

For Paperwork Reduction Act Notice, see the separate instructions. Cat No 11282Y Form **990** (2016)

Part III Statement of Program Service AccomplishmentsCheck if Schedule O contains a response or note to any line in this Part III ☒**1** Briefly describe the organization's mission:

IMPROVING HEALTH, ENRICHING LIFE WHY WE SERVE TO ACHIEVE OPTIMUM HEALTH FOR ALL RESIDENTS IN OUR REGION HOW WE SERVE BY PROVIDING HEALTH EDUCATION, PREVENTIVE SERVICES, EARLY INTERVENTION, AND APPROPRIATE CARE WHOM WE SERVE THE MORE THAN 200,000 RESIDENTS OF NORTHEAST NORTH DAKOTA AND NORTHWEST MINNESOTA WHO WE ARE A COMMUNITY OF OVER 4,000 HEALTH PROFESSIONALS AND SUPPORT STAFF COMMITTED TO SERVING THE REGION FOR MORE THAN 100 YEARS

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

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

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

If "Yes," describe these changes on Schedule O

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

4a	(Code)	(Expenses \$	17,176,606	including grants of \$) (Revenue \$	33,267,692)
See Additional Data						

4b	(Code)	(Expenses \$	10,714,406	including grants of \$) (Revenue \$	16,200,213)
See Additional Data						

4c	(Code)	(Expenses \$	10,688,470	including grants of \$) (Revenue \$	17,401,971)
See Additional Data						

(Code)	(Expenses \$	438,579,076	including grants of \$	1,023,468)	(Revenue \$	462,967,410)
OTHER PROGRAM SERVICES INCLUDE OTHER PATIENT CARE PROGRAMS						

4d	Other program services (Describe in Schedule O)					
(Expenses \$	438,579,076	including grants of \$	1,023,468)	(Revenue \$	462,967,410)	

4e	Total program service expenses ▶	477,158,558
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Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

	Yes	No
20a Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	20a Yes	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b Yes	
21 Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i>	21 Yes	
22 Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i>	22 Yes	
23 Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i>	23 Yes	
24a Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i>	24a Yes	
b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b	No
c Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c	No
d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d	No
25a Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i>	25a	No
b Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i>	25b	No
26 Did the organization report any amount on Part X, line 5, 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>	26	No
27 Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i>	27	No
28 Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions) a A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>	28a	No
b A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>	28b	No
c An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV</i>	28c	No
29 Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i>	29	No
30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i>	30	No
31 Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i>	31	No
32 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>	32	No
33 Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I</i>	33	No
34 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>	34 Yes	
35a Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	No
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>	35b	
36 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i>	36	No
37 Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i>	37	No
38 Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? Note. All Form 990 filers are required to complete Schedule O	38 Yes	

Part V Statements Regarding Other IRS Filings and Tax ComplianceCheck if Schedule O contains a response or note to any line in this Part V ☐

		Yes	No
1a	Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable	1a	123
b	Enter the number of Forms W-2G included in line 1a Enter -0- if not applicable	1b	0
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	4,714
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	2b	Yes
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?	3a	Yes
b	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O	3b	Yes
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a	No
b	If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)		
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a	No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b	No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	5c	
6a	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	6a	No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b	
7	Organizations that may receive deductible contributions under section 170(c).		
a	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?	7a	No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c	No
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d	
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e	No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f	No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g	
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h	
8	Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	8	
9a	Did the sponsoring organization make any taxable distributions under section 4966?	9a	
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	9b	
10	Section 501(c)(7) organizations. Enter		
a	Initiation fees and capital contributions included on Part VIII, line 12	10a	
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b	
11	Section 501(c)(12) organizations. Enter		
a	Gross income from members or shareholders	11a	
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)	11b	
12a	Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?	12a	
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b	
13	Section 501(c)(29) qualified nonprofit health insurance issuers.		
a	Is the organization licensed to issue qualified health plans in more than one state? Note. See the instructions for additional information the organization must report on Schedule O	13a	
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b	
c	Enter the amount of reserves on hand	13c	
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a	No
b	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O	14b	

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

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

Section A. Governing Body and Management

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

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

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

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:
DWIGHT THOMPSON 1200 SOUTH COLUMBIA ROAD GRAND FORKS, ND 58201 (701) 780-5203

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

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

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[illegible]

1b Sub-Total			
c Total from continuation sheets to Part VII, Section A			
d Total (add lines 1b and 1c)	14,457,118	0	1,946,836

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 ▶ 418

		Yes	No
3	Did the organization list any former officer, director or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i>	3	No
4	For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? <i>If "Yes," complete Schedule J for such individual</i>	4	Yes
5	Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? <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
COMPHEALTH MEDICAL STAFFING PO BOX 713100 SALT LAKE CITY, UT 841713100	SERVICES	5,413,559
HURON CONSULTING SERVICES LLC 3005 MOMENTUM PLACE CHICAGO, IL 60689	SERVICES	2,268,341
MAYO COLLABORATIVE SERVICES INC PO BOX 9146 MINNEAPOLIS, MN 554809146	SERVICES	2,261,167
EPIC SYSTEMS CORPORATION PO BOX 88314 MILWAUKEE, WI 532880314	SERVICES	2,211,604
MICROSOFT CORPORATION 1950 N STEMMONS FWY STE 5010 DALLAS, TX 75207	SERVICES	2,071,447

<p>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 ► 99</p>	
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Part VIII

Statement of Revenue

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

Contributions, Gifts, Grants
and Other Similar Amounts

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
1a	Federated campaigns . . .	1a			
b	Membership dues . . .	1b			
c	Fundraising events . . .	1c			
d	Related organizations	1d	1,631,175		
e	Government grants (contributions)	1e	1,277,432		
f	All other contributions, gifts, grants, and similar amounts not included above	1f	203,158		
g	Noncash contributions included in lines 1a-1f \$ _____				
h	Total. Add lines 1a-1f		3,111,765		

Program Service Revenue

	Business Code				
2a	NET SERVICE TO PATIENTS	621110	521,132,690	517,060,527	4,072,163
b	PROGRAM SERVICE REVENUE	621110	20,533,992	19,946,526	587,466
c	RESEARCH GRANTS	621500	321,498	321,498	
d	BIOMED SERVICES/SITE SERVICES FEE	900099	39,996		39,996
e	_____				
f	All other program service revenue				
g	Total. Add lines 2a-2f		542,028,176		

