DLN: 93493318032870

2019

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

OMB No. 1545-0047

Return of Organization Exempt From Income Tax

Department of the Internal Revenue Service ▶ 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.

Open to Public Inspection

| A F | or the 201 | | ar beginning 01-01-2019 ,and | ending 12-31 | -2019 | _ | | |
|-----------------------------|--------------------------|---|--|-------------------|----------------------------|--|-------------------|----------------------------|
| | ck if applicabl | ■ INDIANA UNIVERSITY HE | ALTH NORTH HOSPITAL | | | D Employ | er identifi | ication number |
| | dress change | INC | | | | 35-193 | 2442 | |
| | me change tial return | % CRAIG J JONES Doing business as | | | | - | | |
| | al return/termina | ated | | | | | | |
| | nended return | 050 NI MEDIDIANI CTREET | D. box if mail is not delivered to street ad | dress) Room/suit | e | E Telephor | ne number | |
| □Ар | plication pend | ding | | | | (317) 9 | 63-4842 | |
| | | City or town, state or pro INDIANAPOLIS, IN 4620 | vince, country, and ZIP or foreign postal of | code | | | | |
| | | F Name and address a | 6 | Г | | 4 | | 93,117,483 |
| | | F Name and address of KENNETH D PUCKETT | r principal officer: | | H(a) Is this | - ' | turn for | |
| | | 950 N MERIDIAN ST ST | | | subor H(b) Are a | dinates? Il subordinat | tes | □Yes ☑No |
| | x-exempt stat | INDIANAPOLIS, IN 462 | | | includ | | | ☐ Yes ☐No |
| | · | ▼ 501(c)(3) | c) () ◀ (insert no.) | or 📙 527 | | | • | instructions) |
| J W | ebsite: 🟲 | SEE SCHEDULE O | | | H(c) Group | o exemption | number | • |
| V [| | tion: 🗹 Corporation 🔲 Trust | . D Association D Other S | | L Year of form | ation: 1994 | M State | of legal domicile: IN |
| K Forr | n or organizai | tion: 🖭 Corporation 🗀 Trust | Association L Other | | | | | J |
| Pa | arti Su | ımmary | | · | | | | |
| | | | mission or most significant activities | | | . I I a a léla - Toa a | | - 44 : 4:- :: 4: 1 |
| e) | | e the nealth of our commur and celebrate the experience | ities, support the educational commes of life. | nitment of India | na University | Health, Inc | ., nurture | e the individual |
| Governance | | | | | | | | |
| Ĕ | | | | | | | | |
| 90 | 3 Charle | this boy \ \ \ \ \ if the organi | zation discontinued its operations o | disposed of m | ara than 25% | of its not a | ccotc | |
| ت ت | | | governing body (Part VI, line 1a) | | | o or its fiet a | 3 | 12 |
| Activities & | 4 Numb | er of independent voting me | mbers of the governing body (Part | VI, line 1b) . | | | 4 | 7 |
| ığ. | 5 Total | number of individuals emplo | yed in calendar year 2019 (Part V, I | ine 2a) | | | 5 | 1,418 |
| ₹ | | · · | ate if necessary) | • | | | 6 | 149 |
| ĕ | | · | from Part VIII, column (C), line 12 | | | | 7a | 31,105 |
| | | | come from Form 990-T, line 39 | | | | 7b | 0 |
| | | | | | Pri | ior Year | | Current Year |
| ٥. | 8 Contri | ibutions and grants (Part VIII | , line 1h) | | | : | 840 | 87,079 |
| Ravenue | 9 Progra | am service revenue (Part VII | , line 2g) | | | 265,380, | 249 | 279,590,809 |
| δΛċ | 10 Invest | tment income (Part VIII, colu | mn (A), lines 3, 4, and 7d) | | | 6,268, | 908 | 10,608,057 |
| <u> </u> | 11 Other | revenue (Part VIII, column (| A), lines 5, 6d, 8c, 9c, 10c, and 11e | :) | | 3,468, | 255 | 2,812,234 |
| | 12 Total | revenue—add lines 8 throug | h 11 (must equal Part VIII, column (| A), line 12) | | 275,118, | 252 | 293,098,179 |
| | 13 Grant | s and similar amounts paid (| Part IX, column (A), lines 1-3) | | | | 0 | 920 |
| | 14 Benef | its paid to or for members (I | Part IX, column (A), line 4) | | | | 0 | 0 |
| 85 | 15 Salari | es, other compensation, em | oloyee benefits (Part IX, column (A) | , lines 5–10) | | 74,079, | 791 | 74,854,375 |
| Expenses | 16a Profe | ssional fundraising fees (Par | t IX, column (A), line 11e) | | | | 0 | 0 |
| e di | b Total fo | undraising expenses (Part IX, co | lumn (D), line 25) ▶9,898 | | | | | |
| Ω. | 17 Other | expenses (Part IX, column (| A), lines 11a-11d, 11f-24e) | | | 137,002, | 362 | 146,306,981 |
| | 18 Total | expenses. Add lines 13–17 (| must equal Part IX, column (A), line | 25) | | 211,082, | 153 | 221,162,276 |
| | 19 Rever | nue less expenses. Subtract | ine 18 from line 12 | | | 64,036, | 099 | 71,935,903 |
| SeS. | | | | | Beginning | of Current Y | 'ear | End of Year |
| ets dan | 20 7-4-1 | (D-d V 1: 10) | | | | F20 270 : | 71.6 | (12,000,221 |
| Age 188 | 1 | assets (Part X, line 16) . liabilities (Part X, line 26) . | | | | 539,270, ² 231,715, ⁴ | | 612,988,321 233,518,606 |
| Net Assets or Fund Balances | 1 | ssets or fund balances. Subt | ract line 21 from line 20 | | | 307,554, | | 379,469,715 |
| | | gnature Block | | | | 307,331, | , , , , | 3,3,103,713 |
| Under | penalties o | of perjury, I declare that I ha | ave examined this return, including | | | | | |
| | ledge and b nowledge. | elief, it is true, correct, and | complete. Declaration of preparer (| other than office | er) is based o | n all inform | ation of v | vhich preparer has |
| uny ix | l. | | | | | | | |
| | Cia | nature of officer | | | | 20-11-08 | | |
| Sign | ' | mature of officer | | | Dat | .e | | |
| Here | CA | RA L BREIDSTER CFO | | | | | | |
| | ▼ i yi | pe or print name and title | | 1- | | | | |
| ь. | | Print/Type preparer's name | Preparer's signature | Da | Che | eck 📙 if | PTIN P00395735 | 5 |
| Paid | | Firm's name FRNST & YC | UNG US LIP | | | -employed m's EIN ► | | _ |
| | parer | Shame P ENIOT & TC | | | | | | |
| use | Only | Firm's address ► 111 MONUM | ENT CIR STE 4000 | | Pho | one no. (317) | 681-7000 | |
| | | INDIANAPOL | IS, IN 46204 | | | | | |
| May t | he IRS disc | uss this return with the prep | arer shown above? (see instruction: | s) | | | □γ | es 🗆 No |
| For P | aperwork | Reduction Act Notice, see | the separate instructions. | | Cat. No. 1 | 11282Y | | Form 990 (2019) |

| Form | 990 (2 | 019) | | | | | Page 2 |
|------|---------|------------------|------------------------|-------------------|---|--|--------------------------|
| Pa | rt III | Statement | of Program Servi | ce Accomplis | hments | | |
| | | Check if Sched | dule O contains a resp | onse or note to | any line in this Part III | | 🗹 |
| 1 | Briefly | describe the o | rganization's mission: | | | | |
| | | | | | JCATIONAL COMMITME HE EXPERIENCES OF L | ENT/EFFORTS OF INDIANA UNIV IFE. | ERSITY HEALTH, INC. ("IU |
| 2 | | - | undertake any signific | | - <i>'</i> | hich were not listed on | □ Yes ☑ No |
| | , | | se new services on So | | | | |
| 3 | | • | | | changes in how it cond | ucts any program | |
| • | | - | · · · · · | | · · · · · | | ☐ Yes ☑ No |
| | If "Yes | s," describe the | se changes on Schedu | ule O. | | | |
| 4 | Section | n 501(c)(3) and | | ions are required | to report the amount of | largest program services, as me of grants and allocations to othe | |
| 4a | (Code: | |) (Expenses \$ | 179,316,733 | including grants of \$ | 920) (Revenue \$ | 274,782,012) |
| | See Ad | ditional Data | | | | | |
| 4b | (Code: | |) (Expenses \$ | 2,604,941 | including grants of \$ | 0) (Revenue \$ | 3,991,769) |
| | See Ad | ditional Data | | | | | |
| 4c | (Code: | ditional Data |) (Expenses \$ | 521,754 | including grants of \$ | 0) (Revenue \$ | 799,528) |
| | (Code: | |) (Expenses \$ | 11,420 | including grants of \$ |) (Revenue \$ | 17,500) |
| | Pharma | |) (Expended 4 | 11,420 | | , (Nevertue y | £7,550) |
| 4d | Other | program servic | ces (Describe in Sched | dule O.) | | | |
| | (Expe | nses \$ | 11,420 inc | cluding grants of | \$ |) (Revenue \$ | 17,500) |
| 4e | Total | program serv | rice expenses ▶ | 182,454,8 | 48 | | |

19

| | 330 (2013) | | | rage 3 |
|------------|---|-----|-----|--------|
| Par | 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 <i>Schedule B, Schedule of Contributors</i> (see instructions)? | 2 | Yes | |
| 3 | Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I | 3 | | No |
| 4 | Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II 2 | 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? <i>If "Yes," complete Schedule D</i> ,Part 2 | 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 |
| LO | 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 |
| .1 | If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VIII, VIII, IX, or X as applicable. | | | |
| а | 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 | |
| | 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 |
| | 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 |
| е | 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 | |
| | Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII " | 12a | | No |
| | 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 | |
| .3 | Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E | 13 | | No |
| .4a | 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 |
| L 5 | 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 |
| L6 | 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

20a Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H

Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes,"

No

Nο

18

19

20a

Yes

| Form | 990 (2019) | | | Page 4 |
|------|--|-----|-----|---------------|
| Par | Checklist of Required Schedules (continued) | | | |
| | | | Yes | No |
| 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 |
| 23 | Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i> | 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 | | |
| С | 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? <i>If "Yes," complete Schedule L, Part I</i> | 25b | | No |
| 26 | Did the organization report any amount on Part X, line 5 or 22 for receivables from or payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons? If "Yes," complete Schedule L, Part II | 26 | | No |
| 27 | Did the organization provide a grant or other assistance to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or employee thereof, a grant selection committee member, or to a 35% controlled entity (including an employee thereof) or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i> | 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): | | | |
| а | A current or former officer, director, trustee, key employee, creator or founder, or substantial contributor? <i>If "Yes," complete Schedule L, Part IV</i> | 28a | | No |
| b | A family member of any individual described in line 28a? If "Yes," complete Schedule L, Part IV | 28b | | No |
| С | A 35% controlled entity of one or more individuals and/or organizations described in lines 28a or 28b? <i>If "Yes," complete Schedule L, Part IV</i> | 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? <i>If "Yes," complete Schedule M</i> | 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 | |
| Pai | Statements Regarding Other IRS Filings and Tax Compliance | | | |
| | Check if Schedule O contains a response or note to any line in this Bort V | | | |

| | Giologia de Para di la Culta de Callina de C | | | Page 5 |
|-----|--|-----|-----|----------|
| | Statements Regarding Other IRS Filings and Tax Compliance (continued) | | | |
| 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 | | | |
| 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 | |
| За | 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 | |
| | 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)? If "Yes," enter the name of the foreign country: | 4a | | No |
| _ | See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR). | | | |
| | Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? | 5a | | No No |
| b | | 5b | | |
| | If "Yes," to line 5a or 5b, did the organization file Form 8886-T? | 5c | | |
| | 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 |
| | If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? | 6b | | |
| | Organizations that may receive deductible contributions under section 170(c). | _ | | NI. |
| | 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? | | | No |
| | If "Yes," did the organization notify the donor of the value of the goods or services provided? | 7b | | |
| | Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? | 7c | | No |
| a | If "Yes," indicate the number of Forms 8282 filed during the year | | | |
| 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 | | |
| 9 | Sponsoring organizations maintaining donor advised funds. | | | |
| а | 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: | | | |
| | Initiation fees and capital contributions included on Part VIII, line 12 10a | | | |
| | Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities | | | |
| 11 | Section 501(c)(12) organizations. Enter: | | | |
| a | Gross income from members or shareholders | | | |
| D | Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.) | | | |
| 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. | | | |
| 13 | Section 501(c)(29) qualified nonprofit health insurance issuers. | | | |
| | Is the organization licensed to issue qualified health plans in more than one state? | 13a | | |
| | 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 | | | |
| | Enter the amount of reserves on hand | _ | | |
| | Did the organization receive any payments for indoor tanning services during the tax year? | 14a | | No |
| | If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O | 14b | | |
| | 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? | 15 | | No |
| 16 | If "Yes," complete Form 4720, Schedule O. | 16 | | No |

| orm | 990 (2019) | | | Page |
|----------|--|------------|--------|------------|
| Pai | Governance, Management, and Disclosure For each "Yes" response to lines 2 through 7b below, and for a "No 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 | • | nse to | lines ✓ |
| Se | ction 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 12 | | | |
| | 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 | | | |
| 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 | Yes | |
| 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 | |
| | 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: | | | |
| а | The governing body? | 8a | Yes | |
| b | Each committee with authority to act on behalf of the governing body? | 8 b | 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 |
| Se | ction B. Policies (This Section B requests information about policies not required by the Internal Revenue | : Code | - | |
| 10- | Did the amounisation beautiful should be about any function of the same of the | 10a | Yes | No |
| | Did the organization have local chapters, branches, or affiliates? 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? | 10a 10b | | No |
| 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 | |
| h | Describe in Schedule O the process, if any, used by the organization to review this Form 990. | IIa | 165 | |
| | Did the organization have a written conflict of interest policy? <i>If "No," go to line 13</i> | 12a | Yes | |
| | Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? | 12b | Yes | |
| С | 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? | | | |
| а | 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 | | |
| Se 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: | | | |

Name and title

Part VII

(F)

Estimated

Page 7

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

Average

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

Reportable

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

Reportable

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

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. See instructions for the order in which to list the persons above.

🗹 Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee. (A) (C) (D) (B) (E)

Position (do not check more

| Nume and cide | hours per week (list any hours for related | is b | n one box, unless pers s both an officer and a director/trustee) | | | | on | compensation from the organization (W-2/1099- | compensation from related organizations (W-2/1099- | amount of other compensation from the organization and |
|---------------------------|---|-----------------------------------|--|---------|--------------|------------------------------|--------|--|---|---|
| | organizations below dotted line) | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | MISC) | MISC) | related organizations |
| See Additional Data Table | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
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| | | | | | | | | | | Form 990 (2019) |

(A)

Part VII

775,719

1,422,412

679,241

Form 990 (2019)

| | (A) Name and title | (B) Average hours per week (list any hours | than o | ne b | ox, ι ın of | t che unles ficer | eck moss persection and a | son | Repo compe fror organ | ortable ensation in the nization | (E) Reportable compensation from related organizations | | Estimation (F Estimation (Figure 1) (Figure | ated of other sation the |
|-------|---|---|-----------------------------------|-----------------------|----------------|-------------------------|------------------------------|--------|--------------------------------|---|--|--------|--|-----------------------------------|
| | | for related organizations below dotted line) | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | /1099- (SC) | (W-2/1099- MISC) | | rganizat relat organiz | :ed |
| See | Additional Data Table | | | | | | | | | | | | | |
| | | | | | | | | | | | | + | | |
| | | | | | | | | | | | | + | | |
| | | | | | | | | | | | | + | | |
| | | | | | | | | | | | | | | |
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| | | | | | | | | | | | | \bot | | |
| | | | | | | | | | | | | + | | |
| c T | Sub-Total | art VII, Section | Α. | | | | * | | 1.5 | 514,458 | 6,071,990 | | | 1,226,874 |
| 2 | Total (add lines 1b and 1c) Total number of individuals (including of reportable compensation from the | but not limited | to thos | | | | ▶ e) who | rec | | | | | | 1,220,674 |
| | | | | | | | | | | | | | Yes | No |
| 3 | Did the organization list any former line 1a? <i>If "Yes," complete Schedule</i> . | | | | | | | | | | l employee on | 3 | Yes | |
| 4 | For any individual listed on line 1a, is organization and related organization | s greater than \$ | 150,00 | 0? <i>If</i> | "Yes | s," c | omplet | te Sc | chedule J | sation fror for such | m the | | | |
| 5 | individual | ve or accrue cor | | tion f | rom | any | unrela | ated | | • • tion or ind | ividual for | 4 | Yes | |
| | ection B. Independent Contract | | ete Stii | eaure | - 3 10 |) | icii pei | 3011 | | <u> </u> | | 5 | Yes | |
| 1 | Complete this table for your five high from the organization. Report compe | est compensate | | | | | | | | | | pensa | ation | _ |
| | · | (A) and business addre | | ycui | CITO | 11119 | WICH O | 1 7710 | | | (B) cription of services | | (C Compe | |
| 10510 | ARK HEALTHCARE TECHNOLOGIES, D TWIN LAKES PARKWAY LOTTE, NC 28269 | | | | | | | | I | | NGINEERING | | | ,079,911 |
| MESS | ER CONSTRUCTION CO, N MERIDIAN ST | | | | | | | | | CONSTRUC | TION | | 27 | ,965,031 |

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

(D)

FACILITIES

CONSULTING

CLINICAL ENGINEERING

(C)

(B)

