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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

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

OMB No 1545-0047

2018

Open to Public Inspection

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

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

C Name of organization
INDIANA UNIVERSITY HEALTH WEST HOSPITAL
INC
% CRAIG J JONES

Doing business as

Number and street (or P O box if mail is not delivered to street address) 950 N MERIDIAN STREET Suite 300

Room/suite

City or town, state or province, country, and ZIP or foreign postal code
INDIANAPOLIS, IN 46204

D Employer identification number
35-1814660

E Telephone number
(317) 963-4842

G Gross receipts $ 248,086,495

F Name and address of principal officer
KENNETH D PUCKETT
950 N MERIDIAN ST STE 300
INDIANAPOLIS, IN 46204

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

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

H(c) Group exemption number ▶

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

J Website: ▶ SEE SCHEDULE O

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

L Year of formation 1990

M State of legal domicile IN

Part I Summary

1 Briefly describe the organization's mission or most significant activities
Improve the health of our patients and community through innovation and excellence in care, education, research and service

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**	9
4	Number of independent voting members of the governing body (Part VI, line 1b)	**4**	5
5	Total number of individuals employed in calendar year 2018 (Part V, line 2a)	**5**	1,235
6	Total number of volunteers (estimate if necessary)	**6**	30
7a	Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	0
b	Net unrelated business taxable income from Form 990-T, line 34	**7b**	98,712

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	21,714	259
9	Program service revenue (Part VIII, line 2g)	223,750,030	239,113,407
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	705,329	6,843,697
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	1,690,889	1,727,372
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	226,167,962	247,684,735
13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	22,500	20,000
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)	58,695,019	61,297,448
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶0		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	116,255,481	127,925,448
18	Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	174,973,000	189,242,896
19	Revenue less expenses Subtract line 18 from line 12	51,194,962	58,441,839

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	464,063,976	521,438,931
21	Total liabilities (Part X, line 26)	121,431,762	120,515,303
22	Net assets or fund balances Subtract line 21 from line 20	342,632,214	400,923,628

Part II Signature Block

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

Sign Here

Signature of officer — Date: 2019-11-15

CARA L BREIDSTER CFO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
				P00395735

Firm's name ▶ ERNST & YOUNG US LLP — Firm's EIN ▶

Firm's address ▶ 111 MONUMENT CIRCLE SUITE 4000
INDIANAPOLIS, IN 46204 — Phone no (317) 681-7000

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

IMPROVE THE HEALTH OF OUR PATIENTS AND COMMUNITY THROUGH INNOVATION AND EXCELLENCE IN CARE, EDUCATION, RESEARCH AND SERVICE

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 See Additional Data)	(Expenses $	155,483,010	including grants of $	20,000) (Revenue $	238,439,781)
4b	(Code See Additional Data)	(Expenses $	291,419	including grants of $	) (Revenue $	446,903)
4c	(Code See Additional Data)	(Expenses $	147,842	including grants of $	) (Revenue $	226,723)
4d	Other program services (Describe in Schedule O)	(Expenses $		including grants of $	) (Revenue $	)
4e	**Total program service expenses ▶**		155,922,271			

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		No
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		No
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	Yes	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		No
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		No
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		No
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		No
9	Did the organization report an amount in Part X, line 21 for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		No
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10		No
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI*	11a	Yes	
b	Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b		No
c	Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		No
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d		No
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	Yes	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f	Yes	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a		No
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	Yes	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		No
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		No
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b		No
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV*	15		No
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV*	16		No
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I* (see instructions)	17		No
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		No
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		No
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	Yes	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	Yes	
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21	Yes	
22	Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22		No

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *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**		No
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	**24b**		
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	**24c**		
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	**24d**		
25a	**Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *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**		No
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	**30**		No
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**	Yes	
b	If 'Yes' to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	**35b**	Yes	
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**	70		
b	Enter the number of Forms W-2G included in line 1a *Enter -0-* if not applicable	**1b**	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?		**1c**	Yes	

2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	**2a**	1,235		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)			**2b**	Yes
3a	Did the organization have unrelated business gross income of $1,000 or more during the year? . . .			**3a**	Yes
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O* . . .			**3b**	Yes
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . .			**4a**	No
b	If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . .			**5a**	No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?			**5b**	No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?			**5c**	
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . .			**6a**	No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?			**6b**	
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?			**7a**	No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?			**7b**	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?			**7c**	No
d	If "Yes," indicate the number of Forms 8282 filed during the year	**7d**			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?			**7e**	No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . .			**7f**	No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?			**7g**	
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?			**7h**	
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?			**8**	
9a	Did the sponsoring organization make any taxable distributions under section 4966? . . .			**9a**	
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . .			**9b**	
10	**Section 501(c)(7) organizations.** Enter				
a	Initiation fees and capital contributions included on Part VIII, line 12 . . .	**10a**			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	**10b**			
11	**Section 501(c)(12) organizations.** Enter				
a	Gross income from members or shareholders	**11a**			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)	**11b**			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?			**12a**	
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	**12b**			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state? **Note.** See the instructions for additional information the organization must report on Schedule O			**13a**	
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	**13b**			
c	Enter the amount of reserves on hand	**13c**			
14a	Did the organization receive any payments for indoor tanning services during the tax year?			**14a**	No
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* . .			**14b**	
15	Is the organization subject to the section 4960 tax on payment(s) of more than $1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see instructions and file Form 4720, Schedule N			**15**	No
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O			**16**	No

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

Section A. Governing Body and Management

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

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

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

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

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

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

20 State the name, address, and telephone number of the person who possesses the organization's books and records
▶CRAIG J JONES 950 N MERIDIAN ST STE 300 INDIANAPOLIS, IN 46204 (317) 963-4842

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) MARSHA A STONE CHAIRMAN	5 0 0 0	X		X				4,500	0	0
(2) MARK R BENSON DO DIRECTOR	5 0 0 0	X						4,500	0	0
(3) REV KAREN E DEVAISHER DIRECTOR	5 0 0 0	X						4,500	0	0
(4) CINDA L KELLEY DIRECTOR	5 0 0 0	X						3,750	0	0
(5) MEGAN CRITTENDON MD DIRECTOR	5 0 50 0	X						0	358,965	24,636
(6) Elizabeth Dunlap Director	5 0 50 0	X						0	767,220	34,402
(7) Michelle A Janney Director	5 0 50 0	X						0	1,017,028	126,964
(8) Jill McCrory Director	5 0 0 0	X						3,750	0	0
(9) David A Ingram MD Director	5 0 50 0	X						0	539,320	111,083
(10) KENNETH D PUCKETT PRESIDENT - ISR	10 0 45 0			X				0	525,684	97,308
(11) DEREK E EMPIE SECRETARY	5 0 50 0			X				0	226,820	40,289
(12) ARTHUR VASQUEZ President/Treasurer	55 0 0 0			X				0	268,019	41,667
(13) CARA L BREIDSTER CFO - ISR (PARTIAL YEAR)	10 0 45 0			X				0	313,895	36,365
(14) Harpreetinder Singh MD VP & CMO (Partial Year)	25 0 30 0				X			228,539	233,217	37,087
(15) LISA A SPARKS RN VP & CNO	55 0 0 0				X			202,295	0	38,589
(16) PAMELA CHAPMAN DIRECTOR, OR SERVICES(Part Yr)	55 0 0 0				X			15,830	143,812	38,588
(17) JAMES R BILLMAN PHARMACIST	55 0 0 0					X		158,109	0	27,281

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) ANNE K STEGEMOLLER	55 0					X		165,473	0	36,471
DIRECTOR, PHARMACY	0 0									
(19) LAURA A ROGGY	55 0					X		154,699	0	25,963
PHARMACIST	0 0									
(20) Eric D Peak	55 0					X		153,744	0	14,921
Pharmacist, Senior	0 0									
(21) Jamie L Conley-Lebeter	55 0					X		143,536	0	30,052
Mgr, Pharmacy Oprs	0 0									
(22) JUDITH L COLEMAN	0 0						X	0	297,648	33,403
FORMER TREASURER	55 0									
(23) MATTHEW D BAILEY	0 0						X	0	1,493,222	329,267
FORMER PRESIDENT	55 0									
(24) GREGORY A SPURGIN MD	0 0						X	0	301,623	21,425
FOMER CMO	55 0									
1b Sub-Total ▶										
c Total from continuation sheets to Part VII**, Section A** ▶										
d Total (add lines 1b and 1c) ▶								1,243,225	6,486,473	1,145,761

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 ▶ 38

			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**	Yes	
4	For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than $150,000? *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
ARAMARK HEALTHCARE MANAGEMENT SERVI, 2300 WARRENVILLE RD DOWNERS GROVE, IL 60515	FACILITIES	4,800,480
Cornerstone Medical Construction L, 8902 N Meridian St Ste 205 INDIANAPOLIS, IN 46260	Construction	1,398,748
MESSER CONSTRUCTION COMPANY, 2445 N MERIDIAN STREET INDIANAPOLIS, IN 46208	CONSTRUCTION	815,775
Ermco Inc, 1625 Thompson Rd INDIANAPOLIS, IN 46217	Maintenance	973,199
MEDEFIS CONSOLIDATED, PO BOX 5068 NEW YORK, NY 10087	Staffing	802,141

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 17

Part VIII Statement of Revenue

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

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a				
	b Membership dues	1b				
	c Fundraising events	1c				
	d Related organizations	1d				
	e Government grants (contributions)	1e				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	259			
	g Noncash contributions included in lines 1a - 1f $					
	h **Total.** Add lines 1a-1f		259			
Program Service Revenue		Business Code				
	2a NET PATIENT SERVICE REVENUE	622110	238,439,781	238,439,781		
	b SHARED SERVICES	541900	226,723	226,723		
	c RENT FROM RELATED 501(C)(3) ORGS	532000	446,903	446,903		
	d					
	e					
	f All other program service revenue					
	g **Total.** Add lines 2a–2f		239,113,407			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		6,689,781			6,689,781
	4 Income from investment of tax-exempt bond proceeds		0			
	5 Royalties		0			
		(i) Real	(ii) Personal			
	6a Gross rents	377,705				
	b Less rental expenses	401,760				
	c Rental income or (loss)	-24,055	0			
	d Net rental income or (loss)		-24,055			-24,055
		(i) Securities	(ii) Other			
	7a Gross amount from sales of assets other than inventory		153,916			
	b Less cost or other basis and sales expenses					
	c Gain or (loss)		153,916			
	d Net gain or (loss)		153,916			153,916
	8a Gross income from fundraising events (not including $ _____ of contributions reported on line 1c) See Part IV, line 18 a	0				
	b Less direct expenses b	0				
	c Net income or (loss) from fundraising events		0			
	9a Gross income from gaming activities See Part IV, line 19 a	0				
	b Less direct expenses b	0				
	c Net income or (loss) from gaming activities		0			
	10a Gross sales of inventory, less returns and allowances a	0				
	b Less cost of goods sold b	0				
	c Net income or (loss) from sales of inventory		0			
	Miscellaneous Revenue	Business Code				
	11a CAFETERIA/FOOD SERVICE	721110	884,996			884,996
	b GIFT SHOP	453220	304,750			304,750
	c TELEPHONE	517000	102,785			102,785
	d All other revenue		458,896			458,896
	e **Total.** Add lines 11a–11d		1,751,427			
	12 **Total revenue.** See Instructions		247,684,735	239,113,407		8,571,069

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	20,000	20,000		
2 Grants and other assistance to domestic individuals See Part IV, line 22	0			
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, line 15 and 16	0			
4 Benefits paid to or for members	0			
5 Compensation of current officers, directors, trustees, and key employees	528,435	491,638	36,797	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0			
7 Other salaries and wages	48,819,467	45,419,985	3,399,482	
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	1,669,440	1,553,191	116,249	
9 Other employee benefits	6,767,516	6,296,269	471,247	
10 Payroll taxes	3,512,590	3,267,995	244,595	
11 Fees for services (non-employees)				
a Management	0			
b Legal	125,275		125,275	
c Accounting	10,230		10,230	
d Lobbying	6,298		6,298	
e Professional fundraising services See Part IV, line 17	0			
f Investment management fees	0			
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	50,211,885	24,225,072	25,986,813	0
12 Advertising and promotion	400,936	400,936		
13 Office expenses	548,763	427,294	121,469	
14 Information technology	194,057	186,217	7,840	
15 Royalties	0			
16 Occupancy	3,630,812	3,329,319	301,493	
17 Travel	27,849	18,299	9,550	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19 Conferences, conventions, and meetings	42,025	4,783	37,242	
20 Interest	5,539,546	5,539,546		
21 Payments to affiliates	0			
22 Depreciation, depletion, and amortization	7,869,586	6,484,201	1,385,385	
23 Insurance	1,244,835	296,992	947,843	
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 DRUGS AND MEDICAL SUPPLIES	26,907,166	26,907,166		
b BAD DEBT	19,200,087	19,200,087		
c HOSPITAL ASSESSMENT FEE	10,863,905	10,863,905		
d INSTITUTIONAL DUES/LICENSES	90,703	90,703		
e All other expenses	1,011,490	898,673	112,817	
25 **Total functional expenses.** Add lines 1 through 24e	189,242,896	155,922,271	33,320,625	0
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation Check here ▶ ☐ 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		4,750	1	0
	2	Savings and temporary cash investments		338,891,877	2	391,044,274
	3	Pledges and grants receivable, net		0	3	0
	4	Accounts receivable, net		31,939,139	4	30,077,475
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L		0	5	0
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L		0	6	0
	7	Notes and loans receivable, net		781,984	7	792,506
	8	Inventories for sale or use		1,521,470	8	1,420,805
	9	Prepaid expenses and deferred charges		832,880	9	761,440
	10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	10a 195,362,763			
	b	Less accumulated depreciation	10b 98,020,332	90,091,876	10c	97,342,431
	11	Investments—publicly traded securities		0	11	0
	12	Investments—other securities See Part IV, line 11		0	12	0
	13	Investments—program-related See Part IV, line 11		0	13	0
	14	Intangible assets		0	14	0
	15	Other assets See Part IV, line 11		0	15	0
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)		464,063,976	16	521,438,931
Liabilities	17	Accounts payable and accrued expenses		14,509,341	17	15,072,181
	18	Grants payable		0	18	0
	19	Deferred revenue		255,666	19	131,478
	20	Tax-exempt bond liabilities		0	20	0
	21	Escrow or custodial account liability Complete Part IV of Schedule D		0	21	0
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L		0	22	0
	23	Secured mortgages and notes payable to unrelated third parties		0	23	0
	24	Unsecured notes and loans payable to unrelated third parties		0	24	0
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24) Complete Part X of Schedule D		106,666,755	25	105,311,644
	26	**Total liabilities.** Add lines 17 through 25		121,431,762	26	120,515,303
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		342,612,401	27	400,923,628
	28	Temporarily restricted net assets		19,813	28	0
	29	Permanently restricted net assets		0	29	0
		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		342,632,214	33	400,923,628
	34	Total liabilities and net assets/fund balances		464,063,976	34	521,438,931

