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Form 990

Return of Organization Exempt From Income Tax

OMB No 1545-0047

2016

Open to Public Inspection

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](#)

Department of the Treasury  
Internal Revenue Service

A For the 2016 calendar year, or tax year beginning 01-01-2016 , and ending 12-31-2016

B Check if applicable

☒ Address change

☐ Name change

☐ Initial return

☐ Final

☐ Return/terminated

☐ Amended return

☐ Application pending

C Name of organization

INDIANA UNIVERSITY HEALTH WEST HOSPITAL  
INC  
% SEAN M BARR

Doing business as

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

950 N MERIDIAN STREET SUITE 300

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

INDIANAPOLIS, IN 46204

F Name and address of principal officer

KENNETH D PUCKETT  
950 N MERIDIAN ST STE 300  
INDIANAPOLIS, IN 46204

H(a) Is this a group return for subordinates?

☐ Yes ☒ No

H(b) Are all subordinates included?

☐ Yes ☐ No

If "No," attach a list (see instructions)

H(c) Group exemption number ▶

D Employer identification number

35-1814660

E Telephone number

(317) 962-4112

G Gross receipts \$ 215,124,481

I Tax-exempt status

☒ 501(c)(3) ☐ 501(c) ( ) ◀(insert no ) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ HTTP //IUHEALTH.ORG/WEST/

K Form of organization

☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation 1990

M State of legal domicile IN

Part I Summary

Activities & Governance

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

Improve the health of our patients and community through innovation and excellence in care, education, research and service

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

3 Number of voting members of the governing body (Part VI, line 1a)

4 Number of independent voting members of the governing body (Part VI, line 1b)

5 Total number of individuals employed in calendar year 2016 (Part V, line 2a)

6 Total number of volunteers (estimate if necessary)

7a Total unrelated business revenue from Part VIII, column (C), line 12

7b Net unrelated business taxable income from Form 990-T, line 34

Revenue

8 Contributions and grants (Part VIII, line 1h)

9 Program service revenue (Part VIII, line 2g)

10 Investment income (Part VIII, column (A), lines 3, 4, and 7d )

11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)

12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)

Expenses

13 Grants and similar amounts paid (Part IX, column (A), lines 1–3 )

14 Benefits paid to or for members (Part IX, column (A), line 4)

15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)

16a Professional fundraising fees (Part IX, column (A), line 11e)

b Total fundraising expenses (Part IX, column (D), line 25) ▶0

17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)

18 Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)

19 Revenue less expenses Subtract line 18 from line 12

Net Assets or Fund Balances

20 Total assets (Part X, line 16)

21 Total liabilities (Part X, line 26)

22 Net assets or fund balances Subtract line 21 from line 20

Prior Year

Current Year

2,339933

205,996,877212,484,793

428,635544,587

1,526,4151,745,086

207,954,266214,775,399

40,50030,000

00

52,063,21953,773,833

00

89,971,38098,907,957

142,075,099152,711,790

65,879,16762,063,609

Beginning of Current Year

End of Year

351,695,949408,224,273

122,322,306116,787,021

229,373,643291,437,252

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

2017-11-13

Date

ARTHUR VASQUEZ TREASURER/COO/CFO

Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name

JENNIFER D RHODERICK

Preparer's signature

JENNIFER D RHODERICK

Date

Check ☐ if self-employed

PTIN

P00395735

Firm's name ▶ ERNST & YOUNG US LLP

Firm's EIN ▶

Firm's address ▶ 111 MONUMENT CIRCLE SUITE 4000

Phone no (317) 681-7000

INDIANAPOLIS, IN 46204

May the IRS discuss this return with the preparer shown above? (see instructions)

☐ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate instructions.

Cat No 11282Y

Form 990 (2016)

**Part III Statement of Program Service Accomplishments**

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

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

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

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

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

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

If "Yes," describe these changes on Schedule O

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

<b>4a</b>	(Code )	(Expenses \$ 124,502,432	including grants of \$ 30,000	(Revenue \$ 212,484,793 )
	See Additional Data			















<b>4b</b>	(Code )	(Expenses \$	including grants of \$	(Revenue \$ )
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<b>4c</b>	(Code )	(Expenses \$	including grants of \$	(Revenue \$ )
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<b>4d</b>	Other program services (Describe in Schedule O )	(Expenses \$	including grants of \$	(Revenue \$ )
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<b>4e</b>	Total program service expenses ▶	124,502,432
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**Part IV Checklist of Required Schedules**

	Yes	No
<b>1</b> Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A 	<b>1</b> Yes	
<b>2</b> Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?	<b>2</b>	No
<b>3</b> 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 	<b>3</b>	No
<b>4 Section 501(c)(3) organizations.</b> 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 	<b>4</b> Yes	
<b>5</b> 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 	<b>5</b>	No
<b>6</b> 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 	<b>6</b>	No
<b>7</b> 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 	<b>7</b>	No
<b>8</b> Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III 	<b>8</b>	No
<b>9</b> 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 	<b>9</b>	No
<b>10</b> 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 	<b>10</b>	No
<b>11</b> 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		
<b>a</b> Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI 	<b>11a</b> Yes	
<b>b</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 	<b>11b</b>	No
<b>c</b> 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 	<b>11c</b>	No
<b>d</b> 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 	<b>11d</b>	No
<b>e</b> Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X 	<b>11e</b> Yes	
<b>f</b> 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 	<b>11f</b> Yes	
<b>12a</b> Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII 	<b>12a</b>	No
<b>b</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 	<b>12b</b> Yes	
<b>13</b> Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	<b>13</b>	No
<b>14a</b> Did the organization maintain an office, employees, or agents outside of the United States?	<b>14a</b>	No
<b>b</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	<b>14b</b>	No
<b>15</b> 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	<b>15</b>	No
<b>16</b> 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	<b>16</b>	No
<b>17</b> 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)	<b>17</b>	No
<b>18</b> 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	<b>18</b>	No
<b>19</b> 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	<b>19</b>	No

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

	Yes	No
<b>20a</b> Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i> . . . . .	Yes	
<b>b</b> If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? . . . . .	Yes	
<b>21</b> 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? <i>If "Yes," complete Schedule I, Parts I and II</i> . . . . .	Yes	
<b>22</b> 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? <i>If "Yes," complete Schedule I, Parts I and III</i> . . . . .		No
<b>23</b> Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i> . . . . .	Yes	
<b>24a</b> 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? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i> . . . . .		No
<b>b</b> Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? . . . . .		
<b>c</b> Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? . . . . .		
<b>d</b> Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? . . . . .		
<b>25a Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.</b> Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i> . . . . .		No
<b>b</b> Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i> . . . . .		No
<b>26</b> 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? <i>If "Yes," complete Schedule L, Part II</i> . . . . .		No
<b>27</b> 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? <i>If "Yes," complete Schedule L, Part III</i> . . . . .		No
<b>28</b> 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) <b>a</b> A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> . . . . .		No
<b>b</b> A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> . . . . .		No
<b>c</b> 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? <i>If "Yes," complete Schedule L, Part IV</i> . . . . .		No
<b>29</b> Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i> . . . . .		No
<b>30</b> Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i> . . . . .		No
<b>31</b> Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i> . . . . .		No
<b>32</b> Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i> . . . . .		No
<b>33</b> Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I</i> . . . . .		No
<b>34</b> Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i> . . . . .	Yes	
<b>35a</b> Did the organization have a controlled entity within the meaning of section 512(b)(13)?	Yes	
<b>b</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)? <i>If "Yes," complete Schedule R, Part V, line 2</i> . . . . .	Yes	
<b>36 Section 501(c)(3) organizations.</b> Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i> . . . . .		No
<b>37</b> 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? <i>If "Yes," complete Schedule R, Part VI</i> . . . . .		No
<b>38</b> Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? <b>Note.</b> All Form 990 filers are required to complete Schedule O . . . . .	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
<b>1a</b>	Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable . . . . .	54	
<b>b</b>	Enter the number of Forms W-2G included in line 1a Enter -0- if not applicable . . . . .	0	
<b>c</b>	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? . . . . .	Yes	
<b>2a</b>	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 . . . . .	1,102	
<b>b</b>	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? <b>Note.</b> If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	Yes	
<b>3a</b>	Did the organization have unrelated business gross income of \$1,000 or more during the year? . . . . .		No
<b>b</b>	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O . . . . .		
<b>4a</b>	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)? . . . . .		No
<b>b</b>	If "Yes," enter the name of the foreign country <b>▶</b> _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)		
<b>5a</b>	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . . . . .		No
<b>b</b>	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? . . . . .		No
<b>c</b>	If "Yes," to line 5a or 5b, did the organization file Form 8886-T? . . . . .		
<b>6a</b>	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? . . . . .		No
<b>b</b>	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? . . . . .		
<b>7</b>	<b>Organizations that may receive deductible contributions under section 170(c).</b>		
<b>a</b>	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor? . . . . .		No
<b>b</b>	If "Yes," did the organization notify the donor of the value of the goods or services provided? . . . . .		
<b>c</b>	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? . . . . .		No
<b>d</b>	If "Yes," indicate the number of Forms 8282 filed during the year . . . . .	7d	
<b>e</b>	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		No
<b>f</b>	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . . . . .		No
<b>g</b>	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? . . . . .		
<b>h</b>	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? . . . . .		
<b>8</b>	<b>Sponsoring organizations maintaining donor advised funds.</b> Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? . . . . .		
<b>9a</b>	Did the sponsoring organization make any taxable distributions under section 4966? . . . . .		
<b>b</b>	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . . . .		
<b>10</b>	<b>Section 501(c)(7) organizations.</b> Enter		
<b>a</b>	Initiation fees and capital contributions included on Part VIII, line 12 . . . . .	10a	
<b>b</b>	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities . . . . .	10b	
<b>11</b>	<b>Section 501(c)(12) organizations.</b> Enter		
<b>a</b>	Gross income from members or shareholders . . . . .	11a	
<b>b</b>	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them ) . . . . .	11b	
<b>12a</b>	<b>Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?		
<b>b</b>	If "Yes," enter the amount of tax-exempt interest received or accrued during the year . . . . .	12b	
<b>13</b>	<b>Section 501(c)(29) qualified nonprofit health insurance issuers.</b>		
<b>a</b>	Is the organization licensed to issue qualified health plans in more than one state? <b>Note.</b> See the instructions for additional information the organization must report on Schedule O		
<b>b</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	
<b>c</b>	Enter the amount of reserves on hand . . . . .	13c	
<b>14a</b>	Did the organization receive any payments for indoor tanning services during the tax year? . . . . .		No
<b>b</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
<b>1a</b>	Enter the number of voting members of the governing body at the end of the tax year	10	
If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O			
<b>b</b>	Enter the number of voting members included in line 1a, above, who are independent	7	
<b>2</b>	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?	Yes	
<b>3</b>	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?		No
<b>4</b>	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?		No
<b>5</b>	Did the organization become aware during the year of a significant diversion of the organization's assets?		No
<b>6</b>	Did the organization have members or stockholders?	Yes	
<b>7a</b>	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?	Yes	
<b>7b</b>	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	Yes	
<b>8</b>	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:		
<b>a</b>	The governing body?	Yes	
<b>b</b>	Each committee with authority to act on behalf of the governing body?	Yes	
<b>9</b>	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		No

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

		Yes	No
<b>10a</b>	Did the organization have local chapters, branches, or affiliates?		No
<b>10b</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?		
<b>11a</b>	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	Yes	
<b>b</b>	Describe in Schedule O the process, if any, used by the organization to review this Form 990		
<b>12a</b>	Did the organization have a written conflict of interest policy? If "No," go to line 13	Yes	
<b>12b</b>	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	Yes	
<b>12c</b>	Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done	Yes	
<b>13</b>	Did the organization have a written whistleblower policy?	Yes	
<b>14</b>	Did the organization have a written document retention and destruction policy?	Yes	
<b>15</b>	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?		
<b>15a</b>	The organization's CEO, Executive Director, or top management official		No
<b>15b</b>	Other officers or key employees of the organization	Yes	
If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions)			
<b>16a</b>	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?		No
<b>16b</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?		

**Section C. Disclosure**

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

**18** Section 6104 requires an organization to make its Form 1023 (or 1024 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.  
 ▶ SEAN M BARR 950 N MERIDIAN ST STE 800 INDIANAPOLIS, IN 46204 (317) 962-4112

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

**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

Form **990** (2016)



**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										
<b>1b Sub-Total</b> . . . . .										
<b>c Total from continuation sheets to Part VII, Section A</b> . . . . .										
<b>d Total (add lines 1b and 1c)</b> . . . . .								973,477	5,733,356	1,073,530

**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 ► 25

	Yes	No
<b>3</b> Did the organization list any <b>former</b> officer, director or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i> . . . . .	3 Yes	
<b>4</b> 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? <i>If "Yes," complete Schedule J for such individual</i> . . . . .	4 Yes	
<b>5</b> Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? <i>If "Yes," complete Schedule J for such person</i> . . . . .	5	No

**Section B. Independent Contractors**

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

(A) Name and business address	(B) Description of services	(C) Compensation
ARAMARK HEALTHCARE MANAGEMENT SERVI, 2300 WARRENVILLE RD DOWNERS GROVE, IL 60515	FACILITIES	3,848,411
ERMCO INC, PO BOX 1507 INDIANAPOLIS, IN 46206	MAINTENANCE	623,929
MEDEFIS CONSOLIDATED, PO BOX 5068 NEW YORK, NY 10087	STAFFING	489,824
UNITED HOSPITAL SERVICES LLC, 9948 PARK DAVIS DR INDIANAPOLIS, IN 46235	LAUNDRY	401,652
M MODAL SERVICES LTD, PO BOX 538504 ATLANTA, GA 30353	TRANSCRIPTION	225,680

**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 ► 8

**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	<b>1a</b> Federated campaigns . . .	<b>1a</b>					
	<b>b</b> Membership dues . . .	<b>1b</b>					
	<b>c</b> Fundraising events . . .	<b>1c</b>					
	<b>d</b> Related organizations	<b>1d</b>					
	<b>e</b> Government grants (contributions)	<b>1e</b>					
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above	<b>1f</b>	933				
	<b>g</b> Noncash contributions included in lines 1a-1f \$ _____						
	<b>h Total.</b> Add lines 1a-1f . . . . .			933			
Program Service Revenue			Business Code				
	<b>2a</b> NET PATIENT SERVICE REVENUE		621110	211,674,044	211,674,044		
	<b>b</b> SHARED SERVICES		541900	147,904	147,904		
	<b>c</b> ELECTRONIC HEALTH RECORDS INCENTIVE		900099	267,439	267,439		
	<b>d</b> RENT FROM RELATED 501(C)(3) ORGS		532000	395,406	395,406		
	<b>e</b> _____						
	<b>f</b> All other program service revenue						
	<b>g Total.</b> Add lines 2a-2f . . . . .			212,484,793			
Other Revenue	<b>3</b> Investment income (including dividends, interest, and other similar amounts) . . . . .		405,111			405,111	
	<b>4</b> Income from investment of tax-exempt bond proceeds		0				
	<b>5</b> Royalties . . . . .		0				
	<b>6a</b> Gross rents	(i) Real	(ii) Personal				
		431,475					
		<b>b</b> Less rental expenses	349,082				
	<b>c</b> Rental income or (loss)	82,393	0				
		<b>d</b> Net rental income or (loss) . . . . .		82,393			82,393
	<b>7a</b> Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other				
			139,476				
		<b>b</b> Less cost or other basis and sales expenses					
	<b>c</b> Gain or (loss)		139,476				
		<b>d</b> Net gain or (loss) . . . . .		139,476			139,476
	<b>8a</b> Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18 . . . . .	<b>a</b>	0				
		<b>b</b> Less direct expenses . . . . .	<b>b</b>	0			
		<b>c</b> Net income or (loss) from fundraising events . . . . .		0			
	<b>9a</b> Gross income from gaming activities See Part IV, line 19 . . . . .	<b>a</b>	0				
		<b>b</b> Less direct expenses . . . . .	<b>b</b>	0			
<b>c</b> Net income or (loss) from gaming activities . . . . .		0					
<b>10a</b> Gross sales of inventory, less returns and allowances . . . . .	<b>a</b>	0					
	<b>b</b> Less cost of goods sold . . . . .	<b>b</b>	0				
	<b>c</b> Net income or (loss) from sales of inventory . . . . .		0				
Miscellaneous Revenue		Business Code					
<b>11a</b> CAFETERIA/FOOD SERVICE		721110	794,285			794,285	
<b>b</b> GIFT SHOP		453220	270,867			270,867	
<b>c</b> TELEPHONE		517000	110,939			110,939	
<b>d</b> All other revenue . . . . .			486,602			486,602	
<b>e Total.</b> Add lines 11a-11d . . . . .				1,662,693			
<b>12 Total revenue.</b> See Instructions . . . . .				214,775,399	212,484,793	2,289,673	

