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Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

OMB No 1545-0047

2017

Open to Public Inspection

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

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

C Name of organization
AVERA MCKENNAN

Doing business as

Number and street (or P O box if mail is not delivered to street address) | Room/suite
1325 SOUTH CLIFF AVE

City or town, state or province, country, and ZIP or foreign postal code
SIOUX FALLS, SD 571175045

D Employer identification number
46-0224743

E Telephone number
(605) 322-8000

G Gross receipts $ 1,156,307,947

F Name and address of principal officer
DAVID FLICEK
1325 SOUTH CLIFF AVE
SIOUX FALLS, SD 571175045

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

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

H(c) Group exemption number ▶ 0928

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

J Website: ▶ WWW AVERAMCKENNAN ORG

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

L Year of formation 1911

M State of legal domicile SD

Part I Summary

1 Briefly describe the organization's mission or most significant activities
PROMOTION OF HEALTH

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

3	Number of voting members of the governing body (Part VI, line 1a)	**3**	21
4	Number of independent voting members of the governing body (Part VI, line 1b)	**4**	14
5	Total number of individuals employed in calendar year 2017 (Part V, line 2a)	**5**	8,238
6	Total number of volunteers (estimate if necessary)	**6**	1,908
7a	Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	11,350,580
b	Net unrelated business taxable income from Form 990-T, line 34	**7b**	3,153,657

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	5,804,637	7,484,768
9	Program service revenue (Part VIII, line 2g)	997,538,670	995,826,100
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	16,218,621	8,510,483
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	2,254,411	51,157,256
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	1,021,816,339	1,062,978,607
13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	1,310,717	746,359
14	Benefits paid to or for members (Part IX, column (A), line 4)	0	0
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	491,407,050	520,069,419
16a	Professional fundraising fees (Part IX, column (A), line 11e)	181,520	81,670
b	Total fundraising expenses (Part IX, column (D), line 25) ▶1,341,393		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	488,841,065	493,537,324
18	Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	981,740,352	1,014,434,772
19	Revenue less expenses Subtract line 18 from line 12	40,075,987	48,543,835

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	924,237,536	1,159,178,030
21	Total liabilities (Part X, line 26)	337,671,365	511,785,453
22	Net assets or fund balances Subtract line 21 from line 20	586,566,171	647,392,577

Part II Signature Block

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

Sign Here

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

JIM BRECKENRIDGE CFO - AVERA HEALTH
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
KIM HUNWARDSEN CPA	KIM HUNWARDSEN CPA	2019-05-14		P00484560

Firm's name ▶ EIDE BAILLY LLP — Firm's EIN ▶ 45-0250958

Firm's address ▶ 800 NICOLLET MALL STE 1300
MINNEAPOLIS, MN 554027033 — Phone no (612) 253-6500

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

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission

AVERA IS A HEALTH MINISTRY ROOTED IN THE GOSPEL OUR MISSION IS TO MAKE A POSITIVE IMPACT IN THE LIVES AND HEALTH OF PERSONS AND COMMUNITIES BY PROVIDING QUALITY SERVICES AND GUIDED BY CHRISTIAN VALUES

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

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

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

If "Yes," describe these changes on Schedule O

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

4a (Code) (Expenses $ 853,927,601 including grants of $ 746,359) (Revenue $ 1,035,976,228)

See Additional Data

4b (Code) (Expenses $ including grants of $) (Revenue $)

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

4d Other program services (Describe in Schedule O)

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

4e **Total program service expenses** ▶ 853,927,601

Part IV Checklist of Required Schedules

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

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

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

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

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable . .	**1a**	467		
b	Enter the number of Forms W-2G included in line 1a *Enter -0-* if not applicable	**1b**	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	**1c**		Yes	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	**2a**	8,238		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	**2b**		Yes	
3a	Did the organization have unrelated business gross income of $1,000 or more during the year? . . .	**3a**		Yes	
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O* . . .	**3b**		Yes	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . .	**4a**			No
b	If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . .	**5a**			No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	**5b**			No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	**5c**			
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . .	**6a**			No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	**6b**			
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	**7a**			No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	**7b**			
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	**7c**			No
d	If "Yes," indicate the number of Forms 8282 filed during the year	**7d**			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	**7e**			No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . .	**7f**			No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	**7g**			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	**7h**			
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	**8**			
9a	Did the sponsoring organization make any taxable distributions under section 4966? . . .	**9a**			
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . .	**9b**			
10	**Section 501(c)(7) organizations.** Enter				
a	Initiation fees and capital contributions included on Part VIII, line 12 . . .	**10a**			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	**10b**			
11	**Section 501(c)(12) organizations.** Enter				
a	Gross income from members or shareholders	**11a**			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)	**11b**			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	**12a**			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	**12b**			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state? **Note.** See the instructions for additional information the organization must report on Schedule O	**13a**			
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	**13b**			
c	Enter the amount of reserves on hand	**13c**			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	**14a**			No
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* . .	**14b**			

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

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

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a	21		
	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	14		
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		Yes	
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?	3			No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4			No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5			No
6	Did the organization have members or stockholders?	6		Yes	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a		Yes	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b		Yes	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following				
a	The governing body?	8a		Yes	
b	Each committee with authority to act on behalf of the governing body?	8b			No
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9			No

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

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

Section C. Disclosure

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

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

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

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

20 State the name, address, and telephone number of the person who possesses the organization's books and records
▶JAMIE SCHAEFER 3900 W AVERA DR STE 300 SIOUX FALLS, SD 57108 (605) 322-3992

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
See Additional Data Table										

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
See Additional Data Table										
1b Sub-Total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶								9,770,479	3,225,702	618,171

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 839

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
AVERA HEALTH 3900 WEST AVERA DRIVE SIOUX FALLS, SD 57108	SHARED & ECARE SERVICES	86,709,691
SIOUX FALLS CONSTRUCTION PO BOX 2728 SIOUX FALLS, SD 571072728	CONSTRUCTION	11,618,156
SANFORD SCHOOL OF MEDICINE 1400 W 22ND ST 120 SIOUX FALLS, SD 571051505	PHYSICIAN SERVICES	4,051,492
BWBR ARCHITECTS 300 ST PETER STREET STE 600 SAINT PAUL, MN 55102	ARCHITECT SERVICES	3,012,683
ASSOCIATED REGIONAL & UNIVERSITY 500 CHIPETA WAY SALT LAKE CITY, UT 84108	LAB SERVICES	2,093,908

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 94

Part VIII Statement of Revenue

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

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
Contributions, Gifts, Grants and Other Similar Amounts					
1a Federated campaigns	1a 43,463				
b Membership dues	1b				
c Fundraising events	1c				
d Related organizations	1d 4,458,419				
e Government grants (contributions)	1e 1,562,645				
f All other contributions, gifts, grants, and similar amounts not included above	1f 1,420,241				
g Noncash contributions included in lines 1a-1f $					
h **Total.** Add lines 1a-1f		7,484,768			
Program Service Revenue	Business Code				
2a PATIENT SERVICE REVENU	622110	917,475,622	917,475,622		
b PATIENT AND CLINIC	621500	58,605,577	53,638,537	4,967,040	
c INC FROM SUBSIDIARIES	423000	5,527,611	5,527,611		
d MEANINGFUL USE REVENUE	900099	211,895	211,895		
e					
f All other program service revenue		14,005,395	14,005,395		
g **Total.** Add lines 2a–2f		995,826,100			
3 Investment income (including dividends, interest, and other similar amounts)		300,125			300,125
4 Income from investment of tax-exempt bond proceeds					
5 Royalties					
	(i) Real	(ii) Personal			
6a Gross rents	1,313,557				
b Less rental expenses	1,657,009				
c Rental income or (loss)	-343,452				
d Net rental income or (loss)		-343,452			-343,452
	(i) Securities	(ii) Other			
7a Gross amount from sales of assets other than inventory	54,290,694	3,730			
b Less cost or other basis and sales expenses	44,055,345	2,028,721			
c Gain or (loss)	10,235,349	-2,024,991			
d Net gain or (loss)		8,210,358			8,210,358
Other Revenue 8a Gross income from fundraising events (not including $ _____ of contributions reported on line 1c) See Part IV, line 18	a				
b Less direct expenses	b				
c Net income or (loss) from fundraising events					
9a Gross income from gaming activities See Part IV, line 19	a				
b Less direct expenses	b				
c Net income or (loss) from gaming activities					
10a Gross sales of inventory, less returns and allowances	a 94,065,698				
b Less cost of goods sold	b 45,588,265				
c Net income or (loss) from sales of inventory		48,477,433	45,083,845	3,393,588	
Miscellaneous Revenue	Business Code				
11a COMMERCIAL TESTING	621500	1,662,717		1,662,717	
b SPORTS PROGRAM	900099	1,327,235		1,327,235	
c A/R INTEREST INCOME	900099	33,323	33,323		
d All other revenue					
e **Total.** Add lines 11a–11d		3,023,275			
12 **Total revenue.** See Instructions		1,062,978,607	1,035,976,228	11,350,580	8,167,031

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraisingexpenses
1 Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21	420,786	420,786		
2 Grants and other assistance to domestic individuals See Part IV, line 22	325,573	325,573		
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, line 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	3,258,412	2,257,092	1,001,320	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	1,062,876	1,062,876		
7 Other salaries and wages	416,163,360	391,695,759	23,967,498	500,103
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	27,722,559	25,608,191	2,079,337	35,031
9 Other employee benefits	44,080,623	38,971,156	5,054,575	54,892
10 Payroll taxes	27,781,589	25,796,675	1,946,846	38,068
11 Fees for services (non-employees)				
a Management				
b Legal	372,946	29,436	343,510	
c Accounting	39,000	15,000	24,000	
d Lobbying	58,071		58,071	
e Professional fundraising services See Part IV, line 17	81,670			81,670
f Investment management fees				
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	169,870,108	70,590,581	99,222,784	56,743
12 Advertising and promotion	963,352	580,219	220,470	162,663
13 Office expenses	13,150,477	8,476,488	4,549,769	124,220
14 Information technology	8,187,619	3,752,794	4,388,933	45,892
15 Royalties . .				
16 Occupancy	18,732,891	14,777,116	3,942,063	13,712
17 Travel	2,788,739	2,167,919	612,601	8,219
18 Payments of travel or entertainment expenses for any federal, state, or local public officials .				
19 Conferences, conventions, and meetings	2,380,426	2,233,058	144,618	2,750
20 Interest	10,915,858	10,700,089	215,769	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization . .	40,721,148	35,724,762	4,995,604	782
23 Insurance . . .	3,866,200	2,502,712	1,363,488	
24 Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24e If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O)				
a MEDICAL SUPPLIES	179,914,092	179,914,092		
b BAD DEBT EXPENSE	26,527,142	26,527,142		
c UBI TAX	4,891,444	4,891,444		
d EQUIPMENT LEASE AND REN	4,611,039	4,008,867	600,282	1,890
e All other expenses	5,546,772	897,774	4,434,240	214,758
25 **Total functional expenses.** Add lines 1 through 24e	1,014,434,772	853,927,601	159,165,778	1,341,393
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

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

			(A) Beginning of year		(B) End of year
Assets	1	Cash–non-interest-bearing		1	
	2	Savings and temporary cash investments	30,650,368	2	37,247,763
	3	Pledges and grants receivable, net	3,119,577	3	4,592,734
	4	Accounts receivable, net	133,136,739	4	142,036,525
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L	62,500	5	230,844
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L		6	
	7	Notes and loans receivable, net	2,504,517	7	2,307,416
	8	Inventories for sale or use	22,282,021	8	25,110,366
	9	Prepaid expenses and deferred charges	14,101,648	9	11,925,421
	10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D — 10a: 876,799,599			
	b	Less accumulated depreciation — 10b: 431,529,975	381,880,255	10c	445,269,624
	11	Investments—publicly traded securities	7,042,556	11	8,647,439
	12	Investments—other securities See Part IV, line 11	238,011,941	12	261,759,142
	13	Investments—program-related See Part IV, line 11	10,209,460	13	13,266,394
	14	Intangible assets	40,953,412	14	40,533,688
	15	Other assets See Part IV, line 11	40,282,542	15	166,250,674
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	924,237,536	16	1,159,178,030
Liabilities	17	Accounts payable and accrued expenses	76,519,186	17	90,014,179
	18	Grants payable		18	
	19	Deferred revenue	763,404	19	576,178
	20	Tax-exempt bond liabilities	234,252,193	20	387,185,200
	21	Escrow or custodial account liability Complete Part IV of Schedule D		21	
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L		22	
	23	Secured mortgages and notes payable to unrelated third parties		23	9,811,973
	24	Unsecured notes and loans payable to unrelated third parties		24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24) Complete Part X of Schedule D	26,136,582	25	24,197,923
	26	**Total liabilities.** Add lines 17 through 25	337,671,365	26	511,785,453
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ ☑ and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	570,992,680	27	629,549,776
	28	Temporarily restricted net assets	11,808,971	28	13,586,236
	29	Permanently restricted net assets	3,764,520	29	4,256,565
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	586,566,171	33	647,392,577
	34	Total liabilities and net assets/fund balances	924,237,536	34	1,159,178,030

Part XI Reconcilliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	1,062,978,607
2	Total expenses (must equal Part IX, column (A), line 25)	2	1,014,434,772
3	Revenue less expenses Subtract line 2 from line 1	3	48,543,835
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	586,566,171
5	Net unrealized gains (losses) on investments	5	4,491,820
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	7,790,751
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	647,392,577

Part XII Financial Statements and Reporting

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

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

Additional Data

Software ID:

Software Version:

EIN: 46-0224743

Name: AVERA MCKENNAN

Form 990 (2017)

Form 990, Part III, Line 4a:

AVERA MCKENNAN'S MISSION IS TO PROVIDE HEALTHCARE SERVICES TO SIOUX FALLS, SOUTH DAKOTA RESIDENTS AND RESIDENTS OF THE SURROUNDING AREA AVERA MCKENNAN IS A 501(C)(3) ORGANIZATION AFFILIATED WITH AVERA HEALTH AVERA MCKENNAN CONSISTS OF A 473-BED HOSPITAL, A 53-BED HEART HOSPITAL AND A 138-BED NURSING HOME IN SIOUX FALLS, SD MAJOR SERVICE LINES INCLUDE ONCOLOGY, SURGERY, OBSTETRICS, PEDIATRICS, NEONATOLOGY, EMERGENCY AND TRAUMA, CRITICAL CARE INCLUDING EICU, RADIOLOGY AND DIAGNOSTIC IMAGING, PSYCHIATRY, PULMONARY, ORTHOPEDICS, NEUROLOGY, CARDIOLOGY AND GASTROENTEROLOGY TRANSPLANT SERVICES INCLUDE SOLID ORGAN (KIDNEY, LIVER, AND PANCREAS) AND BONE MARROW TRANSPLANT (CONTINUED ON SCHEDULE O)AVERA MCKENNAN OWNS OR LEASES RURAL CRITICAL HOSPITALS AND A NURSING HOME IN SOUTH DAKOTA INCLUDING A 25-BED CRITICAL ACCESS HOSPITAL AND A 55-BED NURSING HOME IN GREGORY, SD, A 25-BED CRITICAL ACCESS HOSPITAL IN MILBANK, SD, A 21-BED CRITICAL ACCESS HOSPITAL IN DELL RAPIDS, SD, AN 18-BED CRITICAL ACCESS HOSPITAL IN FLANDREAU, SD AND A 25-BED CRITICAL ACCESS HOSPITAL IN MILLER (HAND COUNTY), SD SERVICES OFFERED BY THE RURAL CRITICAL ACCESS HOSPITALS INCLUDE RADIOLOGY AND IMAGING, COLONOSCOPY AND ENDOSCOPY, THERAPY AND REHABILITATION, 24-HOUR EMERGENCY CARE, CHEMOTHERAPY, ORTHOPEDICS, CARDIOVASCULAR TESTING, SURGERY, DIALYSIS AND OBSTETRICS IN ADDITION AVERA MCKENNAN PROVIDES CLINICAL CARE, SECONDARY AND PRIMARY, IN 98 PHYSICIAN CLINICS IN SOUTH DAKOTA, NORTHWEST IOWA, SOUTHWEST MINNESOTA AND NORTHEASTERN NEBRASKA THE PHYSICIAN CLINICS PROVIDE PRIMARY CARE AND URGENT CARE, AND SPECIALTIES SUCH AS CARDIOLOGY, DERMATOLOGY, ENDOCRINOLOGY, GASTROENTEROLOGY, HEMATOLOGY, HEPATOLOGY, INFECTION DISEASE, INTERNAL MEDICINE, NEONATOLOGY, NEPHROLOGY, NEUROLOGY, OB/GYN, ONCOLOGY, OPHTHALMOLOGY, PEDIATRICS, ORTHOPEDICS, PAIN MANAGEMENT, PSYCHIATRY, PULMONOLOGY, GENERAL SURGERY, AND VASCULAR SERVICES FOLLOWING IS A BREAKDOWN OF THESE STATISTICS BY FACILITY AVERA MCKENNAN HOSPITAL23,946 ACUTE PATIENT DISCHARGES325,970 OUTPATIENT VISITS4,006 NEWBORN PATIENT DAYS1,010,840 CLINIC VISITSAVERA HEART HOSPITAL2,081 ACUTE PATIENT DISCHARGES9,297 OUTPATIENT VISITS58,327 CLINIC VISITSAVERA PRINCE OF PEACE44,741 LONG-TERM CARE RESIDENT DAYSAVERA GREGORY HOSPITAL (CAH)533 ACUTE PATIENT DISCHARGES12,102 OUTPATIENT VISITS1,082 SWING-BED PATIENT DAYS18,891 CLINIC VISITSAVERA ROSEBUD COUNTRY CARE CENTER14,143 LONG-TERM CARE RESIDENT DAYSAVERA MILBANK HOSPITAL (CAH)462 ACUTE PATIENT DISCHARGES27,065 OUTPATIENT VISITS87 NEWBORN PATIENT DAYS554 SWING-BED PATIENT DAYS24,663 CLINIC VISITSAVERA DELL RAPIDS HOSPITAL (CAH)188 ACUTE PATIENT DISCHARGES9,513 OUTPATIENT VISITS509 SWING-BED PATIENT DAYS13,951 CLINIC VISITSAVERA FLANDREAU HOSPITAL (CAH)151 ACUTE PATIENT DISCHARGES14,282 OUTPATIENT VISITS140 SWING-BED PATIENT DAYS10,152 CLINIC VISITSAVERA HAND COUNTY HOSPITAL (CAH)279 ACUTE PATIENT DISCHARGES12,089 OUTPATIENT VISITS451 SWING-BED PATIENT DAYS9,132 CLINIC VISITSAVERA MCKENNAN MAINTAINS RECORDS TO IDENTIFY AND MONITOR THE LEVEL OF CHARITY CARE IT PROVIDES THESE RECORDS INCLUDE THE AMOUNT OF CHARGES FORGONE FOR SERVICES AND SUPPLIES FURNISHED UNDER ITS CHARITY CARE POLICY AND EQUIVALENT SERVICE STATISTICS THE AMOUNT OF CHARGES FOREGONE, BASED ON ESTABLISHED RATES, WERE $58,330,248 AVERA MCKENNAN ALSO PROVIDES COMMUNITY BENEFIT HEALTH ACTIVITIES AT LESS THAN OR AT NO COST TO SUPPORT THOSE IN THE AREA SERVICED, SEE SCHEDULE H AS A MEMBER OF THE AVERA HEALTH NETWORK, AVERA MCKENNAN UPHOLDS THE VISION OF THE PRESENTATION AND BENEDICTINE SISTERS TO WORK THROUGH COLLABORATION TO PROVIDE QUALITY, EFFECTIVE HEALTH MINISTRY AND TO IMPROVE THE HEALTHCARE OF INDIVIDUALS AND OUR COMMUNITIES THROUGH A REGIONALLY INTEGRATED NETWORK OF PERSONS AND INSTITUTIONS AVERA MCKENNAN ENGAGES IN ACTIVITIES DESIGNED TO IMPROVE THE HEALTH OF INDIVIDUALS AND COMMUNITIES IN RESPONSE TO A CALLING TO HEAL THE SICK, THE ELDERLY, AND THE OPPRESSED

