERVICES. MEDSTAR HEALTH AND ITS HEALTHCARE FACILITIES WILL:

* TREAT ALL PATIENTS EQUITABLY, WITH DIGNITY, RESPECT, AND COMPASSION.

Part VI Supplemental Information

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- 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.
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* SERVE THE EMERGENCY HEALTH CARE NEEDS OF EVERYONE WHO PRESENTS TO OUR FACILITIES REGARDLESS OF A PATIENT'S ABILITY TO PAY FOR CARE.

* ASSIST THOSE PATIENTS WHO ARE ADMITTED THROUGH OUR ADMISSION PROCESS FOR NON-URGENT, MEDICALLY NECESSARY CARE WHO CANNOT PAY FOR THE CARE THEY RECEIVE.

* BALANCE NEEDED FINANCIAL ASSISTANCE FOR SOME PATIENTS WITH BROADER FISCAL RESPONSIBILITIES IN ORDER TO KEEP ITS HOSPITALS' DOORS OPEN FOR ALL WHO MAY NEED CARE IN THE COMMUNITY.

IN MEETING ITS COMMITMENTS, MEDSTAR HEALTH'S FACILITIES WILL WORK WITH THEIR UNINSURED PATIENTS SEEKING EMERGENCY AND MEDICALLY NECESSARY CARE TO GAIN AN UNDERSTANDING OF EACH PATIENT'S FINANCIAL RESOURCES. BASED ON THIS INFORMATION AND ELIGIBILITY DETERMINATION, MEDSTAR HEALTH FACILITIES WILL PROVIDE FINANCIAL ASSISTANCE TO UNINSURED PATIENTS WHO RESIDE WITHIN THE COMMUNITIES WE SERVE IN ONE OR MORE OF THE FOLLOWING WAYS:

* ASSIST WITH ENROLLMENT IN PUBLICLY-FUNDED ENTITLEMENT PROGRAMS (E.G., MEDICAID).

Part VI Supplemental Information

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* REFER PATIENTS TO STATE OR FEDERAL INSURANCE EXCHANGE NAVIGATOR RESOURCES.

* ASSIST WITH CONSIDERATION OF FUNDING THAT MAY BE AVAILABLE FROM OTHER CHARITABLE ORGANIZATIONS.

* PROVIDE FINANCIAL ASSISTANCE ACCORDING TO APPLICABLE POLICY GUIDELINES.

* PROVIDE FINANCIAL ASSISTANCE FOR PAYMENT OF FACILITY CHARGES USING A SLIDING-SCALE BASED ON THE PATIENT'S HOUSEHOLD INCOME AND FINANCIAL RESOURCES.

* OFFER PERIODIC PAYMENT PLANS TO ASSIST PATIENTS WITH FINANCING THEIR HEALTHCARE SERVICES.

EACH FACILITY PUBLICIZES THE MEDSTAR FINANCIAL ASSISTANCE POLICY BY:

* PROVIDING ACCESS TO THE MEDSTAR FINANCIAL ASSISTANCE POLICY, FINANCIAL ASSISTANCE APPLICATIONS, AND MEDSTAR PATIENT INFORMATION SHEET ON ALL HOSPITAL WEBSITES AND PATIENT PORTALS.

* PROVIDING HARD COPIES OF THE MEDSTAR FINANCIAL ASSISTANCE POLICY,

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MEDSTAR UNIFORM FINANCIAL ASSISTANCE APPLICATION, AND MEDSTAR PATIENT INFORMATION SHEET TO PATIENTS UPON REQUEST.

* PROVIDING NOTIFICATION AND INFORMATION ABOUT THE MEDSTAR FINANCIAL ASSISTANCE POLICY BY OFFERING COPIES AS PART OF ALL REGISTRATION OR DISCHARGES PROCESSES, AND ANSWERING QUESTIONS ON HOW TO APPLY FOR ASSISTANCE.

* PROVIDING WRITTEN NOTICES ON BILLING STATEMENTS.

* DISPLAYING MEDSTAR FINANCIAL ASSISTANCE POLICY INFORMATION AT ALL HOSPITAL REGISTRATION POINTS.

* TRANSLATING THE MEDSTAR FINANCIAL ASSISTANCE POLICY, MEDSTAR UNIFORM FINANCIAL ASSISTANCE APPLICATION, AND THE MEDSTAR PATIENT INFORMATION SHEET INTO PRIMARY LANGUAGES OF ALL SIGNIFICANT POPULATIONS WITH LIMITED ENGLISH PROFICIENCY.

MEDSTAR HEALTH PROVIDES A FINANCIAL ASSISTANCE PROBABLE AND LIKELY ELIGIBILITY DETERMINATION TO THE PATIENT WITHIN TWO BUSINESS DAYS FROM RECEIPT OF THE INITIAL FINANCIAL ASSISTANCE APPLICATION. FINAL ELIGIBILITY DETERMINATIONS ARE MADE AND COMMUNICATED TO THE PATIENT BASED

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ON RECEIPT AND REVIEW OF A COMPLETED APPLICATION.

MEDSTAR HEALTH BELIEVES THAT ITS PATIENTS HAVE PERSONAL RESPONSIBILITIES RELATED TO THE FINANCIAL ASPECTS OF THEIR HEALTHCARE NEEDS. FINANCIAL ASSISTANCE AND PERIODIC PAYMENT PLANS AVAILABLE UNDER THIS POLICY WILL NOT BE AVAILABLE TO THOSE PATIENTS WHO FAIL TO FULFILL THEIR RESPONSIBILITIES. FOR PURPOSES OF THIS POLICY, PATIENT RESPONSIBILITIES INCLUDE:

* COMPLYING WITH PROVIDING THE NECESSARY FINANCIAL DISCLOSURE FORMS TO EVALUATE THEIR ELIGIBILITY FOR PUBLICLY-FUNDED HEALTHCARE PROGRAMS, CHARITY CARE PROGRAMS, AND OTHER FORMS OF FINANCIAL ASSISTANCE (THESE DISCLOSURE FORMS MUST BE COMPLETED ACCURATELY, TRUTHFULLY, AND TIMELY TO ALLOW MEDSTAR HEALTH'S FACILITIES TO PROPERLY COUNSEL PATIENTS CONCERNING THE AVAILABILITY OF FINANCIAL ASSISTANCE).

* WORKING WITH THE FACILITY'S PATIENT ADVOCATES AND PATIENT FINANCIAL SERVICES STAFF TO ENSURE THERE IS A COMPLETE UNDERSTANDING OF THE PATIENT'S FINANCIAL SITUATION AND CONSTRAINTS.

* MAKING APPLICABLE PAYMENTS FOR SERVICES IN A TIMELY FASHION,

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INCLUDING ANY PAYMENTS MADE PURSUANT TO DEFERRED AND PERIODIC PAYMENT

SCHEDULES.

* PROVIDING UPDATED FINANCIAL INFORMATION TO THE FACILITY'S PATIENT ADVOCATES OR CUSTOMER SERVICE REPRESENTATIVES ON A TIMELY BASIS AS THE PATIENT'S FINANCIAL CIRCUMSTANCES MAY CHANGE.

* IT IS THE RESPONSIBILITY OF THE PATIENT TO INFORM THE MEDSTAR HOSPITAL OF THEIR EXISTING ELIGIBILITY UNDER A MEDICAL HARDSHIP DURING THE 12-MONTH PERIOD.

* IN THE EVENT A PATIENT FAILS TO MEET THESE RESPONSIBILITIES, MEDSTAR RESERVES THE RIGHT TO PURSUE ADDITIONAL BILLING AND COLLECTION EFFORTS. IN THE EVENT OF NON-PAYMENT BILLING, AND COLLECTION EFFORTS ARE DEFINED IN THE MEDSTAR BILLING AND COLLECTION POLICY. A FREE COPY IS AVAILABLE ON ALL HOSPITAL WEBSITES AND PATIENT PORTALS OR BY CALLING CUSTOMER SERVICE AT 1-800-280-9006.

