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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

2015

Open to Public Inspection

A For the 2015 calendar year, or tax year beginning 01-01-2015 , and ending 12-31-2015

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

C Name of organization
TRINITY HEALTH SYSTEM GROUP

Doing business as

Number and street (or P O box if mail is not delivered to street address) | Room/suite
380 SUMMIT AVENUE

City or town, state or province, country, and ZIP or foreign postal code
STEUBENVILLE, OH 43952

D Employer identification number
30-0752920

E Telephone number
(740) 283-7000

G Gross receipts $ 256,296,222

F Name and address of principal officer
DAVE WERKIN
380 SUMMIT AVENUE
STEUBENVILLE,OH 43952

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 ▶ 5388

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

J Website: ▶ WWW TRINITYHEALTH COM

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

L Year of formation 1996

M State of legal domicile OH

Part I Summary

1 Briefly describe the organization's mission or most significant activities
A COMMUNITY PARTNER DEDICATED TO EXCELLENCE IN SERVING THE HEALTH NEEDS OF THE TRI-STATE AREA

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**	16
4	Number of independent voting members of the governing body (Part VI, line 1b)	**4**	13
5	Total number of individuals employed in calendar year 2015 (Part V, line 2a)	**5**	2,007
6	Total number of volunteers (estimate if necessary)	**6**	10,403
7a	Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	660,377
b	Net unrelated business taxable income from Form 990-T, line 34	**7b**	291,534

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	608,334	237,656
9	Program service revenue (Part VIII, line 2g)	228,087,043	237,189,259
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	1,493,495	14,593,884
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	3,887,772	4,033,643
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	234,076,644	256,054,442
13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	400	500
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)	103,831,234	112,848,329
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶0		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	119,418,003	130,433,461
18	Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	223,249,637	243,282,290
19	Revenue less expenses Subtract line 18 from line 12	10,827,007	12,772,152

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	223,236,413	225,459,769
21	Total liabilities (Part X, line 26)	80,245,224	82,343,378
22	Net assets or fund balances Subtract line 21 from line 20	142,991,189	143,116,391

Part II Signature Block

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

Sign Here

******
Signature of officer — 2016-11-14 Date

DAVE WERKIN CFO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
JEREMY S HERMAN	JEREMY S HERMAN			P00745789

Firm's name ▶ PLANTE & MORAN PLLC — Firm's EIN ▶ 38-1357951

Firm's address ▶ 1111 SUPERIOR AVE
CLEVELAND, OH 44114 — Phone no (216) 523-1010

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

A COMMUNITY PARTNER DEDICATED TO EXCELLENCE IN SERVING THE HEALTH NEEDS OF THE TRI-STATE AREA

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 $ 129,454,452 including grants of $ 0) (Revenue $ 148,472,237)

OUTPATIENT SERVICES -TRINITY HEALTH SYSTEM'S CANCER TREATMENT CAPABILITIES GREW SUBSTANTIALLY WITH THE CONSTRUCTION OF THE TONY TERAMANA CANCER CENTER OPENED IN JANUARY 2000, THE CENTER HOUSES ONE OF THE MOST POWERFUL TOOLS IN CANCER TREATMENT, THE VARIAN CLINIC 21 EX LINEAR ACCELERATOR THIS UNIT, TERMED THE "GOLD STANDARD" IN CANCER TREATMENT, WAS ONLY ONE OF FOUR IN THE WORLD WHEN IT WAS INSTALLED THE CENTER ALSO UTILIZES A NEWLY PURCHASED SIMULATOR WHICH IS DIRECTLY LINKED TO TRINITY'S CT SCANNER, A PET SCANNER AND A SECOND LINEAR ACCELERATOR THIS FEATURE ALLOWS RADIATION ONCOLOGISTS TO PERFORM TREATMENT PLANNING EQUAL TO MAJOR METROPOLITAN HEALTH CENTERS THE TONY TERAMANA CANCER CENTER ALSO PROVIDES CHEMOTHERAPY AND SURGICAL CONSULTATION SERVICES FOR REGIONAL RESIDENTS THE CHEMOTHERAPY SERVICES AT TONY TERAMANA CANCER CENTER IS PROVIDED WITH COMPASSION, PRIVACY AND OPTIMUM RESULTS IN 2015, THE CENTER SAW 1,515 PATIENTS AND PERFORMED 9,203 PROCEDURES IN LINE WITH TRINITY HEALTH SYSTEM'S VALUES, SERVICE, REVERENCE AND STEWARDSHIP, THE TONY TERAMANA CANCER CENTER CAN MEET THE NEEDS OF CANCER PATIENTS THROUGH A HOLISTIC APPROACH WHICH INCLUDES COMPASSION, CONCERN, DIGNITY AND RESPECT THIS SERVICE IS DUE LARGELY TO THE GENEROSITY OF THE TONY TERAMANA FAMILY, WHOSE $1 MILLION GIFT MADE THIS CENTER A WORLD-CLASS CANCER TREATMENT FACILITY TRINITY HEALTH SYSTEM'S CARDIAC REHABILITATION PROGRAM IS DESIGNED TO EFFECT LIFESTYLE CHANGE IN PATIENTS ENROLLED THESE CHANGES ARE ACHIEVED THROUGH SAFE PHYSICAL CONDITIONING, SOUND EDUCATIONAL SESSIONS, AND GROUP SUPPORT, WHICH EMPHASIZE THE UNDERSTANDING OF RISK FACTORS ASSOCIATED WITH HEART DISEASE THE PROGRAM'S GOAL IS TO ENHANCE THE QUALITY OF LIFE FOR THE PATIENT AGE IS NOT A FACTOR OUR SPECIALLY TRAINED STAFF WORK WITH PATIENTS, THEIR FAMILIES, AND PHYSICIANS TO DEVELOP A PERSONALIZED PROGRAM OF HEALTH AND WELLNESS THE GOALS OF THE CARDIAC REHAB PROGRAM ARE INCREASED UNDERSTANDING OF HEART DISEASE, INCREASED ENDURANCE, DECREASED HEART RATE AND BLOOD PRESSURE, INCREASED MUSCULAR FITNESS, REDUCED CHOLESTEROL/TRIGLYCERIDE LEVELS, DECREASED BODY FAT, BETTER NUTRITION MANAGEMENT AND IMPROVED SENSE OF WELL-BEING AN INTEGRAL PART OF THE OVERALL PROGRAM, EDUCATION, INCREASES A PATIENT'S UNDERSTANDING OF THEIR ILLNESS AND HELPS THEM TO IDENTIFY CURRENT HABITS THAT CAN NEGATIVELY AFFECT THEIR CARDIAC CONDITION WE COVER ISSUES LIKE RISK FACTOR REDUCTION, ANGINA, HEART ATTACK, MEDICATION, DIETARY AND EXERCISE GUIDELINES, SMOKING, AND BREATHING AND RELAXATION METHODS INDIVIDUALS ENROLLED IN THIS PHASE ARE REFERRED BY THEIR PHYSICIAN AFTER AN ASSESSMENT OF CONDITION IS MADE, A PATIENT IS SCHEDULED FOR EXERCISE TRAINING WITH MONITORING RISK FACTORS, DIET, AND LIFESTYLE CHANGES ARE ALSO DISCUSSED CONVENIENT SESSIONS ARE SCHEDULED THREE TIMES PER WEEK AND LAST APPROXIMATELY ONE HOUR ONCE THE OUTPATIENT PROGRAM IS CONCLUDED, PATIENTS MAY CONTINUE THIS PHASE IN ORDER TO INSURE THEIR QUALITY OF LIFE THEIR ONGOING PARTICIPATION IN THE PROGRAM CAN OFFER THEM INCREASED ENDURANCE, DECREASED HEART RATE AND BLOOD PRESSURE, AND INCREASED MUSCULAR FITNESS TRINITY WORKCARE IS THE OCCUPATIONAL HEALTH DEPARTMENT OF TRINITY HEALTH SYSTEM AND PROVIDES A COMPREHENSIVE OCCUPATIONAL HEALTH SERVICE TO THE BUSINESS COMMUNITY OUR PROGRAM IS DESIGNED TO ASSIST THE CLIENT COMPANY DECREASE LOST WORK TIME, MEDICAL EXPENSES, INSURANCE PREMIUMS AND MAINTAIN COMPLIANCE WITH COMPANY AND GOVERNMENT REGULATIONS WORKCARE SERVICES INCLUDE MEDICAL SURVEILLANCE, SUBSTANCE ABUSE TESTING, INJURY TREATMENT AND CASE MANAGEMENT, PHYSICAL THERAPY, WELLNESS PROMOTION AND EMPLOYEE ASSISTANCE PROGRAM IN 2015, THERE WERE 9,763 VISITS TO WORKCARE OUTPATIENT OCCUPATIONAL THERAPY AT TRINITY IS PROVIDED BOTH AS AN EXTENSION OF SERVICES RECEIVED AS AN INPATIENT OR YOU CAN RECEIVE SERVICES AS A NEW PATIENT WE ARE STAFFED TO PROVIDE EXPERTISE WITH ALL NEUROLOGICAL AND ORTHOPEDIC DISORDERS AND SPECIALIZE IN THE AREA OF HAND DISORDERS WE PROVIDE EXERCISE, MODALITIES (PARAFFIN, ULTRASOUND, IONTOPHORESIS, FLUIDOTHERAPY AND E-STIM), FUNCTIONAL ACTIVITIES,SPLINTING/BRACING AND ADL TRAINING PHYSICAL THERAPY ASSESSES YOUR MOVEMENT, STRENGTH AND ENDURANCE AND WILL HELP TO RESTORE QUALITY OF MUSCLE TONE, COORDINATION, BALANCE, STRENGTH, ENDURANCE, JOINT FLEXIBILITY AND FUNCTIONAL MOBILITY OUR DEPARTMENT IS FULLY EQUIPPED TO ALLOW FOR PRIVATE TREATMENT ADDITIONALLY A MODERN GYM IS UTILIZED FOR YOUR EXERCISE NEEDS WE PROVIDE SPECIALIZED PROGRAMS IN EXERCISE, FUNCTIONAL ACTIVITIES AND MODALITIES OUR SPEECH PATHOLOGY DEPARTMENT IS EQUIPPED TO RENDER A BROAD SPECTRUM OF DIAGNOSTIC AND REHABILITATIVE SERVICES TO CHILDREN, ADOLESCENTS AND ADULTS WITH DISORDERS ASSOCIATED WITH DECREASED COGNITIVE SKILLS, APHASIA, APRAXIA, DYSARTHRIA, VOICE, AND DELAYED SPEECH AND LANGUAGE WE ALSO SPECIALIZE IN DIAGNOSTIC AND THERAPEUTIC INTERVENTIONS FOR PATIENTS WITH SWALLOWING DISORDERS TO SUPPORT SENIORS THROUGH TRYING TIMES, WE PROUDLY OFFER THE TRINITY SENIOR PROGRAM, A THERAPEUTIC PROGRAM DESIGNED TO MEET THE EMOTIONAL AND PSYCHOLOGICAL NEEDS OF OLDER ADULTS WE SEE PATIENTS 55 YEARS OR OLDER THAT ARE EXPERIENCING EMOTIONAL DIFFICULTIES SUCH AS DEPRESSION, ANXIETY, GRIEF, ANGER AND OTHER EMOTIONAL ISSUES, THE SHORT TERM OUTPATIENT PROGRAM INCLUDES SUPPORT GROUPS, OCCUPATIONAL AND RECREATIONAL GROUPS, AND HEALTH/MEDICATION EDUCATION TRINITY HOME HEALTH IS SPECIAL HOME CARE FOR SPECIAL PEOPLE THE DISCIPLINES OFFERED ARE SKILLED NURSING CARE, PHYSICAL THERAPY, OCCUPATIONAL THERAPY, MEDICAL SOCIAL SERVICES (OHIO) AND HOME HEALTH AIDES IN 2015, THE HOME HEALTH DEPARTMENT DID OVER 21,000 HOME VISITS

4b (Code) (Expenses $ 78,912,588 including grants of $ 0) (Revenue $ 84,588,982)

