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Form **990**

Department of the Treasury
Internal Revenue Service

# Return of Organization Exempt From Income Tax

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

▶ Do not enter social security numbers on this form as it may be made public
▶ Information about Form 990 and its instructions is at *www IRS gov/form990*

OMB No 1545-0047

**2017**

**Open to Public Inspection**

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

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

**C** Name of organization
TRINITY HEALTH & AFFILIATES

Doing business as

Number and street (or P O box if mail is not delivered to street address) PO BOX 5020 | Room/suite

City or town, state or province, country, and ZIP or foreign postal code
MINOT, ND 587025020

**D Employer identification number**
33-1007002

E Telephone number
(701) 857-5160

**G** Gross receipts $ 345,538,420

**F** Name and address of principal officer
JOHN M KUTCH
PO BOX 5020
MINOT, ND 587025020

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

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

**H(c)** Group exemption number ▶ 3904

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

**J Website:** ▶ WWW TRINITYHEALTH ORG

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

**L** Year of formation

**M** State of legal domicile

## Part I Summary

**1** Briefly describe the organization's mission or most significant activities
MEETING THE NEEDS OF THE WHOLE PERSON THROUGH QUALITY HEALTH CARE AND HEALTH RELATED SERVICES

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

| | | | |
|---|---|---|---|
| **3** | Number of voting members of the governing body (Part VI, line 1a) | **3** | 10 |
| **4** | Number of independent voting members of the governing body (Part VI, line 1b) | **4** | 7 |
| **5** | Total number of individuals employed in calendar year 2017 (Part V, line 2a) | **5** | 0 |
| **6** | Total number of volunteers (estimate if necessary) | **6** | 327 |
| **7a** | Total unrelated business revenue from Part VIII, column (C), line 12 | **7a** | 2,460,870 |
| **b** | Net unrelated business taxable income from Form 990-T, line 34 | **7b** | 0 |

| | | Prior Year | Current Year |
|---|---|---|---|
| **8** | Contributions and grants (Part VIII, line 1h) | 1,000,420 | 989,846 |
| **9** | Program service revenue (Part VIII, line 2g) | 324,534,819 | 339,392,091 |
| **10** | Investment income (Part VIII, column (A), lines 3, 4, and 7d ) | 2,891,532 | 4,086,064 |
| **11** | Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) | -1,517,276 | -1,211,712 |
| **12** | Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12) | 326,909,495 | 343,256,289 |
| **13** | Grants and similar amounts paid (Part IX, column (A), lines 1–3 ) | 305,181 | 328,506 |
| **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) | 130,308,766 | 130,124,828 |
| **16a** | Professional fundraising fees (Part IX, column (A), line 11e) | 0 | 0 |
| **b** | Total fundraising expenses (Part IX, column (D), line 25) ▶1,133,876 | | |
| **17** | Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e) | 155,152,561 | 159,029,946 |
| **18** | Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25) | 285,766,508 | 289,483,280 |
| **19** | Revenue less expenses Subtract line 18 from line 12 | 41,142,987 | 53,773,009 |

| | | Beginning of Current Year | End of Year |
|---|---|---|---|
| **20** | Total assets (Part X, line 16) | 253,406,674 | 669,932,345 |
| **21** | Total liabilities (Part X, line 26) | 41,939,113 | 481,837,654 |
| **22** | Net assets or fund balances Subtract line 21 from line 20 | 211,467,561 | 188,094,691 |

## 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**

****** 2019-05-14
Signature of officer Date

JOHN M KUTCH PRESIDENT/CEO
Type or print name and title

**Paid Preparer Use Only**

| Print/Type preparer's name | Preparer's signature | Date | Check ☐ if self-employed | PTIN |
|---|---|---|---|---|
| KURT BENNION | KURT BENNION | 2019-05-14 | | P01469618 |

Firm's name ▶ CLIFTONLARSONALLEN LLP — Firm's EIN ▶ 41-0746749

Firm's address ▶ 220 SOUTH SIXTH STREET SUITE 300
MINNEAPOLIS, MN 55402 — Phone no (612) 376-4500

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

**Part III Statement of Program Service Accomplishments**

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

**1** Briefly describe the organization's mission

TRINITY HEALTH IS COMMITTED TO PRESERVING AND IMPROVING THE QUALITY OF HEALTH OF THE PEOPLE WE SERVE OUR MISSION IS TO EXCEL AT MEETING THE NEEDS OF THE WHOLE PERSON THROUGH THE PROVISION OF QUALITY HEALTH CARE AND HEALTH RELATED SERVICES

**2** Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? . . . . . ☐ Yes ☑ No

If "Yes," describe these new services on Schedule O

**3** Did the organization cease conducting, or make significant changes in how it conducts, any program services? . . . . . ☐ Yes ☑ No

If "Yes," describe these changes on Schedule O

**4** Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported

**4a** (Code ) (Expenses $ 226,221,316 including grants of $ 328,506 ) (Revenue $ 318,371,603 )

See Additional Data

**4b** (Code ) (Expenses $ 20,593,824 including grants of $ ) (Revenue $ 21,020,488 )

See Additional Data

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

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

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

**4e Total program service expenses ▶** 246,815,140

**Part IV Checklist of Required Schedules**

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

**Part IV** **Checklist of Required Schedules** *(continued)*

| | | | Yes | No |
|---|---|---|---|---|
| **20a** | Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H* | **20a** | Yes | |
| **b** | If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? | **20b** | Yes | |
| **21** | Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II* | **21** | Yes | |
| **22** | Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III* | **22** | Yes | |
| **23** | Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J* | **23** | Yes | |
| **24a** | Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K If "No," go to line 25a* | **24a** | Yes | |
| **b** | Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? | **24b** | | No |
| **c** | Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? | **24c** | | No |
| **d** | Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? | **24d** | | No |
| **25a** | **Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I* | **25a** | | No |
| **b** | Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I* | **25b** | | No |
| **26** | Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? *If "Yes," complete Schedule L, Part II* | **26** | | No |
| **27** | Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III* | **27** | | No |
| **28** | Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions) | | | |
| **a** | A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV* | **28a** | | No |
| **b** | A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV* | **28b** | | No |
| **c** | An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV* | **28c** | | No |
| **29** | Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M* | **29** | Yes | |
| **30** | Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M* | **30** | Yes | |
| **31** | Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I* | **31** | | No |
| **32** | Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II* | **32** | | No |
| **33** | Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301 7701-2 and 301 7701-3? *If "Yes," complete Schedule R, Part I* | **33** | | No |
| **34** | Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1* | **34** | Yes | |
| **35a** | Did the organization have a controlled entity within the meaning of section 512(b)(13)? | **35a** | | No |
| **b** | If 'Yes' to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2* | **35b** | | |
| **36** | **Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2* | **36** | | No |
| **37** | Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI* | **37** | | No |
| **38** | Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O | **38** | Yes | |

**Part V** **Statements Regarding Other IRS Filings and Tax Compliance**

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

| | | | | Yes | No |
|---|---|---|---|---|---|
| **1a** | Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable . . | **1a** | 0 | | |
| **b** | Enter the number of Forms W-2G included in line 1a *Enter -0-* if not applicable | **1b** | 0 | | |
| **c** | Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? . . . . . | **1c** | | | |
| **2a** | Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return . . . . . | **2a** | 0 | | |
| **b** | If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions) | **2b** | | | |
| **3a** | Did the organization have unrelated business gross income of $1,000 or more during the year? . . . | **3a** | | Yes | |
| **b** | If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O* . . . | **3b** | | Yes | |
| **4a** | At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . . | **4a** | | | No |
| **b** | If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR) | | | | |
| **5a** | Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . . | **5a** | | | No |
| **b** | Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? | **5b** | | | No |
| **c** | If "Yes," to line 5a or 5b, did the organization file Form 8886-T? . . . . . | **5c** | | | |
| **6a** | Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . . | **6a** | | | No |
| **b** | If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? . . . . . | **6b** | | | |
| **7** | **Organizations that may receive deductible contributions under section 170(c).** | | | | |
| **a** | Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor? . . . . . | **7a** | | Yes | |
| **b** | If "Yes," did the organization notify the donor of the value of the goods or services provided? . . . . . | **7b** | | Yes | |
| **c** | Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? . . . . . | **7c** | | | No |
| **d** | If "Yes," indicate the number of Forms 8282 filed during the year . . . . | **7d** | | | |
| **e** | Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? | **7e** | | | No |
| **f** | Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . . | **7f** | | | No |
| **g** | If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? . . . . . | **7g** | | | |
| **h** | If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? . . . . . | **7h** | | | |
| **8** | **Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? . . . . . | **8** | | | |
| **9a** | Did the sponsoring organization make any taxable distributions under section 4966? . . . | **9a** | | | |
| **b** | Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . . | **9b** | | | |
| **10** | **Section 501(c)(7) organizations.** Enter | | | | |
| **a** | Initiation fees and capital contributions included on Part VIII, line 12 . . . | **10a** | | | |
| **b** | Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities | **10b** | | | |
| **11** | **Section 501(c)(12) organizations.** Enter | | | | |
| **a** | Gross income from members or shareholders . . . . . | **11a** | | | |
| **b** | Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them ) . . . . . | **11b** | | | |
| **12a** | **Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041? | **12a** | | | |
| **b** | If "Yes," enter the amount of tax-exempt interest received or accrued during the year | **12b** | | | |
| **13** | **Section 501(c)(29) qualified nonprofit health insurance issuers.** | | | | |
| **a** | Is the organization licensed to issue qualified health plans in more than one state? **Note.** See the instructions for additional information the organization must report on Schedule O | **13a** | | | |
| **b** | Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans . . . . | **13b** | | | |
| **c** | Enter the amount of reserves on hand . . . . . | **13c** | | | |
| **14a** | Did the organization receive any payments for indoor tanning services during the tax year? . . . . . | **14a** | | | No |
| **b** | If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* . . | **14b** | | | |

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

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

## Section A. Governing Body and Management

| | | | | Yes | No |
|---|---|---|---|---|---|
| 1a | Enter the number of voting members of the governing body at the end of the tax year | 1a | 10 | | |
| | If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O | | | | |
| b | Enter the number of voting members included in line 1a, above, who are independent | 1b | 7 | | |
| 2 | Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee? | 2 | | | No |
| 3 | Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? | 3 | | | No |
| 4 | Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? | 4 | | | No |
| 5 | Did the organization become aware during the year of a significant diversion of the organization's assets? | 5 | | | No |
| 6 | Did the organization have members or stockholders? | 6 | | Yes | |
| 7a | Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? | 7a | | Yes | |
| b | Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? | 7b | | Yes | |
| 8 | Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following | | | | |
| a | The governing body? | 8a | | Yes | |
| b | Each committee with authority to act on behalf of the governing body? | 8b | | Yes | |
| 9 | Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O* | 9 | | | No |

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

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

## Section C. Disclosure

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

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

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

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

20 State the name, address, and telephone number of the person who possesses the organization's books and records
▶TAYLOR WILSON PO BOX 5020 MINOT, ND 58702 (701) 857-5160

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

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

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

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

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

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

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

| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W- 2/1099-MISC) | (E) Reportable compensation from related organizations (W- 2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| (1) PATRICK HOLIEN<br>CHAIRMAN | 2 00<br>2 50 | X | | X | | | | 0 | 0 | 0 |
| (2) STEVE LYSNE<br>VICE CHAIRMAN | 2 00<br>2 50 | X | | X | | | | 0 | 0 | 0 |
| (3) KAREN KREBSBACH<br>SECRETARY/TREASURER | 2 00<br>2 50 | X | | X | | | | 0 | 0 | 0 |
| (4) BORGI BEELER<br>DIRECTOR | 2 00<br>2 50 | X | | | | | | 0 | 0 | 0 |
| (5) JOHN COUGHLIN<br>DIRECTOR | 2 00<br>2 50 | X | | | | | | 0 | 0 | 0 |
| (6) SCOTT KNUTSON MD<br>DIRECTOR | 20 00<br>20 00 | X | | | | | | 0 | 581,454 | 22,483 |
| (7) BRENT MATTSON<br>DIRECTOR | 2 00<br>2 50 | X | | | | | | 0 | 0 | 0 |
| (8) CLARA SUE PRICE<br>DIRECTOR | 2 00<br>2 50 | X | | | | | | 0 | 0 | 0 |
| (9) MARTIN ROTHBERG MD<br>DIRECTOR | 20 00<br>20 00 | X | | | | | | 0 | 767,651 | 13,003 |
| (10) JOHN KUTCH<br>PRESIDENT & CEO | 20 00<br>20 00 | X | | X | | | | 0 | 813,059 | 22,483 |
| (11) ALISON FRYE<br>ASSISTANT SECRETARY | 0 00<br>40 00 | | | X | | | | 0 | 69,167 | 19,601 |
| (12) DENNIS EMPEY<br>VICE PRESIDENT & CFO | 20 00<br>20 00 | | | X | | | | 0 | 355,522 | 23,983 |
| (13) RANDY SCHWAN<br>VICE PRES - MISSION INTEGRATION | 32 00<br>8 00 | | | | X | | | 0 | 210,818 | 11,369 |
| (14) PAUL SIMONSON<br>VICE PRES - HUMAN RESOURCES | 32 00<br>8 00 | | | | X | | | 0 | 267,862 | 23,983 |
| (15) THOMAS WARSOCKI<br>VICE PRES - PHYSICIAN OPERATIONS | 0 00<br>40 00 | | | | X | | | 0 | 207,195 | 21,651 |
| (16) DAVE KOHLMAN<br>VICE PRES - FACILITIES MANAGEMENT | 28 00<br>12 00 | | | | X | | | 0 | 194,476 | 21,703 |
| (17) KAREN ZIMMERMAN RN<br>VICE PRES & CNO | 40 00<br>0 00 | | | | X | | | 0 | 172,760 | 5,410 |

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

| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W-2/1099-MISC) | (E) Reportable compensation from related organizations (W- 2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| (18) TRENT CHASTAIN VICE PRES - | 28 00 | | | | X | | | 0 | 170,987 | 18,637 |
| REVENUE CYCLE (THROUGH MARCH 2018) | 12 00 | | | | | | | | | |
| (19) RHONDA WALTER VICE PRES - | 40 00 | | | | X | | | 0 | 175,914 | 22,699 |
| VICE PRES - NCF ADMINISTRATOR | 0 00 | | | | | | | | | |
| (20) PHILIP PATTERSON | 36 00 | | | | X | | | 0 | 251,845 | 11,203 |
| VICE PRES & CAO (THROUGH FEB 2018) | 4 00 | | | | | | | | | |
| (21) GLEN TAYLOR WILSON | 20 00 | | | | X | | | 0 | 265,655 | 12,418 |
| VICE PRES - CLINICAL INTEGRATION | 20 00 | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| **1b Sub-Total** ▶ | | | | | | | | | | |
| **c Total from continuation sheets to Part VII, Section A** ▶ | | | | | | | | | | |
| **d Total (add lines 1b and 1c)** ▶ | | | | | | | | 0 | 4,504,365 | 250,626 |

**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 ▶ 0

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

## Section B. Independent Contractors

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

| (A) Name and business address | (B) Description of services | (C) Compensation |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**2** Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 0