UNINSURED PATIENTS OF MEDSTAR HEALTH'S FACILITIES MAY BE ELIGIBLE FOR FULL FINANCIAL ASSISTANCE OR PARTIAL SLIDING-SCALE FINANCIAL ASSISTANCE UNDER THIS POLICY. THE PATIENT ADVOCATE AND PATIENT FINANCIAL SERVICES

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STAFF WILL DETERMINE ELIGIBILITY FOR FULL FINANCIAL ASSISTANCE AND PARTIAL SLIDING-SCALE FINANCIAL ASSISTANCE BASED ON REVIEW OF INCOME FOR THE PATIENT AND THEIR FAMILY (HOUSEHOLD), OTHER FINANCIAL RESOURCES AVAILABLE TO THE PATIENT'S FAMILY, FAMILY SIZE, AND THE EXTENT OF THE MEDICAL COSTS TO BE INCURRED BY THE PATIENT.

COMMUNITY INFORMATION

PART VI, LINE 4

GEOGRAPHIC:

MEDSTAR MONTGOMERY MEDICAL CENTER'S CBSA INCLUDES RESIDENTS IN THE ASPEN HILL/BEL PRE/ROCKVILLE NEIGHBORHOODS OF MONTGOMERY COUNTY, MARYLAND (ZIP CODES 20906 AND 20853). THIS GEOGRAPHIC AREA WAS SELECTED BASED ON HOSPITAL UTILIZATION AND SECONDARY PUBLIC HEALTH DATA, AS WELL AS ITS CLOSE PROXIMITY TO THE HOSPITAL, COUPLED WITH A HIGH DENSITY OF LOW-INCOME RESIDENTS, UNDERSERVED SENIORS AND AN ETHNICALLY DIVERSE POPULATION.

DEMOGRAPHICS:

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THE AREA ENCOMPASSED BY ZIP CODE 20906 HAS 69,112 RESIDENTS. OVER 19.5% OF RESIDENTS ARE AGE 65 AND OLDER, COMPARED TO 13.71% OF MONTGOMERY COUNTY. THE POPULATION IS RACIALLY DIVERSE, WITH 34.6% WHITE, 25.8% BLACK/AFRICAN AMERICAN, 12.1% ASIAN, WHILE 31.5% ARE OF HISPANIC ORIGIN. RELATIVE TO MONTGOMERY COUNTY, THERE ARE A LARGER PROPORTION OF BLACK/AFRICAN AMERICAN AND HISPANIC RESIDENTS. THE MEDIAN INCOME IN THE CBSA \$70,133 IS LOWER THAN THE COUNTYWIDE MEDIAN \$100,352 AND A HIGHER PROPORTION OF RESIDENTS IN ASPEN HILL/BEL PRE LIVE IN POVERTY 7.5% COMPARED TO 4.7% IN MONTGOMERY COUNTY.

THE AREA ENCOMPASSED BY ZIP CODE 20853 HAS 30,286 RESIDENTS. OVER 16.8% OF RESIDENTS ARE AGE 65 AND OLDER, COMPARED TO 13.71% OF MONTGOMERY COUNTY. THE POPULATION IS RACIALLY DIVERSE, WITH 62.2% WHITE, 13.7% BLACK/AFRICAN AMERICAN, 11.8% ASIAN, WHILE 22.4% ARE OF HISPANIC ORIGIN. THE POPULATION IS RACIALLY DIVERSE WITH CLOSE TO 40.0% NON-WHITE RESIDENTS. THE MEDIAN INCOME IN THE CBSA \$70,133 IS LOWER THAN THE COUNTYWIDE MEDIAN \$100,352 AND A HIGHER PROPORTION OF RESIDENTS IN ASPEN HILL/BEL PRE LIVE IN POVERTY 7.5% COMPARED TO 4.7% IN MONTGOMERY

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COUNTY.

PROMOTION OF COMMUNITY HEALTH

PART VI, LINE 5

AS A COMMUNITY PARTNER, MMMC ENGAGES IN A NUMBER OF COMMUNITY BENEFIT ACTIVITIES TO IMPROVE AND PROMOTE THE HEALTH AND WELLBEING OF THE COMMUNITY. PRIORITY AREAS, AS DETERMINED BY THE FY18 CHNA, FALL UNDER THREE AREAS OF FOCUS INCLUDING HEALTH AND WELLNESS, ACCESS TO CARE AND SERVICES, AS WELL AS SOCIAL DETERMINANTS OF HEALTH. SPECIFIC PRIORITIES INCLUDE CHRONIC DISEASE PREVENTION AND MANAGEMENT, BEHAVIORAL AND MENTAL HEALTH, EMERGENCY AND PRIMARY CARE ACCESS, TRANSPORTATION, EMPLOYMENT AND MEDICATION ADHERENCE.

IN EFFORT TO EDUCATE THE COMMUNITY ABOUT CHRONIC DISEASE PREVENTION AND MANAGEMENT, THE HOSPITAL'S COMMUNITY HEALTH OUTREACH EFFORTS ARE FOCUSED ON INITIATIVES THAT ADDRESS AND MINIMIZE HEALTH DISPARITIES THROUGH INCREASED AWARENESS OF SYMPTOMS AND PREVENTION, UTILIZING COMMUNITY EDUCATION AND PHYSICAL ACTIVITY PROGRAMS, AND ALSO HELPING INDIVIDUALS

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- 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.

TAKE STEPS TO REDUCE THOSE RISKS BY CONNECTING THEM TO APPROPRIATE CARE
WHEN FOLLOW UP CARE IS NECESSARY. SOME OF THE IDENTIFIED PROGRAMS INCLUDE
THE FOLLOWING.

LIVING WELL CHRONIC DISEASE PREVENTION AND MANAGEMENT, A FREE SEVEN-WEEK
HEALTH EDUCATION AND BEHAVIOR CHANGE PROGRAM FOCUSED ON CHRONIC DISEASE
SELF-MANAGEMENT FOR PEOPLE LIVING WITH ONE OR MORE CHRONIC DISEASES. THE
PROGRAM IS DESIGNED FOR ADULTS LIVING WITH A CHRONIC CONDITION, SUCH AS
HEART DISEASE, DIABETES, CANCER, DEPRESSION, CHRONIC PAIN, ARTHRITIS,
LUNG DISEASE, MULTIPLE SCLEROSIS OR ANY CHRONIC HEALTH CONCERN.

SENIOR STRENGTH AND BALANCE PROGRAMS ARE ALSO PROGRAMMED TO BE OFFERED ON
AN ONGOING BASIS. THIS INITIATIVE FOCUSES ON PROVIDING FREE WEEKLY
EXERCISE CLASSES FOR PERSONS 55 AND OLDER, COMPOSED OF LOW-IMPACT
AEROBICS MOVEMENTS, CONCENTRATING ON IMPROVING CARDIOVASCULAR HEALTH,
WEIGHT LOSS, STRENGTH, BALANCE AND FLEXIBILITY.

IN EFFORT TO SUPPORT MENTAL HEALTH AND WELLNESS AS WELL AS ACCESS TO

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.
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- 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.