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of

CHICAGO, IL 60674 TRIMEDX LLC, 5451 LAKEVIEW PKWY S DR INDIANAPOLIS, IN 46268

INDIANAPOLIS, IN 46208

7031 Mayflower Park Drive ZIONSVILLE, IN 46077

SOUTH WESTERN COMMUNICATIONS INC,

compensation from the organization ▶ 29

SODEXO INC AFFILIATES, 4880 PAYSPHERE CIRCLE

| | | Check if Sche | dule O co | ontains a | respo | nse or note to any | line in this Part VIII | | | <u> 🗆</u> |
|---|-----|---|--------------------------|-------------|------------|-------------------------|-----------------------------|---|--|--|
| | | | | | | | (A) Total revenue | (B) Related or exempt function revenue | (C) Unrelated business revenue | (D) Revenue excluded from tax under sections 512 - 514 |
| | 12 | a Federated camp | aigns . | | 1a | | | revenue | | 312 314 |
| ints ints | | b Membership due | s | Ī | 1b | | | | | |
| 673 70 | | c Fundraising ever | nts | . [| 1c | | | | | |
| Įš, P | | d Related organiza | ations | | 1d | 87,058 | | | | |
| <u>ā</u> 2‼ | | e Government grants | s (contribu | ıtions) | 1e | | | | | |
| ons, Sim | 1 | f All other contribution | | | 4.5 | 21 | | | | |
| Contributions, Gifts, Grants and Other Similar Amounts | ١ | above g Noncash contribution | | L | 1f | 21 | | | | |
| | | lines 1a - 1f:\$ | | L | 1 g | | | | | |
| ತ್ರ ಕ | | h Total. Add lines | 1a-1f . | | | • | 87,079 | | | |
| | | | | | | Business Code | | | | |
| | 2a | NET PATIENT SERVI | CE REVEN | UE | | 622110 | 274,782,012 | 274,782,012 | | |
| nue | h | SHARED SERVICES | | | | | 3,991,769 | 3,991,769 | | |
| eve. | | • | | | | 541990 | | | | |
| ce F | c | RENT FROM RELATE | D 501(C)(| 3) ORGS. | | 532000 | 799,528 | 799,528 | | |
| Service Revenue | d | PHARMACY | | | | 446110 | 17,500 | 17,500 | | |
| S III | | | | | | 446110 | | | | |
| Program | e | | | | | | | | | |
| Æ | | | | | | | | | | |
| | | All other program | | | | | | | | |
| | | Total. Add lines | | | | 279,590,809 | _ | | | Γ |
| | | Investment income similar amounts) | | - | nds, ii | nterest, and other • | 10,038,20 | 0 | | 10,038,200 |
| | 4 1 | Income from inves | tment of | tax-exer | mpt bo | ond proceeds | • | 0 | | |
| | 5 | Royalties | | | | • | • | 0 | | |
| | | | $ \ -$ | (i) Rea | ıl | (ii) Personal | 4 | | | |
| | 6a | Gross rents | 6a | 1 | .02,099 | | | | | |
| | b | Less: rental expenses | 6b | | 18,042 | | | | | |
| | С | Rental income | - | | 10,012 | | - | | | |
| | | or (loss) | 6c | | 84,057 | | 0 84,05 | | | 04.05 |
| | a | Net rental incom | | i) Securit | | (ii) Other | 64,03 | 7 | | 84,057 |
| | 7a | Gross amount | | i) Securi | ues | (II) Other | - | | | |
| | , | from sales of assets other | of 7a r ory | | | 571,11 | 9 | | | |
| | | than inventory | | | | | 4 | | | |
| | b | Less: cost or other basis and | 7b | | | 1,26 | 2 | | | |
| | | sales expenses | \vdash | | | | - | | | |
| | | Gain or (loss) | 7c | | | 569,85 | ⊣ | | | |
| | | Net gain or (loss) | | | | · · · • | 569,85 | i7 | | 569,857 |
| ne | ъа | Gross income from form form form formal (not including \$ | | of | | | | | | |
| /en | | contributions reporte See Part IV, line 18 | | | 8a | 0 | | | | |
| Rei | h | Less: direct exper | nses . | | 8b | 0 | _ | | | |
| Other Revenue | | Net income or (lo | | | | ents 🛌 | _ | О | | |
| | _ | C 1 1 | | | | · | | | | |
| | Уa | Gross income from See Part IV, line 19 | gaming a | activities. | 9a | 0 | | | | |
| | b | Less: direct exper | nses . | | 9b | 0 | - | | | |
| | c | Net income or (lo | ss) from | gaming a | activiti | es > | | 0 | | |
| | 10 | Cross select of the | antam: I | 055 | | | | | | |
| | TUS | aGross sales of inv returns and allow | | | 10a | 0 | | | | |
| | b | Less: cost of good | ds sold | | 10b | 0 | | | | |
| | c | Net income or (lo | | | invent | | | 0 | | |
| | 4.4 | Miscellaned | | | | Business Code 72111 | 0 2 565 21 | | 21 105 | 2 524 214 |
| | 11 | ·aCAFETERIA/FOOI | ∪ SERVIC | LE | | /2111 | 0 2,565,31 | | 31,105 | 2,534,214 |
| | h | | | | | 90009 | 9 23,35 | 19 | | 23,359 |
| | ט | PEDUCATION | | | | 50009 | 23,33 | | | 23,335 |
| | _ | GIFT SHOP | | | | 45322 | 0 78,82 | 12 | | 78,822 |
| | ٠ | י שונו אווטף | | | | +3322 | 73,62 | | | , 0,322 |
| | ام | All other revenue | | | | | 60,67 | 77 | | 60,677 |
| | | Total. Add lines 1 | | | | • | | | | 33,377 |
| | | ? Total revenue. S | | | | | 2,728,17 | | | |
| | | | | | - | • • | 293,098,17 | 279,590,809 | 31,105 | 13,389,186 Form 990 (2019) |

| Form 990 (2019) | | | | Page 10 |
|---|-------------------------|------------------------------------|---|---------------------------------------|
| Part IX Statement of Functional Expenses | | | | |
| Section 501(c)(3) and 501(c)(4) organizations must o | complete all columns. | All other organizatio | ns must complete col | umn (A). |
| Check if Schedule O contains a response or note to ar | ny line in this Part IX | | | 🗹 |
| Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII. | (A) Total expenses | (B) Program service expenses | (C) Management and general expenses | (D) Fundraising expenses |
| Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 | 0 | | | |
| 2 Grants and other assistance to domestic individuals. See Part IV, line 22 | 920 | 920 | | |
| 3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16. | 0 | | | |
| 4 Benefits paid to or for members | 0 | | | |
| 5 Compensation of current officers, directors, trustees, and key employees | 507,364 | 445,154 | 62,210 | |
| 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 | 59,484,412 | 52,191,690 | 7,292,722 | |
| 8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions) | 2,176,686 | 1,909,827 | 266,859 | |
| 9 Other employee benefits | 8,416,884 | 7,384,983 | 1,031,901 | |
| 10 Payroll taxes | 4,269,029 | 3,745,651 | 523,378 | |
| 11 Fees for services (non-employees): | | | | |
| a Management | 5,889 | | 5,889 | |
| b Legal | 0 | | | |
| c Accounting | 3,750 | | 3,750 | |
| d Lobbying | 1,257 | | 1,257 | |
| 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) | 49,124,273 | 47,252,638 | 1,871,635 | 0 |
| 12 Advertising and promotion | 218,808 | 217,692 | 1,116 | |
| 13 Office expenses | 951,853 | 721,972 | 229,881 | |
| 14 Information technology | 455,429 | 240,459 | 214,970 | |
| 15 Royalties | 0 | | | |
| 16 Occupancy | 9,326,082 | 3,296,723 | 6,029,359 | |
| 17 Travel | 68,036 | 31,418 | 36,618 | |
| 18 Payments of travel or entertainment expenses for any federal, state, or local public officials . | 0 | | | |
| 19 Conferences, conventions, and meetings | 29,774 | 18,976 | 10,798 | |
| 20 Interest | 12,816,024 | | 12,816,024 | |
| 21 Payments to affiliates | 0 | | | |

10,615,380

1,658,646

32,875,589

9,855,480

12,130,306

136,399

6,034,006

221,162,276

22 Depreciation, depletion, and amortization

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

23 Insurance . .

b BAD DEBT

expenses on Schedule O.)

a DRUGS AND MEDICAL SUPPLIES

c HOSPITAL ASSESSMENT FEE

e All other expenses

d INSTITUTIONAL DUES/LICENSES

Total functional expenses. Add lines 1 through 24e
 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).

5,693,660

32,875,589

9,855,480

12,130,306

136,399

3,940,719

182,454,848

364,592

4,921,720

1,294,054

2,083,389

38,697,530

9,898

9,898

Form **990** (2019)

Form 990 (2019)

Liabilities

Fund Balances

ō 29

Assets 30

26

27

28

31

32

33

0 6

7

10c

11 0

12 0 13

14

15

16

17

19

0

0 18

0 20

0 21

0 22

0 23

0 24

25

26

27

29

30

31

32

33

0 28

210,327,967

231.715.962

307,554,754

307,554,754

539,270,716

158,126

539,270,716

20,914,414

473.581

188.412

2.332.371

1,144,255

140,844,785

Page 11

36.603.411

171.399

2.597.290

1,524,064

196,581,194

612,988,321

31,338,641

265.779

0

0

0

0

0

0

0

0

201,914,186

233.518.606

379,469,715

379,469,715

612,988,321

Form 990 (2019)

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

| | | Beginning of year | | End of year |
|---|--|-------------------|---|-------------|
| 1 | Cash-non-interest-bearing | 0 | 1 | |
| 2 | Savings and temporary cash investments | 357,360,930 | 2 | 375,510,9 |
| _ | Disduse and another respirable with | 0 | | |

331,901,870

135,320,676

Pledges and grants receivable, net . 37.241.837 Accounts receivable, net Loans and other payables to any current or former officer, director, trustee,

key employee, creator or founder, substantial contributor, or 35% controlled 0 5

Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B). Notes and loans receivable, net . . .

Inventories for sale or use . .

Assets Prepaid expenses and deferred charges .

10a Land, buildings, and equipment: cost or other 10a basis. Complete Part VI of Schedule D 10b b Less: accumulated depreciation

11 Investments—publicly traded securities . Investments—program-related. See Part IV, line 11 Intangible assets . Other assets. See Part IV, line 11 . . .

12 Investments—other securities. See Part IV, line 11 . 13 Total assets. Add lines 1 through 15 (must equal line 34) .

14 15 16 17 Accounts payable and accrued expenses

18 Grants payable . 19 Deferred revenue . . .

Tax-exempt bond liabilities .

Escrow or custodial account liability. Complete Part IV of Schedule D Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity

20 21 22

23 24 25

and other liabilities not included on lines 17 - 24). Complete Part X of Schedule D

Total liabilities. Add lines 17 through 25 . .

Capital stock or trust principal, or current funds

Total liabilities and net assets/fund balances

complete lines 27, 28, 32, and 33.

Net assets without donor restrictions

Net assets with donor restrictions .

complete lines 29 through 33.

Total net assets or fund balances

Other liabilities (including federal income tax, payables to related third parties,

Organizations that follow FASB ASC 958, check here <a> \square and

Organizations that do not follow FASB ASC 958, check here > \(\begin{align*} \text{and} \end{and} \)

Paid-in or capital surplus, or land, building or equipment fund . . .

Retained earnings, endowment, accumulated income, or other funds

Secured mortgages and notes payable to unrelated third parties Unsecured notes and loans payable to unrelated third parties .

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.

No

Form 990 (2019)

3h

Additional Data

Software ID:

Software Version:

EIN: 35-1932442

INC

Name: INDIANA UNIVERSITY HEALTH NORTH HOSPITAL

Form 990 (2019)

Form 990, Part III, Line 4a: Indiana University Health North Hospital, Inc. ("IU Health North Hospital") has provided leading family-centered care to Carmel and Hamilton County residents since 2005. As a full-service hospital for adults and children with an attached medical office building, IU Health North Hospital brings together physician offices, 149 inpatient beds, and operating rooms in a state-of-the-art facility where compassionate caregivers provide superior patient treatment without regard to a patient's ability to pay.

Form 990, Part III, Line 4b: IU Health North Hospital provides services to related tax-exempt organizations.

Form 990, Part III, Line 4c:

IU Health North Hospital leases physician office and clinic space to related tax-exempt organizations.

(A) (B) (C) (D) (E) (F) Name and Title Position (do not check more Reportable Estimated Average Reportable than one box, unless hours per compensation compensation amount of other person is both an officer week (list from the from related compensation and a director/trustee) organizations any hours organization from the

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

| | any hours | and a director/trustee) | | | | |) | organization | organizations | from the | |
|----------------------------------|---|-----------------------------------|-----------------------|---------|--------------|---------------------|--------|----------------------|----------------------|--|--|
| | for related organizations below dotted line) | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated | Former | (W- 2/1099- MISC) | (W- 2/1099- MISC) | organization and related organizations | |
| Kristy A Schulhof | 53.0 | | | | | | | | | | |
| DIRECTOR (PRECEDENT (PART) (FAR) | | Х | | X | | | | 0 | 1,022,070 | 423,160 | |
| DIRECTOR/PRESIDENT (PART YEAR) | 2.0 | | | | | | | | | | |
| MATTHEW R COOK | 2.0 | | | | | | | | | | |
| | | Х | | | | | | 0 | 884,838 | 150,078 | |
| DIRECTOR | 53.0 | | | | | | | | | | |
| Kenneth D Puckett | 35.0 | | | | | | | | | | |
| | | Х | | Х | | | | 0 | 749,896 | 145,910 | |
| President - Indy Suburban Reg. | 20.0 | | | | | | | | | | |
| PAUL M CALKINS MD | 55.0 | | | | | | | | | | |
| | | | | | Χ | | | 602,605 | 0 | 31,892 | |
| VP & CMO | 0.0 | | | | | | | | | | |
| | | | | | | | | | | | |

520,724

374,099

316,788

321,380

268,310

0

291,075

12,547

11,362

48,361

41,748

35,860

45,345

2.0

53.0 2.0

53.0 35.0

20.0 35.0

20.0 0.0

55.0 5.0

50.0

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| President - Indy Suburban Reg. |
|--------------------------------|
| PAUL M CALKINS MD |
| VP & CMO |
| KEVIN L SMITH MD |
| DIRECTOR |

MEGAN CRITTENDON MD

COO - Indy Suburban Region

CFO - Indy Suburban Region

MICHAEL L HARLOWE

PRESIDENT - TIPTON

DEREK E EMPIE

SECRETARY

DIRECTOR

ARTHUR VASQUEZ

Cara L Breidster

and Independent Contractors

(A) (B) (C) (D) (E) (F) Name and Title Position (do not check more Reportable Estimated Average Reportable than one box, unless amount of other hours per compensation compensation person is both an officer week (list from the from related compensation any hours and a director/trustee) organization organizations from the

88,973

8,391

182,794

159,296

115,837

192,896

166.818

208,726

14,813

0

32,933

40,664

34,137

15,145

7,156

20.0 35.0

20.0 55.0

> 0.0 0.0

0.0 40.0

0.0 40.0

0.0

.

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

| | Commelons | and a an ector, trastee, | | | | | | (14/ 2/4000 | (14/ 2/4.000 | evannization and | |
|---|---|-----------------------------------|-----------------------|---------|--------------|------------------------------|--------|----------------------|----------------------|--|--|
| | for related organizations below dotted line) | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | (W- 2/1099- MISC) | (W- 2/1099- MISC) | organization and related organizations | |
| RUTH A KAIN RN Former Key Employee | 0.0 | | | | | | х | 0 | 264,913 | 41,126 | |
| LISA A SPARKS RN CNO - Indy Suburban Region | 55.0 35.0 20.0 | | | | Х | | | 0 | 231,548 | 43,717 | |
| RANDALL C YUST Former Officer | 55.0 | | | | | | x | 0 | 227,727 | 29,249 | |
| DIANE L HESSON Interim CNO (PART YEAR) | 35.0 20.0 | | | | | х | | 141,699 | 65,495 | 36,484 | |
| MARK A MCLEAN | 35.0 | | | | | | | | | | |

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Χ

Χ

Х

Х

| DIANE L HESSON |
|----------------------------|
| Interim CNO (PART YEAR) |
| MARK A MCLEAN |
| DIR OPERATIONS (PART YEAR) |

TAMARAH D BROWNLEE

ATHANASIA S BANICH

JONATHAN R GOBLE

Former Officer

JANICE M VADAS

CHAD A DILLEY

Director Allied Services

VP-HR - Indy Suburban Region

......

ADMIN DIR-CV(PT YR)/COO-SAXONY

PRES. North/Coo Saxony (Pt Yr)

and Independent Contractors

(A) (B) (C) (D) (E) (F) Name and Title Position (do not check more Reportable Estimated Average Reportable than one box, unless hours per compensation compensation amount of other person is both an officer week (list from the from related compensation

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

| | any hours | and | a dir | ecto | | ustee) |) | organization | organizations | from the | |
|------------------------------|---|-----------------------------------|-----------------------|------|--------------|---------------------|--------|----------------------|----------------------|--|--|
| | for related organizations below dotted line) | Individual trustee or director | Institutional Trustee | | Key employee | Highest compensated | Former | (W- 2/1099- MISC) | (W- 2/1099- MISC) | organization and related organizations | |
| ROBERT E EVARD MD DIRECTOR | 12.0 | Х | | | | | | 0 | 79,612 | 0 | |
| JAY L HESS MD DIRECTOR | 1.0 7.0 | Х | | | | | | 6,500 | 37,500 | 0 | |
| CHARLES E SCHALLIOL CHAIRMAN | 2.0 | Х | | х | | | | 18,750 | 0 | 0 | |
| CHAIRMAN | 2.0 | | | ı | 1 | 1 | | | | | |

0

8,000

7,000

3,500

0

0

6,500

3,000

| JAY L HESS MD | 1.0 | Х | | | 6,500 | 37 |
|---------------------|-------|---|---|--|--------|----|
| DIRECTOR | 7.0 | Λ | | | 0,300 | 3, |
| CHARLES E SCHALLIOL | 2.0 | | | | | |
| | | Х | Х | | 18,750 | |
| CHAIRMAN | 2.0 | | | | · | |
| CLAUDIA J SOMES MD | 2.0 | | | | | |
| | ••••• | Χ | | | 14,375 | |
| DIRECTOR | 2.0 | | | | | |

2.0

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and Independent Contractors

MARSHA A STONE

MARK R BENSON DO

MICHELE M KAWIECKI

REV KAREN E DEVAISHE

JOHN D GOLDENBERG M

DIRECTOR (Part Year)

MICHAEL L KUBACKI

DIRECTOR (Part Year)

DIRECTOR

DIRECTOR

DIRECTOR

DIRECTOR

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......

| efile | e GR/ | <u>APHIC prii</u> | nt - DO NOT PR | ROCESS | As Filed Data - | | | DLN: 9 | 3493318032870 | | |
|-------|----------|------------------------------|---|--|--|--|------------------------------------|---|---------------------------|--|--|
| SCI | 1ED | ULE A | | ublic C | harity Statu | e and Dul | alic Supp | ort | OMB No. 1545-0047 | | |
| | m 990 | | Complet | e if the ore | ganization is a sect 4947(a)(1) nonexe ▶ Attach to Form ! | ion 501(c)(3) c mpt charitable 990 or Form 99 | organization or trust. 0-EZ. | · a section | 2019 | | |
| | | the Treasury | ► Go to | Go to www.irs.gov/Form990 for instructions and the latest information. Open to Inspec | | | | | | | |
| Name | e of th | ne organiza | t ion TH NORTH HOSPITAL | | | | | Employer identific | ation number | | |
| Pa | rt T | Reason | or Public Char | ity Statu | s (All organization | s must comple | te this part) S | 35-1932442 See instructions | | | |
| | | | | | it is: (For lines 1 thro | | | occ mod deciono. | | | |
| 1 | | A church, c | onvention of churc | hes, or ass | ociation of churches | described in sec t | tion 170(b)(1) | (A)(i). | | | |
| 2 | | A school de | scribed in section | 170(b)(1 |)(A)(ii). (Attach Sch | nedule E (Form 9 | 90 or 990-EZ).) | | | | |
| 3 | ▽ | A hospital o | or a cooperative ho | ospital servi | ce organization descr | ribed in section | 170(b)(1)(A)(| iii). | | | |
| 4 | | A medical r name, city, | | on operate | d in conjunction with | a hospital descri | bed in section : | 170(b)(1)(A)(iii). E | nter the hospital's | | |
| 5 | | (b)(1)(A) | (iv). (Complete Pa | art II.) | - | , | , , | ernmental unit descri | bed in section 170 | | |
| 6 | | | · - | | governmental unit de | | | | | | |
| 7 | | | ition that normally 0(b)(1)(A)(vi). | | | s support from a | governmental u | init or from the gener | al public described in | | |
| 8 | | A communi | ty trust described | in section | 170(b)(1)(A)(vi). | (Complete Part I | I.) | | | | |
| 9 | | | | | scribed in 170(b)(1) e instructions. Enter | | | with a land-grant coll college or university: | ege or university or a | | |
| 10 | | from activit investment | ies related to its e | xempt func ated busine | tions—subject to cert ss taxable income (le | tain exceptions, a | and (2) no more | ns, membership fees, than 331/3% of its su sses acquired by the c | ipport from gross | | |
| 11 | | An organiza | tion organized an | d operated | exclusively to test for | r public safety. S | ee section 509 | (a)(4). | | | |
| 12 | | more public | ly supported orga | nizations de | | 09(a)(1) or sec | ction 509(a)(2 | s of, or to carry out th). See section 509(a s 12e, 12f, and 12g. | | | |
| a | | organizatio | | regularİy ap | | | | zation(s), typically by of the supporting orga | | | |
| b | | manageme | | ıg organizal | tion vested in the san | | | organization(s), by ha ge the supported orga | | | |
| c | | Type III f | inctionally integ | rated. A su | | | | nd functionally integra | ted with, its | | |
| d | | Type III n | on-functionally integrated. The o | i ntegrated rganization | . A supporting organi | zation operated fy a distribution | in connection wi | th its supported orgar an attentiveness req | | | |
| е | | Check this | oox if the organiza | tion receive | | ation from the II | | pe I, Type II, Type II | I functionally | | |
| f | Enter | | of supported orga | | | - | | <u> </u> | | | |
| g | Provi | de the follow | ing information ab | out the sup | ported organization(| s). | | | | | |
| | (i) N | lame of supp organizatior | | i) EIN | (iii) Type of organization (described on lines 1- 10 above (see instructions)) | (iv) Is the organization listed in your governing document? (v) Amount of monetary support | | (vi) Amount of other support (see instructions) | | | |
| | | | | | | Yes | No | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| Total | | | tion Act Notice, s | | | Cat. No. 11285 | | Schedule A (Form 9 | | | |