**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
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21.	30,000	30,000		
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22.	0			
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.	0			
<b>4</b> Benefits paid to or for members.	0			
<b>5</b> Compensation of current officers, directors, trustees, and key employees.	258,809	240,084	18,725	
<b>6</b> Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B).	0			
<b>7</b> Other salaries and wages.	43,306,041	40,172,881	3,133,160	
<b>8</b> Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).	1,664,659	1,544,222	120,437	
<b>9</b> Other employee benefits.	5,441,314	5,047,639	393,675	
<b>10</b> Payroll taxes.	3,103,010	2,878,510	224,500	
<b>11</b> Fees for services (non-employees):				
<b>a</b> Management.	0			
<b>b</b> Legal.	0			
<b>c</b> Accounting.	0			
<b>d</b> Lobbying.	5,834		5,834	
<b>e</b> Professional fundraising services. See Part IV, line 17.	0			
<b>f</b> Investment management fees.	0			
<b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	38,388,706	16,548,411	21,840,295	0
<b>12</b> Advertising and promotion.	268,078	268,078		
<b>13</b> Office expenses.	497,667	336,571	161,096	
<b>14</b> Information technology.	242,344	165,042	77,302	
<b>15</b> Royalties.	0			
<b>16</b> Occupancy.	3,003,133	2,931,280	71,853	
<b>17</b> Travel.	17,316	7,912	9,404	
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials.	0			
<b>19</b> Conferences, conventions, and meetings.	29,794	26,710	3,084	
<b>20</b> Interest.	5,917,274	5,917,274		
<b>21</b> Payments to affiliates.	0			
<b>22</b> Depreciation, depletion, and amortization.	6,779,522	5,583,078	1,196,444	
<b>23</b> Insurance.	1,112,621	217,911	894,710	
<b>24</b> 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):				
<b>a</b> DRUGS AND MEDICAL SUPPLIES	23,708,989	23,708,989		
<b>b</b> BAD DEBT	11,065,529	11,065,529		
<b>c</b> HOSPITAL ASSESSMENT FEE	7,111,832	7,111,832		
<b>d</b> INSTITUTIONAL DUES/LICENSES	5,914	5,914		
<b>e</b> All other expenses	753,404	694,565	58,839	
<b>25</b> Total functional expenses. Add lines 1 through 24e.	152,711,790	124,502,432	28,209,358	0
<b>26</b> 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 <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

**Part X Balance Sheet**Check if Schedule O contains a response or note to any line in this Part IX ☐

				(A) Beginning of year		(B) End of year
<b>Assets</b>	<b>1</b>	Cash—non-interest-bearing . . . . .		20,365	<b>1</b>	14,425
	<b>2</b>	Savings and temporary cash investments . . . . .		232,414,339	<b>2</b>	291,199,011
	<b>3</b>	Pledges and grants receivable, net . . . . .		0	<b>3</b>	0
	<b>4</b>	Accounts receivable, net . . . . .		24,433,060	<b>4</b>	26,503,577
	<b>5</b>	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L.		0	<b>5</b>	0
	<b>6</b>	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L.		0	<b>6</b>	0
	<b>7</b>	Notes and loans receivable, net . . . . .		1,021,917	<b>7</b>	157,120
	<b>8</b>	Inventories for sale or use . . . . .		1,455,121	<b>8</b>	1,521,882
	<b>9</b>	Prepaid expenses and deferred charges . . . . .		541,290	<b>9</b>	750,014
	<b>10a</b>	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D.	<b>10a</b>	179,319,441		
	<b>b</b>	Less: accumulated depreciation	<b>10b</b>	91,241,197		
				91,809,857	<b>10c</b>	88,078,244
	<b>11</b>	Investments—publicly traded securities . . . . .		0	<b>11</b>	0
	<b>12</b>	Investments—other securities. See Part IV, line 11 . . . . .		0	<b>12</b>	0
	<b>13</b>	Investments—program-related. See Part IV, line 11 . . . . .		0	<b>13</b>	0
	<b>14</b>	Intangible assets . . . . .		0	<b>14</b>	0
<b>15</b>	Other assets. See Part IV, line 11 . . . . .		0	<b>15</b>	0	
<b>16</b>	<b>Total assets.</b> Add lines 1 through 15 (must equal line 34) . . . . .		351,695,949	<b>16</b>	408,224,273	
<b>Liabilities</b>	<b>17</b>	Accounts payable and accrued expenses . . . . .		13,765,599	<b>17</b>	10,785,793
	<b>18</b>	Grants payable . . . . .		0	<b>18</b>	0
	<b>19</b>	Deferred revenue . . . . .		511,545	<b>19</b>	387,357
	<b>20</b>	Tax-exempt bond liabilities . . . . .		0	<b>20</b>	0
	<b>21</b>	Escrow or custodial account liability. Complete Part IV of Schedule D.		0	<b>21</b>	0
	<b>22</b>	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L . . . . .		0	<b>22</b>	0
	<b>23</b>	Secured mortgages and notes payable to unrelated third parties . . . . .		0	<b>23</b>	0
	<b>24</b>	Unsecured notes and loans payable to unrelated third parties . . . . .		0	<b>24</b>	0
	<b>25</b>	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.		108,045,162	<b>25</b>	105,613,871
	<b>26</b>	<b>Total liabilities.</b> Add lines 17 through 25 . . . . .		122,322,306	<b>26</b>	116,787,021
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow SFAS 117 (ASC 958), check here ► <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.</b>					
	<b>27</b>	Unrestricted net assets		229,373,643	<b>27</b>	291,437,252
	<b>28</b>	Temporarily restricted net assets . . . . .		0	<b>28</b>	0
	<b>29</b>	Permanently restricted net assets		0	<b>29</b>	0
	<b>Organizations that do not follow SFAS 117 (ASC 958), check here ► <input type="checkbox"/> and complete lines 30 through 34.</b>					
	<b>30</b>	Capital stock or trust principal, or current funds . . . . .			<b>30</b>	
	<b>31</b>	Paid-in or capital surplus, or land, building or equipment fund . . . . .			<b>31</b>	
	<b>32</b>	Retained earnings, endowment, accumulated income, or other funds			<b>32</b>	
	<b>33</b>	<b>Total net assets or fund balances . . . . .</b>		229,373,643	<b>33</b>	291,437,252
<b>34</b>	<b>Total liabilities and net assets/fund balances . . . . .</b>		351,695,949	<b>34</b>	408,224,273	

**Part XI Reconciliation of Net Assets**Check if Schedule O contains a response or note to any line in this Part XI ☐

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	214,775,399
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	152,711,790
<b>3</b>	Revenue less expenses Subtract line 2 from line 1	<b>3</b>	62,063,609
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	229,373,643
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	
<b>10</b>	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	<b>10</b>	291,437,252

**Part XII Financial Statements and Reporting**Check if Schedule O contains a response or note to any line in this Part XII ☐

	Yes	No
<b>1</b> Accounting method used to prepare the Form 990 <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O		
<b>2a</b> Were the organization's financial statements compiled or reviewed by an independent accountant? 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 <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		No
<b>b</b> Were the organization's financial statements audited by an independent accountant? 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 <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	Yes	
<b>c</b> 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? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O	Yes	
<b>3a</b> 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?		No
<b>b</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		

# Additional Data

**Software ID:**  
**Software Version:**  
**EIN:** 35-1814660  
**Name:** INDIANA UNIVERSITY HEALTH WEST HOSPITAL  
INC

Form 990 (2016)

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

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

Form 990, Part 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			
ROBERT A PALMER ..... CHAIRMAN	5 0 ..... 0 0	X		X				4,500	0	0
MARSHA A STONE ..... VICE CHAIRMAN	5 0 ..... 0 0	X		X				4,500	0	0
MARK R BENSON DO ..... DIRECTOR	5 0 ..... 0 0	X						4,500	0	0
ROBERT L COLIN ..... DIRECTOR	5 0 ..... 0 0	X						3,750	0	0
REV KAREN E DEVAISHER ..... DIRECTOR	5 0 ..... 0 0	X						3,750	0	0
DANIEL F EVANS JR ..... DIRECTOR	5 0 ..... 55 0	X						0	1,523,416	274,557
JOHN F FITZGERALD MD ..... DIRECTOR	5 0 ..... 55 0	X						0	411,995	126,223
CINDA KELLEY-HUTCHINGS ..... DIRECTOR	5 0 ..... 0 0	X						4,500	0	0
JAMES T PARKER ..... DIRECTOR	5 0 ..... 55 0	X						0	639,755	120,904
JACQUELYNN T SWAN MD ..... DIRECTOR	5 0 ..... 0 0	X						26,000	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			
KENNETH D PUCKETT ..... PRESIDENT & CEO	0 0 ..... 55 0			X				0	317,241	94,984
JEROME P KELLY ..... SECRETARY (PARTIAL YEAR)	0 0 ..... 55 0			X				0	196,412	20,834
DEREK E EMPIE ..... SECRETARY	0 0 ..... 55 0			X				0	173,787	37,304
ARTHUR VASQUEZ ..... TREASURER/COO/CFO	0 0 ..... 55 0			X				0	167,891	25,475
ANDREW D NIGH MD ..... CMO	0 0 ..... 55 0				X			0	762,006	24,608
LISA A SPARKS RN ..... VP & CNO	55 0 ..... 0 0				X			171,659	0	35,650
JAMES R BILLMAN ..... PHARMACIST	55 0 ..... 0 0					X		160,618	0	1,568
LAURA A ROGGY ..... PHARMACIST	55 0 ..... 0 0					X		152,377	0	24,938
LISA M SHOSTRAND RN ..... REGISTERED NURSE SR PARTNER	55 0 ..... 0 0					X		148,460	0	34,164
ERIC D PEAK ..... PHARMACIST	55 0 ..... 0 0					X		144,986	0	14,248



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			
PAMELA V CHAPMAN ..... DIRECTOR, SURGICAL SERVICES	55 0 ..... 0 0					X		143,877	0	35,054
STEPHEN H POLLOM MD ..... FORMER PRESIDENT	0 0 ..... 55 0						X	0	252,915	16,858
KYLE L ALLEN ..... FORMER TREASURER	0 0 ..... 55 0						X	0	257,482	21,712
JUDITH L COLEMAN ..... FORMER TREASURER	0 0 ..... 55 0						X	0	238,175	39,104
MATTHEW D BAILEY ..... FORMER PRESIDENT & CEO	0 0 ..... 55 0						X	0	512,783	105,112
GREGORY A SPURGIN MD ..... FOMER CMO	0 0 ..... 55 0						X	0	279,498	20,233

SCHEDULE A

(Form 990 or 990EZ)

Department of the Treasury

Internal Revenue Service

Name of the organization

INDIANA UNIVERSITY HEALTH WEST HOSPITAL

INC

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](http://www.irs.gov/form990).

OMB No 1545-0047

2016

Open to Public Inspection

Employer identification number

35-1814660

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

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

- 1

☐

A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
- 2

☐

A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ))
- 3

☒

A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- 4

☐

A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state \_\_\_\_\_
- 5

☐

An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II )
- 6

☐

A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- 7

☐

An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II )
- 8

☐

A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II )
- 9

☐

An agricultural research organization described in **170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture See instructions Enter the name, city, and state of the college or university \_\_\_\_\_
- 10

☐

An organization that normally receives (1) more than 33<sup>1</sup>/<sub>3</sub>% 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 33<sup>1</sup>/<sub>3</sub>% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2).** (Complete Part III )
- 11

☐

An organization organized and operated exclusively to test for public safety See **section 509(a)(4).**
- 12

☐

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

☐

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

☐

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

☐

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

☐

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

☐

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

☐

Enter the number of supported organizations \_\_\_\_\_
- g

☐

Provide the following information about the supported organization(s) \_\_\_\_\_

(i)Name of supported organization	(ii)EIN	(iii) Type of organization (described on lines 1- 10 above (see instructions))	(iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
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, 8, or 9 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support							
Calendar year (or fiscal year beginning in) ►		(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
1	Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant ")						
2	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3	The value of services or facilities furnished by a governmental unit to the organization without charge						
4	<b>Total.</b> 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	<b>Public support.</b> Subtract line 5 from line 4						

Section B. Total Support							
Calendar year (or fiscal year beginning in) ►		(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(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	<b>Total support.</b> Add lines 7 through 10						
12	Gross receipts from related activities, etc. (see instructions)					<b>12</b>	
13	<b>First five years.</b> 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 <b>stop here</b> . . . . . ► <input type="checkbox"/>						

Section C. Computation of Public Support Percentage		
14	Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f))	14
15	Public support percentage for 2015 Schedule A, Part II, line 14	15
16a	<b>33 1/3% support test—2016.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization <span>▶ <input type="checkbox"/></span>	
b	<b>33 1/3% support test—2015.</b> 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 <b>stop here.</b> The organization qualifies as a publicly supported organization <span>▶ <input type="checkbox"/></span>	
17a	<b>10%-facts-and-circumstances test—2016.</b> 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 <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization <span>▶ <input type="checkbox"/></span>	
b	<b>10%-facts-and-circumstances test—2015.</b> 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 <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization <span>▶ <input type="checkbox"/></span>	
18	<b>Private foundation.</b> If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions <span>▶ <input type="checkbox"/></span>	

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

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

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ►	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
<b>1</b> Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
<b>2</b> 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						
<b>3</b> Gross receipts from activities that are not an unrelated trade or business under section 513						
<b>4</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
<b>5</b> The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>6 Total.</b> Add lines 1 through 5						
<b>7a</b> Amounts included on lines 1, 2, and 3 received from disqualified persons						
<b>b</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						
<b>c</b> Add lines 7a and 7b						
<b>8 Public support.</b> (Subtract line 7c from line 6.)						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
<b>9</b> Amounts from line 6						
<b>10a</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
<b>b</b> Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
<b>c</b> Add lines 10a and 10b						
<b>11</b> Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
<b>12</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
<b>13 Total support.</b> (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**