INPATIENT SERVICES - IN EASTERN OHIO THE HOSPITAL INCLUDES TRINITY EAST AND TRINITY WEST WHICH HAS A COMBINED CAPACITY OF OVER 500 BEDS TRINITY EAST OFFERS A VARIETY OF SERVICES INCLUDING SKILLED CARE, LONG-TERM CARE, INPATIENT PHYSICAL REHABILITATION AND BEHAVIORAL MEDICINE SERVICES (MENTAL HEALTH & ADDICTION RECOVERY) TRINITY WEST IS A FULL SERVICE ACUTE CARE FACILITY OFFERING 24-HOUR EMERGENCY CARE, KIDNEY DIALYSIS, LITHOTRIPSY, ENDOSCOPY AND RELATED SERVICES, SURGERY AND MEDICAL SURGICAL INPATIENT UNITS, COMPREHENSIVE CARDIAC CARE, PEDIATRICS, WOMEN'S HEALTH, INPATIENT/OUTPATIENT SURGICAL SERVICES, WOUND CLINIC, OCCUPATIONAL MEDICINE AND A FULL ARRAY OF DIAGNOSTIC CAPABILITIES THE TRINITY SKILLED CARE CENTER, A HOSPITAL-BASED SKILLED AND LONG TERM CARE NURSING FACILITY, IS FULLY CERTIFIED FOR 50 BEDS AND WAS DEVELOPED TO MEET THE NEEDS OF PATIENTS WHO REQUIRE ADDITIONAL SKILLED CARE BEYOND THE ACUTE PHASE OF ILLNESS OR INJURY IN 2015, TRINITY SKILLED CARE CENTER HAD 633 ADMISSIONS AND 15,504 PATIENT DAYS THE SKILLED CARE CENTER ALSO HAS AN ONGOING ACTIVITY PROGRAM PATIENTS ARE ENCOURAGED TO PARTICIPATE IN THESE ENJOYABLE ACTIVITIES AS A GROUP OR INDIVIDUALLY THE ATMOSPHERE IS INFORMAL AND RELAXING TO AID IN THE EMOTIONAL WELL-BEING OF EACH PATIENT DISCHARGE PLANNING BEGINS ON ADMISSION TO TRINITY SKILLED CARE CENTER INDIVIDUALIZED GOALS ARE ESTABLISHED WITH THE PATIENT, THE PATIENT'S FAMILY AND A HIGHLY QUALIFIED TEAM OF PROFESSIONALS THIS TEAM INCLUDES THE ATTENDING PHYSICIAN, NURSE, SOCIAL SERVICES, DIETICIAN, PHYSICAL THERAPIST, OCCUPATIONAL THERAPIST AND SPEECH THERAPIST THIS PROCESS ASSURES THE CONTINUITY OF CARE UPON DISCHARGE TRINITY'S REHABILITATION CENTER PROVIDES AN INTEGRATED AND INTERDISCIPLINARY TEAM APPROACH TO HELP PATIENTS WHO HAVE PHYSICAL IMPAIRMENTS PROGRAMS ARE AVAILABLE FOR PATIENTS WITH STROKES AND OTHER NEUROLOGICAL DISORDERS, ARTHRITIS, AMPUTATIONS, JOINT REPLACEMENTS AND OTHER ORTHOPEDIC PROBLEMS, BRAIN INJURY, AND SPINAL CORD INJURY THE CENTER HAS 20 PRIVATE ROOMS, EACH SPECIALLY DESIGNED FOR REHABILITATION PATIENTS ALSO UTILIZE A HOME-LIKE APARTMENT TO REGAIN SKILLS SUCH AS COOKING, BATHING AND DRESSING PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH-LANGUAGE PATHOLOGY AREAS HAVE STATE-OF-THE-ART EQUIPMENT, AND THE THERAPISTS ARE HIGHLY TRAINED REHABILITATION SPECIALISTS A VAN IS AVAILABLE FOR COMMUNITY OUTINGS AND HOME VISITS THESE TRIPS PROVIDE OPPORTUNITIES FOR PATIENTS TO PRACTICE THEIR SKILLS IN THEIR COMMUNITY, HOME AND WORK PLACE WHEN APPROPRIATE WITH A TEAM APPROACH TO TREATMENT, A PERSONALIZED REHABILITATION PROGRAM IS DESIGNED TO MEET THE UNIQUE NEEDS AND GOALS OF EACH PATIENT THE TEAM CONSISTS OF THE PATIENT, HIS/HER FAMILY, PHYSICIANS, REHABILITATION NURSES, PHYSICAL THERAPISTS, OCCUPATIONAL THERAPISTS, SPEECH LANGUAGE PATHOLOGISTS, PSYCHOLOGISTS, SOCIAL WORKERS, THERAPEUTIC RECREATIONAL SPECIALISTS, DIETICIANS, RESPIRATORY THERAPISTS, CASE COORDINATORS AND VOCATIONAL COUNSELORS THROUGH A POSITIVE, PERSONALIZED AND INTERDISCIPLINARY APPROACH, THE TEAM HELPS PATIENTS REGAIN PHYSICAL, EMOTIONAL, SOCIAL AND VERBAL SKILLS IN 2015, THE REHAB CENTER HAD 376 ADMISSIONS AND 4,811 PATIENT DAYS THE WOMEN'S HEALTH & BIRTH CENTER IS PROUD TO OFFER TOTAL MATERNITY CARE OUR SPECIALLY QUALIFIED STAFF OF DEDICATED NURSES AND PHYSICIANS GUIDES YOU AND YOUR FAMILY THROUGH A COMPREHENSIVE EDUCATION EXPERIENCE AND THE CHILDBIRTH EXPERIENCE AT THE WOMEN'S HEALTH & BIRTH CENTER YOU DELIVER YOUR BABY IN A SPECIALLY DESIGNED CHILDBEARING ROOM FOR YOUR ENTIRE HOSPITAL STAY ADMISSION PROCEDURES, LABOR, DELIVERY, AND RECOVERY YOUR POSTPARTUM STAY IS IN A SPECIALLY DESIGNED ROOM THAT MAKES THE FAMILY EXPERIENCE ONE YOU WILL ALWAYS REMEMBER OUR PRIVATE CHILDBEARING ROOMS ARE EQUIPPED FOR THE ENTIRE BIRTH EXPERIENCE ALL FORMS OF PAIN RELIEF EXCEPT GENERAL ANESTHESIA MAY BE PROVIDED IN THIS ROOM CESAREAN DELIVERIES ARE PERFORMED IN THE WOMEN'S HEALTH & BIRTH CENTER IN A MODERN, STATE OF THE ART SURGICAL SUITE, WITH LABOR AND POSTPARTUM CARE PROVIDED IN A WOMEN'S HEALTH & BIRTH CENTER SUITE THE SURGICAL SUITE MAY ALSO BE USED BY THOSE WISHING A MORE TRADITIONAL BIRTH EXPERIENCE FATHERS ARE ENCOURAGED TO STAY AT THE HOSPITAL, SLEEPING ACCOMMODATIONS ARE PROVIDED AT NO EXTRA CHARGE AT THE WOMEN'S HEALTH & BIRTH CENTER, ROOMING-IN IS FLEXIBLE AND DESIGNED TO MEET YOUR INDIVIDUAL NEEDS YOU AND YOUR FAMILY ARE PARTNERS WITH US IN THE CARE OF YOUR BABY IF YOU WANT TO REST OR HAVE TIME ALONE WE CAN CARE FOR YOUR BABY IN OUR WELL-EQUIPPED NURSERY NEAR YOUR ROOM IN THE WOMEN'S HEALTH & BIRTH CENTER, A SPECIALLY TRAINED PERINATAL NURSE IS ASSIGNED TO EACH MOTHER AND BABY TO PROVIDE PERSONAL, INDIVIDUALIZED CARE EXTRA TIME AND TEACHING ARE INTEGRAL PARTS OF THE ATTENTION WE GIVE ALL FAMILIES AFTER DISCHARGE, WE KNOW THAT QUESTIONS OFTEN ARISE AND IT IS GOOD TO HAVE SOMEONE WITH WHOM YOU CAN TALK BUT EVEN MORE, WE ARE INTERESTED IN YOU AND WE WANT TO PROVIDE AS MUCH CARE AND ASSISTANCE AS WE CAN DURING THIS SPECIAL TIME IN YOUR LIFE ONCE HOME, A PERINATAL NURSE FROM THE WOMEN'S HEALTH & BIRTHING CENTER IS AVAILABLE FOR CONSULTATION THROUGH TELEPHONE CALLS TO ALL PATIENTS SIMPLY CALL AT ANY TIME OF THE DAY OR NIGHT IF YOU NEED ASSISTANCE OR INFORMATION IN 2015, THE WOMEN'S HEALTH & BIRTH CENTER DELIVERED 585 BABIES

4c (Code) (Expenses $ 10,083,590 including grants of $ 0) (Revenue $ 3,467,664)

EMERGENCY ROOM - THE EMERGENCY SERVICES OF TRINITY HEALTH SYSTEM ARE AVAILABLE AT TRINITY MEDICAL CENTER WEST THE ER HAS BEEN REMODELED AND EXPANDED TO ACCOMMODATE PATIENTS REQUIRING TREATMENT - IT HAS DOUBLED IN SIZE AND NOW HAS TWICE AS MANY TREATMENT BEDS AVAILABLE AND MORE PHYSICIAN, PROFESSIONAL AND SUPPORT STAFF HAVE BEEN ADDED TO PROVIDE CARE A DEDICATED X-RAY ROOM, HAS BEEN CONSTRUCTED ADJACENT TO THE ER AND SPECIAL TREATMENT AREAS HAVE BEEN CONSTRUCTED FOR CARDIAC EMERGENCIES, TRAUMA, PEDIATRIC EMERGENCIES, OBSTETRICAL EMERGENCIES, SUTURING AND FRACTURES THE ER IS OPEN 24 HOURS / 7 DAYS A WEEK FOR ALL LEVELS OF EMERGENCY AND URGENT CARE IN 2015, WE HAD 46,304 EMERGENCY ROOM VISITS

See Additional Data

4d Other program services (Describe in Schedule O)

(Expenses $ 867,102 including grants of $ 500) (Revenue $ 0)

4e **Total program service expenses ▶** 219,317,732

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	Yes	
2	Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)?	2	Yes	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		No
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	Yes	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		No
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		No
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		No
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		No
9	Did the organization report an amount in Part X, line 21 for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9	Yes	
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10	Yes	
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI*	11a	Yes	
b	Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b		No
c	Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		No
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d	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		No
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a		No
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	Yes	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		No
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		No
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b		No
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV*	15		No
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV*	16		No
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I* (see instructions)	17		No
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		No
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		No
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	Yes	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	Yes	

Part IV Checklist of Required Schedules *(continued)*

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable	1a	161		
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	2,007		
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	16		
	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	13		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2			No
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?	3			No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4			No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5			No
6	Did the organization have members or stockholders?	6		Yes	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a		Yes	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b		Yes	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following				
a	The governing body?	8a		Yes	
b	Each committee with authority to act on behalf of the governing body?	8b		Yes	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9			No

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

			Yes	No
10a	Did the organization have local chapters, branches, or affiliates?	10a		No
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	10b		
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a		No
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	Yes	
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 ▶ DAVE WERKIN 380 SUMMIT AVENUE STEUBENVILLE, OH 43952 (740) 283-7000

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)** ▶								6,643,935	1,650,233	627,729

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 ▶ 72

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
UPMC CANCER CENTER PO BOX 2223270 PITTSBURGH, PA 15251	CANCER DRUGS	3,854,194
WASHINGTON HEALTHCARE STRATEGIES PO BOX 463 BRIDGEVILLE, PA 15017	ANESTHESIOLOGISTS	921,378
JEFFERSON INVESTIGATORS & SECURITY 1439 SUNSET BLVD STEUBENVILLE, OH 43952	SECURITY	576,262
STEEL VALLEY ER PHYSICIANS 2720 SUNSET STEUBENVILLE, OH 43952	ER PHYSICIANS	557,114
THE KHOURY SURGICAL GROUP 390 OAKMONT ROAD WHEELING, WV 26003	CARDIOTHORACIC & VASCULARSURGICAL SERVIC	550,000