| Sch | edule A (Form 990 or 990-EZ) 2019 | | | | | | Page 2 |
|-------------|---|----------------------------|--|--|--|--|-----------------|
| P | art II Support Schedule for | Organizations | Described in S | Sections 170(b |)(1)(A)(iv) ar | nd 170(b)(1)(A | (vi) |
| | (Complete only if you ch | | | | | | under Part III. |
| | If the organization failed | to qualify unde | r the tests listed | below, please | complete Part I | II.) | |
| | ection A. Public Support Calendar year | | I | | | | |
| | (or fiscal year beginning in) ▶ | (a) 2015 | (b) 2016 | (c) 2017 | (d) 2018 | (e) 2019 | (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 The value of services or facilities | | | | | | |
| 3 | 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. | | | | | | |
| <u>s</u> | ection B. Total Support | | T | | 1 | 1 | |
| | Calendar year (or fiscal year beginning in) ▶ | (a) 2015 | (b) 2016 | (c) 2017 | (d) 2018 | (e) 2019 | (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 | | | | | | |
| 10 | business is regularly carried on 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 instruction | ons) | | | 12 | |
| 13 | First five years. If the Form 990 is for | or the organization | 's first, second, th | ird, fourth, or fifth | n tax year as a sec | tion 501(c)(3) org | anization, |
| | check this box and stop here | | | | | ▶ [| |
| S | ection C. Computation of Publi | | | | | | |
| 14 | Public support percentage for 2019 (li | ne 6, column (f) di | vided by line 11, | column (f)) | | 14 | - |
| 15 | Public support percentage for 2018 Sc | hedule A, Part II, | line 14 | | | 15 | |
| 16a | 33 1/3% support test—2019. If the | | | | | | |
| | and stop here. The organization qual | ifies as a publicly s | supported organiza | ation | | | ▶□ |
| b | 33 1/3% support test—2018. If th | e organization did | not check a box o | on line 13 or 16a, | and line 15 is 33 i | 1/3% or more, chec | k this |
| | box and stop here. The organization | qualifies as a pub | licly supported or | ganization | | | ▶ 🗆 |
| 17 a | 10%-facts-and-circumstances tes | t— 2019. If the org | ganization did not | check a box on lin | ne 13, 16a, or 16b | , and line 14 | |
| | is 10% or more, and if the organization in Part VI how the organization meets | n meets the facts | -and-circumstanci cumstances" test. | es test, check thi The organization | s box and stop n e qualifies as a publ | e re. Explain icly supported | |
| | organization | | | - | | | ►□ |
| h | 10%-facts-and-circumstances tes | st— 2018. If the o | rganization did no | t check a box on I | ine 13, 16a, 16b, | or 17a, and line | |
| _ | 15 is 10% or more, and if the organiz | zation meets the "i | facts-and-circums | tances" test, chec | k this box and sto | p here. | |
| | Explain in Part VI how the organization | | | - | | • • | . \Box |
| _ | supported organization | | haven 15 40-4 | C- 10b 47 4 | 76 | | ▶⊔ |
| 18 | _ | | | | | | . □ |
| | instructions | | <u> </u> | | - Cabadu | lo A (Form 000 o | ▶ ⊔ |

| Р | art III Support Schedule for | | | | | | |
|-----------|---|--------------------|-----------------------|-----------------------|----------------------|----------------------|---------------------|
| | (Complete only if you cl | | | | | | er Part II. If |
| S | the organization fails to ection A. Public Support | quality under | the tests listed i | pelow, please co | ompiete Part II.) | | |
| 30 | Calendar year | () 2015 | (1) 2016 | () 2247 | (1) 2010 | () 2010 | (O.T.) |
| | (or fiscal year beginning in) ▶ | (a) 2015 | (b) 2016 | (c) 2017 | (d) 2018 | (e) 2019 | (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 | | | | | | |
| 4 | under section 513 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 | | | | | | |
| L | 3 received from disqualified persons Amounts included on lines 2 and 3 | | | | | | |
| D | 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.) | | | | | | |
| Se | ection B. Total Support | | 1 | | | | Г |
| | Calendar year (or fiscal year beginning in) ▶ | (a) 2015 | (b) 2016 | (c) 2017 | (d) 2018 | (e) 2019 | (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. | | | | | | |
| С | 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 | | | | | | |
| 12 | (Explain in Part VI.) Total support. (Add lines 9, 10c, | | | | | | |
| 13 | 11, and 12.). | | | | | | |
| 14 | First five years. If the Form 990 is for | the organization | n's first, second, th | nird, fourth, or fift | h tax year as a sec | tion 501(c)(3) o | ganization <u>,</u> |
| | check this box and stop here | | | | | | ▶ ⊔ |
| | ection C. Computation of Public S | | | ! (6)) | | 1 1 | |
| 15 | Public support percentage for 2019 (lin | | • | | | 15 | |
| 16 | Public support percentage from 2018 S | - | <u> </u> | | | 16 | |
| | ection D. Computation of Investr Investment income percentage for 201 | | | line 13 column (f | :)) | 17 | |
| 17 10 | Investment income percentage for 201 | - | | - | | 17 | |
| 18 10- | 331/3% support tests—2019. If the | | • | | | 18 33 1/3% and lin | e 17 is not |
| | more than 33 1/3%, check this box and s | | | | | | |
| | more than 33 1/3%, check this box and s 33 1/3% support tests—2018. If the | | | | | | |
| ט | not more than 33 1/3%, check this box | - | | | • | | _ |
| 20 | Private foundation. If the organization | - | - | | | | |
| | Frivate foundation. If the organization | ni ulu not check a | a DOX ON TIME 14, I | .a, or iad, check | , unis pox and see I | HSGRUCHONS | . 📂 📖 |

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

10a

answer line 10b below.

the organization had excess business holdings).

Sections A and D, and complete Part V.) Section A. All Supporting Organizations Yes No

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 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

Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? If "Yes," answer (b) and (c) below. 3a 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 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. 3с

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 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

4b supervised by or in connection with its supported organizations. 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 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 5a amendment to the organizing document).

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

5c Substitutions only. Was the substitution the result of an event beyond the organization's control? Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other 6

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

Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? If "Yes,"

8 complete Part I of Schedule L (Form 990 or 990-EZ). 8

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

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Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting
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than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its

organization had an interest? If "Yes," provide detail in Part VI.

9c

10a

10b

Schedule A (Form 990 or 990-EZ) 2019

9b

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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.
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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,"

Did the organization have any excess business holdings in the tax year? (Use Schedule C, Form 4720, to determine whether

| | edule A (101111 550 01 550 E2) 2015 | | | age 3 |
|----|--|--------|---------|-------|
| Pa | rt IV Supporting Organizations (continued) | | | |
| _ | | | Yes | No |
| | Has the organization accepted a gift or contribution from any of the following persons? | | | |
| а | 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 | | |
| | A family member of a person described in (a) above? | 11b | | |
| | 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 | | |
| S | ection 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 | - | | |
| 2 | 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 | 2 | | |
| | organization. | | | |
| S | ection 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 | 1 | | |
| | supporting organization was vested in the same persons that controlled or managed the supported organization(s). | | | |
| S | ection 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 | | |
| S | ection 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 instruct | ions): | | |
| | The organization satisfied the Activities Test. Complete line 2 below. | | | |
| | b | | | |
| • | The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see | instru | ctions) | |
| 2 | Activities Test. Answer (a) and (b) below. | ſ | Yes | No |
| • | 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 | | |
| ı | 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? <i>Provide details in Part VI</i> . | 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. | 3h | | |

3b

Schedule A (Form 990 or 990-EZ) 2019 Page 6 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. (A) Prior Year (B) Current Year Section A - Adjusted Net Income (optional) Net short-term capital gain 1 2 Recoveries of prior-year distributions 3 Other gross income (see instructions) 3 Add lines 1 through 3 4 4 5 Depreciation and depletion 5 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) 7 Other expenses (see instructions) Adjusted Net Income (subtract lines 5, 6 and 7 from line 4) 8 (A) Prior Year (B) Current Year Section B - Minimum Asset Amount (optional) 1 Aggregate fair market value of all non-exempt-use assets (see instructions for short 1 tax year or assets held for part of year): a Average monthly value of securities 1a **b** Average monthly cash balances **1**b c Fair market value of other non-exempt-use assets 1c d Total (add lines 1a, 1b, and 1c) **1**d e Discount claimed for blockage or other factors (explain in detail in Part VI): Acquisition indebtedness applicable to non-exempt use assets 2 3 Subtract line 2 from line 1d 3 Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see 4 instructions). 5 Net value of non-exempt-use assets (subtract line 4 from line 3) Multiply line 5 by .035 6 6 7 Recoveries of prior-year distributions 7 8 Minimum Asset Amount (add line 7 to line 6) 8 Current Year Section C - Distributable Amount Adjusted net income for prior year (from Section A, line 8, Column A) 1 2 2 Enter 85% of line 1 3 Minimum asset amount for prior year (from Section B, line 8, Column A) Enter greater of line 2 or line 3 4 4 5 5 Income tax imposed in prior year 6 Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions) 7 Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see

| 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. | |
| _ | | |

| 7 Total annual distributions. Add lines 1 through 6. | | | |
|---|---|----------|--------------------|
| 8 Distributions to attentive supported organizations to who details in Part VI). See instructions | sive (provide | | |
| 9 Distributable amount for 2019 from Section C, line 6 | | | |
| 10 Line 8 amount divided by Line 9 amount | | | |
| Section E - Distribution Allocations (see instructions) | (iii) Distributable Amount for 2019 | | |
| | | Pre-2019 | Allibalit for 2013 |
| 1 Distributable amount for 2019 from Section C, line 6 | | 116 2015 | Allount for 2013 |

| details in Part VI). See instructions | | (| |
|---|-----------------------------|--|---|
| 9 Distributable amount for 2019 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-2019 | (iii) Distributable Amount for 2019 |
| 1 Distributable amount for 2019 from Section C, line 6 | | | |
| 2 Underdistributions, if any, for years prior to 2019 (reasonable cause required explain in Part VI). See instructions. | | | |
| 3 Excess distributions carryover, if any, to 2019: | | | |
| a From 2014 | | | |
| b From 2015 | | | |
| c From 2016 | | | |
| d From 2017 | | | |
| e From 2018. | | | |

Schedule A (Form 990 or 990-EZ) (2019)

f Total of lines 3a through e

instructions)

See instructions.

a Excess from 2015. **b** Excess from 2016. c Excess from 2017. **d** Excess from 2018. e Excess from 2019.

3j and 4c. 8 Breakdown of line 7:

\$

g Applied to underdistributions of prior years h Applied to 2019 distributable amount i Carryover from 2014 not applied (see

j Remainder. Subtract lines 3g, 3h, and 3i from 3f. 4 Distributions for 2019 from Section D, line 7:

a Applied to underdistributions of prior years b Applied to 2019 distributable amount c Remainder. Subtract lines 4a and 4b from 4. 5 Remaining underdistributions for years prior to 2019, if any. Subtract lines 3g and 4a from line 2. If the amount is greater than zero, explain in Part VI.

6 Remaining underdistributions for 2019. 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 2020. Add lines

Additional Data

Software ID: Software Version:

EIN: 35-1932442

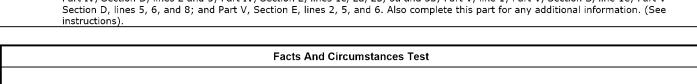
Name: INDIANA UNIVERSITY HEALTH NORTH HOSPITAL

Schedule A (Form 990 or 990-EZ) 2019

Page 8

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



SCHEDULE C (Form 990 or 990-

EZ)

Political Campaign and Lobbying Activities

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

2019

OMB No. 1545-0047

DLN: 93493318032870

▶Complete if the organization is described below. ▶Attach to Form 990 or Form 990-EZ.

Open to Public

| Department of the Treasury Internal Revenue Service | | | o <u>www.irs.gov/Form990</u> for instru | Inspection | | |
|---|--|--|---|---|--|--|
| • S | Section 501(c)(3) org Section 501(c) (othe Section 527 organiz | anizations: Cor than section 5 ations: Complet | | e Part I-C. s I-A and C below. | Do not complete Part I-B. | · |
| • S • S If the | Section 501(c)(3) or Section 501(c)(3) or | ganizations that ganizations that wered "Yes" or | n Form 990, Part IV, Line 4, or Form 9 thave filed Form 5768 (election under s thave NOT filed Form 5768 (election un form 990, Part IV, Line 5 (Proxy Tax | section 501(h)): Co nder section 501(h | mplete Part II-A. Do not co)): Complete Part II-B. Do n | mplete Part II-B. lot complete Part II-A. |
| | | | zations: Complete Part III. | | | |
| | me of the organizati PIANA UNIVERSITY HEA | | ITAL | | 35-1932442 | tification number |
| Par | t I-A Complete | e if the orga | nization is exempt under section | on 501(c) or is | | ation. |
| 1 | Provide a descripti | | ization's direct and indirect political car | npaign activities in | Part IV (see instructions fo | or definition of |
| 2 | | , | litures (see instructions) | | > | \$ |
| 3 | | | aign activities (see instructions) | | | |
| Par | t I-B Complete | e if the orga | nization is exempt under section | on 501(c)(3). | | _ |
| 1 | Enter the amount | of any excise ta | ax incurred by the organization under se | ection 4955 | > \$ | \$ |
| 2 | Enter the amount | of any excise ta | ax incurred by organization managers u | nder section 4955 | > s | \$ |
| 3 | If the organization | incurred a sect | tion 4955 tax, did it file Form 4720 for t | this year? | | ☐ Yes ☐ No |
| 4a | Was a correction r | made? | | | | ☐ Yes ☐ No |
| b | If "Yes," describe | | | | | |
| Par | t I-C Complete | e if the orga | nization is exempt under section | n 501(c), exce | ept section 501(c)(3). | |
| 1 | | | ed by the filing organization for section | • | | \$ |
| 2 | | | anization's funds contributed to other o | | | \$ |
| 3 | Total exempt func | tion expenditur | es. Add lines 1 and 2. Enter here and o | n Form 1120-POL, | line 17b ▶ | \$ |
| 4 | Did the filing orga | nization file For | m 1120-POL for this year? | | | ☐ Yes ☐ No |
| 5 | organization made of political contrib | e payments. For utions received | employer identification number (EIN) of each organization listed, enter the amount that were promptly and directly deliver see (PAC). If additional space is needed, | ount paid from the ed to a separate p | filing organization's funds. olitical organization, such a | Also enter the amount |
| | (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 | | | | | | |
| | | | | 1 | I | |

| Sche | dule C (For | rm 990 or 990-EZ) 2019 | | | | Р | age 3 |
|------|--------------|---|---------|----------|--------|----------|--------------|
| Pa | rt II-B | Complete if the organization is exempt under section $501(c)(3)$ and has NOT fill Form 5768 (election under section $501(h)$). | ed | | | | |
| or e | each "Yes" i | response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying | (| a) | (b) | | |
| ctiv | | | Yes | No | | Amour | nt |
| 1 | | e year, did the filing organization attempt to influence foreign, national, state or local legislation, any attempt to influence public opinion on a legislative matter or referendum, through the use of: | | | | | |
| а | Voluntee | rs? | | No | | | |
| b | Paid staff | or management (include compensation in expenses reported on lines 1c through 1i)? | | No | | | |
| С | Media ad | vertisements? | | No | | | |
| d | Mailings t | o members, legislators, or the public? | | No | | | |
| е | Publicatio | ns, or published or broadcast statements? | | No | | | |
| f | Grants to | other organizations for lobbying purposes? | | No | | | |
| g | Direct co | ntact with legislators, their staffs, government officials, or a legislative body? | | No | | | |
| h | Rallies, d | emonstrations, seminars, conventions, speeches, lectures, or any similar means? | | No | | | |
| i | Other act | ivities? | Yes | | | | 1,257 |
| j | Total. Ad | d lines 1c through 1i | | | | | 1,257 |
| 2a | Did the a | ctivities 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 filir | ng organization incurred a section 4912 tax, did it file Form 4720 for this year? | | | | | |
| Pai | rt III-A | Complete if the organization is exempt under section $501(c)(4)$, section $501(c)(6)$. | (5), c | r sec | tion | | |
| | | 55-(5)(5). | | | | Yes | No |
| 1 | Were sub | stantially all (90% or more) dues received nondeductible by members? | | | 1 | | |
| 2 | Did the o | rganization make only in-house lobbying expenditures of \$2,000 or less? | | | 2 | | |
| 3 | Did the o | rganization agree to carry over lobbying and political expenditures from the prior year? | | | 3 | | |
| | rt III-B | Complete if the organization is exempt under section 501(c)(4), section 501(c) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No" OR (b) Part answered "Yes." | ÌIÍ-A | | | | (6) |
| 1 | • | sessments and similar amounts from members | 1 | | | | |
| 2 | | 62(e) nondeductible lobbying and political expenditures (do not include amounts of political s for which the section 527(f) tax was paid). | | | | | |
| a | | ear | 2a | | | | |
| b | • | r from last year | 2b | | | | |
| C | | | 2c | | | | |
| 3 | | e amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues . | 3 | | | | |
| 4 | the orgar | were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does nization agree to carryover to the reasonable estimate of nondeductible lobbying and political ure next year? | | | | | |
| 5 | | amount of lobbying and political expenditures (see instructions) | 5 | | | | |
| | art IV | Supplemental Information | | | | | |
| | | ••• | _ | _ | | | |
| Pro | vide the de | escriptions required for Part l-A, line 1; Part l-B, line 4; Part l-C, line 5; Part II-A (affiliated group list); | Part II | -A, line | s 1 ar | ıd 2 (se | ee |

instructions), and Part II-B, line 1. Also, complete this part for any additional information.

Return Reference Explanation

Schedule C, Part II-B, Line 1i - Other IU Health North Hospital paid institutional membership dues to the Indiana Hospital Association ("IHA") Activities during 2019 in the amount of \$19,247. Each membership organization notified IU Health North Hospital that a portion of the dues it paid were used for lobbying purposes. The IHA used 6.53%, or \$1,257 of the 2019

expenditures was \$1,257.

membership dues paid by IU Health North Hospital, for lobbying expenditures. The total membership dues paid to this organization by IU Health North Hospital during 2019 that were attributable to lobbying

DLN: 93493318032870

OMB No. 1545-0047

SCHEDULE D (Form 990)

Supplemental Financial Statements ▶ Complete if the organization answered "Yes," on Form 990,

2019

Department of the Treasury Internal Revenue Service

Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b. ► Attach to Form 990. ▶ Go to www.irs.gov/Form990 for instructions and the latest information.