**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 | 133,101 | | | |
| | d Related organizations | 1d | | | | |
| | e Government grants (contributions) | 1e | 5,000 | | | |
| | f All other contributions, gifts, grants, and similar amounts not included above | 1f | 851,745 | | | |
| | g Noncash contributions included in lines 1a-1f $ 173,375 | | | | | |
| | h **Total.** Add lines 1a-1f . . . . . ▶ | | 989,846 | | | |
| Program Service Revenue | | Business Code | | | | |
| | 2a NET PATIENT REVENUE | 621110 | 329,548,642 | 329,548,642 | | |
| | b ~~OTHER PATIENT SERVICES~~ | 621110 | 5,779,798 | 5,779,798 | | |
| | c ~~DIETARY SERVICES~~ | 722320 | 1,602,781 | 1,602,781 | | |
| | d ~~ADMINISTRATIVE SERVICES~~ | 561000 | 1,438,992 | | 1,438,992 | |
| | e ~~OTHER UBIT SERVICES~~ | 900099 | 563,146 | | 563,146 | |
| | f All other program service revenue | | 458,732 | | 458,732 | |
| | g **Total.** Add lines 2a–2f . . . . ▶ | | 339,392,091 | | | |
| Other Revenue | 3 Investment income (including dividends, interest, and other similar amounts) . . . . . ▶ | | 4,083,333 | | | 4,083,333 |
| | 4 Income from investment of tax-exempt bond proceeds ▶ | | | | | |
| | 5 Royalties . . . . . ▶ | | | | | |
| | | (i) Real | (ii) Personal | | | |
| | 6a Gross rents | 104,279 | | | | |
| | b Less rental expenses | 2,259,105 | | | | |
| | c Rental income or (loss) | -2,154,826 | | | | |
| | d Net rental income or (loss) . . . . . ▶ | | -2,154,826 | | | -2,154,826 |
| | | (i) Securities | (ii) Other | | | |
| | 7a Gross amount from sales of assets other than inventory | | 7,459 | | | |
| | b Less cost or other basis and sales expenses | | 4,728 | | | |
| | c Gain or (loss) | | 2,731 | | | |
| | d Net gain or (loss) . . . . . ▶ | | 2,731 | | | 2,731 |
| | 8a Gross income from fundraising events (not including $ 133,101 of contributions reported on line 1c) See Part IV, line 18 . . . . a | | 2,103 | | | |
| | b Less direct expenses . . . b | | 18,298 | | | |
| | c Net income or (loss) from fundraising events . . ▶ | | -16,195 | | | -16,195 |
| | 9a Gross income from gaming activities See Part IV, line 19 . . . a | | | | | |
| | b Less direct expenses . . . b | | | | | |
| | c Net income or (loss) from gaming activities . . ▶ | | | | | |
| | 10a Gross sales of inventory, less returns and allowances . . a | | | | | |
| | b Less cost of goods sold . . b | | | | | |
| | c Net income or (loss) from sales of inventory . . ▶ | | | | | |
| | Miscellaneous Revenue | Business Code | | | | |
| | 11a VENDOR REBATES | 900099 | 959,309 | | | 959,309 |
| | b | | | | | |
| | c | | | | | |
| | d All other revenue . . . . | | | | | |
| | e **Total.** Add lines 11a–11d . . . . . ▶ | | 959,309 | | | |
| | 12 **Total revenue.** See Instructions . . . . . ▶ | | 343,256,289 | 336,931,221 | 2,460,870 | 2,874,352 |

**Part IX Statement of Functional Expenses**

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

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

| Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII. | (A) Total expenses | (B) Program service expenses | (C) Management and general expenses | (D) Fundraisingexpenses |
|---|---|---|---|---|
| 1 Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21 | 143,600 | 143,600 | | |
| 2 Grants and other assistance to domestic individuals See Part IV, line 22 | 184,906 | 184,906 | | |
| 3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, line 15 and 16 | | | | |
| 4 Benefits paid to or for members | | | | |
| 5 Compensation of current officers, directors, trustees, and key employees | | | | |
| 6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) | | | | |
| 7 Other salaries and wages | 107,593,964 | 94,101,044 | 13,261,360 | 231,560 |
| 8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions) | 3,231,630 | 2,728,450 | 498,141 | 5,039 |
| 9 Other employee benefits | 11,716,316 | 10,512,087 | 1,170,736 | 33,493 |
| 10 Payroll taxes | 7,582,918 | 6,732,370 | 835,279 | 15,269 |
| 11 Fees for services (non-employees) | | | | |
| a Management | | | | |
| b Legal | 902,742 | | 902,742 | |
| c Accounting | 397,287 | | 397,287 | |
| d Lobbying | | | | |
| e Professional fundraising services See Part IV, line 17 | | | | |
| f Investment management fees | | | | |
| g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O) | 36,979,567 | 26,839,622 | 10,139,824 | 121 |
| 12 Advertising and promotion | 2,930,775 | 90,752 | 2,806,518 | 33,505 |
| 13 Office expenses | 3,157,875 | 2,474,580 | 641,685 | 41,610 |
| 14 Information technology | 4,309,358 | 2,714,043 | 1,561,403 | 33,912 |
| 15 Royalties | | | | |
| 16 Occupancy | 10,695,111 | 5,452,555 | 5,242,556 | |
| 17 Travel | 225,503 | 221,498 | 2,819 | 1,186 |
| 18 Payments of travel or entertainment expenses for any federal, state, or local public officials | | | | |
| 19 Conferences, conventions, and meetings | 326,459 | 177,133 | 149,326 | |
| 20 Interest | 1,089,971 | 1,089,971 | | |
| 21 Payments to affiliates | | | | |
| 22 Depreciation, depletion, and amortization | 12,556,342 | 9,641,884 | 2,907,962 | 6,496 |
| 23 Insurance | 688,599 | 409,550 | 279,049 | |
| 24 Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24e If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O ) | | | | |
| a MEDICAL SUPPLIES / DRUG | 59,749,464 | 59,747,095 | 2,369 | |
| b BAD DEBT EXPENSE | 16,861,934 | 16,842,827 | 19,375 | -268 |
| c BOOKS & SUBSCRIPTIONS | 3,169,441 | 2,715,432 | 393,194 | 60,815 |
| d FOOD | 2,192,133 | 2,184,729 | 1,277 | 6,127 |
| e All other expenses | 2,797,385 | 1,811,012 | 321,362 | 665,011 |
| 25 **Total functional expenses.** Add lines 1 through 24e | 289,483,280 | 246,815,140 | 41,534,264 | 1,133,876 |
| 26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation Check here ▶ ☐ if following SOP 98-2 (ASC 958-720) | | | | |

## Part X Balance Sheet

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

| | | | (A) Beginning of year | | (B) End of year |
|---|---|---|---|---|---|
| Assets | 1 | Cash–non-interest-bearing | 93,068,227 | 1 | 36,591,039 |
| | 2 | Savings and temporary cash investments | 1,828,740 | 2 | 61,922,636 |
| | 3 | Pledges and grants receivable, net | | 3 | |
| | 4 | Accounts receivable, net | 39,522,923 | 4 | 44,520,337 |
| | 5 | Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L | | 5 | |
| | 6 | Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L | | 6 | |
| | 7 | Notes and loans receivable, net | 15,741 | 7 | 15,991 |
| | 8 | Inventories for sale or use | 7,587,936 | 8 | 7,709,786 |
| | 9 | Prepaid expenses and deferred charges | 4,619,565 | 9 | 4,860,792 |
| | 10a | Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D — 10a: 275,538,725 | | | |
| | b | Less accumulated depreciation — 10b: 192,292,033 | 65,027,775 | 10c | 83,246,692 |
| | 11 | Investments—publicly traded securities | 41,685,767 | 11 | 431,015,072 |
| | 12 | Investments—other securities See Part IV, line 11 | | 12 | |
| | 13 | Investments—program-related See Part IV, line 11 | 50,000 | 13 | 50,000 |
| | 14 | Intangible assets | | 14 | |
| | 15 | Other assets See Part IV, line 11 | | 15 | |
| | 16 | **Total assets.** Add lines 1 through 15 (must equal line 34) | 253,406,674 | 16 | 669,932,345 |
| Liabilities | 17 | Accounts payable and accrued expenses | 27,061,114 | 17 | 34,685,405 |
| | 18 | Grants payable | 13,140 | 18 | 10,260 |
| | 19 | Deferred revenue | | 19 | |
| | 20 | Tax-exempt bond liabilities | | 20 | |
| | 21 | Escrow or custodial account liability Complete Part IV of Schedule D | 27,200 | 21 | 21,274 |
| | 22 | Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L | | 22 | |
| | 23 | Secured mortgages and notes payable to unrelated third parties | 5,407,832 | 23 | 437,223,675 |
| | 24 | Unsecured notes and loans payable to unrelated third parties | | 24 | |
| | 25 | Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24) Complete Part X of Schedule D | 9,429,827 | 25 | 9,897,040 |
| | 26 | **Total liabilities.** Add lines 17 through 25 | 41,939,113 | 26 | 481,837,654 |
| Net Assets or Fund Balances | | **Organizations that follow SFAS 117 (ASC 958), check here ▶ ☑ and complete lines 27 through 29, and lines 33 and 34.** | | | |
| | 27 | Unrestricted net assets | 203,655,661 | 27 | 180,065,328 |
| | 28 | Temporarily restricted net assets | 6,269,183 | 28 | 6,486,646 |
| | 29 | Permanently restricted net assets | 1,542,717 | 29 | 1,542,717 |
| | | **Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ 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 | 211,467,561 | 33 | 188,094,691 |
| | 34 | Total liabilities and net assets/fund balances | 253,406,674 | 34 | 669,932,345 |

## Part XI Reconcilliation of Net Assets

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

| | | | |
|---|---|---|---|
| 1 | Total revenue (must equal Part VIII, column (A), line 12) | 1 | 343,256,289 |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 289,483,280 |
| 3 | Revenue less expenses Subtract line 2 from line 1 | 3 | 53,773,009 |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | 211,467,561 |
| 5 | Net unrealized gains (losses) on investments | 5 | 150,536 |
| 6 | Donated services and use of facilities | 6 | |
| 7 | Investment expenses | 7 | |
| 8 | Prior period adjustments | 8 | |
| 9 | Other changes in net assets or fund balances (explain in Schedule O) | 9 | -77,296,415 |
| 10 | Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 188,094,691 |

## Part XII Financial Statements and Reporting

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

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

# Additional Data

**Software ID:**

**Software Version:**

**EIN:** 33-1007002

**Name:** TRINITY HEALTH & AFFILIATES

Form 990 (2017)

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

TRINITY HEALTH & AFFILIATES PROVIDES HOSPITAL SERVICES TO CENTRAL AND NORTHWEST NORTH DAKOTA AND NORTHEASTERN MONTANA TRINITY HOSPITALS IS THE LARGEST HOSPITAL PROVIDER IN NORTHWEST NORTH DAKOTA, WITH AN ACUTE CARE FACILITY THAT IS VERIFIED BY THE AMERICAN COLLEGE OF SURGEONS AS A LEVEL 2 TRAUMA CENTER TRINITY SERVES AS A REFERRAL CENTER FOR THE FOLLOWING SERVICES HEART, NEURO, GENERAL AND ROBOTIC SURGERY, CANCER AND CARDIAC CARE, OPHTHALMOLOGY AND RETINAL SURGERY, ADVANCED DIAGNOSTICS, NEWBORN INTENSIVE CARE, ORTHOPEDICS, SPORTS MEDICINE, INPATIENT REHABILITATION, BEHAVIORAL HEALTH, KIDNEY DIALYSIS AND LITHOTRIPSY TRINITY HOSPITAL INCLUDES A JOINT REPLACEMENT AND GERIATRIC CENTER, CARDIAC CENTER, STROKE CENTER AND NEUROSURGERY CENTER (SEE SCHEDULE O)TRINITY HOSPITAL - ST JOSEPH'S INCLUDES AN INPATIENT REHABILITATION UNIT, KIDNEY DYALISIS UNIT, INPATIENT MENTAL HEALTH, OUTPATIENT BEHAVIORAL HEALTH, AND BOTH INPATIENT AND OUTPATIENT CHEMICAL DEPENDENCY UNITS TRINITY'S NORTHSTAR CRITICAIR HELICOPTER PROVIDES CRITICAL CARE TRANSPORT WITHIN A 150-MILE RADIUS OF TRINITY HOSPITAL TRINITY ALSO PROVIDES GROUND AMBULANCE SERVICES TO THE CITY OF MINOT AND THE SURROUNDING AREA THROUGH COMMUNITY AMBULANCE SERVICE OF MINOT, INC

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

TRINITY HOMES IS A 230-BED HOSPITAL-BASED SKILLED NURSING FACILITY PARTICIPATING IN THE MEDICARE AND MEDICAID PROGRAMS TRINITY HOMES INCLUDES AN ALZHEIMER'S SPECIAL CARE UNIT AND 13 RETIREMENT APARTMENTS RESIDENTS OF TRINITY HOMES, UNDER THE DIRECTION OF THEIR PHYSICIAN, ARE ABLE TO RECEIVE SKILLED NURSING CARE, PHYSICAL THERAPY, SPEECH THERAPY, OCCUPATIONAL THERAPY, DIETETIC SERVICES, SOCIAL SERVICES, AND ACTIVITIES OF DAILY LIVING ASSISTANCE, SPIRITUAL CARE AND RECREATIONAL ACTIVITIES

| efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493135032909 |
|---|---|---|

# TY 2017 Affiliate Listing

**Name:** TRINITY HEALTH & AFFILIATES

**EIN:** 33-1007002

**TY 2017 Affiliate Listing**

| Name | Address | EIN | Name control |
|---|---|---|---|
| TRINITY HOSPITALS | PO BOX 5020<br>MINOT,<br>ND<br>58702 | 41-2002771 | TRIN |
| TRINITY KENMARE HOSPITAL | PO BOX 697<br>KENMARE,<br>ND<br>58746 | 41-2002769 | TRIN |
| TRINITY HOMES | PO BOX 5020<br>MINOT,<br>ND<br>58702 | 45-0404412 | TRIN |
| TRINITY HEALTH FOUNDATION | PO BOX 5020<br>MINOT,<br>ND<br>58702 | 45-0215346 | TRIN |
| COMMUNITY AMBULANCE SERVICE OF MINOT INC | PO BOX 2195<br>MINOT,<br>ND<br>58702 | 45-0363593 | COMM |

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493135032909

# SCHEDULE A (Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

## Public Charity Status and Public Support

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

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

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

OMB No 1545-0047

**2017**

**Open to Public Inspection**

**Name of the organization**
TRINITY HEALTH & AFFILIATES

**Employer identification number**
33-1007002

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

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

1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**

2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ) )

3 ☑ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**

4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state _____

5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170 (b)(1)(A)(iv).** (Complete Part II )

6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**

7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II )

8 ☐ A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II )

9 ☐ An agricultural research organization described in **170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture See instructions Enter the name, city, and state of the college or university

_____

10 ☐ An organization that normally receives (1) more than 331/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 331/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2).** (Complete Part III )

11 ☐ An organization organized and operated exclusively to test for public safety See **section 509(a)(4).**

12 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g

a ☐ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization **You must complete Part IV, Sections A and B.**

b ☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s) **You must complete Part IV, Sections A and C.**

c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions) **You must complete Part IV, Sections A, D, and E.**

d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions) **You must complete Part IV, Sections A and D, and Part V.**

e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization

f Enter the number of supported organizations _____

g Provide the following information about the supported organization(s)

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

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

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

**Section A. Public Support**

| Calendar year (or fiscal year beginning in) ▶ | (a) 2013 | (b) 2014 | (c) 2015 | (d) 2016 | (e) 2017 | (f) Total |
|---|---|---|---|---|---|---|
| 1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant ") | | | | | | |
| 2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf | | | | | | |
| 3 The value of services or facilities furnished by a governmental unit to the organization without charge | | | | | | |
| 4 **Total.** Add lines 1 through 3 | | | | | | |
| 5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f) | | | | | | |
| 6 **Public support.** Subtract line 5 from line 4 | | | | | | |

**Section B. Total Support**

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

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

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

**Section C. Computation of Public Support Percentage**

14 Public support percentage for 2017 (line 6, column (f) divided by line 11, column (f)) **14**

15 Public support percentage for 2016 Schedule A, Part II, line 14 **15**

16a **33 1/3% support test—2017.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support test—2016.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

17a **10%-facts-and-circumstances test—2017.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶ ☐

b **10%-facts-and-circumstances test—2016.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶ ☐

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

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

**Section A. Public Support**

| Calendar year (or fiscal year beginning in) ▶ | (a) 2013 | (b) 2014 | (c) 2015 | (d) 2016 | (e) 2017 | (f) Total |
|---|---|---|---|---|---|---|
| 1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants ") | | | | | | |
| 2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose | | | | | | |
| 3 Gross receipts from activities that are not an unrelated trade or business under section 513 | | | | | | |
| 4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf | | | | | | |
| 5 The value of services or facilities furnished by a governmental unit to the organization without charge | | | | | | |
| 6 **Total.** Add lines 1 through 5 | | | | | | |
| 7a Amounts included on lines 1, 2, and 3 received from disqualified persons | | | | | | |
| b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year | | | | | | |
| c Add lines 7a and 7b | | | | | | |
| 8 **Public support.** (Subtract line 7c from line 6 ) | | | | | | |

**Section B. Total Support**

| Calendar year (or fiscal year beginning in) ▶ | (a) 2013 | (b) 2014 | (c) 2015 | (d) 2016 | (e) 2017 | (f) Total |
|---|---|---|---|---|---|---|
| 9 Amounts from line 6 | | | | | | |
| 10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources | | | | | | |
| b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975 | | | | | | |
| c Add lines 10a and 10b | | | | | | |
| 11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on | | | | | | |
| 12 Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI ) | | | | | | |
| 13 **Total support.** (Add lines 9, 10c, 11, and 12 ) | | | | | | |

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

**Section C. Computation of Public Support Percentage**

| | | |
|---|---|---|
| 15 Public support percentage for 2017 (line 8, column (f) divided by line 13, column (f)) | 15 | |
| 16 Public support percentage from 2016 Schedule A, Part III, line 15 | 16 | |