Other Revenue

3	Investment income (including dividends, interest, and other similar amounts)		3,220,248			3,220,248
4	Income from investment of tax-exempt bond proceeds					
5	Royalties					
6a	Gross rents	(i) Real	(ii) Personal			
b	Less rental expenses					
c	Rental income or (loss)					
d	Net rental income or (loss)					
7a	Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other			
b	Less cost or other basis and sales expenses	49,763,094	1,560,961			
c	Gain or (loss)	50,453,422	8,361,898			
d	Net gain or (loss)	-690,328	-6,800,937			
8a	Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18	a				
b	Less direct expenses	b				
c	Net income or (loss) from fundraising events					
9a	Gross income from gaming activities See Part IV, line 19	a				
b	Less direct expenses	b				
c	Net income or (loss) from gaming activities					
10a	Gross sales of inventory, less returns and allowances	a				
b	Less cost of goods sold	b				
c	Net income or (loss) from sales of inventory					
	Miscellaneous Revenue	Business Code				
11a	RENTAL OFFICE SPACE/PARKING LOT	531120	146,279		146,279	
b	TELECOMMUNICATIONS	517000	15,696		15,696	
c	SNOW REMOVAL	812900	1,495		1,495	
d	All other revenue					
e	Total. Add lines 11a-11d		163,470			
12	Total revenue. See Instructions		541,032,394	529,837,286	4,235,633	3,847,710

Part IX Statement of Functional Expenses

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

Check if Schedule O contains a response or note to any line in this Part IX ☐**Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.**

	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21.	1,002,628	1,002,628		
2 Grants and other assistance to domestic individuals. See Part IV, line 22.	20,840	20,840		
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.				
4 Benefits paid to or for members.				
5 Compensation of current officers, directors, trustees, and key employees.	11,255,714	2,899,690	8,356,024	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B).				
7 Other salaries and wages.	261,766,095	241,291,958	20,474,137	
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).	8,883,183	8,188,381	694,802	
9 Other employee benefits.	25,629,379	23,624,767	2,004,612	
10 Payroll taxes.	16,061,139	14,397,112	1,664,027	
11 Fees for services (non-employees):				
a Management.				
b Legal.				
c Accounting.				
d Lobbying.				
e Professional fundraising services. See Part IV, line 17.				
f Investment management fees.				
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).				
12 Advertising and promotion.				
13 Office expenses.	2,119,862	2,119,862		
14 Information technology.				
15 Royalties.				
16 Occupancy.				
17 Travel.	2,466,941	1,565,979	900,962	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials.				
19 Conferences, conventions, and meetings.				
20 Interest.	8,356,928	8,356,928		
21 Payments to affiliates.				
22 Depreciation, depletion, and amortization.	26,928,469	26,928,469		
23 Insurance.	2,621,274	2,621,274		
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O):				
a UNRELATED BUSINESS TAX	1,189,667	1,189,667		
b SUPPLIES	84,747,106	84,310,307	436,799	
c PURCHASED SERVICES	35,619,903	21,280,895	14,339,008	
d FEES	26,911,595	22,461,407	4,450,188	
e All other expenses	19,514,345	14,898,394	4,615,951	
25 Total functional expenses. Add lines 1 through 24e.	535,095,068	477,158,558	57,936,510	0
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

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

				(A) Beginning of year		(B) End of year
Assets	1	Cash—non-interest-bearing		11,741	1	11,316
	2	Savings and temporary cash investments		48,045,316	2	45,170,789
	3	Pledges and grants receivable, net			3	
	4	Accounts receivable, net		67,569,816	4	62,838,655
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L			5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L			6	
	7	Notes and loans receivable, net		460,271	7	458,157
	8	Inventories for sale or use		7,384,227	8	6,973,914
	9	Prepaid expenses and deferred charges		596,118	9	2,410,452
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a	499,005,630		
	b	Less: accumulated depreciation	10b	306,568,111		
				199,252,081	10c	192,437,519
	11	Investments—publicly traded securities		126,924,021	11	134,311,511
	12	Investments—other securities. See Part IV, line 11			12	
	13	Investments—program-related. See Part IV, line 11			13	
	14	Intangible assets			14	
15	Other assets. See Part IV, line 11		29,996,420	15	33,658,119	
16	Total assets. Add lines 1 through 15 (must equal line 34)		480,240,011	16	478,270,432	
Liabilities	17	Accounts payable and accrued expenses		46,673,606	17	48,388,679
	18	Grants payable			18	
	19	Deferred revenue		314,982	19	523,483
	20	Tax-exempt bond liabilities			20	
	21	Escrow or custodial account liability. Complete Part IV of Schedule D			21	
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L			22	
	23	Secured mortgages and notes payable to unrelated third parties		193,582,611	23	187,252,933
	24	Unsecured notes and loans payable to unrelated third parties			24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D		28,347,443	25	26,493,864
	26	Total liabilities. Add lines 17 through 25		268,918,642	26	262,658,959
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.					
	27	Unrestricted net assets		211,321,369	27	215,611,473
	28	Temporarily restricted net assets			28	
	29	Permanently restricted net assets			29	
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.					
	30	Capital stock or trust principal, or current funds			30	
	31	Paid-in or capital surplus, or land, building or equipment fund			31	
	32	Retained earnings, endowment, accumulated income, or other funds			32	
	33	Total net assets or fund balances		211,321,369	33	215,611,473
	34	Total liabilities and net assets/fund balances		480,240,011	34	478,270,432

Part XI Reconciliation of Net AssetsCheck if Schedule O contains a response or note to any line in this Part XI ☒

1	Total revenue (must equal Part VIII, column (A), line 12)	1	541,032,394
2	Total expenses (must equal Part IX, column (A), line 25)	2	535,095,068
3	Revenue less expenses Subtract line 2 from line 1	3	5,937,326
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	211,321,369
5	Net unrealized gains (losses) on investments	5	5,700,354
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-7,347,576
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	215,611,473

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

	Yes	No
1 Accounting method used to prepare the Form 990 <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		
2a 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 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	
c If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O	Yes	
3a As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?		No
b If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits		

Additional Data

Software ID:
Software Version:
EIN: 45-0310462
Name: ALTRU HEALTH SYSTEM

Form 990 (2016)

Form 990, Part III, Line 4a:

ORTHOPEDICS - ALTRU'S TEAM OF ORTHOPEDIC SURGEONS PROVIDE INPATIENT AND OUTPATIENT SURGICAL SERVICES TO PATIENTS WITH ISSUES RANGING FROM SIMPLE FRACTURES TO COMPLEX TRAUMATIC INJURIES OUR ORTHOPEDIC SURGEONS ALSO PROVIDE OUTREACH CLINIC SERVICES TO COMMUNITIES THROUGHOUT OUR SERVICE AREA IN 2016, THERE WERE 1,369 HOSPITAL DISCHARGES

Form 990, Part III, Line 4b:

CARDIOLOGY - ALTRU OFFERS COMPREHENSIVE SERVICES INCLUDING INTERVENTIONAL AND MEDICAL CARDIOLOGY. ADDITIONAL SERVICES INCLUDE ECHOCARDIOGRAPHY, CARDIAC STRESS TESTS, AND CARDIAC REHAB. ALTRU HAS BEEN RECOGNIZED THREE TIMES AS A "100 TOP HOSPITALS" FOR CARDIOVASCULAR CARE. OUR CARDIOLOGY TEAM ALSO PROVIDES OUTREACH CLINIC SERVICES TO COMMUNITIES THROUGHOUT OUR SERVICE AREA. IN 2016, THERE WERE 1,264 HOSPITAL DISCHARGES.