<b>15</b> Public support percentage for 2016 (line 8, column (f) divided by line 13, column (f))	<b>15</b>	
<b>16</b> Public support percentage from 2015 Schedule A, Part III, line 15	<b>16</b>	

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

<b>17</b> Investment income percentage for <b>2016</b> (line 10c, column (f) divided by line 13, column (f))	<b>17</b>	
<b>18</b> Investment income percentage from <b>2015</b> Schedule A, Part III, line 17	<b>18</b>	

**19a 33 1/3% support tests—2016.** 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—2015.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ► ☐

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

**Part IV Supporting Organizations**

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

**Section A. All Supporting Organizations**

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

**Part IV Supporting Organizations** (continued)

	Yes	No
<b>11</b> Has the organization accepted a gift or contribution from any of the following persons?		
<b>a</b> 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?		
<b>b</b> A family member of a person described in (a) above?		
<b>c</b> A 35% controlled entity of a person described in (a) or (b) above? <i>If "Yes" to a, b, or c, provide detail in Part VI</i>		
<b>11a</b>		
<b>11b</b>		
<b>11c</b>		

**Section B. Type I Supporting Organizations**

	Yes	No
<b>1</b> 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? <i>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.</i>		
<b>2</b> 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? <i>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.</i>		
<b>1</b>		
<b>2</b>		

**Section C. Type II Supporting Organizations**

	Yes	No
<b>1</b> 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)? <i>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).</i>		
<b>1</b>		

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

	Yes	No
<b>1</b> Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?		
<b>2</b> 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? <i>If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s).</i>		
<b>3</b> 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? <i>If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.</i>		
<b>1</b>		
<b>2</b>		
<b>3</b>		

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

<b>1</b> Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions)		
<b>a</b> <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.		
<b>b</b> <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
<b>c</b> <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).		
<b>2</b> Activities Test <b>Answer (a) and (b) below.</b>		
<b>a</b> 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? <i>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.</i>		
<b>b</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? <i>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.</i>		
<b>3</b> Parent of Supported Organizations <b>Answer (a) and (b) below.</b>		
<b>a</b> Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>Provide details in Part VI.</i>		
<b>b</b> Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i>		
<b>2a</b>		
<b>2b</b>		
<b>3a</b>		
<b>3b</b>		

**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)
<b>1</b> Net short-term capital gain	<b>1</b>	
<b>2</b> Recoveries of prior-year distributions	<b>2</b>	
<b>3</b> Other gross income (see instructions)	<b>3</b>	
<b>4</b> Add lines 1 through 3	<b>4</b>	
<b>5</b> Depreciation and depletion	<b>5</b>	
<b>6</b> 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)	<b>6</b>	
<b>7</b> Other expenses (see instructions)	<b>7</b>	
<b>8 Adjusted Net Income</b> (subtract lines 5, 6 and 7 from line 4)	<b>8</b>	

**Section B - Minimum Asset Amount**

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

**Section C - Distributable Amount**

		Current Year
<b>1</b> Adjusted net income for prior year (from Section A, line 8, Column A)	<b>1</b>	
<b>2</b> Enter 85% of line 1	<b>2</b>	
<b>3</b> Minimum asset amount for prior year (from Section B, line 8, Column A)	<b>3</b>	
<b>4</b> Enter greater of line 2 or line 3	<b>4</b>	
<b>5</b> Income tax imposed in prior year	<b>5</b>	
<b>6 Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	<b>6</b>	
<b>7</b> <input type="checkbox"/> 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 2016 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-2016	(iii) Distributable Amount for 2016
1 Distributable amount for 2016 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2016 (reasonable cause required--see instructions)			
3 Excess distributions carryover, if any, to 2016			
a			
b			
c From 2013. . . . .			
d From 2014. . . . .			
e From 2015. . . . .			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2016 distributable amount			
i Carryover from 2011 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2016 from Section D, line 7 \$			
a Applied to underdistributions of prior years			
b Applied to 2016 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2016, if any Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions)			
6 Remaining underdistributions for 2016 Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions)			
7 Excess distributions carryover to 2017. Add lines 3j and 4c			
8 Breakdown of line 7			
a			
b Excess from 2013. . . . .			
c Excess from 2014. . . . .			
d Excess from 2015. . . . .			
e Excess from 2016. . . . .			



**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).

<b>Facts And Circumstances Test</b>

**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](http://www.irs.gov/form990).**

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**2016**  
**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 INDIANA UNIVERSITY HEALTH WEST HOSPITAL INC	<b>Employer identification number</b> 35-1814660
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**Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.**

<b>1</b>	Provide a description of the organization's direct and indirect political campaign activities in Part IV	
<b>2</b>	Political expenditures	▶ \$
<b>3</b>	Volunteer hours	

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

<b>1</b>	Enter the amount of any excise tax incurred by the organization under section 4955	▶ \$
<b>2</b>	Enter the amount of any excise tax incurred by organization managers under section 4955	▶ \$
<b>3</b>	If the organization incurred a section 4955 tax, did it file Form 4720 for this year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>4a</b>	Was a correction made?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>b</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).**

<b>1</b>	Enter the amount directly expended by the filing organization for section 527 exempt function activities	▶ \$
<b>2</b>	Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities	▶ \$
<b>3</b>	Total exempt function expenditures Add lines 1 and 2 Enter here and on Form 1120-POL, line 17b	▶ \$
<b>4</b>	Did the filing organization file <b>Form 1120-POL</b> for this year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>5</b>	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

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

**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-

**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) 2013	(b) 2014	(c) 2015	(d) 2016	(e) Total
<b>2a</b> Lobbying nontaxable amount					
<b>b</b> Lobbying ceiling amount (150% of line 2a, column(e))					
<b>c</b> Total lobbying expenditures					
<b>d</b> Grassroots nontaxable amount					
<b>e</b> Grassroots ceiling amount (150% of line 2d, column (e))					
<b>f</b> 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)		(b)
		Yes	No	Amount
<b>1</b>	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			
<b>a</b>	Volunteers?		No	
<b>b</b>	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
<b>c</b>	Media advertisements?		No	
<b>d</b>	Mailings to members, legislators, or the public?		No	
<b>e</b>	Publications, or published or broadcast statements?		No	
<b>f</b>	Grants to other organizations for lobbying purposes?		No	
<b>g</b>	Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
<b>h</b>	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
<b>i</b>	Other activities?	Yes		5,834
<b>j</b>	Total. Add lines 1c through 1i			5,834
<b>2a</b>	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
<b>b</b>	If "Yes," enter the amount of any tax incurred under section 4912			
<b>c</b>	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
<b>d</b>	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
<b>1</b> Were substantially all (90% or more) dues received nondeductible by members?	<b>1</b>	
<b>2</b> Did the organization make only in-house lobbying expenditures of \$2,000 or less?	<b>2</b>	
<b>3</b> Did the organization agree to carry over lobbying and political expenditures from the prior year?	<b>3</b>	

**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."**

<b>1</b>	Dues, assessments and similar amounts from members	<b>1</b>	
<b>2</b>	Section 162(e) nondeductible lobbying and political expenditures (do not include amounts of political expenses for which the section 527(f) tax was paid).		
<b>a</b>	Current year	<b>2a</b>	
<b>b</b>	Carryover from last year	<b>2b</b>	
<b>c</b>	Total	<b>2c</b>	
<b>3</b>	Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	<b>3</b>	
<b>4</b>	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?	<b>4</b>	
<b>5</b>	Taxable amount of lobbying and political expenditures (see instructions)	<b>5</b>	

**Part IV Supplemental Information**

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

Return Reference	Explanation
Schedule C, Part II-B, Lines 1i - Other Activities	IU Health West Hospital paid institutional membership dues to the American Hospital Association ("AHA") and Indiana Hospital Association ("IHA") during 2016 in the amount of \$21,132 and \$14,420, respectively. Each membership organization notified IU Health West Hospital that a portion of the dues it paid were used for lobbying purposes. The AHA used 23.65%, or \$4,998 of 2016 membership dues paid by IU Health West Hospital, for lobbying expenditures. The IHA used 5.80%, or \$836 of the 2016 membership dues paid by IU Health West Hospital, for lobbying expenditures. The total membership dues paid to these organizations by IU Health West Hospital during 2016 that were attributable to lobbying expenditures was \$5,834.

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As Filed Data -

DLN: 93493319017637

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](http://www.irs.gov/form990).

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization

INDIANA UNIVERSITY HEALTH WEST HOSPITAL INC

Employer identification number

35-1814660

Part I

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

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

(a) Donor advised funds

(b) Funds and other accounts

1

Total number at end of year

2

Aggregate value of contributions to (during year)

3

Aggregate value of grants from (during year)

4

Aggregate value at end of year

5

Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?

Yes

No

6

Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?

Yes

No

Part II

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

1

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

Preservation of land for public use (e g , recreation or education)

Preservation of an historically important land area

Protection of natural habitat

Preservation of a certified historic structure

Preservation of open space

2

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

2a

Held at the End of the Year

2b

2c

2d

3

Number of conservation easements on a certified historic structure included in (a)

4

Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register

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

► \$

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Cat No 52283D

Schedule D (Form 990) 2016

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

c Beginning balance

d Additions during the year

e Distributions during the year

f Ending balance

	Amount
1c	
1d	
1e	
1f	

2a

Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability?

☐ Yes

☐ No

b

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

☐

Part V

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

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

2

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

a Board designated or quasi-endowment

b Permanent endowment

c Temporarily restricted endowment

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

3a

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

(i) unrelated organizations

(ii) related organizations

b

If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R?

	Yes	No
3a(i)		
3a(ii)		
3b		

4

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

Part VI

Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land				
b Buildings		102,244,322	31,744,115	70,500,207
c Leasehold improvements		102,960	71,500	31,460
d Equipment		68,013,017	54,987,813	13,025,204
e Other		8,959,142	4,437,769	4,521,373
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c))				88,078,244

Part VII

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

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1) Financial derivatives . . . . .		
(2) Closely-held equity interests . . . . .		
(3) Other _____		
(A)		
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Column (b) must equal Form 990, Part X, col (B) line 12 ) ▶		

Part VIII

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

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

Part IX

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

(a) Description	(b) Book value
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 15 ) . . . . . ▶	

Part X

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

1. (a) Description of liability	(b) Book value	
(1) Federal income taxes	0	
INTERCOMPANY PAYABLES (NET)	104,129,164	
DUE TO THIRD-PARTY PAYORS	1,256,548	
SELF-INSURANCE LIABILITIES	228,159	
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. (Column (b) must equal Form 990, Part X, col (B) line 25 ) ▶	105,613,871	

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.

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

**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.

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

**Part XIII Supplemental Information**

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

Return Reference	Explanation
See Additional Data Table	



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

Return Reference	Explanation

## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 35-1814660

**Name:** INDIANA UNIVERSITY HEALTH WEST HOSPITAL  
INC

## Supplemental Information

Return Reference	Explanation
Schedule D, Part X, Line 2 - FIN 48 (ASC 740) Footnote	IU Health West Hospital is a subsidiary in Indiana University Health, Inc 's ("IU Health") Consolidated Audited Financial Statements The Internal Revenue Service (IRS) has determined that IU Health and certain of its affiliated entities are tax-exempt organizations as defined in Section 501(c)(3) of the Internal Revenue Code (IRC) IU Health and its tax-exempt affiliates are, however, subject to federal and state income taxes on unrelated business income under the provision of IRC Section 511 Deferred income taxes, which as of December 31, 2016 and 2015, have no net carrying value, reflect the net tax effect of temporary differences between the carrying amounts of assets and liabilities for financial reporting and the amount used for income tax purposes As of December 31, 2016 and 2015, the Indiana University Health System had gross deferred tax assets of \$116,490,000 and \$79,469,000, respectively, primarily relating to net operating loss carryovers Management determined that a full valuation allowance at both December 31, 2016 and 2015 was necessary to reduce the deferred tax assets to the amount that would more likely than not be realized ASC Topic 740-10-50-3, Income Taxes Disclosure, requires a valuation allowance to reduce the deferred tax assets reported if, based on the weight of the evidence, it is more likely than not that some portion or all of the deferred tax assets will not be realized The change in valuation allowance for the current year is \$37,021,000 At December 31, 2016, the Indiana University Health System has available net operating loss carryforwards of \$291,226,000 These net operating losses will expire between 2018 and 2036 Certain subsidiaries of IU Health are taxable entities The tax expense and liabilities of these subsidiaries are not material to the consolidated financial statements

SCHEDULE H  
(Form 990)

Hospitals

OMB No 1545-0047

2016

Open to Public Inspection

► 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](http://www.irs.gov/form990).

Department of the Treasury

Name of the organization

INDIANA UNIVERSITY HEALTH WEST HOSPITAL  
INC

Employer identification number

35-1814660

Part I

Financial Assistance and Certain Other Community Benefits at Cost

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

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Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)		4,080	3,356,470		3,356,470	2 370 %
b Medicaid (from Worksheet 3, column a)		12,830	27,027,742	19,600,159	7,427,583	5 240 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs		16,910	30,384,212	19,600,159	10,784,053	7 610 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	7	8,841	937,444		937,444	0 660 %
f Health professions education (from Worksheet 5)	1	177	234,873		234,873	0 170 %
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)	1		108		108	
i Cash and in-kind contributions for community benefit (from Worksheet 8)	2	33,508	205,429		205,429	0 150 %
j Total. Other Benefits	11	42,526	1,377,854		1,377,854	0 980 %
k Total. Add lines 7d and 7j	11	59,436	31,762,066	19,600,159	12,161,907	8 590 %

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
<b>1</b> Physical improvements and housing						
<b>2</b> Economic development						
<b>3</b> Community support	1	13,061	45,437		45,437	0.030 %
<b>4</b> Environmental improvements						
<b>5</b> Leadership development and training for community members						
<b>6</b> Coalition building	1	800	7,992		7,992	0.010 %
<b>7</b> Community health improvement advocacy	1	274	7,091		7,091	0.010 %
<b>8</b> Workforce development						
<b>9</b> Other						
<b>10 Total</b>	3	14,135	60,520		60,520	0.050 %

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

**Section A. Bad Debt Expense**

		Yes	No
<b>1</b> Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	<b>1</b>		No
<b>2</b> Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	<b>2</b>		
<b>3</b> 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.	<b>3</b>		
<b>4</b> 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**

<b>5</b> Enter total revenue received from Medicare (including DSH and IME).	<b>5</b>	35,093,036
<b>6</b> Enter Medicare allowable costs of care relating to payments on line 5.	<b>6</b>	38,793,768
<b>7</b> Subtract line 6 from line 5. This is the surplus (or shortfall).	<b>7</b>	-3,700,732
<b>8</b> 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.		
<input type="checkbox"/> Cost accounting system	<input checked="" type="checkbox"/> Cost to charge ratio	<input type="checkbox"/> Other

**Section C. Collection Practices**

<b>9a</b> Did the organization have a written debt collection policy during the tax year?	<b>9a</b>	Yes
<b>b</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.	<b>9b</b>	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 %
<b>1</b>				
<b>2</b>				
<b>3</b>				
<b>4</b>				
<b>5</b>				
<b>6</b>				
<b>7</b>				
<b>8</b>				
<b>9</b>				
<b>10</b>				
<b>11</b>				
<b>12</b>				
<b>13</b>				

**Part V Facility Information****Section A. Hospital Facilities**

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

How many hospital facilities did the organization operate during the tax year?  
**1**

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)