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

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

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

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

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

**Part IV Supporting Organizations**

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

**Section A. All Supporting Organizations**

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

**Part IV Supporting Organizations** (continued)

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

**Section B. Type I Supporting Organizations**

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

**Section C. Type II Supporting Organizations**

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

**Section D. All Type III Supporting Organizations**

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

**Section E. Type III Functionally-Integrated Supporting Organizations**

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

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

| | | | Yes | No |
|---|---|---|---|---|
| **2** | Activities Test **Answer (a) and (b) below.** | | | |
| **a** | Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? *If "Yes," then in* ***Part VI identify those supported organizations and explain*** *how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities* | 2a | | |
| **b** | Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? *If "Yes," explain in* ***Part VI*** *the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement* | 2b | | |
| **3** | Parent of Supported Organizations **Answer (a) and (b) below.** | | | |
| **a** | Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? *Provide details in* ***Part VI.*** | 3a | | |
| **b** | Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? *If "Yes," describe in* ***Part VI.*** *the role played by the organization in this regard* | 3b | | |

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

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

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

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

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

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

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

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

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

# Additional Data

**Software ID:**

**Software Version:**

**EIN:** 33-1007002

**Name:** TRINITY HEALTH & AFFILIATES



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

| Facts And Circumstances Test |
| --- |
| |

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493135032909

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

Department of the Treasury
Internal Revenue Service

# Political Campaign and Lobbying Activities

**For Organizations Exempt From Income Tax Under section 501(c) and section 527**

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

OMB No 1545-0047

**2017**

**Open to Public Inspection**

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

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

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

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

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

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

| Name of the organization | **Employer identification number** |
|---|---|
| TRINITY HEALTH & AFFILIATES | 33-1007002 |

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

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV (see instructions for definition of "political campaign activities")

2 Political campaign activity expenditures (see instructions) ▶ $

3 Volunteer hours for political campaign activities (see instructions)

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

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

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

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

4a Was a correction made? ☐ Yes ☐ No

b If "Yes," describe in Part IV

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

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

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

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

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

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

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

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

**A** Check ▶ ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures)

**B** Check ▶ ☐ if the filing organization checked box A and "limited control" provisions apply

| Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.) | (a) Filing organization's totals | (b) Affiliated group totals |
|---|---|---|
| **1a** Total lobbying expenditures to influence public opinion (grass roots lobbying) | | |
| **b** Total lobbying expenditures to influence a legislative body (direct lobbying) | | |
| **c** Total lobbying expenditures (add lines 1a and 1b) | | |
| **d** Other exempt purpose expenditures | | |
| **e** Total exempt purpose expenditures (add lines 1c and 1d) | | |
| **f** Lobbying nontaxable amount Enter the amount from the following table in both columns | | |
| **g** Grassroots nontaxable amount (enter 25% of line 1f) | | |
| **h** Subtract line 1g from line 1a If zero or less, enter -0- | | |
| **i** Subtract line 1f from line 1c If zero or less, enter -0- | | |

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

**j** If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ **Yes** ☐ **No**

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

**Lobbying Expenditures During 4-Year Averaging Period**

| Calendar year (or fiscal year beginning in) | (a) 2014 | (b) 2015 | (c) 2016 | (d) 2017 | (e) Total |
|---|---|---|---|---|---|
| **2a** Lobbying nontaxable amount | | | | | |
| **b** Lobbying ceiling amount (150% of line 2a, column(e)) | | | | | |
| **c** Total lobbying expenditures | | | | | |
| **d** Grassroots nontaxable amount | | | | | |
| **e** Grassroots ceiling amount (150% of line 2d, column (e)) | | | | | |
| **f** Grassroots lobbying expenditures | | | | | |

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

| *For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity* | | (a) Yes | (a) No | (b) Amount |
|---|---|---|---|---|
| 1 | During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of | | | |
| a | Volunteers? | | No | |
| b | Paid staff or management (include compensation in expenses reported on lines 1c through 1i)? | | No | |
| c | Media advertisements? | | No | |
| d | Mailings to members, legislators, or the public? | | No | |
| e | Publications, or published or broadcast statements? | | No | |
| f | Grants to other organizations for lobbying purposes? | | No | |
| g | Direct contact with legislators, their staffs, government officials, or a legislative body? | | No | |
| h | Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means? | | No | |
| i | Other activities? | Yes | | 133,528 |
| j | Total Add lines 1c through 1i | | | 133,528 |
| 2a | Did the activities in line 1 cause the organization to be not described in section 501(c)(3)? | | No | |
| b | If "Yes," enter the amount of any tax incurred under section 4912 | | | |
| c | If "Yes," enter the amount of any tax incurred by organization managers under section 4912 | | | |
| d | If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year? | | | |

## Part III-A Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).

| | | | Yes | No |
|---|---|---|---|---|
| 1 | Were substantially all (90% or more) dues received nondeductible by members? | 1 | | |
| 2 | Did the organization make only in-house lobbying expenditures of $2,000 or less? | 2 | | |
| 3 | Did the organization agree to carry over lobbying and political expenditures from the prior year? | 3 | | |

## Part III-B Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No" OR (b) Part III-A, line 3, is answered "Yes."

| | | | |
|---|---|---|---|
| 1 | Dues, assessments and similar amounts from members | 1 | |
| 2 | Section 162(e) nondeductible lobbying and political expenditures **(do not include amounts of political expenses for which the section 527(f) tax was paid).** | | |
| a | Current year | 2a | |
| b | Carryover from last year | 2b | |
| c | Total | 2c | |
| 3 | Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues | 3 | |
| 4 | If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year? | 4 | |
| 5 | Taxable amount of lobbying and political expenditures (see instructions) | 5 | |

## Part IV Supplemental Information

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

| Return Reference | Explanation |
|---|---|
| PART II-B, LINE 1 | LOBBYING ACTIVITIES CONSIST OF A PORTION OF OUR ANNUAL MEMBERSHIP DUES IDENTIFIED UPON RENEWAL AS ASSOCIATED WITH LOBBYING ACTIVITY ASSOCIATIONS INCLUDE NORTH DAKOTA HOSPITAL ASSOCIATION, AMERICAN HOSPITAL ASSOCIATION, NORTH DAKOTA LONG TERM CARE ASSOCIATION, NORTH DAKOTA HOSPICE ORGANIZATION, HEALTH POLICY CONSORTIUM, NORTH DAKOTA ASSOCIATION FOR HOME CARE, AND NATIONAL HOSPICE AND PALLIATIVE CARE ORGANIZATION |

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**SCHEDULE D** (Form 990)

Department of the Treasury
Internal Revenue Service

# Supplemental Financial Statements

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

OMB No 1545-0047

**2017**

**Open to Public Inspection**

**Name of the organization**
TRINITY HEALTH & AFFILIATES

**Employer identification number**
33-1007002

## Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.

Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

| | | (a) Donor advised funds | (b) Funds and other accounts |
|---|---|---|---|
| 1 | Total number at end of year | | |
| 2 | Aggregate value of contributions to (during year) | | |
| 3 | Aggregate value of grants from (during year) | | |
| 4 | Aggregate value at end of year | | |

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

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

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

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

☐ Preservation of land for public use (e g , recreation or education)
☐ Preservation of an historically important land area
☐ Protection of natural habitat
☐ Preservation of a certified historic structure
☐ Preservation of open space

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Part IV Escrow and Custodial Arrangements.

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

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

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

| | | Amount |
|---|---|---|
| c | Beginning balance | 1c 330,942 |
| d | Additions during the year | 1d 21,753 |
| e | Distributions during the year | 1e 4,793 |
| f | Ending balance | 1f 347,902 |

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

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

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

| | (a) Current year | (b) Prior year | (c) Two years back | (d) Three years back | (e) Four years back |
|---|---|---|---|---|---|
| 1a Beginning of year balance | 1,692,368 | 1,679,926 | 1,646,618 | 133,476 | 105,740 |
| b Contributions | | 12,442 | 380 | 1,433,291 | 19,211 |
| c Net investment earnings, gains, and losses | | | 55,843 | 79,851 | 8,525 |
| d Grants or scholarships | | | | | |
| e Other expenditures for facilities and programs | | | 22,915 | | |
| f Administrative expenses | | | | | |
| g End of year balance | 1,692,368 | 1,692,368 | 1,679,926 | 1,646,618 | 133,476 |

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

- a Board designated or quasi-endowment ▶ 0 %
- b Permanent endowment ▶ 91 160 %
- c Temporarily restricted endowment ▶ 8 840 %

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

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

| | Yes | No |
|---|---|---|
| (i) unrelated organizations . . . . . 3a(i) | | No |
| (ii) related organizations . . . . . 3a(ii) | | No |
| b If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R? . . . . . 3b | | |

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

## Part VI Land, Buildings, and Equipment.

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

| Description of property | (a) Cost or other basis (investment) | (b) Cost or other basis (other) | (c) Accumulated depreciation | (d) Book value |
|---|---|---|---|---|
| 1a Land | | 2,655,356 | | 2,655,356 |
| b Buildings | | 43,130,542 | 29,564,312 | 13,566,230 |
| c Leasehold improvements | | 19,447 | 19,447 | 0 |
| d Equipment | | 194,654,293 | 162,708,274 | 31,946,019 |
| e Other | | 35,079,087 | | 35,079,087 |
| **Total.** Add lines 1a through 1e *(Column (d) must equal Form 990, Part X, column (B), line 10(c) )* ▶ | | | | 83,246,692 |

**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 | |
| ESTIMATED 3RD PARTY SETTLEMENTS | 9,897,040 |
| (2) | |
| (3) | |
| (4) | |
| (5) | |
| (6) | |
| (7) | |
| (8) | |
| (9) | |
| **Total.** *(Column (b) must equal Form 990, Part X, col (B) line 25 )* ▶ | 9,897,040 |

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

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

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

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

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

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

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

## Part XIII Supplemental Information

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

| Return Reference | Explanation |
|---|---|
| See Additional Data Table | |
| | |
| | |
| | |
| | |
| | |
| | |

**Part XIII Supplemental Information *(continued)***

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

# Additional Data

**Software ID:**
**Software Version:**
**EIN:** 33-1007002
**Name:** TRINITY HEALTH & AFFILIATES

**Supplemental Information**

| Return Reference | Explanation |
|---|---|
| PART IV, LINE 1B | TO PROVIDE PUBLIC EDUCATION FOR HOSPICE CARE |

**Supplemental Information**

| Return Reference | Explanation |
|---|---|
| PART IV, LINE 2B | RESIDENT TRUST FUNDS ARE HELD BY TRINITY HOMES THESE FUNDS ARE TRACKED SEPARATELY FROM TH E ORGANIZATIONS AND ARE HELD IN A SEPARATE BANK ACCOUNT |

**Supplemental Information**

| Return Reference | Explanation |
| --- | --- |
| PART V, LINE 4 | THE PURPOSE OF THE ENDOWMENT FUNDS IS TO SUPPORT STAFF EDUCATION AND SCHOLARSHIPS AND THE PURCHASE OF NEW EQUIPMENT |

**Supplemental Information**

| Return Reference | Explanation |
|---|---|
| PART X, LINE 2 | TRINITY HOSPITALS, TRINITY HOMES, TRINITY HEALTH FOUNDATION, TRINITY KENMARE HOSPITAL, AND COMMUNITY AMBULANCE SERVICE HAVE ALL BEEN RECOGNIZED BY THE INTERNAL REVENUE SERVICE (IRS ) AS A NONPROFIT CORPORATION AS DESCRIBED IN SEC 501(C)(3) OF THE INTERNAL REVENUE CODE ( IRC) AND ARE EXEMPT FROM FEDERAL INCOME TAXES PURSUANT TO SEC 501(A) OF THE IRC ALL UNRE LATED BUSINESS INCOME GENERATED BY TRINITY IS SUBJECT TO FEDERAL INCOME TAX UNDER SECTION 511 OF THE IRC TRINITY'S POLICY IS TO EVALUATE THE LIKELIHOOD THAT ITS UNCERTAIN TAX POSI TIONS WILL PREVAIL UPON EXAMINATION BASED ON THE EXTENT TO WHICH THOSE POSITIONS HAVE SUBS TANTIAL SUPPORT WITHIN THE INTERNAL REVENUE CODE AND REGULATIONS, REVENUE RULINGS, COURT D ECISIONS, AND OTHER EVIDENCE IT IS THE OPINION OF MANAGEMENT THAT THE COMPANY HAS NO SIGN IFICANT UNCERTAIN TAX POSITIONS THAT WOULD BE SUBJECT TO CHANGE UPON EXAMINATION TRINITY' S INCOME TAX RETURNS ARE SUBJECT TO REVIEW AND EXAMINATION BY FEDERAL, STATE, AND LOCAL AU THORITIES |

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SCHEDULE F (Form 990)

Department of the Treasury
Internal Revenue Service

# Statement of Activities Outside the United States

► Complete if the organization answered "Yes" to Form 990, Part IV, line 14b, 15, or 16.
► Attach to Form 990.
► Information about Schedule F (Form 990) and its instructions is at *www.irs.gov/form990*.

OMB No 1545-0047

**2017**

**Open to Public Inspection**

Name of the organization
TRINITY HEALTH & AFFILIATES

**Employer identification number**
33-1007002

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

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

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

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

| (a) Region | (b) Number of offices in the region | (c) Number of employees, agents, and independent contractors in region | (d) Activities conducted in region (by type) (e g , fundraising, program services, investments, grants to recipients located in the region) | (e) If activity listed in (d) is a program service, describe specific type of service(s) in region | (f) Total expenditures for and investments in region |
|---|---|---|---|---|---|
| (1) NORTH AMERICA | 0 | 0 | OTHER - MINERAL RIGHTS | | 10,421 |
| (2) | | | | | |
| (3) | | | | | |
| (4) | | | | | |
| (5) | | | | | |
| 3a Sub-total | 0 | 0 | | | 10,421 |
| b Total from continuation sheets to Part I | | | | | 0 |
| c **Totals** (add lines 3a and 3b) | 0 | 0 | | | 10,421 |

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

| 1 | (a) Name of organization | (b) IRS code section and EIN (if applicable) | (c) Region | (d) Purpose of grant | (e) Amount of cash grant | (f) Manner of cash disbursement | (g) Amount of non-cash assistance | (h) Description of non-cash assistance | (i) Method of valuation (book, FMV, appraisal, other) |
|---|---|---|---|---|---|---|---|---|---|
| (1) | | | | | | | | | |
| (2) | | | | | | | | | |
| (3) | | | | | | | | | |
| (4) | | | | | | | | | |

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

3 Enter total number of other organizations or entities . . . . . ▶

**Part III** **Grants and Other Assistance to Individuals Outside the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 16. Part III can be duplicated if additional space is needed.

| (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, do not 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, do not 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).

| Return Reference | Explanation |
|---|---|
| SCHEDULE F, PART I, LINE 3 | FOREIGN ACTIVITIES THE ORGANIZATION'S FOREIGN ACTIVITIES ARE LIMITED TO THE RECEIPT OF MINERAL RIGHTS FROM PROPERTY IN CANADA |

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SCHEDULE G (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

# Supplemental Information Regarding Fundraising or Gaming Activities

Complete if the organization answered "Yes" on Form 990, Part IV, lines 17, 18, or 19, or if the organization entered more than $15,000 on Form 990-EZ, line 6a

▶ Attach to Form 990 or Form 990-EZ.

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

OMB No 1545-0047

**2017**

**Open to Public Inspection**

Name of the organization
TRINITY HEALTH & AFFILIATES

**Employer identification number**
33-1007002

**Part I** **Fundraising Activities.** Complete if the organization answered "Yes" on Form 990, Part IV, line 17. Form 990-EZ filers are not required to complete this part.