Form 990, Part III, Line 4c:

GENERAL SURGERY - ALTRU'S TEAM OF GENERAL SURGEONS PERFORM INPATIENT AND OUTPATIENT SURGERY AND SEE PATIENTS AT ALTRU HOSPITAL, ALTRU MAIN CLINIC, AND SOME OF ALTRU'S REGIONAL CLINICS IN 2016, THERE WERE 1,028 GENERAL SURGERY HOSPITAL DISCHARGES

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			
KRIS COMPTON BOARD CHAIR	1 00	X		X				0	0	0
LONNIE LAFFEN VICE CHAIR	1 00	X		X				0	0	0
PHILIP GISI SECRETARY	1 00	X		X				0	0	0
ALICE BREKKE BOARD MEMBER	1 00	X						0	0	0
KRISTI HALL-JIRAN BOARD MEMBER	1 00	X						0	0	0
KEITH OKESON BOARD MEMBER	1 00	X						0	0	0
MATTHEW ROLLER MD BOARD MEMBER/PHYSICIAN	40 00	X						526,659	0	38,943
BRADLEY BELLUK MD BOARD MEMBER/PHYSICIAN	40 00	X						542,146	0	45,912
ERIC LUNN MD BOARD MEMBER/PRESIDENT/PHY	40 00	X		X				647,831	0	110,634
DAVID MOLMEN BOARD MEMBER/CEO	40 00	X		X				934,388	0	155,631

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

(A)

(B)

(C)

(D)

(E)

(F)

Name and Title	Average hours per week (list any hours for related organizations below dotted line)	Position (do not check more than one box, unless person is both an officer and a director/trustee)							Reportable compensation from the organization (W- 2/1099-MISC)	Reportable compensation from related organizations (W- 2/1099-MISC)	Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former				
BRADLEY WEHE BOARD MEMBER/COO	40 00	X		X					555,265	0	122,833
DWIGHT THOMPSON CFO/TREASURER	40 00			X					628,591	0	134,606
RENEE M AXTMAN RN ADMIN DIR PRIMARY CARE	40 00				X				275,506	0	69,388
KERRY P CARLSON FORMER ADM DIR MEDICAL SPECIALTY	40 00				X				313,705	0	22,090
SCOTT CHARETTE MD MEDICAL DIRECTOR SURGICAL	40 00				X				632,792	0	66,454
JOSHUA DEERE MEDICAL DIRECTOR	40 00				X				422,374	0	63,834
KELLEE FISK CHIEF PEOPLE OFFICER	40 00				X				443,644	0	116,374
YVONNE GOMEZ MEDICAL DIRECTOR	40 00				X				347,879	0	60,483
KELLY HAGEN RN ADM DIR CARDIOLOGY & MUSCU	40 00				X				262,430	0	63,826
LAURA LIZAKOWSKI PAST MEDICAL DIRECTOR	40 00				X				303,079	0	53,223

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				
WILLIAM MCKINNON MD MEDICAL DIRECTOR	40 00				X			303,917	0	75,315	
MARGARET REED RN CHIEF NURSE OFFICER	40 00				X			317,323	0	20,548	
DENNIS REISNOUR CHIEF STRATEGY OFFICER	40 00				X			342,275	0	74,745	
HEATHER STRANDELL ADMINISTRATIVE DIRECTOR	40 00				X			230,598	0	70,190	
COLLEEN SWANK MD CHIEF MEDICAL OFFICER	40 00				X			468,631	0	120,897	
KENNETH VEIN ADM DIR PLANT SERVICES	40 00				X			328,205	0	87,260	
MARK WAIND ADM DIR INFORMATION SERVIC	40 00				X			366,818	0	114,238	
JILL WILSON ADMIN DIRECTOR	40 00				X			256,659	0	83,905	
RABEEA ABOUFAKHER PHYSICIAN	40 00					X		953,827	0	43,912	
ABDEL AHMED PHYSICIAN	40 00					X		911,630	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			
IKECHUKWU ONYEKA PHYSICIAN	40 00					X		1,319,010	0	46,462
DARIN LEETUN PHYSICIAN	40 00					X		897,380	0	38,671
ATILLA DALMI PHYSICIAN	40 00					X		924,556	0	46,462

SCHEDULE A (Form 990 or 990-EZ)	Public Charity Status and Public Support Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust. ▶ Attach to Form 990 or Form 990-EZ. ▶ Information about Schedule A (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990 .	OMB No 1545-0047
	2016 Open to Public Inspection	
Department of the Treasury Internal Revenue Service Name of the organization ALTRU HEALTH SYSTEM	Employer identification number 45-0310462	

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 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2)**. (Complete Part III)
- 11 ☐ An organization organized and operated exclusively to test for public safety See **section 509(a)(4)**.
- 12 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2)**. See **section 509(a)(3)**. Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g
- a ☐ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization **You must complete Part IV, Sections A and B.**
- b ☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s) **You must complete Part IV, Sections A and C.**
- c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions) **You must complete Part IV, Sections A, D, and E.**
- d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions) **You must complete Part IV, Sections A and D, and Part V.**
- e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization
- f Enter the number of supported organizations _____
- g Provide the following information about the supported organization(s) _____

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1- 10 above (see instructions))	(iv) Is the organization listed in your governing document?		(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 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 Public support. Subtract line 5 from line 4						

Section B. Total Support						
Calendar year (or fiscal year beginning in) ▶	(a)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 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here ▶ <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 33 1/3% support test—2016. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>						
b 33 1/3% support test—2015. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>						
17a 10%-facts-and-circumstances test—2016. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>						
b 10%-facts-and-circumstances test—2015. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>						
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ <input type="checkbox"/>						