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	247,684,735
2	Total expenses (must equal Part IX, column (A), line 25)	2	189,242,896
3	Revenue less expenses Subtract line 2 from line 1	3	58,441,839
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	342,632,214
5	Net unrealized gains (losses) on investments	5	
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	-150,425
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	400,923,628

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: 35-1814660

Name: INDIANA UNIVERSITY HEALTH WEST HOSPITAL INC

Form 990 (2018)

Form 990, Part III, Line 4a:

Indiana University Health West Hospital, Inc ("IU Health West Hospital") is 142-bed multidisciplinary healthcare facility located in Avon, IN The hospital offers a full range of services, including maternity, orthopedics and cancer care Built with a specific goal to meet the needs of our patients, families and visitors, IU Health West Hospital includes features designed to ensure privacy and create a quiet, soothing atmosphere in patient spaces From all-private rooms and intimate, comfortable family waiting areas to separate corridors and elevators away from public spaces for staff and supply movement, IU Health West Hospital delivers on our goals to create a healing sanctuary for patients

Form 990, Part III, Line 4b:

IU Health West Hospital receives rent from a related exempt organization, Indiana University Health Care Associates ("IU Health Physicians"), for space in their Medical Office Building that's connected to the Hospital and the Ortho, Sport & Spine Center

Form 990, Part III, Line 4c:

IU Health West Hospital provides services to related tax-exempt organizations

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493318140389

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.**

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

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
INDIANA UNIVERSITY HEALTH WEST HOSPITAL INC

Employer identification number
35-1814660

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

Section B. Total Support

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

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

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2018 (line 6, column (f) divided by line 11, column (f)) **14**

15 Public support percentage for 2017 Schedule A, Part II, line 14 **15**

16a **33 1/3% support test—2018.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support test—2017.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

17a **10%-facts-and-circumstances test—2018.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶ ☐

b **10%-facts-and-circumstances test—2017.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶ ☐

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

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

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

Section A. Public Support

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

Section B. Total Support

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

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

Section C. Computation of Public Support Percentage

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

Section D. Computation of Investment Income Percentage

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

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

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

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

			Yes	No
1	Are all of the organization's supported organizations listed by name in the organization's governing documents? *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 2018 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

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

Additional Data

Software ID:

Software Version:

EIN: 35-1814660

Name: INDIANA UNIVERSITY HEALTH WEST HOSPITAL INC

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

Facts And Circumstances Test

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SCHEDULE C (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

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

▶**Complete if the organization is described below.** ▶**Attach to Form 990 or Form 990-EZ.**
▶**Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No 1545-0047

2018

Open to Public Inspection

If the organization answered "Yes" on Form 990, Part IV, Line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then
- Section 501(c)(3) organizations Complete Parts I-A and B Do not complete Part I-C
- Section 501(c) (other than section 501(c)(3)) organizations Complete Parts I-A and C below Do not complete Part I-B
- Section 527 organizations Complete Part I-A only

If the organization answered "Yes" on Form 990, Part IV, Line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then
- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)) Complete Part II-A Do not complete Part II-B
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)) Complete Part II-B Do not complete Part II-A

If the organization answered "Yes" on Form 990, Part IV, Line 5 (Proxy Tax) (see separate instructions) or Form 990-EZ, Part V, line 35c (Proxy Tax) (see separate instructions), then
- Section 501(c)(4), (5), or (6) organizations Complete Part III

Name of the organization	Employer identification number
INDIANA UNIVERSITY HEALTH WEST HOSPITAL INC	35-1814660

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)** 2015	**(b)** 2016	**(c)** 2017	**(d)** 2018	**(e)** Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity		(a) 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		6,298
j	Total Add lines 1c through 1i			6,298
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

Part IV Supplemental Information

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

Return Reference	Explanation
Schedule C, Part II-B, Lines 1i - Other Activities	IU Health West Hospital paid institutional membership dues to the American Hospital Association ("AHA") and Indiana Hospital Association ("IHA") during 2018 in the amount of $22,761 and $14,999, respectively Each membership organization notified IU Health West Hospital that a portion of the dues it paid were used for lobbying purposes The AHA used 22 98%, or $5,230 of 2018 membership dues paid by IU Health West Hospital, for lobbying expenditures The IHA used 7 12%, or $1,068 of the 2018 membership dues paid by IU Health West Hospital, for lobbying expenditures The total membership dues paid to these organizations by IU Health West Hospital during 2018 that were attributable to lobbying expenditures was $6,298

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

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
INDIANA UNIVERSITY HEALTH WEST HOSPITAL INC

Employer identification number
35-1814660

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part IV Escrow and Custodial Arrangements.

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

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

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

	Amount
c Beginning balance	1c
d Additions during the year	1d
e Distributions during the year	1e
f Ending balance	1f

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

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

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

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

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

- a Board designated or quasi-endowment ▶
- b Permanent endowment ▶
- c Temporarily restricted endowment ▶

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

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

	Yes	No
(i) unrelated organizations	3a(i)	
(ii) related organizations	3a(ii)	
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				
b Buildings		103,892,736	37,793,927	66,098,809
c Leasehold improvements		1,188,609	626,525	562,084
d Equipment		69,906,308	54,278,868	15,627,440
e Other		20,375,110	5,321,012	15,054,098
Total. Add lines 1a through 1e *(Column (d) must equal Form 990, Part X, column (B), line 10(c))* . . ▶				97,342,431

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	0
INTERCOMPANY PAYABLES (NET)	103,379,800
DUE TO THIRD-PARTY PAYERS	1,723,938
SELF-INSURANCE LIABILITIES	207,906
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col (B) line 25)* ▶	105,311,644

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: 35-1814660

Name: INDIANA UNIVERSITY HEALTH WEST HOSPITAL INC

Supplemental Information

Return Reference	Explanation
Schedule D, Part X, Line 2 - FIN 48 (ASC 740) Footnote	IU Health West Hospital is a subsidiary in Indiana University Health, Inc 's ("IU Health") Consolidated Audited Financial Statements The Internal Revenue Service (IRS) has determi ned that IU Health and certain of its affiliated entities are tax-exempt organizations as defined in Section 501(c)(3) of the Internal Revenue Code (IRC) IU Health and its tax-exe mpt affiliates are, however, subject to federal and state income taxes on unrelated busine ss income under the provision of IRC Section 511 THE TAX CUTS AND JOBS ACT (TCJA) WAS ENA CTED ON DECEMBER 22, 2017 FOR TAX-EXEMPT ENTITIES, TCJA REQUIRES ORGANIZATIONS TO CATEGOR IZE CERTAIN FRINGE BENEFIT EXPENSES AS A SOURCE OF UNRELATED BUSINESS INCOME SUBJECT TO TA X, PAY AN EXCISE TAX ON COMPENSATION ABOVE CERTAIN THRESHOLDS, AND RECORD INCOME OR LOSSES FOR TAX DETERMINATION PURPOSES FROM UNRELATED BUSINESS ACTIVITIES ON AN ACTIVITY-BY-ACTIV ITY BASIS, AMONG OTHER PROVISIONS REGULATIONS NECESSARY TO IMPLEMENT CERTAIN ASPECTS OF T CJA ARE EXPECTED TO BE PROMULGATED BY THE IRS IN 2019 AS OF AND FOR THE YEAR ENDED DECEMB ER 31, 2018, INDIANA UNIVERSITY HEALTH HAS MADE REASONABLE ESTIMATES OF THE PROVISION FOR INCOME TAXES, THE COMPENSATION EXCISE TAX, AND THE EFFECTS, IF ANY, ON EXISTING DEFERRED T AX BALANCES BASED ON ACCOUNTING GUIDANCE INCLUDED IN ACCOUNTING STANDARDS CODIFICATION (AS C) 740, INCOME TAXES INDIANA UNIVERSITY HEALTH WILL CONTINUE TO REFINE ITS CALCULATIONS I N FUTURE PERIODS, AS ADDITIONAL REGULATIONS AND GUIDANCE ARE ISSUED BY THE IRS DEFERRED I NCOME TAXES, WHICH AS OF DECEMBER 31, 2018 AND 2017, HAVE NO NET CARRYING VALUE, REFLECT T HE NET TAX EFFECT OF TEMPORARY DIFFERENCES BETWEEN THE CARRYING AMOUNTS OF ASSETS AND LIAB ILITIES FOR FINANCIAL REPORTING AND THE AMOUNT USED FOR INCOME TAX PURPOSES AS OF DECEMBE R 31, 2018 AND 2017, THE INDIANA UNIVERSITY HEALTH SYSTEM HAD GROSS DEFERRED TAX ASSETS OF $119,965,000 AND $93,794,000, RESPECTIVELY, PRIMARILY RELATING TO NET OPERATING LOSS CARR YOVERS MANAGEMENT DETERMINED THAT A FULL VALUATION ALLOWANCE AT BOTH DECEMBER 31, 2018 AN D 2017 WAS NECESSARY TO REDUCE THE DEFERRED TAX ASSETS TO THE AMOUNT THAT WOULD MORE LIKEL Y THAN NOT BE REALIZED ACCOUNTING STANDARDS CODIFICATION (ASC) 740, INCOME TAXES, REQUIRE S A VALUATION ALLOWANCE TO REDUCE THE DEFERRED TAX ASSETS REPORTED IF, BASED ON THE WEIGHT OF THE EVIDENCE, IT IS MORE LIKELY THAN NOT THAT SOME PORTION OR ALL OF THE DEFERRED TAX ASSETS WILL NOT BE REALIZED THE CHANGE IN VALUATION ALLOWANCE FOR THE CURRENT YEAR IS $26 ,171,000 AT DECEMBER 31, 2018, THE INDIANA UNIVERSITY HEALTH SYSTEM HAS AVAILABLE NET OPE RATING LOSS CARRYFORWARDS OF $482,349,000 NET OPERATING LOSSES GENERATED FROM 1999 THROUG H 2017 WILL EXPIRE BETWEEN 2019 AND 2037 NET OPERATING LOSSES GENERATED DURING 2018 DO NO T EXPIRE CERTAIN SUBSIDIARIES OF IU HEALTH ARE TAXABLE ENTITIES THE TAX EXPENSE AND LIAB ILITIES OF THESE SUBSIDIARIES ARE NOT MATERIAL TO THE CONSOLIDATED FINANCIAL STATEMENTS

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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.
▶ Go to *www.irs.gov/Form990EZ* for instructions and the latest information.

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
INDIANA UNIVERSITY HEALTH WEST HOSPITAL INC

Employer identification number
35-1814660

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 _____ %			
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		No
	☐ 200% ☐ 250% ☐ 300% ☐ 350% ☐ 400% ☐ Other _____ %			
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	Yes	
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	Yes	
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligibile for free or discounted care?	5c		No
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)		4,132	3,749,657		3,749,657	2 210 %
b Medicaid (from Worksheet 3, column a)		5,819	31,683,936	18,890,058	12,793,878	7 520 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs		9,951	35,433,593	18,890,058	16,543,535	9 730 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	6	4,387	1,541,330		1,541,330	0 910 %
f Health professions education (from Worksheet 5)	2	494	234,043		234,043	0 140 %
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)	2	5,480	133,887		133,887	0 080 %
j **Total.** Other Benefits	10	10,361	1,909,260		1,909,260	1 130 %
k **Total.** Add lines 7d and 7j	10	20,312	37,342,853	18,890,058	18,452,795	10 860 %

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	1	25	15,500		15,500	0 010 %
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development						
9 Other						
10 Total	1	25	15,500		15,500	0 010 %

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		No
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 3,523,216		
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		
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	39,499,942
6	Enter Medicare allowable costs of care relating to payments on line 5	6	42,601,997
7	Subtract line 6 from line 5 This is the surplus (or shortfall)	7	-3,102,055
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? **1**

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

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group IU HEALTH WEST 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 18			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a		No
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	6b		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) SEE PART V, SECTION C			
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 19			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
a	If "Yes" (list url) SEE PART V, SECTION C			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed			
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		No
b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

IU HEALTH WEST 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 200 % and FPG family income limit for eligibility for discounted care of 0 %			
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) SEE PART V, SECTION C			
b	☑ The FAP application form was widely available on a website (list url) SEE PART V, SECTION C			
c	☑ A plain language summary of the FAP was widely available on a website (list url) SEE PART V, SECTION C			
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

IU HEALTH WEST 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)

IU HEALTH WEST 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	

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? **4**

	Name and address	Type of Facility (describe)
1	IU HEALTH WEST CARDIACPULMONARY REHAB 1115 N RONALD REAGAN PKWY STE M AVON, IN 46123	DIAGNOSTIC AND OTHER OUTPATIENT
2	IU HEALTH WEST ORTHO SPORT & SPINE CTR 1115 N RONALD REAGAN PKWY AVON, IN 46123	DIAGNOSTIC AND OTHER OUTPATIENT
3	IU HEALTH WEST REHABILITATION SERVICES 1115 N RONALD REAGAN PKWY STE G AVON, IN 46123	DIAGNOSTIC AND OTHER OUTPATIENT
4	IU HEALTH WEST SLEEP DISORDERS CENTER 1115 N RONALD REAGAN PKWY STE 3 AVON, IN 46123	DIAGNOSTIC AND OTHER OUTPATIENT
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