**1** Indicate whether the organization raised funds through any of the following activities Check all that apply

**a** ☐ Mail solicitations
**b** ☐ Internet and email solicitations
**c** ☐ Phone solicitations
**d** ☐ In-person solicitations
**e** ☐ Solicitation of non-government grants
**f** ☐ Solicitation of government grants
**g** ☐ Special fundraising events

**2a** Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services? ☐ **Yes** ☐ **No**

**b** If "Yes," list the ten highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least $5,000 by the organization

| | **(i)** Name and address of individual or entity (fundraiser) | **(ii)** Activity | **(iii)** Did fundraiser have custody or control of contributions? Yes | No | **(iv)** Gross receipts from activity | **(v)** Amount paid to (or retained by) fundraiser listed in col **(i)** | **(vi)** Amount paid to (or retained by) organization |
|---|---|---|---|---|---|---|---|
| 1 | | | | | | | |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |
| 6 | | | | | | | |
| 7 | | | | | | | |
| 8 | | | | | | | |
| 9 | | | | | | | |
| 10 | | | | | | | |
| **Total** | | | ▶ | | | | |

**3** List all states in which the organization is registered or licensed to solicit contributions or has been notified it is exempt from registration or licensing

**Part II** **Fundraising Events.** Complete if the organization answered "Yes" on Form 990, Part IV, line 18, or reported more than $15,000 of fundraising event contributions and gross income on Form 990-EZ, lines 1 and 6b. List events with gross receipts greater than $5,000.

| Revenue | | (a) Event #1 BUILDING HOPE GOLF (event type) | (b) Event #2 GOLF FOR LIFE (event type) | (c) Other events (total number) | (d) Total events (add col (a) through col (c)) |
|---|---|---|---|---|---|
| | 1 Gross receipts | 100,148 | 35,056 | | 135,204 |
| | 2 Less Contributions | 98,859 | 34,242 | | 133,101 |
| | 3 Gross income (line 1 minus line 2) | 1,289 | 814 | | 2,103 |
| Direct Expenses | 4 Cash prizes | 893 | 349 | | 1,242 |
| | 5 Noncash prizes | 396 | 465 | | 861 |
| | 6 Rent/facility costs | 6,768 | 5,906 | | 12,674 |
| | 7 Food and beverages | 571 | | | 571 |
| | 8 Entertainment | | | | |
| | 9 Other direct expenses | 2,262 | 688 | | 2,950 |
| | 10 Direct expense summary Add lines 4 through 9 in column (d) ▶ | | | | 18,298 |
| | 11 Net income summary Subtract line 10 from line 3, column (d) ▶ | | | | -16,195 |

**Part III** **Gaming.** Complete if the organization answered "Yes" on Form 990, Part IV, line 19, or reported more than $15,000 on Form 990-EZ, line 6a.

| Revenue | | (a) Bingo | (b) Pull tabs/Instant bingo/progressive bingo | (c) Other gaming | (d) Total gaming (add col (a) through col (c)) |
|---|---|---|---|---|---|
| | 1 Gross revenue | | | | |
| Direct Expenses | 2 Cash prizes | | | | |
| | 3 Noncash prizes | | | | |
| | 4 Rent/facility costs | | | | |
| | 5 Other direct expenses | | | | |
| | 6 Volunteer labor | ☐ Yes ____% ☐ No | ☐ Yes ____% ☐ No | ☐ Yes ____% ☐ No | |
| | 7 Direct expense summary Add lines 2 through 5 in column (d) ▶ | | | | |
| | 8 Net gaming income summary Subtract line 7 from line 1, column (d) ▶ | | | | |

9 Enter the state(s) in which the organization conducts gaming activities _____

a Is the organization licensed to conduct gaming activities in each of these states? ☐ Yes ☐ No

b If "No," explain _____

10a Were any of the organization's gaming licenses revoked, suspended or terminated during the tax year? ☐ Yes ☐ No

b If "Yes," explain _____

**11** Does the organization conduct gaming activities with nonmembers? ☐ Yes ☐ No

**12** Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming? ☐ Yes ☐ No

**13** Indicate the percentage of gaming activity conducted in

| | | |
|---|---|---|
| **a** The organization's facility | **13a** | % |
| **b** An outside facility | **13b** | % |

**14** Enter the name and address of the person who prepares the organization's gaming/special events books and records

Name ▶ ----------

Address ▶ ----------

**15a** Does the organization have a contract with a third party from whom the organization receives gaming revenue? ☐ Yes ☐ No

**b** If "Yes," enter the amount of gaming revenue received by the organization ▶ $ _____ and the amount of gaming revenue retained by the third party ▶ $ _____

**c** If "Yes," enter name and address of the third party

Name ▶ ----------

Address ▶

----------

**16** Gaming manager information

Name ▶ ----------

Gaming manager compensation ▶ $----------

Description of services provided ▶ ----------

☐ Director/officer ☐ Employee ☐ Independent contractor

**17** Mandatory distributions

**a** Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license? ☐ Yes ☐ No

**b** Enter the amount of distributions required under state law distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ $

**Part IV** **Supplemental Information.** Provide the explanations required by Part I, line 2b, columns (iii) and (v); and Part III, lines 9, 9b, 10b, 15b, 15c, 16, and 17b, as applicable. Also provide any additional information (see instructions).

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

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**SCHEDULE H (Form 990)**

Department of the Treasury
Internal Revenue Service

# Hospitals

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

OMB No 1545-0047

**2017**

**Open to Public Inspection**

**Name of the organization**
TRINITY HEALTH & AFFILIATES

**Employer identification number**
33-1007002

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

| | | | Yes | No |
|---|---|---|---|---|
| 1a | Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a | 1a | Yes | |
| b | If "Yes," was it a written policy? | 1b | Yes | |
| 2 | If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year | | | |
| | ☑ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities | | | |
| 3 | Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year | | | |
| a | Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care | 3a | Yes | |
| | ☐ 100% ☐ 150% ☐ 200% ☑ Other 25000 0000000000 % | | | |
| b | Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care | 3b | Yes | |
| | ☐ 200% ☑ 250% ☐ 300% ☐ 350% ☐ 400% ☐ Other _____ % | | | |
| c | If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care | | | |
| 4 | Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"? | 4 | Yes | |
| 5a | Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? | 5a | Yes | |
| b | If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? | 5b | | No |
| c | If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligibile for free or discounted care? | 5c | | |
| 6a | Did the organization prepare a community benefit report during the tax year? | 6a | Yes | |
| b | If "Yes," did the organization make it available to the public? | 6b | Yes | |
| | Complete the following table using the worksheets provided in the Schedule H instructions Do not submit these worksheets with the Schedule H | | | |

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

| Financial Assistance and Means-Tested Government Programs | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community benefit expense | (d) Direct offsetting revenue | (e) Net community benefit expense | (f) Percent of total expense |
|---|---|---|---|---|---|---|
| a Financial Assistance at cost (from Worksheet 1) | | | 1,251,775 | | 1,251,775 | 0 460 % |
| b Medicaid (from Worksheet 3, column a) | | | 18,408,180 | 18,761,186 | 0 | 0 % |
| c Costs of other means-tested government programs (from Worksheet 3, column b) | | | | | | |
| d **Total** Financial Assistance and Means-Tested Government Programs | | | 19,659,955 | 18,761,186 | 1,251,775 | 0 460 % |
| **Other Benefits** | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4) | | | 367,645 | 52,795 | 314,850 | 0 120 % |
| f Health professions education (from Worksheet 5) | | | 16,130 | | 16,130 | 0 010 % |
| g Subsidized health services (from Worksheet 6) | | | | | | |
| h Research (from Worksheet 7) | | | | | | |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | | | 200 | | 200 | 0 % |
| j **Total.** Other Benefits | | | 383,975 | 52,795 | 331,180 | 0 130 % |
| k **Total.** Add lines 7d and 7j | | | 20,043,930 | 18,813,981 | 1,582,955 | 0 590 % |

## 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 | | | 3,956 | | 3,956 | 0 % |
| 4 Environmental improvements | | | | | | |
| 5 Leadership development and training for community members | | | | | | |
| 6 Coalition building | | | | | | |
| 7 Community health improvement advocacy | | | | | | |
| 8 Workforce development | | | | | | |
| 9 Other | | | | | | |
| 10 Total | | | 3,956 | | 3,956 | 0 % |

## Part III Bad Debt, Medicare, & Collection Practices

### Section A. Bad Debt Expense

| | | | | Yes | No |
|---|---|---|---|---|---|
| 1 | Did the organization report bad debt expense in accordance with Heathcare Financial Management Association Statement No 15? | | 1 | Yes | |
| 2 | Enter the amount of the organization's bad debt expense Explain in Part VI the methodology used by the organization to estimate this amount | 2 | 16,862,202 | | |
| 3 | Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit | 3 | 0 | | |
| 4 | Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements | | | | |

### Section B. Medicare

| | | | | | |
|---|---|---|---|---|---|
| 5 | Enter total revenue received from Medicare (including DSH and IME) | 5 | 83,191,546 | | |
| 6 | Enter Medicare allowable costs of care relating to payments on line 5 | 6 | 98,825,791 | | |
| 7 | Subtract line 6 from line 5 This is the surplus (or shortfall) | 7 | -15,634,245 | | |
| 8 | Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6 Check the box that describes the method used | | | | |

☐ Cost accounting system ☑ Cost to charge ratio ☐ Other

### Section C. Collection Practices

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

## Part IV Management Companies and Joint Ventures

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

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

## Part V Facility Information

**Section A. Hospital Facilities**

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

How many hospital facilities did the organization operate during the tax year?
**3**

| Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility) | Licensed hospital | General medical & surgical | Children's hospital | Teaching hospital | Critical access hospital | Research facility | ER-24 hours | ER-other | Other (describe) | Facility reporting group |
|---|---|---|---|---|---|---|---|---|---|---|
| See Additional Data Table | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

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

**Section B. Facility Policies and Practices**

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

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

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

| | | | Yes | No |
|---|---|---|---|---|
| **Community Health Needs Assessment** | | | | |
| 1 | Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? | 1 | | No |
| 2 | Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C | 2 | | No |
| 3 | During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 | 3 | Yes | |
| | If "Yes," indicate what the CHNA report describes (check all that apply) | | | |
| a | ☑ A definition of the community served by the hospital facility | | | |
| b | ☑ Demographics of the community | | | |
| c | ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | | |
| d | ☑ How data was obtained | | | |
| e | ☑ The significant health needs of the community | | | |
| f | ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | | |
| g | ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs | | | |
| h | ☑ The process for consulting with persons representing the community's interests | | | |
| i | ☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s) | | | |
| j | ☐ Other (describe in Section C) | | | |
| 4 | Indicate the tax year the hospital facility last conducted a CHNA 20 15 | | | |
| 5 | In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted | 5 | Yes | |
| 6 a | Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | 6a | Yes | |
| b | Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C | 6b | | No |
| 7 | Did the hospital facility make its CHNA report widely available to the public? | 7 | Yes | |
| | If "Yes," indicate how the CHNA report was made widely available (check all that apply) | | | |
| a | ☑ Hospital facility's website (list url) WWW TRINITYHEALTH ORG/COMMUNITY | | | |
| b | ☐ Other website (list url) | | | |
| c | ☑ Made a paper copy available for public inspection without charge at the hospital facility | | | |
| d | ☐ Other (describe in Section C) | | | |
| 8 | Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 | 8 | Yes | |
| 9 | Indicate the tax year the hospital facility last adopted an implementation strategy 20 15 | | | |
| 10 | Is the hospital facility's most recently adopted implementation strategy posted on a website? | 10 | | No |
| a | If "Yes" (list url) | | | |
| b | If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? | 10b | Yes | |
| 11 | Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed | | | |
| 12a | Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? | 12a | | No |
| b | If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? | 12b | | |
| c | If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $ | | | |

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

**Financial Assistance Policy (FAP)**

TRINITY HOSPITAL

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

| | | | Yes | No |
|---|---|---|---|---|
| | Did the hospital facility have in place during the tax year a written financial assistance policy that | | | |
| 13 | Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? | 13 | Yes | |
| | If "Yes," indicate the eligibility criteria explained in the FAP | | | |
| a | ☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 250 000000000000 % and FPG family income limit for eligibility for discounted care of 250 000000000000 % | | | |
| b | ☐ Income level other than FPG (describe in Section C) | | | |
| c | ☑ Asset level | | | |
| d | ☐ Medical indigency | | | |
| e | ☑ Insurance status | | | |
| f | ☑ Underinsurance discount | | | |
| g | ☑ Residency | | | |
| h | ☑ Other (describe in Section C) | | | |
| 14 | Explained the basis for calculating amounts charged to patients? . . . . . | 14 | Yes | |
| 15 | Explained the method for applying for financial assistance? . . . . . | 15 | Yes | |
| | If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply) | | | |
| a | ☑ Described the information the hospital facility may require an individual to provide as part of his or her application | | | |
| b | ☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | | |
| c | ☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | | |
| d | ☑ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | | |
| e | ☐ Other (describe in Section C) | | | |
| 16 | Was widely publicized within the community served by the hospital facility? . . . . . | 16 | Yes | |
| | If "Yes," indicate how the hospital facility publicized the policy (check all that apply) | | | |
| a | ☑ The FAP was widely available on a website (list url) HTTPS //WWW TRINITYHEALTH ORG/PATIENTS-VISITORS/FINANCIAL-ASSISTANCE/ | | | |
| b | ☑ The FAP application form was widely available on a website (list url) HTTPS //WWW TRINITYHEALTH ORG/PATIENTS-VISITORS/FINANCIAL-ASSISTANCE/ | | | |
| c | ☑ A plain language summary of the FAP was widely available on a website (list url) HTTPS //WWW TRINITYHEALTH ORG/PATIENTS-VISITORS/FINANCIAL-ASSISTANCE/ | | | |
| d | ☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| e | ☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| f | ☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| g | ☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention | | | |
| h | ☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP | | | |
| i | ☐ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations | | | |
| j | ☑ Other (describe in Section C) | | | |

## Part V Facility Information *(continued)*

### Billing and Collections

TRINITY HOSPITAL

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

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

### Policy Relating to Emergency Medical Care

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

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

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

TRINITY HOSPITAL

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

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

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

**Section B. Facility Policies and Practices**

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

**Name of hospital facility or letter of facility reporting group** TRINITY HOSPITAL ST JOSEPH'S

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

| | | | Yes | No |
|---|---|---|---|---|
| **Community Health Needs Assessment** | | | | |
| 1 | Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? | 1 | | No |
| 2 | Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C | 2 | | No |
| 3 | During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 | 3 | Yes | |
| | If "Yes," indicate what the CHNA report describes (check all that apply) | | | |
| a | ☑ A definition of the community served by the hospital facility | | | |
| b | ☑ Demographics of the community | | | |
| c | ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | | |
| d | ☑ How data was obtained | | | |
| e | ☑ The significant health needs of the community | | | |
| f | ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | | |
| g | ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs | | | |
| h | ☑ The process for consulting with persons representing the community's interests | | | |
| i | ☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s) | | | |
| j | ☐ Other (describe in Section C) | | | |
| 4 | Indicate the tax year the hospital facility last conducted a CHNA 20 15 | | | |
| 5 | In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted | 5 | Yes | |
| 6 a | Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | 6a | Yes | |
| b | Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C | 6b | | No |
| 7 | Did the hospital facility make its CHNA report widely available to the public? | 7 | Yes | |
| | If "Yes," indicate how the CHNA report was made widely available (check all that apply) | | | |
| a | ☑ Hospital facility's website (list url) WWW TRINITYHEALTH ORG/COMMUNITY | | | |
| b | ☐ Other website (list url) | | | |
| c | ☑ Made a paper copy available for public inspection without charge at the hospital facility | | | |
| d | ☐ Other (describe in Section C) | | | |
| 8 | Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 | 8 | Yes | |
| 9 | Indicate the tax year the hospital facility last adopted an implementation strategy 20 15 | | | |
| 10 | Is the hospital facility's most recently adopted implementation strategy posted on a website? | 10 | | No |
| a | If "Yes" (list url) | | | |
| b | If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? | 10b | Yes | |
| 11 | Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed | | | |
| 12a | Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? | 12a | | No |
| b | If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? | 12b | | |
| c | If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $ | | | |

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

**Financial Assistance Policy (FAP)**

TRINITY HOSPITAL ST JOSEPH'S

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

| | | | Yes | No |
|---|---|---|---|---|
| | Did the hospital facility have in place during the tax year a written financial assistance policy that | | | |
| 13 | Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? | 13 | Yes | |
| | If "Yes," indicate the eligibility criteria explained in the FAP | | | |
| a | ☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 250 000000000000 % and FPG family income limit for eligibility for discounted care of 250 000000000000 % | | | |
| b | ☐ Income level other than FPG (describe in Section C) | | | |
| c | ☑ Asset level | | | |
| d | ☐ Medical indigency | | | |
| e | ☑ Insurance status | | | |
| f | ☑ Underinsurance discount | | | |
| g | ☑ Residency | | | |
| h | ☑ Other (describe in Section C) | | | |
| 14 | Explained the basis for calculating amounts charged to patients? | 14 | Yes | |
| 15 | Explained the method for applying for financial assistance? | 15 | Yes | |
| | If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply) | | | |
| a | ☑ Described the information the hospital facility may require an individual to provide as part of his or her application | | | |
| b | ☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | | |
| c | ☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | | |
| d | ☑ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | | |
| e | ☐ Other (describe in Section C) | | | |
| 16 | Was widely publicized within the community served by the hospital facility? | 16 | Yes | |
| | If "Yes," indicate how the hospital facility publicized the policy (check all that apply) | | | |
| a | ☑ The FAP was widely available on a website (list url) HTTPS //WWW TRINITYHEALTH ORG/PATIENTS-VISITORS/FINANCIAL-ASSISTANCE/ | | | |
| b | ☑ The FAP application form was widely available on a website (list url) HTTPS //WWW TRINITYHEALTH ORG/PATIENTS-VISITORS/FINANCIAL-ASSISTANCE/ | | | |
| c | ☑ A plain language summary of the FAP was widely available on a website (list url) HTTPS //WWW TRINITYHEALTH ORG/PATIENTS-VISITORS/FINANCIAL-ASSISTANCE/ | | | |
| d | ☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| e | ☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| f | ☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| g | ☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention | | | |
| h | ☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP | | | |
| i | ☐ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations | | | |
| j | ☑ Other (describe in Section C) | | | |