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

Section B. Total Support

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

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

Section C. Computation of Public Support Percentage

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

Section D. Computation of Investment Income Percentage

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

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

Part IV Supporting Organizations (continued)

	Yes	No
11 Has the organization accepted a gift or contribution from any of the following persons?		
a A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization?		
b A family member of a person described in (a) above?		
c 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>		
11a		
11b		
11c		

Section B. Type I Supporting Organizations

	Yes	No
1 Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? <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>		
2 Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? <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>		
1		
2		

Section C. Type II Supporting Organizations

	Yes	No
1 Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? <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>		
1		

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions)		
a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.		
b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).		
2 Activities Test Answer (a) and (b) below.		
a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <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 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>		
3 Parent of Supported Organizations Answer (a) and (b) below.		
a Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>Provide details in Part VI.</i>		
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>		
2a		
2b		
3a		
3b		

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

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

Section A - Adjusted Net Income

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

Section B - Minimum Asset Amount

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

Section C - Distributable Amount

		Current Year
1 Adjusted net income for prior year (from Section A, line 8, Column A)	1	
2 Enter 85% of line 1	2	
3 Minimum asset amount for prior year (from Section B, line 8, Column A)	3	
4 Enter greater of line 2 or line 3	4	
5 Income tax imposed in prior year	5	
6 Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	
7 <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).

Facts And Circumstances Test

efile GRAPHIC print - DO NOT PROCESS		As Filed Data -		DLN: 93493317059587	
<div>SCHEDULE D (Form 990)</div> <div>Department of the Treasury Internal Revenue Service</div>		<div>Supplemental Financial Statements</div> <div>► 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.</div> <div>Information about Schedule D (Form 990) and its instructions is at www.irs.gov/form990.</div>			<div>OMB No 1545-0047</div> <div>2016</div> <div>Open to Public Inspection</div>
Name of the organization ALTRU HEALTH SYSTEM				Employer identification number 45-0310462	
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? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>					
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? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>					
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) <div><input type="checkbox"/> Preservation of land for public use (e g , recreation or education) <input type="checkbox"/> Preservation of an historically important land area <input type="checkbox"/> Protection of natural habitat <input type="checkbox"/> Preservation of a certified historic structure <input type="checkbox"/> Preservation of open space</div>					
2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year					
				Held at the End of the Year	
a Total number of conservation easements				2a	
b Total acreage restricted by conservation easements				2b	
c Number of conservation easements on a certified historic structure included in (a)				2c	
d Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register				2d	
3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ►					
4 Number of states where property subject to conservation easement is located ►					
5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>					
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)? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>					
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		7,360,071		7,360,071
b Buildings		247,833,884	123,638,461	124,195,423
c Leasehold improvements		10,295,489	6,005,311	4,290,178
d Equipment		228,231,514	176,924,339	51,307,175
e Other		5,284,672		5,284,672
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c))				192,437,519

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) ASSETS HELD BY TRUSTEE	1,073,845
(2) UNAMORTIZED BOND ISSUE AND OTHER COSTS	6,233,455
(3) ASSETS HELD UNDER TRUST AGREEMENTS	19,418,408
(4) ASSETS HELD UNDER BOND INDENTURE AGREEMENTS	6,837,150
(5) DUE FROM AFFILIATES	95,261
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 15) ▶	33,658,119

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		
DUE TO AFFILIATES	184,767	
POST RETIREMENT HEALTH BENEFIT	10,878,007	
OTHER	12,035,005	
ESTIMATED THIRD PARTY LIABILITY	2,635,765	
SPECIAL ASSESSMENTS PAYABLE	760,320	
(6)		
(7)		
(8)		
(9)		
Total. (Column (b) must equal Form 990, Part X, col (B) line 25) ▶	26,493,864	

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

☒

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

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

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

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

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

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

Part XIII Supplemental Information

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

Return Reference	Explanation
See Additional Data Table	

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

Additional Data

Software ID:
Software Version:
EIN: 45-0310462
Name: ALTRU HEALTH SYSTEM

Supplemental Information

Return Reference	Explanation
PART X, LINE 2	ACCOUNTING FOR UNCERTAINTY IN INCOME TAXES THE ORGANIZATION'S POLICY IS TO EVALUATE THE LIKELIHOOD THAT ITS UNCERTAIN TAX POSITIONS WILL PREVAIL UPON EXAMINATION BASED ON THE EXTENT TO WHICH THOSE POSITIONS HAVE SUBSTANTIAL SUPPORT WITHIN THE INTERNAL REVENUE CODE AND REGULATIONS, REVENUE RULINGS, COURT DECISIONS AND OTHER EVIDENCE IT IS THE OPINION OF MANAGEMENT THAT THE ORGANIZATION HAS NO SIGNIFICANT UNCERTAIN TAX POSITIONS THAT WOULD BE SUBJECT TO CHANGE UPON EXAMINATION THE FEDERAL INCOME TAX RETURNS OF THE ORGANIZATION ARE SUBJECT TO EXAMINATION BY INTERNAL REVENUE SERVICE GENERALLY FOR THREE YEARS AFTER THEY WERE FILED ALL FILINGS ARE CURRENT

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SCHEDULE H
(Form 990)

Hospitals

OMB No 1545-0047

2016

Open to Public Inspection

Department of the Treasury

Internal Revenue Service

Name of the organization

ALTRU HEALTH SYSTEM

Employer identification number

45-0310462

► 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.

Part IFinancial Assistance and Certain Other Community Benefits at Cost

1a

Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a

1a

Yes

1b

If "Yes," was it a written policy?

1b

Yes

2

If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year

☒ Applied uniformly to all hospital facilities

☐ Applied uniformly to most hospital facilities

☐ Generally tailored to individual hospital facilities

3

Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year

a

Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care

3a

Yes

b

Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care

3b

Yes

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

Yes

5a

Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?

5a

Yes

b

If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?

5b

Yes

c

If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?

5c

No

6a

Did the organization prepare a community benefit report during the tax year?

6a

Yes

b

If "Yes," did the organization make it available to the public?