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JAMES WIEDERRICH CHAIR	2 00 0 00	X		X				0	0	0
HUGH VENRICK VICE CHAIR	2 00 0 00	X		X				0	0	0
TOM BIEGLER BOARD TRUSTEE	2 00 0 00	X						0	0	0
SISTER CARMELLA LUKE BOARD TRUSTEE	2 00 0 00	X						0	0	0
LUIS ROJAS MD BOARD TRUSTEE	40 00 0 00	X						637,867	0	41,247
RICK KOOIMA MD BOARD TRUSTEE	40 00 0 00	X						282,667	0	41,247
SISTER JOAN REICHELT BOARD TRUSTEE	2 00 2 60	X						0	0	0
KAREN GARNAAS MD CHIEF OF STAFF	40 00 0 00	X						488,865	0	39,603
SISTER MARY CAROLE CURRAN BOARD TRUSTEE	2 00 0 00	X						0	0	0
VAN FISHBACK BOARD TRUSTEE	2 00 0 00	X						0	0	0

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
J PAT COSTELLO BOARD TRUSTEE	2 00 0 00	X						0	0	0
LAURIE KNUTSON BOARD TRUSTEE	2 00 0 00	X						0	0	0
WILLIAM ROSSING MD BOARD TRUSTEE	40 00 0 00	X						598,787	0	39,603
CINDY WALSH BOARD TRUSTEE	2 00 0 00	X						0	0	0
JIM WOSTER BOARD TRUSTEE	2 00 0 00	X						0	0	0
MARY DALLY BOARD TRUSTEE	2 00 0 00	X						0	0	0
ALEJANDRO RAMIREZ BOARD TRUSTEE	2 00 0 00	X						0	0	0
RAED SULAIMAN MD BOARD TRUSTEE	2 00 0 00	X						0	0	0
CAROL TWEDT BOARD TRUSTEE	2 00 0 00	X						0	0	0
SISTER LUCILLE WELBIG BOARD TRUSTEE	2 00 2 00	X						0	0	0

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
DAVID FLICEK PRESIDENT & CEO	40 00 0 00	X		X				0	742,425	43,493
JIM BRECKENRIDGE CFO - AVERA HEALTH	0 10 39 90			X				0	887,406	34,116
LORI POPKES SR VICE PRESIDENT	40 00 0 00				X			327,855	0	35,382
STEVE PETERSEN AVP-PHARMACY	40 00 0 00				X			0	257,630	37,884
MARY LEEDOM AVP-SURGERY	40 00 0 00				X			213,367	0	10,445
CURT HOHMAN SR VICE PRESIDENT	40 00 0 50				X			345,074	0	23,333
TODD ZIMPRICH MD NEUROLOGIST	40 00 0 00					X		1,501,175	0	39,410
KYLE ARNESON MD RADIOLOGIST	40 00 0 00					X		1,461,287	0	47,256
BRIAN KNUTSON MD DERMATOLOGY	40 00 0 00					X		1,252,486	0	38,410
STEVEN CONDRON MD GASTROENTEROLOGY	40 00 0 00					X		1,296,503	0	41,247

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
WISSAM ASFAHANI MD NEUROLOGY SURGERY	40 00 0 00					X		1,195,826	0	42,493
DAVID KAPASKA DO FORMER PRESIDENT & CEO	0 00 0 00						X	0	983,620	23,808
JULIE N NORTON FORMER SEC/TREAS & SRVP FINANCE	0 00 40 00						X	168,720	354,621	39,194

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SCHEDULE A (Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

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

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

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
AVERA MCKENNAN

Employer identification number
46-0224743

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

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

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

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

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

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

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

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

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

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

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

_____

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

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

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

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

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

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

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

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

f Enter the number of supported organizations _____

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

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

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

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

Section A. Public Support

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

Section B. Total Support

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

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

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

Section C. Computation of Public Support Percentage

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

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

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

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

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

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

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

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

Section A. Public Support

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

Section B. Total Support

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

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

Section C. Computation of Public Support Percentage

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

Section D. Computation of Investment Income Percentage

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

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

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

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

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

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

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

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

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

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

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

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

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

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

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

Additional Data

Software ID:

Software Version:

EIN: 46-0224743

Name: AVERA MCKENNAN

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

Facts And Circumstances Test

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493134072969

SCHEDULE C (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

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

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

OMB No 1545-0047

2017

Open to Public Inspection

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

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

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

Name of the organization	**Employer identification number**
AVERA MCKENNAN	46-0224743

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

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

2 Political campaign activity expenditures (see instructions) ▶ $

3 Volunteer hours for political campaign activities (see instructions)

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

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

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

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

4a Was a correction made? ☐ Yes ☐ No

b If "Yes," describe in Part IV

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Lobbying Expenditures During 4-Year Averaging Period

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

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

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity		(a) Yes	(a) No	(b) Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
a	Volunteers?		No	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
c	Media advertisements?		No	
d	Mailings to members, legislators, or the public?		No	
e	Publications, or published or broadcast statements?		No	
f	Grants to other organizations for lobbying purposes?		No	
g	Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?	Yes		58,071
j	Total Add lines 1c through 1i			58,071
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

Part IV **Supplemental Information**

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

Return Reference	Explanation
PART II-B, LINE 1	AVERA MCKENNAN PARTICIPATES THROUGH VARIOUS HOSPITAL ORGANIZATIONS TO PROMOTE LEGISLATION THAT WOULD RESULT IN STRENGTHENING HEALTH CARE DELIVERY SYSTEMS ON A NATIONAL, REGIONAL, AND LOCAL LEVEL DUES WERE PAID TO THE FOLLOWING ORGANIZATIONS AND A PORTION IS ATTRIBUTABLE TO LOBBYING SOUTH DAKOTA ASSOCIATION OF HEALTHCARE ORGANIZATIONS $37,717 AMERICAN HOSPITAL ASSOCIATION 15,179 CATHOLIC HEALTH ASSOCIATION 5,078 LEADINGAGE 97

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SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
AVERA MCKENNAN

Employer identification number
46-0224743

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part IV Escrow and Custodial Arrangements.

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

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

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

		Amount
c	Beginning balance	1c 16,152
d	Additions during the year	1d 155,719
e	Distributions during the year	1e 158,937
f	Ending balance	1f 12,934

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

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

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	3,764,520	3,174,562	2,828,539	2,692,789	2,631,677
b Contributions					
c Net investment earnings, gains, and losses	492,045	589,958	346,023	135,750	61,112
d Grants or scholarships					
e Other expenditures for facilities and programs					
f Administrative expenses					
g End of year balance	4,256,565	3,764,520	3,174,562	2,828,539	2,692,789

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

- a Board designated or quasi-endowment ▶ 0 %
- b Permanent endowment ▶ 100 000 %
- c Temporarily restricted endowment ▶ 0 %

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

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

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

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

Part VI Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land	23,449,969	27,224,590		50,674,559
b Buildings	4,644,031	475,660,973	217,923,676	262,381,328
c Leasehold improvements		4,073,239	1,500,436	2,572,803
d Equipment		273,864,068	206,847,747	67,016,321
e Other		67,882,729	5,258,116	62,624,613
Total. Add lines 1a through 1e *(Column (d) must equal Form 990, Part X, column (B), line 10(c))* ▶				445,269,624

Part VII **Investments—Other Securities.** Complete if the organization answered "Yes" on Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other		
(A) ASSETS LIMITED AS TO USE - AVERA POOLED INVESTMENTS	220,275,476	F
(B) INVESTMENT IN HEART HOSPITAL OF SOUTH DAKOTA, LLC	19,445,433	F
(C) INTEREST IN AVERA HEALTH FOUNDATION	13,953,826	F
(D) INVESTMENTS IN AFFILIATED COMPANIES	5,569,286	F
(E) INVESTMENT IN AVERA HME	2,515,121	F
(F)		
(G)		
(H)		
Total. *(Column (b) must equal Form 990, Part X, col (B) line 12)* ▶	261,759,142	

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

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

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

(a) Description	(b) Book value
(1) OTHER ASSETS	189,548
(2) OTHER RECEIVABLES	45,961,580
(3) DUE FROM RELATED PARTY	1,250,000
(4) CUSTODIAL FUNDS HELD BY RELATED PARTY	118,849,546
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col (B) line 15)* ▶	166,250,674

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
OTHER LIABILITIES	4,850,356
DUE TO OTHER ORGANIZATIONS	1,174,897
MARKET VALUE OF INTEREST SWAP	5,611,756
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	8,346,433
MINORITY INTEREST	4,214,481
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col (B) line 25)* ▶	24,197,923

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

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

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

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

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

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

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

Part XIII Supplemental Information

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

Return Reference	Explanation
See Additional Data Table	

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

Additional Data

Software ID:
Software Version:
EIN: 46-0224743
Name: AVERA MCKENNAN

Supplemental Information

Return Reference	Explanation
PART IV, LINE 1B	THE ORGANIZATION HOLDS FUNDS IN TRUST ON BEHALF OF ITS LONG-TERM CARE RESIDENTS MANY SMAL L DOLLAR TRANSACTIONS FLOW IN AND OUT OF THIS ACCOUNT THE ACCOUNT IS MANAGED BY THE NURSI NG HOME STAFF THE STATE HAS STRICT GUIDELINES ON HOW THESE ACCOUNTS ARE MANAGED

Supplemental Information

Return Reference	Explanation
PART V, LINE 4	THE ORGANIZATION'S ENDOWMENT CONSISTS OF A PORTION OF THEIR INTEREST IN THE NET ASSETS OF AVERA HEALTH FOUNDATION THE AVERA HEALTH FOUNDATION INCLUDES ENDOWMENT FUNDS WHICH HAVE B EEN ESTABLISHED FOR A VARIETY OF PURPOSES AS REQUIRED BY GENERALLY ACCEPTED ACCOUNTING PR INCIPLES, NET ASSETS ASSOCIATED WITH ENDOWMENT FUNDS, INCLUDING FUNDS DESIGNATED BY THE BO ARD OF DIRECTORS TO FUNCTION AS ENDOWMENTS (IF ANY), ARE CLASSIFIED AND REPORTED BASED ON THE EXISTENCE OR ABSENCE OF DONOR-IMPOSED RESTRICTIONS THE ORGANIZATION'S PERMANENTLY RES TRICTED ENDOWMENT FUNDS ARE DONOR RESTRICTED THE ORGANIZATION CURRENTLY DOES NOT HAVE ANY BOARD DESIGNATED ENDOWMENT FUNDS

Supplemental Information

Return Reference	Explanation
PART X, LINE 2	AVERA HEALTH AND MOST OF ITS SPONSORED ORGANIZATIONS ARE CONSIDERED NONPROFIT CORPORATIONS AS DESCRIBED IN SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE AND ARE EXEMPT FROM FEDERA L INCOME TAXES ON RELATED INCOME PURSUANT TO SECTION 501(A) OF THE CODE THESE ORGANIZATIO NS ARE REQUIRED TO FILE A RETURN OF ORGANIZATION EXEMPT FROM INCOME TAX (FORM 990) WITH TH E INTERNAL REVENUE SERVICE (IRS) AVERA HEALTH AND CERTAIN SPONSORED ORGANIZATIONS ALSO FI LE AN EXEMPT ORGANIZATION BUSINESS INCOME TAX RETURN (FORM 990T) WITH THE IRS TO REPORT TH EIR UNRELATED BUSINESS TAXABLE INCOME AVERA HEALTH AND ITS SPONSORED ORGANIZATIONS BELIEV E THAT THEY HAVE APPROPRIATE SUPPORT FOR ANY TAX POSITIONS TAKEN AFFECTING ITS ANNUAL FILI NG REQUIREMENTS, AND AS SUCH, DOES NOT HAVE ANY UNCERTAIN TAX POSITIONS THAT ARE MATERIAL TO THE FINANCIAL STATEMENTS THE ORGANIZATION WOULD RECOGNIZE FUTURE ACCRUED INTEREST AND PENALTIES RELATED TO UNRECOGNIZED TAX BENEFITS AND LIABILITIES IN INCOME TAX EXPENSE IF SU CH INTEREST AND PENALTIES ARE INCURRED THE FEDERAL FORM 990T FILINGS AND TAXABLE SUBSIDIA RY RETURNS FOR CONSOLIDATED SUBSIDIARIES ARE NO LONGER SUBJECT TO FEDERAL TAX EXAMINATIONS BY TAX AUTHORITIES FOR YEARS BEFORE 2015 CERTAIN CONSOLIDATED ENTITIES ARE SUBJECT TO FE DERAL INCOME TAXES DEFERRED INCOME TAX ASSETS AND LIABILITIES ARE RECOGNIZED FOR THE DIFF ERENCES BETWEEN THE FINANCIAL AND INCOME TAX REPORTING BASIS OF ASSETS AND LIABILITIES BAS ED ON ENACTED TAX RATES AND LAWS DEFERRED TAX ASSETS AND LIABILITIES ARE NOT MATERIAL AS OF JUNE 30, 2018 AND 2017 THE ORGANIZATION PAID AN IMMATERIAL AMOUNT OF FEDERAL AND STATE INCOME TAXES FOR THE YEARS ENDED JUNE 30, 2018 AND 2017

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SCHEDULE G (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information Regarding Fundraising or Gaming Activities

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

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

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

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
AVERA MCKENNAN

Employer identification number
46-0224743

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

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

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

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

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

(i) Name and address of individual or entity (fundraiser)	(ii) Activity	(iii) Did fundraiser have custody or control of contributions? Yes	(iii) No	(iv) Gross receipts from activity	(v) Amount paid to (or retained by) fundraiser listed in col (i)	(vi) Amount paid to (or retained by) organization
1 JON OIEN 600 E SUNNYBROOK DR SIOUX FALLS, SD 57105	MAJOR AND PLANNED GIFT SOLICITATIONS		No	0	19,170	-19,170
2 MICHAEL SABA 26560 N SHORE PL HARTFORD, SD 57033	MAJOR AND PLANNED GIFT SOLICITATIONS		No	0	62,500	-62,500
3						
4						
5						
6						
7						
8						
9						
10						
Total ▶					81,670	-81,670

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

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

		(a) Event #1 (event type)	(b) Event #2 (event type)	(c) Other events (total number)	(d) Total events (add col (a) through col (c))
Revenue	1 Gross receipts				
	2 Less Contributions				
	3 Gross income (line 1 minus line 2)				
Direct Expenses	4 Cash prizes				
	5 Noncash prizes				
	6 Rent/facility costs				
	7 Food and beverages				
	8 Entertainment				
	9 Other direct expenses				
	10 Direct expense summary Add lines 4 through 9 in column (d) ▶				
	11 Net income summary Subtract line 10 from line 3, column (d) ▶				

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

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

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

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

b If "No," explain _____

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

b If "Yes," explain _____

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

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

13 Indicate the percentage of gaming activity conducted in

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

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

Name ▶ ----------

Address ▶ ----------

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

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

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

Name ▶ ----------

Address ▶ ----------

16 Gaming manager information

Name ▶ ----------

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

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

☐ Director/officer ☐ Employee ☐ Independent contractor

17 Mandatory distributions

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

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

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

Return Reference	Explanation
FORM 990, SCHEDULE G, PART I, LINE 2B	JOHN OIEN AND MICHAEL SABA WERE PAID FOR SERVICES RELATED TO THE MAJOR AND PLANNED GIFT SOLICITATIONS THE ORGANIZATION DOES NOT RECORD CONTRIBUTIONS IN COLUMN (IV) AS ALL CONTRIBUTIONS FROM THE SOLICITATIONS ARE RECEIVED THROUGH AVERA HEALTH FOUNDATION WHICH IS PART OF AVERA HEALTH, A RELATED ORGANIZATION
FORM 990, SCHEDULE G, PART I, LINE 3	AVERA MCKENNAN IS NOT REQUIRED TO BE REGISTERED OR LICENSED IN ANY STATES THE SOLICITATION AND RECEIPTS OF CONTRIBUTIONS FROM THE DONORS OCCURS AT THE AVERA HEALTH FOUNDATION THE CONTRIBUTIONS ON SCHEDULE B FROM AVERA HEALTH REFLECT PAYMENTS TO MCKENNAN FROM THE FOUNDATION'S TEMPORARILY RESTRICTED FUNDS TO COVER CERTAIN PROGRAM EXPENSES

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SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
AVERA MCKENNAN

Employer identification number
46-0224743

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			15,773,610		15,773,610	1 600 %
b Medicaid (from Worksheet 3, column a)			82,125,356	63,914,886	18,210,470	1 840 %
c Costs of other means-tested government programs (from Worksheet 3, column b)			2,205,444	1,479,159	726,285	0 070 %
d **Total** Financial Assistance and Means-Tested Government Programs			100,104,410	65,394,045	34,710,365	3 510 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			3,626,126	538,936	3,087,190	0 310 %
f Health professions education (from Worksheet 5)			9,006,262	1,558,536	7,447,726	0 750 %
g Subsidized health services (from Worksheet 6)			20,026,814	14,332,798	5,694,016	0 580 %
h Research (from Worksheet 7)			10,275,139	2,436,515	7,838,624	0 790 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)			1,687,795		1,687,795	0 170 %
j **Total.** Other Benefits			44,622,136	18,866,785	25,755,351	2 600 %
k **Total.** Add lines 7d and 7j			144,726,546	84,260,830	60,465,716	6 110 %

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing			14,500		14,500	0 %
2 Economic development			125,000		125,000	0 010 %
3 Community support			12,500		12,500	0 %
4 Environmental improvements						
5 Leadership development and training for community members			1,000		1,000	0 %
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development						
9 Other						
10 Total			153,000		153,000	0 010 %

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

Section A. Bad Debt Expense

				Yes	No
1	Did the organization report bad debt expense in accordance with Heathcare Financial Management Association Statement No 15?		1	Yes	
2	Enter the amount of the organization's bad debt expense Explain in Part VI the methodology used by the organization to estimate this amount	2	26,527,142		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit	3	0		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements				

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	230,808,056		
6	Enter Medicare allowable costs of care relating to payments on line 5	6	257,826,507		
7	Subtract line 6 from line 5 This is the surplus (or shortfall)	7	-27,018,451		
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6 Check the box that describes the method used				