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

**Billing and Collections**

TRINITY HOSPITAL ST JOSEPH'S

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

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

**Policy Relating to Emergency Medical Care**

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

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

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

TRINITY HOSPITAL ST JOSEPH'S

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

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

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

**Section B. Facility Policies and Practices**

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

**Name of hospital facility or letter of facility reporting group** TRINITY KENMARE HOSPITAL

**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** 3

| | | | Yes | No |
|---|---|---|---|---|
| **Community Health Needs Assessment** | | | | |
| 1 | Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? | 1 | | No |
| 2 | Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C | 2 | | No |
| 3 | During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 | 3 | Yes | |
| | If "Yes," indicate what the CHNA report describes (check all that apply) | | | |
| a | ☑ A definition of the community served by the hospital facility | | | |
| b | ☑ Demographics of the community | | | |
| c | ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | | |
| d | ☑ How data was obtained | | | |
| e | ☑ The significant health needs of the community | | | |
| f | ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | | |
| g | ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs | | | |
| h | ☑ The process for consulting with persons representing the community's interests | | | |
| i | ☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s) | | | |
| j | ☐ Other (describe in Section C) | | | |
| 4 | Indicate the tax year the hospital facility last conducted a CHNA 20 15 | | | |
| 5 | In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted | 5 | Yes | |
| 6 a | Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | 6a | Yes | |
| b | Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C | 6b | | No |
| 7 | Did the hospital facility make its CHNA report widely available to the public? | 7 | Yes | |
| | If "Yes," indicate how the CHNA report was made widely available (check all that apply) | | | |
| a | ☑ Hospital facility's website (list url) WWW TRINITYHEALTH ORG/COMMUNITY | | | |
| b | ☐ Other website (list url) | | | |
| c | ☑ Made a paper copy available for public inspection without charge at the hospital facility | | | |
| d | ☐ Other (describe in Section C) | | | |
| 8 | Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 | 8 | Yes | |
| 9 | Indicate the tax year the hospital facility last adopted an implementation strategy 20 15 | | | |
| 10 | Is the hospital facility's most recently adopted implementation strategy posted on a website? | 10 | | No |
| a | If "Yes" (list url) | | | |
| b | If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? | 10b | Yes | |
| 11 | Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed | | | |
| 12a | Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? | 12a | | No |
| b | If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? | 12b | | |
| c | If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $ | | | |

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

**Financial Assistance Policy (FAP)**

TRINITY KENMARE HOSPITAL

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

| | | | Yes | No |
|---|---|---|---|---|
| | Did the hospital facility have in place during the tax year a written financial assistance policy that | | | |
| 13 | Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? | 13 | Yes | |
| | If "Yes," indicate the eligibility criteria explained in the FAP | | | |
| a | ☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 250 000000000000 % and FPG family income limit for eligibility for discounted care of 250 000000000000 % | | | |
| b | ☐ Income level other than FPG (describe in Section C) | | | |
| c | ☑ Asset level | | | |
| d | ☐ Medical indigency | | | |
| e | ☑ Insurance status | | | |
| f | ☑ Underinsurance discount | | | |
| g | ☑ Residency | | | |
| h | ☑ Other (describe in Section C) | | | |
| 14 | Explained the basis for calculating amounts charged to patients? | 14 | Yes | |
| 15 | Explained the method for applying for financial assistance? | 15 | Yes | |
| | If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply) | | | |
| a | ☑ Described the information the hospital facility may require an individual to provide as part of his or her application | | | |
| b | ☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | | |
| c | ☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | | |
| d | ☑ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | | |
| e | ☐ Other (describe in Section C) | | | |
| 16 | Was widely publicized within the community served by the hospital facility? | 16 | Yes | |
| | If "Yes," indicate how the hospital facility publicized the policy (check all that apply) | | | |
| a | ☑ The FAP was widely available on a website (list url) HTTPS //WWW TRINITYHEALTH ORG/PATIENTS-VISITORS/FINANCIAL-ASSISTANCE/ | | | |
| b | ☑ The FAP application form was widely available on a website (list url) HTTPS //WWW TRINITYHEALTH ORG/PATIENTS-VISITORS/FINANCIAL-ASSISTANCE/ | | | |
| c | ☑ A plain language summary of the FAP was widely available on a website (list url) HTTPS //WWW TRINITYHEALTH ORG/PATIENTS-VISITORS/FINANCIAL-ASSISTANCE/ | | | |
| d | ☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| e | ☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| f | ☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| g | ☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention | | | |
| h | ☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP | | | |
| i | ☐ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations | | | |
| j | ☑ Other (describe in Section C) | | | |

## Part V Facility Information *(continued)*

### Billing and Collections

TRINITY KENMARE HOSPITAL

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

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

### Policy Relating to Emergency Medical Care

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

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

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

TRINITY KENMARE HOSPITAL

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

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

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

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

| Form and Line Reference | Explanation |
|---|---|
| See Add'l Data | |
| | |
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**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? **29**

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

## Part VI Supplemental Information

Provide the following information

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7, Part II and Part III, lines 2, 3, 4, 8 and 9b

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e g , open medical staff, community board, use of surplus funds, etc )

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report

### 990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|---|---|
| PART I, LINE 3C | TO BE ELIGIBLE FOR FREE CARE UNDER TRINITY HEALTH'S FINANCIAL ASSISTANCE POLICY, THE SERVICES MUST BE MEDICALLY NECESSARY, THE PERSON'S HOUSEHOLD INCOME MUST BE BELOW 250% OF FEDERAL POVERTY GUIDELINES, THEY MUST RESIDE WITHIN TRINITY HEALTH'S SERVICE AREA, THEY MUST EXHAUST OTHER FINANCIAL ASSISTANCE OPPORTUNITIES (E G MEDICARE, MEDICAID), AND THEY MUST PROVIDE A COMPLETE FINANCIAL ASSISTANCE APPLICATION SPECIAL CONSIDERATION IS GIVEN WHEN INCOME LEVELS EXCEED THE INCOME GUIDELINES FOR CHARITY CARE AND THE HEALTHCARE EXPENSES EXCEED A SIGNIFICANT MULTIPLE OF THE HOUSEHOLD'S ANNUAL INCOME |
| PART I, LINE 7 | TRINITY'S COMMUNITY BENEFIT EXPENSES AND REVENUES WERE CALCULATED USING THE IRS WORKSHEETS PROVIDED IN THE INSTRUCTIONS TO THE 2017 FORM 990, SCHEDULE H |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
|---|---|
| PART I, LN 7 COL(F) | $16,862,202 OF BAD DEBT EXPENSE WAS EXCLUDED IN CALCULATING THE PERCENTAGES REPORTED IN PART I, LINE 7, COLUMN F IN FURTHERANCE OF ITS CHARITABLE PURPOSE, TRINITY PROVIDES A WIDE VARIETY OF BENEFITS TO THE COMMUNITY, INCLUDING OFFERING VARIOUS COMMUNITY-BASED SERVICE PROGRAMS SUCH AS FREE CLINICS, HEALTH SCREENINGS, IN-HOME CAREGIVER SERVICES, SOCIAL SERVICE AND SUPPORT COUNSELING FOR PATIENTS AND FAMILIES, PASTORAL CARE, CRISIS INTERVENTION, TRANSPORTATION TO AND FROM THE HOSPITAL CAMPUSES, AND THE DONATION OF SPACE FOR USE BY COMMUNITY GROUPS ADDITIONALLY, A LARGE NUMBER OF HEALTH-RELATED EDUCATIONAL PROGRAMS ARE PROVIDED FOR THE BENEFIT OF THE COMMUNITY, INCLUDING HEALTH ENHANCEMENTS AND WELLNESS, CLASSES ON SPECIFIC CONDITIONS, TELEPHONE INFORMATION SERVICES, AND COSTS RELATED TO PROGRAMS DESIGNED TO IMPROVE THE GENERAL STANDARDS OF THE HEALTH OF THE COMMUNITY THE COST OF PROVIDING THE ABOVE SERVICES IS NOT INCLUDED IN TRINITY'S CHARITY CARE AMOUNT |
| PART III, LINE 2 | TRINITY PROVIDES MEDICAL CARE WITHOUT CHARGE OR AT REDUCED CHARGE TO RESIDENTS OF ITS COMMUNITY THROUGH THE PROVISION OF CHARITY CARE INCLUDED IN TRINITY'S DEFINITION OF CHARITY CARE ARE THE FOLLOWING (A) SERVICES PROVIDED TO THE UNINSURED OR UNDERINSURED AND (B) SERVICES PROVIDED TO PATIENTS EXPRESSING A WILLINGNESS TO PAY BUT WHO ARE DETERMINED TO BE UNABLE TO PAY BECAUSE OF SOCIOECONOMIC FACTORS TRINITY MAINTAINS RECORDS TO IDENTIFY AND MONITOR THE LEVEL OF CHARITY CARE IT PROVIDES THOSE RECORDS INCLUDE THE AMOUNT OF CHARGES FORGONE FOR CHARITY CARE AMOUNTS DO NOT INCLUDE THE PROVISION FOR UNCOLLECTIBLE ACCOUNTS OR THE DIFFERENCE BETWEEN PUBLIC PROGRAM PAYMENTS (PRIMARILY MEDICARE AND MEDICAID) AND THE RELATED COSTS OF PROVIDING SUCH SERVICES TRINITY USES THE COST-TO-CHARGE RATIO TO DETERMINE THE AMOUNTS REPORTED IN LINE 2 |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
|---|---|
| PART III, LINE 3 | TRINITY IS REPORTING $0 ON LINE 3 BECAUSE THE ORGANIZATION DOES NOT HAVE A RELIABLE ESTIMATE OF THE PORTION OF BAD DEBT EXPENSE ATTRIBUTABLE TO INDIVIDUALS WHO WOULD QUALIFY FOR FINANCIAL ASSISTANCE BUT DID NOT COMPLETE AN APPLICATION |
| PART III, LINE 4 | SEE THE "PATIENT AND RESIDENT ACCOUNTS RECEIVABLE, NET NOTE ON PAGE 9 OF THE ATTACHED FINANCIAL STATEMENTS |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
|---|---|
| PART III, LINE 8 | THE MEDICARE ALLOWABLE COSTS REPORTED ON PART III, LINE 6 WAS DERIVED USING TRINITY HOSPITALS AND KENMARE'S 2018 MEDICARE COST REPORTS |
| PART III, LINE 9B | IT IS THE POLICY OF TRINITY TO PROVIDE MEDICAL SERVICES TO THE COMMUNITY AND REGION REGARDLESS OF THE CUSTOMER'S ABILITY TO PAY THROUGH CONSISTENT BILLING PRACTICES ACCOUNTS WILL BE MONITORED TO ENSURE THAT CUSTOMERS ARE BILLED FOR ONLY THOSE SERVICES PROVIDED TRINITY, THROUGH VERIFICATION OF INFORMATION, IS REQUIRED TO PROVIDE TIMELY AND ACCURATE BILLING, COLLECTION, AND PATIENT ACCOUNT MAINTENANCE INFORMATION REGARDING TRINITY'S BILLING AND PAYMENT GUIDELINES, WHICH INCLUDES FINANCIAL ASSISTANCE PROGRAMS, ARE AVAILABLE AT REGISTRATION AND BUSINESS SERVICES LOCATIONS THIS INFORMATION IS COMMUNICATED VERBALLY OR THROUGH THE USE OF THE TRINITY BILLING & PAYMENT GUIDELINES BROCHURE TO ENHANCE VERBAL COMMUNICATIONS, INTERPRETERS ARE PROVIDED AS NECESSARY |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
|---|---|
| PART VI, LINE 2 | TRINITY HEALTH COMPLETES A THOROUGH COMMUNITY HEALTH NEEDS ASSESSMENT EVERY THREE YEARS, IN COMPLIANCE WITH SECTION 501(R) TRINITY'S FIRST COMMUNITY HEALTH NEEDS ASSESSMENT WAS COMPLETED DURING THE YEAR ENDED JUNE 30, 2013 AND SECOND WAS COMPLETED DURING THE YEAR ENDED JUNE 30, 2016 THE COMMUNITY HEALTH NEEDS ASSESSMENT REPORT FOR BOTH YEARS IS AVAILABLE ONLINE AT HTTP //WWW TRINITYHEALTH ORG/COMMUNITY |
| PART VI, LINE 3 | TRINITY HEALTH'S HOSPITALS WIDELY PUBLICIZE FINANCIAL ASSISTANCE INFORMATION IN ALL OF THE METHODS REQUIRED UNDER SECTION 501(R) AND RELATED REGULATIONS EXAMPLES INCLUDE INFORMATION ON BILLING STATEMENTS, INFORMATION POSTED IN ADMISSIONS AREAS AND EMERGENCY ROOMS, AND INFORMATION PROVIDED AT ADMISSION IN ADDITION, PATIENT ACCESS AND BUSINESS OFFICE STAFF ATTEMPT TO IDENTIFY ALL CASES THAT WILL QUALIFY FOR FINANCIAL ASSISTANCE AT THE TIME OF ADMISSION PATIENTS IDENTIFIED AS POSSIBLE FINANCIAL ASSISTANCE CASES ARE ASKED TO COMPLETE A FINANCIAL ASSISTANCE FORM AND ARE REFERRED TO THE APPROPRIATE COUNSELOR |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
|---|---|
| PART VI, LINE 4 | ALTHOUGH TRINITY HOSPITAL AND TRINITY HOSPITAL - ST JOSEPH'S ARE LOCATED IN MINOT, NORTH DAKOTA, WE HAVE HISTORICALLY DEFINED OUR "COMMUNITY" AS A BROADER AREA THAT INCLUDES NORTHWESTERN NORTH DAKOTA AS WELL AS A PORTION OF NORTHEASTERN MONTANA WITHIN THIS BROADER COMMUNITY, APPROXIMATELY TWO-THIRDS OF OUR INPATIENTS AND OUTPATIENTS RESIDE WITHIN IN AND IMMEDIATELY AROUND THE CITY OF MINOT AND WARD COUNTY UNDERSTANDING OUR COMMUNITY REQUIRES AN UNDERSTANDING OF NORTH DAKOTA'S OIL RESERVES UNDERLYING NORTHWESTERN NORTH DAKOTA IS A MASSIVE ROCK FORMATION, REFERRED TO AS THE BAKKEN SHALE, WHICH HOLDS AN ESTIMATED 18 BILLION BARRELS OF CRUDE OIL WHEN THIS RESOURCE WAS FIRST DISCOVERED IN 1951, RECOVERING IT WAS FINANCIALLY UNFEASIBLE BECAUSE THE OIL WAS EMBEDDED IN THE STONE THEN, AROUND 2008, EVERYTHING CHANGED NEW DRILLING TECHNOLOGY CALLED HYDRAULIC FRACTURING, OR 'FRACKING', BECAME WIDESPREAD, AND OIL PRODUCTION TOOK OFF AS OF 2013, THERE ARE MORE THAN 200 ACTIVE OIL RIGS IN NORTH DAKOTA, PRODUCING ABOUT 20 MILLION BARRELS OF OIL EVERY MONTH THE RIGS AND SUPPORT SYSTEMS HAVE RESCULPTED THE LANDSCAPE, MILLIONS OF DOLLARS HAVE BEEN INVESTED ON INFRASTRUCTURE UPGRADES ACROSS THE AREA AS THE PRICE OF OIL PEAKED IN 2015, THEN DROPPED, ALONG WITH SIGNIFICANT OUTFLOWS OF OIL FIELD WORKERS, THE PRICE HASA STABILIZED AND LEASES ARE NEARING RENEWAL, OIL FIELD WORKERS ARE NOW INFLOWING ONCE AGAIN MAJOR OIL COMPANIES ARE ON THE REHIRE TRACE ONCE AGAIN (FOR APPROXIMATELY 800 WORKERS) ALTHOUGH MUCH OF THE OIL FIELD ACTIVITY OCCURS TO THE WEST OF MINOT, OUR COMMUNITY HAS BEEN SIGNIFICANTLY IMPACTED BY THE FLUCTUATION OF PEOPLE INTO AND OUT OF OUR COMMUNITY DEMAND FOR ALMOST EVERY GOOD, FROM HOUSING TO CLOTHING TO FOOD, TO HUMAN CAPITAL HAS FLUCTUATED, AND OUR COMMUNITY HAS STRUGGLED WITH THESE FLUCTUATIONS |
| PART VI, LINE 5 | IN FURTHERANCE OF ITS CHARITABLE PURPOSE, TRINITY PROVIDES A WIDE VARIETY OF BENEFITS TO THE COMMUNITY, INCLUDING OFFERING VARIOUS COMMUNITY-BASED SERVICE PROGRAMS SUCH AS FREE CLINICS, HEALTH SCREENINGS, IN-HOME CAREGIVER SERVICES, SOCIAL SERVICE AND SUPPORT COUNSELING FOR PATIENTS AND FAMILIES, PASTORAL CARE, CRISIS INTERVENTION, TRANSPORTATION TO AND FROM THE HOSPITAL CAMPUSES, AND THE DONATION OF SPACE FOR USE BY COMMUNITY GROUPS ADDITIONALLY, A LARGE NUMBER OF HEALTH-RELATED EDUCATIONAL PROGRAMS ARE PROVIDED FOR THE BENEFIT OF THE COMMUNITY, INCLUDING HEALTH ENHANCEMENTS AND WELLNESS, CLASSES ON SPECIFIC CONDITIONS, TELEPHONE INFORMATION SERVICES, AND COSTS RELATED TO PROGRAMS DESIGNED TO IMPROVE THE GENERAL STANDARDS OF THE HEALTH OF THE COMMUNITY |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
|---|---|
| PART VI, LINE 6 | THIS FORM 990 INCLUDES TRINITY HOSPITAL, TRINITY HOSPITAL-ST JOSEPH'S, AND TRINITY KENMARE HOSPITAL THESE THREE HOSPITALS ARE PART OF TRINITY HEALTH SYSTEM TRINITY HEALTH IS THE PARENT ORGANIZATION THE SYSTEM ALSO INCLUDES TRINITY HEALTH FOUNDATION, TRINITY HOMES, AND COMMUNITY AMBULANCE SERVICE OF MINOT, ALL OF WHICH ARE TAX-EXEMPT 501(C)(3) ORGANIZATIONS, AS WELL AS MEDICAL ARTS OUTPATIENT SERVICES INC AND B&B DRUG INC , BOTH OF WHICH ARE FOR-PROFIT C CORPORATIONS |
| PART VI, LINE 7, REPORTS FILED WITH STATES | ND |