6b

Yes

Complete the following table using the worksheets provided in the Schedule H instructions Do not submit these worksheets with the Schedule H

7Financial 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)			2,445,008		2,445,008	0 460 %
b Medicaid (from Worksheet 3, column a)			20,016,397		20,016,397	3 740 %
c Costs of other means-tested government programs (from Worksheet 3, column b)			1,017,567		1,017,567	0 190 %
d Total Financial Assistance and Means-Tested Government Programs			23,478,972		23,478,972	4 390 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			907,359		907,359	0 170 %
f Health professions education (from Worksheet 5)			663,027		663,027	0 120 %
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)			222,189		222,189	0 040 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)			107,375		107,375	0 020 %
j Total. Other Benefits			1,899,950		1,899,950	0 350 %
k Total. Add lines 7d and 7j			25,378,922		25,378,922	4 740 %

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

Cat No 50192T

Schedule H (Form 990) 2016

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

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

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

		Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	Yes	
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	2	9,148,528	
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3	0	
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME).	5	124,341,171
6 Enter Medicare allowable costs of care relating to payments on line 5.	6	375,910,924
7 Subtract line 6 from line 5. This is the surplus (or shortfall).	7	-251,569,753
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used.		
<input type="checkbox"/> Cost accounting system	<input type="checkbox"/> Cost to charge ratio	<input checked="" type="checkbox"/> Other

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures

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

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

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

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

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

3

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

		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (Describe)	Facility reporting group
	See Additional Data Table										

Part V Facility Information (continued)**Section B. Facility Policies and Practices**

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

ALTRU 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
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3	Yes
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <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		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <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)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA 20 <u>16</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	Yes
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>WWW.ALTRU.ORG</u>		
b <input type="checkbox"/> Other website (list url) _____		
c <input type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	No
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 _____	10	
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? a If "Yes" (list url) _____	10	
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V

Facility Information (continued)

Financial Assistance Policy (FAP)

ALTRU HOSPITAL			
Name of hospital facility or letter of facility reporting group			
		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13	Yes
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150 000000000000 % and FPG family income limit for eligibility for discounted care of 250 000000000000 %			
b <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input checked="" type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input checked="" type="checkbox"/> Underinsurance discount			
g <input checked="" type="checkbox"/> Residency			
h <input type="checkbox"/> Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes
15	Explained the method for applying for financial assistance? 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)	15	Yes
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
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			
c <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			
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e <input type="checkbox"/> Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	16	Yes
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) WWW ALTRU ORG			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) WWW ALTRU ORG			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) WWW ALTRU ORG			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <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)			
f <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)			
g <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			
h <input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i <input 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			
j <input type="checkbox"/> Other (describe in Section C)			

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

ALTRU HOSPITAL

Name of hospital facility or letter of facility reporting group

		Yes	No
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment?	17	Yes	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP			
a <input checked="" type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <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 d <input checked="" type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C) f <input type="checkbox"/> None of these actions or other similar actions were permitted			
19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	19	Yes	
If "Yes," check all actions in which the hospital facility or a third party engaged			
a <input checked="" type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <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 d <input checked="" type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C)			
20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply)			
a <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 <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications d <input checked="" type="checkbox"/> Made presumptive eligibility determinations e <input type="checkbox"/> Other (describe in Section C) f <input type="checkbox"/> None of these efforts were made			

Policy Relating to Emergency Medical Care

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

ALTRU 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
22		
23		No
24	Yes	

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)
ALTRU REHABILITATION CENTER**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):** _____

2

Community Health Needs Assessment

	Yes	No
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3	Yes
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <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		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <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)		
j <input type="checkbox"/> Other (describe in Section C) _____		
4 Indicate the tax year the hospital facility last conducted a CHNA 20 <u>16</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	Yes
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>WWW.ALTRU.ORG</u>		
b <input type="checkbox"/> Other website (list url) _____		
c <input type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> Other (describe in Section C) _____		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	No
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 _____	10	
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? a If "Yes" (list url) _____	10b	
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V

Facility Information (continued)

Financial Assistance Policy (FAP)

ALTRU REHABILITATION CENTER																																																																																								
Name of hospital facility or letter of facility reporting group																																																																																								
	<table><tr><td></td><td>Yes</td><td>No</td></tr><tr><td>Did the hospital facility have in place during the tax year a written financial assistance policy that</td><td></td><td></td></tr><tr><td>13 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</td><td>13 Yes</td><td></td></tr><tr><td>a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150 000000000000 % and FPG family income limit for eligibility for discounted care of 250 000000000000 %</td><td></td><td></td></tr><tr><td>b <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)</td><td></td><td></td></tr><tr><td>c <input checked="" type="checkbox"/> Asset level</td><td></td><td></td></tr><tr><td>d <input checked="" type="checkbox"/> Medical indigency</td><td></td><td></td></tr><tr><td>e <input checked="" type="checkbox"/> Insurance status</td><td></td><td></td></tr><tr><td>f <input checked="" type="checkbox"/> Underinsurance discount</td><td></td><td></td></tr><tr><td>g <input checked="" type="checkbox"/> Residency</td><td></td><td></td></tr><tr><td>h <input type="checkbox"/> Other (describe in Section C)</td><td></td><td></td></tr><tr><td>14 Explained the basis for calculating amounts charged to patients?</td><td>14 Yes</td><td></td></tr><tr><td>15 Explained the method for applying for financial assistance? 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If "Yes," indicate the eligibility criteria explained in the FAP	13 Yes		a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150 000000000000 % and FPG family income limit for eligibility for discounted care of 250 000000000000 %			b <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)			c <input checked="" type="checkbox"/> Asset level			d <input checked="" type="checkbox"/> Medical indigency			e <input checked="" type="checkbox"/> Insurance status			f <input checked="" type="checkbox"/> Underinsurance discount			g <input checked="" type="checkbox"/> Residency			h <input type="checkbox"/> Other (describe in Section C)			14 Explained the basis for calculating amounts charged to patients?	14 Yes		15 Explained the method for applying for financial assistance? 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)	15 Yes		a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			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			c <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			d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			e <input type="checkbox"/> Other (describe in Section C)			16 Was widely publicized within the community served by the hospital facility? 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14 Explained the basis for calculating amounts charged to patients?	14 Yes																																																																																							
15 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)	15 Yes																																																																																							
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application																																																																																								
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																																																																																								
c <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																																																																																								
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications																																																																																								
e <input type="checkbox"/> Other (describe in Section C)																																																																																								
16 Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	16 Yes																																																																																							
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) WWW ALTRU ORG																																																																																								
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) WWW ALTRU ORG																																																																																								
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) WWW ALTRU ORG																																																																																								
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)																																																																																								
e <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)																																																																																								
f <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)																																																																																								
g <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																																																																																								
h <input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP																																																																																								
i <input 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																																																																																								
j <input type="checkbox"/> Other (describe in Section C)																																																																																								