	Other (Describe)	ER-other	ER-24 hours	Research facility	Critical access hospital	Teaching hospital	Children's hospital	General medical & surgical	Licensed hospital	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)  
IU HEALTH WEST HOSPITAL**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** \_\_\_\_\_

1

**Community Health Needs Assessment**

	Yes	No
<b>1</b> 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? . . . . .	<b>1</b>	No
<b>2</b> 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 . . . . .	<b>2</b>	No
<b>3</b> 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 . . . . . If "Yes," indicate what the CHNA report describes (check all that apply)	<b>3</b>	Yes
<b>a</b> <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b> <input checked="" type="checkbox"/> Demographics of the community		
<b>c</b> <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b> <input checked="" type="checkbox"/> How data was obtained		
<b>e</b> <input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b> <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b> <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b> <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b> <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C) _____		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA 20 <u>15</u>		
<b>5</b> 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 . . . . .	<b>5</b>	Yes
<b>6 a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b>	No
<b>b</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 . . . . .	<b>6b</b>	No
<b>7</b> Did the hospital facility make its CHNA report widely available to the public? . . . . . If "Yes," indicate how the CHNA report was made widely available (check all that apply)	<b>7</b>	Yes
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>SEE PART V, SECTION C</u>		
<b>b</b> <input type="checkbox"/> Other website (list url) _____		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input type="checkbox"/> Other (describe in Section C) _____		
<b>8</b> 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 . . . . .	<b>8</b>	Yes
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>15</u>		
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url) <u>SEE PART V, SECTION C</u>	<b>10</b>	Yes
<b>a</b> _____		
<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b> 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		
<b>12a</b> 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)? . . . . .	<b>12a</b>	No
<b>b</b> If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b> If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

**Part V Facility Information** (continued)**Financial Assistance Policy (FAP)**

IU HEALTH WEST HOSPITAL

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

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
<b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	<b>13</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 % and FPG family income limit for eligibility for discounted care of 0 %			
<b>b</b> <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)			
<b>c</b> <input checked="" type="checkbox"/> Asset level			
<b>d</b> <input checked="" type="checkbox"/> Medical indigency			
<b>e</b> <input checked="" type="checkbox"/> Insurance status			
<b>f</b> <input type="checkbox"/> Underinsurance discount			
<b>g</b> <input checked="" type="checkbox"/> Residency			
<b>h</b> <input checked="" type="checkbox"/> Other (describe in Section C)			
<b>14</b> Explained the basis for calculating amounts charged to patients?	<b>14</b>	Yes	
<b>15</b> Explained the method for applying for financial assistance? 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)	<b>15</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
<b>b</b> <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
<b>c</b> <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
<b>d</b> <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
<b>e</b> <input type="checkbox"/> Other (describe in Section C)			
<b>16</b> Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	<b>16</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) SEE PART V, SECTION C			
<b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) SEE PART V, SECTION C			
<b>c</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) SEE PART V, SECTION C			
<b>d</b> <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>e</b> <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>f</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>g</b> <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
<b>h</b> <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
<b>i</b> <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
<b>j</b> <input checked="" type="checkbox"/> Other (describe in Section C)			

**Part V Facility Information** (continued)**Billing and Collections**

IU HEALTH WEST HOSPITAL

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

		Yes	No
<b>17</b> 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? . . . . .	<b>17</b>	Yes	
<b>18</b> 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			
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C) <b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted			
<b>19</b> 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? . . . . .	<b>19</b>		No
If "Yes," check all actions in which the hospital facility or a third party engaged			
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)			
<b>20</b> 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)			
<b>a</b> <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs <b>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process <b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications <b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations <b>e</b> <input type="checkbox"/> Other (describe in Section C) <b>f</b> <input type="checkbox"/> None of these efforts were made			

**Policy Relating to Emergency Medical Care**

<b>21</b> 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? . . . . .	<b>21</b>	Yes	
If "No," indicate why			
<b>a</b> <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions <b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing <b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) <b>d</b> <input type="checkbox"/> Other (describe in Section C)			



**Part V Facility Information** *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

IU HEALTH WEST HOSPITAL

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

- a** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** ☒ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- c** ☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- d** ☐ The hospital facility used a prospective Medicare or Medicaid method

**23** During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? . . . . .

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? . . . . .

If "Yes," explain in Section C

	Yes	No
<b>22</b>		
<b>23</b>		No
<b>24</b>		No

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

[illegible]

**Part V Facility Information** *(continued)***Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

How many non-hospital health care facilities did the organization operate during the tax year? 4

Name and address	Type of Facility (describe)
<b>1</b> IU HEALTH WEST CARDIACPULMONARY REHAB 1115 N RONALD REAGAN PKWY STE M AVON, IN 46123	DIAGNOSTIC AND OTHER OUTPATIENT
<b>2</b> IU HEALTH WEST ORTHO SPORT & SPINE CTR 1115 N RONALD REAGAN PKWY AVON, IN 46123	DIAGNOSTIC AND OTHER OUTPATIENT
<b>3</b> IU HEALTH WEST REHABILITATION SERVICES 1115 N RONALD REAGAN PKWY STE G AVON, IN 46123	DIAGNOSTIC AND OTHER OUTPATIENT
<b>4</b> IU HEALTH WEST SLEEP DISORDERS CENTER 1115 N RONALD REAGAN PKWY STE 3 AVON, IN 46123	DIAGNOSTIC AND OTHER OUTPATIENT
<b>5</b>	
<b>6</b>	
<b>7</b>	
<b>8</b>	
<b>9</b>	
<b>10</b>	

**Part VI Supplemental Information**

Provide the following information

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7, Part II and Part III, lines 2, 3, 4, 8 and 9b
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e g , open medical staff, community board, use of surplus funds, etc )
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report

Form and Line Reference	Explanation
Schedule H, Part I, Line 3c - Other Factors Used in Determining Elig	<p>IU Health West Hospital uses several factors other than Federal Poverty Guidelines ("FPGs") in determining eligibility for free care under its FAP. These factors include the following:</p> <ol style="list-style-type: none"> <li><b>Indiana Residency Requirement:</b> Financial Assistance will only be made available to residents of the State of Indiana and those eligible for assistance under 42 U.S.C.A. 1396b(v). IU Health West Hospital will employ the same residency test as set forth in Indiana Code 6-3-1-12 to define an Indiana resident. The term Resident includes any individual who was domiciled in Indiana during the taxable year, or any individual who maintains a permanent place of residence in Indiana and spends more than one hundred eighty-three (183) days of the taxable year in Indiana. Patients residing in the state of Indiana while attending an institution of higher education may be eligible for assistance under the FAP if they meet the aforementioned residency test and are not claimed as a dependent on a parent's or guardian's federal income tax return.</li> <li><b>Individual Solutions Department:</b> Prior to seeking Financial Assistance under the FAP, all patients or their guarantors must consult with a member of IU Health's Individual Solutions department to determine if healthcare coverage may be obtained from a government insurance/assistance product or from the Health Insurance Exchange Marketplace.</li> <li><b>Uninsured Patients:</b> All Uninsured Patients presenting for services at IU Health West Hospital eligible under the FAP will not be charged more than the AGB as described in the FAP.</li> <li><b>Services Rendered by Individual Providers:</b> The FAP does not cover services rendered by individual providers. A full listing of providers and services not covered by the FAP is available at <a href="http://www.iuhealth.org/financialassistance">www.iuhealth.org/financialassistance</a> and is updated on a quarterly basis.</li> <li><b>Alternate Sources of Assistance:</b> When technically feasible, a patient will exhaust all other state and federal assistance programs prior to receiving an award from IU Health West Hospital's Financial Assistance Program. Patients who may be eligible for coverage under an applicable insurance policy, including, but not limited to, health, automobile, and homeowners, must exhaust all insurance benefits prior to receiving an award from IU Health West Hospital's Financial Assistance Program. This includes patients covered under their own policy and those who may be entitled to benefits from a third-party policy. Patients may be asked to show proof that such a claim was properly submitted to the proper insurance provider at the request of IU Health West Hospital. Eligible patients who receive medical care from IU Health West Hospital as a result of an injury proximately caused by a third party, and later receive a monetary settlement or award from said third party, may receive Financial Assistance for any outstanding balance not covered by the settlement or award to which IU Health West Hospital is entitled. In the event a Financial Assistance Award has already been granted in such circumstances, IU Health West Hospital reserves the right to reverse the award in an amount equal to the amount IU Health West Hospital would be entitled to receive had no Financial Assistance been awarded.</li> <li><b>Alternate Methods of Eligibility Determination:</b> IU Health West Hospital will conduct a quarterly review of all accounts placed with a collection agency partner for a period of no less than one hundred and twenty (120) days after the account is eligible for an ECA. Said accounts may be eligible for assistance under the FAP based on the patient's individual scoring criteria. To ensure all patients potentially eligible for Financial Assistance under the FAP may receive Financial Assistance, IU Health West Hospital will deem patients/guarantors to be presumptively eligible for Financial Assistance if they are found to be eligible for one of the following programs, received emergency or direct admit care, and satisfied his/her required co-pay/deductible: <ul style="list-style-type: none"> <li>Indiana Children's Special Health Care Services</li> <li>Medicaid</li> <li>Healthy Indiana Plan</li> </ul> </li> <li><b>Patients who are awarded Hospital Presumptive Eligibility (HPE):</b> Enrolled in a state and/or federal program that verifies the patient's gross household income is less than or equal to 200% of the Federal Poverty Level.</li> <li><b>Additional Considerations:</b> Financial Assistance may be granted to a deceased patient's account if said patient is found to have no estate. Additionally, IU Health West Hospital will deny or revoke Financial Assistance for any patient or guarantor who falsifies any portion of a Financial Assistance application.</li> <li><b>Patient Assets:</b> IU Health West Hospital may consider patient/guarantor Assets in the calculation of a patient's true financial burden. A patient's/guarantor's primary residence and one (1) motor vehicle will be exempted from consideration in most cases. A patient's primary residence is defined as the patient's principal place of residence and will be excluded from a patient's extraordinary</li> </ol>

Form and Line Reference	Explanation
Schedule H, Part I, Line 3c - Other Factors Used in Determining Elig	<p>ry asset calculation so long as the patient's equity is less than five-hundred thousand dollars (\$500,000) and the home is occupied by the patient/guarantor, patient's/guarantor's spouse or child under twenty-one (21) years of age One (1) motor vehicle may be excluded as long as the patient's equity in the vehicle is less than fifty-thousand dollars (\$50,000) IU Health West Hospital reserves the right to request a list of all property owned by the patient/guarantor and adjust a patient's award of Financial Assistance if the patient demonstrates a claim or clear title to any extraordinary Asset not excluded from consideration under the above guidance 9 Non-Emergent Services Down Payment Uninsured Patients presenting for scheduled or other non-emergent services will not be charged more than the AGB for their services Patients will receive an estimated AGB cost of their care prior to IU Health West Hospital rendering the services and will be asked to pay a down-payment percentage of the AGB adjusted cost prior to receiving services In the event a patient is unable to fulfill the down-payment, their service may be rescheduled for a later date as medically prudent and in accordance with all applicable federal and state laws and/or regulations 10 Emergency Services Non-Refundable Deposit This section will be implemented with a strict adherence to EMTALA and IU Health Policy ADM 132, Screening and Transfer of Emergency or Unstable Patients Amount of Non-Refundable Deposit All Uninsured Patients presenting for services at IU Health West Hospitals Emergency Department, via transfer from another hospital facility, or direct admission, will be responsible for a one-hundred dollar (\$100.00) non-refundable deposit for services rendered Patients/guarantors will be responsible for any copays and/or deductibles required by their plan prior to full Financial Assistance being applied Uninsured Patients wishing to make an application for Financial Assistance greater than the AGB must fulfill their non-refundable deposit prior to IU Health West Hospital processing said application Uninsured Patients making payments toward their outstanding non-refundable deposit balance will have said payments applied to their oldest application on file, if applicable</p>

## 990 Schedule H, Supplemental Information

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

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part I, Line 7, Column (f) - Bad Debt Expense	The amount of bad debt expense included on Form 990, Part IX, Line 25, column (A), but subtracted for purposes of calculating the percentage of total expense on Line 7, column (f) is \$11,065,529



## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part I, Line 7 - Total Community Benefit Expense	Schedule H, Part I, Line 7, Column (f), Percent of Total Expense, is based on column (e) Net Community Benefit Expense. The percent of total expense based on column (c) Total Community Benefit Expense, which does not include direct offsetting revenue, is 22.42%.

990 Schedule H, Supplemental Information	
Form and Line Reference	Explanation
Schedule H, Part I, Line 7g - Subsidized Health Services	IU Health West Hospital does not include any costs associated with physician clinics as subsidized health services

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
Schedule H, Part II - Promotion of Health in Communities Served	<p>IU Health participates in a variety of community-building activities that address the social determinants of health in the communities it serves. IU Health and its related hospital entities across the State of Indiana ("IU Health Statewide System") invest in economic development efforts across the state, collaborate with like-minded organizations through coalitions that address key issues, and advocate for improvements in the health status of vulnerable populations. This includes making contributions to community-building activities by providing investments and resources to local community initiatives that addressed economic development, community support and workforce development. Several examples include IU Health's support of the following organizations and initiatives that focus on some of the root causes of health issues, such as lack of education, employment and poverty: - Hope Health Center - Starfish Initiative - Teach for America - United Way. Additionally, through the IU Health Statewide Systems team member community benefit service program, "Strength That Cares", team members across the state make a difference in the lives of thousands of Hoosiers every year.</p>

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part III, Line 2 - Methodology Used to Est Bad Debt Exp	The bad debt expense of \$1,978,517 reported on Schedule H, Part III, Line 2 is reported at cost, as calculated using the cost to charge ratio methodology

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
Schedule H, Part III, Line 4 - Bad Debt Expense	<p>IU Health West Hospital is a subsidiary in the consolidated financial statements of IU Health. IU Health's bad debt expense footnote is as follows: The Indiana University Health System does not require collateral or other security for the delivery of health care services from its patients, substantially all of whom are residents of the state of Indiana. However, assignment of benefit payments payable under patients' health insurance programs and plans (e.g., Medicare, Medicaid, health maintenance organizations, and commercial insurance policies) is routinely obtained, consistent with industry practice. The provision for uncollectible accounts, for all payers, is recognized when services are provided based upon management's assessment of historical and expected net collections, taking into consideration business and economic conditions, changes and trends in health care coverage, and other collection indicators. Periodically, management assesses the adequacy of the allowance for uncollectible accounts based upon accounts receivable payer composition and aging, the significance of individual payers to outstanding accounts receivable balances, and historical write-off experience by payer category, as adjusted for collection indicators. The results of this review are then used to make any modifications to the provision for uncollectible accounts and the allowance for uncollectible accounts. In addition, the Indiana University Health System follows established guidelines for placing certain past-due patient balances with collection agencies. Patient accounts that are uncollected, including those placed with collection agencies, are initially charged against the allowance for uncollectible accounts in accordance with collection policies of the Indiana University Health System and, in certain cases, are reclassified to charity care if deemed to otherwise meet financial assistance policies of the Indiana University Health System.</p>