# Additional Data

**Software ID:**
**Software Version:**
**EIN:** 33-1007002
**Name:** TRINITY HEALTH & AFFILIATES

**Form 990 Schedule H, Part V Section A. Hospital Facilities**

| **Section A. Hospital Facilities**<br><br>(list in order of size from largest to smallest—see instructions)<br>How many hospital facilities did the organization operate during the tax year?<br>**3**<br><br>Name, address, primary website address, and state license number | | Licensed hospital | General medical & surgical | Children's hospital | Teaching hospital | Critical access hospital | Research facility | ER-24 hours | ER-other | **Other (Describe)** | **Facility reporting group** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | TRINITY HOSPITAL<br>ONE BURDICK EXPRESSWAY WEST<br>MINOT, ND 58701<br>WWW TRINITYHEALTH ORG<br>5055 | X | X | | X | | | X | | | |
| 2 | TRINITY HOSPITAL-ST JOSEPH'S<br>407 3RD STREET SE<br>MINOT, ND 58701<br>WWW TRINITYHEALTH ORG<br>5036 | X | X | | | | | | | | |
| 3 | TRINITY KENMARE HOSPITAL<br>PO BOX 697<br>KENMARE, ND 587460697<br>WWW TRINITYHEALTH ORG<br>5028 | X | | | | X | | X | | | |

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

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

| Form and Line Reference | Explanation |
|---|---|
| TRINITY HOSPITAL | PART V, SECTION B, LINE 5 THE COMMUNITY HEALTH NEEDS ASSESSMENT ("CHNA") PROCESS PRIMARILY INVOLVED INTERVIEWS IN SPRING 2016 WITH VARIOUS COMMUNITY LEADERS, MEDICAL PROFESSIONALS, AND CITY AND COUNTY GOVERNMENT OFFICIALS PARTICIPANTS INCLUDED THE CITY OF MINOT, FIRST DISTRICT HEALTH UNIT, MINOT AIR FORCE BASE, MINOT COMMISSION ON AGING, MINOT PUBLIC SCHOOL DISTRICT, WARD COUNTY JAIL, WARD COUNTY SHERIFF'S DEPARTMENT, AND WARD COUNTY SOCIAL SERVICES |

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

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

| Form and Line Reference | Explanation |
|---|---|
| TRINITY HOSPITAL ST JOSEPH'S | PART V, SECTION B, LINE 5 THE COMMUNITY HEALTH NEEDS ASSESSMENT ("CHNA") PROCESS PRIMARILY INVOLVED INTERVIEWS IN SPRING 2016 WITH VARIOUS COMMUNITY LEADERS, MEDICAL PROFESSIONALS, AND CITY AND COUNTY GOVERNMENT OFFICIALS PARTICIPANTS INCLUDED THE CITY OF MINOT, FIRST DISTRICT HEALTH UNIT, MINOT AIR FORCE BASE, MINOT COMMISSION ON AGING, MINOT PUBLIC SCHOOL DISTRICT, WARD COUNTY JAIL, WARD COUNTY SHERIFF'S DEPARTMENT, AND WARD COUNTY SOCIAL SERVICES |

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

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

| Form and Line Reference | Explanation |
|---|---|
| TRINITY KENMARE HOSPITAL | PART V, SECTION B, LINE 5 THE COMMUNITY HEALTH NEEDS ASSESSMENT ("CHNA") PROCESS PRIMARILY INVOLVED INTERVIEWS IN SPRING 2016 WITH VARIOUS COMMUNITY LEADERS, MEDICAL PROFESSIONALS, AND CITY AND COUNTY GOVERNMENT OFFICIALS PARTICIPANTS INCLUDED THE CITY OF KENMARE, FIRST DISTRICT HEALTH UNIT, MINOT COMMISSION ON AGING, AND WARD COUNTY SOCIAL SERVICES |

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

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

| Form and Line Reference | Explanation |
|---|---|
| TRINITY HOSPITAL | PART V, SECTION B, LINE 6A TRINITY HOSPITAL CONDUCTED ITS CHNA IN COLLABORATION WITH TRINITY HOSPITAL-ST JOSEPH'S AND TRINITY KENMARE HOSPITAL BECAUSE OF THEIR IDENTICAL COMMUNITIES AND RELATIONSHIP WITHIN TRINITY HEALTH, TRINITY HOSPITAL AND TRINITY HOSPITAL-ST JOSEPH'S PRODUCED A JOINT COMMUNITY HEALTH NEEDS ASSESSMENT REPORT |

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

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

| Form and Line Reference | Explanation |
|---|---|
| TRINITY HOSPITAL ST JOSEPH'S | PART V, SECTION B, LINE 6A TRINITY HOSPITAL-ST JOSEPH'S CONDUCTED ITS CHNA IN COLLABORATION WITH TRINITY HOSPITAL AND TRINITY KENMARE HOSPITAL BECAUSE OF THEIR IDENTICAL COMMUNITIES AND RELATIONSHIP WITHIN TRINITY HEALTH, TRINITY HOSPITAL AND TRINITY HOSPITAL-ST JOSEPH'S PRODUCED A JOINT COMMUNITY HEALTH NEEDS ASSESSMENT REPORT |

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

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

| Form and Line Reference | Explanation |
|---|---|
| TRINITY KENMARE HOSPITAL | PART V, SECTION B, LINE 6A TRINITY KENMARE HOSPITAL CONDUCTED ITS CHNA IN COLLABORATION WITH TRINITY HOSPITAL AND TRINITY HOSPITAL-ST JOSEPH'S |

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

| Form and Line Reference | Explanation |
|---|---|
| TRINITY HOSPITAL | PART V, SECTION B, LINE 11 IN THE MOST RECENTLY CONDUCTED COMMUNITY HEALTH NEEDS ASSESSME NT, TRINITY HOSPITAL IDENTIFIED THE FOLLOWING SIGNIFICANT NEEDS ACCESS, SUBSTANCE ABUSE, MENTAL HEALTH, AND OBESITY IN A PREVIOUS COMMUNITY HEALTH NEEDS ASSESSMENT, ILLNESS AND D ISEASE WAS ALSO IDENTIFIED AS A SIGNIFICANT HEALTH NEED DURING THE YEAR ENDED 6/30/2016, TRINITY HOSPITAL TOOK THE FOLLOWING ACTIONS TO ADDRESS THOSE NEEDS ADDITIONALLY, THROUGH FY 2018, TRINITY HEALTH CONTINUED THESE EFFORTS AND STRATEGIES TO IMPROVE ON EACH TARGETED AREA ACCESSAS IT WAS WITH MOST PROVIDERS ACROSS ND, ACCESS TO SERVICES WAS SIGNIFICANTLY IMPACTED BY WORKFORCE SHORTAGES TRINITY HEALTH RESPONDED TO SHORTAGES IN ITS WORKFORCE BY SUCCESSFULLY RECRUITING SEVERAL PROVIDERS TO ITS MEDICAL STAFF, ADDING ALLIED HEALTH PROV IDERS TO AUGMENT PHYSICIAN ACCESS TRINITY HEALTH ALSO DEPLOYED STRATEGIES TO IMPROVE INFO RMATION AVAILABLE TO CONSUMERS BY DEVELOPING A ROBUST MOBILE DEVICES APPLICATION, LAUNCHIN G AN ELECTRONIC PATIENT PORTAL FEATURING SECURE MESSAGING AND APPOINTMENT REQUESTS WITH PR OVIDERS, AND ENHANCING ITS PHYSICIAN REFERRAL SERVICE TRINITY HEALTH CONTINUED TO AGGRESSI VELY RECRUIT MEDICAL PROVIDERS IN BOTH PRIMARY AND SPECIALTY CARE THIS EFFORT TO IMPROVE ACCESS RESULTED IN NEW PROVIDERS TO OUR PHYSICIAN NETWORK, INCLUDING MENTAL HEALTH PROVIDE RS IN WILLISTON AND MINOT IN 2018, TRINITY HEALTH LAUNCHED ITS FIRSTCARE WALK-IN CLINIC I N DOWNTOWN MINOT THIS WALK-IN CLINIC OFFERS EXPANDED HOURS, INCLUDING EVENING, HOLIDAY AN D WEEKEND HOURS, AND ITS PROVIDERS SEE ALL PATIENT AGES TO MANAGE CONSUMERS' EXPECTATIONS ABOUT WAITING TIMES AT THE WALK-IN CLINIC, TRINITY HEALTH INCLUDES AN ESTIMATED WAIT-TIME ON ITS INTERNET WEBSITE AND MOBILE DEVICE APPLICATION TO HELP PATIENTS FIND THE SERVICES AND PROVIDERS THEY NEED, TRINITY HEALTH BEGAN DEVELOPMENT ON A NEW USER-FRIENDLY WEBSITE BY AUDITING THE EXISTING SITE, RESEARCHING BEST PRACTICES, SURVEYING USERS, AND LISTENING TO FEEDBACK THE STRATEGY FOCUSED ON PUTTING CONSUMERS FIRST TO MEET THEIR NEEDS AND SIMPL IFY THEIR ACTIONS FROM ANY DEVICE THEY USE TO CONNECT WITH TRINITY HEALTH SUBSTANCE ABUSE "BATTLING DRUG AND ALCOHOL ABUSE" WAS A COMMUNITY EDUCATION ACTIVITY TRINITY HEALTH PROVI DED IN THE REGION, AND THIS PRESENTATION WAS GIVEN IN AREA SCHOOLS PROVIDERS ALSO VISITED AREA HIGH SCHOOL CLASSES TO PRESENT INFORMATION ABOUT SUBSTANCE ABUSE AND THE TRAGIC CONS EQUENCES THAT COMMONLY OCCUR, BASED ON THEIR EXPERIENCES IN THE LOCAL EMERGENCY ROOM MENT AL HEALTHMANY PEOPLE WHO ARE AFFECTED BY SUBSTANCE ABUSE SUFFER FROM UNDERLYING MENTAL HEA LTH ISSUES AS WELL TRINITY HEALTH HAS EXPANDED ITS OUTREACH FOR MENTAL HEALTH SERVICES AN D IMPROVED ACCESS BY ADDING PROVIDERS, FOR EXAMPLE, WE ADDED RESOURCES IN MINOT AND WILLIS TON TO HELP ADDRESS A GROWING NEED FOR ACCESS SUBSTANCE ABUSE AND MENTAL HEALTH CARE CANN OT BE ADDRESSED BY ANY ONE ORGANIZATION ALONE, AND TRINITY IS PARTNERING WITH OTHER AGENCI ES IN THE REGION IN AN EFFORT |

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

| Form and Line Reference | Explanation |
|---|---|
| TRINITY HOSPITAL | TO COORDINATE EFFORTS, WORK THROUGH BARRIERS, AND BETTER SERVE ITS COMMUNITY MEMBERS OF T RINITY HEALTH'S TEAM SUPPORTED EFFORTS IN THE COMMUNITY TO BETTER UNDERSTAND THE SCOPE OF OPIOID ABUSE IN OUR COMMUNITY AND HELPED TO DESIGN APPROACHES AIMED AT REDUCING THE RISKS LEADING TO ABUSE AND IMPROVING TREATMENT AWARENESS IN THE COMMUNITY PARENTING EDUCATION W AS A TOPIC PRESENTED TO THE PUBLIC LAST YEAR, HELPING PARENTS NAVIGATE SOME OF THE MORE DI FFICULT SITUATIONS THEY FACE IN RAISING CHILDREN TODAY AT-RISK HOUSEHOLDS, TYPICALLY REFE RRED BY AREA SCHOOLS AND COURTS, WERE AMONG ITS TARGETED AUDIENCES TRINITY HEALTH PARTICIP ATED IN AN OUTREACH EFFORT IN PARTNERSHIP WITH AREA AGENCIES, INCLUDING COURT AND LAW ENFO RCEMENT OFFICIALS, TO IMPROVE COMMUNICATION AND AWARENESS OF MENTAL HEALTH ISSUES RELATED TO ACCESS, PROCEDURES, AND MORE TRINITY HEALTH PROVIDES NEWLY REMODELED SPACE IN THE HOSPI TAL TO ACCOMMODATE A REGIONAL SANE (SEXUAL ASSAULT NURSE EXAMINERS) PROGRAM, WHERE SPECIAL LY TRAINED NURSES INTERVIEW AND ADVOCATE FOR SEXUAL ASSAULT VICTIMS THESE VICTIMS ARE NOW TREATED AND INTERVIEWED IN A MORE COMFORTABLE AND PRIVATE ENVIRONMENT OBESITYOUR FOCUS C ONTINUES TO BE ON CHILDREN, AND HOW TO HELP KIDS DEVELOP HEALTHY HABITS REGARDING NUTRITIO N AND EXERCISE FOR EXAMPLE, TRINITY HEALTH SPONSORED A PROGRAM AT THE WEE LINKS GOLF COUR SE TO ENCOURAGE AND INCENTIVIZE KIDS TO EXERCISE THROUGH ACTIVITY, IN THIS CASE, GOLF TRI NITY HEALTH USES NUTRITIONISTS AND OTHER HEALTHCARE PROFESSIONALS TO VISIT WITH THE KIDS A ND THEIR PARENTS ABOUT AVOIDING OBESITY THROUGH HEALTHY LIFESTYLE CHOICES TRINITY HEALTH ALSO SPONSORED ACTIVITIES TO COMBAT OBESITY FOR EXAMPLE, OUR DIETICIANS LEAD AN ONGOING " GROCERY STORE TOUR" FOR ANYONE IN THE COMMUNITY TO JOIN AND LEARN HOW TO SHOP FOR BETTER H EALTH, AS WELL AS A COOKING CLASSES FOR PEOPLE TO LEARN HOW TO COOK IN HEALTHIER WAYS THI S EFFORT WAS ENHANCED THIS YEAR THROUGH THE PURCHASE OF A "PORTABLE KITCHEN" TO HELP DEMON STRATE THE TECHNIQUES BEING TAUGHT TRINITY HEALTH PROMOTES WELLNESS THROUGH A NATIONALLY- KNOWN PROGRAM, FRANCHISING ITS OWN CROSSFIT PROGRAM LED BY ONE OF OUR PHYSICIANS, THE THE ME OF "EXERCISE IS MEDICINE" WAS PROMOTED TO THE COMMUNITY, COMPLETE WITH A PUBLIC INVITAT ION TO WALK AT A LOCAL PARK THROUGH THE WARM SEASON FEATURING A "DOC WALK," WHERE HEALTHCA RE PROFESSIONALS LED THE COMMUNITY WALK EFFORT ILLNESS AND DISEASETRINITY HEALTH ADDED A NUMBER OF ACTIVITIES AIMED AT IMPROVING HEART HEALTH AWARENESS THROUGH ITS HEALTHY HEARTS PROGRAM, TO PROVIDE A MECHANISM FOR COMMUNITY EDUCATION AND ACTIVITIES TO SUPPORT HEART HE ALTH IN AN EFFORT TO ENHANCE AWARENESS OF THE SIGNS AND SYMPTOMS OF STROKE, TRINITY HEALTH CONTINUED ITS STROKE AWARENESS CAMPAIGN, WHICH INCLUDED SOCIAL MEDIA, SIGNS AND BANNERS, PAID ADVERTISING, AND MEDIA RELEASES ABOUT STROKE STORIES AND TREATMENT THE GOAL OF THE C AMPAIGN IS TO MAKE THE PUBLIC AWARE OF THE ACRONYM, FAST, TO ENCOURAGE INTERVENTION WHEN S OMEONE RECOGNIZES A POTENTIAL |