MENTAL HEALTH PROGRAMS ESTABLISHED SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT) PROGRAM OFFERS A TRIAGE PROCESS OF POINT OF ENTRY WHERE PATIENTS ARE SCREENED FOR ADDICTION AND SUBSTANCE ABUSE, FOLLOWED BY A BRIEF INTERVENTION BY A PEER RECOVERY COACH. WHEN APPROPRIATE, PATIENT IS REFERRED TO ADDICTION TREATMENT SERVICES. IN ADDITION, MEDSTAR MONTGOMERY OFFERS THE MINDOULA BEHAVIORAL HEALTH PROGRAM, A 30 DAYS OF VIRTUALLY OR IN-PERSON CASE MANAGEMENT SERVICES TO THE FIRST THIRTY PATIENTS WITH A DIAGNOSIS OF DEPRESSION, SCHIZOPHRENIA AND AND/OR BIPOLAR DISORDER.

FURTHERMORE, IN EFFORTS TO SUPPORT ACCESS TO CARE AMONG OUR COMMUNITY, MEDSTAR MONTGOMERY HAS IDENTIFIED THE FOLLOWING AS RESOURCE FOR CONNECTING OUR PATIENTS AND COMMUNITY TO PROPER CARE, INCLUDING ESTABLISHED EMERGENCY DEPARTMENT (ED) - PRIMARY CARE (PC) CONNECT INITIATIVE, A COORDINATED REFERRAL PROGRAM FOCUSING ON CONNECTING UNINSURED AND UNDERSERVED SELF-PAY PATIENTS TO PRIMARY CARE AND CHRONIC DISEASE MANAGEMENT PROGRAMS. BILINGUAL POPULATION HEALTH NAVIGATOR PROVIDED REAL TIME NAVIGATION DURING ED VISITS, WORKING WITH PATIENTS TO

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.
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- 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.

ASSIST THEM IN SCHEDULING APPOINTMENTS AT LOCAL SAFETY-NET CLINICS, AND
EDUCATING THEM ON WAYS TO ACCESS CARE IN A NON-EMERGENCY SETTINGS.

MEDSTAR MONTGOMERY WILL ALSO FOCUS ON IDENTIFYING AVAILABLE RESOURCE
PROGRAMS FOR OUR PATIENTS. ONE WAY OF DOING THIS IS BY IDENTIFYING
PATIENTS IN NEED USING AUNT BERTHA RESOURCE FINDER WITHIN OUR EMERGENCY
DEPARTMENT. AUNT BERTHA IS A SOCIAL NEEDS SCREENING TOOL THAT HELPS
IDENTIFY NEARBY RESOURCE AND SUPPORT PROGRAMS AVAILABLE AT LOW COST OR
FREE OF CHARGE TO OUR PATIENTS. THE HOSPITAL WILL ALSO CONTINUE TO
SUPPORT VIABLE PARTNERSHIPS, SUCH AS OLNEY HOME FOR LIFE AND MANOR
CONNECTIONS TRANSPORTATION PROGRAMS, FOCUSING ON FREE TRANSPORTATION
SERVICES FOR SENIORS WHO NEED TO ATTEND THEIR MEDICAL APPOINTMENTS, AS
WELL AS COMMUNITY HEALTH PROGRAMS.

MEDSTAR MONTGOMERY IS A COMMITTED TO MEETING THE NEEDS OF VULNERABLE
POPULATIONS BY ESTABLISHING STRATEGIC PARTNERSHIPS AND ALLIANCES. THE
HOSPITAL WILL CONTINUE TO PROVIDE FINANCIAL SUPPORT TO HOLY CROSS HEALTH
CENTER - ASPEN HILL, WHICH ENABLES THE CLINIC TO TREAT LOW-INCOME,

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.
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- 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.

UNINSURED, ETHNICALLY DIVERSE RESIDENTS AT FREE OR LOW COST. THE HOSPITAL ALSO PROVIDES IN-KIND SPACE FOR DAY-TO-DAY OPERATION OF PROYECTO SALUD'S CLINICAL SPACE. WITH A FOCUS ON PERSONS WHO SPEAK SPANISH AS A PRIMARY LANGUAGE, SERVICES INCLUDE PHYSICAL EXAMINATIONS, HEALTH COUNSELING, EDUCATION, AND LABORATORY SERVICES. IN ADDITION, PROYECTO SALUD OFFERS A SEASONAL FLU CLINIC. PRESCRIPTION MEDICATIONS ARE MADE AVAILABLE THROUGH THE MONTGOMERY CARES PROGRAM. THE CLINIC ALSO PROVIDES REFERRALS FOR COUNTY SPECIALTY SERVICES, SEXUALLY TRANSMITTED INFECTIONS AND HUMAN IMMUNODEFICIENCY VIRUS (HIV) PROGRAMS, WOMEN'S CANCER CONTROL PROGRAM, FAMILY PLANNING, AND ALCOHOL TREATMENT AND REHABILITATION.

IN EFFORTS TO MEET THE SOCIAL DETERMINANTS OF HEALTH NEEDS OF OUR COMMUNITY, MEDSTAR MONTGOMERY HAS IDENTIFIED THE RX FOR SUCCESS PROGRAM AS AN IMPLEMENTATION PROJECT IN EFFORTS TO MEET ACCESS TO EMPLOYMENT NEED IN OUR COMMUNITY. THE RX FOR SUCCESS PROGRAM IS A PIPELINE SUMMER-INTERNSHIP PROGRAM FOR UNDERSERVED HIGH SCHOOL STUDENTS AT KENNEDY HIGH SCHOOL, LOCATED IN OUR COMMUNITY BENEFIT AREA.

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.

IN PARTNERSHIP WITH MEDSTAR PHARMACY, MMMC OFFERS BEDSIDE DELIVERY OF MEDICATIONS FOR PATIENTS BEING DISCHARGED FROM THE HOSPITAL, WHERE A DEDICATED TECHNICIAN WORKS WITH PATIENTS, NURSES, PHYSICIANS, AND CASE MANAGERS, TO ENSURE THAT PATIENTS LEAVING THE HOSPITAL HAVE THEIR DISCHARGE MEDICATIONS BEFORE THEY LEAVE. MMMC ALSO COLLABORATES WITH GIANT PHARMACY TO PROVIDE DISCOUNTED MEDICATIONS TO DISCHARGED PATIENTS WHO CANNOT AFFORD THE COST DURING HOURS MEDSTAR OUTPATIENT PHARMACY IS NOT OPEN. THIS ENSURES THAT PATIENTS GET THEIR PRESCRIPTIONS IN A TIMELY MANNER AND AVOIDS HAVING PATIENTS RETURN TO THE HOSPITAL THE NEXT DAY TO PICK UP PRESCRIPTIONS. IN ADDITION, MMMC COLLABORATES WITH FAMILY AND NURSING CARE FOR PROPER IN HOME MEDICATION ADMINISTRATION, IN ORDER TO DECREASE DRUG INTERACTIONS, ADVERSE EFFECTS AND NON-COMPLIANCE OF DISCHARGED PATIENTS.

AFFILIATED HEALTH CARE SYSTEM

PART VI, LINE 6

AS A PROUD MEMBER OF MEDSTAR HEALTH, MMMC IS ABLE TO EXPAND ITS CAPACITY TO MEET THE NEEDS OF THE COMMUNITY BY COLLABORATING WITH OTHER MEDSTAR

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.
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- 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.

HOSPITALS AND ASSOCIATED ENTITIES. MEDSTAR HEALTH RESOURCES ASSIST THE HOSPITAL IN COMMUNITY HEALTH PLANNING TO MEET THE NEEDS OF THE UNINSURED AND OTHER VULNERABLE POPULATIONS. THROUGH ITS COMMUNITY HEALTH FUNCTION, MEDSTAR HEALTH PROVIDES MMMC WITH TECHNICAL SUPPORT TO ENHANCE COMMUNITY HEALTH PROGRAMMING AND EVALUATION. MEDSTAR'S CORPORATE PHILANTHROPY DEPARTMENT IDENTIFIES AND SEEKS PUBLIC AND PRIVATE FUNDING SOURCES TO ENSURE THE AVAILABILITY OF HIGH QUALITY HEALTH SERVICES, REGARDLESS OF ABILITY TO PAY.