Form and Line Reference	Explanation
Schedule H, Part I, Line 3c - Other Factors Used in Determining Elig	IU Health West Hospital uses several factors other than Federal Poverty Guidelines ("FPGs") in determining eligibility for free care under its FAP These factors include the follow ing 1 Indiana Residency Requirement Financial Assistance will only be made available to residents of the State of Indiana and those eligible for assistance under 42 U S C A 1396 b(v) IU Health West Hospital will employ the same residency test as set forth in Indiana Code 6-3-1-12 to define an Indiana resident The term Resident includes any individual who was domiciled in Indiana during the taxable year, or any individual who maintains a perma nent place of residence in Indiana and spends more than one hundred eight-three (183) days of the taxable year in Indiana Patients residing in the state of Indiana while attending an institution of higher education may be eligible for assistance under the FAP if they m eet the aforementioned residency test and are not claimed as a dependent on a parents or g uardians federal income tax return 2 IU Healths Individual Solutions Department Prior to seeking Financial Assistance under the FAP, all patients or their guarantors must consult with a member of IU Healths Individual Solutions department to determine if healthcare co verage may be obtained from a government insurance/assistance product or from the Health I nsurance Exchange Marketplace 3 Uninsured Patients All Uninsured Patients presenting for services at IU health West Hospital eligible under the FAP will not be charged more than the AGB as described in the FAP 4 Services Rendered by Individual Providers The FAP does not cover services rendered by individual providers A full listing of providers and serv ices not covered by the FAP is available at https //iuhealth org/pay-a-bill/financial-assi stance and is updated on a quarterly basis 5 Alternate Sources of Assistance When techni cally feasible, a patient will exhaust all other state and federal assistance programs pri or to receiving an award from IU Health West Hospitals Financial Assistance Program Patie nts who may be eligible for coverage under an applicable insurance policy, including, but not limited to, health, automobile, and homeowners, must exhaust all insurance benefits pr ior to receiving an award from IU Health West Hospitals Financial Assistance Program This includes patients covered under their own policy and those who may be entitled to benefit s from a third-party policy Patients may be asked to show proof that such a claim was pro perly submitted to the proper insurance provider at the request of IU Health West Hospital Eligible patients who receive medical care from IU Health West Hospital as a result of a n injury proximately caused by a third party, and later receive a monetary settlement or a ward from said third party, may receive Financial Assistance for any outstanding balance n ot covered by the settlement or award to which IU Health West Hospital is entitled In the event a Financial Assistance Award has already been granted in such circumstances, IU Hea lth West Hospital reserves the right to reverse the award in an amount equal to the amount IU Health West Hospital would be entitled to receive had no Financial Assistance been awa rded 6 Alternate Methods of Eligibility Determination IU Health West Hospital will condu ct a quarterly review of all accounts placed with a collection agency partner for a period of no less than one hundred and twenty (120) days after the account is eligible for an EC A Said accounts may be eligible for assistance under the FAP based on the patients indivi dual scoring criteria To ensure all patients potentially eligible for Financial Assistanc e under the FAP may receive Financial Assistance, IU Health West Hospital will deem patien ts/guarantors to be presumptively eligible for Financial Assistance if they are found to b e eligible for one of the following programs, received emergency or direct admit care, and satisfied his/her required co-pay/deductible - Indiana Childrens Special Health Care Ser vices - Medicaid - Healthy Indiana Plan - Patients who are awarded Hospital Presumptive El igibility (HPE) - Enrolled in a state and/or federal program that verifies the patient's g ross household income is less than or equal to 200% of the Federal Poverty Level 7 Additi onal Considerations Financial Assistance may be granted to a deceased patients account if said patient is found to have no estate Additionally, IU Health West Hospital will deny o r revoke Financial Assistance for any patient or guarantor who falsifies any portion of a Financial Assistance application 8 Patient Assets IU Health West Hospital may consider p atient/guarantor Assets in the calculation of a patient's true financial burden A patient 's/guarantor's primary residence and one (1) motor vehicle will be exempted from considera tion in most cases A patient's primary residence is defined as the patient's principal pl ace of residence and will be excluded from a patie

Form and Line Reference	Explanation
Schedule H, Part I, Line 3c - Other Factors Used in Determining Elig	nt's extraordinary asset calculation so long as the patient's equity is less than five-hun dred thousand dollars ($500,000) and the home is occupied by the patient/guarantor, patien t's/guarantor's spouse or child under twenty-one (21) years of age One (1) motor vehicle may be excluded as long as the patient's equity in the vehicle is less than fifty-thousand dollars ($50,000) IU Health West Hospital reserves the right to request a list of all pr operty owned by the patient/guarantor and adjust a patient's award of Financial Assistance if the patient demonstrates a claim or clear title to any extraordinary Asset not exclude d from consideration under the above guidance 9 Non-Emergent Services Down Payment Unins ured Patients presenting for scheduled or other non-emergent services will not be charged more than the AGB for their services Patients will receive an estimated AGB cost of their care prior to IU Health West Hospital rendering the services and will be asked to pay a d own-payment percentage of the AGB adjusted cost prior to receiving services In the event a patient is unable to fulfill the down-payment, their service may be rescheduled for a la ter date as medically prudent and in accordance with all applicable federal and state laws and/or regulations 10 Emergency Services Non-Refundable Deposit This section will be im plemented with a strict adherence to EMTALA and IU Health Policy ADM 1 32, Screening and T ransfer of Emergency or Unstable Patients Amount of Non-Refundable Deposit All Uninsured Patients presenting for services at IU Health West Hospitals Emergency Department, via tra nsfer from another hospital facility, or direct admission, will be responsible for a one-h undred dollar ($100 00) non-refundable deposit for services rendered Patients/guarantors will be responsible for any copays and/or deductibles required by their plan prior to full Financial Assistance being applied Uninsured Patients wishing to make an application for Financial Assistance greater than the AGB must fulfill their non-refundable deposit prior to IU Health West Hospital processing said application Uninsured Patients making payment s toward their outstanding non-refundable deposit balance will have said payments applied to their oldest application on file, if applicable

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part I, Line 6a - C B Report Prepared by a Related Org	IU Health West Hospital's community benefit and other investments, encompassing its total community investment, are included in the IU Health Community Benefit Report which is prepared on behalf of and includes IU Health and its related hospital entities in the State of Indiana The IU Health Community Benefit Report is made available to the public on IU Healths website at https //iuhealth org/in-the-community The IU Health Community Benefit Report is also distributed to numerous key organizations throughout the State of Indiana in order to broadly share the IU Health Statewide Systems community benefit efforts It is also available by request through the Indiana State Department of Health or IU Health

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part I, Line 7, Column (f) - Bad Debt Expense	The amount of bad debt expense included on Form 990, Part IX, Line 25, column (A), but subtracted for purposes of calculating the percentage of total expense on Line 7, column (f) is $19,200,087 BAD DEBT EXPENSE IS REPORTED AT COST BASED ON THE COST-TO-CHARGE RATIO DERIVED FROM WORKSHEET 2, RATIO OF PATIENT CARE COST-TO-CHARGES

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part I, Line 7 - Total Community Benefit Expense	Schedule H, Part I, Line 7, Column (f), Percent of Total Expense, is based on column (e) Net Community Benefit Expense The percent of total expense based on column (c) Total Community Benefit Expense, which does not include direct offsetting revenue, is 21 96%

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part II - Promotion of Health in Communities Served	IU HEALTH PARTICIPATES IN A VARIETY OF COMMUNITY-BUILDING ACTIVITIES THAT ADDRESS THE SOCIAL DETERMINANTS OF HEALTH IN THE COMMUNITIES IT SERVES IU HEALTH AND ITS RELATED HOSPITAL ENTITIES ACROSS THE STATE OF INDIANA ("IU HEALTH STATEWIDE SYSTEM") INVEST IN ECONOMIC DEVELOPMENT EFFORTS ACROSS THE STATE, COLLABORATE WITH LIKE-MINDED ORGANIZATIONS THROUGH COALITIONS THAT ADDRESS KEY ISSUES, AND ADVOCATE FOR IMPROVEMENTS IN THE HEALTH STATUS OF VULNERABLE POPULATIONS THIS INCLUDES MAKING CONTRIBUTIONS TO COMMUNITY-BUILDING ACTIVITIES BY PROVIDING INVESTMENTS AND RESOURCES TO LOCAL COMMUNITY INITIATIVES THAT ADDRESSED ECONOMIC DEVELOPMENT, COMMUNITY SUPPORT AND WORKFORCE DEVELOPMENT SEVERAL EXAMPLES INCLUDE IU HEALTH'S SUPPORT OF THE FOLLOWING ORGANIZATIONS AND INITIATIVES THAT FOCUS ON SOME OF THE ROOT CAUSES OF HEALTH ISSUES, SUCH AS LACK OF EDUCATION, EMPLOYMENT AND POVERTY - Hope HEALTHCARE SERVICES - SHELTERING WINGS - AVON AND BROWNSBURG EDUCATION FOUNDATIONS - United Way ADDITIONALLY, THROUGH THE IU HEALTH STATEWIDE SYSTEM'S TEAM MEMBER COMMUNITY BENEFIT SERVICE PROGRAM, "IU HEALTH SERVES", TEAM MEMBERS ACROSS THE STATE MAKE A DIFFERENCE IN THE LIVES OF THOUSANDS OF HOOSIERS EVERY YEAR

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part III, Line 2 - Methodology Used to Est Bad Debt Exp	The bad debt expense of $3,523,216 reported on Schedule H, Part III, Line 2 is reported at cost, as calculated using the cost to charge ratio methodology SCHEDULE H, PART III, LINE 3 - EST BAD DEBT ATTR TO PATIENTS UNDER FAP AN UNINSURED PATIENT AND/OR GUARANTOR WHO WAS ADMITTED THROUGH AN ELIGIBLE FACILITY'S EMERGENCY DEPARTMENT VIA A DIRECT ADMISSION FROM A PHYSICIAN'S OFFICE, OR TRANSFER FROM ANOTHER HOSPITAL FACILITY, AND WHOSE HOUSEHOLD INCOME IS LESS THAN OR EQUAL TO 200% OF THE FEDERAL POVERTY LEVEL MAY BE ELIGIBLE FOR FULL CHARITY ASSISTANCE AFTER THE SUCCESSFUL COMPLETION OF THE FINANCIAL ASSISTANCE APPLICATION AND SATISFACTION OF HIS/HER NON-REFUNDABLE DEPOSIT TO CAPTURE ALL PATIENTS WHO ARE POTENTIALLY ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER THE IU HEALTH FINANCIAL ASSISTANCE POLICY, IU HEALTH WILL DEEM PATIENTS/GUARANTORS TO BE PRESUMPTIVELY ELIGIBLE FOR FINANCIAL ASSISTANCE IF THEY ARE FOUND TO BE ELIGIBLE FOR ONE OF THE FOLLOWING PROGRAMS, RECEIVED EMERGENCY OR DIRECT ADMIT CARE, AND SATISFIED THE REQUIRED CO-PAY/DEDUCTIBLE 1 INDIANA CHILDREN'S SPECIAL HEALTH CARE SERVICES 2 MEDICAID 3 HEALTHY INDIANA PLAN 4 PATIENTS WHO ARE AWARDED HOSPITAL PRESUMPTIVE ELIGIBILITY 5 ENROLLED IN A STATE AND/OR FEDERAL PROGRAM THAT VERIFIES THE PATIENT'S GROSS HOUSEHOLD INCOME IS LESS THAN OR EQUAL TO 200% OF THE FEDERAL POVERTY LEVEL (FPL) IU HEALTH ALSO CONDUCTS A QUARTERLY REVIEW OF ALL ACCOUNTS PLACED WITH A COLLECTION AGENCY PARTNER FOR A PERIOD OF NO LESS THAN ONE HUNDRED AND TWENTY (120) DAYS AFTER THE ACCOUNT IS ELIGIBLE FOR AN EXTRAORDINARY COLLECTION ACTIONS SAID ACCOUNTS MAY BE ELIGIBLE FOR ASSISTANCE UNDER THE FINANCIAL ASSISTANCE POLICY BASED ON THE PATIENT'S INDIVIDUAL SCORING CRITERIA AND ARE NOT INCLUDED IN BAD DEBT DUE TO THIS COMPREHENSIVE METHODOLOGY, IU HEALTH DOES NOT BELIEVE ANY AMOUNT OF BAD DEBT IS ATTRIBUTABLE TO PATIENTS WHO MAY BE ELIGIBLE UNDER THE FINANCIAL ASSISTANCE POLICY AND NO PORTION OF BAD DEBT IS INCLUDED AS COMMUNITY BENEFIT

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part III, Line 4 - Bad Debt Expense	IU HEALTH'S CONSOLIDATED FINANCIAL STATEMENTS, FOOTNOTE 4, ADDRESSES BAD DEBT EXPENSE AS FOLLOWS THE INDIANA UNIVERSITY HEALTH SYSTEM DOES NOT REQUIRE COLLATERAL OR OTHER SECURITY FROM ITS PATIENTS, SUBSTANTIALLY ALL OF WHOM ARE RESIDENTS OF THE STATE, FOR THE DELIVERY OF HEALTH CARE SERVICES HOWEVER, CONSISTENT WITH INDUSTRY PRACTICE, THE INDIANA UNIVERSITY HEALTH SYSTEM ROUTINELY OBTAINS ASSIGNMENT OF (OR IS OTHERWISE ENTITLED TO RECEIVE) PATIENTS' BENEFITS PAYABLE UNDER THEIR HEALTH INSURANCE PROGRAMS, PLANS OR POLICIES (E G , MEDICARE, MEDICAID, MANAGED CARE PAYERS, AND COMMERCIAL INSURANCE POLICIES) THE INDIANA UNIVERSITY HEALTH SYSTEM USES A PORTFOLIO APPROACH TO ACCOUNT FOR CATEGORIES OF PATIENT CONTRACTS AS A COLLECTIVE GROUP, RATHER THAN RECOGNIZING REVENUE ON AN INDIVIDUAL CONTRACT BASIS THE PORTFOLIOS CONSIST OF MAJOR PAYER CLASSES FOR INPATIENT REVENUE AND OUTPATIENT REVENUE BASED ON THE HISTORICAL COLLECTION TRENDS AND OTHER ANALYSIS, THE INDIANA UNIVERSITY HEALTH SYSTEM BELIEVES THAT REVENUE RECOGNIZED BY UTILIZING THE PORTFOLIO APPROACH APPROXIMATES THE REVENUE THAT WOULD HAVE BEEN RECOGNIZED IF AN INDIVIDUAL CONTRACT APPROACH WERE USED IN SUPPORT OF ITS MISSION, THE INDIANA UNIVERSITY HEALTH SYSTEM PROVIDES CARE TO UNINSURED AND UNDERINSURED PATIENTS THE INDIANA UNIVERSITY HEALTH SYSTEM PROVIDES CHARITY CARE TO PATIENTS WHO LACK FINANCIAL RESOURCES AND ARE DEEMED TO BE MEDICALLY INDIGENT UNDER ITS FINANCIAL ASSISTANCE POLICY, THE INDIANA UNIVERSITY HEALTH SYSTEM PROVIDES MEDICALLY NECESSARY CARE TO UNINSURED PATIENTS WITH INADEQUATE FINANCIAL RESOURCES AT CHARITABLE DISCOUNTS EQUIVALENT TO THE AMOUNTS GENERALLY BILLED, AND IT PROVIDES ELIGIBILITY FOR FULL CHARITY FOR EMERGENT ENCOUNTERS FOR UNINSURED PATIENTS WHO EARN LESS THAN 200% OF THE FEDERAL POVERTY LEVEL AND WHO MEET APPLICATION CRITERIA PATIENTS WHOSE LIABILITY IS DEEMED CATASTROPHIC RELATIVE TO THEIR ANNUAL HOUSEHOLD INCOME ARE ALSO ELIGIBLE FOR REDUCED CHARGES SINCE THE INDIANA UNIVERSITY HEALTH SYSTEM DOES NOT PURSUE COLLECTION OF THESE AMOUNTS, THE DISCOUNTED AMOUNTS ARE NOT REPORTED AS PATIENT SERVICE REVENUE THE INDIANA UNIVERSITY HEALTH SYSTEM USES PRESUMPTIVE ELIGIBILITY SCREENING PROCEDURES FOR FREE CARE AND RECOGNIZES NET PATIENT SERVICE REVENUE ON SERVICES PROVIDED TO SELF-PAY PATIENTS AT THE DISCOUNTED RATE AT THE TIME SERVICES ARE RENDERED THE ESTIMATED COST OF CHARITY CARE, USING THE CONSOLIDATED COST TO CHARGE RATIO, WAS $94,886,000 AND $85,295,000 IN 2018 AND 2017, RESPECTIVELY