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

ALTRU REHABILITATION CENTER

Name of hospital facility or letter of facility reporting group

	Yes	No
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment?	17 Yes	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
a <input checked="" type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <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 d <input checked="" type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C) f <input type="checkbox"/> None of these actions or other similar actions were permitted		
19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	19 Yes	
If "Yes," check all actions in which the hospital facility or a third party engaged		
a <input checked="" type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <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 d <input checked="" type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C)		
20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply)		
a <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 <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications d <input checked="" type="checkbox"/> Made presumptive eligibility determinations e <input type="checkbox"/> Other (describe in Section C) f <input type="checkbox"/> None of these efforts were made		

Policy Relating to Emergency Medical Care

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

ALTRU REHABILITATION CENTER

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
22		
23		No
24	Yes	

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? **56**

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

Part VI Supplemental Information

Provide the following information

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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 6A	PREPARATION OF ANNUAL COMMUNITY BENEFIT REPORT ALTRU HEALTH SYSTEM PREPARES ANNUALLY A COMMUNITY BENEFIT REPORT BASED ON FORMS DESIGNED BY THE CATHOLIC HEALTH ORGANIZATION ONCE ALL REPORTING FORMS HAVE BEEN COMPILED FOR THE YEAR, THE CATHOLIC HEALTH ORGANIZATION'S REFERENCE GUIDE FROM "A GUIDE FOR PLANNING AND REPORTING COMMUNITY BENEFIT" IS USED TO DETERMINE WHAT ITEMS SHOULD BE REPORTED INTO WHAT CATEGORY THE COMMUNITY BENEFIT REPORT IS PUBLISHED AS A PART OF THE CORPORATION'S ANNUAL REPORT, WHICH IS PLACED ON OUR WEB SITE FOR PUBLIC ACCESS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7	COLUMN (F) - PERCENT OF TOTAL EXPENSES IN DETERMINING THE DENOMINATOR FOR THE PERCENT OF TOTAL EXPENSE CALCULATION, THE AMOUNT REPORTED ON FORM 990, PART IX, LINE 25, COLUMN (A) WAS REDUCED BY BAD DEBTS EXPENSE OF \$9,148,528 CHARITY CARE AND CERTAIN OTHER COMMUNITY BENEFITS AT COST THE METHODOLOGY USED TO DETERMINE THE REPORTED AMOUNTS FOR THE CHARITY CARE IS A COST-TO-CHARGE RATIO BASED ON GROSS CHARGES WRITTEN OFF PURSUANT TO OUR CHARITY CARE AND MEANS-TESTED PROGRAMS ELIGIBILITY CRITERIA OTHER COMMUNITY BENEFIT IS DETERMINED FROM INFORMATION THAT WAS COMPILED ON FORMS DESIGNED BY THE CATHOLIC HEALTH ORGANIZATION AND USING THEIR REFERENCE GUIDE, "A GUIDE FOR PLANNING AND REPORTING COMMUNITY BENEFIT," TO DETERMINE WHICH CATEGORY THE AMOUNTS ARE PROPERLY REPORTED UNDER

990 Schedule H, Supplemental Information	
Form and Line Reference	Explanation
PART II, COMMUNITY BUILDING ACTIVITIES	NONE DOCUMENTED ON FORM 990

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 4	<p>FOOTNOTE DISCLOSURE REGARDING BAD DEBTS EXPENSE NOTES 1 AND 13 TO THE AUDITED FINANCIAL STATEMENTS REPORT ON BAD DEBT EXPENSE NOTE 1 - ACCOUNTS RECEIVABLE "PATIENT RECEIVABLES ARE UNCOLLATERALIZED PATIENT AND THIRD-PARTY PAYOR OBLIGATIONS PAYMENTS ON PATIENT RECEIVABLES ARE ALLOCATED TO THE SPECIFIC CLAIMS IDENTIFIED IN THE REMITTANCE ADVICE OR, IF UNSPECIFIED, ARE APPLIED TO THE EARLIEST UNPAID CLAIM PATIENT ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FOR DOUBTFUL ACCOUNTS IN EVALUATING THE COLLECTABILITY OF ACCOUNTS RECEIVABLE, ALTRU HEALTH SYSTEM ANALYZES ITS PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYOR SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR DOUBTFUL ACCOUNTS AND PROVISION FOR BAD DEBTS MANAGEMENT REGULARLY REVIEWS DATA IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS, ALTRU RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATES THAT MANY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE THE DIFFERENCE BETWEEN THE STANDARD RATES AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS CHARGED OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS ALTRU'S PROCESS FOR CALCULATING THE ALLOWANCE FOR DOUBTFUL ACCOUNTS FOR SELF-PAY PATIENTS HAS NOT SIGNIFICANTLY CHANGED FROM DECEMBER 31, 2015 TO DECEMBER 31, 2016 ALTRU DOES NOT MAINTAIN A MATERIAL ALLOWANCE FOR DOUBTFUL ACCOUNTS FROM THIRD-PARTY PAYORS, NOR DID IT HAVE SIGNIFICANT WRITE OFFS FROM THIRD-PARTY PAYORS ALTRU HAS NOT SIGNIFICANTLY CHANGED ITS CHARITY CARE OR UNINSURED DISCOUNT POLICIES DURING FISCAL YEARS 2015 OR 2016 NOTE 13 - " NEITHER THE CHARITY CARE NOR THE UNCOMPENSATED CARE AMOUNTS INCLUDE BAD DEBTS AS SHOWN IN THE STATEMENT OF OPERATIONS "</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 8	NONE OF THE SHORTFALL SHOWN ON PART III, LINE 7 OF \$251,569,753 HAS BEEN TREATED AS COMMUNITY BENEFIT AS REPORTED ON SCHEDULE H THE SOURCE OF THE AMOUNT SHOWN ON PART III, LINE 6 COMES FROM THE MEDICARE ALLOWABLE COSTS REPORTED IN ALTRU'S MEDICARE COST REPORT SUBMITTED FOR THE FISCAL YEAR ENDING DECEMBER 31, 2016, UTILIZING THE FOLLOWING WORKSHEETS WORKSHEETS B PART I, H-7 PARTS 1&2, I-4, AND K-6