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 ▶ 28

Part VIII Statement of Revenue

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns . . 1a				
	b	Membership dues 1b				
	c	Fundraising events 1c				
	d	Related organizations . . . 1d				
	e	Government grants (contributions) 1e	194,030			
	f	All other contributions, gifts, grants, and similar amounts not included above 1f	43,626			
	g	Noncash contributions included in lines 1a-1f $				
	h	**Total.** Add lines 1a-1f . . . . . ▶	237,656			
Program Service Revenue		Business Code				
	2a	PATIENT SERVICE REVENUE	621990	233,451,696	233,451,696	
	b	OTHER RELATED REVENUE	621990	2,782,867	2,782,867	
	c	NON-PATIENT LABORATORY	621500	660,377		660,377
	d	ELECTRONIC MED RECORDS	621990	294,319	294,319	
	e					
	f	All other program service revenue				
	g	**Total.** Add lines 2a–2f . . . . . ▶		237,189,259		
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts) . . . . . ▶		1,999,017		1,999,017
	4	Income from investment of tax-exempt bond proceeds . . ▶				
	5	Royalties . . . . . ▶				
		(i) Real / (ii) Personal				
	6a	Gross rents: 1,008,021 /				
	b	Less rental expenses: 241,780 /				
	c	Rental income or (loss): 766,241 /				
	d	Net rental income or (loss) . . . . . ▶		766,241		766,241
		(i) Securities / (ii) Other				
	7a	Gross amount from sales of assets other than inventory: 12,588,314 / 6,553				
	b	Less cost or other basis and sales expenses: 0 / 0				
	c	Gain or (loss): 12,588,314 / 6,553				
	d	Net gain or (loss) . . . . . ▶		12,594,867		12,594,867
	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				
	b	Less cost of goods sold . . b				
	c	Net income or (loss) from sales of inventory . . ▶				
		Miscellaneous Revenue / Business Code				
	11a	CAFETERIA 722210		1,907,311		1,907,311
	b	TUITION AND FEES 900099		848,935		848,935
	c	GIFT SHOP 453220		511,156		511,156
	d	All other revenue				
	e	**Total.** Add lines 11a–11d . . . . . ▶		3,267,402		
	12	**Total revenue.** See Instructions . . . . . ▶		256,054,442	236,528,882	660,377	18,627,527

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) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21	500	500		
2 Grants and other assistance to domestic individuals See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	900,829		900,829	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	84,717,888	74,255,229	10,462,659	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	5,661,301	4,962,287	699,014	
9 Other employee benefits	16,149,671	14,155,186	1,994,485	
10 Payroll taxes	5,418,640	4,749,438	669,202	
11 Fees for services (non-employees)				
a Management	14,427,104	12,645,357	1,781,747	
b Legal	637,168	558,478	78,690	
c Accounting	309,844	271,578	38,266	
d Lobbying	4,216	3,695	521	
e Professional fundraising services See Part IV, line 17				
f Investment management fees	57,911	50,759	7,152	
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	15,051,904	13,192,994	1,858,910	
12 Advertising and promotion	1,260,399	1,104,740	155,659	
13 Office expenses	3,809,115	3,338,689	470,426	
14 Information technology	2,018,549	1,769,258	249,291	
15 Royalties				
16 Occupancy	6,887,577	6,036,961	850,616	
17 Travel	286,700	251,293	35,407	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	224,988	197,202	27,786	
20 Interest	1,733,430	1,519,351	214,079	
21 Payments to affiliates	739,064	647,790	91,274	
22 Depreciation, depletion, and amortization	9,475,964	8,305,682	1,170,282	
23 Insurance	2,431,986	2,131,636	300,350	
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	24,228,514	24,228,514		
b DRUGS	21,117,307	21,117,307		
c BAD DEBT	10,282,846	10,282,846		
d REPAIRS & MAINTENANCE	4,380,959	3,839,911	541,048	
e All other expenses	11,067,916	9,701,051	1,366,865	
25 **Total functional expenses.** Add lines 1 through 24e	243,282,290	219,317,732	23,964,558	0
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

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

				(A) Beginning of year		(B) End of year
Assets	1	Cash–non-interest-bearing			1	
	2	Savings and temporary cash investments		12,967,043	2	4,805,663
	3	Pledges and grants receivable, net			3	
	4	Accounts receivable, net		26,331,236	4	33,914,801
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L			5	36,514
	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			7	
	8	Inventories for sale or use		3,790,730	8	3,803,783
	9	Prepaid expenses and deferred charges		2,085,494	9	3,433,250
	10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	10a 229,103,570			
	b	Less accumulated depreciation	10b 185,499,398	46,535,021	10c	43,604,172
	11	Investments—publicly traded securities		99,364,369	11	99,207,836
	12	Investments—other securities See Part IV, line 11		1,626,006	12	1,955,711
	13	Investments—program-related See Part IV, line 11			13	
	14	Intangible assets		3,978,161	14	5,790,624
	15	Other assets See Part IV, line 11		26,558,353	15	28,907,415
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)		223,236,413	16	225,459,769
Liabilities	17	Accounts payable and accrued expenses		18,506,354	17	20,174,985
	18	Grants payable			18	
	19	Deferred revenue			19	
	20	Tax-exempt bond liabilities		36,976,405	20	35,397,450
	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		1,185,613	23	828,213
	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		23,576,852	25	25,942,730
	26	**Total liabilities.** Add lines 17 through 25		80,245,224	26	82,343,378
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		134,031,167	27	134,056,145
	28	Temporarily restricted net assets		6,829,043	28	6,554,623
	29	Permanently restricted net assets		2,130,979	29	2,505,623
		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		142,991,189	33	143,116,391
	34	Total liabilities and net assets/fund balances		223,236,413	34	225,459,769

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	256,054,442
2	Total expenses (must equal Part IX, column (A), line 25)	2	243,282,290
3	Revenue less expenses Subtract line 2 from line 1	3	12,772,152
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	142,991,189
5	Net unrealized gains (losses) on investments	5	-14,111,338
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	1,464,388
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	143,116,391

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	Yes	
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	Yes	

Additional Data

Software ID:
Software Version:
EIN: 30-0752920
Name: TRINITY HEALTH SYSTEM GROUP

Form 990, Part III - 4 Program Service Accomplishments (See the Instructions)

(Code	) (Expenses $	867,102	including grants of $	500	) (Revenue $	0	)
ALL OTHER PROGRAM SERVICES							

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			
MICHAEL BARBER CHAIRMAN	2 00 2 00	X		X				0	0	0
MICHAEL BIASI BOARD MEMBER	2 00 2 00	X						0	0	0
FRED BROWER PRESIDENT & CEO	15 00 45 00	X		X				0	489,050	405,218
DAN DAILY BOARD MEMBER	2 00 2 00	X						0	0	0
PAUL DIBIASE MD BOARD MEMBER	2 00 2 00	X						0	0	0
ERIC EXLEY SECRETARY	2 00 2 00	X		X				0	0	0
JOHN FIGEL MD BOARD MEMBER	40 00 2 00	X						248,390	0	10,837
SHEILA HENDRICKS BOARD MEMBER	2 00 2 00	X						0	0	0
JOHN COLUMBUS MD BOARD MEMBER	2 00 2 00	X						0	0	0
CLYDE METZGER MD BOARD MEMBER	12 00 2 00	X						71,325	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			
MARK MORELLI VICE CHAIRMAN	2 00 2 00	X		X				0	0	0
JAMES PADDEN TREASURER	2 00 2 00	X		X				0	0	0
JAMES POPE BOARD MEMBER	2 00 2 00	X						0	0	0
DOUGLAS SCHAEFER BOARD MEMBER	2 00 2 00	X						0	0	0
DAVID SKIVIAT SR BOARD MEMBER	2 00 2 00	X						0	0	0
SR DIANA LYNN ECKEL BOARD MEMBER	2 00 2 00	X						0	0	0
DAVID WERKIN CFO	10 00 40 00			X				0	261,327	30,866
GRAY GONCZ DO VP, MEDICAL AFFAIRS	5 00 35 00				X			0	279,810	11,842
JOANN MULROONEY COO	5 00 35 00				X			0	244,371	32,685
LEWIS MUSSO VP,HUMAN RESOURCES	5 00 35 00				X			0	185,226	61,080

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			
STEVE BROWN VP MSO	5 00 35 00				X			0	190,449	28,586
NASROLLAH JAHDI MD PHYSICIAN	40 00 0 00					X		1,595,309	0	0
RAMANA MURTY MD PHYSICIAN	40 00 0 00					X		1,436,040	0	16,210
KUMAR AMIN MD PHYSICIAN	40 00 0 00					X		1,149,350	0	10,837
RAFAEL SCHMULEVICH MD PHYSICIAN	40 00 0 00					X		1,091,942	0	19,568
SATHISH MAGGE MD PHYSICIAN	40 00 0 00					X		1,051,579	0	0

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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

2015

Open to Public Inspection

Name of the organization
TRINITY HEALTH SYSTEM GROUP

Employer identification number
30-0752920

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 11, 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 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)

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

11 ☐ 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 11a through 11d that describes the type of supporting organization and complete lines 11e, 11f, and 11g

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- 9 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) and 170(b)(1)(A)(vi)** (Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any unusual grants)						
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) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(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 2015 (line 6, column (f) divided by line 11, column (f)) **14**

15 Public support percentage for 2014 Schedule A, Part II, line 14 **15**

16a **33 1/3% support test—2015.** 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—2014.** 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—2015.** 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—2014.** 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 9 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) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(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) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(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 2015 (line 8, column (f) divided by line 13, column (f))	15
16	Public support percentage from 2014 Schedule A, Part III, line 15	16

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2015** (line 10c, column (f) divided by line 13, column (f))	17
18	Investment income percentage from **2014** Schedule A, Part III, line 17	18

19a **33 1/3% support tests—2015.** 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—2014.** 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 11 of Part I If you checked 11a of Part I, complete Sections A and B If you checked 11b of Part I, complete Sections A and C If you checked 11c of Part I, complete Sections A, D, and E If you checked 11d 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 11a or 11b 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 (a) its supported organizations, (b) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (c) 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 IRC 4958(c)(3)(C)), a family member of a substantial contributor, or a 35-percent controlled entity with regard to a substantial contributor? *If "Yes," complete Part I of Schedule L (Form 990)*	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 II of Schedule L (Form 990)*	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 9(a)) 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 9(a)) 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 IRC 4943 because of IRC 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? *If "Yes," answer b 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		
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		

Part IV Supporting Organizations (continued)

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, (1) a written notice describing the type and amount of support provided during the prior tax year, (2) a copy of the Form 990 that was most recently filed as of the date of notification, and (3) 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 **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 2015 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-2015	(iii) Distributable Amount for 2015
1 Distributable amount for 2015 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2015 (reasonable cause required--see instructions)			
3 Excess distributions carryover, if any, to 2015			
a			
b			
c			
d From 2013.			
e From 2014.			
f **Total** of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2015 distributable amount			
i Carryover from 2010 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2015 from Section D, line 7 $			
a Applied to underdistributions of prior years			
b Applied to 2015 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2015, if any Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions)			
6 Remaining underdistributions for 2015 Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions)			
7 **Excess distributions carryover to 2016.** Add lines 3j and 4c			
8 Breakdown of line 7			
a			
b			
c Excess from 2013.			
d From 2014.			
e From 2015.			

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

Return Reference	Explanation

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SCHEDULE C (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527
▶Complete if the organization is described below. ▶Attach to Form 990 or Form 990-EZ.
▶Information about Schedule C (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2015

Open to Public Inspection

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

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

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

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

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

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

Name of the organization	Employer identification number
TRINITY HEALTH SYSTEM GROUP	30-0752920

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
2 Political expenditures ▶ $
3 Volunteer hours

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-
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) 2012	(b) 2013	(c) 2014	(d) 2015	(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		4,216
j	Total Add lines 1c through 1i			4,216
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	THE HOSPITAL PAYS DUES TO THE AMERICAN HOSPITAL ASSOCIATION AND OHIO HOSPITAL ASSOCIATION, OF WHICH A PORTION RELATES TO LOBBYING

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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

2015

Open to Public Inspection

Name of the organization
TRINITY HEALTH SYSTEM GROUP

Employer identification number
30-0752920

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	2,102
d Additions during the year	1d	1,524
e Distributions during the year	1e	1,103
f Ending balance	1f	2,523

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" to Form 990, Part IV, line 10.

	(a)Current year	(b)Prior year	b (c)Two years back	(d)Three years back	(e)Four years back
1a Beginning of year balance	743,000	743,000	743,000	743,000	743,000
b Contributions	334,000				
c Net investment earnings, gains, and losses	-7,559	43,168	121,559	73,352	3,827
d Grants or scholarships					
e Other expenditures for facilities and programs					
f Administrative expenses	7,559	43,168	121,559	73,352	3,827
g End of year balance	1,077,000	743,000	743,000	743,000	743,000

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

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

Part VI Land, Buildings, and Equipment.