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part III, Line 8 - Medicare Shortfall	The amount reported on Schedule H, Part III, Line 6 is calculated, in accordance with the Form 990 instructions, using "allowable costs" from the IU Health West Hospital Medicare Cost Report "Allowable costs" for Medicare Cost Report purposes, however, are not reflective of all costs associated with IU Health West Hospitals participation in Medicare programs For example, the Medicare Cost Report excludes certain costs such as billed physician services, the costs of Medicare Parts C and D, fee schedule reimbursed services, and durable medical equipment services Inclusion of all costs associated with IU Health Wests participation in Medicare programs would significantly increase the Medicare shortfall reported on Schedule H, Part III, Line 7 IU Health West Hospital's Medicare shortfall is attributable to reimbursements that are less than the cost of providing patient care and services to Medicare beneficiaries and does not include any amounts that result from inefficiencies or poor management IU Health West Hospital accepts all Medicare patients knowing that there may be shortfalls, therefore it has taken the position that any shortfall should be counted as part of its community benefit Additionally, it is implied in Internal Revenue Service Revenue Ruling 69-545 that treating Medicare patients is a community benefit Revenue Ruling 69-545, which established the community benefit standard for nonprofit hospitals, states that if a hospital serves patients with governmental health benefits, including Medicare, then this is an indication that the hospital operates to promote the health of the community

Form and Line Reference	Explanation
Schedule H, Part III, Line 9b - Written Debt Collection Policy	IU Health West Hospitals FAP and Written Debt Collection Policy describe the collection pr actices applicable to patients, including those who may qualify for financial assistance 1 Financial Assistance Application Patients or their guarantors wishing to apply for Fina ncial Assistance are encouraged to submit a Financial Assistance Application within ninety (90) days of their discharge Patients or their guarantors may submit an application up t o two-hundred and forty (240) days from the date of their first billing statement from IU Health, however, accounts may be subject to ECA as soon as one hundred and twenty (120) da ys after having received their first billing statement Patients or their guarantors submi tting an incomplete application will receive written notification of the applications defi ciency upon discovery by IU health The application will be pended for a period of forty-f ive (45) days from the date the notification is mailed IU Health will suspend any ECA unt il the application is complete, or the patient fails to cure any deficiencies in their app lication in the allotted period Patients with limited English proficiency may request to have a copy of the FAP, a FAP Application, and FAP Plain Language Summary in one of the be low languages - Arabic - Burmese - Burmese-Falam - Burmese-Hakha Chin - Mandarin/Chinese - Spanish The patient, and/or their representative, such as the patients physician, family members, legal counsel, community or religious groups, social services or hospital person nel may request a FAP Application to be mailed to a patients primary mailing address free of charge IU Health West Hospital keeps all applications and supporting documentation con fidential Patients applying for assistance under the FAP will be required to complete a F inancial Assistance Application Patients must include the following documentation with th eir Financial Assistance Application - All sources of Income for the last three (3) month s, - Most recent three (3) months of pay stubs or Supplemental Security Income via Social Security, - Most recent three (3) statements from checking and savings accounts, certifica tes of deposit, stocks, bonds and money market accounts, - Most recent state and Federal I ncome Tax forms including schedules C, D, E, and F In the event a patients and/or guarant ors income does not warrant the filing of a federal tax return, the patient may submit a n otarized affidavit attesting to the foregoing, - Most recent W-2 statement, - For patients or members of the Household who are currently unemployed, Wage Inquiry from WorkOne, and - If applicable, divorce/dissolution decrees and child custody order 2 Eligibility Determ ination IU Health West Hospital will inform patients or guarantors of the results of their application by providing the patient or guarantor with a Financial Assistance Determinati on within ninety (90) days of receiving a completed Application and all requested document ation If a patient or guarantor is granted less than full charity assistance and the pati ent or guarantor provides additional information for reconsideration, IU Health Revenue Cy cle Services may amend a prior Financial Assistance Determination If a patient or guarant or seeks to appeal the Financial Assistance Determination further, a written request must be submitted, along with the supporting documentation, to the Financial Assistance Committ ee for additional review/reconsideration All decisions of the Financial Assistance Commit tee are final A patients Financial Assistance Application and eligibility determination a re specific to each individual date(s) of service and related encounters 3 Extraordinary Collection Actions IU Health West Hospital may refer delinquent patient accounts to a thi rd-party collection agency after utilizing reasonable efforts to determine a patients elig ibility for assistance under the FAP IU Health West Hospital and its third-party collecti on agencies may initiate ECA against a patient or their guarantor in accordance with this Policy and 26 C F R 1 501(r) Said ECA may include the following - Selling a patients or their guarantors outstanding financial responsibility to a third party - Reporting adver se information about the patient or their guarantor to consumer credit reporting agencies or credit bureaus - Deferring or denying, or requiring a payment before providing, medica lly necessary care because of a patients or their guarantors nonpayment of one or more bil ls for previously provided care covered under the FAP - Actions requiring a legal or judi cial process, including but not limited to placing a lien on patients or their guarantors property, foreclosing on a patients or their guarantors real property attaching or seizing a patients or their guarantors bank account or other personal property, commencing a civi l action against a patient or their guarantor, causing a patient or guarantors arrest, cau sing a patient and/or guarantor to be subject to a

Form and Line Reference	Explanation
Schedule H, Part III, Line 9b - Written Debt Collection Policy	writ of body attachment, and garnishing a patient or guarantors wages When it is necessa ry to engage in such action, IU Health West Hospital and its third party collection agenci es, will engage in fair, respectful and transparent collections activities Patients or gu arantors currently subject to an ECA who have not previously applied for Financial Assista nce may apply for assistance up to two-hundred and forty (240) days of the date of their f irst billing statement from IU Health West Hospital IU Health West Hospital and their thi rd-party collection agencies will suspend any ECA engaged on a patient or their guarantor while an Application is being processed and considered 4 Refunds Patients eligible for a ssistance under the FAP who remitted payment to IU Health West Hospital in excess of their patient responsibility will be alerted to the overpayment as promptly after discovery as is reasonable given the nature of the overpayment Patients with an outstanding account ba lance on a separate account not eligible for assistance under the FAP will have their refu nd applied to the outstanding balance Patients without an outstanding account balance des cribed above will be issued a refund check for their overpayment as soon as technically fe asible

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part VI, Line 2 - Needs Assessment	Communities are multifaceted and so are their health needs IU Health West Hospital understands that the health of individuals and communities are shaped by various social and environmental factors, along with health behaviors and additional influences IU Health West Hospital assesses the health care needs of the communities it serves by conducting a Community Health Needs Assessment (CHNA) For the 2018 CHNA, IU Health West Hospital conducted the community survey data collection in collaboration with Indiana University, University of Evansville and an Indiana Hospital Collaborative, including Community Health Network, Franciscan Alliance, St Vincent Health and other hospital partners After completion of the CHNA, IU Health West Hospital reviewed secondary data, findings from other community health assessments of areas served by the hospital, input obtained from individuals who participated in community meetings, input obtained from key stakeholders, and a community survey to identify and analyze the needs identified by each source The top health needs of the IU Health West Hospital community are those that are supported by multiple data sources Additionally, the effectiveness of an intervention for each need and IU Healths ability to impact positive change was evaluated

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part VI, Line 3 - Patient Education of Eligibility for Assist	IU Health West Hospital is committed to serving the healthcare needs of all of its patients regardless of their ability to pay for such services To assist in meeting those needs, IU Health West Hospital has established a FAP to provide Financial Assistance to Uninsured Patients IU Health West Hospital is committed to ensuring its patients are compliant with all provisions of the Patient Protection & Affordable Care Act To that end, IU Health West Hospital will make a good faith effort to locate and obtain health insurance coverage for patients prior to considering patients for coverage under the FAP IU Health West Hospital takes several measures to inform its patients of the FAP and FAP-eligibility These measures include the following 1 Conspicuous public displays will be posted in appropriate acute care settings such as the emergency department and registration areas describing the available assistance and directing eligible patients to the Financial Assistance Application 2 IU Health West Hospital will include a conspicuous written notice on all patient billing statements that notifies the patient about the availability of this Policy, and the telephone number of its Customer Service Department which can assist patients with any questions they may have regarding this Policy 3 IU Health Customer Service representatives will be available via telephone Monday through Friday, excluding major holidays, from 8 00 a m to 7 00 p m Eastern Time to address questions related to this Policy 4 IU Health West Hospital will broadly communicate this Policy as part of its general outreach efforts 5 IU Health West Hospital will educate its patient facing team members of the FAP and the process for referring patients to the Program

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part VI, Line 4 - Community Information	IU Health West Hospital is located in Hendricks County, Indiana, a county located in central Indiana Based on the most recent Census Bureau (2018) statistics, Hendricks Countys population is 167,009 persons with approximately 50% being female and 50% male The countys population estimates by race are 83 8% White, 7 4% Black, 4 0% Hispanic or Latino, 3 0% Asian, 0 3% American Indian or Alaska Native, 0 1% Native Hawaiian or Other Pacific Islander and 2 1% persons reporting two or more races Hendricks County has relatively moderate levels of educational attainment Among adults 25 and above, 94% completed their education with a high school diploma or equivalent 35% had a bachelors degree or higher About 6% ended their formal education before finishing high school

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part VI, Line 5 - Promotion of Community Health	IU HEALTH WEST HOSPITAL IS A SUBSIDIARY OF INDIANA UNIVERSITY HEALTH, INC , A TAX-EXEMPT HEALTHCARE ORGANIZATION, WHOSE BOARD OF DIRECTORS IS COMPOSED OF MEMBERS, OF WHICH SUBSTANTIALLY ALL ARE INDEPENDENT COMMUNITY MEMBERS IN ORDER TO HELP THE COMMUNITY IN ACCESSING HEALTHCARE, IU HEALTH WEST HOSPITAL PARTNERS WITH HOPE HEALTHCARE SERVICES IN AVON, INDIANA, TO HELP MEET THE NEEDS OF HENDRICKS COUNTY RESIDENTS WHO CONTINUE TO BE UN- OR UNDER-INSURED HOPE HEALTHCARE SERVICES SERVES MORE THAN 800 PEOPLE EACH YEAR WITH PRIMARY MEDICAL AND DENTAL CARE, CHRONIC DISEASE MANAGEMENT, AND MEDICATION MANAGEMENT MULTIPLE IU HEALTH WEST PHYSICIANS VOLUNTEER AT THE CLINIC, WHERE MEDICAL AND DENTAL CARE IS SUPPORTED ENTIRELY BY VOLUNTEER HEALTHCARE PROVIDERS ADDITIONALLY TO ASSIST WITH OBESITY PREVENTION, IU HEALTH WEST HOSPITAL AND THE TOWN OF BROWNSBURG, IN PARTNER TO PRESENT THE TOWN'S FARMERS MARKET FROM MAY-SEPTEMBER ON THE TOWN HALL GREEN IN ADDITION TO CREATING A VENUE FOR RESIDENTS TO ACCESS LOCALLY GROWN FRESH PRODUCE, THE HOSPITAL AND TOWN ARE COMMITTED TO SUPPORTING AT RISK INDIVIDUALS AND FAMILIES, BY ACCEPTING WIC AND SNAP PAYMENTS FOR PRODUCE, AND BY PROVIDING A COLLECTION LOCATION FOR PRODUCE DONATIONS TO BROWNSBURG AREA FOOD PANTRIES TO IMPROVE THE PRE K-12TH EDUCATION, IU HEALTH WEST HOSPITAL AND THE AVON SCHOOL CORPORATION HOST A FREE, FOUR WEEK KINDERGARTEN PREPARATORY PROGRAM EVERY JUNE THE CHILDREN INVITED TO PARTICIPATE HAVE BEEN IDENTIFIED THROUGH THE DISTRICT'S KINDERGARTEN ASSESSMENT AS NEEDING A BOOST IN ORDER TO BE READY TO SUCCEED IN THE CLASSROOM KINDERGARTEN TEACHERS STAFF THE CLASSROOM, WITH THE HELP OF 40+ HOSPITAL VOLUNTEERS OVER THE COURSE OF FOUR WEEKS, ALL OF WHOM HELP CHILDREN LEARN THE CLASSROOM BASICS, SUCH AS RAISING HANDS AND WALKING IN LINES, AND HELP SET THE STAGE FOR READING, WRITING AND MATH SUCCESS IN THE YEARS AHEAD