☐ Cost accounting system ☐ Cost to charge ratio ☑ Other

Section C. Collection Practices

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

Part IV **Management Companies and Joint Ventures**

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

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

Part V Facility Information

Section A. Hospital Facilities

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

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

7

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

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group AVERA MCKENNAN

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

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

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

AVERA MCKENNAN

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150 000000000000 % and FPG family income limit for eligibility for discounted care of 400 000000000000 %			
b	☐ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☑ Insurance status			
f	☐ Underinsurance discount			
g	☐ Residency			
h	☑ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)			
a	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a	☑ The FAP was widely available on a website (list url) WWW AVERA ORG/PATIENTS-VISITORS/CHARITY-PATIENT-ASSISTANCE-PROGRAMS/			
b	☑ The FAP application form was widely available on a website (list url) WWW AVERA ORG/PATIENTS-VISITORS/CHARITY-PATIENT-ASSISTANCE-PROGRAMS/			
c	☑ A plain language summary of the FAP was widely available on a website (list url) WWW AVERA ORG/PATIENTS-VISITORS/CHARITY-PATIENT-ASSISTANCE-PROGRAMS/			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☑ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

AVERA MCKENNAN

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

AVERA MCKENNAN

Name of hospital facility or letter of facility reporting group

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

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group HEART HOSPITAL OF SOUTH DAKOTA LLC

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

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

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

HEART HOSPITAL OF SOUTH DAKOTA LLC

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150 000000000000 % and FPG family income limit for eligibility for discounted care of 400 000000000000 %			
b	☐ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☑ Insurance status			
f	☐ Underinsurance discount			
g	☐ Residency			
h	☑ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)			
a	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a	☑ The FAP was widely available on a website (list url) WWW AVERA ORG/PATIENTS-VISITORS/CHARITY-PATIENT-ASSISTANCE-PROGRAMS/			
b	☑ The FAP application form was widely available on a website (list url) WWW AVERA ORG/PATIENTS-VISITORS/CHARITY-PATIENT-ASSISTANCE-PROGRAMS/			
c	☑ A plain language summary of the FAP was widely available on a website (list url) WWW AVERA ORG/PATIENTS-VISITORS/CHARITY-PATIENT-ASSISTANCE-PROGRAMS/			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☑ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

HEART HOSPITAL OF SOUTH DAKOTA LLC

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

HEART HOSPITAL OF SOUTH DAKOTA LLC

Name of hospital facility or letter of facility reporting group

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

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group AVERA GREGORY HEALTHCARE CENTER

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 4

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

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

AVERA GREGORY HEALTHCARE CENTER

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150 000000000000 % and FPG family income limit for eligibility for discounted care of 400 000000000000 %			
b	☐ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☑ Insurance status			
f	☐ Underinsurance discount			
g	☐ Residency			
h	☑ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)			
a	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a	☑ The FAP was widely available on a website (list url) WWW AVERA ORG/PATIENTS-VISITORS/CHARITY-PATIENT-ASSISTANCE-PROGRAMS/			
b	☑ The FAP application form was widely available on a website (list url) WWW AVERA ORG/PATIENTS-VISITORS/CHARITY-PATIENT-ASSISTANCE-PROGRAMS/			
c	☑ A plain language summary of the FAP was widely available on a website (list url) WWW AVERA ORG/PATIENTS-VISITORS/CHARITY-PATIENT-ASSISTANCE-PROGRAMS/			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☑ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

AVERA GREGORY HEALTHCARE CENTER

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

AVERA GREGORY HEALTHCARE CENTER

Name of hospital facility or letter of facility reporting group

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

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group AVERA MILBANK AREA HOSPITAL

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

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

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

AVERA MILBANK AREA HOSPITAL

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150 000000000000 % and FPG family income limit for eligibility for discounted care of 400 000000000000 %			
b	☐ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☑ Insurance status			
f	☐ Underinsurance discount			
g	☐ Residency			
h	☑ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)			
a	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a	☑ The FAP was widely available on a website (list url) WWW AVERA ORG/PATIENTS-VISITORS/CHARITY-PATIENT-ASSISTANCE-PROGRAMS/			
b	☑ The FAP application form was widely available on a website (list url) WWW AVERA ORG/PATIENTS-VISITORS/CHARITY-PATIENT-ASSISTANCE-PROGRAMS/			
c	☑ A plain language summary of the FAP was widely available on a website (list url) WWW AVERA ORG/PATIENTS-VISITORS/CHARITY-PATIENT-ASSISTANCE-PROGRAMS/			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☑ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

AVERA MILBANK AREA HOSPITAL

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

AVERA MILBANK AREA HOSPITAL

Name of hospital facility or letter of facility reporting group

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

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group AVERA DELLS AREA HEALTH CENTER

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 5

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

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

AVERA DELLS AREA HEALTH CENTER

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150 000000000000 % and FPG family income limit for eligibility for discounted care of 400 000000000000 %			
b	☐ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☑ Insurance status			
f	☐ Underinsurance discount			
g	☐ Residency			
h	☑ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)			
a	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a	☑ The FAP was widely available on a website (list url) WWW AVERA ORG/PATIENTS-VISITORS/CHARITY-PATIENT-ASSISTANCE-PROGRAMS/			
b	☑ The FAP application form was widely available on a website (list url) WWW AVERA ORG/PATIENTS-VISITORS/CHARITY-PATIENT-ASSISTANCE-PROGRAMS/			
c	☑ A plain language summary of the FAP was widely available on a website (list url) WWW AVERA ORG/PATIENTS-VISITORS/CHARITY-PATIENT-ASSISTANCE-PROGRAMS/			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☑ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

AVERA DELLS AREA HEALTH CENTER

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

AVERA DELLS AREA HEALTH CENTER

Name of hospital facility or letter of facility reporting group

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

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group AVERA FLANDREAU MEDICAL CENTER

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 6

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

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

AVERA FLANDREAU MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150 000000000000 % and FPG family income limit for eligibility for discounted care of 400 000000000000 %			
b	☐ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☑ Insurance status			
f	☐ Underinsurance discount			
g	☐ Residency			
h	☑ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)			
a	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a	☑ The FAP was widely available on a website (list url) WWW AVERA ORG/PATIENTS-VISITORS/CHARITY-PATIENT-ASSISTANCE-PROGRAMS/			
b	☑ The FAP application form was widely available on a website (list url) WWW AVERA ORG/PATIENTS-VISITORS/CHARITY-PATIENT-ASSISTANCE-PROGRAMS/			
c	☑ A plain language summary of the FAP was widely available on a website (list url) WWW AVERA ORG/PATIENTS-VISITORS/CHARITY-PATIENT-ASSISTANCE-PROGRAMS/			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☑ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

AVERA FLANDREAU MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

AVERA FLANDREAU MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group AVERA HAND COUNTY MEMORIAL HOSPITAL

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 7

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

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

AVERA HAND COUNTY MEMORIAL HOSPITAL

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150 000000000000 % and FPG family income limit for eligibility for discounted care of 400 000000000000 %			
b	☐ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☑ Insurance status			
f	☐ Underinsurance discount			
g	☐ Residency			
h	☑ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)			
a	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a	☑ The FAP was widely available on a website (list url) WWW AVERA ORG/PATIENTS-VISITORS/CHARITY-PATIENT-ASSISTANCE-PROGRAMS/			
b	☑ The FAP application form was widely available on a website (list url) WWW AVERA ORG/PATIENTS-VISITORS/CHARITY-PATIENT-ASSISTANCE-PROGRAMS/			
c	☑ A plain language summary of the FAP was widely available on a website (list url) WWW AVERA ORG/PATIENTS-VISITORS/CHARITY-PATIENT-ASSISTANCE-PROGRAMS/			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☑ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

AVERA HAND COUNTY MEMORIAL HOSPITAL

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

AVERA HAND COUNTY MEMORIAL HOSPITAL

Name of hospital facility or letter of facility reporting group

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

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

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

Form and Line Reference	Explanation
See Add'l Data	

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

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility (list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? **41**

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

Part VI Supplemental Information

Provide the following information

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

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

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

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

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

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

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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 3C	THE METHODOLOGY USED TO DETERMINE ELIGIBILITY FOR FINANCIAL ASSISTANCE TAKES INTO CONSIDERATION INCOME, NET ASSETS, FAMILY SIZE AND RESOURCES AVAILABLE TO PAY FOR CARE IN ADDITION, PRESUMPTIVE CHARITY CARE MAY BE APPLIED IN SITUATIONS WHERE ALL OTHER AVENUES HAVE BEEN EXHAUSTED

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7	A COMBINATION OF COSTING METHODOLOGY WAS USED TO CALCULATE THE AMOUNTS REPORTED IN THE TABLE A COST ACCOUNTING SYSTEM WAS USED TO CALCULATE MEDICAID AND MEANS-TESTED GOVERNMENT PROGRAM EXPENSES AND SHORTFALLS AND SUBSIDIZED HEALTH SERVICES FOR OUR TERTIARY MEDICAL CENTER A COST TO CHARGE RATIO DERIVED FROM WORKSHEET 2, RATIO OF PATIENT CARE COST-TO-CHARGES WAS USED TO CALCULATE CHARITY CARE AT COST FOR ALL ENTITIES AND MEDICAID AND MEANS-TESTED GOVERNMENT PROGRAM EXPENSES AND SHORTFALLS AND SUBSIDIZED HEALTH SERVICES FOR ANY OPERATIONS OUTSIDE OF THE TERTIARY MEDICAL CENTER FOR ALL OTHER AMOUNTS, COSTS AND REVENUES AS REFLECTED BY THE GENERAL LEDGER SYSTEM WERE USED

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7G	PHYSICIAN CLINIC COSTS FOR TRANSPLANT SERVICES ARE INCLUDED IN SUBSIDIZED HEALTH SERVICES REVENUES OF $777,690 AND COSTS OF $2,082,683 WERE INCLUDED FOR A NET COMMUNITY BENEFIT OF $1,304,993 OUR FACILITY IS THE PRINCIPAL PROVIDER OF BONE MARROW AND PANCREAS TRANSPLANT SERVICES THROUGHOUT OUR SERVICE AREA, IN ADDITION TO DEVELOPING A LIVER TRANSPLANT PROGRAM, WITH THE CLINICS AS A CRUCIAL COMPONENT OF SUCCESSFUL PRE AND POST TRANSPLANT CARE

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LN 7 COL(F)	BAD DEBT EXPENSE OF $26,527,142 IS INCLUDED ON FORM 990, PART IX, LINE 25, COLUMN (A) BUT EXCLUDED FOR PURPOSES OF CALCULATING THIS PERCENTAGE

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART II, COMMUNITY BUILDING ACTIVITIES	THE COMMUNITY BUILDING ACTIVITIES INCLUDE MONETARY ASSISTANCE TO ORGANIZATIONS THAT FOCUS THEIR EFFORTS ON PROVIDING FURNITURE FOR LOW INCOME FAMILIES, NEIGHBORHOOD IMPROVEMENT PROJECTS IN HIGH NEEDS AREAS, CHILDREN AND YOUTH DEVELOPMENT PROGRAMS, LOCAL ECONOMIC DEVELOPMENT, AND JOB CREATION AND TRAINING PROGRAMS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 2	BAD DEBT EXPENSE IS REPORTED NET OF DISCOUNTS AND CONTRACTUAL ALLOWANCES A PAYMENT ON AN ACCOUNT PREVIOUSLY WRITTEN OFF REDUCES BAD DEBT EXPENSE IN THE CURRENT YEAR BAD DEBT EXPENSE ON LINE 2 IS REPORTED AT CHARGES AS PRESENTED ON THE FINANCIAL STATEMENTS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 3	AVERA MCKENNAN HAS SEVERAL PROCEDURES IN PLACE TO DETERMINE WHICH PATIENTS WOULD QUALIFY FOR FINANCIAL ASSISTANCE, THEREFORE THE HOSPITAL FEELS CONFIDENT THAT NO AMOUNT OF BAD DEBT EXPENSE IS ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 4	THE FOOTNOTE TO THE ORGANIZATION'S FINANCIAL STATEMENTS THAT DESCRIBES BAD DEBT EXPENSES CAN BE FOUND ON PAGE 10 OF THE ATTACHED AUDITED FINANCIAL STATEMENTS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 8	THE MEDICARE REVENUES RECEIVED (LINE 5), ALLOWABLE COSTS (LINE 6), AND THE RESULTING LOSS (LINE 7) DOES NOT INCLUDE A SIGNIFICANT PORTION OF THE ORGANIZATION'S EXPENSES THESE LINES REQUIRE USE OF THE MEDICARE COST REPORT AS PREPARED BY THE REQUIRED GUIDELINES WHICH DISALLOWS NUMEROUS COSTS OF HOSPITALS, PARTICULARLY IF THEY ARE PART OF AN INTEGRATED SYSTEM SUCH AS AVERA MCKENNAN IN THESE CASES THE ENTITY MUST FILE A HOME OFFICE COST REPORT WHICH "STEPS DOWN" OVERHEAD TO NON-COST REPORT ENTITIES DISPROPORTIONATELY TO ACTUAL ALLOWABLE SHARE AND ESSENTIALLY REMOVING THE COSTS FROM THE HOSPITAL'S COST REPORT ENTIRELY EXAMPLES OF A PORTION OF THESE OVERHEAD COSTS WOULD BE FINANCE, BUSINESS OFFICE, INFORMATION TECHNOLOGY, HUMAN RESOURCES AND ADMINISTRATION EXAMPLES OF NON-COST REPORT ENTITIES OPERATED BY AVERA MCKENNAN INCLUDE CLINICS, MOBILE IMAGING SERVICES, LONG-TERM CARE FACILITIES, AND OTHER HEALTH CARE RELATED BUSINESSES THERE ARE ALSO COSTS COMPLETELY DISALLOWED BY COST REPORT RULES SUCH AS BAD DEBT EXPENSE, HOSPITALISTS CARE, CRNA'S, AND INTEREST EXPENSE AVERA MCKENNAN ALSO RECEIVES A MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) ADJUSTMENT AS PART OF THE COST REPORT DUE TO ITS SIGNIFICANT NUMBER OF LOW-INCOME PATIENTS SERVED PART III, LINE 5 REQUIRES INCLUSION OF THIS REVENUE THOUGH EXPENSES INCLUDED ARE MUCH LOWER SCHEDULE H INSTRUCTIONS ALSO REQUIRE THE EXCLUSION OF $1,172,076 OF MEDICARE LOSSES BECAUSE THEY ARE INCLUDED IN SCHEDULE H, PART 1, LINE 7F OR 7G INCLUDING THE MEDICARE PERCENTAGE OF DISALLOWED COSTS, ENTITIES WHICH DON'T FILE A COST REPORT BUT NEVERTHELESS CARE FOR MEDICARE PATIENTS, AND THE IMPACT OF THE HOME OFFICE COST REPORT, THE MEDICARE SHORTFALL IS $53,747,836 AS OPPOSED TO A SHORTFALL OF $27,018,451 AVERA MCKENNAN FOLLOWS THE CATHOLIC HEALTH ASSOCIATION GUIDELINES IN REPORTING COMMUNITY BENEFITS AND THEREFORE ANY MEDICARE SHORTFALL (AS CALCULATED INCLUDING OUR NON-COST REPORT ENTITIES) IS EXCLUDED FROM OUR COMMUNITY BENEFIT REPORT HOWEVER, MEDICARE IS THE ORGANIZATION'S LARGEST PAYER AND PATIENTS WITH MEDICARE COVERAGE ARE ACCEPTED REGARDLESS OF WHETHER OR NOT A SURPLUS OR DEFICIT IS REALIZED FROM PROVIDING THE SERVICES THIS BASIS THEREFORE MEANS PROVIDING MEDICARE SERVICES PROMOTES ACCESS TO HEALTHCARE SERVICES WHICH IS A KEY ADVANTAGE FOR OUR COMMUNITY MEDICARE ALLOWABLE COSTS OF CARE ARE BASED ON THE MEDICARE COST REPORT THE MEDICARE COST REPORT IS COMPLETED BASED ON THE RULES AND REGULATIONS SET FORTH BY CENTERS FOR MEDICARE & MEDICAID SERVICES

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 9B	IF THE PATIENT QUALIFIES FOR THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY FOR LOW-INCOME, UNINSURED PATIENTS AND IS COOPERATING WITH THE ORGANIZATION WITH REGARD TO EFFORTS TO SETTLE AN OUTSTANDING BILL WITHIN CURRENT SELF-PAY COLLECTION POLICY GUIDELINES AND TIMEFRAMES, THE ORGANIZATION OR ITS AGENT SHALL NOT SEND, NOR INTIMATE THAT IT WILL SEND, THE UNPAID BILL TO ANY OUTSIDE COLLECTION AGENCY AVERA ORGANIZATIONS WILL ALLOW ALL INDIVIDUALS 120 DAYS FROM THE FIRST POST DISCHARGE STATEMENT TO APPLY FOR FINANCIAL ASSISTANCE BEFORE SENDING THE UNCOLLECTED ACCOUNT TO AN OUTSIDE COLLECTION AGENCY AVERA WILL PROVIDE THE PATIENT WITH A STATEMENT OR FINAL NOTICE THAT CONTAINS A LISTING OF THE SPECIFIC COLLECTION ACTION(S) IT INTENDS TO INITIATE, AND A DEADLINE AFTER WHICH THEY MAY BE INITIATED NO EARLIER THAN 30 DAYS BEFORE ACTION IS INITIATED IF THE PATIENT QUALIFIES FOR 100% CHARITY CARE, NO FURTHER BILLS WILL BE SENT A LETTER WILL BE SENT INSTEAD INDICATING THAT THE PATIENT'S BILL HAS BEEN COMPLETELY FORGIVEN

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 2	COMMUNITY NEEDS ASSESSMENT OCCURS AT VARIOUS POINTS IN THE SYSTEM THROUGH ANNUAL STRATEGIC PLANNING SESSIONS, COMMUNITY LEADERS ARE BROUGHT IN TO UPDATE AND EDUCATE AVERA MCKENNAN BOARD MEMBERS AND ADMINISTRATIVE COUNCIL ON THE SUCCESSES, CHALLENGES, AND SERVICE GAPS IN THE COMMUNITY EXAMPLES INCLUDE SCHOOL DISTRICT OFFICIALS, STATE HEALTH DEPARTMENT, AND COMMUNITY HEALTH ORGANIZATIONS LEADERS ALSO SERVE ON BOARDS OF VARIOUS COMMUNITY ORGANIZATIONS WHICH SEEK TO ADDRESS THE HEALTH AND WELL-BEING OF AREA CITIZENS LOCAL GOVERNING BOARDS AT OUTLYING FACILITIES, WHO ARE MEMBERS OF THE COMMUNITY, DISCUSS AND HELP DIRECT RESOURCES TO AREAS OF TARGETED NEEDS AS WELL