Complete if the organization answered 'Yes' to 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)	Accumulated (c)depreciation	(d)Book value
1a Land		703,748		703,748
b Buildings		35,546,251	31,281,749	4,264,502
c Leasehold improvements		80,017	60,875	19,142
d Equipment		192,704,935	154,156,774	38,548,161
e Other		68,619		68,619
Total. Add lines 1a through 1e *(Column (d) must equal Form 990, Part X, column (B), line 10(c))* ▶				43,604,172

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		
Total. *(Column (b) must equal Form 990, Part X, col (B) line 12)* ▶		

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

(a) Description of investment	(b) Book value	(c) Method of valuation Cost or end-of-year market value
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) INTEREST IN NET ASSETS OF THE FOUNDATION	17,566,445
(2) DUE FROM AFFILIATES	7,336,851
(3) OTHER RECEIVABLES	566,669
(4) DUE FROM THIRD PARTY PAYORS	1,786,000
(5) INVESTMENT IN VALLEY SURGERY	696,400
(6) INVESTMENT IN MORELLI LAND ENTERPRISES	955,050
Total. *(Column (b) must equal Form 990, Part X, col (B) line 15)* . . . . . ▶	28,907,415

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
Federal income taxes	
AMOUNTS DUE TO AFFILIATES	1,059,137
RETIREMENT BENEFITS PAYABLE	16,588,070
INSURANCE CLAIMS RESERVE	8,295,523
Total. *(Column (b) must equal Form 990, Part X, col (B) line 25)* ▶	25,942,730

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
Part IV, Line 1b	IT IS CURRENTLY HELD IN A SUBSIDARY LEDGER THAT IS NOT ON OUR BALANCE SHEET

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

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SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No 1545-0047

2015

Open to Public Inspection

Name of the organization
TRINITY HEALTH SYSTEM GROUP

Employer identification number
30-0752920

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)		53,814	2,178,384	1,791,600	386,784	0 170 %
b Medicaid (from Worksheet 3, column a)			40,139,292	23,702,208	16,437,084	7 050 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs		53,814	42,317,676	25,493,808	16,823,868	7 220 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	5	4,869	224,420	51,535	172,885	0 070 %
f Health professions education (from Worksheet 5)	11	63	240,841		240,841	0 100 %
g Subsidized health services (from Worksheet 6)			3,428,568	2,105,170	1,323,398	0 570 %
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)	2	228	33,031	0	33,031	0 010 %
j **Total.** Other Benefits	18	5,160	3,926,860	2,156,705	1,770,155	0 750 %
k **Total.** Add lines 7d and 7j	18	58,974	46,244,536	27,650,513	18,594,023	7 970 %

Part II Community Building Activities

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

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

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	10,282,846		
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	182,000		
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	63,859,934		
6	Enter Medicare allowable costs of care relating to payments on line 5	6	65,154,629		
7	Subtract line 6 from line 5 This is the surplus (or shortfall)	7	-1,294,695		
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	1 VALLEY SURGERY CENTER	AMBULATORY SURGERY	33 000 %	0 %	33 000 %
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? 2

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

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group TRINITY MEDICAL CENTER WEST

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	☐ Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA 20 13			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes	
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	6b		No
7	Did the hospital facility make its CHNA report widely available to the public?	7	Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a	☐ Hospital facility's website (list url) HTTP //WWW TRINITYHEALTH COM			
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 13			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
a	If "Yes" (list url) HTTP //WWW TRINITYHEALTH COM			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		No
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed			
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		No
b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

TRINITY MEDICAL CENTER WEST

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a	☐ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 000000000000 % and FPG family income limit for eligibility for discounted care of _____ %			
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	Included measures to publicize the policy 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) _____			
b	☐ The FAP application form was widely available on a website (list url) _____			
c	☐ A plain language summary of the FAP was widely available on a website (list url) _____			
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	☐ Notice of availability of the FAP was conspicuously displayed throughout the hospital facility			
h	☐ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☐ Other (describe in Section C)			

Billing and Collections

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 non-payment?	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	☐ Actions that require a legal or judicial process			
d	☐ Other similar actions (describe in Section C)			
e	☐ None of these actions or other similar actions were permitted			

Part V Facility Information *(continued)*

TRINITY MEDICAL CENTER WEST

Name of hospital facility or letter of facility reporting group

			Yes	No
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	☐ Actions that require a legal or judicial process			
d	☐ 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	☐ Notified individuals of the financial assistance policy on admission			
b	☐ Notified individuals of the financial assistance policy prior to discharge			
c	☐ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills			
d	☐ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy			
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)			
Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)				
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 its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged			
b	☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged			
c	☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged			
d	☐ Other (describe in Section C)			
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care?	**23**		No
	If "Yes," explain in Section C			
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?	**24**		No
	If "Yes," explain in Section C			

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group TRINITY MEDICAL CENTER EAST

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	☐ Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA 20 13			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes	
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	6b		No
7	Did the hospital facility make its CHNA report widely available to the public?	7	Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a	☐ Hospital facility's website (list url) HTTP //WWW TRINITYHEALTH COM			
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 13			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
a	If "Yes" (list url) HTTP //WWW TRINITYHEALTH COM			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		No
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed			
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		No
b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

TRINITY MEDICAL CENTER EAST

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a	☐ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 000000000000 % and FPG family income limit for eligibility for discounted care of _____ %			
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	Included measures to publicize the policy 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) _____			
b	☐ The FAP application form was widely available on a website (list url) _____			
c	☐ A plain language summary of the FAP was widely available on a website (list url) _____			
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	☐ Notice of availability of the FAP was conspicuously displayed throughout the hospital facility			
h	☐ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☐ Other (describe in Section C)			

Billing and Collections

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 non-payment?	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	☐ Actions that require a legal or judicial process			
d	☐ Other similar actions (describe in Section C)			
e	☐ None of these actions or other similar actions were permitted			

Part V Facility Information *(continued)*

TRINITY MEDICAL CENTER EAST

Name of hospital facility or letter of facility reporting group

			Yes	No
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	☐ Actions that require a legal or judicial process			
d	☐ 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	☐ Notified individuals of the financial assistance policy on admission			
b	☐ Notified individuals of the financial assistance policy prior to discharge			
c	☐ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills			
d	☐ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy			
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)			
Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)				
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 its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged			
b	☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged			
c	☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged			
d	☐ Other (describe in Section C)			
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, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 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

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

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

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

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

Part VI Supplemental Information

Provide the following information

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

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

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

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

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

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

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

Form and Line Reference	Explanation
Part I, Line 3c	PATIENTS WHO QUALIFY FOR THE SLIDING SCALE PAYMENT AS DEFINED BY THE INDIGENT CARE POLICY ARE ELIGIBLE FOR THIS DISCOUNT, WHICH WILL BE APPLIED SUBSEQUENT TO THE SLIDING SCALE REDUCTIONS UNINSURED PATIENTS WILL RECEIVE A 40% DISCOUNT OFF TOTAL CHARGES

Form and Line Reference	Explanation
Part I, Line 7	A COST-TO-CHARGE RATIO WAS USED TO COMPLETE THE CHARITY CARE (LINE 7A) AND MEANS-TESTED GOVERNMENT PROGRAMS (LINE 7B) THE COST-TO-CHARGE RATIO WAS DERIVED FROM WORKSHEET 2 THAT ACCOMPANIES THE INSTRUCTIONS TO THIS SCHEDULE THE HOSPITAL'S COST ACCOUNTING RECORDS WERE USED TO COMPLETE THE OTHER BENEFITS SECTION (LINE 7E - 7I)

Form and Line Reference	Explanation
Part I, Line 7g	SUBSIDIZED HEALTH SERVICES INCLUDE THE PRENATAL CLINIC, FAMILY BIRTH CENTER, AND BEHAVIORAL MEDICINE

Form and Line Reference	Explanation
Part I, Ln 7 Col(f)	THE BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 24 - BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE SCHEDULE H, PART I, COLUMN F PERCENTAGE EQUALS $10,282,846

Form and Line Reference	Explanation
Part III, Line 4	ACCOUNTS RECEIVABLE FINANCIAL STATEMENT FOOTNOTE PATIENT ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FOR DOUBTFUL ACCOUNTS IN EVALUATING THE COLLECTIBILITY OF ACCOUNTS RECEIVABLE, TRINITY ANALYZES ITS HISTORICAL AND EXPECTED NET COLLECTIONS CONSIDERING BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN HEALTH CARE COVERAGE, AND OTHER COLLECTION INDICATORS FOR EACH OF ITS MAJOR PAYOR SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR DOUBTFUL ACCOUNTS AND PROVISIONS FOR BAD DEBTS PERIODICALLY THROUGHOUT THE YEAR, MANAGEMENT ASSESSES THE ADEQUACY OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS BASED UPON SPECIFIC ACCOUNTS, HISTORICAL WRITE OFF EXPERIENCE, AND CURRENT MARKET CONDITIONS THE RESULTS OF THIS REVIEW ARE THEN USED TO MAKE ANY MODIFICATIONS TO THE PROVISION FOR BAD DEBTS TO ESTABLISH AN APPROPRIATE ALLOWANCE FOR UNCOLLECTIBLE RECEIVABLES FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, TRINITY ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND A PROVISION FOR BAD DEBTS, IF NECESSARY, FOR EXPECTED UNCOLLECTIBLE DEDUCTIBLES AND COPAYMENTS ON ACCOUNTS FOR WHICH THE THIRD-PARTY PAYOR HAS NOT YET PAID, OR FOR PAYORS WHO ARE KNOWN TO BE HAVING FINANCIAL DIFFICULTIES THAT MAKE REALIZATION OF AMOUNTS DUE UNLIKELY FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS, WHICH INCLUDES BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLES AND COPAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL, TRINITY RECORDS A PROVISION FOR BAD DEBTS ON THE BASIS OF ITS EXPERIENCE THE DIFFERENCE BETWEEN THE STANDARD RATES AND THE AMOUNT ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS CHARGED OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS THE HOSPITAL HAS ESTIMATED THAT APPROXIMATELY 2 PERCENT OF THE ORGANIZATION'S BAD DEBT EXPENSE IS ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY THE BAD DEBT EXPENSE REPORTED ON PART III, LINE 2, IS THE BAD DEBT EXPENSE REPORTED ON FORM 990, PART IX

Form and Line Reference	Explanation
Part III, Line 8	THE AMOUNTS REPORTED FOR MEDICARE ARE FROM THE MEDICARE COST REPORT - WHICH IS BASED ON THE METHODOLOGY REQUIRED FOR COMPLETING THE MEDICARE COST REPORT THE MEDICARE SHORTFALL SHOULD BE TREATED AS A COMMUNITY BENEFIT JEFFERSON COUNTY, WHERE TRINITY HEALTH SYSTEM IS LOCATED, HAS ONE OF THE HIGHEST PROPORTIONS OF ELDERLY IN THE STATE OF OHIO AS A RESULT, THE USE OF HEALTH CARE SERVICE, AND ALSO MEDICARE, IS HIGHER THAN THE STATE AVERAGE TRINITY ACCEPTS ALL PATIENTS REGARDLESS OF THEIR ABILITY TO PAY

Form and Line Reference	Explanation
Part III, Line 9b	THE HEALTH SYSTEM IS COMMITTED TO SERVE EVERYONE AND ACCEPTS ALL PATIENTS REGARDLESS OF THEIR ABILITY TO PAY A PATIENT IS CLASSIFIED AS A CHARITY PATIENT BY REFERENCE TO CERTAIN ESTABLISHED POLICIES OF THE HEALTH SYSTEM ESSENTIALLY, THESE POLICIES DEFINE CHARITY SERVICES AS THOSE SERVICES FOR WHICH NO PAYMENT IS ANTICIPATED IN ASSESSING A PATIENT'S ABILITY TO PAY, THE HEALTH SYSTEM UTILIZES THE GENERALLY RECOGNIZED POVERTY INCOME LEVELS ESTABLISHED BY THE FEDERAL GOVERNMENT, BUT ALSO INCLUDES CERTAIN CASES WHERE INCURRED CHARGES ARE SIGNIFICANT WHEN COMPARED TO PATIENT INCOME AND RESOURCES THE HEALTH SYSTEM'S POLICY PROVIDES CHARITY CARE TO PATIENTS UP TO 200% OF THE FEDERAL POVERTY LEVEL THE HOSPITAL PROVIDES CARE TO PERSONS COVERED BY GOVERNMENTAL PROGRAMS AT BELOW COST RECOGNIZING ITS MISSION TO THE COMMUNITY, SERVICES ARE PROVIDED TO BOTH MEDICARE AND MEDICAID PATIENTS TO THE EXTENT REIMBURSEMENT IS BELOW COST, THE HOSPITAL RECOGNIZED THESE AMOUNTS AS CHARITY CARE IN MEETING ITS MISSION TO THE ENTIRE COMMUNITY IN 2015, CHARITY CARE APPROXIMATED $6,143,839 TO EDUCATE AND INFORM OUR PATIENTS ABOUT THEIR ELIGIBILITY FOR ASSISTANCE UNDER FEDERAL, STATE OR LOCAL GOVERNMENT PROGRAMS OR UNDER OUR CHARITY CARE POLICY, SELF-PAY INPATIENTS ARE INTERVIEWED BY THE ORGANIZATION'S FINANCIAL COUNSELORS AT THIS TIME, THE CHARITY IS DISCUSSED AND EXPLAINED TO THE PATIENT AND THEY MAY REQUEST A CHARITY APPLICATION TO COMPLETE IF A PATIENT HAPPENS TO BE DISCHARGED WITHOUT BEING INTERVIEWED, THE FIRST PATIENT BILLING STATEMENT ALSO STATES THE CHARITY GUIDELINES AND THEY ARE GIVEN THE OPPORTUNITY TO CONTACT THE HOSPITAL FOR AN APPLICATION FOR OUTPATIENT ACCOUNTS, ANY BALANCE BILLING AFTER INSURANCE ALSO EXPLAINS THE CHARITY GUIDELINES TO PATIENTS