STATE FILING OF COMMUNITY BENEFIT REPORT

PART VI, LINE 7

THE COMMUNITY BENEFIT REPORT FOR MMMC IS FILED IN THE STATE OF MARYLAND.

**SCHEDULE J
(Form 990)**

Department of the Treasury
Internal Revenue Service

Name of the organization

Compensation Information

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

- ▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23.
- ▶ Attach to Form 990.
- ▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2017

Open to Public Inspection

MONTGOMERY GENERAL HOSPITAL, INC.

Employer identification number

52-0646893

Part I Questions Regarding Compensation

1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.

- | | |
|--|---|
| <input type="checkbox"/> First-class or charter travel | <input type="checkbox"/> Housing allowance or residence for personal use |
| <input type="checkbox"/> Travel for companions | <input type="checkbox"/> Payments for business use of personal residence |
| <input type="checkbox"/> Tax indemnification and gross-up payments | <input type="checkbox"/> Health or social club dues or initiation fees |
| <input type="checkbox"/> Discretionary spending account | <input type="checkbox"/> Personal services (such as, maid, chauffeur, chef) |

b If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain

2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked on line 1a?

3 Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.

- | | |
|---|---|
| <input checked="" type="checkbox"/> Compensation committee | <input checked="" type="checkbox"/> Written employment contract |
| <input checked="" type="checkbox"/> Independent compensation consultant | <input checked="" type="checkbox"/> Compensation survey or study |
| <input checked="" type="checkbox"/> Form 990 of other organizations | <input checked="" type="checkbox"/> Approval by the board or compensation committee |

4 During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:

- a** Receive a severance payment or change-of-control payment?
 - b** Participate in, or receive payment from, a supplemental nonqualified retirement plan?
 - c** Participate in, or receive payment from, an equity-based compensation arrangement?
- If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.

Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.

5 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:

- a** The organization?
 - b** Any related organization?
- If "Yes" on line 5a or 5b, describe in Part III.

6 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:

- a** The organization?
 - b** Any related organization?
- If "Yes" on line 6a or 6b, describe in Part III.

7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described on lines 5 and 6? If "Yes," describe in Part III.

8 Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III

9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?

	Yes	No
1a		
1b		
2		
3		
4a		X
4b		X
4c		X
5a		X
5b		X
6a		X
6b		X
7		X
8		X
9		

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

Schedule J (Form 990) 2017

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.

SCHEDULE J, PART III

MR. SAMET'S COMPENSATION IN PART II, COLUMN (B) INCLUDES \$1,914,117

REPRESENTING BENEFITS RECEIVED FROM EXECUTIVE RETIREMENT PLANS THAT ARE

COMPRISED OF TARGET BENEFITS DETERMINED ANNUALLY BASED ON COMPENSATION

AND YEARS OF SERVICE AND LONG-TERM RETENTION ARRANGEMENTS.

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

Department of the Treasury
Internal Revenue Service

Name of the organization

MONTGOMERY GENERAL HOSPITAL, INC.

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2017

**Open to Public
Inspection**

Employer identification number

52-0646893

ORGANIZATION MEMBERS

PART VI, LINE 6

THE ORGANIZATION IS AN AFFILIATE AND SUBSIDIARY OF MEDSTAR HEALTH, INC.
MEDSTAR HEALTH, INC., OR ONE OF ITS AFFILIATES AND SUBSIDIARIES, IS THE
SOLE MEMBER OF THE ORGANIZATION.

DESCRIPTION OF MEMBERS

PART VI, LINES 7A

AS AN AFFILIATE AND SUBSIDIARY OF MEDSTAR HEALTH, INC., THE ORGANIZATION
MAY RECOMMEND PERSON(S) FOR MEMBERSHIP ON THE ORGANIZATION'S GOVERNING
BODY. ANY SUCH RECOMMENDATION BY THE ORGANIZATION IS SUBJECT TO APPROVAL
BY THE GOVERNANCE COMMITTEE OF THE BOARD OF DIRECTORS OF MEDSTAR HEALTH,
INC. THE BOARD OF MEDSTAR HEALTH, INC. HAS DELEGATED CERTAIN APPROVAL
AUTHORITY TO THE GOVERNANCE COMMITTEE AND THE PRESIDENT & CEO OF MEDSTAR
HEALTH, INC.

DECISIONS OF GOVERNING BODY

PART VI, LINES 7B

AS AN AFFILIATE AND SUBSIDIARY OF MEDSTAR HEALTH, INC., THE BYLAWS OF THE
ORGANIZATION ARE SUBJECT TO CERTAIN RESERVED POWERS, WHICH PROVIDE THAT
THE SOLE MEMBER OF THE ORGANIZATION MUST APPROVE CERTAIN DECISIONS,
INCLUDING BUT NOT LIMITED TO MATTERS CONCERNING THE SALE OR PURCHASE OF
REAL OR PERSONAL PROPERTY, CAPITAL BUDGETS, STRATEGIC PLANNING,
INVESTMENTS, AND CORPORATE GOVERNANCE.

Name of the organization MONTGOMERY GENERAL HOSPITAL, INC.	Employer identification number 52-0646893
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FORM 990 REVIEW PROCESS

PART VI, LINE 11B

THE PROCESS FOR REVIEWING THE FORM 990 INCLUDED EDUCATION AND TRANSPARENCY. SENIOR FINANCIAL EXECUTIVES, WORKING WITH INDEPENDENT OUTSIDE EXPERTS, THOROUGHLY REVIEWED FORM 990 AND ACCOMPANYING INSTRUCTIONS. IN ADDITION, SENIOR EXECUTIVES REVIEWED THE RELEVANT SECTIONS OF THE FORM 990 WITH THE FOLLOWING COMMITTEES OF THE ORGANIZATION'S GOVERNING BODY: FINANCE, AUDIT, GOVERNANCE, STRATEGIC PLANNING, AND EXECUTIVE COMPENSATION. FOLLOWING THESE MEETINGS, THE GOVERNING BODY WAS PROVIDED A COPY OF THE FORM 990 IN ITS FINAL FORM AND GIVEN AN OPPORTUNITY TO PROVIDE ANY INPUT OR COMMENTS RELATING TO THE FORM 990 PRIOR TO ITS FILING.

CONFLICT OF INTEREST POLICY

PPART VI, LINE 12C

APPOINTMENT OF BOARDS OF DIRECTORS

MEDSTAR HEALTH (AND ITS SUBSIDIARIES) REQUIRE ALL NOMINATED DIRECTORS, PRIOR TO THEIR APPOINTMENT OR ELECTION, TO DISCLOSE THE EXISTENCE OF (OR POTENTIAL EXISTENCE OF) ANY TRANSACTION WITH MEDSTAR THAT WOULD RESULT IN A CONFLICT OF INTEREST. SUCH DISCLOSURES (IF ANY) ARE REVIEWED BY THE GOVERNANCE COMMITTEE OF THE MEDSTAR HEALTH BOARD OF DIRECTORS WHICH DETERMINES HOW THE MATTER SHOULD BE RESOLVED.