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 3	NOTICES ARE POSTED IN ENGLISH AND SPANISH IN A VISIBLE MANNER IN LOCATIONS WHERE THERE IS A HIGH VOLUME OF INPATIENT OR OUTPATIENT ADMITTING/REGISTRATION, SUCH AS EMERGENCY DEPARTMENTS, BILLING OFFICES, ADMITTING OFFICES, AND OUTPATIENT SERVICE SETTINGS AS WELL AS THE ORGANIZATION WEBSITE POSTED NOTICES STATE THAT THE ORGANIZATION HAS A FINANCIAL ASSISTANCE POLICY FOR LOW-INCOME UNINSURED PATIENTS WHO MAY NOT BE ABLE TO PAY THEIR BILL AND THAT THIS POLICY PROVIDES FOR CHARITY CARE AND REDUCED-PAYMENT FOR HEALTHCARE SERVICES THERE IS ALSO IDENTIFICATION OF A CONTACT PHONE NUMBER THAT A PATIENT CAN CALL TO OBTAIN MORE INFORMATION ABOUT THE FINANCIAL ASSISTANCE POLICY AND ABOUT HOW TO APPLY FOR SUCH ASSISTANCE ADDITIONALLY, ADMITTING STAFF MAKES AVAILABLE A BROCHURE DESIGNED TO HELP PATIENTS UNDERSTAND HOW WE BILL PATIENTS AND PROVIDES SUMMARY INFORMATION ON FINANCIAL ASSISTANCE IF YOU ARE UNABLE TO PAY PATIENT ADVOCATES WORK WITH UNINSURED PATIENTS IN OUR MAIN TERTIARY FACILITY TO ENROLL THEM IN APPLICABLE SOCIAL PROGRAMS AND IDENTIFY CHARITY ELIGIBILITY, ELIGIBILITY AND ENROLLMENT FOR COUNTY, STATE OR FEDERAL RISK POOLS, AND ELIGIBILITY FOR MODIFIED MEDICARE OR MEDICAID PROGRAMS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 4	AVERA MCKENNAN'S SERVICE AREA IS A LARGELY RURAL POPULATION SERVICES ARE PROVIDED THROUGH A HEALTH CARE NETWORK OF CLINICS, CRITICAL ACCESS HOSPITALS AND TERTIARY FACILITIES COVERING COMMUNITIES IN FOUR STATES THE MAIN TERTIARY FACILITY IS LOCATED IN A POPULATION CENTER OF OVER 178,000 SERVED BY ANOTHER NON-PROFIT HOSPITAL OF SIMILAR SIZE, VETERANS ADMINISTRATION HOSPITAL, A HOSPITAL DEDICATED TO DIAGNOSIS AND TREATMENT OF HEART DISEASE, AND A HOSPITAL FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS OUTSIDE OF THIS POPULATION CENTER, MOST OF THE COMMUNITIES SERVED HAVE LESS THAN 4,000 RESIDENTS THE PRIMARY SERVICE AREA INCLUDES FOUR COUNTIES COVERING APPROXIMATELY 2,600 SQUARE MILES AND CONTAINS SEVEN FEDERALLY DESIGNATED MEDICALLY UNDERSERVED COMMUNITIES THE 2016 U S CENSUS BUREAU DATA ESTIMATES 9 9% OF RESIDENTS IN THE PRIMARY SERVICE AREA ARE AT OR BELOW THE POVERTY LEVEL OUR SECONDARY SERVICE AREA COVERS AN ADDITIONAL 17 COUNTIES IN SOUTH DAKOTA, IOWA AND MINNESOTA WITH AN ESTIMATED TOTAL POPULATION OF 235,000 BASED ON 2016 U S CENSUS BUREAU

Form and Line Reference	Explanation
PART VI, LINE 5	SURPLUS FUNDS ARE REINVESTED IN FACILITIES TO IMPROVE PATIENT CARE MEDICAL STAFF PRIVILEGE S ARE EXTENDED TO ALL QUALIFIED PHYSICIANS IN THE COMMUNITY THE AVERA MCKENNAN BOARD OF T RUSTEES IS PRINCIPALLY COMPRISED OF COMMUNITY MEMBERS FROM THE PRIMARY SERVICE AREA MEMBE RS COME FROM A VARIETY OF BACKGROUNDS RANGING FROM PRIVATE INDUSTRY AND BANKING TO HEALTHC ARE AVERA MCKENNAN IS A VERIFIED LEVEL II TRAUMA CENTER AND WAS THE FIRST SUCH CENTER IN T HE STATE OF SOUTH DAKOTA AVERA MCKENNAN'S EMERGENCY DEPARTMENT IS STAFFED 24 HOURS A DAY WITH BOARD-CERTIFIED EMERGENCY SPECIALISTS AND PROVIDES EMERGENCY CARE REGARDLESS OF ABILI TY TO PAY AVERA MCKENNAN HAD 35,681 EMERGENCY DEPARTMENT VISITS IN FY 2018 OPERATING BOT H FIXED WING AND HELICOPTER MEDICAL AIR TRANSPORTS, AVERA MCKENNAN'S FLIGHT TEAMS COVER A LARGE GEOGRAPHIC AREA PROVIDING STATE-OF-THE-ART AIR TRANSPORT SERVICES AND ACCESS TO CRIT ICAL CARE, WITH 1,704 FLIGHTS IN THE PAST YEAR HEALTH CARE CLINIC IN 1992, AVERA MCKENNAN ESTABLISHED A HEALTH CARE CLINIC TO PROVIDE FREE CARE FOR PEOPLE WHO ARE UNINSURED OR UND ERINSURED IN THE COMMUNITY THE CLINIC IS MANAGED BY A REGISTERED NURSE AND STAFFED BY REG ISTERED NURSES, TWO MIDLEVEL PROVIDERS, MEDICAL RESIDENTS AND VOLUNTEER HEALTH CARE PROVID ERS THE GOAL OF THE CLINIC IS TO PREVENT OR TREAT PATIENTS' MEDICAL CONDITIONS BEFORE THE Y BECOME CATASTROPHIC THE CLINIC AVERAGES 450 VISITS PER MONTH, PROVIDING PREVENTATIVE CA RE, DIAGNOSIS AND TREATMENT OF ILLNESSES AND INJURIES, MEDICATION ASSISTANCE AND ASSISTANC E IN OBTAINING SPECIALIST CARE FOR PATIENTS WITH COMPLEX CASES THE CLINIC ALSO SERVES TO TRAIN PHYSICIANS, NURSES AND OTHER HEALTH CARE STUDENTS IT PROVIDES A FREE EVENING CLINIC ONE EVENING PER MONTH, STAFFED BY MEDICAL STUDENTS UNDER SUPERVISION OF PHYSICIANS AVERA MCKENNAN IS THE ONLY HEALTH CARE ORGANIZATION TO PROVIDE FREE SERVICES SUCH AS THIS IN TH E STATE OF SOUTH DAKOTA THE CLINIC HAD 4,554 VISITS IN 2018, AND WAS OPERATED AT AN ANNUA L COST OF $1,200,023 PARTNERSHIP IN LIVE WELL SIOUX FALLS THE CITY OF SIOUX FALLS RECEIV ED A COMMUNITY HEALTH TRANSFORMATION GRANT FROM THE SOUTH DAKOTA DEPARTMENT OF HEALTH, SPA RKING A PROJECT TO IMPROVE THE HEALTH AND WELL-BEING OF THE CITIZENS OF SIOUX FALLS GUIDE D BY THE CITY OF SIOUX FALLS HEALTH DEPARTMENT, THIS ONGOING PROJECT IS KNOWN AS LIVE WELL SIOUX FALLS IT INVOLVES MORE THAN 24 COMMUNITY PARTNER ORGANIZATIONS AMONG THESE PARTNE RS ARE AVERA MCKENNAN AND THE OTHER MAJOR HEALTH CARE SYSTEM IN SIOUX FALLS, SANFORD HEALT H AVERA PLANS TO WORK IN PARTNERSHIP WITH THE CITY OF SIOUX FALLS AND SANFORD HEALTH TO A DDRESS THE PRIORITIES OF LIVE WELL SIOUX FALLS, AND ARRIVE AT SOLUTIONS WHICH ARE COLLABOR ATIVE IN NATURE AVERA MCKENNAN COLLABORATES WITH LIVE WELL SIOUX FALLS TO PROMOTE THE BIG SQUEEZE, A HYPERTENSION INITIATIVE IN APRIL TO PROMOTE BLOOD PRESSURE SCREENING AND EDUCAT ION, WITH THE GOAL OF DIAGNOSING HIGH BLOOD PRESSURE ONE IN THREE AMERICAN ADULTS HAVE HI GH BLOOD PRESSURE, BUT ONLY HALF OF THEM HAVE IT UNDER CONTROL, ADDING TO THE RISK OF STRO KE, HEART ATTACK AND VASCULAR DISEASE RESIDENCY/HEALTH PROFESSIONS TRAINING AND INTERNSHIP S IN 2018, AVERA MCKENNAN HAD 62 MEDICAL RESIDENTS IN TRAINING AT AVERA MCKENNAN IN INTER NAL MEDICINE, FAMILY PRACTICE, PSYCHIATRY, GERIATRICS AND TRANSITIONAL RESIDENCY PROGRAMS OFFERED IN PARTNERSHIP WITH THE UNIVERSITY OF SOUTH DAKOTA SCHOOL OF MEDICINE OVER 1,000 STUDENTS IN MEDICINE, NURSING, PHARMACY, PHYSICIAN ASSISTANT PROGRAMS, MEDICAL ASSISTING, RADIOLOGY AND RESPIRATORY THERAPY ALSO COMPLETED CLINICAL ROTATIONS AT AVERA MCKENNAN IN NON-CLINICAL AREAS, AVERA MCKENNAN OFFERS UNPAID, PAID, AND NONPAID INTERNSHIPS IN THE ARE AS OF RESEARCH, FINANCE, ADMINISTRATION, THERAPIES, EXERCISE SCIENCE AND SOCIAL WORK AVER A MCKENNAN IS CURRENTLY LEGALLY AFFILIATED WITH APPROXIMATELY 158 INSTITUTIONS OF HIGHER E DUCATION PATIENT AND COMMUNITY EDUCATION AVERA MCKENNAN IS A REGIONAL LEADER IN OFFERING EDUCATIONAL PROGRAMS FOR A VARIETY OF LEARNERS, LEADERS AND EMPLOYEES UTILIZING ADVANCED TECHNOLOGY, MANY OF THESE PROGRAMS ARE PROVIDED ELECTRONICALLY THROUGHOUT THE TRI-STATE AR EA EDUCATIONAL SESSIONS ARE OFFERED TO MEDICAL STAFF, EMPLOYEES, HEALTH CARE PROFESSIONAL S, STUDENTS AT ALL LEVELS AND THE GENERAL PUBLIC UTILIZING AVERA MCKENNAN'S EDUCATION CEN TER, A BROAD CROSS-SECTION OF CLASSES INVOLVING DIVERSE AUDIENCES ARE PROVIDED AS A COMMUN ITY SERVICE EACH YEAR 1 ONLINE RESOURCES AVERA MCKENNAN OFFERS VAST FREE PATIENT EDUCATI ONAL ONLINE RESOURCES ON ITS PUBLIC WEBSITE ON NUMEROUS HEALTH TOPICS, WITH SUGGESTIONS FO R LIFESTYLE CHANGE, BEHAVIOR MODIFICATION AND MANAGEMENT FOR IMPROVED HEALTH 2 TO BE WELL FREE EDUCATION EVENTS WERE HELD ON TOPICS INCLUDING ORTHOPEDICS, CANCER, DIABETES, WEIGHT LOSS/HEALTHY EATING, MULTIPLE SCLEROSIS, ANXIETY AND ACUPUNCTURE 3 FORUMS THE AVERA BE HAVIORAL HEALTH CENTER OFFERS FREE FRIDAY FORUMS, IN WHICH SCHOOL COUNSELORS AND THERAPIST S ARE INVITED TO PRESENTATIONS ON CHILDREN'S MENTA

Form and Line Reference	Explanation
PART VI, LINE 5	L HEALTH TOPICS SUCH AS CONFLICT CYCLES, REACTIVE ATTACHMENT DISORDER, DEPRESSION AND BIPO LAR DISORDER IN CHILDREN, AND TEEN SUBSTANCE USE, ABUSE AND ADDICTION 4 THE AVERA BEHAVI ORAL HEALTH CENTER OFFERS FREE MONTHLY EDUCATIONAL SESSIONS ON VARIOUS TOPICS FOLLOWED BY DISCUSSION FOR ADULTS WHO HAVE BEEN IMPACTED BY A LOVED ONE'S MENTAL ILLNESS TOPICS HAVE INCLUDED GRIEF AND LOSS, ANXIETY, AND PARENTING STRATEGIES FOR MANAGING CHALLENGING BEHAVI ORS 5 WOMEN'S & CHILDREN'S SERVICES AVERA MCKENNAN'S WOMEN'S & CHILDREN'S SERVICES OFFER S A NUMBER OF PARENTING AND COMMUNITY EDUCATION OPPORTUNITIES, FOR FREE OR AT A MINIMAL CO ST IN FISCAL YEAR 2018, 85 CHILDBIRTH EDUCATION CLASSES WERE HELD WITH 389 ATTENDEES A T OTAL OF 7 PARENT AND FAMILY EDUCATION CLASSES WERE HELD WITH 89 ATTENDEES A TOTAL OF 54 C AR SEATS WERE ISSUED THROUGH THE SOUTH DAKOTA CHILD SAFETY SEAT DISTRIBUTION PROGRAM FREE BURN EDUCATION WAS PROVIDED TO 2,840 STUDENTS DURING PRESENTATIONS IN SCHOOLS 6 DAYCARE TRAINING FREE OF CHARGE, AVERA MCKENNAN OFFERS TWO IN-SERVICE TRAINING SESSIONS PER MONTH TO DAYCARE PROVIDERS THROUGH EMBE, WITH A TOTAL OF 18 SCHEDULED ANNUALLY, AND ADDITIONAL SESSIONS FOR REQUESTED TOPICS SUPPORT GROUPS AVERA MCKENNAN OFFERS APPROXIMATELY 10 FREE SUPPORT GROUPS THEY RANGE IN TOPIC FROM CANCER TO LIVER DISEASE, DIABETES, BONE MARROW T RANSPLANT, STROKE AND GRIEF AND LOSS THE ORGANIZATION PROVIDES FREE MEETING SPACE AS WELL AS SPEAKERS AND LEADERS INFORMATION AND ASSISTANCE AVERA MCKENNAN OPERATES A 24-HOUR ME DICAL CALL CENTER, THROUGH WHICH PATIENTS HAVE ACCESS TO THE ASK-A-NURSE PROGRAM PATIENTS CAN CALL A TOLL-FREE NUMBER AND TALK PERSONALLY WITH A REGISTERED NURSE TO ASK HEALTH QUE STIONS OR RECEIVE GENERAL HEALTH INFORMATION AVERA MCKENNAN'S WEB SITE ALSO PROVIDES AN E XTENSIVE HEALTH LIBRARY THAT CONSUMERS CAN ACCESS FREE OF CHARGE INTERPRETER SERVICE AVER A MCKENNAN EMPLOYS TWO FULL-TIME SPANISH INTERPRETERS IN-HOUSE, AND THEIR SERVICES ARE OFF ERED TO PATIENTS FREE OF CHARGE IN ADDITION, IN COOPERATION WITH EXTERNAL AGENCIES, AVERA MCKENNAN IS ABLE TO HANDLE 210 DIFFERENT LANGUAGES AND DIALECTS THROUGH PHONE, VIDEO REMO TE INTERPRETING AND OTHER MEANS INTERPRETATION SERVICES ARE AVAILABLE FOR PATIENTS WHEN T HEY ARE AT AVERA MCKENNAN IN PERSON, OR WHEN THEY CALL BY PHONE ALL THE ABOVE SERVICES AR E PROVIDED AT NO COST TO THE PATIENT

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 6	AVERA IS A SPONSORED MINISTRY OF THE BENEDICTINE AND PRESENTATION SISTERS THE COMMUNITIES IN WHICH AVERA OPERATES ALL HAVE UNIQUE HEALTH AND COMMUNITY BENEFIT NEEDS IN KEEPING WITH THE CATHOLIC HEALTHCARE ASSOCIATION GUIDELINES, EACH HOSPITAL STRIVES TO MEET ITS COMMUNITY'S IDENTIFIED NEEDS THE CORPORATE STAFF OF AVERA HEALTH ADVOCATES FOR ALL MEMBERS REGARDING COMMUNITY BENEFIT RELATED MATTERS OF STATE, REGIONAL AND NATIONAL IMPORTANCE

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 5, CONTINUED	TRANSPORT TO TRANSPLANT AVERA MCKENNAN DEVELOPED THE TRANSPORT TO TRANSPLANT PROJECT, WHICH REMOVES TRANSPORTATION BARRIERS FOR PATIENTS FROM RURAL AREAS WHICH MAY PREVENT THEM FROM COMPLETING THE EVALUATION AND TESTING NEEDED FOR KIDNEY AND/OR PANCREAS TRANSPLANT A VAN FUNDED THROUGH A GRANT FROM THE AVERA MCKENNAN FOUNDATION IS USED TO TRANSPORT PATIENTS WHO DEMONSTRATE A FINANCIAL NEED PATIENTS ARE BROUGHT TO THE AVERA TRANSPLANT INSTITUTE FOR A CONDENSED MULTI-DAY EVALUATION WITH ALL TESTING AND VISITS COMPLETED IN LESS THAN ONE WEEK ULTIMATELY, THE PROJECT RESULTS IN IMPROVED MORBIDITY AND MORTALITY, AS KIDNEY TRANSPLANT DOUBLES PATIENT SURVIVAL AS COMPARED TO REMAINING ON DIALYSIS AVERA FAMILY WELLNESS THIS PROGRAM COMBINES POSITIVE ACTIVITIES LIKE VIOLIN LESSONS AND FAMILY WELLNESS COORDINATION AT NO CHARGE FOR CHILDREN BEGINNING IN EARLY CHILDHOOD PROGRAMS IN THE SIOUX FALLS SCHOOL DISTRICT THE FAMILIES HAVE DIRECT ACCESS TO MENTAL HEALTH SERVICES WHEN NEEDED THE GOAL IS TO LESSEN THE NUMBER OF ADVERSE CHILDHOOD EXPERIENCES TO IMPROVE THE CHANCES FOR CHILDREN LIVING IN POVERTY TO BE SUCCESSFUL IN SCHOOL AND IN LIFE FAMILIES WITH THE MOST DIFFICULT SITUATIONS ARE BEING REFERRED BY THE SCHOOL DISTRICT CURRENTLY, OVER 350 STUDENTS AND THEIR FAMILIES ARE BEING SERVED BY THE PROGRAM THE WALSH FAMILY VILLAGE THIS HOSPITALITY HOUSE COMPLEX ADJACENT TO THE AVERA MCKENNAN CAMPUS PROVIDES A HOME AWAY FROM HOME FOR PATIENTS AND THEIR FAMILIES WHO COME FOR CARE AT AVERA MCKENNAN FROM OUTSIDE OF SIOUX FALLS THE PROJECT WAS FUNDED BY DONATIONS AND IS OPERATED BY AVERA MCKENNAN ELEVEN GUEST ROOMS ARE AVAILABLE AVERA MCKENNAN ALSO DONATES USE OF A BUILDING IN THE COMPLEX FOR A RONALD MCDONALD HOUSE FOR FAMILIES OF PEDIATRIC PATIENTS IF THEY CAN AFFORD IT, GUESTS ARE CHARGED A LOW FEE PER NIGHT GUESTS ARE NOT TURNED AWAY DUE TO INABILITY TO PAY THE FEE EMPLOYEES REGULARLY DONATE NON-PERISHABLE FOOD ITEMS TO STOCK A FOOD PANTRY FOR GUESTS IN FISCAL YEAR 2018, THE WALSH FAMILY VILLAGE SERVED 7,221 GUESTS, STAYING IN 4,015 NIGHTLY ROOMS, AN 88 PERCENT OCCUPANCY AVERA MCKENNAN PROVIDES A SUBSIDY OF APPROXIMATELY $239,858 PER YEAR TO OPERATE THE HOSPITALITY COMPLEX PREVENTION AND SUPPORT OF SUBSTANCE USE DISORDER AVERA MCKENNAN IS A PARTNER WITH FACE IT TOGETHER SIOUX FALLS, A NONPROFIT ORGANIZATION WHICH SERVES AS THE LOCAL FACE AND VOICE FOR RECOVERY FROM ADDICTION THROUGH ITS RECOVERY SUPPORT SERVICES, ADVOCACY AND AWARENESS PROGRAMS AVERA HAS BEEN A PARTNER WITH FACE IT TOGETHER SINCE ITS INCEPTION, AND IN A RECENT AWARENESS CAMPAIGN COMMUNITY CONNECTIONS AVERA MCKENNAN REACHES OUT TO PEOPLE AND COMMUNITIES THROUGHOUT EASTERN SOUTH DAKOTA, SOUTHWESTERN MINNESOTA AND NORTHWEST IOWA THROUGH HOME TOWN CONNECTIONS PROVIDING A CRITICAL FEEDBACK LINK TO LOCAL REFERRING DOCTORS, THIS PROGRAM COMPLETES THE COMMUNICATIONS LINKS NECESSARY TO KEEP LOCAL HEALTH CARE PROVIDERS CURRENT ON THE TREATMENT OF THEIR PATIENTS AT AVERA MCKENNAN SUPPORT OF THE ARTS AND CULTURAL LIFE AVERA MCKENNAN HOSTS SIOUX FALLS' ONLY INDOOR SCULPTUREWALK, AN EXTENSION OF THE COMMUNITY'S DOWNTOWN SCULPTUREWALK ARTISTS DONATE SCULPTURES FOR ONE YEAR, WHICH ARE PLACED AT LOCATIONS THROUGHOUT AVERA MCKENNAN'S CAMPUS, IN BUILDINGS CONNECTED BY SKYWALKS BROCHURES CONTAIN A MAP, AND VISITORS WHO FOLLOW THE ROUTE SUGGESTED WALK APPROXIMATELY 1 MILE, MAKING THIS A HEALTHY AS WELL AS A CULTURAL JOURNEY COMMUNITY BENEFITS AVERA MCKENNAN PROVIDES ADDITIONAL COMMUNITY BENEFITS INCLUDING SUPPORT OF YOUTH PROGRAMS, HOMELESS PROGRAMS, COMMUNITY ARTS PROGRAMMING, HEALTH PREVENTION, AWARENESS AND EDUCATION ABOUT CANCER, HEART DISEASE AND OTHER CONDITIONS, AND SUPPORT OF THE SIOUX EMPIRE UNITED WAY AND OTHER SERVICES IN THE REGION PRESCHOOL VISION AND HEARING SCREENING AVERA MCKENNAN PROVIDED FREE SCREENING FOR 1,150 PRESCHOOL AND GRADE SCHOOL CHILDREN IN FISCAL YEAR 2018