Form and Line Reference	Explanation
Part VI, Line 2	TRINITY HEALTH SYSTEM, WHICH CONSISTS OF TWO HOSPITALS - TRINITY EAST AND TRINITY WEST, IS A 500 BED HEALTH SYSTEM LOCATED IN STEUBENVILLE, OHIO TRINITY HEALTH SYSTEM IS AN EXTENS ION OF THE MISSIONS AND PROUD HERITAGES OF ITS CO-SPONSORS, TRI STATE HEALTH SERVICES (REF LECTING THE PERSPECTIVES OF THE LOCAL COMMUNITY) AND SYLVANIA FRANCISCAN HEALTH (REPRESENT ING THE PERSPECTIVES OF THE HEALTH CARE MINISTRY OF THE SISTERS OF ST FRANCIS OF SYLVANIA , OHIO) AS A NON-PROFIT, CHARITABLE HEALTH CARE DELIVERY SYSTEM, TRINITY HEALTH SYSTEM IS DEDICATED TO PRESERVING THE SECULAR COMMUNITY TRADITIONS AND THE CATHOLIC TRADITIONS OF I TS CO-SPONSORS IN THE DELIVERY OF HEALTH CARE IN THE GREATER STEUBENVILLE, OHIO REGION THE SISTERS OF ST FRANCIS OF SYLVANIA, OHIO SPONSOR THEIR HEALTH AND HUMAN SERVICES MINISTRY THROUGH FRANCISCAN SERVICES CORPORATION THE ORGANIZATION, LOCATED IN OHIO, TEXAS, AND KE NTUCKY INCLUDE SIX HOSPITALS, EIGHT LONG-TERM CARE FACILITIES, FOUR ASSISTED LIVING FACILI TIES, INDEPENDENT SENIOR HOUSING, A COUNSELOR CENTER AND A LONG-TERM DOMESTIC SHELTER TRIN ITY HEALTH SYSTEM IS ORGANIZED TO PROMOTE THE HEALTH OF THE COMMUNITY OUR MISSION IS TO B E A COMMUNITY PARTNER DEDICATED TO EXCELLENCE IN SERVING THE HEALTH NEEDS OF THE TRI-STATE AREA WE PURSUE THAT MISSION THROUGH TWO RESPECTED HOSPITALS, AS WELL AS IN OUTPATIENT FAC ILITIES, PHYSICIAN'S OFFICES, COMMUNITY OUTREACH SITES AND HOMES THROUGHOUT THE TRI-STATE AREA OUR MISSION IS THE PURPOSE OF THE ORGANIZATION WE ARE ORGANIZED TO IDENTIFY AND RESP OND TO COMMUNITY NEEDS WE EXECUTE OUR MISSION UNDER THE AUTHORITY OF OUR BOARD MEMBERS I NCLUDE COMMUNITY REPRESENTATIVES WHO RESIDE IN THE ORGANIZATION'S PRIMARY SERVICE AND ARE NEITHER EMPLOYEES NOR CONTRACTORS OF THE ORGANIZATION, NOR FAMILY MEMBER THEREOF THE BOAR D'S MISSION ALSO INCLUDES PROCESSES FOR DETERMINING AND RESPONDING TO HEALTH NEEDS SERVIN G MORE THAN 228,000 PATIENTS IN 2015, TRINITY IS A LEADING HEALTHCARE SYSTEM IN THE VALLEY OUR 1,800 EMPLOYEES AND PHYSICIANS UTILIZE STATE-OF-THE-ART FACILITIES, ADVANCED TECHNOL OGIES AND THE LATEST PROCEDURES TO ACCOMPLISH OUR MISSION AND TO IMPROVE THE HEALTH OF THE COMMUNITIES WE SERVE IN CONJUNCTION WITH THE TRI-STATE HEALTH SERVICES, ONE OF OUR SPONSO RS, WE PROVIDE A MOBILE MEDICAL VAN THAT GOES TO VARIOUS PLACES IN OUR COMMUNITY TO EDUCAT E THE POPULATION ABOUT DIFFERENT TOPICS AND PROVIDE HEALTHCARE FOR THE POOR AND OTHER DISA DVANTAGED RESIDENTS AT EACH SITE THE VAN VISITS, THE FOLLOWING TESTS ARE AVAILABLE FREE BREATHING TEST, FREE BLOOD PRESSURE, FREE BLOOD TEST FOR AAT DEFICIENCY (DETERMINES THOSE AT RISK OF DEVELOPING COPD) THE HEALTH SYSTEM'S PRIMARY SERVICE AREA ENCOMPASSES A THREE C OUNTY AREA IN OHIO AND WEST VIRGINIA THE COUNTIES ARE JEFFERSON COUNTY, OHIO AND BROOKE A ND HANCOCK COUNTIES, WV RESIDENTS FROM THESE 3 COUNTIES PROVIDE FOR OVER 11,300 ADMISSION S TO THE SYSTEM AND ACCOUNT FOR 85% OF THE HOSPITAL'S ADMISSIONS JEFFERSON COUNTY IS LOCA TED ON THE OHIO AND WEST VIRGINIA BORDERS ALONG THE OHIO RIVER, APPROXIMATELY 40 MILES WES T OF PITTSBURGH, PA JEFFERSON COUNTY HAS EXPERIENCED A DECLINING POPULATION OVER THE PAST 20 YEARS AND HAS THE HIGHEST PROPORTION OF ELDERLY IN THE STATE OF OHIO AS A RESULT, THE USE OF HEALTH CARE SERVICES IS HIGHER THAN THE STATE AVERAGE WE ARE ALSO DEDICATED TO MED ICAL EDUCATION, SPONSORING A TWO YEAR NURSING DEGREE PROGRAM THE PURPOSE OF THE TRINITY HE ALTH SYSTEM SCHOOL OF NURSING IS TO PREPARE A BEGINNING PROFESSIONAL NURSE THE PROGRAM AS SISTS INDIVIDUALS TO ACHIEVE CURRICULUM OUTCOMES AND DEMONSTRATES PROFESSIONAL COMPETENCIE S NECESSARY TO PRACTICE IN A VARIETY OF HEALTH CARE SETTINGS AND INCORPORATES THE CORE VAL UES OF TRINITY HEALTH SYSTEM THE PHILOSOPHY OF THE TRINITY HEALTH CARE SYSTEM SCHOOL OF NU RSING IS REFLECTIVE OF FACULTY BELIEFS AND IS IN ACCORD WITH THE MISSION OF THE TRINITY HE ALTH SYSTEM THE SCHOOL OF NURSING FULFILLS ITS RESPONSIBILITY TO SOCIETY BY PREPARING A P ROFESSIONAL NURSE WHO PRACTICES SAFELY AND ETHICALLY WITHIN THE HOSPITAL OR OTHER HEALTHCA RE SETTINGS THE TRINITY HEALTH SYSTEM SCHOOL OF NURSING IS A 24-MONTH DIPLOMA PROGRAM, IS ACCREDITED BY THE NATIONAL LEAGUE FOR NURSING ACCREDITING COMMISSION, (INITIAL PROGRAM ACC REDITATION JUNE, 1965) AND IS APPROVED BY THE OHIO BOARD OF NURSING THE SCHOOL OF NURSING IS CERTIFIED BY THE OHIO BOARD OF REGENTS, AN AFFILIATE OF THE HELENE FUND HEALTH TRUST, AND IS APPROVED BY THE OHIO DEPARTMENT OF EDUCATION FOR VETERAN'S ADMINISTRATION BENEFITS THE SCHOOL IS AFFILIATED WITH TWO MODERN PROGRESSIVE MEDICAL FACILITIES, TRINITY MEDICAL C ENTER EAST AND TRINITY MEDICAL CENTER WEST, THAT PROVIDE STUDENT CLINICAL LEARNING EXPERIE NCE IN BOTH OUT-PATIENT AND IN-PATIENT ACUTE/MEDICAL SURGICAL CARE, EXTENDED-CARE, REHABIL ITATIVE CARE, AND HEALTH CLINIC SETTINGS TRINITY MEDICAL CENTER EAST/WEST ARE ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION FOR HEALTHCARE ORGANIZATION AND HOLD INSTITUTIONA L MEMBERSHIP IN THE OHIO HOSPITAL ASSOCIATION AND

Form and Line Reference	Explanation
Part VI, Line 2	THE VOLUNTARY HOSPITAL ASSOCIATION OF AMERICA EASTERN GATEWAY COMMUNITY COLLEGE (EGCC) IS AN ACCREDITED EDUCATIONAL INSTITUTION THE COLLEGE WAS CHARTERED FOR OPERATION IN 1966 AS A PUBLIC COLLEGE BY THE OHIO BOARD OF REGENTS STUDENTS RECEIVE FULL CREDIT FOR COLLEGE CO URSES THROUGH THIS AFFILIATION CLASSES ARE TAUGHT BY EGCC FACULTY AT THE SCHOOL OF NURSIN G CAMPUS

Form and Line Reference	Explanation
Part VI, Line 3	THE HEALTH SYSTEM IS COMMITTED TO SERVE EVERYONE REGARDLESS OF THEIR ABILITY TO PAY A PATIENT IS CLASSIFIED AS A CHARITY PATIENT BY REFERENCE TO CERTAIN ESTABLISHED POLICIES OF THE HEALTH SYSTEM ESSENTIALLY, THESE POLICIES DEFINE CHARITY SERVICES AS THOSE SERVICES FOR WHICH NO PAYMENT IS ANTICIPATED IN ASSESSING A PATIENT'S ABILITY TO PAY, THE HEALTH SYSTEM UTILIZES THE GENERALLY RECOGNIZED POVERTY INCOME LEVELS ESTABLISHED BY THE FEDERAL GOVERNMENT, BUT ALSO INCLUDES CERTAIN CASES WHERE INCURRED CHARGES ARE SIGNIFICANT WHEN COMPARED TO PATIENT INCOME AND RESOURCES THE HEALTH SYSTEM'S POLICY PROVIDES CHARITY CARE TO PATIENTS UP TO 200% OF THE FEDERAL POVERTY LEVEL THE HOSPITAL PROVIDES CARE TO PERSONS COVERED BY GOVERNMENTAL PROGRAMS AT BELOW COST RECOGNIZING ITS MISSION TO THE COMMUNITY, SERVICES ARE PROVIDED TO BOTH MEDICARE AND MEDICAID PATIENTS TO THE EXTENT REIMBURSEMENT IS BELOW COST, THE HOSPITAL RECOGNIZED THESE AMOUNTS AS CHARITY CARE IN MEETING ITS MISSION TO THE ENTIRE COMMUNITY IN 2015,CHARITY CARE APPROXIMATED $6,143,839 TO EDUCATE AND INFORM OUR PATIENTS ABOUT THEIR ELIGIBILITY FOR ASSISTANCE UNDER FEDERAL, STATE, OR LOCAL GOVERNMENT PROGRAMS OR UNDER OUR CHARITY CARE POLICY, SELF-PAY INPATIENTS ARE INTERVIEWED BY THE ORGANIZATION'S FINANCIAL COUNSELORS AT THIS TIME, THE CHARITY ISDISCUSSED AND EXPLAINED TO THE PATIENT AND THEY MAY REQUEST A CHARITY APPLICATION TO COMPLETE IF A PATIENT HAPPENS TO BE DISCHARGED WITHOUT BEING INTERVIEWED, THE FIRST PATIENT BILLING STATEMENT ALSO STATES THE CHARITY GUIDELINES AND THEY ARE GIVEN THE OPPORTUNITY TO CONTACT US FOR CHARITY APPLICATIONS FOR OUTPATIENT ACCOUNTS, ANY BALANCE BILLING AFTER INSURANCE ALSO EXPLAINS THE CHARITY GUIDELINES TO PATIENTS