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 9B	PROVISION FOR COLLECTION PRACTICES TO BE FOLLOWED FOR PATIENTS WHO ARE KNOWN TO QUALIFY FOR CHARITY CARE OR FINANCIAL ASSISTANCE ARE FOUND IN ALTRU'S POLICIES 2611 "DEDUCTIONS FROM REVENUES AND 2614 "CHARITY CARE " ALTRU'S COMMUNITY CARE PROGRAM IS DESIGNED TO PROVIDE FINANCIAL ASSISTANCE TO THOSE WHO HAVE NO INSURANCE AND/OR LIMITED MEANS TO PAY FOR THEIR MEDICAL SERVICES AND DO NOT QUALIFY FOR OTHER PROGRAMS IN ADDITION TO QUALITY HEALTHCARE, PATIENTS OF ALTRU HEALTH SYSTEM ARE PROVIDED FINANCIAL COUNSELING REGARDING THEIR MEDICAL BILLS, BY SOMEONE WHO CAN UNDERSTAND AND OFFER POSSIBLE SOLUTIONS FOR THOSE WHO CANNOT PAY IN FULL PROGRAMS ARE ALSO AVAILABLE FOR UNINSURED PATIENTS, AND FOR THOSE FOUND TO BE IN MEDICAL HARDSHIP

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 2	NEEDS ASSESSMENT ALTRU HEALTH SYSTEM'S MISSION - IMPROVING HEALTH, ENRICHING LIFE - CONFIRMS THAT OUR RESPONSIBILITY TO THE REGION GOES BEYOND PROVIDING QUALITY HEALTHCARE SERVICES ALL OF OUR RESOURCES ARE DEVOTED TO IMPROVING HEALTH IN THE COMMUNITIES WE SERVE AT ALTRU, GOOD HEALTH MEANS THAT EVERY INDIVIDUAL SHOULD ENJOY THE BEST ACHIEVABLE AND SO SHOULD OUR COMMUNITIES ALTRU'S COMMUNITY HEALTH NEEDS ASSESSMENT WAS APPROVED BY THE BOARD OF DIRECTORS ON SEPTEMBER 26, 2016 AS A RESULT OF THE ASSESSMENT, ALTRU PRIORITIZED AND IS FOCUSING ON THE FOLLOWING FIVE ISSUES 1) ACCESS TO BEHAVIORAL HEALTH SERVICES, INCLUDING ADDICTION TREATMENT AND COUNSELING, 2) PRESCRIPTION AND ILLEGAL DRUG ABUSE, 3) RATE OF OBESITY, 4) BINGE DRINKING/EXCESSIVE DRINKING, AND 5) CARE COORDINATION AND ACCESS TO HEALTH CARE

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 3	<p>PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE ALTRU HAS SEVERAL AVENUES IN WHICH INFORMATION REGARDING FINANCIAL ASSISTANCE PROGRAMS IS COMMUNICATED TO PATIENTS UNINSURED AND SELF-PAY PATIENTS IN THE HOSPITAL RECEIVE A VISIT FROM PATIENT REPRESENTATIVES AFTER INTAKE DURING THIS MEETING, THEY ARE INFORMED OF VARIOUS FEDERAL, STATE AND COMMUNITY-BASED PROGRAMS THAT MAY PROVIDE ASSISTANCE UNINSURED OR SELF-PAY PATIENTS FROM OUTPATIENTS RECEIVE CONTACT FROM PATIENT REPRESENTATIVES BY PHONE OR EMAIL INFORMING THEM OF POTENTIAL SOURCES OF FINANCIAL ASSISTANCE BOTH SETS OF PATIENTS ARE ALSO PROVIDED INFORMATION ON HOW TO MOVE FORWARD IN APPLYING FOR THE PROGRAMS IF PATIENTS ARE FOUND TO BE STRUGGLING WITH MEDICAL EXPENSES, OUR CREDIT AND COLLECTIONS REPRESENTATIVES UTILIZE LETTERS AND PHONE CALLS TO INFORM THEM OF VARIOUS RESOURCES THAT MAY PROVIDE ASSISTANCE FINANCIAL ASSISTANCE INFORMATION IS ALSO AVAILABLE TO THE PUBLIC AS A WHOLE ALTRU'S WEBSITE, ALTRU.ORG, INCLUDES FINANCIAL ASSISTANCE CONTACT INFORMATION AND ELIGIBILITY GUIDELINES PATIENTS MAY REVIEW THIS ON THEIR OWN AND CONTACT AGENCIES THAT MAY PROVIDE ASSISTANCE BASED ON THEIR CIRCUMSTANCES ALSO, ALTRU DISTRIBUTES BROCHURES FEATURING OUR COMMUNITY CARE PROGRAM AND OTHER FEDERAL AND STATE PROGRAMS THESE BROCHURES ARE AVAILABLE TO BOTH PATIENTS AND VISITORS IN WAITING ROOMS OF OUR INPATIENT AND OUTPATIENT FACILITIES AS WELL AS IN ALL BUSINESS OFFICE LOCATIONS</p>