ANNUAL DISCLOSURES - ALL OFFICERS, DIRECTORS, AND SENIOR MANAGERS

Name of the organization MONTGOMERY GENERAL HOSPITAL, INC.	Employer identification number 52-0646893
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ALL OFFICERS, DIRECTORS AND SENIOR MANAGERS ARE REQUIRED, NOT LESS THAN ANNUALLY, TO COMPLETE A SURVEY OF QUESTIONS CONCERNING ANY TRANSACTIONS OR RELATIONSHIPS WHICH WOULD OR COULD REPRESENT A CONFLICT OF INTEREST. SUCH DISCLOSURES (IF ANY) RELATED TO DIRECTORS ARE REVIEWED BY THE GOVERNANCE COMMITTEE OF THE MEDSTAR HEALTH BOARD OF DIRECTORS WHICH DETERMINES HOW THE MATTER SHOULD BE RESOLVED. SUCH DISCLOSURES (IF ANY) RELATED TO OFFICERS AND SENIOR MANAGERS ARE REVIEWED BY AN APPROPRIATE EXECUTIVE WHO DETERMINES HOW THE MATTER SHOULD BE RESOLVED. IN ADDITION, OFFICERS AND DIRECTORS OF MARYLAND HOSPITALS AND NURSING CENTERS ARE REQUIRED TO ANNUALLY DISCLOSE ADDITIONAL INFORMATION RELATING TO POTENTIAL CONFLICTS OF INTEREST AND SUCH DISCLOSURES ARE REPORTED TO THE MARYLAND HEALTH SERVICES COST REVIEW COMMISSION (HSCRC).

EXECUTIVE COMPENSATION PROCESS

PART VI, LINE 15

THE EXECUTIVE COMPENSATION COMMITTEE OF THE BOARD OF DIRECTORS OF MEDSTAR HEALTH, INC. (THE "COMMITTEE") HAS OVERSIGHT OVER THE EXECUTIVE COMPENSATION PROGRAM (THE "PROGRAM") OF MEDSTAR HEALTH, INC. AND ITS AFFILIATES. TOTAL COMPENSATION FOR THE TOP MANAGEMENT OFFICIALS, OFFICERS AND KEY EMPLOYEES OF MEDSTAR HEALTH, INC. AND ITS AFFILIATES ARE REVIEWED AND APPROVED BY THE COMMITTEE WITH ASSISTANCE AND GUIDANCE FROM AN INDEPENDENT THIRD PARTY ADVISOR. THE MEMBERS OF THE COMMITTEE ARE INDEPENDENT FROM ALL OF THE PARTICIPANTS IN THE PROGRAM.

THE MAIN OBJECTIVE OF THE PROGRAM IS TO PROVIDE MARKET COMPETITIVE TOTAL COMPENSATION THAT IS INTERNALLY EQUITABLE AND HAS A STRONG

Name of the organization MONTGOMERY GENERAL HOSPITAL, INC.	Employer identification number 52-0646893
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PAY-FOR-PERFORMANCE LINKAGE. PERFORMANCE IS EVALUATED AT THE SYSTEM, OPERATING UNIT, AND INDIVIDUAL LEVELS. THE OVERALL TOTAL COMPENSATION PHILOSOPHY IS MANAGED AT THE 75TH PERCENTILE OF THE COMPETITIVE MARKET FOR COMPARABLE SIZE (NET REVENUE) AND TYPE ("TAX-EXEMPT HEALTHCARE ORGANIZATIONS"). WHERE APPROPRIATE, ADDITIONAL INDUSTRY DATA IS CONSIDERED (GENERAL BUSINESS AND/OR TAXABLE HEALTHCARE) FOR SELECTED POSITIONS THAT CAN BE RECRUITED FROM OR POTENTIALLY LOST TO THESE INDUSTRIES (E.G., INFORMATION TECHNOLOGY, FINANCE, ETC.).

THE COMMITTEE HAS ENGAGED ERNST & YOUNG LLP ("E&Y") TO SERVE AS AN ADVISOR ON THE REASONABLENESS AND COMPETITIVENESS OF THE PROGRAM. IN DETERMINING REASONABLENESS AND COMPETITIVENESS, E&Y REVIEWS MARKET PRACTICES AND TRENDS, AND MAKES RECOMMENDATIONS RELATED TO THE PROGRAM. E&Y UTILIZES INFORMATION FROM CUSTOM SURVEYS, NATIONAL COMPENSATION SURVEYS, PROPRIETARY DATABASES, AND CLIENT EXPERIENCES TO DETERMINE ITS FINAL RECOMMENDATIONS. E&Y PRESENTS THEIR FINDINGS AND RECOMMENDATIONS TO THE COMMITTEE. THE COMMITTEE MAKES THE FINAL DECISIONS ON ALL OF THE COMPENSATION DETERMINATIONS OF THE PROGRAM. ALL DECISIONS MADE BY THE COMMITTEE ARE CONTEMPORANEOUSLY DOCUMENTED.

FINANCIAL STATEMENT AVAILABILITY

PART VI, LINE 19

MEDSTAR HEALTH POSTS ITS ANNUAL FINANCIAL AUDIT AND QUARTERLY FINANCIAL REPORTS TO THE ELECTRONIC MUNICIPAL MARKET ACCESS (EMMA) SYSTEM. THE ORGANIZATION ALSO E-MAILS ITS ANNUAL AND QUARTERLY DISCLOSURES TO HOLDERS OF THE COMPANY'S PUBLICLY TRADED DEBT. THE COMPANY'S GOVERNANCE DOCUMENTS

Name of the organization MONTGOMERY GENERAL HOSPITAL, INC.	Employer identification number 52-0646893
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AND CONFLICTS OF INTEREST POLICIES ARE AVAILABLE UPON REQUEST THROUGH ITS CORPORATE (OR AS APPLICABLE ENTITY) PUBLIC INFORMATION OFFICES.

OTHER CHANGES IN NET ASSETS

PART XI, LINE 9

NET EQUITY TRANSFER	\$ (12,437,117)
TRNA - PLEDGE RECEIVABLE	\$ 3,076,748
CHANGE IN ACCUMULATED NET ASSETS.....	\$ 2,960,814
DISTRIBUTION FROM PARTNERSHIP	\$ 1,020,000

TOTAL	\$ (5,379,555)

ATTACHMENT 1

FORM 990, PART III, LINE 1 - ORGANIZATION'S MISSION

AS A PROUD MEMBER OF MEDSTAR HEALTH, MEDSTAR MONTGOMERY MEDICAL CENTER'S (MEDSTAR MONTGOMERY) MISSION IS TO ENHANCE OUR COMMUNITY'S HEALTH AND WELL-BEING BY OFFERING HIGH QUALITY, COMPASSIONATE AND PERSONALIZED CARE. MEDSTAR MONTGOMERY IS LOCATED IN OLNEY, IN NORTHEASTERN MONTGOMERY COUNTY, MARYLAND, A SUBURB OF WASHINGTON, D.C. AFTER OVER 90 YEARS, THE HOSPITAL REMAINS TRUE TO ITS ROOTS, OFFERING A WIDE RANGE OF WELLNESS PROGRAMS AND OUTPATIENT SERVICES IN ADDITION TO INPATIENT TREATMENT. IN FISCAL YEAR 2018, MEDSTAR MONTGOMERY HAD APPROXIMATELY 10,117 INPATIENT ADMISSIONS AND OBSERVATION CASES, AND APPROXIMATELY 75,070 OUTPATIENT VISITS INCLUDING 35,944 EMERGENCY VISITS.