**990 Schedule H, Supplemental Information**

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

Form and Line Reference	Explanation
Schedule H, Part III, Line 9b - Written Debt Collection Policy	<p>IU Health West Hospitals FAP and Written Debt Collection Policy describe the collection practices applicable to patients, including those who may qualify for financial assistance</p> <p>1 Financial Assistance Application Patients or their guarantors wishing to apply for Financial Assistance are encouraged to submit a Financial Assistance Application within ninety (90) days of their discharge. Patients or their guarantors may submit an application up to two-hundred and forty (240) days from the date of their first billing statement from IU Health, however, accounts may be subject to ECA as soon as one hundred and twenty (120) days after having received their first billing statement. Patients or their guarantors submitting an incomplete application will receive written notification of the applications deficiency upon discovery by IU Health. The application will be pending for a period of forty-five (45) days from the date the notification is mailed. IU Health will suspend any ECA until the application is complete, or the patient fails to cure any deficiencies in their application in the allotted period. Patients with limited English proficiency may request to have a copy of the FAP, a FAP Application, and FAP Plain Language Summary in one of the below languages - Arabic - Burmese - Burmese-Falam - Burmese-Hakha Chin - Mandarin/Chinese - Spanish. The patient, and/or their representative, such as the patient's physician, family members, legal counsel, community or religious groups, social services or hospital personnel may request a FAP Application to be mailed to a patient's primary mailing address free of charge. IU Health West Hospital keeps all applications and supporting documentation confidential. Patients applying for assistance under the FAP will be required to complete a Financial Assistance Application. Patients must include the following documentation with their Financial Assistance Application - All sources of Income for the last three (3) months, - Most recent three (3) months of pay stubs or Supplemental Security Income via Social Security, - Most recent three (3) statements from checking and savings accounts, certificates of deposit, stocks, bonds and money market accounts, - Most recent state and Federal Income Tax forms including schedules C, D, E, and F. In the event a patient and/or guarantors income does not warrant the filing of a federal tax return, the patient may submit a notarized affidavit attesting to the foregoing, - Most recent W-2 statement, - For patients or members of the Household who are currently unemployed, Wage Inquiry from WorkOne, and - If applicable, divorce/dissolution decrees and child custody order.</p> <p>2 Eligibility Determination IU Health West Hospital will inform patients or guarantors of the results of their application by providing the patient or guarantor with a Financial Assistance Determination within ninety (90) days of receiving a completed Application and all requested documentation. If a patient or guarantor is granted less than full charity assistance and the patient or guarantor provides additional information for reconsideration, IU Health Revenue Cycle Services may amend a prior Financial Assistance Determination. If a patient or guarantor seeks to appeal the Financial Assistance Determination further, a written request must be submitted, along with the supporting documentation, to the Financial Assistance Committee for additional review/reconsideration. All decisions of the Financial Assistance Committee are final. A patient's Financial Assistance Application and eligibility determination are specific to each individual date(s) of service and related encounters.</p> <p>3 Extraordinary Collection Actions IU Health West Hospital may refer delinquent patient accounts to a third-party collection agency after utilizing reasonable efforts to determine a patient's eligibility for assistance under the FAP. IU Health West Hospital and its third-party collection agencies may initiate ECA against a patient or their guarantor in accordance with this Policy and 26 C.F.R. 1.501(r). Said ECA may include the following - Selling a patient's or their guarantors outstanding financial responsibility to a third party - Reporting adverse information about the patient or their guarantor to consumer credit reporting agencies or credit bureaus - Deferring or denying, or requiring a payment before providing, medically necessary care because of a patient's or their guarantors nonpayment of one or more bills for previously provided care covered under the FAP - Actions requiring a legal or judicial process, including but not limited to placing a lien on patients or their guarantors property, foreclosing on a patient's or their guarantors real property attaching or seizing a patient's or their guarantors bank account or other personal property, commencing a civil action against a patient or their guarantor, causing a patient or guarantors arrest, causing a patient and/or guarantor to be subject to a</p>

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



## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part VI, Line 2 - Needs Assessment	<p>Communities are multifaceted and so are their health needs IU Health West Hospital understands that the health of individuals and communities are shaped by various social and environmental factors, along with health behaviors and additional influences IU Health West Hospital assesses the health care needs of the communities it serves by conducting a Community Health Needs Assessment This assessment includes collaboration with other community organizations such as the Hendricks County Health Department, Kingsway Community Care Center, Plainfield Parks and Recreation, and the Hendricks County Senior Services After completion of the CHNA, IU Health West Hospital reviewed the information gathered from community leader focus groups, community input surveys and statistical data The needs identified were analyzed and ranked using the Hanlon method of prioritization to determine the prevalence and severity of community health needs and which ones were most critical Additionally, the effectiveness of an intervention for each need and IU Health West Hospitals ability to impact positive change was evaluated</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
Schedule H, Part VI, Line 3 - Patient Education of Eligibility for Assist	<p>IU Health West Hospital is committed to serving the healthcare needs of all of its patients regardless of their ability to pay for such services. To assist in meeting those needs, IU Health West Hospital has established a FAP to provide Financial Assistance to Uninsured Patients. IU Health West Hospital is committed to ensuring its patients are compliant with all provisions of the Patient Protection &amp; Affordable Care Act. To that end, IU Health West Hospital will make a good faith effort to locate and obtain health insurance coverage for patients prior to considering patients for coverage under the FAP. IU Health West Hospital takes several measures to inform its patients of the FAP and FAP-eligibility. These measures include the following:</p> <ol style="list-style-type: none"><li>1. Conspicuous public displays will be posted in appropriate acute care settings such as the emergency department and registration areas describing the available assistance and directing eligible patients to the Financial Assistance Application.</li><li>2. IU Health West Hospital will include a conspicuous written notice on all patient billing statements that notifies the patient about the availability of this Policy, and the telephone number of its Customer Service Department which can assist patients with any questions they may have regarding this Policy.</li><li>3. IU Health Customer Service representatives will be available via telephone Monday through Friday, excluding major holidays, from 8:00 a.m. to 7:00 p.m. Eastern Time to address questions related to this Policy.</li><li>4. IU Health West Hospital will broadly communicate this Policy as part of its general outreach efforts.</li><li>5. IU Health West Hospital will educate its patient-facing team members of the FAP and the process for referring patients to the Program.</li></ol>

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part VI, Line 4 - Community Information	<p>IU Health West Hospital is located in Hendricks County, Indiana, a county located in central Indiana. Based on the most recent Census Bureau (2016) statistics, Hendricks Countys population is 160,610 persons with approximately 50% being female and 50% male. The countys population estimates by race are 88.6% White, 4.9% Black, 3.0% Hispanic or Latino, 2.1% Asian, 0.3% American Indian or Alaska Native and 1.1% persons reporting two or more races. Hendricks County has relatively moderate levels of educational attainment, highest among adults 25 and above. 31% completed their education with a high school diploma or equivalent. An additional 31% had some college, including those with an associates degree. 32% had a bachelors degree or higher. About 7% ended their formal education before finishing high school.</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
Schedule H, Part VI, Line 5 - Promotion of Community Health	<p>IU Health West Hospital is a subsidiary of Indiana University Health, Inc , a tax-exempt healthcare organization, whose Board of Directors is composed of members, of which substantially all are independent community members. In order to help the community in accessing healthcare, IU Health West Hospital partners with Kingsway Community Care Center (KCCC) in Avon, IN to help meet the needs of Hendricks County residents who continue to be un- or under-insured. KCCC serves more than 800 people each year with primary medical and dental care, chronic disease management, and medication management. Multiple IU Health West physicians volunteer at the clinic, where medical and dental care is supported entirely by volunteer healthcare providers. Additionally to assist with obesity prevention, IU Health West Hospital and the Town of Brownsburg, IN partner to present the towns farmers market from May-September on the Town Hall Green. In addition to creating a venue for residents to access locally grown fresh produce, the hospital and town are committed to supporting at risk individuals and families, by accepting WIC and SNAP payments for produce, and by providing a collection location for produce donations to Brownsburg area food pantries. To improve the Pre K-12th education, IU Health West Hospital and the Avon School Corporation host a free, four week kindergarten preparatory program every June. The children invited to participate have been identified through the districts kindergarten assessment as needing a boost in order to be ready to succeed in the classroom. Kindergarten teachers staff the classroom, with the help of 40+ hospital volunteers over the course of four weeks, all of whom help children learn the classroom basics, such as raising hands and walking in lines, and help set the stage for reading, writing and math success in the years ahead.</p>

Form and Line Reference	Explanation
Schedule H, Part VI, Line 6 - Affiliated Health Care System	<p>             IU Health West Hospital is part of the IU Health Statewide System. The IU Health Statewide system is Indiana's most comprehensive healthcare system. A unique partnership with the Indiana University School of Medicine, one of the nation's leading medical schools, gives patients access to innovative treatments and therapies. IU Health is comprised of hospitals, physicians and allied services dedicated to providing preeminent care throughout Indiana and beyond. National Recognition - Six hospitals designated as Magnet by the American Nurses Credentialing Center recognizing excellence in nursing care - Ten clinical programs ranked among the top 50 national programs in U.S. News &amp; World Reports 2015-16 edition of America's Best Hospitals - Ten out of ten specialty programs at Riley Hospital for Children at IU Health ranked among the top 50 children's hospitals in the nation. Education and Research - As an academic health center, IU Health works in partnership with the IU School of Medicine to train physicians, blending breakthrough research and treatments with the highest quality of patient care. Each year, more than 1,000 residents and fellows receive training in IU Health hospitals. Research conducted by IU School of Medicine faculty gives IU Health physicians and patients access to the most leading-edge and comprehensive treatment options. In 2012, IU Health and the IU School of Medicine announced that they will invest \$150 million over five years in the Strategic Research Initiative, a new research collaboration that will enhance the institutions joint capabilities in fundamental scientific investigation, translational research and clinical trials. The initial focus will be on projects in the fields of neuroscience, cancer and cardiovascular disease with the goal to fund transformative proposals that will fundamentally change our understanding of these diseases and lead to important new therapies for patients. The three target research areas represent research strengths at IU School of Medicine, key strategic service lines for IU Health, and important medical needs in a time of an aging population and rising healthcare costs - Cancer. One of the initiative's primary goals is to enable the IU Health Melvin and Bren Simon Cancer Center to attain the National Cancer Institute's top status of "comprehensive," which would recognize it as one of the top-tier cancer centers in the national - Neuroscience. The neurosciences research program will tackle a broad range of brain injuries, neurodegenerative disorders and neurodevelopmental disorders - Cardiovascular. The cardiovascular research initiative will develop a comprehensive program for the study and treatment of heart failure, from newborns to older adults. A top priority is developing a cardiovascular genetics program. The Strategic Research Initiative will provide patients with access to internationally renowned physicians and to new therapies developed through translational research and critical trials, and will make use of the latest genetic tools to develop personalized therapies that are more effective for individuals and efficient for healthcare providers. IU Health Statewide System IU Health is a part of the IU Health Statewide System which continues to broaden its reach and positive impact throughout the state of Indiana. IU Health is Indiana's most comprehensive academic health center and consists of IU Health Methodist Hospital, IU Health University Hospital, Riley Hospital for Children at IU Health, and IU Health Saxony Hospital. Other hospitals in the IU Health Statewide System include the following - IU Health Arnett Hospital - IU Health Ball Memorial Hospital - IU Health Bedford Hospital - IU Health Blackford Hospital - IU Health Bloomington Hospital - IU Health Goshen Hospital - IUHLPLiquidation, Inc. f/k/a IU Health La Porte Hospital - IU Health North Hospital - IU Health Paoli Hospital - IUHLPSH, LLC f/k/a IU Health Starke Hospital - IU Health Tipton Hospital - IU Health West Hospital - IU Health White Memorial Hospital. Although each hospital in the IU Health Statewide System prepares and submits its own community benefits plan relative to the local community, the IU Health Statewide System considers its community benefit plan as part of an overall vision for strengthening Indiana's overall health. A comprehensive community outreach strategy and community benefit plan is in place that encompasses the academic medical center downtown Indianapolis, suburban Indianapolis and statewide entities around priority areas that focus on health improvement efforts statewide. IU Health is keenly aware of the positive impact it can have on the communities of need in the state of Indiana by focusing on the most pressing needs in a systematic and strategic way. Some ways we address our community health priorities as a system include IU Health Day of Service. The annual IU Health Day of Service is a high-impact event aimed at engaging IU Health team members in active           </p>

Form and Line Reference	Explanation
Schedule H, Part VI, Line 6 - Affiliated Health Care System	<p>ities that address an identified community priority. Each year, more than 20,000 IU Health team member volunteer during the Day of Service. Community Health Initiatives With investment in high-quality and impactful initiatives to address community health needs statewide, IU Health is helping Indiana residents improve their health and their quality of life. In 2016, IU Health impacted many people statewide through presentations, health risk screenings, health education programs, and additional health educational opportunities made available to the community, especially to our community members in the greatest need of such services. Examples of the types of programming and investment we make in community outreach areas include:</p> <ul style="list-style-type: none"> <li>Access to Healthcare: IU Health is committed to providing quality and complete healthcare for Hoosiers. Access to healthcare was a leading community health need identified in all communities served by IU Health across the state. IU Health is focusing on the needs of the underserved to create initiatives and support efforts that: <ul style="list-style-type: none"> <li>Educate community members to understand and navigate the healthcare system</li> <li>Increase the availability of low-cost services and provide financial assistance. IU Health provides free or reduced-cost care and supports a number of clinics to provide free or reduced-cost care to individuals without access to insurance or the ability to pull the full cost of their healthcare. These clinics include: <ul style="list-style-type: none"> <li>IU Student Outreach Clinic</li> <li>Hope Healthcare Services</li> <li>Gennesaret Free Clinics</li> <li>Trinity Free Clinic</li> <li>Healthy Weight &amp; Nutrition</li> </ul> </li> </ul> </li> </ul> <p>Like most of the nation, Hoosiers see the alarming rise of obesity in their communities as a leading concern. Nationally, Indiana has the 15th highest adult obesity rate in the nation (The State of Obesity: Better Policies for a Healthier America, 2016). Obesity prevention was a critical community health need identified in IU Health communities across the state. IU Health is committed to launching innovative efforts aimed at preventing and reversing obesity in our communities to help community members get active, get health and get strong. IU Health is working to create initiatives and support efforts to:</p> <ul style="list-style-type: none"> <li>Improve access to healthy foods</li> <li>Create healthier school environments</li> <li>Increase access to safe places for community members to be physically active</li> </ul> <p>IU Health initiatives aimed at preventing and reversing obesity in our communities include:</p> <ul style="list-style-type: none"> <li>Strong Schools</li> <li>Change the Play</li> <li>My Healthy Habits App</li> <li>Youth Diabetes Prevention Clinic</li> <li>Healthy Food Access Grant</li> </ul> <p>The Healthy Food Access Grant is an extension of the work started in 2011 with the Garden on the Go program to address obesity in the Indianapolis community. According to the USDA, between 25 and 30 million (9%) Americans are currently living in communities that do not provide adequate access to healthy food within a mile of their home. In Indianapolis, it is estimated that over 300,000 (36%) residents live in food deserts and have limited access to healthy and affordable food options. Indianapolis is reported as having the highest incidence of food deserts in the country (USDA, 2014). The lack of consumption and lack of access to healthy affordable food, particularly fresh produce, contributes to a poor diet and often can lead to higher rates of obesity and other diet-related diseases, such as diabetes and heart disease. Approximately 31% of Marion County residents are considered obese, up nearly 7% from 2010. When controlling for obesity, weight-related health problems, and health of environment, the Indianapolis area ranks among the worst metropolitan areas in the United States in terms of health. In sum, obesity is on the rise while increasingly more Indianapolis residents have less access to healthy and affordable food, which can contribute to lower consumption rates of fresh fruits and vegetables and higher rates of diet-related diseases. To address this important community and population health i</p>