Form and Line Reference	Explanation
Schedule H, Part VI, Line 6 - Affiliated Health Care System	IU Health West Hospital is part of the IU Health Statewide System The IU Health Statewide system is Indianas most comprehensive healthcare system With hospitals, physician office s and allied services, IU Health provides access to a full range of specialty and primary care services for adults and children A unique partnership with Indiana University School of Medicine - one of the nation's leading medical schools - gives patients access to grou ndbreaking research and innovative treatments to complement high-quality care National Re cognition - Eight hospitals designated as Magnet by the American Nurses Credentialing Cent er recognizing excellence in nursing care - Indiana University Health Medical Center is ho nored to be nationally ranked by U S News & World Report for the 21st year in a row That means IU Health continues to be ranked among the best healthcare systems in the nation an d the top healthcare system in Indiana This ranking recognizes the exceptional care, unma tched expertise and continued excellence of our entire team of caregivers, while giving yo u confidence that you made the right choice in trusting IU Health with your care - IU Hea lth Medical Center was among the 4 percent of U S hospitals to earn a national ranking an d has the most nationally ranked specialties in Indiana - Nine out of ten specialty progr ams at Riley Hospital for Children at IU Health ranked among the top 50 childrens hospital s in the nation Education and Research As an academic health center, IU Health works in pa rtnership with the IU School of Medicine to train physicians, blending breakthrough resear ch and treatments with the highest quality of patient care Each year, more than 1,000 res idents and fellows receive training in IU Health hospitals Research conducted by IU Schoo l of Medicine faculty gives IU Health physicians and patients access to the most leading-e dge and comprehensive treatment options IN 2012, IU HEALTH COMMITTED TO A STRATEGIC RESEA RCH INITIATIVE TO SUPPORT RATABLY FOR A FIVE-YEAR PERIOD ENDED DECEMBER 31, 2016, CERTAIN BASIC, CLINICAL, AND TRANSLATIONAL RESEARCH PROGRAMS OF THE IU SCHOOL OF MEDICINE THE TOT AL COMMITMENT AGGREGATED $75,000,000 IN 2017, A NEW FIVE-YEAR TERM OF $55,000,000 WAS AGR EED UPON EFFECTIVE JULY 1, 2017 THROUGH JUNE 30, 2022 FOR THE YEARS ENDED DECEMBER 31, 20 18 AND 2017, THE INDIANA UNIVERSITY HEALTH SYSTEM EXPENSED $11,000,000 AND $5,000,000, RES PECTIVELY, UNDER THESE AGREEMENTS WITHIN SUPPLIES, DRUGS, PURCHASED SERVICES, AND OTHER EX PENSES IN THE ACCOMPANYING CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS , OF WHICH $25,652,000 AND $32,875,000 WAS ACCRUED RELATED TO THESE AGREEMENTS WITHIN ACCO UNTS PAYABLE AND ACCRUED EXPENSES AT DECEMBER 31, 2018 AND 2017, RESPECTIVELY The three t arget research areas represent research strengths at IU School of Medicine, key strategic service lines for IU Health, and important medical needs in a time of an aging population and rising healthcare costs - Cancer One of the initiative's primary goals is to enable the IU Health Melvin and Bren Simon Cancer Center to attain the National Cancer Institute' s top status of "comprehensive," which would recognize it as one of the top-tier cancer ce nters in the nation - Neuroscience The neurosciences research program will tackle a broa d range of brain injuries, neurodegenerative disorders and neurodevelopmental disorders - Cardiovascular The cardiovascular research initiative will develop a comprehensive progr am for the study and treatment of heart failure, from newborns to older adults A top prio rity is developing a cardiovascular genetics program The Strategic Research Initiative wi ll provide patients with access to internationally renowned physicians and to new therapie s developed through translational research and clinical trials, and will make use of the l atest genetic tools to develop personalized therapies that are more effective for individu als and efficient for healthcare providers IU Health Statewide System IU Health is a part of the IU Health Statewide System which continues to broaden its reach and positive impac t throughout the state of Indiana IU Health is Indianas most comprehensive academic healt h center and consists of IU Health Methodist Hospital, IU Health University Hospital, Rile y Hospital for Children at IU Health, and IU Health Saxony Hospital Other hospitals in th e IU Health Statewide System include the following - IU Health Arnett Hospital - IU Healt h Ball Memorial Hospital - IU Health Bedford Hospital - IU Health Blackford Hospital - IU Health Bloomington Hospital - IU Health Frankfort Hospital - IU Health Jay Hospital - IU H ealth North Hospital - IU Health Paoli Hospital - IU Health Tipton Hospital - IU Health We st Hospital - IU Health White Memorial Hospital Although each hospital in the IU Health St atewide System prepares and submits its own community benefits plan relative to the local community, the IU Health Statewide System consider

Form and Line Reference	Explanation
Schedule H, Part VI, Line 6 - Affiliated Health Care System	s its community benefit plan as part of an overall vision for strengthening Indianas overa ll health A comprehensive community outreach strategy and community benefit plan is in pl ace that encompasses the academic medical center downtown Indianapolis, suburban Indianapo lis and statewide entities around priority areas that focus on health improvement efforts statewide IU Health is keenly aware of the positive impact it can have on the communities of need in the state of Indiana by focusing on the most pressing needs in a systematic an d strategic way In 2018, IU Health provided more than $711 million in total community ben efit and served more than one million individuals Some ways we address our community heal th priorities as a system include IU Health Day of Service The annual IU Health Days of S ervice is a high-impact event aimed at engaging IU Health team members in activities that address an identified community priority IN 2018, MORE THAN 2,848 IU HEALTH TEAM MEMBERS DEDICATED MORE THAN 9,694 VOLUNTEER HOURS IN THEIR COMMUNITIES Community Health Initiativ es With investments in high-quality and impactful initiatives to address community health needs statewide, IU Health is helping Indiana residents improve their health and their qua lity of life In 2018, IU Health impacted many people statewide through presentations, hea lth risk screenings, health education programs, and additional health educational opportun ities made available to the community, especially to our community members in the greatest need of such services The Indiana University Health Board of Directors also approved Com munity Health Improvement Grants With these grants, nearly $750,000 will fund projects th at address IU Health priorities - behavioral health/substance abuse, obesity, tobacco use, and infant mortality - as well as community-specific needs The grants, administered by t he Indiana University Health Foundation, were awarded to the following - Family Vitality Initiative development and implementation, IU Health South Central Region, $230,000 over t wo years By bringing together existing healthcare providers, social workers and researche rs, this integrated program will take a holistic approach to addressing substance-related healthcare issues, especially among the most vulnerable populations of women and children The South Central Region has seen alarming increases in the numbers of infants who test p ositive for opiates at birth, opioid-related encounters in each emergency department, and mothers struggling with addiction including smoking - Hope Healthcare Services Program, I U Health West, $203,000 over two years Hope Healthcare Services in Avon is the only entit y in Hendricks County that provides primary medical and dental care to uninsured patients It is staffed entirely by volunteer clinicians, many of them IU Health team members, and helps more than 900 patients a year out of nearly 15,000 uninsured adults in Hendricks Cou nty This grant will fund the clinics first-ever employee, a nurse practitioner, allowing for consistent operating hours, and behavioral health services on-site and via tele-health With this staffed clinic, they anticipate seeing more than 4,000 patients per year - Pe rinatal Coordinator to address infant mortality, IU Health East Central Region, $124,000 o ver two years This grant funds a new staff member who will focus on infants and children in Delaware, Blackford and Jay counties This includes facilitating inter-professional col laboration, educating hospital staff, increasing collaboration with supporting agencies in volved with bereavement, safe sleep, tobacco-free and addiction programs, and tracking out comes in the areas of birthweight, birth defects and mortality - Continuum of Mental Heal th Care Program, IU Health West Central Region, $85,247 for one year In terms of mental i llness and access to mental health care, Indiana ranks 48th out of 51 states In its pilot year, this project will increase capaci

Additional Data

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Name: INDIANA UNIVERSITY HEALTH WEST HOSPITAL INC

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

Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? **1** 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	IU HEALTH WEST HOSPITAL 1111 N RONALD REAGAN PKWY AVON, IN 46123 SEE PART V, SECTION C 19-003776-1	X	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
Schedule H, Part V, Section A, Line 1 Primary Website Address	https //iuhealth org/find-locations/iu-health-west-hospital

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

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Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 3e Prioritized Health Needs	IU HEALTH WEST HOSPITAL'S 2018 COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) REPORT INCLUDES A PRIORITIZED DESCRIPTION OF SIGNIFICANT HEALTH NEEDS IN THE COMMUNITY THE CHNA REPORT IDENTIFIED THE FOLLOWING SEVEN NEEDS AS PRIORITIES FOR IU HEALTH WEST HOSPITAL - Access to Health Care Services - Drug and Substance Abuse - Food Insecurity - Mental Health - Obesity and Diabetes - Smoking and Tobacco Usage - Social Determinants of Health

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
Schedule H, Part V, Section B, Line 5 Input from Community	In conducting its most recent Community Health Needs Assessment ("CHNA") IU Health West Ho spital took into account input from persons who represent the broad interests of the commu nities it serves Primary data were gathered in three different methodologies for this ass essment Community Meetings, Key Stakeholder Interviews, and a Community Survey For purpo ses of this CHNA, IU Health West Hospitals community is defined as Hendricks and Marion Co unties, Indiana These two counties accounted for 87 8 percent of the hospitals inpatient cases in 2016 Community Meetings Hendricks County On July 24, 2018, a meeting of communit y representatives was held at the IU Health West Hospital in Avon, which is part of Hendri cks County The meeting was attended by 15 community members invited by IU Health because they represent important community organizations and sectors such as local health departm ents, police/fire departments, non-profit organizations, business community, health care p roviders, local policymakers, faith-based organizations, and schools Through this meeting , IU Health sought a breadth of perspectives on the communitys health needs The specific organizations represented at the meeting are listed below - American Lung Association - A von Community School Corporation - Avon Washington Township Fire Department - Franciscan A lliance - HOPE Healthcare Services - Hendricks County Health Department - Hendricks County Senior Services - Hendricks County Substance Abuse Task Force - Hendricks County Tobacco Coalition - Hendricks Regional Health - IU Health West Hospital - Kids Count - Mental Heal th American Hendricks County - Susies Place The meeting was requested by IU Health to obta in community input into the communitys health needs The session began with a presentation that discussed the goals and status of the CHNA process and the purpose of the community meeting Then, secondary data were presented, along with a summary of the most "unfavorabl e" community health indicators For Hendricks County those indicators were (in alphabetica l order) - Access to healthy food - Air pollution - Crime (violent crime) - Excessive dri nking - Mental health and supply of mental health providers - Obesity and lack of physical activity Participants then were asked to discuss whether the identified, unfavorable indi cators accurately identified the most significant community health issues and were encoura ged to add issues that they believed were significant Several issues were added, such as tobacco use, low income housing, access to affordable healthcare, adverse childhood event s, and aging population Air pollution was removed from the list, and the excessive drinki ng line item was amended to include substance abuse During the meeting, a range of other topics was discussed, including - Poverty rate numbers and relationship to 'ALICE' data - Immigrants in the community and representation in data - Western part of Hendricks County where food deserts are a bigg

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Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Input from Community	er issue that didnt seem to come through in secondary data - Social associations data comp ared to abundance of churches and civic clubs in Hendricks County - Mental health services issues facing the sheriffs department/jail population - Low numbers of providers compared to the population and low number of providers who have spots available for Medicaid patie nts - Vaping - Trauma in childhood as a leading indicator of many of the adult issues disc ussed - Challenge of finding affordable housing After discussing the needs identified thro ugh secondary data and adding others to the list, each participant was asked to identify " three" that are most significant From this process, the group identified the following ne eds as most significant in Hendricks County - Mental health and supply of mental health p roviders - Access to affordable healthcare - Adverse childhood events - Tobacco use - Tied for fifth Access to healthy food, excessive drinking & substance abuse, and aging popula tion Interviews Hendricks County An interview was also conducted with a representative of the Hendricks county health department The interview was conducted to assure that appropr iate and additional input was received from governmental public health officials The resu lts of the community meetings were discussed and insights were sought regarding significan t community health needs, why such needs are present, and how they can be addressed The i nterview was guided by a structured protocol The interview was guided by a structured pro tocol that focused on opinions regarding significant community health needs, describing wh y such needs are present, and seeking ideas for how to address them The interviewee confi rmed that the needs identified by the community meeting participants were significant The se needs were - Mental health and supply of mental health providers - Access to affordabl e healthcare - Adverse childhood events There is a lack of mental and behavioral health pr oviders, including psychiatrists, substance abuse specialists, inpatient care, and others It is often difficult to locate resources for those with substance abuse issues or suicid al ideations In general, there is an undersupply of providers in the county, and more pro grams may be needed to incentivize providers to practice locally Access to affordable car e is an issue, especially with a recent closure of a facility that provided services for l ower-income residents Low income populations and those that do not receive healthcare ben efits through their employers are disproportionately affected The need for affordable pri mary care also generates a need for more preventive health care and screenings, as many re sidents do not go to a provider unless an emergency situation occurs Substance abuse and drug addiction is a major concern, particularly around opioids Availability of opioids is high and the cost of these drugs has decreased, leading to increased usage Additionally, pill abuse is also rising as