Name of the organization MONTGOMERY GENERAL HOSPITAL, INC.	Employer identification number 52-0646893
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ATTACHMENT 2FORM 990, PART III - PROGRAM SERVICE, LINE 4A

MEDSTAR MONTGOMERY'S LARGEST PROGRAM IS ACCESS TO AND THE PROVISION OF ACUTE HOSPITAL SERVICES TO THE COMMUNITIES OF NORTHEASTERN MONTGOMERY COUNTY, MARYLAND AND THE SURROUNDING AREAS. IN ADDITION TO THE PROGRAM SERVICE EXPENSES LISTED ABOVE, MEDSTAR MONTGOMERY INCURRED \$39.8M OF MANAGEMENT AND GENERAL EXPENSES IN PROVIDING SERVICES TO ITS COMMUNITIES. THE ACUTE CARE HOSPITAL OFFERS A CARDIAC AND VASCULAR PROGRAM, GENERAL SURGERY, ORTHOPEDICS, CANCER CARE, AND OBSTETRICS. WITH THE ADDITION OF SPECIALISTS FROM MEDSTAR GEORGETOWN UNIVERSITY HOSPITAL AND MEDSTAR WASHINGTON HOSPITAL CENTER, MEDSTAR MONTGOMERY BRINGS SPECIALTY CARE CLOSER TO ITS PATIENTS. MEDSTAR MONTGOMERY ALSO OFFERS INPATIENT AND OUTPATIENT MENTAL HEALTH SERVICES. MEDSTAR MONTGOMERY INCLUDES AN EMERGENCY DEPARTMENT WITH A DEDICATED PEDIATRIC CENTER, A FAST-TRACK UNIT AND A SEPARATE UNIT FOR CRISIS EVALUATION.

ATTACHMENT 3990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
MERIDIAN ANESTHESIA PRACTICE 3801 INTERNATIONAL DRIVE SILVER SPRING, MD 20906	PHYSICAN SERVICES	4,987,576.
SODEXO INC. LA MAISON FRANCAIS WASHINGTON, DC 20007	PROFESSIONAL SVCS	1,191,548.
CERNER CORPORATION 51 VALLEY STREAM PARKWAY	MEDICAL SERVICES	805,065.

Name of the organization MONTGOMERY GENERAL HOSPITAL, INC.	Employer identification number 52-0646893
<u>ATTACHMENT 3 (CONT'D)</u>	

990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
MALVERN, PA 19335-1406		
AMN HEALTHCARE INC 2735 COLLECTION CENTER DR CHICAGO, IL 60693	STAFFING SERVICES	1,361,324.
EMERGENCY MEDICINE ASSOCIATES 20010 CENTURY BLVD, STE 200 GERMANTOWN, MD 20877	MEDICAL SERVICES	605,052.

ATTACHMENT 4FORM 990, PART IX - OTHER FEES

<u>DESCRIPTION</u>	<u>(A) TOTAL FEES</u>	<u>(B) PROGRAM SERVICE EXP.</u>	<u>(C) MANAGEMENT AND GENERAL</u>	<u>(D) FUNDRAISING EXPENSES</u>
PURCHASED PROFESSIONAL SERVICE	6,201,232.	5,172,261.	1,028,971.	
PHYSICIAN SERVICES	3,759,931.	3,759,931.		
SUBSIDY EXPENSE - INTERCO.	3,103,458.	3,103,458.		
PROFESSIONAL FEES-OTHER	2,451,756.	2,408,910.	42,846.	
NON-PHYS INTERCO PURCH SRVS	1,811,511.	1,806,121.	5,390.	
BILLING SERVICE EXPENSE	500,573.	491,334.	9,239.	
LAB SERVICES	461,348.	461,348.		
COMMERCIAL LAUNDRY	216,638.	216,638.		
MISC PURCHASED SERVICES	147,047.	147,047.		
PROFESSIONAL FEE-NON MD	126,058.	122,558.	3,500.	
CLEANING-CONTRACT SERVICE	117,955.	117,955.		
MISCELLANEOUS	511,863.	97,607.	414,256.	
TOTALS	<u>19,409,370.</u>	<u>17,905,168.</u>	<u>1,504,202.</u>	

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
▶ Attach to Form 990.

Department of the Treasury
Internal Revenue Service

Name of the organization

MONTGOMERY GENERAL HOSPITAL, INC.

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

Employer identification number

52-0646893

Open to Public
Inspection

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) MEDSTAR HEALTH ANESTHESIA SERVICES E LLC 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832	HEALTH SVCS	MD	3,013,442.	139,228.	N/A
(2)					
(3)					
(4)					
(5)					
(6)					

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) CHURCH HOME CORPORATION 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	MEDICAL FUND	MD	501 (C) (3)	PF	N/A		X
(2) FRANKLIN SQUARE HOSPITAL CENTER, INC. 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD 21237	HOSPITAL	MD	501 (C) (3)	3	N/A		X
(3) HARBOR HOSPITAL, INC. 3001 SOUTH HANOVER STREET BALTIMORE, MD 21225	HOSPITAL	MD	501 (C) (3)	3	N/A		X
(4) MEDSTAR HEALTH, INC. 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	MEDICAL SVCS	MD	501 (C) (3)	12C III	N/A		X
(5) THE GOOD SAMARITAN HOSPITAL OF MARYLAND, 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	HOSPITAL	MD	501 (C) (3)	3	N/A		X
(6) THE UNION MEMORIAL HOSPITAL 201 EAST UNIVERSITY PARKWAY BALTIMORE, MD 21218	HOSPITAL	MD	501 (C) (3)	3	N/A		X
(7) MEDSTAR HEALTH RESEARCH INSTITUTE 108 IRVING STREET NW WASHINGTON, DC 20010	HOSPITAL	DC	501 (C) (3)	4	N/A		X

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

Schedule R (Form 990) 2017

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

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Department of the Treasury
Internal Revenue Service

Name of the organization

MONTGOMERY GENERAL HOSPITAL, INC.

Employer identification number

52-0646893

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

(1)	(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)						
(2)						
(3)						
(4)						
(5)						
(6)						

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.

(1)	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
							Yes	No
(1)	THE MEDSTAR-GEORGETOWN MEDICAL CENTER, I HOSPITAL ADMIN, 1 MAIN BLDG WASHINGTON, DC 20007 52-2218584	HOSPITAL	DC	501 (C) (3)	3	N/A		X
(2)	WASHINGTON HOSPITAL CENTER CORPORATION 110 IRVING STREET NW WASHINGTON, DC 20010 52-1272129	HOSPITAL	DC	501 (C) (3)	3	N/A		X
(3)	HH MEDSTAR HEALTH, INC. 10980 GRANTCHESTER WAY COLUMBIA, MD 21044 52-1542230	MEDICAL SVCS	MD	501 (C) (3)	12C III	N/A		X
(4)	MEDSTAR AMBULATORY SERVICES, INC. 10980 GRANTCHESTER WAY COLUMBIA, MD 21044 52-1132992	ADMIN SVCS	MD	501 (C) (3)	12C III	N/A		X
(5)	BAY LIFE SERVICES, INC. 10980 GRANTCHESTER WAY COLUMBIA, MD 21044 52-1496539	MENTAL HEALTH	MD	501 (C) (3)	10	N/A		X
(6)	MEDSTAR SURGERY CENTER, INC. 4061 POWDERMILL ROAD, SUITE 21 CALVERTON, MD 20705 52-1061679	MEDICAL SVCS	MD	501 (C) (3)	10	N/A		X
(7)	CHURCH HOME AND HOSPITAL OF THE CITY OF 10980 GRANTCHESTER WAY COLUMBIA, MD 21044 52-0591600	MEDICAL FUND	MD	501 (C) (3)	12A I	N/A		X

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Schedule R (Form 990) 2017

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

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Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization

MONTGOMERY GENERAL HOSPITAL, INC.

Employer identification number

52-0646893

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

(1)	(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)						
(2)						
(3)						
(4)						
(5)						
(6)						

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.