Form and Line Reference	Explanation
Schedule H, Part VI - Other	<p>Disclosure in Accordance with Revenue Procedure 2015-21 In accordance with Revenue Procedure 2015-21, IU Health West Hospital discloses the following information with respect to Section 501(r) issues that were discovered during the 2016 tax year and how they have been corrected, to satisfy Section 501(r)(1) and 501(r)(2)(B) requirements. For all items, the cause was a good-faith effort by IU Health West Hospital to implement the requirements of the Section 501(r) regulations. IU Health West Hospital obtained information about the requirements and implemented them, though there were some gaps due to the detailed nature of the regulations. The issues were discovered in December 2016 when IU Health's System FAP, as applicable to IU Health West Hospital, was reviewed by the IRS as part of a courtesy review in conjunction with an audit of a tax-exempt organization related to IU Health West Hospital. The corrections were completed, in conjunction with the IRS courtesy review, in January 2017. The IRS confirmed in January 2017 that it believed IU Health's System FAP, effective January 2017, was in compliance with Section 501(r) and the Final Regulations. IU Health West Hospital has not identified any persons directly affected by these issues because the discrepancies related primarily to the specificity of information contained in the FAP. All individuals would have been in the same position. Specific Issues and Corrections:</p> <p>1. Requirement: Inclusion of a Provider List Pursuant to Treas. Reg. 1.501(r)-4(b)(1)(iii)(F), a hospital facility's FAP is required to include a list of providers, other than the hospital facility itself, who are delivering emergency or other medically necessary care in the hospital facility and to be specific about which providers are covered by the hospital facility's FAP (and which are not). Pursuant to 5 of Notice 2015-46, a hospital facility's provider list is required to be updated "at least quarterly" in order for a hospital organization to be considered as having taken reasonable steps to ensure that its list is accurate. Condition V B 4 a of IU Health West Hospital's FAP, effective January 2016, stated that it "does not cover services rendered by individual providers that a "full listing of providers and services not covered by this policy is available at <a href="http://www.iuhealth.org/financialassistance">www.iuhealth.org/financialassistance</a> and is updated on a quarterly basis." During 2016, the IU Health West Hospital's Financial Assistance webpage contained a paragraph stating that a "complete list of all IU Health West Hospital providers not covered under IU Health West Hospital's FAP is available via the Find A Doctor page or as a PDF file." The "Find A Doctor page" allowed a search by first or last name of the provider. The result was a listing showing provider's pictures, specialties, and Hospitals &amp; Affiliations. None of the information provided specifically identified whether a provider's services were or were not covered by IU Health West Hospital's FAP. The PDF file, entitled "Find A Doctor Printable Directory", did not specifically identify whose services were covered by IU Health West Hospital's FAP and whose were not. In addition, the listing was dated December 23, 2015 (almost one year old). These omissions led to the conclusion that IU Health West Hospital's FAP, effective January 2016, was not compliant with Treas. Reg. 1.501(r)-4(b)(1)(iii)(F) or Notice 2015-46. Corrective Action: IU Health West Hospital's Financial Assistance website at <a href="http://iuhealth.org/patients/my-iu-health/pay-a-bill/financial-assistance/">http://iuhealth.org/patients/my-iu-health/pay-a-bill/financial-assistance/</a> was updated in January 2017 to include the following information: "IU Health West Hospital's FAP does not cover individual physician charges. A listing of all providers who render services at an IU Health West Hospital facility and whose individual professional charges are not covered by this FAP, along with a list of any services that are not covered by this FAP, are available "herewas updated on December 31, 2016." By clicking "here" on the website, an individual was able to view a PDF file listing all individual physicians providing medical services at IU Health West Hospital with the specification that their services are not covered under IU Health West Hospital's FAP. Furthermore, IU Health West Hospital now updates the list no less frequently than quarterly.</p> <p>2. Requirement: Description of Process and Time Frames Regarding FAP-eligibility and ECAs Pursuant to Treas. Reg. 1.501(r)-6(c), a hospital facility's FAP (or a separate written billing &amp; collections policy) must describe the process and time frames that each hospital facility uses with respect to the reasonable efforts it will make to determine whether an individual is FAP eligible before engaging in any ECAs. Treas. Reg. 1.501(r)-6(c) defines two methods that will constitute reasonable efforts under paragraphs (c)(2) and (c)(3) as follows: - (c)(2) Presumptive FAP-eligibility determinations, and - (c)(3) Various, other efforts based on notification</p>

Form and Line Reference	Explanation
Schedule H, Part VI - Other	<p>ion and processing of applications Condition VI D 1 of IU Health West Hospital's FAP, effective January 2016, provided that IU Health West Hospital may refer delinquent patient accounts to a third-party collection agency after utilizing "reasonable efforts" to determine a patient's eligibility for assistance under the FAP VI D 2 stated that IU Health West Hospital and its third-party collection agencies may initiate ECAs against a patient in accordance with the FAP and 26 CFR 1 501(r) The problem with this wording is that IU Health West Hospital did not describe the process and time frames that are involved with its "reasonable efforts" This omission led to the conclusion that IU Health West Hospital's FAP, effective January 2016, was not compliant with IRC 501(r)(4) Corrective Action IU Health West Hospital added language to VI D 1 and VI D 2 of its FAP, effective January 2017, to fully describe the process and time frames that are involved with its reasonable efforts to determine a patient's eligibility for assistance under the FAP 3 Requirement Description of ECAs and Final Authority in Making Determinations Regarding FAP-eligibility and ECAs IRC 501(r)(4)(A)(iv) requires that a hospital facility's FAP address the actions that the organization may take in event of nonpayment Treas Reg 1 501(r)-(4)(b)(4)(C) requires that a hospital facility's FAP must describe the office, department, committee, or other body with the final authority or responsibility for determining that the hospital facility has made reasonable efforts to determine whether an individual is FAP-eligible and may engage in ECAs against the individual Condition IU Health West Hospital's FAP, effective January 2016, did not contain the required wording described above This omission led to the conclusion that IU Health West Hospital FAP, effective January 2016, was not compliant with IRC 501(r)(4) Corrective Action IU Health West Hospital added language to VI D 2 through VI D 4 of its FAP, effective January 2017, to fully describe the actions it may take in the event of nonpayment Furthermore, IU Health West Hospital's Financial Assistance Committee is identified in IV of the FAP as the body responsible for the effectuation of the FAP including making final determinations if IU Health West Hospital had made reasonable efforts to determine a patient's eligibility for assistance under the FAP 4 Requirement Inclusion of a Facilities List Treas Reg 1 501(r)-4(d)(3) states that a hospital organization may establish a FAP (and B&amp;CP and EMCP) that is shared with multiple hospital facilities provided that any joint policy clearly identifies each facility to which it applies Condition In II, "Scope," IU Health West Hospital's FAP, effective January 2016, stated that it "applies to all Uninsured Patients receiving care rendered at all non-profit IU Health West Hospital facilities, including those receiving emergent and/or medical necessary services " This language did not clearly identify each hospital facility, by name, to which it applied Lacking this required language resulted in the conclusion that IU Health West Hospital's FAP, effective January 2016, was not compliant with IRC 501(r)(4) Corrective Action IU Health West Hospital added language to VI B 3 of its FAP, effective January 2017, to clearly identify each hospital facility, by name, to which it applied</p>



**Additional Data**

**Software ID:**

**Software Version:**

**EIN:** 35-1814660

**Name:** INDIANA UNIVERSITY HEALTH WEST HOSPITAL  
INC

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

Section A. Hospital Facilities		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
(list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? <b>1</b>											
Name, address, primary website address, and state license number											
1	IU HEALTH WEST HOSPITAL 1111 N RONALD REAGAN PKWY AVON, IN 46123 HTTP //IUHEALTH.ORG/WEST/ 16-003776-1	X	X		X			X			

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 - Input from Community	<p>In conducting each of its most recent CHNA, IU Health West Hospital took into account input from persons who represent the broad interests of the community it serves by conducting eight focus groups and collecting community surveys. The focus groups included public health officials and community leaders to discuss the healthcare needs of the service area and what role IU Health could play in addressing the identified needs. To obtain a more complete picture of the factors that play into IU Health West Hospital's community health, input from public health officials and community leaders in Hendricks County was gathered through eight community and audience-specific focus groups/town halls. The goal of soliciting these leaders' feedback was to gather insights into the quantitative data that may not be easily identified from the secondary statistical data alone.</p> <p>Attendees who participated in the focus group included: Susan Rozzi - Leadership Hendricks County Rick Myers - Local Publisher Tom Klein - Avon Town Manager - Chet Linson - Hope Healthcare Services Clay Chafin - Plainfield Parks and Recreation Marina Keers - Hendricks County Senior Services Maryanne McMahon - Avon Schools Philip Parnin - Brownsburg Parks and Recreation Scott Olinger - Plainfield Schools Julie Haan - Hendricks County Health Department Tammy Brinkman - Hendricks County Health Department.</p> <p>Upon arrival to the focus group, participants were asked to list their believed five prioritized health needs for the IU Health West community. These responses were collected and aggregated into a comprehensive list of identified needs to be further discussed later in the session and ranked for severity of need within the community. IU Health facilitators then provided participants with a presentation featuring the mission of IU Health, current outreach priorities and local health data, including demographics, insurance information, poverty rates, county health rankings, causes of death, physical activity, chronic conditions, preventive behaviors and community needs index. Upon completion of the data presentation, IU Health facilitated a discussion on the comprehensive list of identified needs from earlier in the session. The objective of this method was intended to inspire candid discussions prior to a second identification of five prioritized health needs by each participant. The votes on the five prioritized health needs were tallied and final input from the group was encouraged during this process in order to validate the previously identified needs. In addition, the community at large was surveyed through the Hendricks County Health Partnership site. The Hendricks County Health Partnership organized and began a formal planning process in 2014 using the methods known as Mobilizing for Action through Planning and Partnerships. This process was facilitated using a Community Health Improvement Process led by an Advisory Board composed of members representing the Hendricks County Health Department.</p>

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 - Input from Community	<p>t, Hendricks Regional Health, IU Health West, the Top 10 Coalition and Franciscan St Francis Health. The six-step process occurred throughout 2015 and focused on assessing the health status of the community and planning activities based on assessment information in order to represent the low income, uninsured and minority populations. The shared, collaborative survey provides comparable data across communities going forward, with the ability for local communities to add audience-specific questions, while still maintaining the survey at a manageable length. The survey was available both online and in hard copy form. Hendricks County extended its survey period to support survey distribution/completion at marquee community events, including the Hendricks County Fair, which draws a broad audience of diverse residents. Additionally, IU Health West provided survey information and the link in its Thrive magazine publication, which is directly mailed to 28,000 county homeowners and is also available online. Social media resources were also utilized to connect residents to the survey tool. As of June 2015, 561 respondents in Hendricks County completed the Community Health Needs Assessment survey. Of those, 20% had income less than \$25,000 a year and 25% reported income of \$25,000 to just under \$50,000. Not quite one in five (17.7%) had income between \$50,000 and \$74,999. The balance (43%) reported income of \$75,000 or more. By age, the largest share of respondents was 35 to 44 years old (24%). The smallest share was 75 or older (5%). Young adults, between 18 and 24, were 8% of the respondents, and the next age groups, 25 to 34, were 23%. Mid-life respondents, ages 45 to 54, were 18% and the next groups (age 55 to 64) were 14% of survey responses. People aged 65 to 74 accounted for 7% of survey responses as of June.</p>

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 7a - CHNA Website	A copy of IU Health's CHNA is available on its website at the following URL <a href="http://iuhealth.org/about-iu-health/in-the-community/">http://iuhealth.org/about-iu-health/in-the-community/</a>

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 10a - Implementation Strategy Website	A copy of IU Health's CHNA implementation strategy is available on its website at the following URL <a href="http://iuhealth.org/about-iu-health/in-the-community/">http://iuhealth.org/about-iu-health/in-the-community/</a>

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 - Addressing Identified Needs	<p>IU Health West Hospital prioritized and determined which of the community health needs identified in its most recently conducted CHNA were most critical for it to address by using the Hanlon Method of prioritization. This method prioritizes identified needs based upon the prevalence and severity of the need and the effectiveness of interventions available to address the needs. Based upon the Hanlon Method of prioritization, IU Health West Hospital selected the following four needs to be addressed:</p> <ul style="list-style-type: none"> <li>- Mental Health</li> <li>- Access to Healthcare</li> <li>- Physical Activity &amp; Nutrition</li> <li>- Smoking Cessation</li> </ul> <p>Mental Health: IU Health West Hospital's implementation strategy to address the identified need of mental health includes the following:</p> <ul style="list-style-type: none"> <li>- Offers Adults Coping with Grief, a free weekly bereavement support group</li> <li>- Offers a Breastfeeding Support Group and Toddler time for mothers of infants and young children</li> <li>- Support Sheltering Wings school/church/team outreach program</li> <li>- Explore opportunities to support Mental Health America of Hendricks County, Cummins Mental Health and Hamilton Center Access to Healthcare</li> </ul> <p>IU Health West Hospital's implementation strategy to address the identified need of access to healthcare includes the following:</p> <ul style="list-style-type: none"> <li>- Present free podcasts that offer timely health, wellness, fitness and safety information from IU Health West Hospital physicians and other healthcare professionals</li> <li>- Partners with Hope Health Center in Avon, IN to help meet the needs of Hendricks County residents who continue to be uninsured</li> <li>- Provide operational funding to support Hope Health Center and support partnership to transition ED-utilizing patients to HHC</li> <li>- Support expansion of HealthNet Westside clinic hours and support partnership to transition ED-utilizing patients to HealthNet</li> <li>- Explore partnership with HCHP, HCC and/or HealthNet to offer free community health screenings</li> </ul> <p>Physical Activity &amp; Nutrition: IU Health West Hospital's implementation strategy to address the identified need of physical activity &amp; nutrition includes the following:</p> <ul style="list-style-type: none"> <li>- Partners with the Town of Brownsburg, IN partner to present the town's farmers market May-September on the Town Hall Green</li> <li>- Supports local farmers markets and advocates for WIC/SNAP/Fresh Bucks programming at all affiliated markets</li> <li>- Support running/walking events in community including all Plainfield Parks &amp; Recs events</li> <li>- Support summer camp scholarships for Avon, IN parks</li> </ul> <p>Smoking Cessation: IU Health West Hospital's implementation strategy to address the identified need of smoking cessation includes the following:</p> <ul style="list-style-type: none"> <li>- Offer classes at no cost</li> <li>- Posted a HealthCast (podcast) discussing importance of quitting smoking</li> <li>- Support tobacco coalition efforts to initiate a smoking ordinance in Brownsburg, IN</li> <li>- Educate/evaluate opportunities related to phenomenon of vaping industry growth in Hendricks County</li> </ul> <p>Also, based upon the Hanlon Method of prioritization, the following identified community health needs were not amongst the needs c</p>

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 - Addressing Identified Needs	hosen to be addressed - Prenatal Health - Chronic Disease - Injury Prevention After compl eting a gap analysis, IU Health West Hospital determined that the severity and lack of res ources available to address the four needs chosen to be addressed outweighed the severity of and resources available to address the three needs not chosen