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Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Input from Community	it is often easy to get a prescription for an opioid Pain management treatment in general is difficult to access in the county Obesity and physical inactivity are concerns in the community Certain areas of the county do not live close to stores selling healthy foods, so often go to fast food instead Additionally, sidewalks and other healthy-living infras tructure are in short supply Obesity is also leading to chronic issues as the population ages, including bad knees, bad backs, diabetes, hypertension, and other conditions Housin g is a concern in the community, particularly affordable housing for low income residents Current rental units can be unclean, and environmental health issues are common More res ources are needed for public health programming, as there are fewer low income clinics, st affing issues exist, and programs are not as widely disseminated as possible Community Me etings Marion County Between May 7 and 9, 2018, three meetings of community representative s were held in Indianapolis, the county seat of Marion County In total, the meetings were attended by 42 community members invited by IU Health because they represent important co mmunity organizations and sectors such as local health departments, police/fire departmen ts, non-profit organizations, local business, health care providers, mayors/local policyma kers, faith-based organizations, parks and recreation departments, and schools Through th e meetings, IU Health sought a breadth of perspectives on the communitys health needs The specific organizations represented at the meetings are listed below - Adult and Child He alth - All Senior Citizens Connect - Central Indiana Council on Aging (CICOA) - City of In dianapolis - Coburn Place - Community Health Network - Gennesaret Free Clinics - Gleaners Food Bank - Health by Design - IU Health Methodist Hospital - IU Health University Hospita l - Indiana Youth Institute - Indianapolis Fire Department - Indianapolis Metropolitan Pol ice Department - Indy Hunger Network - Indianapolis Parks and Recreation - Irvington Devel opment Organization - Jump IN for Healthy Kids - Lawrence Community Gardens - Marion Count y Public Health Department - New Beginnings Church - Paramount Schools of Excellence - Pro gress House - Purdue Extension - The Polis Center - University of Indianapolis The meeting began with a presentation that discussed the goals and status of the CHNA process and the purpose of the community meetings Then, secondary data were presented, along with a summ ary of the most unfavorable community health indicators For Marion County, those indicato rs were (in alphabetical order) - Air pollution - Communicable diseases and STDs - Crime - Mental health and supply of mental health providers - Obesity and lack of physical activ ity - Poverty and high 'Community Need Index' - Smoking and tobacco use Meeting participan ts then were asked to discuss whether the identified, unfavorable indicators accurately id entified the most significant

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Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 7a CHNA Website	A COPY OF IU HEALTH WEST HOSPITAL'S CHNA IS AVAILABLE ON ITS WEBSITE AT THE FOLLOWING URL https //iuhealth org/in-the-community

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Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 10a Implementation Strategy Website	A COPY OF IU HEALTH WEST HOSPITAL'S CHNA IMPLEMENTATION STRATEGY IS AVAILABLE ON ITS WEBSITE AT THE FOLLOWING URL https //iuhealth org/in-the-community

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
Schedule H, Part V, Section B, Line 11 Addressing Identified Needs	In conjunction with the CHNA, IU Health West Hospitals Board adopted an implementation str ategy in April 2019 related to the 2018 CHNA IU Health West Hospital prioritized and dete rmined which of the community health needs identified in its most recently conducted CHNA were most critical for it to address IU Health West Hospital will address the following c ommunity health needs between 2019 and 2021 - Access to Healthcare Services - Drug and Su bstance Abuse (including Opioids and Alcohol) - Food Insecurity - Mental Health - Obesity and Diabetes - Smoking and Tobacco Usage - Social Determinants of Health IU Health uses th e term "Behavioral Health" to refer to Mental Health and Drug and Substance Abuse (includi ng Opioids and Alcohol) Access to Healthcare IU Health West Hospitals implementation stra tegy to address the identified need of Access to Healthcare includes the following - Prov ide operational funding to support HOPE Healthcare Services - Participate in or support 4 -6 Healthy Indiana Plan (HIP)/Medicaid/Medicare registration events with the Hendricks Cou nty Health Partnership Behavioral Health (includes Drug & Substance Abuse and Mental Heal th) IU Health West Hospitals implementation strategy to address the identified need of Beh avioral Health includes the following - Partner with the Hendricks County Health Partners hip to create a three-minute education video for student athletes - Partner with the Hend ricks County Health Partnership to create a three-minute education video for providers and parents - Partner with the Hendricks County Health Partnership to host public forums abo ut the stigma of substance use disorders Include live testimonials from individuals with substance use disorders (SUD) - Provide funding to support safe shelter for and evaluatio n of Sheltering Wings residents - Support Sheltering Wings educational outreach efforts - Provide funding to support counseling for Susies Place clients - Replicate the Academic Health Centers successful Addictions and Pain Management Program in the IU Health West se rvice area Provide 24/7 peer counseling via telemedicine for patients who present in the emergency department (ED) with substance use disorders (SUD) Food Insecurity IU Health We st Hospitals implementation strategy to address the identified need of Food Insecurity inc ludes the following - Make fresh produce affordable and accessible to low-income resident s - Support Women, Infants, and Children (WIC) and Supplemental Nutrition Assistance Prog ram (SNAP) acceptance at all county farmers markets - Fund Double Up Bucks program to inc rease value of vouchers for participants Obesity and Diabetes IU Health West Hospitals im plementation strategy to address the identified need of Obesity and Diabetes include the f ollowing - Continue current partnership with Brownsburg Farmers Market - Utilize bushel builders cards to encourage regular attendance - Provide 50 Hendricks County residents wi th a free 10-week program to i

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Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Addressing Identified Needs	mprove their overall health through fitness and nutrition - Provide three health screenin gs during the 10-week period to measure changes in cholesterol, triglycerides, glucose, A1 C, blood pressure, weight and Body Mass Index (BMI) - Support state grant to fund ten mil e section of trail expansion - Fund a 5K event and offer prep/training tips to encourage new walkers and runners - Partner with the Brownsburg Parks & Recreation to make improvem ents to local parks, thus encouraging greater physical activity in the parks by Hendricks County residents and visitors Smoking and Tobacco Usage IU Health West Hospitals implemen tation strategy to address the identified need of Smoking and Tobacco Usage include the fo llowing - Collaborate with the Hendricks County Health Partnership to present a template of a comprehensive smoke-free workplace policy to the Town of Brownsburg - Collaborate wi th the Hendricks County Health Partnership to reinitiate contact with school administrator s and guidance counselors to ensure educational posters are displayed in schools - Write and distribute press release about student outreach program - Encourage school administra tors to send educational material to all parents Social Determinants of Health IU Health West Hospitals implementation strategy to address the identified need of Social Determinan ts of Health include the following - Provide operational funding to support HOPE Healthca re Services - Make fresh produce affordable and accessible to low-income residents - Sup port Women, Infants, and Children (WIC) and Supplemental Nutrition Assistance Program (SNA P) acceptance at all county farmers markets - Fund Double Up Bucks program to increase va lue of vouchers for participants - Support state grant to fund ten mile section of trail expansion - Fund a 5K event and offer prep/training tips to encourage new walkers and run ners - Partner with the Brownsburg Parks & Recreation to make improvements to local parks , thus encouraging greater physical activity in the parks by Hendricks County residents an d visitors IU West Hospital will address all community health needs based on their 2018 C ommunity Health Needs Assessment There were no identified needs that will not be addresse d

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

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Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13b Income Level Other than FPG	IN ADDITION TO FPG, IU HEALTH WEST HOSPITAL MAY TAKE INTO CONSIDERATION A PATIENT'S INCOME AND/OR ABILITY TO PAY IN CALCULATION OF A FINANCIAL ASSISTANCE AWARD

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Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13h Other FAP Factors	IU Health West Hospital takes into consideration several other factors in determining pati ent eligibility for financial assistance These factors include the following 1 IU Healt hs Individual Solutions Department Prior to seeking Financial Assistance under the FAP, al l patients or their guarantors must consult with a member of IU Healths Individual Solutio ns department to determine if healthcare coverage may be obtained from a government insura nce/assistance product or from the Health Insurance Exchange Marketplace 2 Alternate Sou rces of Assistance When technically feasible, a patient will exhaust all other state and f ederal assistance programs prior to receiving an award from IU Health West Hospitals Finan cial Assistance Program Patients who may be eligible for coverage under an applicable ins urance policy, including, but not limited to, health, automobile, and homeowners, must exh aust all insurance benefits prior to receiving an award from IU Health West Hospitals Fina ncial Assistance Program This includes patients covered under their own policy and those who may be entitled to benefits from a third-party policy Patients may be asked to show p roof that such a claim was properly submitted to the proper insurance provider at the requ est of IU Health West Hospital Eligible patients who receive medical care from IU Health West Hospital as a result of an injury proximately caused by a third party, and later rece ive a monetary settlement or award from said third party, may receive Financial Assistance for any outstanding balance not covered by the settlement or award to which IU Health Wes t Hospital is entitled In the event a Financial Assistance Award has already been granted in such circumstances, IU Health West Hospital reserves the right to reverse the award in an amount equal to the amount IU Health West Hospital would be entitled to receive had no Financial Assistance been awarded 3 Alternate Methods of Eligibility Determination IU H ealth West Hospital will conduct a quarterly review of all accounts placed with a collecti on agency partner for a period of no less than one hundred and twenty (120) days after the account is eligible for an Extraordinary Collection Action ("ECA") Said accounts may be eligible for assistance under the FAP based on the patients individual scoring criteria T o ensure all patients potentially eligible for Financial Assistance under the FAP may rece ive Financial Assistance, IU Health West Hospital will deem patients/guarantors to be pres umptively eligible for Financial Assistance if they are found to be eligible for one of th e following programs, received emergency or direct admit care, and satisfied his/her requi red co-pay/deductible - Indiana Childrens Special Health Care Services - Medicaid - Healt hy Indiana Plan - Patients who are awarded Hospital Presumptive Eligibility (HPE) - Enroll ed in a state and/or federal program that verifies the patient's gross household income is less than or equal to 200% of

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
Schedule H, Part V, Section B, Line 13h Other FAP Factors	the Federal Poverty Level 4 Additional Considerations Financial Assistance may be grante d to a deceased patients account if said patient is found to have no estate Additionally, IU Health West Hospital will deny or revoke Financial Assistance for any patient or guara ntor who falsifies any portion of a Financial Assistance application 5 Non-Emergent Serv ices Down Payment Uninsured Patients presenting for scheduled or other non-emergent servic es will not be charged more than the Amounts Generally Billed ("AGB") AGB for their servic es Patients will receive an estimated AGB cost of their care prior to IU Health West Hosp ital rendering the services and will be asked to pay a down-payment percentage of the AGB adjusted cost prior to receiving services In the event a patient is unable to fulfill the down-payment, their service may be rescheduled for a later date as medically prudent and in accordance with all applicable federal and state laws and/or regulations 6 Emergency Services Non-Refundable Deposit This section will be implemented with a strict adherence t o EMTALA and IU Health Policy ADM 1 32, Screening and Transfer of Emergency or Unstable Pa tients Amount of Non-Refundable Deposit All Uninsured Patients presenting for services at IU Health West Hospitals Emergency Department, via transfer from another hospital facilit y, or direct admission, will be responsible for a one-hundred dollar ($100 00) non-refunda ble deposit for services rendered Patients/guarantors will be responsible for any copays and/or deductibles required by their plan prior to full Financial Assistance being applied Uninsured Patients wishing to make an application for Financial Assistance greater than the AGB must fulfill their non-refundable deposit prior to IU Health West Hospital process ing said application Uninsured Patients making payments toward their outstanding non-refu ndable deposit balance will have said payments applied to their oldest application on file , if applicable

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
Schedule H, Part V, Section B, Line 16a FAP Website	A copy of IU Health West Hospitals FAP is available on the following website https //iuhealth org/pay-a-bill/financial-assistance

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
Schedule H, Part V, Section B, Line 16b FAP Application Website	A copy of IU Health West Hospitals FAP Application is available on the following website https //iuhealth org/pay-a-bill/financial-assistance

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
Schedule H, Part V, Section B, Line 16c FAP PLS Website	A plain language summary of the FAP, including translated copies, is available on the following website https //iuhealth org/pay-a-bill/financial-assistance

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
Schedule H, Part V, Section B, Line 16j Other Measures to Publicize	IU Health West Hospital takes several other measures to publicize its FAP within the community These measures include the following 1 Conspicuous public displays will be posted in appropriate acute care settings such as the emergency department and registration areas describing the available assistance and directing eligible patients to the Financial Assistance Application 2 IU Health West Hospital will include a conspicuous written notice on all patient billing statements that notifies the patient about the availability of this Policy, and the telephone number of its Customer Service Department which can assist patients with any questions they may have regarding this Policy 3 IU Health Customer Service representatives will be available via telephone Monday through Friday, excluding major holidays, from 8 00 a m to 7 00 p m Eastern Time to address questions related to this Policy 4 IU Health West Hospital will broadly communicate this Policy as part of its general outreach efforts 5 IU Health West Hospital will educate its patient facing team members of the FAP and the process for referring patients to the Program

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

Schedule I (Form 990)

Department of the Treasury
Internal Revenue Service

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

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

▶ **Attach to Form 990.**

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

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
INDIANA UNIVERSITY HEALTH WEST HOSPITAL INC

Employer identification number
35-1814660

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) HENDRICKS COUNTY ECONOMIC DEVELOPMENT PARTNERSHIP 5250 E US HIGHWAY 36 AVON, IN 46123	35-1817139	501(C)(6)	20,000				COMMUNITY ECONOMIC DEV

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

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

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

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

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

Return Reference	Explanation
Schedule I, Part I, Line 2 - Org 's Proc for Mon the Use of Grant Funds	Although IU Health West Hospital does not monitor the use of grant funds once distributed, through due diligence the organization has reasonably confirmed that the entities to which the contributions are made are highly reputable in the community and use the funds for the purposes intended

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Schedule J (Form 990)

Compensation Information

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

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

▶ **Attach to Form 990.**

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

OMB No 1545-0047

2018

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
INDIANA UNIVERSITY HEALTH WEST HOSPITAL INC

Employer identification number
35-1814660

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**	Yes	
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**	Yes	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	**4c**		No
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III			
	Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.			
5	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of			
a	The organization?	**5a**		No
b	Any related organization?	**5b**		No
	If "Yes," on line 5a or 5b, describe in Part III			
6	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of			
a	The organization?	**6a**		No
b	Any related organization?	**6b**		No
	If "Yes," on line 6a or 6b, describe in Part III			
7	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III	**7**	Yes	
8	Were any amounts reported on Form 990, Part VII, paid or 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							

Part III Supplemental Information

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

Return Reference	Explanation
Schedule J, Part I, Line 3 - Comp of the Org 's CEO/Executive Director	IU HEALTH WEST HOSPITAL'S PRESIDENT IS EMPLOYED BY IU HEALTH IU HEALTH'S PROCESS FOR DETERMINING COMPENSATION INCLUDES THE USE OF A COMPENSATION SURVEY/STUDY CONDUCTED BY AN INDEPENDENT COMPENSATION CONSULTANT WITH REVIEW AND APPROVAL BY THE COMMITTEE ON PERSONNEL AND COMPENSATION AND THE BOARD OF DIRECTORS PLEASE SEE SCHEDULE O FOR ADDITIONAL DETAILS SCHEDULE J, PART I, LINE 4A - SEVERANCE MATTHEW D BAILEY ENTERED INTO A SEVERANCE AGREEMENT WITH IU HEALTH DURING 2018 SEVERANCE OF $190,847 THAT WAS RECEIVED DURING 2018 IS INCLUDED IN COLUMN B(III), OTHER REPORTABLE COMPENSATION DEFERRED SEVERANCE OF $308,429 IS INCLUDED IN COLUMN C, RETIREMENT AND OTHER DEFERRED COMPENSATION