Form and Line Reference	Explanation
Part VI, Line 4	THE HEALTH SYSTEM CONSIDERS JEFFERSON COUNTY, OHIO AND BROOKE AND HANCOCK, WEST VIRGINIA, TO BE ITS PRIMARY SERVICE AREA, WITH THE MAJORITY OF BUSINESS COMING FROM JEFFERSON COUNTY RESIDENTS (JEFFERSON COUNTY ACCOUNTS FOR 66% OF INPATIENT BUSINESS) THE POPULATION OF JEFFERSON COUNTY HAS DECLINED OVER THE PAST 20 YEARS AND IS PROJECTED TO CONTINUE TO DECLINE IN ALL AGE COHORTS THE UNEMPLOYMENT RATE OF THE SERVICE AREA IS WELL ABOVE BOTH STATE AND NATIONAL AVERAGES, WITH THE MOST RECENT DATA REPORTED FOR THE FIRST QUARTER OF 2009 FOR JEFFERSON COUNTY TO BE 10 5% BROOKE AND HANCOCK COUNTIES REPORT SIMILAR UNEMPLOYMENT RATES FOR THE FIRST QUARTER AT 9 9% AND 10 4%, RESPECTIVELY A KEY CHALLENGE FOR THE HEALTH SYSTEM IS OPERATING WITHIN AN AREA THAT IS EXPERIENCING SIGNIFICANT POPULATION DECLINES AND A DETERIORATING ECONOMIC CLIMATE THE HEALTH SYSTEM EXPERIENCES SIGNIFICANT OUT-MIGRATION, BOTH DIRECTED BY THE HOSPITAL AS WELL AS BY PATIENT/PHYSICIAN PREFERENCE UNTIL 2006, OUT MIGRATION HAD BEEN ON A RISE FOR PRIMARY SERVICE AREA RESIDENTS WHO UTILIZE PENNSYLVANIA AND OHIO HOSPITALS HOWEVER, BEGINNING IN 2007, OUT MIGRATION FROM TRINITY'S PRIMARY SERVICE AREA TO OTHER HOSPITALS IN OHIO, PENNSYLVANIA, AND WEST VIRGINIA HAS DECLINED IN 2007, (MOST RECENT PUBLIC DATA AVAILABLE), WE HAVE SEEN REDUCTION IN OUT MIGRATION FROM OUR PRIMARY SERVICE AREA TO PENNSYLVANIA, OHIO AND WEST VIRGINIA HOSPITALS OF (10 1%), (4 8%) AND (2 5%) RESPECTIVELY WE HAVE ALSO REALIZED AN INCREASE IN MARKET SHARE IN JEFFERSON COUNTY FROM 2006 LEVEL OF 65 68% TO 2007 LEVEL OF 66 27% WE HAVE SEEN SIMILAR INCREASES IN BROOKE AND HANCOCK COUNTIES AS WELL WITH THE MARKET SHARE INCREASING FROM 2006 LEVEL OF 20 99% TO 2007 LEVEL OF 21 46% OVERALL, THE DATA DOCUMENTS THAT WE MET OUR PLANNING GOAL OF IMPROVING THE MARKET SHARE BY 1 PERCENTAGE POINT A YEAR OVERALL, THE SERVICE AREA OF THE SYSTEM HAS A LOWER AVERAGE HOUSEHOLD INCOME THAN THE STATE OF OHIO AND A HIGHER UNEMPLOYMENT RATE JEFFERSON COUNTY IS ECONOMICALLY DEPRESSED WITH A PER-CAPITA INCOME LOWER THAN STATE AVERAGES ALL 3 COUNTIES IN THE SYSTEM'S IMMEDIATE SERVICE AREA HAVE A HIGHER PROPORTION OF THE POPULATION AT OR BELOW THE POVERTY LEVEL THE ECONOMIC CONDITIONS OF THE AREA HAVE HINDERED THE GROWTH OF THE HOSPITAL AND MORE SELF-PAY PATIENTS HAVE TAKEN ADVANTAGE OF THE HOSPITAL'S SERVICES CHARITY CARE AND BAD DEBT ACCOUNTS HAVE INCREASED EACH YEAR FOR THE LAST FEW YEARS AS RECENTLY UNEMPLOYED RESIDENTS LOSE THEIR HEALTH BENEFITS, WE EXPECT HIGHER CHARITY CARE LEVELS THE PAYOR MIX AT TRINITY HEALTH SYSTEM IS HEAVILY WEIGHTED TO THE GOVERNMENTAL PAYERS, WITH 42% OF THE 2015 YTD REVENUE GENERATED FROM MEDICARE AND 10% GENERATED FROM THE MEDICAID PROGRAM WITH THE 2 PROGRAMS RECORDING SIGNIFICANT SHORTFALLS BETWEEN PAYMENT TO HOSPITALS AND HOSPITAL COSTS, THE ECONOMIC CHALLENGES FOR TRINITY ARE GREAT

Form and Line Reference	Explanation
Part VI, Line 5	- TRINITY'S HEART CENTER MEANS NO MORE WASTED TIME IN TRAVEL TO PITTSBURGH HOSPITALS - WHE N TIME IS A KEY FACTOR FOR HEART RELATED PROBLEMS MINUTES ARE CRUCIAL TO THE SURVIVAL OF PEOPLE WITH THE SUDDEN ONSET OF SERIOUS CARDIAC PROBLEMS NOW SUPERIOR HEART CARE WILL BE A LOT CLOSER TO WHERE YOU LIVE AND WORK TRINITY'S HEART CENTER OFFERS ALL AREAS OF HEART CARE INCLUDING OPEN HEART SURGERY, ANGIOPLASTY, NUCLEAR CARDIOLOGY, ULTRASOUND, EKG, ELEC TROPHYSIOLOGY PROCEDURES, CARDIAC REHABILITATION, STRESS TESTING, AND EDUCATIONAL PROGRAMS - TRINITY HEALTH SYSTEM ONCE AGAIN SPONSORED HEARTLAND DESIGNED AS THE "LARGEST HEART RI SK APPRAISAL UNDER ONE ROOF", THE EVENT MARKS ITS 21ST YEAR TRINITY HEALTH SYSTEM IS OFFE RING THIS PROGRAM TO HELP COMMUNITY MEMBERS IMPROVE THEIR HEALTH THROUGH SCREENINGS AND IN FORMATION THE EVENT INCLUDES THE COMMUNITY BLOOD ANALYSIS WHICH TESTS PARTICIPANTS BLOOD FOR OVER 30 DIFFERENT SCREENS OUR SCREENING HAS BEEN WELL ATTENDED FOR 21 YEARS AND WE AL WAYS EXPECT A LARGE CROWD SEVERAL TRINITY HEALTH SYSTEM SERVICES PERSONNEL WILL BE ON HAN D TO DISCUSS THEIR SERVICES AND PROVIDE SCREENINGS IN CONJUNCTIONS WITH THE SCREENINGS CO ST OF THE BLOOD SCREENING IS $30 00 OVER 21,500 AREA RESIDENTS HAVE PARTICIPATED IN THE E VENT OVER THE YEARS - TRINITY HEALH SYSTEM OFFERS A WIDE VARIETY OF HEALTH EDUCATION AND A SSISTANCE PROGRAMS THAT ARE AVAILABLE TO THE COMMUNITY MANY OF THESE SERVICES ARE EITHER FREE OR ARE AVAILABLE FOR A NOMINAL FEE - COMMUNITY SERVICE REFERRAL IS A FREE SERVICE PRO VIDED TO THE COMMUNITY THE HOSPITAL CAN PROVIDE INFORMATION AND REFERRALS TO NUMEROUS ARE A AGENCIES WITH PROVIDE SUCH PROGRAMS AS SELF-HELP GROUPS, SOCIAL SERVICES (EMERGENCY FOOD /SHELTER, ETC), TRANSPORTATION, MEDICAL SUPPLY COMPANIES, AND NATIONAL MEDICAL HOTLINES THE AGENCIES DO NOT HAVE TO PAY A FEE TO BE LISTED WITH REFERRAL SERVICES - TRINITY HEALTH SYSTEM'S CARDIAC REHABILITATION PROGRAM IS DESIGNED TO EFFECT LIFESTYLE CHANGE IN PATIENT S ENROLLED THESE CHANGES ARE ACHIEVED THROUGH SAFE, PHYSICAL CONDITIONING, SOUND EDUCATIO NAL SESSIONS, AND GROUP SUPPORT, WHICH EMPHASIZE THE UNDERSTANDING OF RISK FACTORS ASSOCIA TED WITH HEART DISEASE THE PROGRAM'S GOAL IS TO ENHANCE THE QUALITY OF LIFE FOR THE PATIE NT BY PARTICIPATING IN OUR CARDIAC REHABILITATION PROGRAM, PATIENTS CAN LEARN HOW TO ACHI EVE AND MAINTAIN THE HEALTHIEST LIFESTYLE POSSIBLE OUR SPECIALLY TRAINED STAFF WORKS WITH PATIENTS, THEIR FAMILIES, AND PHYSICIANS TO DEVELOP A PERSONALIZED PROGRAM OF HEALTH AND WELLNESS AS AN INTEGRAL PART OF THE OVERALL PROGRAM, EDUCATION INCREASES A PATIENT'S UNDE RSTANDING OF THEIR ILLNESS AND HELPS THEM TO IDENTIFY CURRENT HABITS THAT CAN NEGATIVELY A FFECT THEIR CARDIAC CONDITION WE COVER ISSUES LIKE RISK FACTOR REDUCTION, ANGINA, HEART A TTACK, MEDICATION, DIETARY AND EXERCISE GUIDELINES, SMOKING, AND BREATHING AND RELAXATION METHODS REGULAR EXERCISE INCREASES STRENGTH AND IMPROVES MUSCLE TONE IT CAN ALSO DECREAS E A PATIENT'S RESTING HEART RATE AND BLOOD PRESSURE, ASSIST IN WEIGHT CONTROL, DECREASE ST RESS, AND ENHANCE THEIR ABILITY TO PERFORM DAILY ACTIVITIES SUPPORT WILL HELP PATIENTS AN D THEIR FAMILIES REALIZE THEY ARE NOT ALONE AND TO DEVELOP RELATIONSHIPS WITH OTHER CLIENT S AND STAFF - THE DIABETES OUTPATIENT EDUCATION PROGRAM AT TRINITY HEALTH SYSTEM IS SPECI FICALLY DESIGNED TO AID THE PATIENT WITH DIABETES TO MAKE RESPONSIBLE DECISIONS IN THE CAR E OF THEIR DISEASE THE PROGRAM IS OFFERED IN SEVEN SESSIONS CONTENT INCLUDES DISEASE PR OCESS, ACUTE COMPLICATIONS/SICK DAYS, TRAVELING, NUTRITIONAL SESSIONS BY A CERTIFIED DIETI CIAN, EXERCISE AND MONITORING, MEDICATIONS, AND GENERAL HEALTH CARE / CHRONIC COMPLICATION S - TRINITY HEALTH SYSTEM'S CHILDBIRTH PREPARATION CLASSES CAN HELP PREPARE MOTHERS AND FA MILIES FOR THE NEW CHALLENGES THAT COME WITH THE BIRTH OF A CHILD OUR PROFESSIONAL STAFF OF NURSES CAN HELP PARENTS, GRANDPARENTS AND SIBLINGS PREPARE FOR AN UPCOMING BIRTH EVENT, AND CAN OFFER INSIGHTFUL ADVICE AND INFORMATION ON HOW TO CARE FOR A NEWBORN OUR PROGRAM GUIDES AND SUPPORTS PARENTS DURING PREGNANCY, LABOR, DELIVERY, AND PARENTHOOD WE WILL DI SCUSS ISSUES RELATING TO UPCOMING LABOR, DELIVERY, ANESTHESIA, PRENATAL TESTING, INFANT CA RE, SAFETY THIS COURSE INCLUDES PREPARING PARENTS FOR LABOR AND BIRTH THROUGH THE USE OF RELAXATION AND BREATHING TECHNIQUES PARENTS WILL ALSO BE GIVEN A TOUR OF AND ORIENTATION TO TRINITY'S FAMILY BIRTH CENTER - TRINITY HEALTH SYSTEM'S PULMONARY REHABILITATION PROGR AM IS DESIGNED TO EFFECT LIFESTYLE CHANGE IN PATIENTS ENROLLED THESE CHANGES ARE ACHIEVED THROUGH SAFE, PHYSICAL CONDITIONING, SOUND EDUCATIONAL SESSIONS, AND GROUP SUPPORT, WHICH EMPHASIZE THE UNDERSTANDING OF CHRONIC OBSTRUCTED PULMONARY DISEASE THE PROGRAM'S GOAL I S TO ENHANCE THE QUALITY OF LIFE FOR THE PATIENT AGE IS NOT A FACTOR BY PARTICIPATING IN OUR PULMONARY REHABILITATION PROGRAM, PATIENTS CAN LEARN HOW TO ACHIEVE AND MAINTAIN THE HEALTHIEST LIFESTYLE POSSIBLE OUR SPECIALLY TRAIN