Additional Data

Software ID:
Software Version:
EIN: 46-0224743
Name: AVERA MCKENNAN

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

Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? **7** Name, address, primary website address, and state license number		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	**Other (Describe)**	**Facility reporting group**
1	AVERA MCKENNAN 1325 S CLIFF AVE SIOUX FALLS, SD 57117 WWW AVERA ORG/MCKENNAN 10563	X	X	X	X		X	X		35 PROVIDER BASED CLINICS	
2	HEART HOSPITAL OF SOUTH DAKOTA LLC 4500 W 69TH STREET SIOUX FALLS, SD 57108 WWW AVERA ORG/HEART-HOSPITAL 41953	X	X					X		2/3 OWNER IN JOINT VENTURE	
3	AVERA MILBANK AREA HOSPITAL 901 VIRGIL AVE MILBANK, SD 57252 WWW AVERA ORG/MILBANK 48451	X	X			X		X		2 PROVIDER BASED CLINICS & 2 RURAL HEALTH PB CLINICS	
4	AVERA GREGORY HEALTHCARE CENTER 400 PARK AVE GREGORY, SD 57533 WWW AVERA ORG/GREGORY-HOSPITAL 54875	X	X			X		X		2 PROVIDER BASED CLINICS & 2 RURAL HEALTH PB CLINICS	
5	AVERA DELLS AREA HEALTH CENTER 909 N IOWA AVENUE DELL RAPIDS, SD 57022 WWW AVERA ORG/DELL-RAPIDS 50754	X	X			X		X		3 PROVIDER BASED CLINICS	

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

Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? **7** Name, address, primary website address, and state license number		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	**Other (Describe)**	**Facility reporting group**
6	AVERA FLANDREAU MEDICAL CENTER 214 N PRAIRIE FLANDREAU, SD 57028 WWW AVERA ORG/FLANDREAU-MEDICAL 10540	X	X			X		X		1 RURAL HEALTH PROVIDER BASED CLINIC	
7	AVERA HAND COUNTY MEMORIAL HOSPITAL 300 W 5TH ST MILLER, SD 57362 WWW AVERA ORG/MILLER 53862	X	X			X		X		1 PROVIDER BASED CLINIC	

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
AVERA MCKENNAN	PART V, SECTION B, LINE 5 IN CONDUCTING THE MOST RECENT CHNA, AVERA MCKENNAN SOLICITED COMMUNITY INPUT IN A VARIETY OF METHODS A GENERALIZABLE SURVEY OF RESIDENTS IN THE SIOUX FALLS METROPOLITAN STATISTICAL AREA WAS CONDUCTED IN MARCH 2015 THREE FOCUS GROUP INTERVIEWS WERE CONDUCTED IN MAY 2015 INDIVIDUAL INTERVIEWS WITH 13 COMMUNITY LEADERS WERE HELD REPRESENTING INTERESTS IN BANKING, BUSINESS, NONPROFIT HUMAN SERVICES, NONPROFIT CHILD CARE SERVICES, COMMUNITY COLLEGE ADMINISTRATION, COMMUNITY COLLEGE STUDENT, MINORITY HEALTH CARE PROVIDER, FAITH BASED HUMAN SERVICES AND HEALTH CARE PUBLIC POLICY WERE HELD IN JUNE-AUGUST 2015 SOUTH DAKOTA GOOD & HEALTH COMMUNITY CHECKLIST WAS USED TO CONDUCT ASSESSMENTS COVERING WORKSITE, HEALTH CARE, COMMUNITY AND SCHOOL SECTORS
HEART HOSPITAL OF SOUTH DAKOTA, LLC	PART V, SECTION B, LINE 5 IN CONDUCTING THE MOST RECENT CHNA, HEART HOSPITAL OF SOUTH DAKOTA, LLC, SOLICITED COMMUNITY INPUT IN A VARIETY OF METHODS A GENERALIZABLE SURVEY OF RESIDENTS IN THE SIOUX FALLS METROPOLITAN STATISTICAL AREA WAS CONDUCTED IN MARCH 2015 THREE FOCUS GROUP INTERVIEWS WERE CONDUCTED IN MAY 2015 INDIVIDUAL INTERVIEWS WITH 13 COMMUNITY LEADERS WERE HELD REPRESENTING INTERESTS IN BANKING, BUSINESS, NONPROFIT HUMAN SERVICES, NONPROFIT CHILD CARE SERVICES, COMMUNITY COLLEGE ADMINISTRATION, COMMUNITY COLLEGE STUDENT, MINORITY HEALTH CARE PROVIDER, FAITH BASED HUMAN SERVICES AND HEALTH CARE PUBLIC POLICY WERE HELD IN JUNE-AUGUST 2015 SOUTH DAKOTA GOOD & HEALTH COMMUNITY CHECKLIST WAS USED TO CONDUCT ASSESSMENTS COVERING WORKSITE, HEALTH CARE, COMMUNITY AND SCHOOL SECTORS

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
AVERA GREGORY HEALTHCARE CENTER	PART V, SECTION B, LINE 5 COMMUNITY INPUT WAS SOLICITED USING FOCUS GROUPS, PERSONAL INTERVIEWS AND GOVERNMENT MEETINGS FOCUS GROUPS INCLUDED TWO GROUPS COVERING A VARIETY OF COMMUNITY MEMBERS AND A THIRD GROUP COMPRISED OF SCHOOL BOARD MEMBERS, PRINCIPALS AND SUPERINTENDENT OF SCHOOLS PERSONAL INTERVIEWS WERE ALSO CONDUCTED WITH THE LEADERS OF THE LOCAL FOOD BANK, THRIFT CLOTHING STORE AND SENIOR MEALS CENTER CHNA TEAM MEMBERS ALSO ATTENDED LOCAL AND COUNTY GOVERNMENT MEETINGS TO SOLICIT FEEDBACK
AVERA MILBANK AREA HOSPITAL	PART V, SECTION B, LINE 5 COMMUNITY INPUT WAS SOLICITED THROUGH SURVEYS AND PERSONAL INTERVIEWS THE FACILITY SURVEYED COMMUNITY MEMBERS USING BOTH ONLINE AND PRINTED SURVEYS PERSONAL INTERVIEWS WERE CONDUCTED WITH THE HIGH SCHOOL PRINCIPAL, SCHOOL DISTRICT SUPERINTENDENT, COMMUNITY HEALTH NURSE AND DIRECTOR OF INTER-LAKES COMMUNITY ACTION PARTNERSHIP

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
AVERA DELLS AREA HEALTH CENTER	PART V, SECTION B, LINE 5 COMMUNITY INPUT WAS SOLICITED USING A VARIETY OF METHODS THE FACILITY DISTRIBUTED AND COLLECTED COMMUNITY SURVEYS IN FEBRUARY 2016 IN MARCH 2016, THREE FOCUS GROUPS REPRESENTING A VARIETY OF COMMUNITY RESIDENTS WERE HELD AN INDIVIDUAL INTERVIEW WAS HELD WITH MOODY COUNTY COMMUNITY SERVICES MANAGER DATA WAS ALSO GATHERED FROM AVERA MEDICAL GROUP DELL RAPIDS MEDICAL STAFF AND CLINIC MANAGER, AND AVERA DELLS AREA HOSPITAL INTERIM ADMINISTRATOR AND DIRECTOR OF NURSING
AVERA FLANDREAU MEDICAL CENTER	PART V, SECTION B, LINE 5 COMMUNITY INPUT WAS SOLICITED USING FOCUS GROUPS AND A SURVEY THREE FOCUS GROUPS OF INDIVUDALS WITH A VESTED INTEREST IN THE HOSPITAL AND HEALTH OF THE COUNTY PARTICIPATED COMMUNITY SURVEYS WERE CONDUCTED IN AUGUST 2015 A COMMUNITY COALITION WAS CREATED WITH A CORE OF TEN COMMUNITY LEADERS ALONG WITH AN ADDITIONAL GROUP OF 40 COMMUNITY LEADERS WHO ACTIVELY ENGAGED IN PRIMARY DATA COLLECTION

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
AVERA HAND COUNTY MEMORIAL HOSPITAL	PART V, SECTION B, LINE 5 THE HOSPITAL USED A SURVEY TOOL TO BEGIN THE PROCESS OF QUALITATIVE DATA COLLECTION THE SURVEY WAS AVAILABLE TO HAND COUNTY COMMUNITY HEALTH STAFF, MILLER AREA HEALTH BOARD, MILLER SENIOR CITIZENS AND HOSPITAL AUXILIARY MEMBERS DURING WINTER OF 2015 THESE GROUPS REPRESENTED A CROSS SECTION OF THE COMMUNITY SERVED IN ADDITION, COMMUNITY SMALL GROUPS WERE SELECTED FOR PRESENTATION AND DIALOGUE THESE CONSISTED OF AHCMH AUXILIARY, FOUNDATION COMMITTEE MEMBERS, MILLER SCHOOL GUIDANCE COUNSELOR, ON HAND DEVELOPMENT LEADERSHIP AND HAND COUNTY PUBLIC HEALTH NURSE
AVERA MCKENNAN	PART V, SECTION B, LINE 6A THE CHNA WAS CONDUCTED WITH HEART HOSPITAL OF SOUTH DAKOTA, LLC AND SANFORD USD MEDICAL CENTER

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
HEART HOSPITAL OF SOUTH DAKOTA, LLC	PART V, SECTION B, LINE 6A THE CHNA WAS CONDUCTED WITH AVERA MCKENNAN HOSPITAL AND UNIVERSITY HEALTH CENTER AND SANFORD USD MEDICAL CENTER
AVERA MCKENNAN	PART V, SECTION B, LINE 6B SIOUX FALLS HEALTH DEPARTMENT

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
HEART HOSPITAL OF SOUTH DAKOTA, LLC	PART V, SECTION B, LINE 6B SIOUX FALLS HEALTH DEPARTMENT
AVERA MCKENNAN	PART V, SECTION B, LINE 11 AVERA MCKENNAN ADOPTED AN IMPLEMENTATION STRATEGY TO ADDRESS THREE HIGHLY IDENTIFIED NEEDS IN THE 2015 CHNA CONDUCTED IN FY2016 THOSE NEEDS ARE OBESITY (INCLUDES NUTRITION, PHYSICAL ACTIVITY AND OTHER CHRONIC DISEASE RISK FACTORS), MENTAL HEALTH SERVICES AND SUBSTANCE ABUSE AND ACCESS TO CARE (INCLUDES ISSUES SUCH AS AVAILABILITY, COST AND COORDINATION OF CARE) IN FY2018 A COMMUNITY BEHAVIORAL HEALTH TASK FORCE WAS ORGANIZED WITH AVERA MCKENNAN BEHAVIORAL HEALTH LEADERSHIP PARTICIPATING THE TASK FORCE IS WORKING TO DEFINE THE COMMUNITY'S BEHAVIORAL HEALTH STATUS, DEMOGRAPHICS AND ISSUES AND DEVELOPING AN ACTION PLAN THIS INVOLVES 12 OTHER HEALTH CARE, NON-PROFIT AND CITY AGENCIES AVERA MCKENNAN PARTICIPATED IN THE HAYWARD THRIVE PROJECT, EDUCATING AN UNDERSERVED NEIGHBORHOOD ON FOOD PREPARATION, GARDENING, GROCERY SHOPPING, WELLNESS SCREENINGS AND COMMUNITY ENGAGEMENT ALONG WITH A BLOCK PARTY THE ORGANIZATION CONTINUES TO SUPPORT THE SIOUX EMPIRE NETWORK OF CARE DEVELOPMENT AND EXPANSION TO COORDINATE CARE ACCESS THE FACILITY ALSO PILOTED A PROJECT TO ADDRESS TRANSPORTATION FOR APPOINTMENTS AND ACCESS TO MEDICATIONS RESULTS OF THE PILOT WERE MIXED, BUT LYFT ENTERED THE SIOUX FALLS MARKET IN 2018 AND SINCE THEN AVERA MCKENNAN HAS SUBSIDIZED OVER 2,000 PATIENT RIDES AVERA WORKED WITH A LOCAL GROCER, PAROCHIAL GRADE SCHOOL AND LOCAL NON-PROFIT GROUNDWORKS, TO PROVIDE THIRD GRADERS WITH MONTHLY EDUCATION ON HEALTH/WELLNESS, FOOD CHOICES AND PREPARATION AND EXERCISE YOUTH, EDUCATION, AND HOUSING WERE IDENTIFIED BUT WILL NOT BE DIRECTLY ADDRESSED OTHER ORGANIZATIONS IN THE COMMUNITY ARE ADDRESSING THESE CONCERNS THESE AREAS ALSO FALL OUTSIDE OF OUR AREA OF EXPERTISE AND THOSE AGENCIES ARE BETTER EQUIPPED TO HANDLE THE SPECIFIC ISSUES FINALLY, WITH FINITE RESOURCES THE DECISION WAS MADE TO FOCUS ON NO MORE THAN THE FIVE INITIATIVES IN ORDER TO MAKE THE GREATEST IMPACT

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
HEART HOSPITAL OF SOUTH DAKOTA, LLC	PART V, SECTION B, LINE 11 HEART HOSPITAL OF SOUTH DAKOTA, LLC ADOPTED AN IMPLEMENTATION STRATEGY IN FY2016 TO ADDRESS THREE HIGHLY IDENTIFIED NEEDS THOSE NEEDS ARE OBESITY (INCLUDES NUTRITION, PHYSICAL ACTIVITY AND OTHER CHRONIC DISEASE RISK FACTORS), MENTAL HEALTH SERVICES AND SUBSTANCE ABUSE AND ACCESS TO CARE (INCLUDES ISSUES SUCH AS AVAILABILITY, COST AND COORDINATION OF CARE) IN FY2018, HEART HOSPITAL PARTICIPATED IN THE HAYWARD THRIVE PROJECT, EDUCATING AN UNDERSERVED NEIGHBORHOOD ON FOOD PREPARATION, GARDENING, GROCERY SHOPPING, WELLNESS SCREENINGS AND COMMUNITY ENGAGEMENT ALONG WITH A BLOCK PARTY THE FACILITY CONTINUES TO EXPLORE AVENUES TO ADDRESS TRANSPORTATION FOR PATIENTS THROUGH THE CITY AND ASSOCIATION WITH AVERA MCKENNAN HEART HOSPITAL CONTINUES TO WORK ON IMPLEMENTATION OF AND PARTICIPATION IN PLANS TO ADDRESS COMMUNITY EDUCATION ON OBESITY AND ASSOCIATED FACTORS ALONG WITH ACCESS TO CARE HEART HOSPITAL EDUCATES YOUTH ABOUT HEALTHY HEARTS THROUGH THE MEGA HEART TOUR AND PARTNERS WITH SIOUX FALLS FIRE AND RESCUE AND OTHER FIRST RESPONDERS TO TEACH CHILDREN THE BASICS OF HANDS-ONLY CPR YOUTH AND EDUCATION AND HOUSING WERE IDENTIFIED BUT WILL NOT BE DIRECTLY ADDRESSED OTHER ORGANIZATIONS IN THE COMMUNITY ARE ADDRESSING THESE CONCERNS THESE AREAS ALSO FALL OUTSIDE OF OUR CORE AREA OF EXPERTISE AND THOSE AGENCIES ARE BETTER EQUIPPED TO HANDLE THE SPECIFIC ISSUES FINALLY, WITH FINITE RESOURCES, THE DECISION WAS MADE TO FOCUS ON NO MORE THAN THE FIVE INITIATIVES IN ORDER TO MAKE THE GREATEST IMPACT
AVERA GREGORY HEALTHCARE CENTER	PART V, SECTION B, LINE 11 AVERA GREGORY ADOPTED AN IMPLEMENTATION PLAN IN FY2016 TO ADDRESS THREE IDENTIFIED NEEDS COMMUNITY MEMBERS WITH DISABILITIES, ENROLLMENT AND ACCESS TO HEALTH INSURANCE, OBESITY/DIABETES AND TOBACCO USE FY2018 UPDATES ARE AS FOLLOWS THE FACILITY IS CONTINUING TO USE A FEASIBILITY STUDY THAT IT COMMISSIONED, AND A COMMUNITY SURVEY WAS CONDUCTED IN CONCERT WITH PLANS FOR A NEW FACILITY THAT WILL ALLOW US TO OFFER MORE PREVENTATIVE MEDICINE INTERVENTIONS IN THE FUTURE WE CONTINUE TO GROW OUR RESPIRATORY THERAPY PROGRAM WITH THE HIRE OF A FULL TIME RESPIRATORY THERAPIST IN ADDITION, WE HAVE EMPLOYED A MASTERS LEVEL ATHLETIC TRAINER TO PROVIDE EDUCATION ON EXERCISE TO THE LOCAL SCHOOLS AND WORK WITH STUDENT ATHLETES THROUGHOUT THE YEAR CONTRIBUTING TO A LIFELONG FITNESS CULTURE THE ADMINISTRATOR AND MAYOR CONTINUE DISCUSSIONS ON EXERCISE TRAILS AND FACILITIES THE ADMINISTRATION HAS WORKED IN PARTNERSHIP WITH THE BUSINESS DEVELOPMENT GROUP AND THE CITY GOVERNMENT IN ORDER TO BUILD A STRATEGIC PLAN AND DEVELOP THE COMMUNITY'S INFRASTRUCTURE THIS WILL ALLOW THE DEVELOPMENT OF MORE GREEN SPACE AND OUTSIDE ACTIVITIES THAT CONTRIBUTE TO THE GOALS LISTED ABOVE THE FACILITY HAS SPONSORED SIX COMMUNITY MEALS TO DEMONSTRATE PROPER NUTRITION AND HEALTHY COOKING HABITS IN THE COMMUNITY THIS YEAR TOBACCO CESSATION EDUCATION IS OFFERED AT EVERY CLINICAL VISIT FOR PATIENTS WHO SMOKE CPR TRAINING WAS ALSO PROVIDED TO HIGH SCHOOL SENIORS