Return Reference	Explanation
Schedule J, Part I, Line 4b - Supplemental Nonqualified Retirement Plan	KENNETH D PUCKETT, MATTHEW D BAILEY, MICHELLE A JANNEY, AND DAVID A INGRAM PARTICIPATE IN AN IU HEALTH SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN, PROVISIONS OF WHICH ARE DESIGNED TO RETAIN ITS CRITICAL EMPLOYEES THE PLAN PROVIDES FOR AN ADDITIONAL RETIREMENT BENEFIT FOR SERVICE THROUGH NORMAL RETIREMENT OR OTHER KEY DATES IF THE EXECUTIVE LEAVES PRIOR TO RETIREMENT OR OTHER KEY DATES, THE BENEFIT MAY BE FORFEITED OR REDUCED EACH OF THESE EXECUTIVES HAS AMOUNTS INCLUDED IN COLUMN C, DEFERRED COMPENSATION, REPRESENTING THE CURRENT YEAR UNVESTED CONTRIBUTIONS MADE UNDER THE SUPPLEMENTAL RETIREMENT PLAN NO AMOUNTS WERE ACTUALLY PAID TO THESE EXECUTIVES DURING THE YEAR

Return Reference	Explanation
Schedule J, Part I, Line 7 - Non-Fixed Payments	AMOUNTS DISCLOSED IN COLUMN B(II) INCLUDE A LONG-TERM AND SHORT-TERM INCENTIVE FOR CERTAIN EXECUTIVES AND SHORT-TERM INCENTIVE FOR OTHER EMPLOYEES ALTHOUGH THESE PLANS ARE BASED ON A FIXED FORMULA THAT HAS BEEN APPROVED BY THE BOARD OF DIRECTORS BASED UPON CERTAIN QUALITATIVE AND QUANTITATIVE FACTORS AND GOALS, ALL DISCRETIONARY INCENTIVE PLANS MUST BE APPROVED BY THE BOARD OF DIRECTORS PRIOR TO ANY INCENTIVE PAYOUT

Additional Data

Software ID:

Software Version:

EIN: 35-1814660

Name: INDIANA UNIVERSITY HEALTH WEST HOSPITAL INC

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
KENNETH D PUCKETT PRESIDENT - ISR	(I)	0	0	0	0	0	0	0
	(II)	371,435	134,940	19,309	69,054	28,254	622,992	0
DEREK E EMPIE SECRETARY	(I)	0	0	0	0	0	0	0
	(II)	193,647	32,625	548	11,674	28,615	267,109	0
ARTHUR VASQUEZ President/Treasurer	(I)	0	0	0	0	0	0	0
	(II)	228,525	39,050	444	13,147	28,520	309,686	0
Harpreetinder Singh MD VP & CMO (Partial Year)	(I)	205,294	13,688	9,557	6,064	12,292	246,895	0
	(II)	209,496	13,968	9,753	6,188	12,543	251,948	0
MEGAN CRITTENDON MD DIRECTOR	(I)	0	0	0	0	0	0	0
	(II)	329,163	29,262	540	17,463	7,173	383,601	0
LISA A SPARKS RN VP & CNO	(I)	181,838	19,539	918	10,408	28,181	240,884	0
	(II)	0	0	0	0	0	0	0
PAMELA CHAPMAN DIRECTOR, OR SERVICES (Part Yr)	(I)	14,683	1,102	45	837	2,989	19,656	0
	(II)	133,398	10,010	404	7,602	27,160	178,574	0
JAMES R BILLMAN PHARMACIST	(I)	153,194	206	4,709	1,696	25,585	185,390	0
	(II)	0	0	0	0	0	0	0
ANNE K STEGEMOLLER DIRECTOR, PHARMACY	(I)	147,305	17,868	300	8,612	27,859	201,944	0
	(II)	0	0	0	0	0	0	0
LAURA A ROGGY PHARMACIST	(I)	149,748	0	4,951	7,976	17,987	180,662	0
	(II)	0	0	0	0	0	0	0
JUDITH L COLEMAN FORMER TREASURER	(I)	0	0	0	0	0	0	0
	(II)	242,034	53,304	2,310	13,691	19,712	331,051	0
GREGORY A SPURGIN MD FOMER CMO	(I)	0	0	0	0	0	0	0
	(II)	227,977	62,522	11,124	17,875	3,550	323,048	0
MATTHEW D BAILEY FORMER PRESIDENT	(I)	0	0	0	0	0	0	0
	(II)	287,416	158,544	1,047,262	322,129	7,138	1,822,489	343,365
Elizabeth Dunlap Director	(I)	0	0	0	0	0	0	0
	(II)	500,462	242,162	24,596	11,000	23,402	801,622	0
Michelle A Janney Director	(I)	0	0	0	0	0	0	0
	(II)	502,367	371,179	143,482	121,065	5,899	1,143,992	0
David A Ingram MD Director	(I)	0	0	0	0	0	0	0
	(II)	457,117	79,034	3,169	111,083	0	650,403	0
CARA L BREIDSTER CFO - ISR (PARTIAL YEAR)	(I)	0	0	0	0	0	0	0
	(II)	272,747	37,215	3,933	13,532	22,833	350,260	0
Eric D Peak Pharmacist, Senior	(I)	151,422	0	2,322	7,721	7,200	168,665	0
	(II)	0	0	0	0	0	0	0
Jamie L Conley-Lebeter Mgr, Pharmacy Oprs	(I)	130,907	12,509	120	5,928	24,124	173,588	0
	(II)	0	0	0	0	0	0	0

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

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
INDIANA UNIVERSITY HEALTH WEST HOSPITAL INC

Employer identification number
35-1814660

990 Schedule O, Supplemental Information

Return Reference	Explanation
Page 1, Line J Web Site	https //iuhealth org/find-locations/iu-health-west-hospital

990 Schedule O, Supplemental Information

Return Reference	Explanation
Part VI, Section A, Lines 6, 7a and 7b Members or Stockholders	Line 6 The sole member of IU Health West Hospital is IU Health, a 501(c)(3) tax-exempt organization Line 7A The Board of Directors of IU Health West Hospital shall consist of from three (3) to twelve (12) voting members appointed by IU Health, including up to four (4) directors who are members of the Medical Staff in good standing or physicians employed by IU Health West Hospital or IU Health Line 7B The Board of Directors shall not, without the prior approval of the IU Health - Authorize any merger, consolidation, reorganization, sale or transfer of all or substantially all of the assets of IU Health West Hospital, - Authorize any plan of dissolution of IU Health West Hospital, any liquidating distribution of the IU Health West Hospitals assets or other action related to the dissolution or liquidation of IU Health West Hospital, - Authorize any voluntary declaration of bankruptcy of IU Health West Hospital, - Amend, repeal, revise or adopt changes to the organizational documents of IU Health West Hospital, - Authorize the consolidation of any entity with, or acquisition of any entity by, IU Health West Hospital, - Authorize any agreement to act as primary obligor, or to serve as a guarantor, surety or co-obligor with respect to the indebtedness of any other party, to borrow amounts from third-party lenders or to loan money to any person or entity, - Authorize any pledge of, or grant any security interest or mortgage in, or otherwise encumber, any tangible assets in excess of an appropriate monetary threshold, other than in the ordinary course of business or pursuant to an approved budget or strategic plan, - Authorize any agreement to act as primary obligor, or to serve as a guarantor, surety or co-obligor with respect to the indebtedness of any other party, to borrow amounts from third-party lenders or to loan money to any person or entity, - Approve any management agreement for the management of all or substantial part of IU Health West Hospitals operations, - Authorize the establishment or acquisition by IU Health West Hospital of any subsidiaries, affiliates or joint venture arrangements or the acquisition by IU Health West Hospital of the stock or other equity interest or substantially all the assets of any other business or entity, or - Adopt or amend an operating budget, capital budget, strategic plan, or long-range plan, or significantly deviate therefrom

990 Schedule O, Supplemental Information

Return Reference	Explanation
Part VI, Section A, Line 11b Review of Form 990	The Indianapolis Suburban Region Chief Financial Officer reviewed and approved the Form 990 Following the CFO's review and approval, a complete copy of the Form 990 was made available to each board member prior to its filing Each member was also informed of the availability of the IU Health Tax Department to answer any questions

990 Schedule O, Supplemental Information

Return Reference	Explanation
Part VI, Section B, Lines 12, 13, and 14 Policies	IU Health West Hospital is part of the IU Health system As the sole member and controlling parent of IU Health West Hospital, IU Health and its board of directors have mandated that certain policies be followed to ensure greater standardization throughout the system Thus, IU Health West Hospitals Board of Directors was not required to separately adopt a conflict of interest, whistleblower, document retention and destruction and joint venture policies because IU Healths Board of Directors had already adopted and required these policies to be followed by its subsidiaries

990 Schedule O, Supplemental Information

Return Reference	Explanation
Part VI, Section B, Line 12c Conflict of Interest Policy	IU Health West Hospital follows IU Healths Conflict of Interest Policy IU Healths Conflict of Interest Policy includes the following provisions All IU Health employees, associates, colleagues and contracted personnel, including employed physicians and paid medical directors ("IU Health Representatives") are covered by and subject to its Conflict of Interest Policy IU Health regularly and consistently monitors and enforces compliance with the policy through the following procedures (1) On an annual basis, each IU Health Representative at the level of Manager or above, together with every other person designated by the Corporate Compliance Department ("Department"), must complete, sign and submit a Conflict of Interest Questionnaire ("Questionnaire") to the Department Governing board members, committee members, corporate officers, medical staff and researchers must comply with the administrative requirements noted in the respective policies and procedures relative to those areas (2) An IU Health Representative must supplement a Questionnaire in writing, if after completion of the original Questionnaire, a situation arises, or may reasonably be expected to arise, that would change any answer or information on the original Questionnaire if the situation had existed or been anticipated at the time of completion of the original Questionnaire (3) If a fully and properly completed Questionnaire reveals facts or other information that might reasonably indicate a Conflict of Interest or violation of the policy, the IU Health Representative completing the questionnaire must secure approval by his/her supervisor, evidenced in writing (4) The Department will review each Questionnaire and determine whether a Conflict of Interest exists and, if so, whether and how it should or may be eliminated, avoided or managed in order to comply with the spirit of the policy and with the best interests of IU Health and its patients In making the determination, the Corporate Compliance Department may consult with the IU Health Representatives supervisor and other appropriate individuals and groups (5) The scope of the policy is not limited to those who are required to complete Questionnaires If an IU Health Representative is involved in a situation or relationship that would constitute a violation of the policy in the absence of disclosure and approval as described above, then the IU Health Representative must disclose the matter to his/her supervisor, secure his/her supervisors approval in writing, and disclose the matter to the Department Otherwise, the IU Health Representative is in violation of the policy and subject to corrective action, up to and including termination (6) The Chief Compliance Officer, in consultation with onsite Compliance personnel, may from time to time appoint standing or ad hoc committees to assist in resolving issues that arise under provisions of the policy

990 Schedule O, Supplemental Information

Return Reference	Explanation
Part VI, Section B, Line 15 Process for Determining Compen	IU Health West Hospitals President is employed by IU Health IU Healths process for determ ining compensation is as follows (1) The Board of Directors has established a Committee o n Personnel and Compensation The individuals on this Committee are made up of individuals who are on the Board and who do not have a conflict of interest with IU Health There are no physicians or employees on this Committee This Committee develops and reviews annuall y the executive compensation philosophy, market analysis as to comparability and reasonabl eness One of the purposes of this Committee is to review, approve and make recommendation s regarding executive compensation and benefits to the IU Health Board As deemed appropri ate, this Committee also reviews the same detail with the Committee on Finance The Commit tee on Finance is represented by certain members of the Board as well (2) Each year the C ommittee on Personnel and Compensation engages an outside compensation consulting firm to conduct a compensation and benefits study for all senior vice presidents and above The cu rrent compensation advisor is SullivanCotter SullivanCotter performs an independent compe nsation survey The relevant comparability data includes compensation and benefit levels paid by similarly situated organizations (both governmental and tax exempt) for functional ly comparable positions as well as the availability of similar services in the geographic area The Committee reviews the entire compensation package including base compensation, short term and long term incentive plans, basic health and welfare benefits, qualified and nonqualified plans as well as any additional fringe benefits Further, SullivanCotter wil l provide recommendations based upon the reasonable compensation information as it relates to salary increases, bonuses and benefits that are consistent with the compensation philo sophy of the Committee A separate analysis using the same methodology is done for the Chi ef Executive Officer (3) The Committee reviews the salary survey and, if appropriate, mak es recommendations on increases in salary and any changes in bonuses or benefits The Comm ittee's goal is to ensure that the total compensation and benefits package is reasonable b ased upon the independent data provided by SullivanCotter The Committee votes on any chan ges in compensation or benefits This review, discussion and vote are documented in the mi nutes for the meeting There are no executives present during the final discussion and app roval of compensation (4) The Board reviews the report prepared by SullivanCotter as well as the recommendations of the Committee on Personnel and Compensation as to changes in co mpensation approved by the Committee As requested, the Committee on Finance also provides its review of recommendations on changes in executive compensation and benefits This rev iew, discussion and vote are documented in the minutes (5) The Board then reviews the rec ommendations provided by the C