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

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

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| TRINITY HOSPITAL | PART V, SECTION B, LINE 13H OTHER CRITERIA USED BY TRINITY HOSPITAL TO DETERMINE ELIGIBILITY UNDER THEIR FAP 1 ELIGIBILITY FOR MEDICARE OR MEDICAID IS ALSO CONSIDERED IN DETERMINING ELIGIBILITY FOR FINANCIAL ASSISTANCE 2 TRINITY HOSPITAL MAY PRESUMPTIVELY DETERMINE AN INDIVIDUAL'S ELIGIBILITY FOR CHARITY CARE UNDER THIS POLICY WITHOUT A COMPLETED APPLICATION IF THE HOSPITAL IS ABLE TO VERFIY INCOME FROM A RELIABLE THIRD PARTY, I E SOCIAL SECURITY, MEDICAID, ETC |

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

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

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

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

| | Name and address | Type of Facility (describe) |
|---|---|---|
| **1** | 1 - TRINITY HOMES<br>305 8TH AVENUE NE<br>MINOT, ND 58701 | SKILLED NURSING HOME |
| **1** | 2 - TRINITY HOSPITALS HOME HEALTHHOSPICE<br>1015 SOUTH BROADWAY SUITE 306<br>MINOT, ND 58701 | HOME HEALTH & HOSPICE |
| **2** | 3 - TRINITY HOSPITALS<br>HOSPITAL ROAD<br>BELCOURT, ND 58316 | DIALYSIS SERVICES |
| **3** | 4 - TCC-BELCOURT (KDU)<br>1310 HOSPITAL LOOP ROAD<br>BELCOURT, ND 58316 | DIALYSIS SERVICES |
| **4** | 5 - ORAL & FACIAL SURGERY CENTER-PLAZA 16<br>2815 16TH STREET SW<br>MINOT, ND 58702 | ORAL & FACIAL SURGICAL SERVICES |
| **5** | 6 - ORAL & FACIAL SURGERY CENTER-WILLISTON<br>2224 1ST AVE W<br>WILLISTON, ND 58801 | ORAL & FACIAL SURGICAL SERVICES |
| **6** | 7 - TRINITY REGIONAL EYECARE-WILLISTON<br>1321 W DAKOTA PARKWAY<br>WILLISTON, ND 55801 | EYE HEALTH SERVICES |
| **7** | 8 - TRINITY REGIONAL EYECARE-DEVIL'S LAKE<br>404 HWY 2 EAST<br>DEVILS LAKE, ND 58301 | EYE HEALTH SERVICES |
| **8** | 9 - VISION GALLERIA AT TRINITY - PLAZA 16<br>2815 16TH STREET SW<br>MINOT, ND 58702 | OPTICAL AND CONTACT LENS DISPENSARY |
| **9** | 10 - SAME DAY SURGERY CENTER<br>407 3RD ST SE<br>MINOT, ND 58701 | SURGICAL SERVICES |
| **10** | 11 - WESTERN DAKOTA SURGERY<br>1102 MAIN ST<br>WILLISTON, ND 58801 | SURGICAL SERVICES |
| **11** | 12 - TRINITY HEALTH CENTER-MEDICAL ARTS<br>400 BURDICK EXPRESSWAY EAST<br>MINOT, ND 58701 | PROVIDER-BASED CLINIC |
| **12** | 13 - TRINITY HEALTH CENTER-EAST<br>20 BURDICK EXPRESSWAY WEST<br>MINOT, ND 58701 | PROVIDER-BASED CLINIC |
| **13** | 14 - TRINITY HEALTH CENTER-WEST<br>101 3RD AVENUE SW<br>MINOT, ND 58701 | PROVIDER-BASED CLINIC |
| **14** | 15 - TRINITY REGIONAL EYECARE-MINOT CENTER<br>120 BURDICK EXPRESSWAY EAST<br>MINOT, ND 58701 | PROVIDER-BASED CLINIC |

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

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

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

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

| | Name and address | Type of Facility (describe) |
|---|---|---|
| **16** | 16 - TRINITY HEALTH CENTER-RIVERSIDE<br>1900 8TH AVENUE SE<br>MINOT, ND 58701 | PROVIDER-BASED CLINIC |
| **1** | 17 - TRINITY HEALTH CENTER-TOWN & COUNTRY<br>831 SOUTH BROADWAY<br>MINOT, ND 58701 | PROVIDER-BASED CLINIC |
| **2** | 18 - MAIN MEDICAL BUILDING<br>315 SOUTH MAIN<br>MINOT, ND 58701 | PROVIDER-BASED CLINIC |
| **3** | 19 - TRINITY HEALTH SOUTH RIDGE<br>1500 24TH AVENUE SW<br>MINOT, ND 58701 | PROVIDER-BASED CLINIC |
| **4** | 20 - TCC-WESTERN DAKOTA<br>1321 WEST DAKOTA PARKWAY<br>WILLISTON, ND 58801 | PROVIDER-BASED CLINIC |
| **5** | 21 - TRINITY HEALTH CENTER-3RD STREET<br>420 3RD ST SE<br>MINOT, ND 58701 | PROVIDER-BASED CLINIC |
| **6** | 22 - TRINITY HEALTH CENTER-5TH AVENUE<br>307 5TH AVE SE<br>MINOT, ND 58701 | PROVIDER-BASED CLINIC |
| **7** | 23 - TRINITY COMMUNITY CLINIC KENMARE<br>307 1ST AVENUE NW<br>KENMARE, ND 58746 | RURAL HEALTH CLINIC |
| **8** | 24 - TCC-GARRISON<br>PO BOX 1179<br>GARRISION, ND 585401179 | RURAL HEALTH CLINIC |
| **9** | 25 - TCC-MOHALL<br>504 1ST ST SW<br>MOHALL, ND 58760 | RURAL HEALTH CLINIC |
| **10** | 26 - TCC-NEW TOWN<br>PO BOX 1029<br>NEW TOWN, ND 587631029 | RURAL HEALTH CLINIC |
| **11** | 27 - TCC-VELVA<br>PO BOX 70<br>VELVA, ND 587900070 | RURAL HEALTH CLINIC |
| **12** | 28 - TCC-WESTHOPE<br>PO BOX 383<br>WESTHOPE, ND 587930383 | RURAL HEALTH CLINIC |
| **13** | 29 - COMMUNITY AMBULANCE SERVICE OF MINOT<br>PO BOX 2195<br>MINOT, ND 58702 | AMBULANCE SERVICES |

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**Schedule I (Form 990)**

Department of the Treasury
Internal Revenue Service

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

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

▶ **Attach to Form 990.**

▶ **Information about Schedule I (Form 990) and its instructions is at *www.irs.gov/form990*.**

OMB No 1545-0047

**2017**

**Open to Public Inspection**

Name of the organization
TRINITY HEALTH & AFFILIATES

**Employer identification number**
33-1007002

## Part I General Information on Grants and Assistance

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

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

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

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

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

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

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

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

| (a) Type of grant or assistance | (b) Number of recipients | (c) Amount of cash grant | (d) Amount of noncash assistance | (e) Method of valuation (book, FMV, appraisal, other) | (f) Description of noncash assistance |
|---|---|---|---|---|---|
| (1) HARDSHIP ASSISTANCE | 31 | 71,317 | | | |
| (2) CANCER ASSISTANCE | 102 | 113,589 | | | |
| (2) | | | | | |
| (3) | | | | | |
| (4) | | | | | |
| (5) | | | | | |
| (6) | | | | | |
| (7) | | | | | |

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

| Return Reference | Explanation |
|---|---|
| PART I, LINE 2 | TRINITY HEALTH & AFFILIATES DOES NOT HAVE A PROCEDURE FOR MONITORING USE OF GRANT FUNDS |

# Additional Data

**Software ID:**
**Software Version:**
**EIN:** 33-1007002
**Name:** TRINITY HEALTH & AFFILIATES

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

| **(a)** Name and address of organization or government | **(b)** EIN | **(c)** IRC section if applicable | **(d)** Amount of cash grant | **(e)** Amount of non-cash assistance | **(f)** Method of valuation (book, FMV, appraisal, other) | **(g)** Description of non-cash assistance | **(h)** Purpose of grant or assistance |
|---|---|---|---|---|---|---|---|
| MINOT FAMILY YMCA<br>3515 16TH ST SW<br>MINOT, ND 58701 | 45-0237612 | 501(C)(3) | 100,000 | | | | SUPPORT OPERATIONS |
| MINOT POLICE DEPARTMENT<br>515 2ND AVE SW<br>MINOT, ND 58701 | 45-0353644 | MINOT POLICE DEPT | 7,000 | | | | SUPPORT K-9 PROGRAM |

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

| **(a)** Name and address of organization or government | **(b)** EIN | **(c)** IRC section if applicable | **(d)** Amount of cash grant | **(e)** Amount of non-cash assistance | **(f)** Method of valuation (book, FMV, appraisal, other) | **(g)** Description of non-cash assistance | **(h)** Purpose of grant or assistance |
|---|---|---|---|---|---|---|---|
| NORTH DAKOTA STATE FAIR<br>PO BOX 1796<br>MINOT, ND 58702 | 45-0215346 | 501(C)(3) | 18,000 | | | | SUPPORT OPERATIONS |

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# Schedule J (Form 990)

Department of the Treasury
Internal Revenue Service

## Compensation Information

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

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

▶ **Attach to Form 990.**

▶ **Information about Schedule J (Form 990) and its instructions is at *www.irs.gov/form990*.**

OMB No 1545-0047

**2017**

**Open to Public Inspection**

Name of the organization
TRINITY HEALTH & AFFILIATES

**Employer identification number**
33-1007002

## Part I Questions Regarding Compensation

| | | | Yes | No |
|---|---|---|---|---|
| **1a** | Check the appropiate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a Complete Part III to provide any relevant information regarding these items | | | |
| | ☐ First-class or charter travel | ☐ Housing allowance or residence for personal use | | |
| | ☐ Travel for companions | ☐ Payments for business use of personal residence | | |
| | ☐ Tax idemnification and gross-up payments | ☐ Health or social club dues or initiation fees | | |
| | ☐ Discretionary spending account | ☐ Personal services (e g , maid, chauffeur, chef) | | |
| **b** | If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain | **1b** | | |
| **2** | Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a? | **2** | | |
| **3** | Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director Check all that apply Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III | | | |
| | ☐ Compensation committee | ☐ Written employment contract | | |
| | ☐ Independent compensation consultant | ☐ Compensation survey or study | | |
| | ☐ Form 990 of other organizations | ☐ Approval by the board or compensation committee | | |
| **4** | During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization | | | |
| **a** | Receive a severance payment or change-of-control payment? | **4a** | | No |
| **b** | Participate in, or receive payment from, a supplemental nonqualified retirement plan? | **4b** | | No |
| **c** | Participate in, or receive payment from, an equity-based compensation arrangement? | **4c** | | No |
| | If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III | | | |
| | **Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.** | | | |
| **5** | For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of | | | |
| **a** | The organization? | **5a** | Yes | |
| **b** | Any related organization? | **5b** | Yes | |
| | If "Yes," on line 5a or 5b, describe in Part III | | | |
| **6** | For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of | | | |
| **a** | The organization? | **6a** | | No |
| **b** | Any related organization? | **6b** | | No |
| | If "Yes," on line 6a or 6b, describe in Part III | | | |
| **7** | For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III | **7** | | No |
| **8** | Were any amounts reported on Form 990, Part VII, paid or accured pursuant to a contract that was subject to the initial contract exception described in Regulations section 53 4958-4(a)(3)? If "Yes," describe in Part III | **8** | | No |
| **9** | If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53 4958-6(c)? | **9** | | |

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

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

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

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

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

| Return Reference | Explanation |
|---|---|
| PART I, LINE 3 | JOHN KUTCH, PRESIDENT & CEO, IS COMPENSATED BY TRINITY HEALTH, A RELATED ORGANIZATION TRINITY HEALTH USES THE FOLLOWING METHODS TO DETERMINE THE COMPENSATION FOR JOHN 1 COMPENSATION COMMITTEE 2 INDEPENDENT COMPENSATION CONSULTANT 3 FORM 990 OF OTHER ORGANIZATIONS 4 COMPENSATION SURVEY OR STUDY 5 APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE |
| PART I, LINE 5 | PHYSICIANS RECEIVE INCENTIVE COMPENSATION FROM TRINITY HEALTH, A RELATED ORGANIZATION, BASED ON MULTIPLE FACTORS INCLUDING THE NUMBER OF PATIENTS SERVED AND RELATIVE VALUE UNITS (RVUS), WHICH IS CLOSELY CONNECTED TO REVENUES |

# Additional Data

**Software ID:**

**Software Version:**

**EIN:** 33-1007002

**Name:** TRINITY HEALTH & AFFILIATES

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

| (A) Name and Title | | (B) Breakdown of W-2 and/or 1099-MISC compensation | | | (C) Retirement and other deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation in column (B) reported as deferred on prior Form 990 |
|---|---|---|---|---|---|---|---|---|
| | | (i) Base Compensation | (ii) Bonus & incentive compensation | (iii) Other reportable compensation | | | | |
| **1**SCOTT KNUTSON MD DIRECTOR | (I) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (II) | 541,454 | 40,000 | 0 | 4,050 | 18,433 | 603,937 | 0 |
| **1**MARTIN ROTHBERG MD DIRECTOR | (I) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (II) | 717,651 | 50,000 | 0 | 5,550 | 7,453 | 780,654 | 0 |
| **2**JOHN KUTCH PRESIDENT & CEO | (I) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (II) | 797,156 | 14,967 | 936 | 4,050 | 18,433 | 835,542 | 0 |
| **3**DENNIS EMPEY VICE PRESIDENT & CFO | (I) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (II) | 354,586 | 0 | 936 | 5,550 | 18,433 | 379,505 | 0 |
| **4**RANDY SCHWAN VICE PRES - MISSION INTEGRATION | (I) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (II) | 206,020 | 3,862 | 936 | 3,200 | 8,169 | 222,187 | 0 |
| **5**PAUL SIMONSON VICE PRES - HUMAN RESOURCES | (I) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (II) | 260,178 | 6,748 | 936 | 5,550 | 18,433 | 291,845 | 0 |
| **6**THOMAS WARSOCKI VICE PRES - PHYSICIAN OPERATIONS | (I) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (II) | 202,375 | 3,884 | 936 | 3,218 | 18,433 | 228,846 | 0 |
| **7**DAVE KOHLMAN VICE PRES - FACILITIES MANAGEMENT | (I) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (II) | 189,770 | 3,770 | 936 | 4,511 | 17,192 | 216,179 | 0 |
| **8**KAREN ZIMMERMAN RN VICE PRES & CNO | (I) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (II) | 171,824 | 0 | 936 | 4,169 | 1,241 | 178,170 | 0 |
| **9** TRENT CHASTAIN VICE PRES - REVENUE CYCLE (THROUGH MARCH 2018) | (I) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (II) | 170,051 | 0 | 936 | 204 | 18,433 | 189,624 | 0 |
| **10** RHONDA WALTER VICE PRES - VICE PRES - NCF ADMINISTRATOR | (I) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (II) | 174,978 | 0 | 936 | 4,266 | 18,433 | 198,613 | 0 |
| **11**PHILIP PATTERSON VICE PRES & CAO (THROUGH FEB 2018) | (I) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (II) | 251,845 | 0 | 0 | 3,750 | 7,453 | 263,048 | 0 |
| **12**GLEN TAYLOR WILSON VICE PRES - CLINICAL INTEGRATION | (I) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (II) | 264,719 | 0 | 936 | 5,489 | 6,929 | 278,073 | 0 |

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# Schedule K (Form 990)

Department of the Treasury
Internal Revenue Service

## Supplemental Information on Tax-Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990.
▶ Information about Schedule K (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