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
AVERA MILBANK AREA HOSPITAL	PART V, SECTION B, LINE 11 AVERA MILBANK ADOPTED AN IMPLEMENTATION PLAN IN FY2016 TO ADDRESS THREE IDENTIFIED NEEDS MENTAL HEALTH, TRANSLATION SERVICES AND PATIENT EDUCATION 1) MENTAL HEALTH NEEDS FY2018 - WE SUCCESSFULLY ON-BOARDED A PSYCHOLOGIST WHO KEEPS A VERY FULL SCHEDULE ASSISTING THOSE IN NEED WE ALSO CONTINUE TO BE AN ACTIVE MEMBER IN THOSE COMMUNITY ORGANIZATIONS WHO HAVE THE SAME GOAL TO IMPROVE THE MENTAL HEALTH OF OUR COMMUNITY 2) TELEPHONIC TRANSLATION SERVICES FY2018 - WE CONTINUE TO UTILIZE THE SAME RESOURCES AS FY2017 3) COMMUNITY EDUCATION FY2018 - OUR FACILITY HOSTED AND PARTICIPATED IN EDUCATION SESSIONS TO COMMUNITY MEMBERS THESE WE GEARED TOWARD ALL AGES AND TOPICS FROM A CANCER SUPPORT GROUP TO A WOMEN'S EVENT COVERING PARENTING, WOMEN'S, AND WELLNESS MEDICAL SCREENING TOPICS
AVERA DELLS AREA HEALTH CENTER	PART V, SECTION B, LINE 11 AVERA DELLS ADOPTED AN IMPLEMENTATION PLAN IN FY2016 TO ADDRESS THREE IDENTIFIED NEEDS PUBLIC AWARENESS OF HEALTH CARE SERVICES, IMPROVEMENT OF LOCAL/EMERGENCY TRANSPORTATION SERVICES AND EDUCATION/MOTIVATION ON HEALTHIER LIFESTYLES FOR COMMUNITY MEMBERS DURING FY2018 THE FACILITY CONTINUES TO PARTICIPATE AND SUPPORT LOCAL COMMUNITY EVENTS THE LOCAL NEWSPAPER IS UTILIZED FOR FACILITY ARTICLES, AND ONLINE TOOLS ARE USED TO PROMOTE HEALTHCARE SERVICES AWARENESS THE FACILITY CONTINUES TO USE THE ON-CAMPUS HELICOPTER FOR EMERGENT PATIENT TRANSPORT FREE 30-DAY GYM MEMBERSHIPS WERE GIVEN TO NEW COMMUNITY MEMBERS EXERCISE EQUIPMENT IS CONTINUALLY DONATED TO LOCAL SCHOOLS FREE DIETARY CONSULTS WERE PROVIDED TO IDENTIFIED PATIENTS AND PARTICIPATION IN LOCAL WELLNESS ACTIVITIES CONDUCTED GREATER CONVENIENCE TO CARE WAS IDENTIFIED IN THE ASSESSMENT BUT WILL NOT BE FURTHER ADDRESSED BY THE FACILITY CLINIC HOURS ALREADY INCLUDE EXPANSION TO HOURS OUTSIDE OF 8-5 AND THE CLINIC DOES NOT HAVE THE FINANCIAL RESOURCES TO EXPAND FURTHER

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
AVERA FLANDREAU MEDICAL CENTER	PART V, SECTION B, LINE 11 AVERA FLANDREAU ADOPTED AN IMPLEMENTATION PLAN IN FY2016 TO ADDRESS FIVE IDENTIFIED NEEDS NUTRITION, PHYSICAL ACTIVITY, CHRONIC DISEASE PREVENTION/MANAGEMENT, PUBLIC AWARENESS AND GREATER CONVENIENCE OF CARE DURING FY2018 THE FACILITY CONTINUED FREE DIETARY CONSULTATIONS BY A REGISTERED DIETICIAN TO COMMUNITY MEMBERS THE PUBLIC HEALTH OFFICE PROVIDED NUTRITION EDUCATION THROUGHOUT THE SCHOOL YEAR AT THE LOCAL ELEMENTARY SCHOOL AND VARIETY OF HEALTH AND CAREER TOPICS TO HIGH SCHOOL STUDENTS PROVIDERS WERE EDUCATED ON COORDINATED CARE SERVICES AND THE HEALTH TRACKER TOOL AND COORDINATORS ARE PHYSICALLY ON SITE EVERY OTHER WEEK THE FACILITY CONTINUES TO PROMOTE, SUPPORT AND PARTICIPATE IN COMMUNITY WELLNESS ACTIVITIES AND PROVIDE SCREENING SERVICES AT LOCAL EVENTS A NEW WEBSITE CONTINUES TO BE USED AND EFFORTS CONTINUE IN A VARIETY OF AVENUES TO PROMOTE HEALTH CARE SERVICES AWARENESS EARLY CLINIC HOURS HAVE BEEN ADDED, SCREENING AVAILABILITY EXPANDED AND A FOURTH PROVIDER ADDED TO EXPAND CARE OPTIONS
AVERA HAND COUNTY MEMORIAL HOSPITAL	PART V, SECTION B, LINE 11 AVERA HAND COUNTY ADOPTED AN IMPLEMENTATION PLAN IN FY2016 TO ADDRESS THREE IDENTIFIED NEEDS ASSISTANCE NAVIGATING MEDICAL RECORDS THROUGH PATIENT PORTAL/HOSPITAL WEBSITE, ACCESS TO PUBLIC TRANSPORTATION AND ACCESS TO AFFORDABLE HOUSING DURING FY2018, MULTIPLE EDUCATION PROGRAMS HAVE BEEN HELD AT THE FACILITY TO EDUCATE COMMUNITY MEMBERS ON PORTAL SERVICES, BENEFITS OF SIGNUP AND CONTINUED ACCESS AS WELL AS AT LOCAL FARM SHOW, AND ONE ON ONE EDUCATION WHEN NEEDED PROVIDERS AND SUPERVISORS HAVE BEEN EDUCATED ON THE TRANSPORTATION PROVIDERS, THEIR SCHEDULES AND CHANGES, AND OFFER TRANSPORTATION ASSISTANCE TO THOSE WHO NEED THE SERVICE THE ADMINISTRATOR SERVES ON THE LOCAL HOUSING DEVELOPMENT AND HOUSING COMMITTEES WORKING WITH THE CITY TO DEVELOP AFFORDABLE HOUSING OPPORTUNITIES IN THE REGION

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
AVERA MCKENNAN	PART V, SECTION B, LINE 13H PRESUMPTIVE CHARITY CARE MAY BE APPLIED IN SITUATIONS WHERE ALL OTHER AVENUES OF FINANCIAL ASSISTANCE HAVE BEEN EXHAUSTED THE FACILITY HAS THE DISCRETION TO WEIGH EXTENUATING CIRCUMSTANCES WHEN DETERMINING ELIGIBILITY FOR AND THE AMOUNT OF CHARITY CARE TO PROVIDE
HEART HOSPITAL OF SOUTH DAKOTA, LLC	PART V, SECTION B, LINE 13H PRESUMPTIVE CHARITY CARE MAY BE APPLIED IN SITUATIONS WHERE ALL OTHER AVENUES OF FINANCIAL ASSISTANCE HAVE BEEN EXHAUSTED THE FACILITY HAS THE DISCRETION TO WEIGH EXTENUATING CIRCUMSTANCES WHEN DETERMINING ELIGIBILITY FOR AND THE AMOUNT OF CHARITY CARE TO PROVIDE

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
AVERA GREGORY HEALTHCARE CENTER	PART V, SECTION B, LINE 13H PRESUMPTIVE CHARITY CARE MAY BE APPLIED IN SITUATIONS WHERE ALL OTHER AVENUES OF FINANCIAL ASSISTANCE HAVE BEEN EXHAUSTED THE FACILITY HAS THE DISCRETION TO WEIGH EXTENUATING CIRCUMSTANCES WHEN DETERMINING ELIGIBILITY FOR AND THE AMOUNT OF CHARITY CARE TO PROVIDE
AVERA MILBANK AREA HOSPITAL	PART V, SECTION B, LINE 13H PRESUMPTIVE CHARITY CARE MAY BE APPLIED IN SITUATIONS WHERE ALL OTHER AVENUES OF FINANCIAL ASSISTANCE HAVE BEEN EXHAUSTED THE FACILITY HAS THE DISCRETION TO WEIGH EXTENUATING CIRCUMSTANCES WHEN DETERMINING ELIGIBILITY FOR AND THE AMOUNT OF CHARITY CARE TO PROVIDE

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
AVERA DELLS AREA HEALTH CENTER	PART V, SECTION B, LINE 13H PRESUMPTIVE CHARITY CARE MAY BE APPLIED IN SITUATIONS WHERE ALL OTHER AVENUES OF FINANCIAL ASSISTANCE HAVE BEEN EXHAUSTED THE FACILITY HAS THE DISCRETION TO WEIGH EXTENUATING CIRCUMSTANCES WHEN DETERMINING ELIGIBILITY FOR AND THE AMOUNT OF CHARITY CARE TO PROVIDE
AVERA FLANDREAU MEDICAL CENTER	PART V, SECTION B, LINE 13H PRESUMPTIVE CHARITY CARE MAY BE APPLIED IN SITUATIONS WHERE ALL OTHER AVENUES OF FINANCIAL ASSISTANCE HAVE BEEN EXHAUSTED THE FACILITY HAS THE DISCRETION TO WEIGH EXTENUATING CIRCUMSTANCES WHEN DETERMINING ELIGIBILITY FOR AND THE AMOUNT OF CHARITY CARE TO PROVIDE

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
AVERA HAND COUNTY MEMORIAL HOSPITAL	PART V, SECTION B, LINE 13H PRESUMPTIVE CHARITY CARE MAY BE APPLIED IN SITUATIONS WHERE ALL OTHER AVENUES OF FINANCIAL ASSISTANCE HAVE BEEN EXHAUSTED THE FACILITY HAS THE DISCRETION TO WEIGH EXTENUATING CIRCUMSTANCES WHEN DETERMINING ELIGIBILITY FOR AND THE AMOUNT OF CHARITY CARE TO PROVIDE
AVERA MCKENNAN	PART V, SECTION B, LINE 16J A SUMMARY OF THE FINANCIAL ASSISTANCE POLICY IS POSTED IN THE HOSPITAL FACILITY'S EMERGENCY ROOMS, WAITING ROOMS, AND ADMISSIONS OFFICE AND INCLUDED ON THE BILLING STATEMENT IN ADDITION, THE FINANCIAL ASSISTANCE POLICY IS DISCUSSED WITH THE PATIENT UPON ADMISSION TO THE FACILITY

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
HEART HOSPITAL OF SOUTH DAKOTA, LLC	PART V, SECTION B, LINE 16J A SUMMARY OF THE FINANCIAL ASSISTANCE POLICY IS POSTED IN THE HOSPITAL FACILITY'S EMERGENCY ROOMS, WAITING ROOMS, AND ADMISSIONS OFFICE AND INCLUDED ON THE BILLING STATEMENT
AVERA GREGORY HEALTHCARE CENTER	PART V, SECTION B, LINE 16J A SUMMARY OF THE FINANCIAL ASSISTANCE POLICY IS POSTED IN THE HOSPITAL FACILITY'S EMERGENCY ROOMS, WAITING ROOMS, AND ADMISSIONS OFFICE AND INCLUDED ON THE BILLING STATEMENT IN ADDITION, THE FINANCIAL ASSISTANCE POLICY IS DISCUSSED WITH THE PATIENT UPON ADMISSION TO THE FACILITY

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
AVERA MILBANK AREA HOSPITAL	PART V, SECTION B, LINE 16J A SUMMARY OF THE FINANCIAL ASSISTANCE POLICY IS POSTED IN THE HOSPITAL FACILITY'S EMERGENCY ROOMS, WAITING ROOMS, AND ADMISSIONS OFFICE AND INCLUDED ON THE BILLING STATEMENT IN ADDITION, THE FINANCIAL ASSISTANCE POLICY IS DISCUSSED WITH THE PATIENT UPON ADMISSION TO THE FACILITY
AVERA DELLS AREA HEALTH CENTER	PART V, SECTION B, LINE 16J A SUMMARY OF THE FINANCIAL ASSISTANCE POLICY IS POSTED IN THE HOSPITAL FACILITY'S EMERGENCY ROOMS, WAITING ROOMS, AND ADMISSIONS OFFICE AND INCLUDED ON THE BILLING STATEMENT IN ADDITION, THE FINANCIAL ASSISTANCE POLICY IS DISCUSSED WITH THE PATIENT UPON ADMISSION TO THE FACILITY

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

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Form and Line Reference	Explanation
AVERA FLANDREAU MEDICAL CENTER	PART V, SECTION B, LINE 16J A SUMMARY OF THE FINANCIAL ASSISTANCE POLICY IS POSTED IN THE HOSPITAL FACILITY'S EMERGENCY ROOMS, WAITING ROOMS, AND ADMISSIONS OFFICE AND INCLUDED ON THE BILLING STATEMENT IN ADDITION, THE FINANCIAL ASSISTANCE POLICY IS DISCUSSED WITH THE PATIENT UPON ADMISSION TO THE FACILITY
AVERA HAND COUNTY MEMORIAL HOSPITAL	PART V, SECTION B, LINE 16J A SUMMARY OF THE FINANCIAL ASSISTANCE POLICY IS POSTED IN THE HOSPITAL FACILITY'S EMERGENCY ROOMS, WAITING ROOMS, AND ADMISSIONS OFFICE AND INCLUDED ON THE BILLING STATEMENT IN ADDITION, THE FINANCIAL ASSISTANCE POLICY IS DISCUSSED WITH THE PATIENT UPON ADMISSION TO THE FACILITY

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
AVERA MCKENNAN	PART V, SECTION B, LINE 20E IF A PATIENT IS SELF-PAY AND HAS A LARGE BALANCE, AN AVERA PATIENT ADVOCATE WILL HELP THEM APPLY FOR OTHER FORMS OF ASSISTANCE IF THEY ARE NOT ELIGIBLE FOR ANY OTHER COVERAGE, THE PATIENT IS GIVEN A FINANCIAL ASSISTANCE APPLICATION TO COMPLETE AND RETURN TO THE FACILITY
HEART HOSPITAL OF SOUTH DAKOTA, LLC	PART V, SECTION B, LINE 20E IF A PATIENT IS SELF-PAY AND HAS A LARGE BALANCE, AN AVERA PATIENT ADVOCATE WILL HELP THEM APPLY FOR OTHER FORMS OF ASSISTANCE IF THEY ARE NOT ELIGIBLE FOR ANY OTHER COVERAGE, THE PATIENT IS GIVEN A FINANCIAL ASSISTANCE APPLICATION TO COMPLETE AND RETURN TO THE FACILITY

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
AVERA GREGORY HEALTHCARE CENTER	PART V, SECTION B, LINE 20E IF A PATIENT IS SELF-PAY AND HAS A LARGE BALANCE, AN AVERA PATIENT ADVOCATE WILL HELP THEM APPLY FOR OTHER FORMS OF ASSISTANCE IF THEY ARE NOT ELIGIBLE FOR ANY OTHER COVERAGE, THE PATIENT IS GIVEN A FINANCIAL ASSISTANCE APPLICATION TO COMPLETE AND RETURN TO THE FACILITY
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Form 990 Part V Section C Supplemental Information for Part V, Section B.