Form and Line Reference	Explanation
Part VI, Line 5	ED STAFF WORKS WITH PATIENTS, THEIR FAMILIES, AND PHYSICIANS TO DEVELOP A PERSONALIZED PRO GRAM OF HEALTH AND WELLNESS THE GOALS OF TRINITY HEALTH SYSTEM'S PULMONARY REHABILITATION PROGRAM ARE INCREASED UNDERSTANDING OF LUNG DISEASE, INCREASED MUSCULAR FITNESS, INCREAS ED ENDURANCE, IMPROVED SENSE OF WELL-BEING, AND DECREASED SHORTNESS OF BREATH WITH ACTIVIT Y - GRANDCARE AT TRINITY MEDICAL CENTER WEST IS THE NEXT BEST THING TO GRANDMA'S ARMS WHEN A CHILD IS SICK WORK SCHEDULES OR PLANS CAN BE DISRUPTED AND USUALLY CANCELLED DUE TO A LACK OF QUALIFIED CHILD CARE PROGRAMS FOR SICK CHILDREN CHILDREN FROM SIX WEEKS TO SIXTEE N YEARS OF AGE ARE WELCOME AND THE SERVICE IS AVAILABLE 24 HOURS A DAY AND SEVEN DAYS A WE EK ONLY CHILDREN SUFFERING FROM CHICKEN POX, OR PHYSICALLY AND EMOTIONALLY HANDICAPPED AR E EXCLUDED ALL SERVICES SUCH AS ISOLATION AND PRESCRIBED THERAPIES ARE AVAILABLE MEMBERS OF THE PEDIATRIC DEPARTMENT NURSING STAFF ARE IN CHARGE OF CARE MEALS AND SNACKS ARE INC LUDED THE SPEAKER'S BUREAU WILL ADDRESS COMMUNITY ORGANIZATIONS, SCHOOLS, CHURCHES, AND BU SINESSES TOPICS INCLUDE ACLS, ERGONOMICS, ORTHOPEDIC, ADVANCE DIRECTIVES, EXERCISE, DISO RDERS/DISEASE, AIDS/HIV, FOOT/ANKLE DISORDERS, OSTEOARTHRITIS, AQUATICS, GASTROENTEROLOGY DISEASES, OSTEOPOROSIS, BIRTH CONTROL, HEALTH CARE REFORM, PHYSICAL THERAPY, BODY RECALL, HEART DISEASE, PROSTATE DISEASE, CANCER, HEARTLAND, SEIZURES, CARDIAC REHABILITATION, HOME HEALTH, SENIORS BENEFITS, CHILD DEVELOPMENT, IMPOTENCE, SEXUALLY TRANSMITTED DISEASE, CHI LDBIRTH, INCONTINENCE, CHILDHOOD IMMUNIZATIONS, INFECTIOUS DISEASES, SKIN DISORDERS, CPR/F IRST AID, MEDICATIONS/DRUG THERAPY, SMOKING CESSATION, DIABETIC FOOT CARE, NEONATOLOGY, SP ORTS MEDICINE, DRUG ABUSE, NEUROLOGICAL DISORDERS, STRESS MANAGEMENT, EATING DISORDERS, NU TRITION, TEENAGE SEXUALITY, EKG, OCCUPATIONAL THERAPY, WEIGHT MANAGEMENT, ENT DISORDERS, O PTHALMOLOGY, WELLNESS, ENTEROSTOMAL THERAPY, AND WOMEN'S HEALTH ISSUES - THE EMERGENCY SER VICES OF TRINITY HEALTH SYSTEM ARE AVAILABLE AT TRINITY MEDICAL CENTER WEST EMERGENCY SER VICES ARE OPEN TO ALL, REGARDLESS OF ABILITY TO PAY IN 2015, WE HAD OVER 46,000 ER VISITS THE TRINITY MEDICAL CENTER WEST EMERGENCY DEPARTMENT HAS BEEN REMODELED AND EXPANDED TO ACCOMMODATE PATIENTS REQUIRING TREATMENT THE EMERGENCY DEPARTMENT HAS DOUBLED IN SIZE AND TWICE AS MANY TREATMENT BEDS ARE NOW AVAILABLE A DEDICATED X-RAY ROOM HAS BEEN CONSTRUCT ED ADJACENT TO THE EMERGENCY DEPARTMENT PHYSICIAN, PROFESSIONAL AND SUPPORT STAFF HAVE BE EN ADDED TO PROVIDE CARE FOR PATIENTS 24 HOURS / 7 DAYS PER WEEK SPECIAL TREATMENT AREAS HAVE BEEN CONSTRUCTED FOR CARDIAC EMERGENCIES, OBSTETRICAL EMERGENCIES, PEDIATRIC EMERGEN CIES, TRAUMA, SUTURING (STITCHES), AND FRACTURES TRINITY SERVICES ALL LEVELS OF EMERGENCY AND URGENT CARE INCLUDING CARDIAC EMERGENCIES, ACUTE RESPIRATORY EMERGENCIES, TRAUMA, CH EST PAIN CENTER, FRACTURES, AND SUTURING AS WELL AS MEDICAL EMERGENCIES INCLUDING, BUT NO T LIMITED TO ACUTE APPENDICITIS, CEREBRAL ANEURYSMS, GALL BLADDER ATTACKS, ACUTE ABDOMINA L PAIN, PEDIATRIC EMERGENCIES, AND UNEXPECTED BLEEDING OR SEVERE PAIN - TRINITY DEVELOPED A PARTNERSHIP WITH THE YMCA THE YMCA IS A MEMBERSHIP ORGANIZATION DEDICATED TO IMPROVING THE QUALITY OF LIFE IN OUR COMMUNITY THROUGH PROGRAMS, SERVICE AND LEADERSHIP, THE YMCA P ROMOTES ETHICAL VALUES THAT CONTRIBUTE TO ITS MEMBERS' GROWTH IN BUILDING HEALTHY SPIRITS, MINDS AND BODIES THE YMCA IS OPEN FOR ALL, PROVIDING FINANCIAL ASSISTANCE TO THOSE IN NE ED FOR MORE THAN 100 YEARS, THE YMCA HAS SERVED THE COMMUNITIES IN THE TRI-STATE AREA OF OHIO, WEST VIRGINIA AND PENNSYLVANIA WHEN YOU JOIN THE STEUBENVILLE YMCA, YOU BECOME PART OF AN INTERNATIONAL MOVEMENT TO BUILD STRONG KIDS, STRONG FAMILIES, AND STRONG COMMUNITIE S APPROACHING 4,000 MEMBERS, THE YMCA HAS BEEN ABLE TO EXPAND PROGRAMMING THROUGHOUT THE YEAR AS A RESULT OF THE POSITIVE RESPONSE FROM THE ENTIRE COMMUNITY

Form and Line Reference	Explanation
Part VI, Line 6	TRINITY HEALTH SYSTEM, WHICH CONSISTS OF TWO HOSPITALS - TRINITY EAST AND TRINITY WEST, IS A 500 BED HEALTH SYSTEM LOCATED IN STEUBENVILLE, OHIO TRINITY HEALTH SYSTEM IS AN EXTENSION OF THE MISSIONS AND PROUD HERITAGES OF ITS CO-SPONSORS, TRI STATE HEALTH SERVICES (REFLECTING THE PERSPECTIVES OF THE LOCAL COMMUNITY) AND SYLVANIA FRANCISCAN HEALTH (REPRESENTING THE PERSPECTIVES OF THE HEALTH CARE MINISTRY OF THE SISTERS OF ST FRANCIS OF SYLVANIA, OHIO) AS A NON-PROFIT, CHARITABLE HEALTH CARE DELIVERY SYSTEM, TRINITY HEALTH SYSTEM IS DEDICATED TO PRESERVING THE SECULAR COMMUNITY TRADITIONS AND THE CATHOLIC TRADITIONS OF ITS CO-SPONSORS IN THE DELIVERY OF HEALTH CARE IN THE GREATER STEUBENVILLE, OHIO REGION

Form and Line Reference	Explanation
Part VI, Line 7, Reports Filed With States	OH

Additional Data

Software ID:
Software Version:
EIN: 30-0752920
Name: TRINITY HEALTH SYSTEM GROUP

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?
2

	Name, address, primary website address, and state license number	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (Describe)	Facility reporting group
1	TRINITY MEDICAL CENTER WEST 4000 JOHNSON ROAD STEUBENVILLE,OH 43952	X	X					X			
2	TRINITY MEDICAL CENTER EAST 380 SUMMIT AVENUE STEUBENVILLE,OH 43952	X	X								

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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

2015

Open to Public Inspection

Name of the organization
TRINITY HEALTH SYSTEM GROUP

Employer identification number
30-0752920

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a Complete Part III to provide any relevant information regarding these items			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax idemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (e g , maid, chauffeur, chef)		
b	If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	**1b**		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?	**2**		
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director Check all that apply Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III			
	☐ Compensation committee	☐ Written employment contract		
	☐ Independent compensation consultant	☐ Compensation survey or study		
	☐ Form 990 of other organizations	☐ Approval by the board or compensation committee		
4	During the year, did any person listed on Form 990, Part VII, Section A, line 1a with respect to the filing organization or a related organization			
a	Receive a severance payment or change-of-control payment?	**4a**		No
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**		No
c	Participate in, or receive payment from, an equity-based compensation arrangement?	**4c**		No
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III			
	Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.			
5	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of			
a	The organization?	**5a**		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 non-fixed 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 3	THE CEO IS COMPENSATED BY TRINITY HEALTH SYSTEM, WHO USES A COMPENSATION COMMITTEE, COMPENSATION SURVEY OR STUDY AND APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE, TO DETERMINE COMPENSATION
PART II	TRINITY HEALTH SYSTEM GROUP MAINTAINS A NON-QUALIFIED RETIREMENT PLAN FOR FRED BROWER AND LEWIS MUSSO THE PLAN IS A SERP AND THE INCREASE IN BENEFITS IS CALCULATED ANNUALLY BASED ON THE TERMS OF THE AGREEMENT THAT AMOUNT IS INCLUDED IN THEIR DEFERRED COMPENSATION FOR THE FISCAL YEAR ENDED DECEMBER 31, 2015

Additional Data

Software ID:
Software Version:
EIN: 30-0752920
Name: TRINITY HEALTH SYSTEM GROUP

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				
1FRED BROWER PRESIDENT & CEO	(I)	0	0	0	354,932	50,286	405,218	0
	(II)	489,050	0	0	0	0	489,050	0
1JOHN FIGEL MD BOARD MEMBER	(I)	248,390	0	0	0	10,837	259,227	0
	(II)	0	0	0	0	0	0	0
2DAVID WERKINCFO	(I)	0	0	0	10,076	20,790	30,866	0
	(II)	251,724	0	9,603	0	0	261,327	0
3GRAY GONCZ DO VP, MEDICAL AFFAIRS	(I)	0	0	0	10,600	1,242	11,842	0
	(II)	279,810	0	0	0	0	279,810	0
4JOANN MULROONEYCOO	(I)	0	0	0	9,704	22,981	32,685	0
	(II)	244,371	0	0	0	0	244,371	0
5LEWIS MUSSO VP,HUMAN RESOURCES	(I)	0	0	0	17,310	43,770	61,080	0
	(II)	185,226	0	0	0	0	185,226	0
6STEVE BROWNVP MSO	(I)	0	0	0	6,506	22,080	28,586	0
	(II)	190,449	0	0	0	0	190,449	0
7NASROLLAH JAHDI MD PHYSICIAN	(I)	596,152	999,157	0	0	0	1,595,309	0
	(II)	0	0	0	0	0	0	0
8RAMANA MURTY MD PHYSICIAN	(I)	817,110	618,930	0	0	16,210	1,452,250	0
	(II)	0	0	0	0	0	0	0
9KUMAR AMIN MDPHYSICIAN	(I)	848,387	300,963	0	0	10,837	1,160,187	0
	(II)	0	0	0	0	0	0	0
10RAFAEL SCHMULEVICH MD PHYSICIAN	(I)	838,571	253,371	0	0	19,568	1,111,510	0
	(II)	0	0	0	0	0	0	0
11SATHISH MAGGE MD PHYSICIAN	(I)	832,483	219,096	0	0	0	1,051,579	0
	(II)	0	0	0	0	0	0	0

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Schedule K (Form 990)

Department of the Treasury

Internal Revenue Service

Supplemental Information on Tax Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.