**2017**

Open to Public Inspection

Name of the organization
TRINITY HEALTH & AFFILIATES

Employer identification number
33-1007002

## Part I Bond Issues

| | (a) Issuer name | (b) Issuer EIN | (c) CUSIP # | (d) Date issued | (e) Issue price | (f) Description of purpose | (g) Defeased | | (h) On behalf of issuer | | (i) Pool financing | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Yes | No | Yes | No | Yes | No |
| A | WARD COUNTY NORTH DAKOTA | 45-6002248 | | 09-27-2017 | 56,875,000 | REFUND SERIES 2006 BONDS, HOSPITAL CONSTRUCTION | | X | | X | | X |
| B | WARD COUNTY NORTH DAKOTA | 45-6002248 | 394023EW8 | 12-28-2017 | 382,748,522 | HOSPITAL CONSTRUCTION | | X | | X | | X |

## Part II Proceeds

| | | A | B | C | D |
|---|---|---|---|---|---|
| 1 | Amount of bonds retired | 2,864,500 | | | |
| 2 | Amount of bonds legally defeased | | | | |
| 3 | Total proceeds of issue | 56,875,000 | 382,748,522 | | |
| 4 | Gross proceeds in reserve funds | | 24,842,000 | | |
| 5 | Capitalized interest from proceeds | | 29,339,094 | | |
| 6 | Proceeds in refunding escrows | | | | |
| 7 | Issuance costs from proceeds | 510,395 | 3,562,519 | | |
| 8 | Credit enhancement from proceeds | | | | |
| 9 | Working capital expenditures from proceeds | | | | |
| 10 | Capital expenditures from proceeds | 9,960,000 | 4,994,451 | | |
| 11 | Other spent proceeds | 46,404,605 | | | |
| 12 | Other unspent proceeds | | 377,754,070 | | |
| 13 | Year of substantial completion | 2019 | 2019 | | |

| | | A | | B | | C | | D | |
|---|---|---|---|---|---|---|---|---|---|
| | | Yes | No | Yes | No | Yes | No | Yes | No |
| 14 | Were the bonds issued as part of a current refunding issue? | X | | | X | | | | |
| 15 | Were the bonds issued as part of an advance refunding issue? | | X | | X | | | | |
| 16 | Has the final allocation of proceeds been made? | | X | | X | | | | |
| 17 | Does the organization maintain adequate books and records to support the final allocation of proceeds? | X | | X | | | | | |

## Part III Private Business Use

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

## Part III Private Business Use (Continued)

| | | A | | B | | C | | D | |
|---|---|---|---|---|---|---|---|---|---|
| | | Yes | No | Yes | No | Yes | No | Yes | No |
| 3a | Are there any management or service contracts that may result in private business use of bond-financed property? | | X | | X | | | | |
| b | If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property? | | | | | | | | |
| c | Are there any research agreements that may result in private business use of bond-financed property? | | X | | X | | | | |
| d | If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property? | | | | | | | | |
| 4 | Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶ | | | | 0 % | | | | |
| 5 | Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶ | | 0 630 % | | 0 % | | | | |
| 6 | Total of lines 4 and 5 | | 0 630 % | | 0 % | | | | |
| 7 | Does the bond issue meet the private security or payment test? | | X | | X | | | | |
| 8a | Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued? | | X | | X | | | | |
| b | If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of | | | | | | | | |
| c | If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1 141-12 and 1 145-2? | | | | | | | | |
| 9 | Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1 141-12 and 1 145-2? | X | | X | | | | | |

## Part IV Arbitrage

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

**Part IV Arbitrage** (Continued)

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

**Part V Procedures To Undertake Corrective Action**

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

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

| Return Reference | Explanation |
|---|---|
| DATE REBATE COMPUTATION PERFORMED | ISSUER NAME WARD COUNTY, NORTH DAKOTA DATE THE REBATE COMPUTATION WAS PERFORMED 06/01/2018 |

| Return Reference | Explanation |
| --- | --- |
| SCHEDULE K, PART IV, LINE 5, COLUMN B | CAPITALIZED INTEREST FUND WELLS FARGO SECURITIES, LLC, 2 0 YEARS, NO* PROJECT FUND BAYERISCHE LANDESBANK, 2 6 YEARS, YES PROJECT FUND NATIXIS FUNDING CORP, 2 6 YEARS, NO** DEBT SERVICE RESERVE FUND TD SECURITIES, 2 6 YEARS, YES DEBT SERVICE RESERVE FUND WELLS FARGO SECURITIES, LLC, 0 5 YEARS, YES *THE INVESTMENT IN THE CAPITALIZED INTEREST FUND DID NOT TECHNICALLY SATISFY THE SAFE HARBORS FOR GIC'S BECAUSE THE CONTRACT WAS AWARDD TO THE LOWEST BONA FIDE OFFER RATHER THAN TO THE HIGHEST YIELDING BONA FIDE OFFER **THE PROJECT FUND INVESTMENT WAS SPLIT BETWEEN TWO CONTRACTS WITH SEPARATE PROVIDERS TO ACHIEVE DIVERSIFICATION OF COUNTERPARTY EXPOSURE AS REQUIRED BY THE TERMS OF THE SOLICITATION, THE BID FROM BAYERISCHE LANDESBANK, AS THE WINNING BIDDER WITH RESPECT TO THE FIRST CONTRACT, WAS AUTOMATICALLY DISQUALIFIED WITH RESPECT TO THE SECOND CONTRACT |

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SCHEDULE M (Form 990)

Department of the Treasury
Internal Revenue Service

# Noncash Contributions

▶Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.
▶ Attach to Form 990.
▶Information about Schedule M (Form 990) and its instructions is at www.irs.gov/form990

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
TRINITY HEALTH & AFFILIATES

Employer identification number
33-1007002

## Part I Types of Property

| | (a) Check if applicable | (b) Number of contributions or items contributed | (c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g | (d) Method of determining noncash contribution amounts |
|---|---|---|---|---|
| 1 Art—Works of art | X | 2 | 2,625 | FMV |
| 2 Art—Historical treasures | | | | |
| 3 Art—Fractional interests | | | | |
| 4 Books and publications | X | | 510 | FMV |
| 5 Clothing and household goods | X | | 93,826 | FMV |
| 6 Cars and other vehicles | | | | |
| 7 Boats and planes | | | | |
| 8 Intellectual property | | | | |
| 9 Securities—Publicly traded | | | | |
| 10 Securities—Closely held stock | | | | |
| 11 Securities—Partnership, LLC, or trust interests | | | | |
| 12 Securities—Miscellaneous | | | | |
| 13 Qualified conservation contribution—Historic structures | | | | |
| 14 Qualified conservation contribution—Other | | | | |
| 15 Real estate—Residential | | | | |
| 16 Real estate—Commercial | | | | |
| 17 Real estate—Other | | | | |
| 18 Collectibles | | | | |
| 19 Food inventory | X | 4 | 704 | FMV |
| 20 Drugs and medical supplies | | | | |
| 21 Taxidermy | | | | |
| 22 Historical artifacts | | | | |
| 23 Scientific specimens | | | | |
| 24 Archeological artifacts | | | | |
| 25 Other ▶ ( GIFT CARDS ) | X | 56 | 10,866 | FMV |
| 26 Other ▶ ( MINERAL RIGHTS ) | X | 1 | 10,421 | FMV |
| 27 Other ▶ ( EQUIPMENT ) | X | 1 | 1,200 | FMV |
| 28 Other ▶ ( _____ ) | | | | |

29 Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement — 29: 0

| | | Yes | No |
|---|---|---|---|
| 30a | During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 28, that it must hold for at least three years from the date of the initial contribution, and which is not required to be used for exempt purposes for the entire holding period? | | No |
| b | If "Yes," describe the arrangement in Part II | | |
| 31 | Does the organization have a gift acceptance policy that requires the review of any nonstandard contributions? | | No |
| 32a | Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions? | | No |
| b | If "Yes," describe in Part II | | |
| 33 | If the organization did not report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II | | |

**Part II** **Supplemental Information.**

Provide the information required by Part I, lines 30b, 32b, and 33, and whether the organization is reporting in Part I, column (b), the number of contributions, the number of items received, or a combination of both. Also complete this part for any additional information.

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

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

Department of the Treasury
Internal Revenue Service

# Supplemental Information to Form 990 or 990-EZ

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

Name of the organization
TRINITY HEALTH & AFFILIATES

**Employer identification number**
33-1007002

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PART VI, SECTION A, LINE 1 | THE EXECUTIVE COMMITTEE IS COMPOSED OF THE OFFICERS OF THE BOARD OF DIRECTORS, EACH VESTED WITH FULL VOTING AUTHORITY THEY MEET AS NEEDED TO PLAN FOR THE BOARD'S WORK AND TO FULFI LL TASKS ASSIGNED TO THEM BY THE BOARD THE EXECUTIVE COMMITTEE IS AUTHORIZED TO ACT AND M AKE DECISIONS ON BEHALF OF THE ENTIRE BOARD WHEN URGENT MATTERS ARISE BETWEEN REGULARLY SC HEDULED BOARD MEETINGS THE EXECUTIVE COMMITTEE IS OBLIGATED TO PRESENT ITS ACTIONS TO THE ENTIRE BOARD IF A DECISION HAS BEEN MADE IN ITS ABSENCE |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
| --- | --- |
| FORM 990, PART VI, SECTION A, LINE 6 | TRINITY HEALTH IS THE SOLE MEMBER OF EACH CORPORATION INCLUDED IN THIS GROUP RETURN |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PART VI, SECTION A, LINE 7A | AT EACH ANNUAL MEETING, THE SOLE MEMBER, TRINITY HEALTH, APPOINTS THE BOARD OF DIRECTORS AT LEAST SEVEN OF THE BOARD OF DIRECTORS ALSO SERVE AS A MEMBER OF THE BOARD OF DIRECTORS OF TRINITY HEALTH IN THE BYLAWS OF TRINITY HEALTH FOUNDATION, THIS OVERLAP ONLY NEEDS TO BE THREE ANY DIRECTOR WHO CEASES TO BE A MEMBER OF THE TRINITY HEALTH BOARD OF DIRECTORS AUTOMATICALLY BECOMES DISQUALIFIED FROM SERVING AS A DIRECTOR OF THE AFFILIATES' BOARD AND IS REPLACED WITH ANOTHER BOARD MEMBER CURRENTLY SERVING ON THE BOARD OF TRINITY HEALTH, U NLESS THERE ARE AT LEAST A MINIMUM OF SEVEN (OR THREE IN THE CASE OF TRINITY HEALTH FOUNDA TION) OTHER BOARD MEMBERS CURRENTLY SERVING AS A DIRECTOR OF TRINITY HEALTH |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PART VI, SECTION A, LINE 7B | THE FOLLOWING POWERS ARE RESERVED EXCLUSIVELY TO THE SOLE MEMBER, TRINITY HEALTH (A) APPR OVE THE APPOINTMENT OF OFFICERS, (B) APPROVE ANY AMENDMENTS TO THE ARTICLES OF INCORPORATI ON OR BYLAWS, (C) APPROVE THE ANNUAL OPERATING AND CAPITAL BUDGETS, (D) APPROVE THE SELECT ION OF AUDITORS AND LEGAL COUNSEL, (E) APPROVE ANY STRATEGIC PLANS ADOPTED, (F) APPROVE AN Y UNBUDGETED BORROWING, ANY ENCUMBRANCE OF ASSETS, AND ANY EXPENDITURES FOR CAPITAL IMPROV EMENTS WHERE THE AMOUNT EXCEEDS FIVE PERCENT OF THE CAPITAL BUDGET PREVIOUSLY APPROVED, (G ) CHANGE THE NUMBER OF DIRECTORS OF THE BOARD OF DIRECTORS, AND (H) APPROVE ANY ACTION THA T IS NOT IN THE ORDINARY COURSE OF BUSINESS |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
| --- | --- |
| FORM 990, PART VI, SECTION B, LINE 11B | PRIOR TO BEING FILED WITH THE IRS, A COPY OF THE FORM 990 WAS GIVEN TO THE GOVERNING BODY OF TRINITY HEALTH & AFFILIATES FOR REVIEW |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PART VI, SECTION B, LINE 12C | ALL SALARIED EMPLOYEES (AT MANAGER LEVEL AND ABOVE AS DETERMINED BY TRINITY) AND SUCH OTHE R EMPLOYEES AS FROM TIME TO TIME MAY BE DIRECTED TO DO SO, ARE REQUIRED TO COMPLETE TRINIT Y HEALTH'S CONFLICT OF INTEREST STATEMENT ON AN ANNUAL BASIS ANY EMPLOYEE WHO HAS ASSUMED , OR IS ABOUT TO ASSUME, A FINANCIAL OR OTHER INTEREST OR RELATIONSHIP THAT MIGHT INVOLVE A CONFLICT OF INTEREST MUST IMMEDIATELY INFORM HIS/HER SUPERVISOR, A MEMBER OF THE COMPLIA NCE COMMITTEE, OR THE COMPLIANCE OFFICER ISSUES INVOLVING CONFLICT OF INTEREST SHALL BE R EVIEWED AND A DETERMINATION OF EACH SHALL BE MADE BY THE TRINITY COMPLIANCE COMMITTEE IF A CONFLICT EXISTS, THE CONFLICTED PERSON MUST ABSTAIN FROM DISCUSSION OF AND VOTING ON THE CONFLICTED TOPIC |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
| --- | --- |
| FORM 990, PART VI, SECTION B, LINE 15 | THE EXECUTIVE COMMITTEE OF THE BOARD OF DIRECTORS OF TRINITY HEALTH REVIEWED COMPENSATION INFORMATION FOR THE CEO, WHICH HAD BEEN PREVIOUSLY PREPARED BY DELOITTE AND TOURCHE DELOI TTE AND TOUCHE ANALYZED FOUR COMPENSATION SURVEYS OF HEALTH CARE EMPLOYERS AND REVIEWED FO RM 990 FILINGS FOR A PEER GROUP ANALYSIS |

**990 Schedule O, Supplemental Information**

| Return Reference | Explanation |
| --- | --- |
| FORM 990, PART VI, SECTION C, LINE 19 | ON OUR WEBSITE WWW TRINITYHEALTH ORG WE LIST OUR BOARD OF DIRECTORS, MISSION, VISION, VALU ES AND OUR ANNUAL REPORT WHICH INCLUDES FINANCIAL INFORMATION THE GOVERNING DOCUMENTS AND CONFLICT OF INTEREST POLICY ARE MADE AVAILABLE UPON REQUEST |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
| --- | --- |
| FORM 990, PART IX, LINE 11G | MEDICAL PROFESSIONALS PROGRAM SERVICE EXPENSES 26,839,622 MANAGEMENT AND GENERAL EXPENSE S 10,139,824 FUNDRAISING EXPENSES 121 TOTAL EXPENSES 36,979,567 |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
| --- | --- |
| FORM 990, PART XI, LINE 9 | NET ASSET TRANSFERS -77,296,415 |

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# SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

## Related Organizations and Unrelated Partnerships

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

OMB No 1545-0047

**2017**

**Open to Public Inspection**

Name of the organization
TRINITY HEALTH & AFFILIATES

**Employer identification number**
33-1007002

**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 |
|---|---|---|---|---|---|
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**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 | (g) Section 512(b)(13) controlled entity? No |
|---|---|---|---|---|---|---|---|
| (1)TRINITY HEALTH<br>PO BOX 5020<br><br>MINOT, ND 58702<br>45-0226558 | HEALTHCARE | ND | 501(C)(3) | LINE 12C, III-FI | N/A | | No |
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**Part III** **Identification of Related Organizations Taxable as a Partnership** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a partnership during the tax year.

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Predominant income(related, unrelated, excluded from tax under sections 512-514) | (f) Share of total income | (g) Share of end-of-year assets | (h) Disproprtionate allocations? Yes | (h) No | (i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065) | (j) General or managing partner? Yes | (j) No | (k) Percentage ownership |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
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**Part IV** **Identification of Related Organizations Taxable as a Corporation or Trust** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a corporation or trust during the tax year.

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income | (g) Share of end-of-year assets | (h) Percentage ownership | (i) Section 512(b)(13) controlled entity? Yes | (i) No |
|---|---|---|---|---|---|---|---|---|---|
| **(1)**MEDICAL ARTS OUTPATIENT SERVICES INC<br>400 BURDICK EXPRESSWAY EAST<br>MINOT, ND 58701<br>45-0278212 | RETAIL PHARMACY & DURABLE MEDICAL EQUIPMENT | ND | N/A | C | | | | | No |
| **(2)**B&B DRUG INC<br>20 BURDICK EXPRESSWAY EAST<br>MINOT, ND 58701<br>45-0260565 | RETAIL DRUG STORE | ND | N/A | C | | | | | No |
| | | | | | | | | | |
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**Part V Transactions With Related Organizations** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.

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

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

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

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

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

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