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13b - Income Level Other than FPG	In addition to FPG, IU Health West Hospital may take into consideration a patients income and/or ability to pay in calculation of a financial assistance award



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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13h - Other FAP Factors	<p>IU Health West Hospital takes into consideration several other factors in determining patient eligibility for financial assistance. These factors include the following:</p> <p>1. IU Health's Individual Solutions Department Prior to seeking Financial Assistance under the FAP, all patients or their guarantors must consult with a member of IU Health's Individual Solutions department to determine if healthcare coverage may be obtained from a government insurance/assistance product or from the Health Insurance Exchange Marketplace.</p> <p>2. Alternate Sources of Assistance When technically feasible, a patient will exhaust all other state and federal assistance programs prior to receiving an award from IU Health West Hospitals Financial Assistance Program. Patients who may be eligible for coverage under an applicable insurance policy, including, but not limited to, health, automobile, and homeowners, must exhaust all insurance benefits prior to receiving an award from IU Health West Hospitals Financial Assistance Program. This includes patients covered under their own policy and those who may be entitled to benefits from a third-party policy. Patients may be asked to show proof that such a claim was properly submitted to the proper insurance provider at the request of IU Health West Hospital. Eligible patients who receive medical care from IU Health West Hospital as a result of an injury proximately caused by a third party, and later receive a monetary settlement or award from said third party, may receive Financial Assistance for any outstanding balance not covered by the settlement or award to which IU Health West Hospital is entitled. In the event a Financial Assistance Award has already been granted in such circumstances, IU Health West Hospital reserves the right to reverse the award in an amount equal to the amount IU Health West Hospital would be entitled to receive had no Financial Assistance been awarded.</p> <p>3. Alternate Methods of Eligibility Determination IU Health West Hospital will conduct a quarterly review of all accounts placed with a collection agency partner for a period of no less than one hundred and twenty (120) days after the account is eligible for an Extraordinary Collection Action ("ECA"). Said accounts may be eligible for assistance under the FAP based on the patients individual scoring criteria. To ensure all patients potentially eligible for Financial Assistance under the FAP may receive Financial Assistance, IU Health West Hospital will deem patients/guarantors to be presumptively eligible for Financial Assistance if they are found to be eligible for one of the following programs, received emergency or direct admit care, and satisfied his/her required co-pay/deductible:</p> <ul style="list-style-type: none"> <li>- Indiana Childrens Special Health Care Services - Medicaid - Health by Indiana Plan - Patients who are awarded Hospital Presumptive Eligibility (HPE) - Enrolled in a state and/or federal program that verifies the patient's gross household income is less than or equal to 200% of</li> </ul>

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

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

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 16a - FAP Website	A copy of IU Health West Hospitals FAP is available on the following website <a href="http://iuhealth.org/patients/my-iu-health/pay-a-bill/financial-assistance/">http //iuhealth org/patients/my-iu-health/pay-a-bill/financial-assistance/</a>

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 16b - FAP Application Website	A copy of IU Health West Hospitals FAP Application is available on the following website <a href="http://iuhealth.org/patients/my-iu-health/pay-a-bill/financial-assistance/">http //iuhealth org/patients/my-iu-health/pay-a-bill/financial-assistance/</a>

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 16c - FAP PLS Website	A plain language summary of the FAP, including translated copies, is available on the following website <a href="http://iuhealth.org/patients/my-iu-health/pay-a-bill/financial-assistance/">http //iuhealth org/patients/my-iu-health/pay-a-bill/financial-assistance/</a>

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

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

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

Schedule I  
(Form 990)

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

Complete if the organization answered "Yes," on Form 990, Part IV, line 21 or 22.  
▶ Attach to Form 990.  
▶ Information about Schedule I (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047

2016

Open to Public  
Inspection

Department of the  
Treasury  
Internal Revenue Service

Name of the organization  
INDIANA UNIVERSITY HEALTH WEST HOSPITAL  
INC

Employer identification number  
35-1814660

Part I

General Information on Grants and Assistance

- 1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? 

☒ Yes ☐ No
- 2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States

Part II

Grants and Other Assistance to Domestic Organizations and Domestic Governments. Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than \$5,000. Part II can be duplicated if additional space is needed.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
(1) HENDRICKS COUNTY ECONOMIC DEVELOPMENT PARTNERSHIP 5250 E US HIGHWAY 36 AVON, IN 46123	35-1817139	501(C)(6)	20,000		N/A	N/A	GENERAL SUPPORT
(2) UNITED WAY OF CENTRAL INDIANA 3901 N MERIDIAN ST INDIANAPOLIS, IN 46208	35-1007590	501(C)(3)	10,000		N/A	N/A	GENERAL SUPPORT

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

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

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

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

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



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](http://www.irs.gov/form990).

OMB No 1545-0047

2015

Open to Public  
Inspection

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

Part I

Questions Regarding Compensation

	Yes	No
<b>1a</b> 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. <div><div><input type="checkbox"/> First-class or charter travel</div><div><input type="checkbox"/> Travel for companions</div><div><input type="checkbox"/> Tax idemnification and gross-up payments</div><div><input type="checkbox"/> Discretionary spending account</div><div><input type="checkbox"/> Housing allowance or residence for personal use</div><div><input type="checkbox"/> Payments for business use of personal residence</div><div><input type="checkbox"/> Health or social club dues or initiation fees</div><div><input type="checkbox"/> Personal services (e g , maid, chauffeur, chef)</div></div>		
<b>b</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	<b>1b</b>	
<b>2</b> 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?	<b>2</b>	
<b>3</b> 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. <div><div><input type="checkbox"/> Compensation committee</div><div><input type="checkbox"/> Independent compensation consultant</div><div><input type="checkbox"/> Form 990 of other organizations</div><div><input type="checkbox"/> Written employment contract</div><div><input type="checkbox"/> Compensation survey or study</div><div><input type="checkbox"/> Approval by the board or compensation committee</div></div>		
<b>4</b> 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: <b>a</b> Receive a severance payment or change-of-control payment?	<b>4a</b>	No
<b>b</b> Participate in, or receive payment from, a supplemental nonqualified retirement plan?	<b>4b</b>	Yes
<b>c</b> Participate in, or receive payment from, an equity-based compensation arrangement? If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.	<b>4c</b>	No
<b>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</b>		
<b>5</b> 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: <b>a</b> The organization?	<b>5a</b>	No
<b>b</b> Any related organization? If "Yes," on line 5a or 5b, describe in Part III.	<b>5b</b>	No
<b>6</b> 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: <b>a</b> The organization?	<b>6a</b>	No
<b>b</b> Any related organization? If "Yes," on line 6a or 6b, describe in Part III.	<b>6b</b>	No
<b>7</b> 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.	<b>7</b>	Yes
<b>8</b> Were any amounts reported on Form 990, Part VII, paid or accrued 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.	<b>8</b>	No
<b>9</b> If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	<b>9</b>	

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

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

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

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

**Part III Supplemental Information**

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

Return Reference	Explanation
Schedule J, Part I, Line 3 - Comp of the Org's CEO/Executive Director	IU Health West Hospitals President & CEO is employed by IU Health. IU Health's process for determining compensation includes the use of a compensation survey/study conducted by an independent compensation consultant with review and approval by the Committee on Personnel and Compensation and the Board of Directors. Please see Schedule O for additional details.
Schedule J, Part I, Line 4b - Supplemental Nonqualified Retirement Plan	Daniel F. Evans, Jr., John F. Fitzgerald, M.D., James T. Parker, Kenneth D. Puckett, and Matthew D. Bailey participate in an IU Health supplemental executive retirement plan, provisions of which are designed to retain its critical employees. The plan provides for an additional retirement benefit for service through normal retirement or other key dates. If the executive leaves prior to retirement or other key dates, the benefit may be forfeited or reduced. Each of these executives has amounts included in column c, deferred compensation, representing the current year unvested contributions made under the supplemental retirement plan. No amounts were actually paid to these executives during the year.
Schedule J, Part I, Line 7 - Non-Fixed Payments	Amounts disclosed in Column B(ii) include a long-term and short-term incentive for certain executives and short-term incentive for other employees. Although these plans are based on a fixed formula that has been approved by the Board of Directors based upon certain qualitative and quantitative factors and goals, all discretionary incentive plans must be approved by the Board of Directors prior to any incentive payout.

Additional Data

Software ID:

Software Version:

EIN: 35-1814660

Name: INDIANA UNIVERSITY HEALTH WEST HOSPITAL  
INC

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1DANIEL F EVANS JR DIRECTOR	(i)	0	0	0	0	0	0	0
	(ii)	1,158,577	302,286	62,553	260,986	-	-	0
						13,571	1,797,973	
1JOHN F FITZGERALD MD DIRECTOR	(i)	0	0	0	0	0	0	0
	(ii)	321,115	80,993	9,887	125,887	-	-	0
						336	538,218	
2JAMES T PARKERDIRECTOR	(i)	0	0	0	0	0	0	0
	(ii)	427,772	204,100	7,883	89,855	-	-	0
						31,049	760,659	
3KENNETH D PUCKETT PRESIDENT & CEO	(i)	0	0	0	0	0	0	0
	(ii)	288,435	26,252	2,554	67,046	-	-	0
						27,938	412,225	
4JEROME P KELLY SECRETARY (PARTIAL YEAR)	(i)	0	0	0	0	0	0	0
	(ii)	124,553	35,064	36,795	6,966	-	-	0
						13,868	217,246	
5DEREK E EMPIESECRETARY	(i)	0	0	0	0	0	0	0
	(ii)	172,175	1,312	300	9,135	-	-	0
						28,169	211,091	
6ARTHUR VASQUEZ TREASURER/COO/CFO	(i)	0	0	0	0	0	0	0
	(ii)	129,835	18,000	20,056	4,985	-	-	0
						20,490	193,366	
7ANDREW D NIGH MDCMO	(i)	0	0	0	0	0	0	0
	(ii)	743,642	7,500	10,864	17,225	-	-	0
						7,383	786,614	
8LISA A SPARKS RNVP & CNO	(i)	158,746	12,403	510	8,977	26,673	207,309	0
	(ii)	0	0	0	0	-	-	0
						0	0	
9JAMES R BILLMAN PHARMACIST	(i)	158,932	1,170	516	1,568	0	162,186	0
	(ii)	0	0	0	0	-	-	0
						0	0	
10LAURA A ROGGY PHARMACIST	(i)	146,398	1,171	4,808	7,918	17,020	177,315	0
	(ii)	0	0	0	0	-	-	0
						0	0	
11LISA M SHOSTRAND RN REGISTERED NURSE SR PARTNER	(i)	143,290	2,072	3,098	7,645	26,519	182,624	0
	(ii)	0	0	0	0	-	-	0
						0	0	
12ERIC D PEAKPHARMACIST	(i)	140,869	1,076	3,041	7,289	6,959	159,234	0
	(ii)	0	0	0	0	-	-	0
						0	0	
13PAMELA V CHAPMAN DIRECTOR, SURGICAL SERVICES	(i)	132,396	11,199	282	7,559	27,495	178,931	0
	(ii)	0	0	0	0	-	-	0
						0	0	
14STEPHEN H POLLOM MD FORMER PRESIDENT	(i)	0	0	0	0	0	0	0
	(ii)	218,759	27,802	6,354	14,308	-	-	0
						2,550	269,773	
15KYLE L ALLEN FORMER TREASURER	(i)	0	0	0	0	0	0	0
	(ii)	207,072	28,415	21,995	12,807	-	-	0
						8,905	279,194	
16JUDITH L COLEMAN FORMER TREASURER	(i)	0	0	0	0	0	0	0
	(ii)	208,421	27,778	1,976	11,993	-	-	0
						27,111	277,279	
17GREGORY A SPURGIN MD FOMER CMO	(i)	0	0	0	0	0	0	0
	(ii)	232,368	40,272	6,858	17,225	-	-	0
						3,008	299,731	
18MATTHEW D BAILEY FORMER PRESIDENT & CEO	(i)	0	0	0	0	0	0	0
	(ii)	395,853	90,614	26,316	82,274	-	-	0
						22,838	617,895	

**SCHEDULE O**  
(Form 990 or 990-EZ)Department of the Treasury  
Internal Revenue ServiceName of the organization  
INDIANA UNIVERSITY HEALTH WEST HOSPITAL  
INC**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

**2016****Open to Public  
Inspection****Employer identification number**

35-1814660

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
Part VI, Section A, Line 2 - Family or Business Relationships	John F Fitzgerald, M D and James T Parker served on the board of directors of Indiana University Health Plans, Inc

**990 Schedule O, Supplemental Information**

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

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
Part VI, Section A, Line 11b - Review of Form 990	The Treasurer/COO/CFO and Finance, Audit, and Planning Committee reviewed and approved the Form 990. Following their review and approval, a complete copy of the Form 990 was made available to each board member prior to its filing. Each member was also informed of the availability of the IU Health Tax Department to answer any questions.

**990 Schedule O, Supplemental Information**

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



**990 Schedule O, Supplemental Information**

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

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
Part VI, Section B, Line 15 - Process for Determining Compensation	<p>IU Health West Hospitals President &amp; CEO is employed by IU Health. IU Health's process for determining compensation is as follows: (1) The Board of Directors has established a Committee on Personnel and Compensation. The individuals on this Committee are made up of individuals who are on the Board and who do not have a conflict of interest with IU Health. There are no physicians or employees on this Committee. This Committee develops and reviews annually the executive compensation philosophy, market analysis as to comparability and reasonableness. One of the purposes of this Committee is to review, approve and make recommendations regarding executive compensation and benefits to the IU Health Board. As deemed appropriate, this Committee also reviews the same detail with the Committee on Finance. The Committee on Finance is represented by certain members of the Board as well. (2) Each year the Committee on Personnel and Compensation engages an outside compensation consulting firm to conduct a compensation and benefits study for all senior vice presidents and above. The current compensation advisor is the Hay Group. Hay Group performs an independent compensation survey. The relevant comparability data includes compensation and benefit levels paid by similarly situated organizations (both governmental and tax exempt) for functionally comparable positions as well as the availability of similar services in the geographic area. The Committee reviews the entire compensation package including base compensation, short term and long term incentive plans, basic health and welfare benefits, qualified and nonqualified plans as well as any additional fringe benefits. Further, Hay Group will provide recommendations based upon the reasonable compensation information as it relates to salary increases, bonuses and benefits that are consistent with the compensation philosophy of the Committee. A separate analysis using the same methodology is done for the Chief Executive Officer. (3) The Committee reviews the salary survey and, if appropriate, makes recommendations on increases in salary and any changes in bonuses or benefits. The Committee's goal is to ensure that the total compensation and benefits package is reasonable based upon the independent data provided by Hay Group. The Committee votes on any changes in compensation or benefits. This review, discussion and vote are documented in the minutes for the meeting. There are no executives present during the final discussion and approval of compensation. (4) The Board reviews the report prepared by the Hay Group as well as the recommendations of the Committee on Personnel and Compensation as to changes in compensation approved by the Committee. As requested, the Committee on Finance also provides its review of recommendations on changes in executive compensation and benefits. This review, discussion and vote are documented in the minutes. (5) The Board then reviews the recommendations provided by the Committee on</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
Part VI, Section B, Line 15 - Process for Determining Compensation	<p>Personnel and Compensation and votes on the changes as well. No additional compensation or benefits are paid to the executives until the changes have been approved by the Committee and the Board. The discussion and approval are documented in the minutes of the meeting. There are no executives present during the final discussion and approval of compensation. The General Counsel prepares a formal written opinion reviewing the compensation and benefits approval process, comparing that process to the Intermediate Sanctions Test of IRC Section 4958 and, if the facts warrant, provides comments regarding the compensation and benefits approval process as this relates to meeting the requirements for a rebuttable presumption of reasonableness as provided in the Intermediate Sanctions Test. (6) After the end of each year, the Committee and Board also reviews the achievements of the executive group as it relates to the long-term and short-term shared and individual goals developed by the executive and the Board. These achievements may also be reviewed with the Committee on Finance. The Board, at its discretion, may approve bonus payments based upon the achievement of the goals and the compensation survey. The discussion and vote of the Committee and Board is documented in the minutes for each such meeting. The bonuses are not paid until approval is made by the Board. (7) The Committee on Personnel and Compensation and Audit Committee also review the required Form 990 disclosures related to executive compensation and benefits as well as compensation practices and approval processes prior to the filing of the Form 990 return with the Internal Revenue Service. IU Health West Hospital has a process in place to determine the compensation for the other officers and key employees. IU Health West Hospital uses an independent compensation consultant who utilizes a variety of methods and procedures to obtain compensation ranges for comparable officer and employee positions. The independent compensation consultant provides IU Health West Hospital with recommended compensation ranges for its officers and other employees, which are then used as a guide for setting reasonable compensation by management. Management decisions with regard to determining compensation are subject to the review and approval of the Compensation Committee and Board of Directors.</p>