Open to Public Inspection

| | ne of the organization IANA UNIVERSITY HEALTH NORTH HOSPITAL | | | Employer ide | ntification | number |
|-----|---|------------------------|--------------------------------|----------------------|----------------------|--------------|
| INC | IANA UNIVERSITY HEALIH NUKTH HUSPITAL | | | 35-1932442 | | |
| Pā | organizations Maintaining Donor Advis | | | r Accounts. | | |
| | Complete if the organization answered "Yes | | rt IV, line 6. dvised funds | (b) Funds | and other a | ccounts |
| 1 | Total number at end of year | (a) Donor o | 471004 141140 | (5) (4) | , and other a | |
| 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 organization's property, subject to the organization's exc | | | | | Yes 🗌 No |
| 6 | Did the organization inform all grantees, donors, and dor charitable purposes and not for the benefit of the donor oprivate benefit? | or donor advisor, or | or any other purpose c | | missible | Yes 🗌 No |
| Pa | t II Conservation Easements. | U am Faura 000 Ba | | | | |
| 1 | Complete if the organization answered "Yes Purpose(s) of conservation easements held by the organi | | | | | |
| 1 | Preservation of land for public use (e.g., recreation | ` - | - · · · · · | historically impa | wtant land a | |
| | | or education) L | | , , | | ea |
| | Protection of natural habitat | L | Preservation of a c | certified historic s | structure | |
| _ | Preservation of open space | 116 | | | | |
| 2 | Complete lines 2a through 2d if the organization held a q easement on the last day of the tax year. | ualified conservation | contribution in the for | | tion t the End of | the Year |
| а | Total number of conservation easements | | | 2a | t the Line of | the real |
| 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) acquire structure listed in the National Register | ed after 7/25/06, an | d not on a historic | 2d | | |
| 3 | Number of conservation easements modified, transferred tax year ▶ | l, released, extinguis | hed, or terminated by t | the organization | during the | |
| 4 | Number of states where property subject to conservation | easement is located | > | | | |
| 5 | Does the organization have a written policy regarding the and enforcement of the conservation easements it holds? | | | of violations, | ☐ Yes | □ No |
| 6 | Staff and volunteer hours devoted to monitoring, inspect • | ing, handling of viola | tions, and enforcing co | onservation ease | ments during | g the year |
| 7 | Amount of expenses incurred in monitoring, inspecting, h ▶ \$ | nandling of violations | , and enforcing conserv | vation easement | s during the | year |
| 8 | Does each conservation easement reported on line 2(d) a | above satisfy the req | uirements of section 17 | 70(h)(4)(B)(i) | | |
| | and section $170(h)(4)(B)(ii)$? | | | | ☐ Yes | □ No |
| 9 | In Part XIII, describe how the organization reports conse balance sheet, and include, if applicable, the text of the f the organization's accounting for conservation easements | ootnote to the orgar | | | | |
| Pai | Organizations Maintaining Collections of Complete if the organization answered "Yes | | | er Similar As | sets. | |
| 1a | If the organization elected, as permitted under SFAS 116 art, historical treasures, or other similar assets held for p provide, in Part XIII, the text of the footnote to its finance | oublic exhibition, edu | cation, or research in f | | | orks of |
| b | If the organization elected, as permitted under SFAS 116 historical treasures, or other similar assets held for public following amounts relating to these items: | (ASC 958), to repo | t in its revenue statem | | | |
| (| i) Revenue included on Form 990, Part VIII, line $f 1$ | | | > \$ | | |
| (| i)Assets included in Form 990, Part X | | | > \$ | | |
| 2 | If the organization received or held works of art, historica following amounts required to be reported under SFAS 1: | al treasures, or othe | similar assets for final | | le the | |
| а | Revenue included on Form 990, Part VIII, line 1 | | | > \$ | | |
| b | Assets included in Form 990, Part X | | | ▶ \$ | | |
| For | Paperwork Reduction Act Notice, see the Instructions | | | | dule D (For | rm 990\ 2019 |

d Equipment .

| Sche | dule D (Form 990) 2019 | | | | | | | | | Page 2 |
|------------|---|----------------------|-----------------------------|----------------|-------------|---------------------------|---------------|---------------|------------------|---------------|
| Par | t IIII Organizations Maintaining (| Collections of A | rt, Histori | cal Treas | sures, o | r Other S | imilar As | sets (cont | inued) | |
| 3 | Using the organization's acquisition, accessitems (check all that apply): | sion, and other rec | ords, check | any of the | following t | :hat are a s | significant u | se of its col | lection | |
| а | Public exhibition | | d | ☐ Loa | n or excha | ange progr | ams | | | |
| b | ☐ Scholarly research | | е | ☐ Oth | er | | | | | |
| С | Preservation for future generations | | | | | | | | | |
| 4 | Provide a description of the organization's Part XIII. | collections and exp | olain how the | ey further t | he organiz | ation's ex | empt purpo | se in | | |
| 5 | During the year, did the organization solici assets to be sold to raise funds rather than | | | | | | | ☐ Yes | □ N € | 0 |
| Pai | TEXT Escrow and Custodial Arran Complete if the organization ar X, line 21. | | n Form 990 | , Part IV, | line 9, o | r reported | d an amou | nt on Forn | n 990, I | Part |
| 1 a | Is the organization an agent, trustee, cust | | | | | | | _ | _ | |
| | included on Form 990, Part X? | | | | | | | ☐ Yes | □ No | 5 |
| | TE IIV. | /TTT d - b d | | to let e e | ı | | Α. | | | - |
| b | If "Yes," explain the arrangement in Part > | • | - | | | 1c | Al | mount | | - |
| c c | Beginning balance | | | | | 1d | | | | - |
| d | Additions during the year | | | | | | | | | - |
| e | Distributions during the year | | | | | 1e 1f | | | | - |
| f | Ending balance | | | | | 11 | | | | - |
| 2a | Did the organization include an amount on | Form 990, Part X, | line 21, for | escrow or o | custodial a | ccount lial | oility? | ☐ Yes | □ No | 5 |
| b | If "Yes," explain the arrangement in Part X | III. Check here if t | the explanati | ion has bee | n provide | d in Part X | ш | | | |
| Pa | rt V Endowment Funds. | | | | | | | | | |
| | Complete if the organization ar | | | | | anna bandi I | (d) Thurs | h / - \ | F | |
| 1- | Beginning of year balance | (a) Current ye | ar (b) P | rior year | (c) Iwo y | ears back | (d) Three yea | irs back (e) | Four year | s раск |
| | | | | | | | | | | |
| | Contributions | | | | | | | | | |
| | Net investment earnings, gains, and losses | | | | | | | | | |
| | Grants or scholarships | | | | | | | | | |
| | Other expenditures for facilities and programs | | | | | | | | | |
| f | Administrative expenses | | | | | | | | | |
| g | End of year balance | | | | | | | | | |
| 2 | Provide the estimated percentage of the cu | urrent year end bal | lance (line 1 | g, column (| a)) held a | s: | | | | |
| а | Board designated or quasi-endowment | | | | | | | | | |
| b | Permanent endowment ▶ | | | | | | | | | |
| С | Temporarily restricted endowment ▶ | | | | | | | | | |
| | The percentages on lines 2a, 2b, and 2c sh | nould equal 100%. | | | | | | | | |
| 3a | Are there endowment funds not in the posorganization by: | session of the orga | anization that | t are held a | ınd admini | istered for | the | | Yes | No |
| | (i) unrelated organizations | | | | | | | 3a(i) | | |
| | (ii) related organizations | | | | | | | 3a(ii) | | |
| b | If "Yes" on 3a(ii), are the related organizat | • | | | | | | 3b | | |
| 4 | Describe in Part XIII the intended uses of | | endowment f | funds. | | | | | | |
| Pai | t VI Land, Buildings, and Equipn | | - Faur- 000 | Dow't TV | line dd- | Caa == | 000 D- | | 0 | |
| | Complete if the organization ar Description of property (a) Cost or | | 1 Form 990 Cost or other | | | . See Fori umulated de | | | 0. Jook value | <u> </u> |
| | | tment) | , 3000 01 0010 | - 40.0 (00.161 | (5) 7.00 | aiatea de | | (4) | value | • |
| 4. | l and | | | | | | - | | | |
| | Land | | | 166 044 42 | 1 | | F7 014 700 | | 400 | 906 76 |
| | Buildings | | | 166,811,49 | | | 57,914,732 | | 108 | ,896,761 |
| C | Leasehold improvements | I | | 1,086,83 | ŏΙ | | 384,649 | | | 702,189 |

84,918,580

79,084,959

Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).)

19,446,731

67,535,513

196,581,194

65,471,849

11,549,446

| Part VII | Investments—Other Securities. Complete if the organization answered "Yes" on Form 990, | Part IV I | ine 11h | See Form 990 I | Part X. line 12 |
|------------------------|---|----------------------|---------|---------------------|---|
| | (a) Description of security or category (including name of security) | (b) Book value | 116 | (c) Metho | d of valuation: -year market value |
| | Il derivatives | | | | |
| (A) | | | | | |
| (B) | | | | | |
| (C) | | | | | |
| (D) | | | | | |
| (E) | | | | | |
| (F) | | | | | |
| (G) | | | | | |
| (H) | | | | | |
| Total. (Colum | n (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, I | ine 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) | | | | | |
| | n (b) must equal Form 990, Part X, col.(B) line 13.) | | Þ | | |
| Part IX | Other Assets. Complete if the organization answered 'Yes' on Form 990, P (a) Description | art IV, li | ne 11d. | . See Form 990, Par | t X, line 15. (b) Book value |
| (1) | | | | | |
| (2) | | | | | |
| (3) | | | | | |
| (4) | | | | | |
| (5) | | | | | |
| (6) | | | | | |
| (7) | | | | | |
| (8) | | | | | |
| (9) | | | | | |
| Total. (Colu Part X | Other Liabilities. | | | | 000 Park V. Park 25 |
| 1. | Complete if the organization answered 'Yes' on Form 990, F (a) Description of liability | art IV, lii | ne 11e | or 111.5ee Form | 990, Part X, line 25. (b) Book value |
| (1) Federal (5) | income taxes | | | | 0 |
| (6) | | | | | |
| (7) | | | | | |
| (8) | | | | | |
| (9) | | | | | |
| | n (b) must equal Form 990, Part X, col.(B) line 25.) | | | | 201,914,186 |
| 2. Liability fo | or uncertain tax positions. In Part XIII, provide the text of the footnot 's liability for uncertain tax positions under FIN 48 (ASC 740). Check | | | | ments that reports the |

Schedule D (Form 990) 2019

Page 4

| 1 | lotal revenue, gains, and other s | 1 | | | |
|-------|--|--|---|--------------|----------------------|
| 2 | Amounts included on line 1 but no | ot on Form 990, Part VIII, line 12: | | | |
| а | Net unrealized gains (losses) on i | nvestments | 2a | | |
| b | Donated services and use of facili | ties | 2b | | |
| C | Recoveries of prior year grants | | 2c | 1 | |
| d | Other (Describe in Part XIII.) . | | 2d | | |
| е | Add lines 2a through 2d | | | 2e | |
| 3 | Subtract line ${f 2e}$ from line ${f 1}$. | | | 3 | |
| 4 | Amounts included on Form 990, F | Part VIII, line 12, but not on line 1: | | | |
| а | Investment expenses not include | d 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 4 | c. (This must equal Form 990, Part I, line 12.) | | 5 | |
| Par | | penses per Audited Financial Statem zation answered 'Yes' on Form 990, Par | | Return. | |
| 1 | Total expenses and losses per au | dited financial statements | | 1 | |
| 2 | Amounts included on line 1 but no | ot on Form 990, Part IX, line 25: | | | |
| а | Donated services and use of facili | ties | 2a | | |
| b | Prior year adjustments | | 2b | | |
| c | Other losses | | 2c | | |
| d | Other (Describe in Part XIII.) . | | 2d | | |
| е | Add lines 2a through 2d | | | 2e | |
| 3 | Subtract line ${f 2e}$ from line ${f 1}$. | | | 3 | |
| 4 | Amounts included on Form 990, F | Part IX, line 25, but not on line 1: | | | |
| а | Investment expenses not include | d 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 4 | kc. (This must equal Form 990, Part I, line 18 | .) | 5 | |
| Pai | t XIII Supplemental Info | rmation | | | |
| Prov | vide the descriptions required for P lines 2d and 4b; and Part XII, lines | art II, lines 3, 5, and 9; Part III, lines 1a and 2d and 4b. Also complete this part to provide | 4; Part IV, lines 1b and 2b; Pare any additional information. | t V, line 4; | Part X, line 2; Part |
| | Return Reference | | Explanation | | |
| See A | Additional Data Table | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| chedule D (Form 990) 2019 | Page 5 | | | |
|--|---------------|--|--|--|
| Part XIII Supplemental Information (continued) | | | | |
| Return Reference Explanation | | | | |
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Schedule D (Form 990) 2019

Additional Data

Software ID:

Software Version:

EIN: 35-1932442

Name: INDIANA UNIVERSITY HEALTH NORTH HOSPITAL

INC

Supplemental Information

| Return Reference | Explanation |
|--|--|
| Schedule D, Part X, Line 2 - FIN 48 (ASC 740) Footnote | IU Health North Hospital is a subsidiary in Indiana University Health, Inc.'s ("TU Health") Consolidated Audited Financial Statements. The Internal Revenue Service (IRS) has determ ined that Indiana University Health and certain of its affiliated entities are tax-exempt organizations as defined in Section 501(c)(3) of the Internal Revenue Code (IRC). Indiana University Health and its tax-exempt affiliates are, however, subject to federal and state income taxes on unrelated business income under the provisions of IRC Section 511. The Ta x Cuts and Jobs Act (TCJA) was enacted on December 22, 2017. For tax-exempt entities, TCJA requires organizations to 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-activity basis, among other provisions. Proposed regulations and interim guidance, necessary for implementation, have been issued on most aspects of TCJA. It is e xpected that proposed regulations will be issued as final regulations by the IRS in 2020. As of and for the year ended December 31, 2019, Indiana University Health has made reasona ble estimates of the provision for income taxes, the compensation excise tax, and the effects, if any, on existing deferred tax balances. Indiana University Health will continue to refine its calculations in future periods, as additional regulations and guidance are issued by the IRS. Deferred income taxes that, as of December 31, 2019 and 2018, have no net carrying value reflect the net tax effect of temporary differences between the carrying amounts of assets and liabilities for financial reporting and the amounts used for income tax x purposes. As of December 31, 2019 and 2018, the Indiana University Health System had gross deferred tax assets of \$143,157,000 and \$119,965,000 respectively, primarily relating to net operating loss carryovers. Management determined that a full valuation allowance at December 31, 2019 and 2018, was necessary to reduce the defe |

efile GRAPHIC print - DO NOT PROCESS **SCHEDULE H** (Form 990)

Department of the

Treasury

As Filed Data -

DLN: 93493318032870 OMB No. 1545-0047

Open to Public Inspection

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.

| Nam | e of the organization | IOCDITAL | | | Emplo | yer identificat | ion n | umber | |
|--------|--|--------------------------------------|--------------------------|------------------------|------------------------|------------------|------------|-----------|--------|
| INC | INA UNIVERSITY HEALTH NORTH F | OSPITAL | | | 35-19 | 32442 | | | |
| Pa | rt I Financial Assist | ance and Certair | n Other Commu | nity Benefits at (| Cost | | | | |
| | Billib a service Park to the service | <i>c</i> | | TEUN - U -Li- | ha annakian Ca | | | Yes | No |
| 1a | Did the organization have a If "Yes," was it a written pol | | policy during the tax | | to question ba . | | 1a | Yes | 1 |
| ь 2 | If the organization had mult | , | | | scribes application of | of the financial | 1 b | Yes | |
| _ | assistance policy to its vario | | | | seribes application c | are maneral | | | |
| | Applied uniformly to all | hospital facilities | ☐ App | lied uniformly to mo | st hospital facilities | | | | ĺ |
| | Generally tailored to ind | dividual hospital facil | ities | | | | | | |
| 3 | Answer the following based organization's patients during | | stance eligibility crite | eria that applied to t | he largest number o | f the | | | |
| а | Did the organization use Feder If "Yes," indicate which of th | | | | | ? | 3a | Yes | |
| | □ 100% □ 150% ☑ | 200% Other _ | | | % | | | | |
| b | Did the organization use FPG | G as a factor in deter | mining eligibility for | providing discounte | d care? If "Yes," ind | icate | | | |
| | which of the following was t | he family income lim | it for eligibility for d | iscounted care: . | | | 3b | | No |
| | □ 200% □ 250% □ | 300% 🗆 350% 🗀 | ☐ 400% ☐ Othe | r | | _ % | | | |
| c | If the organization used fact used for determining eligibil used an asset test or other to discounted care. | ity for free or discou | nted care. Include ir | n the description whe | ether the organization | on | | | |
| 4 | Did the organization's finance provide for free or discounte | | | argest number of its | | , | 4 | Yes | |
| 5a | Did the organization budget the tax year? | amounts for free or | discounted care pro | vided under its finar | ncial assistance polic | y during | 5a | Yes | |
| b | If "Yes," did the organization | n's financial assistan | ce expenses exceed | the budgeted amou | nt? | | 5b | | No |
| c | If "Yes" to line 5b, as a resu care to a patient who was e | | | anization unable to p | | unted | 5c | | |
| 6a | Did the organization prepare | e a community benef | it report during the | tax year? | | | 6a | Yes | |
| b | If "Yes," did the organization | | • | | | | 6b | Yes | |
| | Complete the following table with the Schedule H. | e using the workshee | ts provided in the S | chedule H instructio | ns. Do not submit th | iese worksheets | | | |
| 7 | Financial Assistance and | I Certain Other Com | nmunity Benefits at | Cost | | | | | |
| | nancial Assistance and | (a) Number of | (b) Persons served | (c) Total community | (d) Direct offsetting | (e) Net commun | ity | (f) Perc | ent of |
| c | Means-Tested Sovernment Programs | activities or programs (optional) | (optional) | benefit expense | revenue | benefit expens | e | total exp | pense |
| | Financial Assistance at cost | | | | | | | | |
| | (from Worksheet 1) | | 1,630 | 1,884,697 | | 1,884 | ,697 | 0 | .890 % |
| | Medicaid (from Worksheet 3, column a) | | 4,406 | 33,534,638 | 19,330,103 | 14,204 | ,535 | 6 | .720 % |
| C | Costs of other means-tested government programs (from Worksheet 3, column b) | | | | | | | | |
| d | Total Financial Assistance and Means-Tested Government Programs | | 6,036 | 35,419,335 | 19,330,103 | 16,089 | 232 | 7 | .610 % |
| _ | Other Benefits | | ,,,,, | | , | | | | |
| е | Community health improvement services and community benefit operations (from Worksheet 4). | 8 | 9,430 | 986,162 | 25,366 | 960 | .796 | 0 | .450 % |
| f | Health professions education (from Worksheet 5) | | 217 | 537,965 | 23,300 | | | | |
| g | Subsidized health services (from Worksheet 6) | 2 | 217 | 337,963 | | 337 | ,965 | 0 | .250 % |
| h | Research (from Worksheet 7) . | | | | | | | | |
| i | Cash and in-kind contributions for community benefit (from Worksheet 8) | 2 | 9,082 | 98,335 | | 98 | ,335 | 0 | .050 % |
| j | Total. Other Benefits | 12 | 18,729 | 1,622,462 | 25,366 | 1,597 | | | .750 % |
| k | Total. Add lines 7d and 7j | 12 | 24,765 | 37,041,797 | 19,355,469 | 17,686 | | | .360 % |

Cat. No. 50192T

| Sch | edule H (Form 990) 2019 | | | | | | | | | F | Page 2 |
|--------------|---|---|--|--|-----------------|---------------------------------|-----------|--|-----------|---------------------------------|---------------|
| Pa | during the tax year communities it ser | r, and describe in | | | | | | | | | ties |
| | | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total commun building expense | | d) Direct d reven | | (e) Net commu building expen | | (f) Pero total ex | |
| 1 | Physical improvements and housing | | | | | | | | | | |
| | Economic development | | | | | | | | | | |
| 3 | Community support | | | | | | | | | | |
| 4 | Environmental improvements | | | | | | | | | | |
| | Leadership development and training for community members | | | | | | | | | | |
| 6 | Coalition building | | | | | | | | _ | | |
| | Community health improvement advocacy | 1 | | 3 | 59 | | | | 359 | | 0 % |
| | Workforce development | | | | | | | | | | |
| | Other Total | 1 | | | 59 | | | | 359 | | 0 % |
| Pa | rt IIII Bad Debt, Medica | are, & Collection | Practices | | 35 | | | | 333 | | |
| Sec 1 | tion A. Bad Debt Expense Did the organization report b | | accordance with Hea | althcare Financial | Mana | gement A | ssociatic | n Statement | | Yes | No |
| 2 | No. 15? | | expense. Explain in | Part VI the | • | I I | | | 1 | | No |
| _ | methodology used by the org | | | | | 2 | | 2,431,347 | | | |
| 3 | Enter the estimated amount eligible under the organization | | | | ients | | | | | | |
| | methodology used by the orgincluding this portion of bad | | | | y, for | 3 | | | | | |
| 4 | Provide in Part VI the text of | | | | at des | _ | ad debt e | xpense or the | | | |
| Sec | page number on which this f tion B. Medicare | ootnote is contained | in the attached fina | ancial statements. | | | | | | | |
| 5 | Enter total revenue received | from Medicare (inclu | ıding DSH and IME) | | | 5 | | 31,754,867 | | | |
| 6 | Enter Medicare allowable cos | , | • | | | 6 | | 41,638,200 | | | |
| 7 | Subtract line 6 from line 5. T | - | | | | 7 | | -9,883,333 | | | |
| 8 | Describe in Part VI the exten Also describe in Part VI the o Check the box that describes | osting methodology | | | | | | t. | | | |
| | Cost accounting system | ✓ Cost | to charge ratio | | ther | | | | | | |
| | tion C. Collection Practices Did the organization have a | writtan daht callactio | n nalicy during the | tay year? | | | | | | | |
| 9a b | If "Yes," did the organization contain provisions on the col | s collection policy th | nat applied to the la se followed for patie | rgest number of it nts who are know | s pat n to c | qualify for | financia | | 9a 9b | Yes Yes | |
| Pa | rt IV Management Com | panies and Joint | t Ventures | | | | | | _ | | |
| | <mark>(ମଧ୍ୟା</mark> ଏସ୍ଥିଲି _ଅ ମ୍ମୋଡ଼ e by off | icers, directors, trus teg s | oblestration of entity | pr | ofit % | Mzation's or stock ship % | tr emp | Officers, directors, ustees, or key oloyees' profit % ock ownership % | pro |) Physic fit % or wnershi | stock |
| 1 | | | | | | | | | | | |
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| 11 | | | | | | | | | - | | |
| 12 | | | | | | | | | | | |
| 13 | | | | | | | | | | | |
| | | | | | | | | Schedule | (Fo | rm 990 |) 2019 |