(1)	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
							Yes	No
(1)	FRANKLIN SQUARE HOSPITAL CENTER FOUNDATI 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD 21237 52-2329546	FOUNDATION	MD	501 (C) (3)	12A I	N/A		X
(2)	GOOD SAMARITAN HOSPITAL FOUNDATION, INC. 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239 52-2307122	FOUNDATION	MD	501 (C) (3)	12A I	N/A		X
(3)	GOOD SAMARITAN NURSING CENTER, INC. 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239 52-1672866	MEDICAL SVCS	MD	501 (C) (3)	10	N/A		X
(4)	GS HOUSING, INC. 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239 52-1481656	ELDER HOUSING	MD	501 (C) (3)	10	N/A		X
(5)	GS PROPERTIES, INC. 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239 52-1429853	ADMIN SVCS	MD	501 (C) (3)	12A I	N/A		X
(6)	MEDSTAR HEALTH INFUSION, INC. 4061 POWDERMILL ROAD, SUITE 21 CALVERTON, MD 20705 52-1980510	MEDICAL SVCS	MD	501 (C) (3)	10	N/A		X
(7)	MEDSTAR HEALTH VISITING NURSES ASSOCIATI 4061 POWDERMILL ROAD CALVERTON, MD 20705 53-0196597	MEDICAL SVCS	MD	501 (C) (3)	10	N/A		X

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Schedule R (Form 990) 2017

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

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▶ Attach to Form 990.

Department of the Treasury
Internal Revenue Service

Open to Public
Inspection

Name of the organization

MONTGOMERY GENERAL HOSPITAL, INC.

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Employer identification number

52-0646893

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

(1)	(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)						
(2)						
(3)						
(4)						
(5)						
(6)						

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(1)	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
							Yes	No
(1)	MEDSTAR VNA HEALTHCARE 4061 POWDERMILL ROAD, SUITE 21 CALVERTON, MD 20705 52-1458516	MEDICAL SVCS	MD	501 (C) (3)	10	N/A		X
(2)	MGH COMMUNITY HEALTH, INC. 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832 52-1372467	MEDICAL SVCS	MD	501 (C) (3)	10	N/A		X
(3)	MGH HEALTH FOUNDATION, INC. 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832 52-1129959	FOUNDATION	MD	501 (C) (3)	7	N/A		X
(4)	MGH HEALTH SERVICES, INC. 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832 52-1366812	FOUNDATION	MD	501 (C) (3)	12B II	N/A		X
(5)	MGH WOMEN'S BOARD 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832 52-6039600	FOUNDATION	MD	501 (C) (3)	12C III	N/A		X
(6)	NATIONAL REHABILITATION HOSPITAL 102 IRVING STREET NW WASHINGTON, DC 20010 52-1369749	HOSPITAL	DC	501 (C) (3)	3	N/A		X
(7)	REGIONAL REHAB AT OLNEY, INC. 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832 52-2310902	MEDICAL SVCS	MD	501 (C) (3)	3	N/A		X

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Schedule R (Form 990) 2017

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

2017

Department of the Treasury
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▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.

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Name of the organization

MONTGOMERY GENERAL HOSPITAL, INC.

Employer identification number

52-0646893

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

(1)	(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)						
(2)						
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(4)						
(5)						
(6)						

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(1)	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
							Yes	No
(1)	SUBURBAN / NRH MEDICAL REHABILITATION, I 102 IRVING STREET NW WASHINGTON, DC 20010 52-1931151	MEDICAL SVCS	DC	501 (C) (3)	3	N/A		X
(2)	THE THOMAS O'NEIL CATHOLIC HEALTH CARE F 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239 52-1104382	FOUNDATION	MD	501 (C) (3)	12D III	N/A		X
(3)	VNA, INC. 4061 POWDERMILL ROAD, SUITE 21 CALVERTON, MD 20705 52-1332411	ADMIN SVCS	MD	501 (C) (3)	12A I	N/A		X
(4)	WHC FOUNDATION, INC. 110 IRVING STREET NW WASHINGTON, DC 20010 52-1791670	FOUNDATION	DC	501 (C) (3)	7	N/A		X
(5)	WOODBOURNE WOODS, INC. 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239 52-2299070	ELDER HOUSING	MD	501 (C) (3)	10	N/A		X
(6)	HOSPICE OF ST. MARY'S, INC. PO BOX 527 LEONARDTOWN, MD 20650 52-2153926	SUPPORT ORG	MD	501 (C) (3)	12A I	N/A		X
(7)	ST. MARY'S HOSPITAL OF ST. MARY'S COUNTY 25500 POINT LOOKOUT ROAD LEONARDTOWN, MD 20650 52-0619006	HOSPITAL	MD	501 (C) (3)	3	N/A		X

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

Schedule R (Form 990) 2017

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

Department of the Treasury
Internal Revenue Service

Open to Public
Inspection

Name of the organization

MONTGOMERY GENERAL HOSPITAL, INC.

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

Employer identification number

52-0646893

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

(1)	(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)						
(2)						
(3)						
(4)						
(5)						
(6)						

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.

(1)	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
							Yes	No
(1)	ST. MARY'S HOSPITAL FOUNDATION, INC. PO BOX 527 LEONARDTOWN, MD 20650 52-1051368	SUPPORT ORG	MD	501 (C) (3)	12A I	N/A		X
(2)	MEDSTAR SOUTHERN MD HOSPITAL CENTER 7503 SURREATTS ROAD CLINTON, MD 20735 46-0726303	HOSPITAL	MD	501 (C) (3)	3	N/A		X
(3)	MEDSTAR HEALTH INC AND AFFILIATES 10980 GRANTCHESTER WAY COLUMBIA, MD 21044 46-7454613	RETIREMENT TR	MD	501 (A)	N/A	N/A		X
(4)								
(5)								
(6)								
(7)								

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

Schedule R (Form 990) 2017

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) MEDSTAR SHAH MSO, LLC 46-27005 10980 GRANTCHESTER WAY COLUMBIA	MGMT SVCS	MD	N/A	N/A								
(2) 22590 SHADY COURT, LLC 22590 SHADY COURT CALIFORNIA,	REAL ESTATE	MD	N/A	N/A								
(3) 24035 THREE NOTCH ROAD, LLC 24035 THREE NOTCH ROAD, LLC HO	REAL ESTATE	MD	N/A	N/A								
(4) 37767 MARKET DRIVE, LLC 37767 MARKET DRIVE, LLC CHARLO	REAL ESTATE	MD	N/A	N/A								
(5) 26840 POINT LOOKOUT ROAD, LLC 26840 POINT LOOKOUT ROAD LEONA	REAL ESTATE	MD	N/A	N/A								
(6) GREATER CHESAPEAKE SURGERY CEN 1212 YORK ROAD, STE B100 LUTHE	SURGERY CENTE	MD	N/A	N/A								
(7) MONTGOMERY COMMUNITY MAGNETIC 4110 ASPEN HILL ROAD, SUITE 20	MRI SCREENING	MD	N/A	N/A								

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?
(1) MEDSTAR PHARMACIES, INC. 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	DRUG SALES	MD	N/A	C CORP				Yes No
(2) EXTENCARE, INC. 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	MEDICAL SERVICES	MD	N/A	C CORP				
(3) HELIX RESOURCES MANAGEMENT, INC. 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	ADMIN SERVICES	MD	N/A	C CORP				
(4) HELIXCARE MEDICAL GROUP, LLC 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	MEDICAL SERVICES	MD	N/A	C CORP				
(5) HELIXCARE PROPERTIES, LLC 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	MEDICAL SERVICES	MD	N/A	C CORP				
(6) PARKWAY VENTURES, INC. 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	HOLDING COMPANY	MD	N/A	C CORP				
(7) PHYSICIANS ADMINISTRATIVE SERVICES, INC. 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	BILLING SERVICES	MD	N/A	C CORP				

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) PHYSIOTHERAPY ASSOCIATES NRH R 4714 GETTYSBURG ROAD MECHANICS	PHYSIOTHERAPY	PA	N/A	N/A								
(2) FRANKLIN SQUARE MEDICAL CENTER 101 EAST STATE STREET KENNETT	NURSING HOME	PA	N/A	N/A								
(3) PHYSICIAN IMAGING OF WASHINGTON 840 CRESCENT CENTRE DR, STE. 20	RADIOLOGY SVC	TN	N/A	N/A								
(4) FRANKLIN IMAGING, LLC 52-15886 7253 AMBASSADOR RD. BALTIMORE,	IMAGING	MD	N/A	N/A								
(5) MEDSTAR HEALTH/SURGCENTER DEVE 10980 GRANTCHESTER WAY COLUMB	SURGERY	MD	N/A	N/A								
(6)												
(7)												