▶ Attach to Form 990.

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

OMB No 1545-0047

2015

Open to Public Inspection

Name of the organization

TRINITY HEALTH SYSTEM GROUP

Employer identification number

30-0752920

Part I Bond Issues

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pool financing	
							Yes	No	Yes	No	Yes	No
A	CITY OF STEUBENVILLE OHIO	34-6002729	860068BZ7	08-12-2010	42,796,876	REFINANCE 2007 BOND ISSUE		X		X		X

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired				
2	Amount of bonds legally defeased				
3	Total proceeds of issue	42,796,876			
4	Gross proceeds in reserve funds				
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows				
7	Issuance costs from proceeds	629,721			
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds				
11	Other spent proceeds	34,961,794			
12	Other unspent proceeds				
13	Year of substantial completion	2010			

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

Part III Private Business Use

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

Part III Private Business Use *(Continued)*

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

Part IV Arbitrage

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

Part IV Arbitrage *(Continued)*

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

Part V Procedures To Undertake Corrective Action

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

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

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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

2015

Open to Public Inspection

Name of the organization
TRINITY HEALTH SYSTEM GROUP

Employer identification number
30-0752920

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) JOHN FIGEL MD		PERSONAL LOAN		X	50,000	36,514		No		No	Yes	
Total		▶ $				36,514						

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

Part V Supplemental Information

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

Return Reference	Explanation

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SCHEDULE O (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

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

OMB No 1545-0047

2015

Open to Public Inspection

Name of the organization	Employer identification number
TRINITY HEALTH SYSTEM GROUP	30-0752920

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part V, line 3b	TRINITY HOSPITAL HOLDING COMPANY (34-1842025), A SUBORDINATE ORGANIZATION OF TRINITY HEALTH SYSTEM GROUP, FILES A FORM 990-T THAT INCLUDES THE UNRELATED BUSINESS INCOME AND EXPENSES SHOWN IN THIS RETURN
PART V, LINE 1 AND 2	THE FORM W-2S, 1099S, AND FORM 941S ARE FILING UNDER THE INDIVIDUAL ENTITIES INCLUDED WITH IN THE GROUP RETURN THE INDIVIDUAL ENTITIES INCLUDED WITHIN THIS RETURN ARE TRINITY WEST, EIN# 34-0875691, TRINITY EAST, EIN# 34-0714474, AND TRINITY HOLDING COMPANY, EIN# 34-1842 025

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Section A, line 6	THE SOLE MEMBER OF THE CORPORATION SHALL BE TRINITY HEALTH SYSTEM, AN OHIO NONPROFIT CORPORATION THE MEMBERS OF THE SOLE MEMBER ARE FRANCISCAN SERVICES CORPORATION AND TRI-STATE HEALTH SERVICES, INC , BOTH OHIO NONPROFIT CORPORATIONS ("CO-SPONSORING MEMBERS")
Form 990, Part VI, Section A, line 7a	ALL TRUSTEES ARE ELECTED BY MEMBERS RECOMMENDATIONS FOR APPOINTMENT TO THE BOARD OF TRUST EES ARE MADE BY TRINITY HEALTH SYSTEM BOARD OF TRUSTEES THROUGH ITS NOMINATING COMMITTEE FINAL APPROVAL OF EACH NOMINEE BY THE CO-SPONSORING MEMBERS IS REQUIRED

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Section A, line 7b	TRINITY HEALTH SYSTEM GROUP HAS ONE MEMBER, TRINITY HEALTH SYSTEM. TRINITY HEALTH SYSTEM MUST APPROVE THE FOLLOWING ACTIONS OF THE CORPORATION OR ANY OF ITS SUBSIDIARIES AS A CONDITION BEFORE THEY BECOME EFFECTIVE. 1) MERGER, CONSOLIDATION, OR SUBSTANTIAL SALE 2) CREATION OF SUBSIDIARIES OF AFFILIATION WITH OTHER ENTITIES 3) CONVEYANCING REAL PROPERTY OR CREATING LIENS THEREON 4) TRANSFER OF PERSONAL PROPERTY, INCURRING OR GUARANTEEING INDEBTEDNESS OR GRANTING LIENS IN EXCESS OF AN AMOUNT PRESCRIBED FROM TIME TO TIME BY THE MEMBERS 5) APPROVAL OF CORPORATION OR SUBSIDIARY TRUSTEES AND DIRECTORS BASED ON AGREED UPON CRITERIA 6) CAPITAL EXPENDITURES OR GRANTS IN EXCESS OF AN AMOUNT PRESCRIBED FROM TIME TO TIME BY THE MEMBERS 7) ADDITION OR TERMINATION OF SERVICES 8) APPROVAL OF SELECTION OF THE SLATE OF CANDIDATES FOR THE OFFICE OF CEO OF THE CORPORATION OR ANY OF ITS SUBSIDIARIES PROVIDED, HOWEVER, THAT A REPRESENTATIVE OF EACH MEMBER WILL SERVE ON THE SELECTION COMMITTEE 9) APPROVAL OF THE ANNUAL BUDGET AND STRATEGIC PLAN FOR THE CORPORATION AND ITS SUBSIDIARIES
Form 990, Part VI, Section B, line 11	THE 990 TAX RETURN FOR THE FOUNDATION, HEALTH SYSTEM AND GROUP RETURN IS REVIEWED ANNUALLY WITH THE EXECUTIVE COMMITTEE OF THE BOARD. THE COMPLETE BOARD WILL BE NOTIFIED THE 990 IS COMPLETE AND WILL BE MADE AVAILABLE TO THEM AT THEIR REQUEST

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Section B, line 12c	EACH BOARD MEMBER, OFFICER AND VICE PRESIDENT IS REQUIRED TO COMPLETE A DISCLOSURE OF POTENTIAL CONFLICTS FORM CONFLICTS ARE DEFINED BY THE APPLICABLE POLICY, ON AN ANNUAL BASIS EACH SUBMISSION IS REVIEWED BY THE BOARD CHAIR AND THE SYSTEM CEO, INCORPORATED INTO A SUMMARY REPORT THAT IS PROVIDED TO THE BOARD, AND THE INDIVIDUAL ORIGINALS ARE MAINTAINED IN EACH MEMBER'S BOARD BOOK UPON THE HEARING OR DELIBERATION OF ANY MATTER THAT COMES BEFORE THE BOARD OF TRUSTEES, THE BOARD CHAIR OR ANY INDIVIDUAL MEMBER OF THE BOARD CAN RAISE A QUESTION RELATED TO ANY CONFLICT THAT THEY MAY IDENTIFY THE BOARD CHAIR, IN CONSULTATION WITH THE CEO AND THE FULL BOARD, WILL MAKE A DETERMINATION ON THE QUESTION AND THE PROCEDURE TO BE FOLLOWED IN THE INDIVIDUAL CASE THE BOARD CHAIR, OR HIS DESIGNEE IF THE CHAIR IS CONFLICTED, WILL MANAGE THE CONFLICT TO ASSURE AN UNBIASED AND OBJECTIVE DISCUSSION AND DECISION
Form 990, Part VI, Section B, line 15	THE CEO & CFO'S COMPENSATION IS PAID BY A RELATED ORGANIZATION, TRINITY HEALTH SYSTEM EAC H EXECUTIVE'S COMPENSATION IS REVIEWED AND APPROVED BY THE EXECUTIVE COMMITTEE OF THE BOAR D OF TRUSTEES THE REVIEW IS DOCUMENTED IN THE MEETING MINUTES THE BOARD IS PROVIDED WITH SALARY COMPARISON DATA, WHICH IS PREPARED BY THE OHIO HOSPITAL ASSOCIATION EACH YEAR AN OUTSIDE FIRM DOES A COMPENSATION SURVEY THAT IS ALSO PROVIDED TO THE BOARD THIS PROCESS W AS LAST UNDERTAKEN IN 2015

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Section C, line 19	TRINITY HEALTH SYSTEM MAKES ITS GOVERNING DOCUMENTS, CONFLICTS OF INTEREST POLICIES OR FINANCIAL STATEMENTS AVAILABLE TO THE GENERAL PUBLIC UPON REQUEST FINANCIAL STATEMENTS ARE MADE AVAILABLE TO TRINITY BONDHOLDERS UPON THEIR REQUEST THROUGH MUNICIPAL INFORMATION REPOSITORIES
FORM 990, PART VII, COMPENSATION	PAUL DIBIASE, JOHN FIGEL, WILLIAM JOHNS AND CLYDE METZGER ARE COMPENSATED BY TRINITY HOSPI TAL HOLDING COMPANY (34-1842025), A SUBORDINATE ORGANIZATION OF TRINITY HEALTH SYSTEM GROU P, WHO DOES NOT FILE THEIR OWN FORM 990 ACCORDINGLY, COMPENSATION HAS BEEN REPORTED IN CO LUMN D OF FORM 990, PART VII

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part XI, line 9	CHANGE IN PENSION OBLIGATION 1,364,164 CHANGE IN INTEREST IN FOUNDATION NET ASSETS - 233,776 PERMANENTLY RESTRICTED CONTRIBUTION 334,000
FORM 990, PAGE 1, LINE H(C), GROUP EXEMPTION NUMBER	TRINITY HEALTH SYSTEM GROUP IS INCLUDED WITHIN TWO GROUP EXEMPTION NUMBERS, #5388 FOR TRIN ITY HOSPITAL HOLDING COMPANY (TRINITY HEALTH SYSTEM, #34-1818681, PARENT), AND #0928 TO TH E CATHOLIC HEALTH ASSOCIATION AND ITS AFFILIATED ORGANIZATIONS, OF WHICH IT IS A SUBORDINA TE.

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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

2015

Open to Public Inspection

Name of the organization
TRINITY HEALTH SYSTEM GROUP

Employer identification number
30-0752920

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
(1)TRINITY HEALTH SYSTEM 380 SUMMIT AVENUE STEUBENVILLE, OH 43952 34-1818681	SUPPORT & MANAGEMENT	OH	501(c)(3)	Line 11b, II	TRI-STATE HEALTH SERVICES & SYLVANIA FRANCISCAN HEALTH		No
(2)TRINITY HEALTH SYSTEM FOUNDATION 380 SUMMIT AVENUE STEUBENVILLE, OH 43952 34-1329423	CHARITABLE FUNDRAISING	OH	501(c)(3)	Line 11a, I	TRINITY HEALTH SYSTEM	Yes	

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity?	
								Yes	No
TRINITY MANAGEMENT SERVICES ORGANIZATION **(1)**INC 380 SUMMIT AVENUE STEUBENVILLE, OH 43952 34-1471026	MANAGEMENT SERVICES	OH	N/A	C				Yes	

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

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

		Yes	No
1	During the tax year, did the orgranization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?		
a	Receipt of **(i)** interest, **(ii)**annuities, **(iii)**royalties, or**(iv)**rent from a controlled entity	**1a**		**No**
b	Gift, grant, or capital contribution to related organization(s)	**1b**		**No**
c	Gift, grant, or capital contribution from related organization(s)	**1c**		**No**
d	Loans or loan guarantees to or for related organization(s)	**1d**		**No**
e	Loans or loan guarantees by related organization(s)	**1e**	**Yes**	
f	Dividends from related organization(s)	**1f**		**No**
g	Sale of assets to related organization(s)	**1g**		**No**
h	Purchase of assets from related organization(s)	**1h**		**No**
i	Exchange of assets with related organization(s)	**1i**		**No**
j	Lease of facilities, equipment, or other assets to related organization(s)	**1j**	**Yes**	
k	Lease of facilities, equipment, or other assets from related organization(s)	**1k**	**Yes**	
l	Performance of services or membership or fundraising solicitations for related organization(s)	**1l**		**No**
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**	**Yes**	
q	Reimbursement paid by related organization(s) for expenses	**1q**		**No**
r	Other transfer of cash or property to related organization(s)	**1r**		**No**
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)TRINITY HEALTH SYSTEM	M	5,241,128	CASH
(2)TRINITY MANAGEMENT SERVICES ORGANIZATION	P	7,942,198	CASH
(3)TRINITY HEALTH SYSTEM	E	68,275	CASH

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