6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes." list the other hospital facilities in 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 If "Yes" (list url): SEE PART V, SECTION C 10b b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? 11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed. 12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by 12a Νo 12b b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . .

c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its

hospital facilities? \$

Schedule H (Form 990) 2019

Schedule H (Form 990) 2019

j 🗹 Other (describe in Section C)

| P | Part V Facility Information (continued) | | | | |
|----|--|---|----------|------------|----|
| Fi | Financial Assistance Policy (FAP) | | | | |
| | IU HEALTH NORTH HOSPIT | -AL | | | |
| Na | 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 polic | y that: | | | |
| 13 | 13 Explained eligibility criteria for financial assistance, and whether such assistance included fr | ee or discounted care? | 13 | Yes | |
| | If "Yes," indicate the eligibility criteria explained in the FAP: | | | | |
| 14 | a ✓ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free car 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 15 | Yes Yes | |
| 16 | a ✓ Described the information the hospital facility may require an individual to provide as p b ✓ Described the supporting documentation the hospital facility may require an individual her application c ✓ Provided the contact information of hospital facility staff who can provide an individual FAP and FAP application process d ☐ Provided the contact information of nonprofit organizations or government agencies the assistance with FAP applications e ☐ Other (describe in Section C) 16 Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply): | to submit as part of his or with information about the at may be sources of | 16 | Yes | |
| | The FAP was widely available on a website (list url): | | | | |

| | 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 | | | |
| | 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 | | | |
| | i V Other (describe in Section C) | 1 | I | I |

Schedule H (Form 990) 2019

Page **5**

| 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) | | | |
| | ${f b}$ \square 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 | | | |
| | f d $igsquare$ 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 | | | |
| | $f d$ \Box 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): | | | |
| | 3 M Described a surities provided by the control of | | | |

2 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 (if not, describe in Section C) b 🗹 Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C) c 🗹 Processed incomplete and complete FAP applications (if not, describe in Section C) d Made presumptive eligibility determinations (if not, describe in Section C) e Other (describe in Section C) 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:

f a \Box The hospital facility did not provide care for any emergency medical conditions **b** The hospital facility's policy was not in writing c \square The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) **d** Other (describe in Section C) Schedule H (Form 990) 2019

If "Yes," explain in Section C.

| Schedule H (Form 990) 2019 Page | | |
|---|---|--|
| Part V Facility Information (con | tinued) | |
| 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e descriptions for each hospital facility in | on for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate a facility reporting group, designated by facility reporting group letter and hospital facility, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility. | |
| Form and Line Reference | Explanation | |
| See Add'l Data | | |
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| | Schedule H (Form 990) 2019 | |

| Schedule H (Form 990) 2019 | Page 9 |
|--|---|
| Part V Facility Information (continued) | |
| Section D. Other Health Care Facilities That Are Not Licen (list in order of size, from largest to smallest) | sed, Registered, or Similarly Recognized as a Hospital Facility |
| How many non-hospital health care facilities did the organizatio | n operate during the tax year? |
| Name and address | Type of Facility (describe) |
| 1 Carmel Rehab 2476 East 116th StreetG100 CARMEL, IN 46032 | rehabilitation services |
| 2 | |
| 3 | |
| 4 | |
| 5 | |
| 6 | |
| 7 | |
| 8 | |
| 9 | |
| 10 | |
| | Schedule H (Form 990) 2019 |

| Schedu | hedule H (Form 990) 2019 Page 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.). | | |

Affiliated health care system. If the organization is part of an affiliated health care system, describe the respective roles of the

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

organization and its affiliates in promoting the health of the communities served.

community benefit report.

| Form and Line Reference | Explanation |
|---|--|
| Schedule H, Part I, Line 3c - Other Factors Used in Determining Elig. | LU Health North Hospital uses several factors other than Faderal Poverty Guidelines ("FPGs.") in determining eligibility for free care under its FAP. These factors include the follo wing: 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. 139 6b(v). IU Health North Hospital will employ the same residency test as set forth in Indian a Code 6-3-1-12 to define an Indiana resident. The term Resident includes any individual w ho was domiciled in Indiana during the taxable year, or any individual who maintains a per manent 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 meet the aforementioned residency test and are not claimed as a dependent on a parents or guardians federal income tax return. 2. IU Healths Individual Solutions Department Prior to seeking Financial Assistance under the FAP, all patients or their guarantors must consu It with a member of IU Healths Individual Solutions department to determine if healthcare coverage may be obtained from a government insurance/assistance product or from the Health Insurance Exchange Marketplace. 3. Uninsured Patients All Uninsured Patients presenting for services at IU health North 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 services not covered by the FAP is available at https://lukealth.org/pay-a-bill/financial-assistance and federal assistance programs. Prior to receiving an award from IU Health North Hospital sinsurance benefits a prior to receiving an award from 10 Health North Hospital sinsurance benefits of the FAP will be a service of the s |

| the AGB for their services. Patients will receive an estimated AG B cost of their care prior to IU Health North Hospital rendering the services and will be asked to pay a down-payment percentage of the AGB adjusted cost prior to receiving service s. In the event a patient is unable to fulfill the down-payment, | Form and Line Reference | Explanation |
|--|-------------------------|---|
| applicable federa I and state laws and/or regulations. 10. Emergency Services Non-Refundable Deposit This se ction will be implemented with a strict adherence to EMTALA and IU Health Policy ADM 1.32, Screening and Transfer of Emergency or Unstable Patients. Amount of Non-Refundable Deposi t All Uninsured Patients presenting for services at IU Health North Hospitals Emergency De partment, via transfer from another hospital facility, or direct admission, will be respon sible for a one-hundred dollar (\$100.00) non-refundable deposit for services rendered. Pat ients/guarantors will be responsible for any | | thousand dollars (\$500,000) and the home is occupied by the patient/gua rantor, patient'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 North Hospital reserves the right to request a list of all property owned by the patient/guarantor and adjust a patient's award of Finan cial Assistance if the patient demonstrates a claim or clear title to any extraordinary As set not excluded from consideration under the above guidance. 9. Non-Emergent Services Dow n Payment Uninsured 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 AG B cost of their care prior to IU Health North Hospital rendering the services and will be asked to pay a down-payment percentage of the AGB adjusted cost prior to receiving service s. In the event a patient is unable to fulfill the down-payment, their service may be resc heduled for a later date as medically prudent and in accordance with all applicable federa I and state laws and/or regulations. 10. Emergency Services Non-Refundable Deposit This se ction will be implemented with a strict adherence to EMTALA and IU Health Policy ADM 1.32, Screening and Transfer of Emergency or Unstable Patients. Amount of Non-Refundable Deposit All Uninsured Patients presenting for services at IU Health North Hospitals Emergency De partment, via transfer from another hospital facility, or direct admission, will be responsible for a one-hundred dollar (\$100.00) non-refundable deposit for services rendered. Pat ients/guarantors will be responsible for any copays and/or deductibles required by their p lan prior to full Financial Assistance being applied. Uninsured Patients wishing to make a n application for Financial Assistance greater than the AGB must fulfill their non-refundable deposit prior to IU Health North Hospital processing said applicatio |

| Form and Line Reference | Explanation |
|-----------------------------------|--|
| Report Prepared by a Related Org. | IU Health North 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 Health's website at https://iuhealth.org/in-the- |

Report is made available to the public on IU Health's website at https://iuhealth.org/in-the-community/Community-Benefit. 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 System's community benefit efforts. It is also available by request through the Indiana State Department of Health or IU Health.

| | 1 |
|--|--|
| Form and Line Reference | Explanation |
| Schedule H, Part I, Line 7, Column (c) | Schedule H, Part I, Line 7, Column (f), Percent of Total Expense, is based on column (e) Net Community |

- Total Community Benefit Expense

Benefit Expense. The percent of total expense based on column (c) Total Community Benefit Expense, which excludes direct offsetting revenue, is 17.53%.

990 Schedule H, Supplemental Information Form and Line Reference Explanation Schedule H, Part I, Line 7, Column (f) - The amount of bad debt expense subtracted for purposes of calculating the percentage of total expense on Line 7, column (f) is \$9,855,480. BAD DEBT EXPENSE IS REPORTED AT COST BASED ON THE COST-TO-

Percent of Total Expense CHARGE RATIO DERIVED FROM WORKSHEET 2, RATIO OF PATIENT CARE COST-TO-CHARGES.

| Form and Line Reference | Explanation |
|------------------------------|--|
| Health in Communities Served | IU Health North Hospital is part of the IU Health Statewide System. The IU Health Statewide System participates in a variety of community-building activities that address the social determinants of health in the communities it serves through investments in economic development efforts across the state, collaboration with like-minded organizations through coalitions that address key issues and advocacy 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 address issues, such as access to healthcare, community support and economic development. Several examples include IU Health North Hospital's support of the following organizations and initiatives that focus on some of the root causes of health issues, such as lack of education, insufficient access to resources, employment and poverty: - Partnership for a Healthy Hamilton County - Aspire Indiana, Inc Trinity Free Clinic - Indiana Center for the Prevention of Youth Abuse and Suicide - Shepherd's Center of Hamilton County 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 | | | | | | | |
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| Form and Line Reference | Explanation | | | | | | | |
| Schedule H, Part III, Line 2 - Bad Debt Expense Methodology | The amount reported on line 2 as bad debt 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 ELIGIBLISTY 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. | | | | | | | |

| Form and Line Reference | Explanation | | | | | | | | |
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| Expense | IU Health North Hospital is a subsidiary in the consolidated financial statements of IU Health. IU Health's bad debt expense footnote is 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 Indian | | | | | | | | |

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| Form and Line Reference | Explanation | | | | | | | |
| | The amount reported on Schedule H, Part III, Line 6 is calculated, in accordance with the Form 990 instructions, using "allowable costs" from IU Health North Hospitals Medicare Cost Report. "Allowable costs" for Medicare Cost Report purposes, however, are not reflective of all costs associated with IU Health North 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 North Hospitals participation in Medicare programs would significantly increase the Medicare shortfall reported on Schedule H, Part III, Line 7. IU Health North 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 North 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 | | | | | | | |
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| Schedule H, Part III, Line 9b - Written Debt Collection Policy | IU Health North Hospitals FAP and Written Debt Collection Policy describe the collection p ractices applicable to patients, including those who may qualify for financial assistance. 1. Financial Assistance Application Patients or their guarantors wishing to apply for Fin ancial Assistance are encouraged to submit a Financial Assistance Application within ninet y (90) days of their discharge. Patients or their guarantors may submit an application up to 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) days after having received their first billing statement. Patients or their guarantors submitting an incomplete application will receive written notification of the applications def iciency upon discovery by IU health. The application will be pended for a period of forty- five (45) days from the date the notification is mailed. IU Health will suspend any ECA un til the application is complete, or the patient fails to cure any deficiencies in their ap plication 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 below languages: - Arabic - Burmese- Burmese-Falam - Burmese-Hakha Chin - Mandarin/Chinese - Spanish The patient, and/or their representative, such as the patients physician, famil y members, legal counsel, community or religious groups, social services or hospital perso nnel may request a FAP Application to be mailed to a patients primary mailing address free of charge. IU Health keeps all application with their Financial Assistance Application: - All sources of Income for the last three (3) months; - 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, certificates of deposit, stocks, bonds and money marriet accounts; or Most recent shade and patients of pa | | | | | | | |

| Schedule H, Part III, Line 9b - Written and garnishing a patient or guarantors wages. When it is necessary to engage in such action, IU Health | Form and Line Reference | Explanation | | | | | | | | |
|---|---|--|--|--|--|--|--|--|--|--|
| collections activities. Patients or guarantors currently subject to an ECA who have not previously applied for Financial Assistance may apply for assist ance up to two-hundred and forty (240) days of the date of their first billing statement from IU Health. IU Health and their third-party collection agencies will suspen any ECA en gaged on a patient or their guarantor while an Application is being processed and consider ed 4. Refunds Patients eligible for assistance under the FAP who remitted payment to IU Health North Hospital in excess of their patient responsibility will be alerted to the over payment as promptly after discovery as is reasonable given the nature of the overpayment. Patients with an outstanding account balance on a separate account not eligible for assist ance under the FAP will have their refund applied to | Schedule H, Part III, Line 9b - Written Debt Collection Policy | North Hospital and its third party collection agencies, will engage in fair, respectful and transparent collections activities. Patients or guarantors currently subject to an ECA who have not previously applied for Financial Assistance may apply for assist ance up to two-hundred and forty (240) days of the date of their first billing statement from IU Health. IU Health and their third-party collection agencies will suspend any ECA en gaged on a patient or their guarantor while an Application is being processed and consider ed. 4. Refunds Patients eligible for assistance under the FAP who remitted payment to IU Health North Hospital in excess of their patient responsibility will be alerted to the over payment as promptly after discovery as is reasonable given the nature of the overpayment. Patients with an outstanding account balance on a separate account not eligible for assist ance under the FAP will have their refund applied to the outstanding balance. Patients wit hout an outstanding account balance described above will be issued | | | | | | | | |

| Form and Line Reference | Explanation |
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| Schedule H, Part VI, Line 2 - Needs Assessment | Communities are multifaceted and so are their health needs. IU Health North 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 North Hospital assesses the health care needs of the communities it serves by conducting a Community Health Needs Assessment (CHNA) for each of its hospital locations. For the 2018 CHNAs, Indiana University Health 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 North 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 communities are those that are supported by multiple data sources. Additionally, the effectiveness of an intervention for each need and IU Health's ability to impact positive change was evaluated. IU Health believes its CHNA process is comprehensive and additional assessments are not required. |

Form and Line Reference Schedule H, Part VI, Line 3 - Patient Education of Eligibility for Assist. Education of Eligibility for Assist. IU Health North 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 North Hospital has established a FAP to provide Financial Assistance to Uninsured Patients. IU Health North Hospital is committed to ensuring its patients are compliant with all provisions of the Patient Protection & Affordable Care Act. To that end, IU Health North 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 North

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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 North 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 North Hospital will broadly communicate this Policy as

of the FAP and the process for referring patients to the Program.

Hospital takes several measures to inform its patients of the FAP and FAP-eligibility. These measures include

part of its general outreach efforts. 5. IU Health North Hospital will educate its patient facing team members

| Form and Line Reference | Explanation |
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| Community Information | IU Health North Hospital is located in Hamilton County, Indiana, a county located in central Indiana. Its service area counties include Marion, Hamilton, Boone, Hendricks, Hancock, Madison and Tipton counties. Hamilton County includes ZIP codes within the towns of Arcadia, Atlanta, Carmel, Cicero, Fishers, Noblesville, Sheridan, and Westfield. Based on the most recent Census Bureau (2019) statistics, Hamilton County's population is 338,011 persons with approximately 51% being female and 49% male. The county's |

population estimates by race are 82.8% White, 4.5% Black, 4.3% Hispanic or Latino, 6.5%% Asian, 0.2% American Indian or Alaska Native, and 2.1% persons reporting two or more races. Hamilton County has relatively high levels of educational attainment. Among residents ages 25 and up, 96.4% completed their education with a high school diploma or equivalent. Among resident ages 25 and up, 57.8% earned a bachelor's degree or higher.

| Form and Line Reference | Explanation | | | | | | | |
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| Schedule H, Part VI, Line 5 - Promotion of Community Health | IU Health North 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. During 2019, IU Health North Hospital's promotion of community health included the following highlights: In 2019, IU Health North Hospital maintained a strong presence across the northern Indianapolis suburbs in Hamilton County and supported numerous not-for-profit agencies including local parks departments, medical and dental clinics that provide care to the un- and under-insured, behavioral health agencies, and organizations that provide health and social services to seniors who are in need. As part of these efforts, IU Health North Hospital also continued its participation in the Partnership for a Healthy Hamilton County in conjunction with Community Health Network, Riverview Health, Ascension St. Vincent Carmel and several other health-related agencies in the county. This group seeks to transform communities by influencing and leading health innovation through community collaborations. IU Health North Hospital provided a 10-week fitness and nutrition program, Fresh & Fit, to 100 Hamilton County residents helping them to improve their overall health by lowering cholesterol, blood pressure, blood sugar, A1C and weight. Participants in Fresh & Fit also report additional benefits of the program including increase energy, improved mental well-being, reduced pain and a reduction in medications. IU Health North Hospital is a subsidiary of IU Health. IU Health and its related hospital entities across the state of Indiana extend medical privileges to all physicians who meet the credentialing qualifications necessary for appointment to its medical staff. IU Health does not deny appointment on the basis of gender, race, creed or national origin IU Health, in conjunction with the IU School of Medicine, trains the next generation of physicians in an exceptional environment. Blending breakthrough res | | | | | | | |

| Form and Line Reference | Explanation | | | | | | | | |
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| Schedule H, Part VI, Line 6 - Affiliated Health Care System | IU Health North Hospital is part of the IU Health Statewide System. The IU Health Statewide e system is Indiana's most comprehensive healthcare system. A unique partnership with the Indiana University School of Medicine ("IU School of Medicine"), one of the nation's leading medical schools, gives patients access to innovative treatments and therapies. IU Health is comprised of hospitals, physicians and allied services dedicated to providing preemin ent care throughout Indiana and beyond. National Recognition - Eight hospitals designated as Magnet by the American Nurses Credentialing Center recognizing excellence in nursing care IU Health Medical Center is honored to be nationally ranked by U.S. News Wes World Rep ort for the 22nd year in a row. According to the U.S. News rankings, IU Health Medical Center is the No. 1 ranked hospital in Indiana and Indianapolis and the only nationally ranke do adult hospital in the state. For 2019-2020, IU Health Medical Center was rated as high p erforming nationally in five specialties, with a sixth specialty achieving a top 50 nation al ranking: - Cancer - high performing - Gastroenterology - high performing - Geriatrics - ranked 45th in nation - Nephrology - high performing - Neurology & Neurosurgery - high per forming - Urology - high performing Besides IU Health Medical Center, IU Health has three other hospitals among the 10 top ranked hospitals in Indiana: IU Health Bill Demoral (#5), IU Health Arnett (#8) and IU Health Billomington (#8) hospitals. The annual rankings, no w in their 30th year, are designed to assist patients and their doctors in making informed decisions about where to receive care for challenging health conditions or for common ele ctive procedures. Education and Research As an academic health center, IU Health works in patrnership with the IU School of Medicine to train physicians, blending breakthrough rese arch and treatments with the highest quality of patient care. Each year, more than 1,000 residents and fellows receive training in IU Health | | | | | | | | |

| Form and Line Reference | Explanation | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| Schedule H, Part VI, Line 6 - Affiliated Health Care System | the IU Health Statewide System prepares and submits its own community benefit plan relati ve to the local community, the IU Health Statewide System considers the sum of these plans part of a statewide vision for strengthening Indiana's overall health. A comprehensive community outreach strategy and community benefit plan is in place that encompasses the acad emic medical center downtown Indianapolis, suburban Indianapolis and statewide entities ar ound priority areas that focus on health improvement efforts statewide. IU Health is keen! y aware of the positive impact it can have on the communities of need in the state of Indi ana by focusing on the most pressing needs in a systematic and strategic way. In 2019, IU Health provided more than \$738 million in total community benefit and served more than one million individuals. Some ways we address our community health priorities as a system inc lude: IU Health Day of Service The annual IU Health Days of Service is a high-impact event aimed at engaging IU Health team members in activities that address an identified community priority health need. Each year, more than 2,000 IU Health team members volunteer durin g the Days of Service. Community Health Initiatives With investments in high-quality and il mpactful initiatives to address community health meds statewide, IU Health is helping Indi ana residents improve their health and their quality of life. In 2019, IU Health impacted many people statewide through educational opportunities made available to the community, especially to our community members in the greatest need of such services. Twent y-four local organizations are benefitting from grants awarded by IU Health. In 2019, IU H ealth Community Outreach and Engagement awarded more than \$900,000 to community organizati ons and institutions which - like IU Health - are addressing the health needs of the community. These needs include access to affordable healthcare, behavioral health and substance abuse, healthy weight and nutrition and social determinants of h | | | | | | | | |

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| Form and Line Reference | Explanation | | | | | |
| Schedule H, Part VI, Line 7 - State Filing of Community Benefit Report | IN | | | | | |

Additional Data

Software ID:

Software Version:

EIN: 35-1932442

Name: INDIANA UNIVERSITY HEALTH NORTH HOSPITAL

TNC

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| Form 990 Schedule H, Part V Se | ection A. Hosp | ital | Facil | ities | | | | | | | |
| 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 tate. Name, address, primary website a state license number | e x year? | 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 NORTH HOSPITA 11700 N MERIDIAN ST CARMEL, IN 46032 SEE PART V, SECTION C 20-004171-1 | L | 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 Explanation

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 1i. 3. 4. 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility

| in a facility reporting group, designated by "Facility A," "Facility B," etc. | | |
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| Form and Line Reference | Explanation | |
| | III Health North Hospitals 2018 Community Health Needs Assessment (CHNA) Report includes a | |

Schedule H, Part V, Section B, Line 3e prioritized description of significant health needs in the community. The CHNA report identified the Prioritized Health Needs following seven needs as priorities for IU Health North: - ACCESS TO HEALTH CARE SERVICES - DRUG AND SUBSTANCE ABUSE - Food Insecurity - HEALTH CARE AND SOCIAL SERVICES FOR SENIORS -

MENTAL HEALTH - OBESITY AND DIABETES - 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. | | |
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| 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 North H ospital took into account input from persons who represent the broad interests of the comm unities it serves. Primary data were gathered in three different methodologies for this as sessment: Community Meetings, Key Stakeholder Interviews, and a Community Survey. For purp oses of this CHNA, IU Health North Hospitals community is defined as Hamilton and Marion C ounties, Indiana. These two counties accounted for 68 percent of the hospitals inpatient c ases in 2016. Community Meetings Hamilton County On April 17, 2018, a meeting of community representatives was held at the Hamilton County 4H Fairgrounds in Noblesville, the county seat of Hamilton County. The meeting was attended by 38 community members invited by IU H ealth because they represent important community organizations and sectors such as: local health departments, police/fire departments, non-profit organizations, local business, hea lth care providers, mayors/local policymakers, faith-based organizations, parks and recrea tion departments, and schools. Through this meeting, IU Health sought a breadth of perspec tives on the communitys health needs. The specific organizations represented at the meetin g are listed below Aspire Indiana - Central Indiana Council on Aging (CICOA) - Chaucies Place - Community Health Network North - Department of Child Services - Fishers City Coun cil - Fishers Fire & Emergency Services - Good Samaritan Network - HAND, Inc HOPE Famil y Care Center - Hamilton County Youth Assistance Progra m - Hamilton Heights School Corporation - Hamilton Southeastern Schools - IU Health - IU H ealth Indy Suburban Region/IU Health North Hospital and IU Health Saxony Hospital - Nobles ville Chamber of Commerce - Noblesville Town Council - Noblesville Schools - Partnership f or a Healthy Hamilton County - Prevail, Inc PrimeLife Enrichment, Inc Riverview Healt th - Riverview Health Physicians - Shepherds Center of Hamilton County - St. Franc | |

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 ng, a range of other topics was discussed, including: - Individuals with a mental health d iagnosis -Individuals with a history of substance abuse/misuse - Individuals with chronic conditions - Children and Input from Community seniors as priority populations - Nutritional education - Emplo yment - Limited supply of health care professionals After discussing the needs identified, each participant was asked through a voting process to identify the two they consider to be most significant. From this process, the groups identified the following needs as most significant for Hamilton County: - Transportation - Housing - Access to health services - Chronic disease management - Cost of medication - Insurance coverage/enrollment - Social s upport Interviews Hamilton County An interview also was conducted with a representative of the Hamilton County Health Department. The interview was conducted to assure that appropriate and additional input was received from a governmental public health official. The ind ividual that was interviewed participated in the community meeting. Accordingly, the results of the community meeting were discussed and insights were sought regarding significant community health needs, why such needs are present, and how they can be addressed. The int erview was guided by a structured protocol that focused on opinions regarding significant community health needs, describing why such needs are present, and seeking ideas for how t o address them. According to the interviewee, many in Indiana incorrectly believe that sin ce Hamilton County is affluent, there is little need to focus on improving community healt h. The county does have needs and has pockets of vulnerable populations that need continue d attention. The county also needs more public health funding to provide adequate programs and services. The interviewee confirmed that the three top needs identified by community meeting participants were significant, adding that all three have been chronic issues in t he county. These three needs were: - Transportation - Access to Health Services - Housing Mental health and substance abuse services are particularly difficult to access in the county. Only one real treatment center and no inpatient facilities exist, requiring residents to travel long distances to services outside of the county. Primary care also is difficult to access for patients with certain types of insurance coverage. Many providers are not accepting new patients with Medicare or Medicaid. This issue became more problematic a few years ago after a community clinic closed. Regarding populations at risk, individuals with a mental health diagnosis, the uninsured or underinsured, children, and seniors are most at risk. Seniors face issues including a lack of transportation, difficulties accessing m ental health services, and isolation. A lack of specialized providers for pain management, physical therapy, and related pain management services is contributing to an over-prescri bing of opiates. The need for

| Form and Line Reference | Explanation |
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| Schedule H, Part V, Section B, Line 5 Input irom Community | health education in the community is significant. Health department and other community re sources are limited. Education is needed particularly regarding risks associated with subs tance abuse and sexually-transmitted diseases. Many uninsured are using emergency rooms fo r primary care since they do not know where else to go. A service that could connect these residents to providers accepting low income and Medicaid patients is needed. Medication a ssistance for seniors also is an issue. Many seniors are confused by the array of medicati ons they have been prescribed, leading to lack of medication adherence and compliance. C ommunity Meetings Marion County Between May 7 and 9, 2018, three meetings of community rep resentatives were held in Indianapolis, the county see of Marion County. In total, the me etings were attended by 42 community members invited by IU Health in partnership with Comm unity Health Network because they represent important community organizations and sectors such as: local health departments, police/fire departments, non-profit organizations, loca I business, health care providers, mayors/local policymakers, faith-based organizations, p arks and recreation departments, and schools. Through these meetings, IU Health sought a b readth of perspectives on the communitys health needs. The specific organizations represented at the meetings are listed below Adult and Child Health - All Senior Citizens Conne ct Central Indiana Council on Aging (CICOA) - City of Indianapolis - Coburn Place - Comm unity Health Network - Gennesaret Free Clinics - Gleaners Food Bank - Health by Design - I U Health Methodist Hospital - IU Health University Hospital - Indiana Youth Institute - In dianapolis Parks and Recreation - Irvington Development Organization - Jump IN for Healthy Kids - Lawrence Community Gardens - Marion County Public Health Department - New Beginnings Church - Paramount Schools of Excellence - Progress House - Purdue Extension - The Polis Center - University of Indianapolis The meeting began |

Section C. Supplemental Information for Part V. Section B.Provide descriptions required for Part V. Section B. lines 1i, 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 990 Part V Section C Supplemental Information for Part V, Section B.

| Form and Line Reference | Explanation |
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| | A copy of IU Health North Hospital's CHNA is available on its website at the following URL: https://iuhealth.org/in-the-community/community-benefit |

Section C. Supplemental Information for Part V. Section B. Provide descriptions required for Part V. Section B. lines 1i. 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 990 Part V Section C Supplemental Information for Part V, Section B.

| Form and Line Reference | Explanation |
|---|--|
| Schedule n. Part V. Section b. Line 10a | A copy of IU Health North Hospital's CHNA implementation strategy is available on its website at the |

Implementation Strategy Website

| 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 North Hospital's Board adopted an implementation s trategy in April 2019 related to the 2018 CHNA. IU Health North Hospital prioritized and d etermined which of the community health needs identified in its most recently conducted CH NA were most critical for it to address. IU Health North Hospital will address the following community health needs between 2019 and 2021: - Access to Healthcare Services - Drug and Substance Abuse (including Opioids and Alcohol) - Food Insecurity - Healthcare and Socia I Services for Seniors - Mental Health - Obesity and Diabetes - Social Determinants of Hea Ith IU Health uses the term "Behavioral Health" to refer to Mental Health and Drug and Sub stance Abuse (including Opioids and Alcohol). Access to Healthcare IU Health North Hospita I's implementation strategy to address the identified need of Access to Healthcare include s the following: - Provide funding for Trinity Free Clinic to support the medical and dent al needs of Hamilton County residents who are uninsured and underinsured In 2019, IU He alth North provided support to Trinity, which allowed the clinic to expand its mental heal th screening program, increase hours of acute medical and dental care, expand well-child v isits to include fluoride varnish, and provide continued care for hypertension patients who have difficulty accessing primary care Encourage IU Health team members to assist in staffing the medical clinic Provide funding for the Heart & Soul Clinic's operations in Westfield to support medical and dental needs of Hamilton County residents who are uninsu red and underinsured In 2019, IU Health North provided support to Heart & Soul, which was used to assist the Fishers Youth Assistance Summer Meals Program and PHHC's overall operations during its transition to become its own 501c3 organization Develop programs and strategies to improve the overall health of Hamilton County r esidents and employees Participate in PHHC committees related to pertinent Co | |

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 easure cholesterol, triglycerides, glucose, A1C and blood pressure. - Provide education to encourage positive changes to impact future screening results. - Provide in-hospital training for team members Addressing Identified Needs so the hospital is able to create an environment that is welcoming a nd conducive for those living with dementia. - Provide funding to the Shepherd's Center of Hamilton County in support of its Reaching Resources program, which allows seniors to age as independently and gracefully as possible. - Provide 24/7 peer counseling via telemedic ine for patients who present in the emergency department (ED) with substance abuse issues. - Provide telemedicine visits with trained behavioral health clinicians to patients who p resent in the emergency department (ED) with behavioral health needs. - Provide funding for a Fishers EMS Duty Officer (EDO) to provide follow-up home visits for patients who have been discharged from the hospital with behavioral health-related issues. - Provide funding for Aspire Indiana to address specific behavioral health needs in Hamilton County. - In 2 019, IU Health North provided support to Aspire to purchase two new pediatric exam tables for the Noblesville clinic and one for the Carmel clinic, and to provide employment assist ance for Aspire clients. - Collaborate with the Max Challenge of Fishers to provide 100 Ha milton County residents with a free 10-week program to improve their overall health through fitness and nutrition. - Provide three health screenings during the 10-week period to me asure changes in cholesterol, triglycerides, glucose, A1C, blood pressure, weight and Body Mass Index (BMI). Behavioral Health (includes Drug & Substance Abuse and Mental Health) I U Health North Hospital's implementation strategy to address the identified need of Behavi oral Health includes the following: - Invest in the Partnership for a Healthy Hamilton Cou nty (PHHC) to encourage collaboration among area health agencies and organizations. - Deve lop programs and strategies to improve the overall health of Hamilton County residents and employees, - Participate in PHHC committees related to pertinent Community Health Needs A ssessment (CHNA) priorities. - Support the Fishers Youth Assistance Summer Meals Program. - Create a pilot program that provides in-home visits by a licensed social worker for seni ors who need behavioral health services. - Provide in-hospital training for team members s o the hospital is able to create an environment that is welcoming and conducive for those living with dementia. - Provide funding to the Shepherd's Center of Hamilton County in sup port of its Reaching Resources program, which allows seniors to age as independently and g racefully as possible. - Provide 24/7 peer counseling via telemedicine for patients who pr esent in the emergency department (ED) with substance abuse issues. - In 2019, 91 percent of patients who were offered peer recovery counseling accepted the service and were open t o discussing ways to treat

the

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 ir substance abuse disorder. The peer recovery counselors spent 2,004 total minutes coachi ng patients with substance abuse disorders. - Provide telemedicine visits with trained beh avioral health Addressing Identified Needs clinicians to patients who present in the emergency department (ED) with be havioral health needs. -In 2019, approximately 60 patients were transferred from the ED t o behavioral health services for follow-up services or referral to an inpatient facility. - Provide funding for a Fishers EMS Duty Officer (EDO) to provide follow-up home visits for patients who have been discharged from the hospital with behavioral health-related issue s. - In 2019, 366 Hamilton County resident patients and 44 non-Hamilton County resident pa tients received a follow-up call via the program, 122 total individuals did not answer or respond to the follow-up call but there were 237 referrals to services in the community. T here were 53 home visit referrals, 17 referrals to financial assistance for medication and other needs, five referrals to transportation services, 55 referrals to social services and 15 referrals to a primary care provider or contact. - Provide annual funding to the Indiana Center for Prevention of Youth Abuse & Suicide. - In 2019, IU Health North provided s upport to ICPYAS, and approximately 70 schools hosted the Smart Steps program in 2019. - C ollaborate with the Indiana Center for Prevention of Youth Abuse & Suicide to provide training for community and IU Health team members on the recognition and prevention of child s exual abuse. - In 2019, 525 adults completed the Stewards of Children training. - Provide funding for Breathe Easy Hamilton County efforts. - Provide senior executive support for the Breathe Easy Hamilton County initiative. - Attend and financially support the annual Br eathe Easy Hamilton County luncheon. - Provide funding for Aspire Indiana to address speci fic behavioral health needs in Hamilton County. Food Insecurity IU Health North Hospital's implementation strategy to address the identified need of Food Insecurity includes the following: -Invest in the Partnership for a Healthy Hamilton County (PHHC) to encourage col laboration among area health agencies and organizations. - Develop programs and strategies to improve the overall health of Hamilton County residents and employees. - Participate in PHHC committees related to pertinent Community Health Needs Assessment (CHNA) priorities . - Support the Fishers Youth Assistance Summer Meals program through investment in the Partnership for a Healthy Hamilton County (PHHC), - With PHHC's assistance, the program increased access to healthy food by providing a total of 46,220 meals in 2019, an average of 5 14 students served each week. - Collaborate with the Fishers Parks & Recreation to provide 20 garden boxes measuring 10'x10' on the campus. - Provide funding to the Fishers Parks & Recreation to cover the cost of garden plot rental for community members who rent one of the Fishers Parks garden plots

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 1i, 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

| Talame, reporting group, accordinated by radinary, reporting | | | | | | |
|--|--|--|--|--|--|--|
| Form and Line Reference | Explanation | | | | | |
| | In addition to EPG, III Health North Hospital may take into consideration a natients income and/or ability | | | | | |

in a facility reporting group, designated by "Facility A." "Facility B." etc.

Schedule H. Part V. Section B. Line 13b to pay in calculation of a financial assistance award. Income Level Other than FPG

| Form and Line Reference | Explanation |
|---|---|
| Schedule H, Part V, Section B, Line 13h Other FAP Factors | IU Health North Hospital takes into consideration several other factors in determining pat ient eligibility for financial assistance. These factors include the following: 1. IU Heal ths Individual Solutions Department Prior to seeking Financial Assistance under the FAP, a ll patients or their guarantors must consult with a member of IU Healths Individual Soluti ons department to determine if healthcare coverage may be obtained from a government insur ance/assistance product or from the Health Insurance Exchange Marketplace. 2. Alternate So urces of Assistance When technically feasible, a patient will exhaust all other state and federal assistance programs prior to receiving an award from IU Health North Hospitals Fin ancial Assistance Program. Patients who may be eligible for coverage under an applicable i nsurance policy, including, but not limited to, health, automobile, and homeowners, must e xhaust all insurance benefits prior to receiving an award from IU Health North Hospitals F inancial Assistance Program. This includes patients covered under their own policy and tho se who may be entitled to benefits from a third-party policy. Patients may be asked to sho w proof that such a claim was properly submitted to the proper insurance provider at the request of IU Health North Hospital. Eligible patients who receive medical care from IU Health North Hospital as a result of an injury proximately caused by a third party, and later receive a monetary settlement or award from said third party, may receive Financial Assis tance for any outstanding balance not covered by the settlement or award to which IU Health North Hospital is entitled. In the event a Financial Assistance Award has already been g ranted in such circumstances, IU Health North Hospital would be entitled to receive had no Financial Assistance been awarded. 3. Alternate Methods of Eligibility Determination IU Health North Hospital will conduct a quarterly review of all accounts placed with a collection agency partner for a period of no less than one |

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 to 200% of the Federal Poverty Level 4. Additional Considerations Financial Assistance may be granted Schedule H, Part V, Section B, Line 13h Other FAP Factors to a deceased patients account if said patient is found to have no estate. Add itionally, IU Health North Hospital will deny or revoke Financial Assistance for any patie nt or guarantor who falsifies any portion of a Financial Assistance application. 5. Non-Em ergent Services Down Payment Uninsured Patients presenting for scheduled or other non-emer gent services will not be charged more than the Amounts Generally Billed ("AGB") for their services. Patients will receive an estimated AGB cost of their care prior to IU Health No rth Hospital 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 ful fill the downpayment, their service may be rescheduled for a later date as medically prud ent and in accordance with all applicable federal and state laws and/or regulations. 6. Em ergency Services Non-Refundable Deposit This section will be implemented with a strict adh erence to EMTALA and IU Health Policy ADM 1.32, Screening and Transfer of Emergency or Uns table Patients, 7, Amount of Non-Refundable Deposit All Uninsured Patients presenting for services at IU Health North Hospitals Emergency Department, via transfer from another hosp ital facility, or direct admission, will be responsible for a one-hundred 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 g reater than the AGB must fulfill their non-refundable deposit prior to IU Health North Hos pital processing said application. Uninsured Patients making payments toward their outstan ding non-refundable deposit balance will have said payments applied to their oldest applic ation 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

| Form and Line Reference | Explanation |
|--|---|
| Schedule H, Part V, Section B, Line 16a FAP Website | A copy of IU Health North Hospitals FAP is available on the following website: https://iuhealth.org/pay-a-bill/financial-assistance |

in a facility reporting group, designated by "Facility A." "Facility B." etc.

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 | | | | |
| Calcadada II Dant V Cantina D. Lina 16h | A copy of IU Health North Hospitals FAP Application is available on the following website: | | | | |

in a facility reporting group, decignated by "Eacility A." "Eacility P." etc.

Schedule H, Part V, Section B. Line 16b https://iuhealth.org/pay-a-bill/financial-assistance FAP Application Website

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

Form and Line Reference Explanation

Schedule H, Part V, Section B, Line 16c
FAP PLS Website Explanation

A plain language summary of the FAP, including translated copies, is available on the following website: https://iuhealth.org/pay-a-bill/financial-assistance

in a facility reporting group, designated by "Facility A," "Facility B," etc.