990 Schedule O, Supplemental Information

Return Reference	Explanation
Part VI, Section B, Line 15 Process for Determining Compen	ommittee on Personnel and Compensation and votes on the changes as well No additional com pensation or benefits are paid to the executives until the changes have been approved by t he Committee and the Board The discussion and approval are documented in the minutes of t he meeting There are no executives present during the final discussion and approval of co mpensation The General Counsel prepares a formal written opinion reviewing the compensati on and benefits approval process, comparing that process to the Intermediate Sanctions Tes t of IRC Section 4958 and, if the facts warrant, provides comments regarding the compensat ion and benefits approval process as this relates to meeting the requirements for a rebutt able presumption of reasonableness as provided in the Intermediate Sanctions Test (6) Aft er the end of each year, the Committee and Board also reviews the achievements of the exec utive group as it relates to the long-term and short-term shared and individual goals deve loped by the executive and the Board These achievements may also be reviewed with the Com mittee on Finance The Board, at its discretion, may approve bonus payments based upon the achievement of the goals and the compensation survey The discussion and vote of the Comm ittee and Board is documented in the minutes for each such meeting The bonuses are not pa id until approval is made by the Board (7) The Committee on Personnel and Compensation an d Audit Committee also review the required Form 990 disclosures related to executive compe nsation and benefits as well as compensation practices and approval processes prior to the filing of the Form 990 return with the Internal Revenue Service IU Health West Hospital has a process in place to determine the compensation for the other officers and key employ ees IU Health West Hospital uses an independent compensation consultant who utilizes a va riety of methods and procedures to obtain compensation ranges for comparable officer and e mployee positions The independent compensation consultant provides IU Health West Hospita l with recommended compensation ranges for its officers and other employees, which are the n used as a guide for setting reasonable compensation by management Management decisions with regard to determining compensation are subject to the review and approval of the Comp ensation Committee and Board of Directors

990 Schedule O, Supplemental Information

Return Reference	Explanation
Part VI, Section C, Line 19 Public Disclosure	IU Health West Hospital's Articles of Incorporation are available to the public through the Indiana Secretary of State's web-site IU Health West Hospitals conflict of interest policy is described on Form 990, Schedule O IU Health West Hospital is a consolidated subsidiary in the consolidated financial statements for IU Health The consolidated financial statements for IU Health are available to the public through its bond filings

990 Schedule O, Supplemental Information

Return Reference	Explanation
PART XI, LINE 9 - OTHER CHANGES IN NET ASSETS OR FUND BALANCES	DURING 2018, IU HEALTH WEST HOSPITAL RECORDED THE FOLLOWING OTHER CHANGES IN NET ASSETS OR FUND BALANCES Equity Transfer (Settlement of Debt) (130,354) IU HEALTH FOUNDATION - RESTRICTED INVESTMENTS (20,071) TOTAL OTHER CHANGES IN NET ASSETS (150,425)

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION SHARED SERVICES/PROF FEES TOTAL FEES 50211885

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

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
INDIANA UNIVERSITY HEALTH WEST HOSPITAL INC

Employer identification number
35-1814660

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

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

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

See Additional Data Table

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

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

See Additional Data Table

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) 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	

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

See Additional Data Table

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

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

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

		Yes	No
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	Yes	
f Dividends from related organization(s)	1f		No
g Sale of assets to related organization(s)	1g		No
h Purchase of assets from related organization(s)	1h		No
i Exchange of assets with related organization(s)	1i		No
j Lease of facilities, equipment, or other assets to related organization(s)	1j	Yes	
k Lease of facilities, equipment, or other assets from related organization(s)	1k	Yes	
l Performance of services or membership or fundraising solicitations for related organization(s)	1l	Yes	
m Performance of services or membership or fundraising solicitations by related organization(s)	1m	Yes	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n		No
o Sharing of paid employees with related organization(s)	1o	Yes	
p Reimbursement paid to related organization(s) for expenses	1p		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

See Additional Data Table

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

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners section 501(c)(3) organizations?		(f) Share of total income	(g) Share of end-of-year assets	(h) 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	

Part VII Supplemental Information

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

Return Reference	Explanation

Additional Data

Software ID:

Software Version:

EIN: 35-1814660

Name: INDIANA UNIVERSITY HEALTH WEST HOSPITAL INC

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
950 N Meridian St Ste 800 Indianapolis, IN 46204 13-4350599	Healthcare	IN	501(c)(3)	10	IUH	Yes	
950 N Meridian St Ste 800 Indianapolis, IN 46204 26-3571507	Healthcare	IN	501(c)(3)	10	IUHB	Yes	
846 N Senate Ave Indianapolis, IN 46202 36-4550324	Healthcare	IN	501(c)(3)	12 I	NA		No
950 N Meridian St Ste 300 Indianapolis, IN 46204 35-1955872	Healthcare	IN	501(c)(3)	3	NA		No
950 N Meridian St Ste 300 Indianapolis, IN 46204 26-3162145	Healthcare	IN	501(c)(3)	3	IUH	Yes	
950 N Meridian St Ste 300 Indianapolis, IN 46204 35-0867958	Healthcare	IN	501(c)(3)	3	IUH	Yes	
950 N Meridian St Ste 300 Indianapolis, IN 46204 35-1925641	Healthcare	IN	501(c)(3)	10	IUHBMH	Yes	
950 N Meridian St Ste 300 Indianapolis, IN 46204 23-7042323	Healthcare	IN	501(c)(3)	3	IUH	Yes	
950 N Meridian St Ste 300 Indianapolis, IN 46204 01-0646166	Healthcare	IN	501(c)(3)	3	IUHBMH	Yes	
950 N Meridian St Ste 300 Indianapolis, IN 46204 35-1720796	Healthcare	IN	501(c)(3)	3	IUH	Yes	
950 N Meridian St Ste 800 Indianapolis, IN 46204 31-1111784	Fundraising	IN	501(c)(3)	12 I	IUHBMH	Yes	
950 N Meridian St Ste 300 Indianapolis, IN 46204 35-1747218	Healthcare	IN	501(c)(3)	10	IUH	Yes	
950 N Meridian St Ste 800 Indianapolis, IN 46204 35-1125434	Healthcare	IN	501(c)(3)	10	IUH	Yes	
950 N Meridian St Ste 800 Indianapolis, IN 46204 31-1070868	Healthcare	IN	501(c)(3)	10	IUHLP	Yes	
950 N Meridian St Ste 800 Indianapolis, IN 46204 27-3533027	Healthcare	IN	501(c)(3)	10	IUH	Yes	
950 N Meridian St Ste 300 Indianapolis, IN 46204 35-1932442	Healthcare	IN	501(c)(3)	3	IUH	Yes	
950 N Meridian St Ste 300 Indianapolis, IN 46204 35-2090919	Healthcare	IN	501(c)(3)	3	IUH	Yes	
950 N Meridian St Ste 800 Indianapolis, IN 46204 46-3803873	Insurance	IN	501(c)(4)	N/A	IUH	Yes	
950 N Meridian St Ste 300 Indianapolis, IN 46204 26-2772226	Healthcare	IN	501(c)(3)	3	IUH	Yes	
950 N Meridian St Ste 300 Indianapolis, IN 46204 27-3532963	Healthcare	IN	501(c)(3)	3	IUH	Yes	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
340 W 10th St No FS5100 Indianapolis, IN 46202 20-1093251	Fundraising	IN	501(c)(3)	12 II	NA		No
PO Box 250 LaPorte, IN 46352 31-0952775	Fundraising	IN	501(c)(3)	12 I	NA		No
1200 Madison Ave Indianapolis, IN 46225 46-5270582	Insurance	IN	501(c)(4)	N/A	IUH	Yes	
1200 Madison Ave Indianapolis, IN 46225 47-2619552	Insurance	IN	501(c)(4)	N/A	IUH	Yes	
1800 N Capitol Ave Indianapolis, IN 46202 35-6043086	Fundraising	IN	501(c)(3)	12 I	IUH	Yes	
950 N Meridian St Ste 800 Indianapolis, IN 46204 35-0876390	Healthcare	IN	501(c)(3)	12 III-FI	NA		No
950 N Meridian St Ste 300 Indianapolis, IN 46204 35-1844176	Healthcare	IN	501(c)(3)	3	IUH	Yes	
4141 Shore Dr Indianapolis, IN 46254 35-1786005	Healthcare	IN	501(c)(3)	3	IUH	Yes	
4141 Shore Dr Indianapolis, IN 46254 35-1932349	Fundraising	IN	501(c)(3)	12 I	RHI	Yes	
705 Riley Hospital Dr Indianapolis, IN 46202 35-6018517	Fundraising	IN	501(c)(3)	12 III-FI	NA		No
950 N Meridian St Ste 800 Indianapolis, IN 46204 23-7427350	Healthcare	IN	501(c)(3)	10	IUHCA	Yes	
950 N Meridian St Ste 300 Indianapolis, IN 46204 81-5174295	Healthcare	IN	501(c)(3)	3	IUH	Yes	
950 N Meridian St Ste 800 Indianapolis, IN 46204 35-1809127	FUNDRAISING	IN	501(c)(3)	12 I	IUH	Yes	
950 N Meridian St Ste 300 Indianapolis, IN 46204 82-2736786	Healthcare	IN	501(c)(3)	3	IUH	Yes	

Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership

(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?		(i) Code V-UBI amount in Box 20 of Schedule K-1 (Form 1065)	(j) General or Managing Partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) Ball Outpatient Sur Ctr LLC 569 Brookwood Village Ste 901 Birmingham, AL 35244 27-0275794	Healthcare	IN	NA									
(1) Beltway Surgery Centers LLC 569 Brookwood Village Ste 901 Birmingham, AL 35244 35-2072586	Healthcare	IN	NA									
(2) BOSC Holdings LLC 950 N Meridian St Ste 800 Indianapolis, IN 46204 45-4147343	Healthcare	IN	NA									
(3) BSC Holdings LLC 950 N Meridian St Ste 800 Indianapolis, IN 46204 45-2314634	Healthcare	IN	NA									
(4) CHV Fund I LLC 950 N Meridian St Ste 800 Indianapolis, IN 46204 26-2523206	Venture Capital	IN	NA									
(5) CHV Fund II Management LLC 950 N Meridian St Ste 800 Indianapolis, IN 46204 37-1717823	Venture Capital	IN	NA									
(6) CHV Fund II LLC 950 N Meridian St Ste 800 Indianapolis, IN 46204 80-0902337	Venture Capital	IN	NA									
(7) CHV Fund Management LLC 950 N Meridian St Ste 800 Indianapolis, IN 46204 26-2523151	Venture Capital	IN	NA									
(8) Health Venture Management LLC 950 N Meridian St Ste 300 Indianapolis, IN 46204 20-5740218	Management	IN	NA									
(9) IEC Holdings LLC 950 N Meridian St Ste 800 Indianapolis, IN 46204 45-4148032	Healthcare	IN	NA									
(10) Indiana Endoscopy Centers LLC 569 Brookwood Village Ste 901 Birmingham, AL 35244 20-8398421	Healthcare	IN	NA									
(11) ROC Surgery LLC 569 Brookwood Village Ste 901 Birmingham, AL 35244 27-1497960	Healthcare	IN	NA									
(12) ROCS Holdings LLC 950 N Meridian St Ste 800 Indianapolis, IN 46204 45-4148369	Healthcare	IN	NA									
(13) Senate St Surgery Center LLC 569 Brookwood Village Ste 901 Birmingham, AL 35244 42-1709357	Healthcare	IN	NA									
(14) SSSC Holdings LLC 950 N Meridian St Ste 800 Indianapolis, IN 46204 45-4148167	Healthcare	IN	NA									

Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership

(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?		(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	
(16) IU HEALTH FORT WAYNE LLC 950 N Meridian St Ste 800 INDIANAPOLIS, IN 46204 83-1224627	Healthcare	IN	NA									

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity?	
								Yes	No
(1) BMH Medical Pavilion Association Inc 2525 W University Ave Muncie, IN 47303 35-1858408	Condo Management	IN	NA	C				Yes	
(1) Cardinal Health Ventures Inc 950 N Meridian St Ste 800 Indianapolis, IN 46204 35-1611424	Management	IN	NA	C				Yes	
(2) CHV Capital Inc 950 N Meridian St Ste 800 Indianapolis, IN 46204 26-0752507	Venture Capital	IN	NA	C				Yes	
(3) IU Health 457(B) Plan 1100 N Market St Wilmington, DE 19890 47-6948347	Investments	IN	NA	T				Yes	
(4) IU Health ACO Inc 950 N Meridian St Ste 800 Indianapolis, IN 46204 45-4421020	Healthcare	IN	NA	C				Yes	
(5) IU Health Board Designated Trust 400 Howard St San Francisco, CA 94105 30-6309021	Investments	IN	NA	T				Yes	
(6) IU Health NTGI S&P500 Fund CF PO Box 804358 Chicago, IL 60680 30-6298263	Investments	IN	NA	T				Yes	
(7) IU Health Plans Holding Company Inc 950 N Meridian St Ste 800 Indianapolis, IN 46204 46-3794815	Insurance	IN	NA	C				Yes	
(8) IU Health Plans Inc 950 N Meridian St Ste 800 Indianapolis, IN 46204 26-2127080	HMO	IN	NA	C				Yes	
(9) IU Health Risk Purchasing Group Inc 151 Meeting St Ste 301 Charleston, SC 29401 26-0202446	Insurance	IN	NA	C				Yes	
(10) IU Health Risk Retention Group Inc 151 Meeting St Ste 301 Charleston, SC 29401 20-1107674	Insurance	SC	NA	C				Yes	
(11) IU Health Southern IN Physicians Inc 950 N Meridian St Ste 300 Indianapolis, IN 46204 35-1913875	Healthcare	IN	NA	C				Yes	
(12) IUH Assurance SPC Ltd PO Box 69 94 Solaris Ave Camana Bay, Grand Cayman CJ 98-0395429	Insurance	CJ	NA	C				Yes	
(13) Proteuo Fund LP PO Box 31106 89 Nexus Way Camana Bay, Grand Cayman CJ 98-1075227	Investments	CJ	NA	C				Yes	
(14) SCANS Inc 950 N Meridian St Ste 800 Indianapolis, IN 46204 45-3080392	Healthcare	IN	NA	C				Yes	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity?	
								Yes	No
(16) IU Health Plans Insurance Company 950 N Meridian St Ste 800 Indianapolis, IN 46204 81-1097215	Insurance	IN	NA	C				Yes	

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

	(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
(1)	IU Health Care Associates Inc	J	446,903	FMV
(1)	IU Health Care Associates Inc	L	222,354	FMV
(2)	IU Health Care Associates Inc	M	12,670,252	FMV
(3)	Methodist Occupational Health Centers Inc	M	121,221	FMV
(4)	IU Health Care Associates Inc	O	181,611	FMV
(5)	IU Health North Hospital Inc	O	84,786	FMV
(6)	IUH Assurance SPC Ltd	R	394,353	FMV
(7)	IU Health Risk Retention Group Inc	R	682,787	FMV