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Form and Line Reference	Explanation
AVERA DELLS AREA HEALTH CENTER	PART V, SECTION B, LINE 20E IF A PATIENT IS SELF-PAY AND HAS A LARGE BALANCE, AN AVERA PATIENT ADVOCATE WILL HELP THEM APPLY FOR OTHER FORMS OF ASSISTANCE IF THEY ARE NOT ELIGIBLE FOR ANY OTHER COVERAGE, THE PATIENT IS GIVEN A FINANCIAL ASSISTANCE APPLICATION TO COMPLETE AND RETURN TO THE FACILITY
AVERA FLANDREAU MEDICAL CENTER	PART V, SECTION B, LINE 20E IF A PATIENT IS SELF-PAY AND HAS A LARGE BALANCE, AN AVERA PATIENT ADVOCATE WILL HELP THEM APPLY FOR OTHER FORMS OF ASSISTANCE IF THEY ARE NOT ELIGIBLE FOR ANY OTHER COVERAGE, THE PATIENT IS GIVEN A FINANCIAL ASSISTANCE APPLICATION TO COMPLETE AND RETURN TO THE FACILITY

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
AVERA HAND COUNTY MEMORIAL HOSPITAL	PART V, SECTION B, LINE 20E IF A PATIENT IS SELF-PAY AND HAS A LARGE BALANCE, AN AVERA PATIENT ADVOCATE WILL HELP THEM APPLY FOR OTHER FORMS OF ASSISTANCE IF THEY ARE NOT ELIGIBLE FOR ANY OTHER COVERAGE, THE PATIENT IS GIVEN A FINANCIAL ASSISTANCE APPLICATION TO COMPLETE AND RETURN TO THE FACILITY
AVERA MCKENNAN	PART V, SECTION B, LINE 24 THE HOSPITAL FINANCIAL ASSISTANCE POLICY DOES NOT COVER ELECTIVE PROCEDURES THE HOSPITAL MAY HAVE CHARGED FAP ELIGIBLE PATIENTS GROSS CHARGES FOR SERVICES THAT ARE NOT COVERED UNDER THE FINANCIAL ASSISTANCE POLICY

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
HEART HOSPITAL OF SOUTH DAKOTA, LLC	PART V, SECTION B, LINE 24 THE HOSPITAL FINANCIAL ASSISTANCE POLICY DOES NOT COVER ELECTIVE PROCEDURES THE HOSPITAL MAY HAVE CHARGED FAP ELIGIBLE PATIENTS GROSS CHARGES FOR SERVICES THAT ARE NOT COVERED UNDER THE FINANCIAL ASSISTANCE POLICY
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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
AVERA MILBANK AREA HOSPITAL	PART V, SECTION B, LINE 24 THE HOSPITAL FINANCIAL ASSISTANCE POLICY DOES NOT COVER ELECTIVE PROCEDURES THE HOSPITAL MAY HAVE CHARGED FAP ELIGIBLE PATIENTS GROSS CHARGES FOR SERVICES THAT ARE NOT COVERED UNDER THE FINANCIAL ASSISTANCE POLICY
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Form and Line Reference	Explanation
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AVERA HAND COUNTY MEMORIAL HOSPITAL	PART V, SECTION B, LINE 24 THE HOSPITAL FINANCIAL ASSISTANCE POLICY DOES NOT COVER ELECTIVE PROCEDURES THE HOSPITAL MAY HAVE CHARGED FAP ELIGIBLE PATIENTS GROSS CHARGES FOR SERVICES THAT ARE NOT COVERED UNDER THE FINANCIAL ASSISTANCE POLICY

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

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

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

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

	Name and address	Type of Facility (describe)
1	1 - AVERA MCKENNAN BEHAVIORAL HEALTH CENTER 4400 W 69TH ST SIOUX FALLS, SD 57108	INPATIENT & OUTPATIENT BEHAVIORAL HEALTH SERVICES
1	2 - AVERA PLAZA 2 PHARMACY 1301 S CLIFF AVENUE SIOUX FALLS, SD 57105	RETAIL PHARMACY
2	3 - AVERA PRINCE OF PEACE 4500 S PRINCE OF PEACE PLACE SIOUX FALLS, SD 57103	SKILLED NURSING FACILITY
3	4 - AVERA MCKENNAN HOME INFUSION 1020 S CLIFF AVENUE SIOUX FALLS, SD 57105	COMPREHENSIVE HOME INFUSION THERAPIES & SUPPLIES
4	5 - MCKENNAN REGIONAL LABORATORY 1325 S CLIFF AVENUE SIOUX FALLS, SD 57105	LABORATORY SERVICES
5	6 - AVERA MEDICAL GROUP MATERNAL FETAL MED 1417 SOUTH CLIFF AVENUE SUITE 100 SIOUX FALLS, SD 57105	HIGH-RISK PREGNANCY CARE CLINIC
6	7 - AVERA MEDICAL GROUP WORTHINGTON 508 TENTH STREET WORTHINGTON, MN 56187	PRIMARY CARE CLINIC
7	8 - AVERA MEDICAL GROUP PEDIATRIC SPECIALIST 1417 S CLIFF AVENUE SUITE 010 SIOUX FALLS, SD 57105	PEDIATRIC SPECIALTIES CLINIC
8	9 - AVERA ROSEBUD COUNTRY CARE CENTER 300 PARK AVENUE GREGORY, SD 57533	SKILLED NURSING FACILITY
9	10 - AVERA MCKENNAN FITNESS CENTER 3400 S SOUTHEASTERN DRIVE SIOUX FALLS, SD 57105	FITNESS CENTER
10	11 - AVERA 69TH STREET PHARMACY - BEHAVIORAL 4400 W 69TH ST SUITE 300 SIOUX FALLS, SD 57108	RETAIL PHARMACY
11	12 - AVERA MEDICAL GROUP WINDOM 820 - 2ND AVENUE WINDOM, MN 56101	PRIMARY CARE CLINIC
12	13 - AVERA MEDICAL GROUP ORTHO & SPORTS MED 911 E 20TH STREET SIOUX FALLS, SD 57105	ORTHOPEDIC CLINIC
13	14 - AVERA MCKENNAN HOSP & UNIV CAMPUS PHARM 1325 S CLIFF AVENUE SIOUX FALLS, SD 57105	RETAIL PHARMACY
14	15 - AVERA INSTITUTE FOR HUMAN GENETICS 4400 W 69TH ST SUITE 200 SIOUX FALLS, SD 57108	GENETIC RESEARCH PROGRAM

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

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

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

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

	Name and address	Type of Facility (describe)
16	16 - LAUREL OAKS APARTMENTS 4510 S PRINCE OF PEACE PLACE SIOUX FALLS, SD 57103	INDEPENDENT LIVING APARTMENTS
1	17 - AVERA MEDICAL GROUP SIBLEY 600-9TH AVENUE NORTH SIBLEY, IA 51249	PRIMARY CARE CLINIC
2	18 - AVERA MEDICAL GROUP COMPREHENSIVE BREAST 1000 EAST 23RD STREET SUITE 360 SIOUX FALLS, SD 57105	SPECIALTY CLINIC
3	19 - AVERA RESEARCH INSTITUTE 3720 W 69TH ST SIOUX FALLS, SD 57108	CLINICAL RESEARCH STUDIES
4	20 - AVERA MEDICAL GROUP OPTOMETRY 702 TENTH STREET WORTHINGTON, MN 56187	OPHTHALMOLOGY AND OPTOMETRY CLINIC
5	21 - AVERA DERMATOLOGY PHARMACY 6701 SOUTH MINNESOTA AVENUE SIOUX FALLS, SD 57108	RETAIL PHARMACY
6	22 - AVERA MEDICAL GROUP OCCUPATIONAL MED 2100 S MARION RD SIOUX FALLS, SD 57106	BUSINESS AND CORPORATE HEALTH CARE CLINIC
7	23 - AVERA MEDICAL GROUP WOMEN'S MIDLIFE CARE 911 EAST 20TH STREET - SUITE 200 SIOUX FALLS, SD 57105	WOMEN'S SERVICES CLINIC
8	24 - AVERA MEDICAL GROUP OPTOMETRY 1006 4TH AVENUE WINDOM, MN 56101	OPHTHALMOLOGY AND OPTOMETRY CLINIC
9	25 - CURAQUICK AVERA CLINIC 3000 S MINNESOTA AVE SIOUX FALLS, SD 57105	PRIMARY CARE CLINIC
10	26 - AVERA MEDICAL GROUP BIG STONE CITY 451 MAIN STREET BIG STONE CITY, SD 57216	PRIMARY CARE CLINIC
11	27 - HEGG MEDICAL CLINIC AVERA 2121 HEGG DRIVE ROCK VALLEY, IA 51247	PRIMARY CARE CLINIC
12	28 - HEALTH CARE CLINIC 300 NORTH DAKOTA AVENUE SUITE 117 SIOUX FALLS, SD 57104	FREE HEALTHCARE CLINIC
13	29 - COMMUNITY BLOOD BANK 1301 SOUTH CLIFF AVENUE SUITE 3 SIOUX FALLS, SD 57105	COMMUNITY BLOOD SERVICES
14	30 - YORKSHIRE EYE CLINIC 2311 YORKSHIRE DRIVE BROOKINGS, SD 57006	OPHTHALMOLOGY AND OPTOMETRY CLINIC

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

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

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

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

	Name and address	Type of Facility (describe)
31	31 - AVERA MEDICAL GROUP ESTHERVILLE 926 NORTH 8TH STREET ESTHERVILLE, IA 51334	PRIMARY CARE CLINIC
1	32 - RURAL MEDICAL CLINICS 301 SOUTH WALNUT STREET FREEMAN, SD 57029	PRIMARY CARE CLINIC
2	33 - DAKOTA FAMILY MEDICAL CENTER 101 SOUTH FRONT PO BOX 27 CHAMBERLAIN, SD 57325	PRIMARY CARE CLINIC
3	34 - PIPESTONE MEDICAL GROUP AVERA 920 - 4TH AVENUE SW PIPESTONE, MN 56164	PRIMARY CARE CLINIC
4	35 - AVERA MEDICAL GROUP MCGREEVY SALEM 740 SOUTH HILL SALEM, SD 57058	PRIMARY CARE CLINIC
5	36 - AVERA MEDICAL GROUP LARCHWOOD 916 HOLDER STREET PO BOX 8 LARCHWOOD, IA 51241	PRIMARY CARE CLINIC
6	37 - AVERA MEDICAL GROUP BUTTE 730 WILSON STREET BUTTE, NE 68722	SATELLITE PRIMARY CARE CLINIC
7	38 - AVERA MEDICAL GROUP ELKTON 203 ELK STREET ELKTON, SD 57026	SATELLITE PRIMARY CARE CLINIC
8	39 - AVERA MEDICAL GROUP FULDA 201 N ST PAUL AVENUE FULDA, MN 56131	SATELLITE PRIMARY CARE CLINIC
9	40 - AVERA MEDICAL GROUP LAKEFIELD 221 - 3RD AVENUE LAKEFIELD, MN 56150	SATELLITE PRIMARY CARE CLINIC
10	41 - AVERA MEDICAL GROUP VOLGA 210 KASAN AVENUE VOLGA, SD 57071	SATELLITE PRIMARY CARE CLINIC

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Schedule I (Form 990)

Department of the Treasury
Internal Revenue Service

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

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

▶ **Attach to Form 990.**

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

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
AVERA MCKENNAN

Employer identification number
46-0224743

Part I General Information on Grants and Assistance

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

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

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

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

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

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

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

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

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of noncash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of noncash assistance
(1) SCHOLARSHIPS	4	43,500			
(2) ASSISTANCE WITH MEDICAL EXPENSES	3094	282,073			
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					

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

Return Reference	Explanation
PART I, LINE 2	THE GOVERNING BOARD AND MANAGEMENT DEVELOP PROGRAMS WHICH ENHANCE THE CHARITABLE MISSION OF THE ORGANIZATION DISBURSEMENT FOR GRANTS OR ASSISTANCE FOR THESE PROGRAMS ARE MADE IN ACCORDANCE WITH PRESCRIBED PROCEDURES AND ARE SUBJECT TO CONDITIONS ESTABLISHED BY THE ORGANIZATION'S GOVERNING BOARD AND MANAGEMENT, WHICH ARE DESIGNED TO ENSURE THAT INDIVIDUALS AND ORGANIZATIONS RECEIVING GRANTS OR ASSISTANCE ARE ADEQUATELY INVESTIGATED TO ENSURE THAT THEY ARE QUALIFIED RECIPIENTS

Additional Data

Software ID:
Software Version:
EIN: 46-0224743
Name: AVERA MCKENNAN

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
SOUTH DAKOTA DEPARTMENT OF HEALTH - ALL WOMEN COUNT 615 E 4TH STREET PIERRE, SD 57501	46-6000364	STATE OF SD	15,000				DONATION
DARWIN FOUNDATION 4600 EAST-WEST HWY SUITE 525 BETHESDA, MD 20814	37-1473821	501(C)(3)	200,000				DONATION

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
EAST AFRICA MEDICAL ASSISTANCE FOUNDATION 400 SOUTH 4TH STREET SUITE 401-225 MINNEAPOLIS, MN 55415	36-3412789	501(C)(3)	10,000				DONATION

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Schedule J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

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

▶ **Attach to Form 990.**

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

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
AVERA MCKENNAN

Employer identification number
46-0224743

Part I Questions Regarding Compensation

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

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

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

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

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

Part III Supplemental Information

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

Return Reference	Explanation
PART I, LINE 4A	DAVID KAPASKA, DO IS LISTED AS A FORMER PRESIDENT AND CEO ON PART VII OF THE 990 AND RECEIVED A SEVERANCE PAYMENT IN THE AMOUNT OF $454,243
SCHEDULE J, PART I, LINE 3	THE PRESIDENT/CEO IS COMPENSATED BY AVERA HEALTH AVERA MCKENNAN RELIED ON THE RELATED ORGANIZATION FOR DETERMINING THE COMPENSATION FOR THE PRESIDENT/CEO USING THE METHODS DESCRIBED IN PART I, LINE 3

Additional Data

Software ID:
Software Version:
EIN: 46-0224743
Name: AVERA MCKENNAN

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1LUIS ROJAS MD BOARD TRUSTEE	(I)	584,633	24,400	28,834	13,500	27,747	679,114	0
	(II)	0	0	0	0	0	0	0
1RICK KOOIMA MD BOARD TRUSTEE	(I)	267,374	10,869	4,424	13,500	27,747	323,914	0
	(II)	0	0	0	0	0	0	0
2KAREN GARNAAS MD CHIEF OF STAFF	(I)	429,494	37,979	21,392	13,500	26,103	528,468	0
	(II)	0	0	0	0	0	0	0
3WILLIAM ROSSING MD BOARD TRUSTEE	(I)	560,862	15,896	22,029	13,500	26,103	638,390	0
	(II)	0	0	0	0	0	0	0
4DAVID FLICEK PRESIDENT & CEO	(I)	0	0	0	0	0	0	0
	(II)	689,489	0	52,936	13,500	29,993	785,918	0
5JIM BRECKENRIDGE CFO - AVERA HEALTH	(I)	0	0	0	0	0	0	0
	(II)	815,781	0	71,625	13,500	20,616	921,522	0
6LORI POPKES SR VICE PRESIDENT	(I)	260,058	44,408	23,389	8,391	26,991	363,237	0
	(II)	0	0	0	0	0	0	0
7STEVE PETERSEN AVP-PHARMACY	(I)	0	0	0	0	0	0	0
	(II)	226,018	9,733	21,879	12,640	25,244	295,514	0
8MARY LEEDOM AVP-SURGERY	(I)	190,594	0	22,773	10,117	328	223,812	0
	(II)	0	0	0	0	0	0	0
9CURT HOHMAN SR VICE PRESIDENT	(I)	287,573	55,032	2,469	13,500	9,833	368,407	0
	(II)	0	0	0	0	0	0	0
10TODD ZIMPRICH MD NEUROLOGIST	(I)	905,865	570,623	24,687	13,500	25,910	1,540,585	0
	(II)	0	0	0	0	0	0	0
11KYLE ARNESON MD RADIOLOGIST	(I)	558,690	900,464	2,133	13,500	33,756	1,508,543	0
	(II)	0	0	0	0	0	0	0
12BRIAN KNUTSON MD DERMATOLOGY	(I)	1,070,875	175,865	5,746	13,500	24,910	1,290,896	0
	(II)	0	0	0	0	0	0	0
13STEVEN CONDRON MD GASTROENTEROLOGY	(I)	1,137,892	152,831	5,780	13,500	27,747	1,337,750	0
	(II)	0	0	0	0	0	0	0
14WISSAM ASFAHANI MD NEUROLOGY SURGERY	(I)	1,089,071	35,401	71,354	13,500	28,993	1,238,319	0
	(II)	0	0	0	0	0	0	0
15DAVID KAPASKA DO FORMER PRESIDENT & CEO	(I)	0	0	0	0	0	0	0
	(II)	374,121	0	609,499	13,500	10,308	1,007,428	0
16JULIE N NORTON FORMER SEC/TREAS & SRVP FINANCE	(I)	141,753	0	26,967	6,231	7,093	182,044	0
	(II)	322,184	0	32,437	11,769	14,101	380,491	0

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Schedule L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions with Interested Persons

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, lines 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.**
▶ **Attach to Form 990 or Form 990-EZ.**
▶ **Information about Schedule L (Form 990 or 990-EZ) and its instructions is at *www.irs.gov/form990*.**

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
AVERA MCKENNAN

Employer identification number
46-0224743

Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 501(c)(29) organizations only)

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b

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

2 Enter the amount of tax incurred by organization managers or disqualified persons during the year under section 4958 . . . . . ▶ $

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization . . . . . ▶ $

Part II Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a, or Form 990, Part IV, line 26, or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization? To	From	(e) Original principal amount	(f) Balance due	(g) In default? Yes	No	(h) Approved by board or committee? Yes	No	(i) Written agreement? Yes	No
(1) WILLIAM ROSSING MD	BOARD MEMBER AND EMPLOYEE	PHYSICIAN LOAN FORGIVENESS		X	72,000	43,200		No	Yes		Yes	
(2) KAREN GARNAAS MD	BOARD MEMBER AND EMPLOYEE	PHYSICIAN LOAN FORGIVENESS		X	72,000	43,200		No	Yes		Yes	
(3) LUIS ROJAS MD	BOARD MEMBER AND EMPLOYEE	PHYSICIAN LOAN FORGIVENESS		X	200,000	144,444		No	Yes		Yes	
Total					▶ $	230,844						

Part III Grants or Assistance Benefiting Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

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

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
See Additional Data Table					

Part V Supplemental Information

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

Return Reference	Explanation

Additional Data

Software ID:
Software Version:
EIN: 46-0224743
Name: AVERA MCKENNAN

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) MATTHEW LEEDOM	FAMILY OF KEY EMPLOYEE	88,265	EMPLOYEE COMPENSATION		No
(1) SARAH KAPPEL	FAMILY OF KEY EMPLOYEE	131,364	EMPLOYEE COMPENSATION		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(3) KATHERINE SMIDT	FAMILY OF FORMER PRESIDENT/CEO AND BOARD MEMBER	159,583	EMPLOYEE COMPENSATION		No
(1) ALLISON CHRISTENSEN	FAMILY OF KEY EMPLOYEE	65,736	EMPLOYEE COMPENSATION		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(a) Name of interested person	**(b)** Relationship between interested person and the organization	**(c)** Amount of transaction	**(d)** Description of transaction	**(e)** Sharing of organization's revenues?	
				Yes	**No**
(5) VICTORIA PETERSEN	FAMILY OF KEY EMPLOYEE	41,915	EMPLOYEE COMPENSATION		No
(1) DEANN MATTHIESSEN	FAMILY OF KEY EMPLOYEE	99,788	EMPLOYEE COMPENSATION		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(7) NICK CHRISTENSEN	FAMILY OF KEY EMPLOYEE	68,148	EMPLOYEE COMPENSATION		No
(1) KATHY KOOIMA	FAMILY OF BOARD MEMBER	32,887	EMPLOYEE COMPENSATION		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(a) Name of interested person	**(b)** Relationship between interested person and the organization	**(c)** Amount of transaction	**(d)** Description of transaction	**(e)** Sharing of organization's revenues?	
				Yes	**No**
(9) KRISTY MICKELSON	FAMILY OF KEY EMPLOYEE	52,301	EMPLOYEE COMPENSATION		No
(1) GRANT FLICEK	FAMILY OF OFFICER AND BOARD MEMBER	59,526	EMPLOYEE COMPENSATION		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(a) Name of interested person	**(b)** Relationship between interested person and the organization	**(c)** Amount of transaction	**(d)** Description of transaction	**(e)** Sharing of organization's revenues?	
				Yes	**No**
(11) SUSAN O'HARE	FAMILY OF BOARD MEMBER	100,665	EMPLOYEE COMPENSATION		No
(1) CHRISTIANE MAROUN MD	FAMILY OF BOARD MEMBER	67,734	EMPLOYEE COMPENSATION		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(13) ASHLEY STEFFEN	FAMILY OF KEY EMPLOYEE	94,964	EMPLOYEE COMPENSATION		No

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SCHEDULE O (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.
▶ Attach to Form 990 or 990-EZ.
▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
AVERA MCKENNAN

Employer identification number
46-0224743

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 2	JIM BRECKENRIDGE, DAVID FLICEK, DAVID KAPASKA, STEVE PETERSEN, AND JULIE NORTON HAVE A BUSINESS RELATIONSHIP