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, 14q, 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 |
|-----------------------------|---|
| Other Measures to Publicize | IU Health North 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 North 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 North Hospital will broadly communicate this Policy as part of its general outreach efforts. 5. IU Health North Hospital will educate its patient facing team members of the FAP and the process for referring patients to the Program. |

| efil | e GRAPHIC pi | rint - DO NOT PROCESS | As Filed Dat | ta - | DLN: 93 | 49331 | 18032 | 870 |
|---|--|---|--------------------|---|-------------------------|---------|---------|------|
| Sch | edule J | Co | ompensat | ion Information | OI | MB No. | 1545-0 | 0047 |
| (For | n 990) | For certain Office | | Trustees, Key Employees, and Hig ated Employees | hest | 20 | 110 | |
| ► Complete if the organization answered "Yes" on Form 990, Part IV, line 23. ► Attach to Form 990. | | | | | | | | • |
| Depar | tment of the Treasury | ▶ Go to <u>www.irs.go</u> | | n to Form 990. r instructions and the latest inform | mation. | Open (| | |
| | al Revenue Service ne of the organiza | ation | | | Employer identifica | | ectio | |
| IND | IANA UNIVERŠITY H | EALTH NORTH HOSPITAL | | | | tion ne | illibei | |
| INC | | ons Regarding Compensa | tion | | 35-1932442 | | | |
| Га | Questi | ons Regarding Compensa | CIOII | | | | Yes | No |
| 1a | | | | f the following to or for a person liste ny relevant information regarding the | | | | |
| | First-class | s or charter travel | | Housing allowance or residence for | personal use | | | |
| | _ | companions | 님 | Payments for business use of perso | | | | |
| | | nification and gross-up payment | s 📙 | Health or social club dues or initiati | | | | |
| | ☐ Discretion | nary spending account | Ш | Personal services (e.g., maid, chau | ffeur, chef) | | | |
| b | | | | follow a written policy regarding pay ove? If "No," complete Part III to expl | | 1b | | |
| 2 | | | | or allowing expenses incurred by all | 20 127 | 2 | | |
| | directors, truste | es, officers, including the CEO/E | executive Directo | or, regarding the items checked on Lir | ne la? | | | |
| 3 | | | | ed to establish the compensation of t | he | | | |
| | | | | not check any boxes for methods CEO/Executive Director, but explain | in Part III. | | | |
| | Compens | ation committee | | Written employment contract | | | | |
| | ☐ Independ | ent compensation consultant | | Compensation survey or study | | | | |
| | ☐ Form 990 | of other organizations | Ш | Approval by the board or compensa | ition committee | | | |
| 4 | During the year related organiza | | 990, Part VII, Se | ection A, line 1a, with respect to the f | iling organization or a | | | |
| а | Receive a sever | ance payment or change-of-con | trol payment? . | | | 4a | Yes | |
| b | Participate in, o | r receive payment from, a suppl | emental nonqual | lified retirement plan? | | 4b | Yes | |
| c | | | | nsation arrangement? | | 4c | | No |
| | If "Yes" to any o | of lines 4a-c, list the persons and | d provide the app | plicable amounts for each item in Par | t III. | | | |
| | Only 501(c)(3 |), 501(c)(4), and 501(c)(29) | organizations | must complete lines 5-9. | | | | |
| 5 | | | = | the organization pay or accrue any | | | | |
| | compensation c | ontingent on the revenues of: | | | | | | |
| а | The organization | n? | | | | 5a | | No |
| b | | | | | | 5b | | No |
| _ | , | 5a or 5b, describe in Part III. | A 11 4 11 1 | | | | | |
| 6 | | ed on Form 990, Part VII, Section ontingent on the net earnings of | | the organization pay or accrue any | | | | |
| a | - | n? | | | | 6a | | No |
| b | | | | | | 6b | | No |
| 7 | • | 6a or 6b, describe in Part III. | n Aline to did | the organization provide any nonfixe | d | | | |
| , | payments not d | escribed in lines 5 and 6? If "Yes | s," describe in Pa | art III | u | 7 | Yes | |
| 8 | subject to the ir | nitial contract exception describe | ed in Regulations | red pursuant to a contract that was section 53.4958-4(a)(3)? If "Yes," d | | | | Ne |
| 9 | If "Yes" on line | 8, did the organization also follo | w the rebuttable | presumption procedure described in | Regulations section | 9 | | No_ |
| For F | <u>``</u> | iction Act Notice, see the Ins | | | 50053T Schedule J | | 1 990) | 2019 |

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 | Jua | | kdown of W-2 and/o compensation | | (C) Retirement and other | (D) Nontaxable benefits | (E) Total of columns | (F) Compensation in |
| | | (i) Base compensation | (ii) Bonus & incentive compensation | (iii) Other reportable compensation | deferred compensation | | (B)(i)-(D) | column (B) reported as deferred on prior Form 990 |
| See Additional Data Table | | | | I | | | | |
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Page 3

Schedule 1 (Form 990) 2019

Schedule J (Form 990) 2019

qualifications & performance, and business needs) are used to recommend compensation ranges for its officers and other employees, which are then used as a guide for setting reasonable compensation by management. Please see schedule O for additional details... SCHEDULE J, PART I, LINE 4A -Jonathan R. Goble entered into a severance agreement with IU Health during 2018. Severance of \$208,726 that was received during 2019 is included in column B SEVERANCE (III), other reportable compensation. Deferred severance of \$231,294 was disclosed in 2018 in column C, retirement and other deferred compensation. Kristy A. Schulhof entered into a severance agreement with IU Health during 2019. Severance of \$55,348 that was received during 2019 is included in column B(III), other

reportable compensation. Deferred severance of \$374,645 is included in column C, retirement and other deferred compensation. Matthew R. Cook, Kristy A. Schulhof, and Kenneth D. Puckett participate in an IU Health supplemental executive retirement plan, provisions of which are designed Schedule J. Part I. Line 4b -Supplemental Nonqualified Retirement to retain these critical employees. The plan provides for an additional retirement benefit for service through normal retirement or other key dates. If the executive Plan leaves prior to retirement or other key dates, that benefit may be forfeited or reduced. Each of these executives listed above, with the exception of Kristy A. Schulhof have an amount included in column c, deferred compensation, representing the current year unvested contributions made under the supplemental retirement plan. These amounts were not paid to these executives during the year. The following executives have an amount included in column B (III), other reportable compensation, representing the current year vested amounts received under the supplemental executive retirement plan: - Kristy A. Schulhof (\$461,442)

Schedule J, Part I, Line 7 - Non-Fixed **Payments** 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

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 discretionary incentive plans must be approved by the Board of Directors prior to any incentive payout, Form 990, Part VII, Section A, Line 5 / Schedule J. Part II --Compensation paid for services rendered by Paul Calkins Paul Calkins was employed as the VP & Chief Medical Officer, by IU Health North Hospital from January 2019 through August 2019. Paul Calkins ceased employment with IU Health North effective 8/16/2019. After this date, IU Health North contracted and paid Anesthesia Consultants, Inc. for Paul Calkins' services as the VP & Chief Medical Officer of IU Health North, During 2019, compensation paid by IU Health North to

Software ID: Software Version:

EIN: 35-1932442

Name: INDIANA UNIVERSITY HEALTH NORTH HOSPITAL

INC

| Part | Form 990, Schedule | J, | Part II - Officers, Di | irectors, Trustees, K | ey Employees, and H | lighest Compensate | d Employees | | |
|--|-----------------------------|------|----------------------------------|---------------------------------------|---------------------|--------------------|-------------|---------------------------------------|--------------------------------|
| Comperation | (A) Name and Title | | (i) Base Compensation (ii) (iii) | | | other deferred | | (E) Total of columns (B)(i)-(D) | (F) Compensation in column (B) |
| Service Office Corp. Cor | | | | | | compensation | | | prior Form 990 |
| MATTHEWN RCDOK Q | | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| DIRECTOR O | | (ii) | 0 | 0 | 208,726 | 0 | 0 | 208,726 | 208,726 |
| Common C | 1MATTHEW R COOK DIRECTOR | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SECOND LASTIN NO C C C C C C C | | (ii) | 581,502 | 248,092 | 55,244 | 126,007 | 24,071 | 1,034,916 | 0 |
| SERENT EMPT 10 426,132 94,055 540 1,200 1,347 533,271 | | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SORGER (PINE 10 0 0 0 0 0 0 0 0 | DIRECTOR | (ii) | 426,132 | 94,052 | 540 | 11,200 | 1,347 | 533,271 | 0 |
| MANDALIC F.V.ET 10 107,866 10,377 11,958 14,966 30,379 313,655 16,966 17,966 17,966 17,966 17,966 18,247 19,926 14,422 256,976 19,966 18,447 19,926 14,422 256,976 19,966 1 | | (i) | 0 | 0 | 0 | 0 | 0 | . 0 | 0 |
| ARAMINAL CLUST 10 | SECRETARY | (ii) | 231,195 | 36.357 | 758 | 14.966 | 30.379 | 313.655 | 0 |
| 10 10 10 10 10 10 10 10 | | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SPALE, IN CAUSILS IN D 0 | Former Officer | (ii) | 107,866 | 62.817 | 57 044 | 14 926 | 14 323 | 256 976 | |
| VEX. STATE Color | 5PAUL M CALKINS MD | - | | 02,027 | | | | · · · · · · · · · · · · · · · · · · · | 0 |
| SOUTH A KAN N N CONTROL CONTRO | VP & CMO | (ii) | 0 | | | | | | |
| Name | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 7,355 8,992 2,522 5,723 8,584 103,280 | Former Key Employee | | 196 146 | 27.601 | 21 076 | 15.000 | 2E 120 | 206.020 | |
| DIR COPERTY PART PA | | 4 | | · · · · · · · · · · · · · · · · · · · | | , | | · · · · · · · · · · · · · · · · · · · | 0 |
| SIDAME LIESSON 17.392 166,650 161 162 162 163 164 16.876 1.925 3.494 8.039 77.028 166,650 161 162 162 163 164 16.876 1.925 3.494 8.039 77.028 162 163 | | | | | | | | | |
| Inferience (i) | 8DIANE L HESSON | | | , | | | | | 0 |
| SMICHAEL LIABLOWE Color | Interim CNO (PART YEAR) | | | | | | | | |
| Manual Color Manu | 9MICHAEL L HARLOWE | | · | · · · · · · · · · · · · · · · · · · · | | | · | | 0 |
| DIANICE M VADAS (i) 173,502 8,740 552 11,523 3,622 197,939 | | | | 32,253 | 2,322 | 11,05/ | 24,203 | 320,935 | |
| Director Allied Services (ii) | 101ANICE M VADAS | | 173 502 | 0 740 | 0 | 0 | 2 622 | 0 | 0 |
| AlkFisty A Schulber Control Co | | | | 8,740 | 552 | 11,523 | 3,622 | 197,939 | |
| DIRECTOR/PRESIDENT (ii) 302,984 148,510 570,576 392,112 31,048 1,445,230 (iii) 268,019 40,264 13,097 18,008 23,740 363,128 136,000 | 11Kriety A Schulhof | | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Table Tabl | DIRECTOR/PRESIDENT | | | 0 | 0 | 0 | 0 | 0 | 0 |
| CFO - Indy Suburban Region CFO - Indy Suburban Region CFO - Indy Suburban CFO - Indy Suburban Region CFO - Indy Suburban Regio | | - | 302,984 | 148,510 | 570,576 | 392,112 | 31,048 | 1,445,230 | 60,777 |
| 13Kenneth D Puckett Color | (1) | | 0 | 0 | 0 | 0 | 0 | 0 |
| President - Indy Suburban Reg. (ii) | 10/2 1/ 0.0 1 1/ | | | | 13,097 | 18,008 | 23,740 | 363,128 | 0 |
| AMEGAN CRITTENDON MD Column Colum | President - Indy Suburban | `´ | | 0 | 0 | 0 | 0 | 0 | 0 |
| DIRECTOR (ii) 365,105 6,684 2,310 11,362 0 385,461 SATHANASIA S BANICH PRES. North/Coo Saxony (Pt Yr) (ii) 155,087 11,429 302 4,871 27,631 199,320 SATIONAL S DEPARTS RN CNO - Indy Suburban Region (i) 0 0 0 0 0 0 0 | | + | 462,981 | 211,080 | 75,835 | 116,713 | 29,197 | 895,806 | o |
| 15ATHANASIA S BANICH PRES. North/Coo Saxony (Pt Press. N | | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PRES. North/Coo Saxony (Pt Yr) | | | | 6,684 | 2,310 | 11,362 | 0 | 385,461 | 0 |
| 16LISA A SPARKS RN (i) | PRES. North/Coo Saxony (Pt | (i) | 7,801 | 575 | 15 | 245 | 1,390 | 10,026 | 0 |
| CNO - Indy Suburban Region Cii) 195,530 35,029 989 14,942 28,775 275,265 17ARTHUR VASQUEZ COO - Indy Suburban Region Cii) 269,606 46,696 486 18,075 30,286 365,149 18TAMARAH D BROWNLEE Cii) 0 0 0 0 0 0 0 0 Region Ciii 163,933 28,597 366 8,259 32,405 233,560 19CHAD A DILLEY ADMIN DIR-CV(PT YR)/COO-SAYONY COO-SAYONY Coo-SAY | | - | 155,087 | 11,429 | 302 | 4,871 | 27,631 | 199,320 | 0 |
| 17ARTHUR VASQUEZ | | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| COO - Indy Suburban Region COO - Indy Sub | | | 195,530 | 35,029 | 989 | 14,942 | 28,775 | 275,265 | 0 |
| 18TAMARAH D BROWNLEE (i) 269,606 46,696 486 18,075 30,286 365,149 18TAMARAH D BROWNLEE (i) 0 0 0 0 0 Region (ii) 163,933 28,597 366 8,259 32,405 233,560 19CHAD A DILLEY ADMIN DIR-CV(PT YR)/COO-SAYONY (iii) 131,520 23,762 4,014 6,348 199 165,843 19CHAD A DILLEY ADMIN DIR-CV(PT YR)/COO-SAYONY (iii) 131,520 23,762 4,014 6,348 199 165,843 19CHAD A DILLEY ADMIN DIR-CV(PT YR)/COO-SAYONY (iii) 131,520 23,762 4,014 6,348 199 165,843 19CHAD A DILLEY ADMIN DIR-CV(PT YR)/COO-SAYONY (iii) 165,843 199 165,843 19CHAD A DILLEY ADMIN DIR-CV(PT YR)/COO-SAYONY (iiii) 165,843 199 165,843 19CHAD A DILLEY ADMIN DIR-CV(PT YR)/COO-SAYONY (iiii) 165,843 199 165,843 19CHAD A DILLEY ADMIN DIR-CV(PT YR)/COO-SAYONY (iiiii) 165,843 199 165,843 19CHAD A DILLEY ADMIN DIR-CV(PT YR)/COO-SAYONY (iiiiiii) 165,843 19CHAD A DILLEY ADMIN DIR-CV(PT YR)/COO-SAYONY (iiiiiiiiii) 165,843 19CHAD A DILLEY ADMIN DIR-CV(PT YR)/COO-SAYONY (iiiiiiiiiii) 165,843 19CHAD A DILLEY ADMIN DIR-CV(PT YR)/COO-SAYONY (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii | | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 18TAMARAH D BROWNLEE (i) | | (ii) | 269,606 | 46,696 | 486 | 18,075 | 30,286 | 365,149 | 0 |
| Region (ii) 163,933 28,597 366 8,259 32,405 233,560 19CHAD A DILLEY ADMIN DIR-CV(PT YR)/COO-SAYONY. | | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 19CHAD A DILLEY (i) 131,520 23,762 4,014 6,348 199 165,843 ADMIN DIR-CV(PT YR)/COO-SAXONY | | (ii) | 163,933 | 28,597 | 366 | 8,259 | 32,405 | 233,560 | 0 |
| SAYONY | | (i) | 131,520 | | 4,014 | , | | | |
| בין אין און אין בין אין אין בין אין אין אין אין אין אין אין אין אין א | | (ii) | 12,230 | 2,210 | 373 | 590 | 19 | 15,422 | 0 |

| efile GRAPH | IC print | : - DO NOT PROCESS | As Filed Data - | | DLN: | 93493318032870 |
|---|--|--|--|---|--|---|
| SCHEDUL (Form 990 or EZ) | 990- | Complete to prov Form 990 or | on to Form 990 or 9 r responses to specific questi ide any additional informatio n 990 or 990-EZ. 90 for the latest information. | ions on on. | OMB No. 1545-0047 2019 Open to Public Inspection | |
| Name l Bะthe rofg INDIANA UNIVERS INC | | H NORTH HOSPITAL | | | Employer identi 35-1932442 | fication number |
| 990 Schedul | e O, Sup | oplemental Information | 1 | | | |
| Return Reference | | | | Explanation | | |
| Page 1, Line J Web Site: | Changes Articles executes merger vithe Ame to specif Providin Engagin and cler are in fu | s to Organizational Documen of Incorporation with the India d amended and restated byla with IU Health West Hospital. Inded Articles of Incorporation ically address: - Increasing of the Hospital services to the common g in and supporting health egy; - Engaging in any lawful artherance of, supportive of, a | ts Indiana University and Secretary of Stat was effective March 1 A summary of the up are included below oommunity access to munity through owner ducation, training and activities within the pullied with or incidenta | Part VI, Section A - Governing Both Health North Hospital, Inc. ("IU e's Office effective March 1, 201, 2019 in order to reflect its charpodated bylaws are shown on Scharticle II, Which defines the purquality health care services to the ship and operation of a hospital research activities, including prurposes for which a corporation of the purposes of the corporation felit basis while adhering to and | Health North Hospi 19. IU Health North nge in operation foll hedule O, lines 7a a rposes of the legal ne indigent, poor, an in Hendricks Coun ograms for nurses, may be organized ution; - Engage in all | ital") filed Amended Hospital also lowing the boards and 7b. A summary of entity was amended nd underserved; - hty, Indiana; - health professionals under the Act, which I of the above |

990 Schedule O, Supplemental Information

Return Explanation

Reference

| Part VI, | IU Health North Hospital is part of a multi-entity hospital system controlled by IU Health, a 501(c)(3) tax-exempt organization |
|-------------|---|
| Section A, | whose board is comprised of voting members, of which substantially all are independent community members. |
| Line 1b | |
| Independent | |
| Voting | |
| Members | |

| Return Reference | Explanation |
|---|---|
| Part VI, Section A, Lines 6, 7a and 7b Members or Stockholders | Line 6: The sole member of IU Health North Hospital is IU Health, a 501(c)(3) tax-exempt organization. Line 7A: The Board of Directors of the IU Health North Hospital shall consist of up to fifteen (15) voting members all appointed by IU Health, who shall include representatives from the Medical staffs of IU Health North Hospital and IU Health West Hospital, and the President of the Indianapolis Suburban Region, who shall be an ex-officio, voting director of the Board. At all times, the IU Health North Hospital directors shall consist of the same individuals appointed by IU Health to serve as directors of IU Health West Hospital. Line 7B: The Board of Directors shall not, without the prior approval of the IU Health: - Any proposed amendment to the Corporation's Articles of Incorporation or these Bylaws; - Adoption of the Corporation's annual capital and operating budgets; - Approval of any unbudgeted operating or capital budget items or deviations, including any issuance or guarantee of any unbudgeted debt; - Approval of any strategic plan for the Corporation, including any amendments to a strategic plan; - Approval of any encumbrance, sale or conveyance of assets; - Any merger, consolidation, joint venture or affiliation involving the Corporation or any of its affiliates and any other entity; - Appointment and removal of the Corporation's President and other officers; - Construction, acquisition or lease of Hospital buildings; - Approve any management agreement for the management of all or substantial part of IU Health West Hospital's operations; - Projects or contracts that require Member approval in accordance with the Member's resolution and policy governing system-wide Contract Execution Authority and Payment Approval Limits; and - The dissolution of the Corporation or any of its affiliates. |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|--|
| Part VI, Section A, Line 11b Review of Form 990 | The Indianapolis Suburban Chief Financial Officer and Finance Committee reviewed and approved the Form 990. Following their 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 IU Health's Tax Department to answer any questions. |

| Return Reference | Explanation |
|--|---|
| Part VI, Section B, Lines 12, 13, 14, and 16b Policies | IU Health North Hospital is part of the IU Health system. As the sole member and controlling parent of IU Health North Hospital, IL Health and its Board of Directors have mandated that certain policies be followed to ensure greater standardization throughout the system. Thus, IU Health North Hospital's Board of Directors was not required to separately adopt a conflict of interest, whistleblower, document retention and destruction and joint venture policies because IU Health's Board of Directors had already adopted and required these policies to be followed by its subsidiaries. |

| Return Reference | Explanation |
|---|--|
| Part VI, Section B, Line 12c Conflict of Interest Policy | IU Health North Hospital follows IU Health's Conflict of Interest Policy. IU Health's 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: (a) 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. (b) 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. (c) 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. (d) 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 Representative's supervisor and other appropriate individuals and groups. (e) The scope of the policy is not limit |

| Return Reference | Explanation |
|--|--|
| Part VI, Section B, Line 15a & 15b - Process for Determining Compen. | IU Health North Hospital's Regional President is employed by IU Health, Inc. IU Health Nor th Hospital's President is also employed by IU Health, Inc. IU Health's process for determ ining compensation is as follows: (1) The Board of Directors ("Board") has established a T alent Management and Executive Compensation Committee ("TMECC"), the purpose of which incl udes reviewing and making recommendations regarding executive (Senior Vice Presidents and above) pay and benefits (collectively referred to as "compensation") on an annual basis. T he TMECC is made up of members of the Board that are neither physicians nor employees and do not otherwise have a conflict of interest regarding any of IU Health's compensation arr angements. The TMECC reviews an executive's entire compensation package including base sal ary, short-term and long-term incentives, health and welfare benefits, qualified and nonqu alified retirement plans, as well as any additional fringe benefits. As deemed appropriate, the Committee on Finance, which is also made up of members of the Board, may also review executive compensation and benefits. (2) The TMECC engages an independent compensation co nsulting firm on an annual basis to conduct a compensation analysis for its executive grou p, which consists of employees at the level of senior vice president and above. The current compensation advisor is SullivanCotter. SullivanCotter performs its analysis in the form of a compensation survey ("survey") that includes relevant comparability data for compens ation levels paid by similarly situated organizations (both governmental and tax exempt) for functionally comparable positions as well as the availability of similar services in the geographic area. SullivanCotter then prepares a survey report and provides recommendation s to the TMECC, if deemed appropriate, on changes in executive compensation. A separate a nalysis using the same methodology is done for the President and Chief Executive Officer. (3) The TMECC then reviews SullivanCotter's report an |

| Return Reference | Explanation |
|--|--|
| Part VI, Section B, Line 15a & 15b - Process for Determining Compen. | sation. Changes in executive compensation are made if approved by the TMECC and Board on a n annual basis, or as necessary throughout the year. The discussion and approval are docum ented in the minutes of the meeting. There are no executives present during the final disc ussion and approval. IU Health's General Counsel also prepares a formal written opinion re viewing the executive compensation approval process, comparing it to the Intermediate Sanc tions Test of IRC Section 4958. If warranted, IU Health's General Counsel may also provide comments regarding the executive compensation approval process as it relates to meeting the requirements for a rebuttable presumption of reasonableness as provided in the Intermed iate Sanctions Test. (6) After the end of each year, the TMECC and Board also review the a chievements of the executive group as it relates to the long-term and short-term shared and individual goals developed by the executives and the Board. These achievements may also be reviewed with the Committee on Finance. The Board, at its discretion, may approve bonus payments based upon the achievement of the goals. The discussion and vote of the TMECC and Board is documented in the minutes for each such meeting. The bonuses are not paid until approval is made by the Board. (7) The TMECC and Audit Committee also review Form 990 dis closures related to executive compensation as well as the organization's practices and approval processes prior to the filing of the Form 990 return with the Internal Revenue Servi ce. IU Health North Hospital and other related entities have a process in place to determine the compensation for the other officers and key employees. IU Health Human Resources us es market data from multiple compensation experts/vendors who utilize a variety of methods and procedures to obtain compensation ranges for comparable officer and employee position s. This market data and multiple other factors (including market pay benchmarks, internal equity, candidate/employee qualifications & performance |

| Return Reference | Explanation |
|-----------------------|--|
| Section C, Line 19 | IU Health North Hospital's Articles of Incorporation are available to the public through the Indiana Secretary of State's web-site. IU Health North Hospital's conflict of interest policy is described on Form 990, Schedule O. IU Health North Hospital is a subsidiary in IU Health's Consolidated Audited Financial Statements. IU Health's Consolidated Audited Financial Statements are available for public inspection through its bond filings and as an attachment to IU Health's Form 990 as well as IU Health North's Form 990. |

| Return Reference | Explanation |
|--|---|
| Part VII, Section B, Attach 2 Comp of the Five Highest Pd Ind. Contractors | The amounts paid to Messer Construction Co. totaling \$27,965,031 include both goods and services associated with the construction of IU Health Joe & Shelly Schwarz Cancer Center located on the IU Health North Hospital campus. The amounts for goods vs. services were not easily separated for reporting on the 990, Part VII, Section B, Independent contractors. |

| Return Reference | Explanation |
|---------------------|--|
| | IU Health North Hospital recorded the following other changes in net assets or fund balances in 2019: EQUITY TRANSFER (SETTLEMENT OF DEBT): (20,942) |