**990 Schedule O, Supplemental Information**

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

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION SHARED SERVICES/PROF FEES TOTAL FEES 38388706

efile GRAPHIC print - DO NOT PROCESS		As Filed Data -		DLN: 93493319017637	
SCHEDULE R (Form 990)	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 <a href="http://www.irs.gov/form990">www.irs.gov/form990</a> .				OMB No 1545-0047
					2016
	Department of the Treasury Internal Revenue Service				Open to Public Inspection
Name of the organization INDIANA UNIVERSITY HEALTH WEST HOSPITAL INC				Employer identification number  35-1814660	

Part I Identification of Disregarded Entities Complete if the organization answered "Yes" on Form 990, Part IV, line 33.					
(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity

Part II Identification of Related Tax-Exempt Organizations Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.							
See Additional Data Table							
(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No

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

See Additional Data Table

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

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

See Additional Data Table

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

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

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

1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?

a Receipt of (i) interest, (ii)annuities, (iii) royalties, or(iv) rent from a controlled entity . . . . .

b Gift, grant, or capital contribution to related organization(s) . . . . .

c Gift, grant, or capital contribution from related organization(s) . . . . .

d Loans or loan guarantees to or for related organization(s) . . . . .

e Loans or loan guarantees by related organization(s) . . . . .

f Dividends from related organization(s) . . . . .

g Sale of assets to related organization(s) . . . . .

h Purchase of assets from related organization(s) . . . . .

i Exchange of assets with related organization(s) . . . . .

j Lease of facilities, equipment, or other assets to related organization(s) . . . . .

k Lease of facilities, equipment, or other assets from related organization(s) . . . . .

l Performance of services or membership or fundraising solicitations for related organization(s) . . . . .

m Performance of services or membership or fundraising solicitations by related organization(s) . . . . .

n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) . . . . .

o Sharing of paid employees with related organization(s) . . . . .

p Reimbursement paid to related organization(s) for expenses . . . . .

q Reimbursement paid by related organization(s) for expenses . . . . .

r Other transfer of cash or property to related organization(s) . . . . .

s Other transfer of cash or property from related organization(s) . . . . .

Yes

No

No

No

No

No

Yes

No

No

No

No

Yes

Yes

Yes

Yes

No

Yes

No

No

Yes

No

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

See Additional Data Table

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

Schedule R (Form 990) 2016



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.

[illegible]

**Part VII**   **Supplemental Information**

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

Return Reference	Explanation
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Additional Data

Software ID:  
Software Version:  
EIN: 35-1814660  
Name: INDIANA UNIVERSITY HEALTH WEST HOSPITAL  
INC

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c) (3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
(1)  950 N Meridian St Ste 800 Indianapolis, IN 46204 13-4350599	Healthcare	IN	501(c)(3)	10	IUH	Yes	
(1)  200 High Park Ave Goshen, IN 46527 35-1974765	Healthcare	IN	501(c)(3)	12 I	IUH	Yes	
(2)  200 High Park Ave Goshen, IN 46527 35-6001540	Healthcare	IN	501(c)(3)	3	GHS	Yes	
(3)  950 N Meridian St Ste 800 Indianapolis, IN 46204 26-3571507	Healthcare	IN	501(c)(3)	10	IUHB	Yes	
(4)  846 N Senate Ave Indianapolis, IN 46202 36-4550324	Healthcare	IN	501(c)(3)	12 I	NA		No
(5)  950 N Meridian St Ste 800 Indianapolis, IN 46204 20-1017034	Healthcare	IN	501(c)(3)	10	IUH	Yes	
(6)  950 N Meridian St Ste 300 Indianapolis, IN 46204 35-1955872	Healthcare	IN	501(c)(3)	3	NA		No
(7)  950 N Meridian St Ste 800 Indianapolis, IN 46204 35-6079797	Fundraising	IN	501(c)(3)	12 I	IUHA	Yes	
(8)  950 N Meridian St Ste 300 Indianapolis, IN 46204 26-3162145	Healthcare	IN	501(c)(3)	3	IUH	Yes	
(9)  950 N Meridian St Ste 300 Indianapolis, IN 46204 35-0867958	Healthcare	IN	501(c)(3)	3	IUH	Yes	
(10)  950 N Meridian St Ste 300 Indianapolis, IN 46204 35-1925641	Healthcare	IN	501(c)(3)	10	IUHBMH	Yes	
(11)  950 N Meridian St Ste 300 Indianapolis, IN 46204 23-7042323	Healthcare	IN	501(c)(3)	3	IUH	Yes	
(12)  950 N Meridian St Ste 300 Indianapolis, IN 46204 01-0646166	Healthcare	IN	501(c)(3)	3	IUHBMH	Yes	
(13)  950 N Meridian St Ste 300 Indianapolis, IN 46204 35-1720796	Healthcare	IN	501(c)(3)	3	IUH	Yes	
(14)  950 N Meridian St Ste 800 Indianapolis, IN 46204 31-1111784	Fundraising	IN	501(c)(3)	12 I	IUHBMH	Yes	
(15)  950 N Meridian St Ste 300 Indianapolis, IN 46204 35-1747218	Healthcare	IN	501(c)(3)	10	IUH	Yes	
(16)  200 High Park Ave Goshen, IN 46527 46-2565300	Fundraising	IN	501(c)(3)	12 I	GHS	Yes	
(17)  950 N Meridian St Ste 800 Indianapolis, IN 46204 35-1125434	Healthcare	IN	501(c)(3)	10	IUH	Yes	
(18)  950 N Meridian St Ste 800 Indianapolis, IN 46204 31-1070868	Healthcare	IN	501(c)(3)	10	IUHLP	Yes	
(19)  950 N Meridian St Ste 800 Indianapolis, IN 46204 27-3533027	Healthcare	IN	501(c)(3)	10	IUH	Yes	

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations							
(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
(21)  950 N Meridian St Ste 300 Indianapolis, IN 46204 35-1932442	Healthcare	IN	501(c)(3)	3	IUH	Yes	
(1)  950 N Meridian St Ste 800 Indianapolis, IN 46204 31-0992486	Fundraising	IN	501(c)(3)	10	IUHP	Yes	
(2)  950 N Meridian St Ste 300 Indianapolis, IN 46204 35-2090919	Healthcare	IN	501(c)(3)	3	IUHB	Yes	
(3)  950 N Meridian St Ste 800 Indianapolis, IN 46204 46-3803873	Insurance	IN	501(c)(4)	N/A	IUH	Yes	
(4)  950 N Meridian St Ste 300 Indianapolis, IN 46204 26-2772226	Healthcare	IN	501(c)(3)	3	IUH	Yes	
(5)  PO Box 952 Monticello, IN 47960 35-1671806	Fundraising	IN	501(c)(3)	12 III-FI	IUHWMH	Yes	
(6)  950 N Meridian St Ste 300 Indianapolis, IN 46204 27-3532963	Healthcare	IN	501(c)(3)	3	IUH	Yes	
(7)  340 W 10th St No FS5100 Indianapolis, IN 46202 20-1093251	Fundraising	IN	501(c)(3)	12 II	NA		No
(8)  PO Box 250 LaPorte, IN 46352 31-0952775	Fundraising	IN	501(c)(3)	12 I	NA		No
(9)  1200 Madison Ave Indianapolis, IN 46225 46-5270582	Insurance	IN	501(c)(4)	N/A	IUH	Yes	
(10)  1200 Madison Ave Indianapolis, IN 46225 47-2619552	Insurance	IN	501(c)(4)	N/A	IUH	Yes	
(11)  1800 N Capitol Ave Indianapolis, IN 46202 35-6043086	Fundraising	IN	501(c)(3)	12 I	IUH	Yes	
(12)  950 N Meridian St Ste 800 Indianapolis, IN 46204 35-0876390	Healthcare	IN	501(c)(3)	12 III-FI	NA		No
(13)  950 N Meridian St Ste 800 Indianapolis, IN 46204 35-1945384	Healthcare	IN	501(c)(3)	3	IUH	Yes	
(14)  950 N Meridian St Ste 300 Indianapolis, IN 46204 35-1844176	Healthcare	IN	501(c)(3)	3	IUH	Yes	
(15)  950 N Meridian St Ste 800 Indianapolis, IN 46204 35-2023710	Healthcare	IN	501(c)(3)	12 I	IUH	Yes	
(16)  950 N Meridian St Ste 800 Indianapolis, IN 46204 35-1766531	Healthcare	IN	501(c)(3)	3	MMG	Yes	
(17)  4141 Shore Dr Indianapolis, IN 46254 35-1786005	Healthcare	IN	501(c)(3)	3	MHH	Yes	
(18)  4141 Shore Dr Indianapolis, IN 46254 35-1932349	Fundraising	IN	501(c)(3)	12 I	RHI	Yes	
(19)  705 Riley Hospital Dr Indianapolis, IN 46202 35-6018517	Fundraising	IN	501(c)(3)	12 III-FI	NA		No

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c) (3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
(41)  950 N Meridian St Ste 800 Indianapolis, IN 46204 31-1231905	Fundraising	IN	501(c)(3)	12 I	IUHTH	Yes	
(1)  950 N Meridian St Ste 800 Indianapolis, IN 46204 23-7427350	Healthcare	IN	501(c)(3)	10	IUHCA	Yes	

[illegible]



Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust									
(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of- year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity?	
								Yes	No
(1) BMH Medical Pavilion Association Inc 2525 W University Ave Muncie, IN 47303 35-1858408	Condo Management	IN	NA	C				Yes	
(1) Cardinal Health Ventures Inc 950 N Meridian St Ste 800 Indianapolis, IN 46204 35-1611424	Management	IN	NA	C				Yes	
(2) CHV Capital Inc 950 N Meridian St Ste 800 Indianapolis, IN 46204 26-0752507	Venture Capital	IN	NA	C				Yes	
(3) IU Health 457(B) Plan 1100 N Market St Wilmington, DE 19890 47-6948347	Investments	IN	NA	T				Yes	
(4) IU Health ACO Inc 950 N Meridian St Ste 800 Indianapolis, IN 46204 45-4421020	Healthcare	IN	NA	C				Yes	
(5) IU Health Board Designated Trust 400 Howard St San Francisco, CA 94105 30-6309021	Investments	IN	NA	T				Yes	
(6) IU Health NTGI S&P500 Fund CF PO Box 804358 Chicago, IL 60680 30-6298263	Investments	IN	NA	T				Yes	
(7) IU Health Plans Holding Company Inc 950 N Meridian St Ste 800 Indianapolis, IN 46204 46-3794815	Insurance	IN	NA	C				Yes	
(8) IU Health Plans Inc 950 N Meridian St Ste 800 Indianapolis, IN 46204 26-2127080	HMO	IN	NA	C				Yes	
(9) IU Health Risk Purchasing Group Inc 151 Meeting St Ste 301 Charleston, SC 29401 26-0202446	Insurance	IN	NA	C				Yes	
(10) IU Health Risk Retention Group Inc 151 Meeting St Ste 301 Charleston, SC 29401 20-1107674	Insurance	SC	NA	C				Yes	
(11) IU Health Southern IN Physicians Inc 950 N Meridian St Ste 300 Indianapolis, IN 46204 35-1913875	Healthcare	IN	NA	C				Yes	
(12) IUH Assurance SPC Ltd PO Box 69 94 Solaris Ave Camana Bay, Grand Cayman CJ 98-0395429	Insurance	CJ	NA	C				Yes	
(13) Occ-Health Revenue Systems Inc 950 N Meridian St Ste 800 Indianapolis, IN 46204 20-3308057	Work Comp PPO	IN	NA	C				Yes	
(14) Parkmor Drug Inc 1501 S Main St Goshen, IN 46526 13-1394980	Pharmacy Sales	IN	NA	C				Yes	



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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of- year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity?	
								Yes	No
(16) PILR Inc 200 High Park Ave Goshen, IN 46526 20-4294750	Development	IN	NA	C				Yes	
(1) Proteuo Fund LP PO Box 31106 89 Nexus Way Camana Bay, Grand Cayman CJ 98-1075227	Investments	CJ	NA	C				Yes	
(2) Radiation Oncology Resources Inc 200 High Park Ave Goshen, IN 46526 26-2008424	Healthcare	IN	NA	C				Yes	
(3) SCANS Inc 950 N Meridian St Ste 800 Indianapolis, IN 46204 45-3080392	Healthcare	IN	NA	C				Yes	
(4) Univ Hlth (Shanghai) Mgt Con Co Ltd 88 Century Ave Shanghai CH	Management	CH	NA	C				Yes	
(5) University Health Management Inc 950 N Meridian St Ste 800 Indianapolis, IN 46204 27-2891143	Management	IN	NA	C				Yes	
(6) University Health Mgmt (China) Inc 950 N Meridian St Ste 800 Indianapolis, IN 46204 27-3891311	Management	IN	NA	C				Yes	
(7) IU Health Plans Insurance Company 950 N Meridian St Ste 800 Indianapolis, IN 46204 81-1097215	Insurance	IN	NA	C				Yes	

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

<b>(a)</b> Name of related organization		<b>(b)</b> Transaction type(a-s)	<b>(c)</b> Amount Involved	<b>(d)</b> Method of determining amount involved
<b>(1)</b>	IU Health Care Associates Inc	J	395,406	FMV
<b>(1)</b>	IU Health Care Associates Inc	L	143,235	FMV
<b>(2)</b>	IU Health Care Associates Inc	M	5,658,560	FMV
<b>(3)</b>	Methodist Occupational Health Centers Inc	M	111,832	FMV
<b>(4)</b>	IU Health Care Associates Inc	O	110,000	FMV
<b>(5)</b>	IUH Assurance SPC Ltd	R	343,980	FMV
<b>(6)</b>	IU Health Risk Retention Group Inc	R	660,134	FMV