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 6	THE SOLE MEMBER OF THE ORGANIZATION IS AVERA HEALTH, A NONPROFIT CORPORATION ORGANIZED AND EXISTING UNDER THE LAWS OF THE STATE OF SOUTH DAKOTA AND EXEMPT UNDER SECTION 501(C)(3) O F THE INTERNAL REVENUE CODE OF 1986, AS AMENDED

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7A	AVERA HEALTH, AS THE SOLE MEMBER, HAS THE POWER TO APPOINT AND REMOVE, WITH OR WITHOUT CAUSE, ALL MEMBERS OF THE BOARD OF DIRECTORS

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B	AVERA HEALTH, AS THE SOLE MEMBER, HAS THE FOLLOWING RIGHTS AS THE MEMBER 1) TO APPROVE TH E ADOPTION, AMENDMENT OR REPEAL OF THE STATEMENTS OF PHILOSOPHY, MISSION AND VALUES OF COR PORATION, 2) TO INITIATE THE ADOPTION, AMENDMENT OR REPEAL OF ANY PROVISION OF THE ARTICLE S OF INCORPORATION OR BYLAWS OF CORPORATION, AND TO GIVE FINAL APPROVAL OF ANY SUCH ACTION WITH RESPECT THERETO, 3) TO APPROVE AND ACT UPON THE ALIENATION OF REAL PROPERTY AND PREC IOUS ARTIFACTS UNDER THE CANONICAL STEWARDSHIP OF THE SISTERS OF THE PRESENTATION OF THE B LESSED VIRGIN MARY OF ABERDEEN, SOUTH DAKOTA ("PRESENTATION SISTERS") OR THE BENEDICTINE S ISTERS OF SACRED HEART MONASTERY ("BENEDICTINE SISTERS"), PURSUANT TO THE POLICIES ESTABLI SHED BY THE MEMBER, 4) TO APPROVE ANY PLAN OF MERGER, CONSOLIDATION OR DISSOLUTION OF THE CORPORATION, OR THE DIVESTITURE OF A SPONSORED WORK OR MINISTRY ASSOCIATED WITH THE CORPOR ATION, 5) TO APPROVE THE CREATION OF NEW SPONSORED WORKS OR MINISTRIES TO BE CONDUCTED BY OR UNDER THE AUTHORITY OF THE CORPORATION, 6) TO APPOINT AND REMOVE, WITH OR WITHOUT CAUSE , THE BOARD OF DIRECTORS OF THE CORPORATION 7) TO APPOINT AND/OR REMOVE, WITH OR WITHOUT CAUSE, THE PRESIDENT AND CHIEF EXECUTIVE OFFICER OF THE CORPORATION 8) TO APPROVE OPERATI NG/CAPITAL BUDGETS AND STRATEGIC PLANS OF THE CORPORATION 9) TO APPROVE EXPENDITURES OUTS IDE OF OPERATING AND CAPITAL BUDGETS EXCEEDING DEFINED THRESHOLDS ACCORDING TO POLICY WHIC H MAY BE ADOPTED FROM TIME TO TIME BY THE MEMBER 10) TO APPROVE ACQUISITIONS, SALES AND L EASES, ACCORDING TO POLICY WHICH MAY BE ADOPTED FROM TIME TO TIME BY THE MEMBER 11) TO ES TABLISH AND MAINTAIN EMPLOYEE BENEFIT PROGRAMS 12) TO ESTABLISH AND MAINTAIN INSURANCE PR OGRAMS 13) TO APPROVE MAJOR COMMUNITY FUND DRIVES 14) TO APPROVE THE APPOINTMENT OF AUDI TORS 15) TO ADOPT POLICIES DESIGNED TO EFFECTUATE THE RESERVED POWERS OF THE MEMBER

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 8B	AVERA MCKENNAN DOES NOT HAVE ANY COMMITTEES WITH AUTHORITY TO ACT ON BEHALF OF THE GOVERNING BODY

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	THE FORM 990 IS REVIEWED BY THE AVERA HEALTH VP OF FINANCIAL REPORTING, TAX MANAGER, FACIL ITY CEO AND FINANCE COMMITTEE (IF APPLICABLE) AFTER INITIAL REVIEW THE FORM 990 IS MADE A VAILABLE TO THE BOARD AND OTHER OPERATION FINANCE LEADERS

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	THE CONFLICT OF INTEREST POLICY COVERS BOARD MEMBERS, OFFICERS, AND KEY EMPLOYEES AT EACH BOARD MEETING, A REQUEST IS MADE FOR ALL BOARD MEMBERS TO DISCLOSE ANY POTENTIAL CONFLICT OF INTEREST PERTAINING TO ANY ITEM LISTED ON THE AGENDA OR PERTAINING TO ANY POTENTIAL IT EM THAT COULD BE DISCUSSED DURING THE COURSE OF THE MEETING THE DECLARATION OF CONFLICT O F INTEREST IS RECORDED IN THE MEETING MINUTES THE BOARD MAKES A DETERMINATION OF WHETHER THERE IS A CONFLICT OF INTEREST AND IF SO, IMPLEMENTS THE PROCEDURE FOR EVALUATING THE ISS UE OR TRANSACTION INVOLVED THE BOARD MEMBER OR OFFICER WITH THE CONFLICT MUST REFRAIN FRO M VOTING A STATEMENT OF CONFLICT OF INTEREST DISCLOSURE IS MADE ON AN ANNUAL BASIS BY OFF ICERS AND DIRECTORS THE INFORMATION IS MAINTAINED IN A DATABASE AND A REPORT IS PROVIDED TO THE BOARD

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15B	THE CEO AND CFO-AVERA HEALTH ARE COMPENSATED BY AVERA HEALTH ANNUALLY THE COMPENSATION CO MMITTEE OF AVERA HEALTH, WHICH IS COMPRISED OF SIX (6) SYSTEM MEMBERS APPOINTED BY THE REL IGIOUS ORDERS, MEETS WITH AN INDEPENDENT CONSULTANT REGARDING FAIR MARKET VALUE OF OFFICER S AND KEY EMPLOYEES THE COMPENSATION COMMITTEE APPROVES ALL SALARIES BASED ON COMPARABLE DATA AND DOCUMENTS THE BASIS FOR THEIR DECISION IN MEETING MINUTES DEPENDING ON THE INDIV IDUAL'S ROLE WITH THE ORGANIZATION, SOME OFFICERS AND KEY EMPLOYEES ARE COMPENSATED BY AVE RA MCKENNAN

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	THE ORGANIZATION'S GOVERNING DOCUMENTS AND CONFLICT OF INTEREST POLICY ARE NOT MADE AVAILA BLE TO THE GENERAL PUBLIC THE ORGANIZATION'S FINANCIAL STATEMENTS ARE ATTACHED TO THE FOR M 990 PER IRS INSTRUCTIONS AND THEREFORE AVAILABLE TO THE GENERAL PUBLIC

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 16B	THERE IS NO WRITTEN POLICY OR PROCEDURE REQUIRING THE ORGANIZATION TO EVALUATE ITS PARTICI PATION IN JOINT VENTURE ARRANGEMENTS IN THE EVENT OF ANY SUCH PROPOSED TRANSACTION THE BO ARD, OR A COMMITTEE WITH DELEGATED AUTHORITY, REVIEWS ALL MATERIALS, VALUATIONS, AND OPERA TIONAL ASPECTS FOR ANY PROPOSED TRANSACTION SUCH TRANSACTION WOULD BE EVALUATED IN ACCORD ANCE WITH THE EXEMPT STATUS OF THE ORGANIZATION AND ITS APPLICABLE PURPOSES ANY TRANSACTI ON ALSO MUST BE APPROVED BY THE BOARD AND THE MEMBER

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART IX, LINE 11G	MEDICAL FEES PROGRAM SERVICE EXPENSES 12,547,040 MANAGEMENT AND GENERAL EXPENSES 261,703 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 12,808,743 FFS OTHER PROGRAM SERVICE EXPENSES 5 5,232,235 MANAGEMENT AND GENERAL EXPENSES 98,961,081 FUNDRAISING EXPENSES 56,743 TOTAL EXPENSES 154,250,059 RESEARCH EXPENSES PROGRAM SERVICE EXPENSES 2,705,072 MANAGEMENT AN D GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 2,705,072 MANAGEMENT FEES P ROGRAM SERVICE EXPENSES 106,234 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 106,234

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART X, LINE 20	THE ISSUE PRICE INCLUDES THE FILING ORGANIZATION'S SHARE OF THE ENTIRE BOND ISSUE, WHICH W AS ISSUED TO AVERA HEALTH ON BEHALF OF THE AVERA OBLIGATED GROUP THE AVERA OBLIGATED GROU P CONSISTS OF AVERA HEALTH, AVERA MCKENNAN, AVERA ST LUKE'S, AVERA QUEEN OF PEACE, AVERA SACRED HEART, AVERA MARSHALL, AVERA ST MARY'S, AVERA ST ANTHONY'S, AVERA ST BENEDICT, A VERA HOLY FAMILY, AVERA TYLER, AVERA GETTYSBURG AND AVERA AT HOME IN ACCORDANCE WITH IRS INSTRUCTIONS, INFORMATION RELATED TO THE TAX EXEMPT BOND REPORTING IS BEING REPORTED ON AV ERA HEALTH'S TAX RETURN (EIN 46-0422673)

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9	EQUITY TRANSFERS, NET 5,451,267 OTHER CHANGES IN UNRESTRICTED NET ASSETS 141,819 CHANGE IN INVESTMENT OF AVERA HEALTH FOUNDATION 2,197,665

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XII, LINE 2C	THE AUDIT COMMITTEE OF AVERA HEALTH, PARENT ORGANIZATION OF AVERA MCKENNAN, SELECTS THE AU DITOR AND REVIEWS THE CONSOLIDATED AUDITED FINANCIAL STATEMENTS FOR AVERA HEALTH, WHICH IN CLUES AVERA MCKENNAN

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SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
AVERA MCKENNAN

Employer identification number
46-0224743

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) SIOUX FALLS HOSPITAL MANAGEMENT LLC 1325 S CLIFF AVE PO BOX 5045 SIOUX FALLS, SD 571175045 56-2141521	MANAGEMENT COMPANY OF HEART HOSPITAL	NC	5,445,239	18,085,061	WEST 69TH STREET LLC
(2) WEST 69TH STREET LLC 1325 S CLIFF AVE PO BOX 5045 SIOUX FALLS, SD 571175045 46-0224743	HOLDING COMPANY	SD	5,445,239	18,085,061	AVERA MCKENNAN
(3) ALUMEND LLC 1325 S CLIFF AVE PO BOX 5045 SIOUX FALLS, SD 571175045 46-0224743	RESEARCH AND DEVELOPMENT	SD	-2,705,068	1,961,994	AVERA MCKENNAN
(4) MRIS LLC 1325 S CLIFF AVE PO BOX 5045 SIOUX FALLS, SD 571175045 47-0874983	HEALTHCARE SERVICES	SD	0	0	AVERA MCKENNAN

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

See Additional Data Table

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

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

See Additional Data Table

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity? Yes	(i) No
(1)ACCOUNTS MANAGEMENT INC 5132 S CLIFF AVE SUITE 101 SIOUX FALLS, SD 57108 46-0373021	COLLECTION AGENCY	SD	N/A	C					No
(2)AVERA PROPERTY INSURANCE INC 610 W 23RD ST STE 1 PO BOX 38 YANKTON, SD 57078 46-0463155	INSURANCE	SD	N/A	C					No
(3)VALLEY HEALTH SERVICES 501 SUMMIT STREET YANKTON, SD 57078 46-0357149	RENTAL REAL ESTATE	SD	N/A	C					No
(4)ALUCENT BIOMEDICAL INC 675 S ARAPEEN DR STE 102 SALT LAKE CITY, UT 84108 47-1818349	BIOTECHNOLOGY	SD	ALUMEND LLC	C	-5,513,639	2,753,283	100 000 %	Yes	
(5)SOUTH DAKOTA STATE MEDICAL HOLDING COMPANY INC 2600 W 49TH STREET SIOUX FALLS, SD 57105 46-0401087	INSURANCE	SD	N/A	C					No
(6)DAKOTACARE ADMINISTRATIVE SERVICES INC 2600 W 49TH STREET SIOUX FALLS, SD 57105 46-0424322	INSURANCE	SD	N/A	C					No

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

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

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

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)AVERA HEART HOSPITAL OF SOUTH DAKOTA LLC	R	3,148,135	INTERCOMPANY DETAIL FROM GL
(2)AVERA HEART HOSPITAL OF SOUTH DAKOTA LLC	S	10,502,949	INTERCOMPANY DETAIL FROM GL
(3)AVERA HEART HOSPITAL OF SOUTH DAKOTA LLC	L	2,165,883	INTERCOMPANY DETAIL FROM GL
(4)AVERA HEART HOSPITAL OF SOUTH DAKOTA LLC	Q	894,048	INTERCOMPANY DETAIL FROM GL

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

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

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

Part VII Supplemental Information

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

Return Reference	Explanation
FORM 990, SCHEDULE R, PART V, LINE 2, COLUMN C	THE AMOUNTS REPORTED IN COLUMN C ARE REPORTED BASED ON A REVIEW OF GENERAL LEDGER ACTIVITY IN INTERCOMPANY ACCOUNTS, AND REVIEW OF EQUITY ACCOUNTS FOR CONTRIBUTIONS AND DISTRIBUTIONS

Additional Data

Software ID:
Software Version:
EIN: 46-0224743
Name: AVERA MCKENNAN

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity? Yes	(g) Section 512 (b)(13) controlled entity? No
300 N 2ND STREET ONEILL, NE 68763 47-0463911	HEALTHCARE SERVICES	NE	501(C)(3)	LINE 3	AVERA HEALTH		No
826 NORTH 8TH STREET ESTHERVILLE, IA 51334 42-0680370	HEALTHCARE SERVICES	IA	501(C)(3)	LINE 3	AVERA HEALTH		No
826 NORTH 8TH STREET ESTHERVILLE, IA 51334 42-1317452	SUPPORT HEALTH RELATED SERVICES	IA	501(C)(3)	LINE 10	AVERA HOLY FAMILY		No
401 WEST GLYNN DRIVE PARKSTON, SD 57366 46-0226738	HEALTHCARE SERVICES	SD	501(C)(3)	LINE 3	AVERA HEALTH		No
WEST GLYNN DRIVE PO BOX B PARKSTON, SD 57366 46-0458725	SUPPORT HEALTH RELATED SERVICES	SD	501(C)(3)	LINE 12A, I	ST BENEDICT HEALTH CENTER		No
3900 WEST AVERA DRIVE STE 300 SIOUX FALLS, SD 57108 46-0422673	PROMOTION OF HEALTH	SD	501(C)(3)	LINE 10	N/A		No
525 NORTH FOSTER MITCHELL, SD 57301 46-0224604	HEALTHCARE SERVICES	SD	501(C)(3)	LINE 3	AVERA HEALTH		No
501 SUMMIT STREET YANKTON, SD 57078 46-0225483	HEALTHCARE SERVICES	SD	501(C)(3)	LINE 3	AVERA HEALTH		No
606 EAST GARFIELD GETTYSBURG, SD 57442 46-0234354	HEALTHCARE SERVICES	SD	501(C)(3)	LINE 3	AVERA ST MARY'S		No
5116 S SOLBERG AVE SIOUX FALLS, SD 57108 46-0399291	HOME SERVICES	SD	501(C)(3)	LINE 10	AVERA HEALTH		No
1000 W 4TH STREET SUITE 9 YANKTON, SD 57078 46-0337013	HEALTHCARE EDUCATION	SD	501(C)(3)	LINE 10	SACRED HEART HEALTH SERVICES		No
305 SOUTH STATE STREET ABERDEEN, SD 57401 46-0224598	HEALTHCARE SERVICES	SD	501(C)(3)	LINE 3	AVERA HEALTH		No
801 EAST SIOUX AVENUE PIERRE, SD 57501 46-0230199	HEALTHCARE SERVICES	SD	501(C)(3)	LINE 3	AVERA HEALTH		No
300 S BRUCE STREET MARSHALL, MN 56258 41-0919153	HEALTHCARE SERVICES	MN	501(C)(3)	LINE 3	AVERA HEALTH		No
240 WILLOW STREET TYLER, MN 56178 41-0853163	HEALTHCARE SERVICES	MN	501(C)(3)	LINE 3	AVERA MARSHALL		No
3900 WEST AVERA DRIVE STE 300 SIOUX FALLS, SD 57108 46-0451539	HEALTH FINANCING AND HEALTH PLAN ADMIN	SD	501(C)(4)		AVERA HEALTH		No

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal Domicile (State or Foreign Country)	(d) Direct Controlling Entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations?		(i) Code V-UBI amount in Box 20 of Schedule K-1 (Form 1065)	(j) General or Managing Partner?		(k) Percentage ownership
							Yes	No		Yes	No	
AVERA HOME MEDICAL EQUIPMENT OF FLOYD LLC 714 LINCOLN ST NE LEMARS, IA 51031 82-0582350	MEDICAL SERVICES - HOME MEDICAL EQUIPMENT	SD	N/A									
AVERA HOME MEDICAL EQUIPMENT OF SIOUX CENTER LLC 38 19TH ST SW SIOUX CENTER, IA 51250 75-3203100	MEDICAL SERVICES - HOME MEDICAL EQUIPMENT	SD	N/A									
Q&M PROPERTIES LLC 525 NORTH FOSTER MITCHELL, SD 57301 73-1652049	MEDICAL CLINIC BUILDING	SD	AVERA QUEEN OF PEACE	EXCLUDED		325,453		No			No	50 000 %
SURGICAL ASSOCIATES ENDOSCOPY CLINIC LLC 310 S PENNSYLVANIA ST ABERDEEN, SD 57401 46-0461429	SURGICAL ASSOCIATES	SD	N/A									
AVERA HME OF SPENCER HOSPITAL LLC 2400 S MINNESOTA AVENUE 102 SIOUX FALLS, SD 57117 80-0619999	MEDICAL SERVICES - HOME MEDICAL EQUIPMENT	SD	N/A									
HEART HOSPITAL OF SOUTH DAKOTA LLC 4500 W 69TH STREET SIOUX FALLS, SD 57108 56-2143771	HEALTHCARE SERVICES	SD	AVERA MCKENNAN	RELATED	10,890,478	36,170,122		No			No	66 670 %
BROOKINGS HEALTH SYSTEM - AVERA HME LLC 101 22ND AVE SUITE 101 BROOKINGS, SD 57006 45-3204123	MEDICAL SERVICES - HOME MEDICAL EQUIPMENT	SD	N/A									
NATIONAL RURAL ACO 4 LLC DBA PRAIRIE HILLS CARE ORGANIZATION 7509 NW TIFFANY SPRINGS PARKWAY KANSAS CITY, MO 64153 37-1780735	ACCOUNTABLE CARE ORGANIZATION	KS	N/A									
NATIONAL RURAL ACO 5 LLC DBA GREAT PLAINS CARE ORGANIZATION 7509 NW TIFFANY SPRINGS PARKWAY KANSAS CITY, MO 64153 38-3958290	ACCOUNTABLE CARE ORGANIZATION	KS	N/A									