9 Other (S Changes in Net Assets or Fund

Balances

Return Explanation
Reference

FORM 990 DESCRIPTION:SHARED SERVICES/PROF. FEES TOTAL FEES:49124273
PART IX
LINE 11G

efile GRAPHIC print - DO NOT PROCESS As Filed Data -DLN: 93493318032870 OMB No. 1545-0047 **SCHEDULE R Related Organizations and Unrelated Partnerships** 2019 (Form 990) ▶ 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. Open to Public Department of the Treasury Inspection Internal Revenue Service **Employer identification number** Name of the organization INDIANA UNIVERSITY HEALTH NORTH HOSPITAL 35-1932442 Identification of Disregarded Entities. Complete if the organization answered "Yes" on Form 990, Part IV, line 33. Part I (b) (e) Legal domicile (state Direct controlling Name, address, and EIN (if applicable) of disregarded entity Primary activity Total income End-of-year assets or foreign country) 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) (g) Legal domicile (state Exempt Code section Direct controlling Section 512(b) Primary activity Public charity status or foreign country) (if section 501(c)(3)) (13) controlled entity? Yes No For Paperwork Reduction Act Notice, see the Instructions for Form 990. Cat. No. 50135Y Schedule R (Form 990) 2019

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

| See Additional Data Table (a) Name, address, and EIN of | | (b) Primary | (c) | (d) | (e) | (f) | (g) Share of | (1 | h) | (i) | 6 | o | (k) |
|--|---|-----------------------|--|--------|---|--|-------------------------------------|-------------------|------------------------------------|---|--------------|---------|--|
| Name, address, and EIN of related organization | Name, address, and EIN of related organization | | Legal domicile (state or foreign country) | entity | Predominant income(related unrelated, excluded from tax under sections 512-514) | Share of d, total incom | Share of e end-of-year assets | Disprop alloca | ortionate utions? | Code V-UBI amount in box 20 of Schedule K-1 (Form 1065) | mana part | aging o | ercentage wnership |
| | | | | | 314) | | | Yes | No | | Yes | No | |
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| Part IV Identification of Related Organi because it had one or more related | | | | | | nization ans | wered "Ye | s" on F | orm 9 | 990, Part IV | , line | 34 | |
| See Additional Data Table | | | | | ,, | | | | | | | | |
| (a) Name, address, and EIN of related organization | (b) Primary activity | Le dor (state d | (c) egal micile or foreign | | entity (C | (e) pe of entity corp, S corp, or trust) | (f) Share of total income | | (g) e of end- year assets | of- Perce owne | ntage | (13) | (i) ion 512(b) controlled entity? |
| | | cou | intry) | | | | | | | _ | | Ye | s No |
| | | | | | | | | | | | | | |
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| Schedule R (Form 990) 2019 | | Pa | ige 3 |
|---|------------|--------|--------------|
| Part V Transactions With Related Organizations. Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36. | | | |
| Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule. | | Yes | No |
| 1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV? | | | |
| a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity | 1a | | N |
| b Gift, grant, or capital contribution to related organization(s) | 1 b | | N |
| c Gift, grant, or capital contribution from related organization(s) | 1c | Yes | |
| d Loans or loan guarantees to or for related organization(s) | 1d | | N |
| e Loans or loan guarantees by related organization(s) | 1e | Yes | |
| f Dividends from related organization(s) | 1f | | N |
| g Sale of assets to related organization(s) | 1 g | \neg | N |
| h Purchase of assets from related organization(s) | 1h | | N |
| i Exchange of assets with related organization(s) | 1i | | N |
| 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 | ┢ |
| Performance of services or membership or fundraising solicitations for related organization(s) | 11 | 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 | | N |
| o Sharing of paid employees with related organization(s) | 10 | Yes | |
| p Reimbursement paid to related organization(s) for expenses | 1 p | | N |
| q Reimbursement paid by related organization(s) for expenses | 1 q | | N |
| r. Other transfer of cash or property to related organization(s) | 10 | Vac | ⊢ |

| p Reimbursement paid to related organization(s) for expenses | | | | 1 p | No |
|--|---|------------------------|------------------------------|------------|-------|
| q Reimbursement paid by related organization(s) for expenses | | | | 1 q | No |
| ${f r}$ Other transfer of cash or property to related organization(s) | | | | 1r Y | res |
| f 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 complet | e this line, including covered | relationships and tra | nsaction thresholds. | | |
| See Additional Data Table | | | | | |
| (a) Name of related organization | (b) Transaction type (a-s) | (c) Amount involved | (d) Method of determining | amount inv | olved |
| | | | | | |
| | | | | | |
| | | | | | |

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) | or | (e) e all partners section 501(c)(3) ·ganizations? | (f) Share of total income | (g) Share of end-of-year assets | (h) Disproprtiona allocations? | | Code V-UBI amount in box 20 of Schedule K-1 (Form 1065) | (j) General d managin partner? | g ? | (k) Percentage ownership |
|---|--------------------------------|---|--|-----|--|------------------------------------|--|--------------------------------------|----|--|---|--------|--------------------------------|
| | | | 317) | Yes | No | | | Yes | No | | Yes | No | |
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| | | | | | | | | | | Schedul | e R (Form | 1990 | 0) 2019 |

| Schedule R (Fo | rm 990) 2019 | | Page 5 |
|------------------|--------------------------|--|---------------|
| Part VII | Supplemental Info | ormation | |
| | Provide additional infor | mation for responses to questions on Schedule R. (see instructions). | |
| Return Reference | | Explanation | |
| | | | |

Software ID: Software Version:

EIN: 35-1932442

Name: INDIANA UNIVERSITY HEALTH NORTH HOSPITAL

| x-Exempt Organizati (b) Primary activity | (c) | (d) | 1 (2) | 1 | | |
|--|--|---|--|-------------------------------|--|--|
| | Legal domicile (state or foreign country) | Exempt Code section | (e) Public charity status (if section 501(c) | (f) Direct controlling entity | (g) Section 512 (b)(13) controlled entity? | |
| | | | (3)) | | Yes No | |
| Healthcare | IN | 501(c)(3) | 10 | IUH | Yes | |
| Healthcare | IN | 501(c)(3) | 3 | NA NA | No | |
| | | | | | | |
| Healthcare | IN | 501(c)(3) | 3 | IUH | Yes | |
| Healthcare | IN | 501(c)(3) | 3 | IUH | Yes | |
| Healthcare | IN | 501(c)(3) | 10 | ІИНВМН | Yes | |
| Healthcare | IN | 501(c)(3) | 3 | IUH | Yes | |
| Healthcare | IN | 501(c)(3) | 3 | IUHBMH | Yes | |
| Healthcare | IN | 501(c)(3) | 3 | IUH | Yes | |
| Fundraicing | TN | 501(c)(3) | 12 [| THERME | Yes | |
| | | | | | | |
| Healthcare | IN | 501(c)(3) | 10 | ІОН | Yes | |
| Healthcare | IN | 501(c)(3) | 3 | IUH | Yes | |
| Healthcare | IN | 501(c)(3) | 3 | IUH | Yes | |
| Healthcare | IN | 501(c)(3) | 10 | IUH | Yes | |
| Healthcare | IN | 501(c)(3) | 3 | IUH | Yes | |
| Insurance | IN | 501(c)(4) | N/A | IUH | Yes | |
| Healthcare | IN | 501(c)(3) | 3 | IUH | Yes | |
| Healthcare | IN | 501(c)(3) | 3 | IUH | Yes | |
| Healthcare | IN | 501(c)(3) | 3 | IUH | Yes | |
| Healthcare | IN | 501(c)(3) | 10 | IUH | Yes | |
| Healthcare | IN | 501(c)(3) | 10 | IUHLP | Yes | |
| | Healthcare Healthcare IN | Healthcare | Healthcare | | |

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations (c) (d) (e) (f) (g) Name, address, and EIN of related organization Primary activity Legal domicile Exempt Code Public charity Direct controlling Section 512 (state section entity (b)(13)status (if section 501(c) or foreign country) controlled (3)) entity? Yes No ΙN 501(c)(4) N/A IUH Yes Insurance 950 N Meridian St Ste 800 Indianapolis, IN 46204 46-5270582 IN 501(c)(4) IUH N/A Yes Insurance 950 N Meridian St Ste 800 Indianapolis, IN 46204 47-2619552 Fundraising IN 501(c)(3) 12 I IUH Yes 1633 N Capitol Ave Ste 1200 Indianapolis, IN 46202 35-6043086 IN 501(c)(3) 12 III-FI NA Healthcare No 950 N Meridian St Ste 800 Indianapolis, IN 46204 35-0876390 Healthcare 501(c)(3) IUH Yes IN 950 N Meridian St Ste 300 Indianapolis, IN 46204 35-1844176

Fundraising

Healthcare

Healthcare

Fundraising

705 Riley Hospital Dr Indianapolis, IN 46202

950 N Meridian St Ste 800 Indianapolis, IN 46204

340 W 10th St No FS5100 Indianapolis, IN 46202

35-6018517

23-7427350

36-4550324

20-1093251

846 N Senate Ave Indianapolis, IN 46202 501(c)(3)

501(c)(3)

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No

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 Disprop allocal | rtionate | (i) Code V-UBI amount in Box 20 of Schedule K-1 (Form 1065) | (j) Gene or Manag Partn | eral ging er? | (k) Percentage ownership |
| Ball Outpatient Sur Ctr LLC | Healthcare | IN | NA | | | | | | | | | |
| 569 Brookwood Village Ste 901 Birmingham, AL 35244 27-0275794 | | | | | | | | | | | | |
| Beltway Surgery Centers LLC | Healthcare | IN | NA | | | | | | | | | |
| 569 Brookwood Village Ste 901 Birmingham, AL 35244 35-2072586 | | | | | | | | | | | | |
| BOSC Holdings LLC | Healthcare | IN | NA | | | | | | | | | |
| 950 N Meridian St Ste 800 Indianapolis, IN 46204 45-4147343 | | | | | | | | | | | | |
| BSC Holdings LLC | Healthcare | IN | NA | | | | | | | | | |
| 950 N Meridian St Ste 800 Indianapolis, IN 46204 45-2314634 | | | | | | | | | | | | |
| CHV Fund I LLC | Venture Capit | IN | NA | | | | | | | | | |
| 950 N Meridian St Ste 800 Indianapolis, IN 46204 26-2523206 | | | | | | | | | | | | |
| CHV Fund II Management LLC | Venture Capit | IN | NA | | | | | | | | | |
| 950 N Meridian St Ste 800 Indianapolis, IN 46204 37-1717823 | | | | | | | | | | | | |
| CHV Fund II LLC | Venture Capit | IN | NA | | | | | | | | | |
| 950 N Meridian St Ste 800 Indianapolis, IN 46204 80-0902337 | | | | | | | | | | | | |
| CHV Fund Management LLC | Venture Capit | IN | NA | | | | | | | | | |
| 950 N Meridian St Ste 800 Indianapolis, IN 46204 26-2523151 | | | | | | | | | | | | |
| Health Venture Management LLC | Management | IN | NA | | | | | | | | | _ |
| 950 N Meridian St Ste 800 Indianapolis, IN 46204 20-5740218 | | | | | | | | | | | | |
| IEC Holdings LLC | Healthcare | IN | NA | | | | | | | | | |
| 950 N Meridian St Ste 800 Indianapolis, IN 46204 45-4148032 | | | | | | | | | | | | |
| Indiana Endoscopy Centers LLC | Healthcare | IN | NA | | | | | | | | | _ |
| 569 Brookwood Village Ste 901 Birmingham, AL 35244 20-8398421 | | | | | | | | | | | | |
| ROC Surgery LLC | Healthcare | IN | NA | | | | | | | | | |
| 569 Brookwood Village Ste 901 Birmingham, AL 35244 27-1497960 | | | | | | | | | | | | |
| ROCS Holdings LLC | Healthcare | IN | NA | | | | | | | | | |
| 950 N Meridian St Ste 800 Indianapolis, IN 46204 45-4148369 | | | | | | | | | | | | |
| Senate St Surgery Center LLC | Healthcare | IN | NA | | | | | | | | | |
| 569 Brookwood Village Ste 901 Birmingham, AL 35244 42-1709357 | | | | | | | | | | | | |
| SSSC Holdings LLC | Healthcare | IN | NA | | | | | | | | | |
| 950 N Meridian St Ste 800 Indianapolis, IN 46204 45-4148167 | | | | | | | | | | | | |

(j) (c) (h) (e) General Legal (d) (f) (g) Disproprtionate (k) (b) (a) Predominant Share of total Share of end-Domicile Direct or allocations? Percentage Code V-UBI amount in Name, address, and EIN of Primary activity income(related, Managing Controlling of-vear assets (State income Box 20 of Schedule K-1 ownership related organization unrelated. Partner? Entity or excluded from (Form 1065) Foreign tax under Country) sections 512-514) Yes No Yes No

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

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Healthcare

Healthcare

Healthcare

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Healthcare

HEALTHCARE

SSC Holdings LLC

46-4472887

35-2259204 EHSC Holdinas LLC

45-4147879

47-3087761

47-3102482

27-5271091

83-1224627

950 N Meridian St Ste 800 INDIANPAOLIS, IN 46204

Eagle High Surg Center LLC

950 N Meridian St Ste 800 Indianapolis, IN 46204

950 N Meridian St Ste 800 Indianapolis, IN 46204

IUH EWA Surgery Ctr LLC

569 Brookwood Village Ste 901 Birmingham, AL 35244

569 Brookwood Village Ste 901 Birmingham, AL 35244

IU HEALTH FORT WAYNE LLC

950 N Meridian St Ste 800 INDIANAPOLIS, IN 46204

IUH Saxony Surgery Ctr LLC

EWASC Holdings LLC

569 Brookwood Village Ste 901 Birmingham, AL 35244

Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust (b) (c) (d) (e) (f) (h) (i) (a) (g) Lègal Section 512 Name, address, and EIN of Primary activity Direct controlling Type of entity Share of total Share of end-of-Percentage related organization domicile entity (C corp, S corp, income ownership (b)(13)year (state or foreign controlled or trust) assets country) entity? Yes No CHV Capital Inc ΙN NΑ Yes Venture Capit 950 N Meridian St Ste 800 Indianapolis, IN 46204 26-0752507 IU Health 457(B) Plan DE NΑ Yes Investments 1100 N Market St Wilmington, DE 19890 47-6948347 IU Health ACO Inc ΙN NΑ Healthcare Yes 950 N Meridian St Ste 800 Indianapolis, IN 46204 45-4421020 IU Health Board Designated Trust CA NΑ Investments Yes 400 Howard St San Francisco, CA 94105 30-6309021 IU Health NTGI S&P500 Fund CF Investments ΙL NΑ Yes PO Box 804358 Chicago, IL 60680 30-6298263 ΙN NΑ Yes IU Health Plans Holding Company Inc Insurance 950 N Meridian St Ste 800 Indianapolis, IN 46204 46-3794815 IU Health Plans Insurance Company Insurance ΙN NΑ Yes 950 N Meridian St Ste 800 Indianapolis, IN 46204 81-1097215 IU Health Plans Inc НМО ΙN NΑ Yes 950 N Meridian St Ste 800 Indianapolis, IN 46204 26-2127080 IU Health Risk Purchasing Group Inc ΙN NΑ Insurance Yes 151 Meeting St Ste 301 Charleston, SC 29401 26-0202446 IU Health Risk Retention Group Inc SC NΑ Insurance Yes 151 Meeting St Ste 301 Charleston, SC 29401 20-1107674 IUH Assurance SPC Ltd Insurance CJ NΑ Yes PO BOX 69 94 SOLARIS AVE CAMANA BAY, GRAND CAYMAN CJ 98-0395429 Proteuo Fund LP CJ NΑ Yes Investments PO BOX 31106 89 NEXUS WAY CAMANA BAY, GRAND CAYMAN 98-1075227 SCANS Inc ΙN NΑ Healthcare Yes 950 N MERIDIAN ST STE 800 INDIANAPOLIS, IN 46204 45-3080392 BMH Medical Pavilion Association Inc Condo Management IN NΑ Yes 2525 W University Ave

ΙN

Management

NA

Yes

Muncie, IN 47303 35-1858408

35-1611424

Cardinal Health Ventures Inc.

950 N Meridian St Ste 800 Indianapolis, IN 46204

(h) (a) (b) (d) (e) Name, address, and EIN of Primary activity Legal Direct controlling Type of entity Share of total Share of end-of-Percentage Section 512 related organization domicile entity (C corp. S corp. (b)(13)income ownership vear (state or foreign controlled or trust) assets country antitu2

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

Investments

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Cerberus Residential Opport Inst Ltd

190 Elgin Avenue George Town George Town, Grand Cayman

| | | Country) | | | endity: | | |
|---|------------|----------|----|---|---------|-----|----|
| | | | | | | Yes | No |
| IU Health Southern IN Physicians Inc 950 N Meridian St Ste 300 Indianapolis, IN 46204 35-1913875 | Healthcare | IN | NA | С | | Yes | |

Yes

INA

(a) (b) (c) Name of related organization Amount Involved Transaction (d) type(a-s) Method of determining amount involved IU Health Care Associates Inc. 427,555 FMV FMV IU Health Care Associates Inc 362,225 IU Health Care Associates Inc. М 11,019,468 FMV FMV Methodist Occupational Health Centers Inc М 133,680 FMV IU Health Care Associates Inc. 0 100,953 FMV IU Health Tipton Hospital Inc 0 1,137,449 IU HEALTH WEST HOSPITAL INC 101,743 FMV 0 IUH ASSURANCE SPC LTD 513,079 FMV R IU Health Risk Retention Group Inc 797,135 FMV R IU HEALTH FOUNDATION INC С 87,058 FMV

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1,712,285

1,546,637

FMV

FMV

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

IU HEALTH WHITE MEMORIAL HOSPITAL INC

IU HEALTH ARNETT INC