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?
								Yes No
(1) MEDSTAR FAMILY CHOICE, INC. 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	MANAGED CARE	MD	N/A	C CORP				
(2) MEDSTAR ENTERPRISES, INC. 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705	ADMIN SERVICES	MD	N/A	C CORP				
(3) SITEL, INC. 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	EDUCATIONAL SVCS	MD	N/A	C CORP				
(4) STAR BILLING, INC. 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705	BILLING SERVICES	MD	N/A	C CORP				
(5) WASHINGTON RISK NETWORK MANAGEMENT, INC. 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705	MEDICAL SERVICES	MD	N/A	C CORP				
(6) WASHINGTON HOSPITAL CENTER PHYSICIAN HOS 100 IRVING STREET NW WASHINGTON, DC 20010	MEDICAL SERVICES	MD	N/A	C CORP				
(7) MEDSTAR PHYSICIAN PARTNERS, INC. 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705	MEDICAL SERVICES	MD	N/A	C CORP				

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1)												
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
(1) FRANKLIN SQUARE DRIVE LAND CONDO ASSOCIA 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	CONDO OWNER ASSOC	MD	N/A	C CORP					
(2) MGH DIVERSIFIED SERVICES, INC. 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832	MEDICAL SERVICES	MD	N/A	C CORP	719,340.	9,476,305.	100.0000	X	
(3) ST. MARY'S HEALTH ALLIANCE, INC. 25500 POINT LOOKOUT ROAD LEONARDTOWN, MD 20650	MEDICAL SERVICES	MD	N/A	C CORP					
(4) GREENSPRING FINANCIAL INSURANCE LIMITED 23 LIME TREE BAY AVENUE PO BOX 1051 KY1-1102, GRAND CAYMA	INSURANCE	MD	N/A	C CORP					
(5) ST MARY'S CONDO ASSOCIATION 25500 POINT LOOKOUT RD LEONARDTOWN, MD 20650	CONDOMINIUMS	MD	N/A	C CORP					
(6) MEDSTAR HEALTH MASTER RETIREMENT TRUST 102 SOUTH CHURCH ST. GRAND CAYMAN, CJ KY1-1002	INVESTMENTS	CJ	N/A	C CORP					
(7) MEDSTAR HEALTH, INC. - INVESTMENT FUND I 102 SOUTH CHURCH ST. GRAND CAYMAN, CJ KY1-1002	INVESTMENTS	CJ	N/A	C CORP					

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

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

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

- a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity.
- b Gift, grant, or capital contribution to related organization(s).
- c Gift, grant, or capital contribution from related organization(s).
- d Loans or loan guarantees to or for related organization(s).
- e Loans or loan guarantees by related organization(s).
- f Dividends from related organization(s).
- g Sale of assets to related organization(s).
- h Purchase of assets from related organization(s).
- i Exchange of assets with related organization(s).
- j Lease of facilities, equipment, or other assets to related organization(s).
- k Lease of facilities, equipment, or other assets from related organization(s).
- l Performance of services or membership or fundraising solicitations for related organization(s).
- m Performance of services or membership or fundraising solicitations by related organization(s).
- n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s).
- o Sharing of paid employees with related organization(s).
- p Reimbursement paid to related organization(s) for expenses.
- q Reimbursement paid by related organization(s) for expenses.
- r Other transfer of cash or property to related organization(s).
- s Other transfer of cash or property from related organization(s).

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	Yes	No
(1)	MEDSTAR HEALTH RESEARCH INSTITUTE	P	93,952.	FMV		X
(2)	MEDSTAR HEALTH, INC.	P	649,932.	FMV		X
(3)						X
(4)						X
(5)						X
(6)						X

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	
(1)													
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
(9)													
(10)													
(11)													
(12)													
(13)													
(14)													
(15)													
(16)													

Part VII Supplemental Information

Provide additional information for responses to questions on Schedule R. See instructions.

**IRS e-file Signature Authorization
for an Exempt Organization**

For calendar year 2017, or fiscal year beginning 07/01, 2017, and ending 06/30, 2018

▶ Do not send to the IRS. Keep for your records.

▶ Go to www.irs.gov/Form8879EO for the latest information.

2017

Department of the Treasury
Internal Revenue Service

Name of exempt organization

MONTGOMERY GENERAL HOSPITAL, INC.

Employer identification number

52-0646893

Name and title of officer

JOEL BRYAN, VICE PRESIDENT/TREASURER

Part I Type of Return and Return Information (Whole Dollars Only)

Check the box for the return for which you are using this Form 8879-EO and enter the applicable amount, if any, from the return. If you check the box on line 1a, 2a, 3a, 4a, or 5a, below, and the amount on that line for the return being filed with this form was blank, then leave line 1b, 2b, 3b, 4b, or 5b, whichever is applicable, blank (do not enter -0-). But, if you entered -0- on the return, then enter -0- on the applicable line below. Do not complete more than one line in Part I.

1a	Form 990 check here ▶	<input checked="" type="checkbox"/>	b	Total revenue, if any (Form 990, Part VIII, column (A), line 12) . . .	1b	<u>173639871.</u>
2a	Form 990-EZ check here ▶	<input type="checkbox"/>	b	Total revenue, if any (Form 990-EZ, line 9)	2b	
3a	Form 1120-POL check here ▶	<input type="checkbox"/>	b	Total tax (Form 1120-POL, line 22)	3b	
4a	Form 990-PF check here ▶	<input type="checkbox"/>	b	Tax based on investment income (Form 990-PF, Part VI, line 5).	4b	
5a	Form 8868 check here ▶	<input type="checkbox"/>	b	Balance Due (Form 8868, line 3c)	5b	

Part II Declaration and Signature Authorization of Officer

Under penalties of perjury, I declare that I am an officer of the above organization and that I have examined a copy of the organization's 2017 electronic return and accompanying schedules and statements and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS (a) an acknowledgement of receipt or reason for rejection of the transmission, (b) the reason for any delay in processing the return or refund, and (c) the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

Officer's PIN: check one box only

I authorize KPMG LLP to enter my PIN

2	1	2	3	7
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 as my signature
ERO firm name Enter five numbers, but do not enter all zeros

on the organization's tax year 2017 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

As an officer of the organization, I will enter my PIN as my signature on the organization's tax year 2017 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ▶ Joel Bryan

Date ▶ May 9, 2019

Part III Certification and Authentication

ERO's EFIN/PIN. Enter your six-digit electronic filing identification number (EFIN) followed by your five-digit self-selected PIN.

5	4	0	2	8	0	2	2	1	0	2
---	---	---	---	---	---	---	---	---	---	---

Do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2017 electronically filed return for the organization indicated above. I confirm that I am submitting this return in accordance with the requirements of Pub. 4163, Modernized e-File (MeF) Information for Authorized IRS e-file Providers for Business Returns.

ERO's signature ▶ Joel H White

Date ▶ 5/8/2019

**ERO Must Retain This Form - See Instructions
Do Not Submit This Form To the IRS Unless Requested To Do So**

For Paperwork Reduction Act Notice, see back of form.

Cumulative e-File History 2017

Federal

Tax Return
07353X

Return Type
990

Taxpayer
MONTGOMERY GENERAL HOSPITAL,
INC.

Submitted Date 2019-05-10 14:19:24

Acknowledgement Date 2019-05-10 14:26:33

Status Accepted

Submission ID 54028020191305000005