Form and Line Reference	Explanation
PART VI, LINE 4	<p>COMMUNITY INFORMATION ALTRU HEALTH SYSTEM SERVES A 17-COUNTY AREA THAT IS DIVIDED INTO THREE DISTINCT SERVICE AREAS (PRIMARY, SECONDARY, AND REFERRAL) AND HAS A POPULATION OF APPROXIMATELY 224,000 PERSONS (2016 ESTIMATE) WHO RESIDE IN A DIVERSE AREA OF AGRICULTURE AND INDUSTRY. THE SERVICE AREA STRETCHES 265 MILES EAST AND WEST AND 120 MILES NORTH AND SOUTH. GRAND FORKS SITS IN THE MIDDLE OF THE RED RIVER VALLEY, ONE OF THE WORLD'S RICHEST AGRICULTURAL AREAS. PRINCIPAL CROPS INCLUDE SUGAR BEETS, POTATOES, EDIBLE BEANS, AND SMALL GRAINS SUCH AS WHEAT AND BARLEY. MUCH OF THE INDUSTRY IN THE AREA IS RELATED TO AGRICULTURE AND FOOD PROCESSING. THE PRIMARY SERVICE AREA, COMPRISED OF GRAND FORKS COUNTY (NORTH DAKOTA) AND POLK COUNTY (MINNESOTA), IS HOME TO 103,456 PEOPLE (2016 ESTIMATE). LOCATED IN THIS MARKET IS ALTRU HOSPITAL, ALTRU REHABILITATION CENTER, ALTRU CANCER CENTER, AND 13 OTHER LOCATIONS THAT ARE HOME TO OUR PROVIDERS' CLINIC PRACTICES AND OTHER SERVICES OFFERED BY ALTRU. ALTRU HOSPITAL SERVES AS THE MAJOR REFERRAL CENTER FOR THE PEOPLE OF THE REGION. AS SUCH, IT PROVIDES A BROAD SPECTRUM OF PROGRAMS AND SERVICES. A FULL RANGE OF SERVICES ARE AVAILABLE FOR PATIENTS SUFFERING FROM CANCER, HEART DISEASE, END-STAGE RENAL DISEASE, NEUROLOGICAL DISORDERS, ALCOHOL OR CHEMICAL DEPENDENCY, HIGH RISK OBSTETRICAL COMPLICATIONS, AND PSYCHIATRIC DISORDERS. ALTRU HOSPITAL'S INPATIENT MARKET SHARE IN 2016 FOR OUR PRIMARY MARKET WAS 76 PERCENT BASED ON CLAIMS DATA FROM MHA. ABOUT 80 PERCENT OF THE PHYSICIANS IN THE PRIMARY AREA ARE EMPLOYED BY ALTRU HEALTH SYSTEM. ALSO LOCATED IN GRAND FORKS COUNTY IS NORTHWOOD COMMUNITY HEALTH CENTER (IN NORTHWOOD, ND). A COUPLE NOTABLE POPULATIONS ALTRU SERVES THAT ARE LOCATED IN OUR PRIMARY SERVICE AREA INCLUDE THE UNIVERSITY OF NORTH DAKOTA AND GRAND FORKS AIR FORCE BASE. THE UNIVERSITY OF NORTH DAKOTA IS THE STATE'S OLDEST INSTITUTION OF HIGHER LEARNING WITH AN ENROLLMENT OF ABOUT 14,648 STUDENTS (FALL 2016). THE NUMBER OF RESIDENTS AT GRAND FORKS AIR FORCE BASE WAS COUNTED AT 2,367 IN THE 2010 CENSUS WITH A POPULATION OF 35,582 (2016 ESTIMATE), THE SECONDARY SERVICE AREA IS COMPRISED OF FIVE COUNTIES TO THE WEST, NORTH, AND EAST OF GRAND FORKS COUNTY: NELSON, WALSH, AND PEMBINA COUNTIES IN NORTH DAKOTA, AND MARSHALL AND KITTSON COUNTIES IN MINNESOTA. THIS AREA IS LARGE LY RURAL AND AGRICULTURAL. WITHIN THIS AREA, ALTRU HAS FIVE REGIONAL CLINIC LOCATIONS, IT IS ALSO HOME TO SEVERAL SMALL HOSPITALS AS LISTED BELOW. SECONDARY SERVICE AREA HOSPITALS: LOCATIONUNITY MEDICAL CENTER, GRAFTON, NDFIRST CARE HEALTH CENTER, PARK RIVER, NDPEMBINA COUNTY MEMORIAL HOSPITAL, CAVALIER, NDNELSON COUNTY HEALTH SYSTEM, MCVILLE, NDKITTSON MEMORIAL HOSPITAL, HALLOCK, MNNORTH VALLEY HEALTH CENTER, WARREN, MN. IN 2016, ALTRU'S HOSPITAL INPATIENT MARKET SHARE IN THIS SERVICE AREA WAS AROUND 65 PERCENT ACCORDING TO CLAIMS PROVIDED BY MHA. THE SYSTEM EMPLOYS MANY OF THE PHYSICIANS IN THE SECONDARY SERVICE AREA. ALL OF THESE PHYSICIANS ARE ON MEDICAL STAFFS OF COMMUNITY HOSPITALS THROUGHOUT THE REGION, AND REFER PATIENTS TO GRAND FORKS AND ELSEWHERE FOR SPECIALTY CARE. THE SYSTEM'S REFERRAL AREA IS COMPRISED OF TEN COUNTIES ENCIRCLING THE PRIMARY AND SECONDARY SERVICE AREAS (ROLETTE, TOWNER, BENSON, RAMSEY, CAVALIER, AND TRAILL COUNTIES IN NORTH DAKOTA AND ROSEAU, LAKE OF THE WOODS, PENNINGTON, AND RED LAKE COUNTIES IN MINNESOTA). THIS REGION IS ALSO MOSTLY RURAL AND AGRICULTURAL AND INCLUDES SEVERAL SMALLER HOSPITALS AS LISTED SERVING THE PRIMARY CARE NEEDS OF THEIR COMMUNITIES. ALTRU HAS SIX REGIONAL CLINICS IN THIS SERVICE AREA AND ALTRU HOSPITAL'S INPATIENT MARKET SHARE IN THIS REGION IS ABOUT 31 PERCENT ACCORDING TO 2016 CLAIMS DATA PROVIDED BY MHA. ALTRU, ONCE AGAIN, EMPLOYS MANY OF THE PHYSICIANS IN THIS AREA, AND THESE PHYSICIANS HAVE PRACTICE PATTERNS SIMILAR TO THOSE OF THE PHYSICIANS IN OUR SECONDARY SERVICE AREA. REFERRAL SERVICE AREA HOSPITALS: LOCATIONCAVALIER COUNTY MEMORIAL HOSPITAL, LANGDON, ND; HILLSBORO MEDICAL CENTER, HILLSBORO, ND; LAKEWOOD HEALTH CENTER, BAUDETTE, MN; MERCY HOSPITAL, DEVILS LAKE, ND; SANFORD-THIEF RIVER FALLS MEDICAL CENTER, THIEF RIVER FALLS, MN; PRESENTATION MEDICAL CENTER, ROLLA, ND; TOWNER COUNTY MEDICAL CENTER, CANDO, ND; SANFORD MAYVILLE MEDICAL CENTER, MAYVILLE, ND; LIFE CARE MEDICAL CENTER, ROSEAU, MN; QUENTIN N. BURDICK MEMORIAL HOSPITAL, BELCOURT, ND. AS PREVIOUSLY MENTIONED, ALTRU'S 17-COUNTY SERVICE AREA HAS A POPULATION OF APPROXIMATELY 224,000 (2016 ESTIMATE). USING DATA FROM SG2(A VENDOR SPECIALIZING IN HEALTH CARE PLANNING INFORMATION), THE INSURANCE COVERAGE FOR COMMUNITIES IN OUR SERVICE AREA IS ESTIMATED TO BE AS FOLLOWS: 2016 PROJECTIONS AS A PERCENT: MEDICAID 14,225 12% MEDICARE 23,792 21% MEDICARE-ADVANTAGE 8,864 8% COMMERCIAL 57,781 51% UNINSURED 9,026 8%. A PERCENTAGE BREAKDOWN OF INPATIENT UTILIZATION FOR ALTRU HOSPITAL BASED ON DISCHARGES BY TYPE OF PAYER PER 2016 PROJECTION SHOWS APPROXIMATELY 13 PERCENT OF DISCHARGES WERE FOR MEDICAID AND 8 PERCENT WERE SELF PAY (UNINSURED).</p>

Form and Line Reference	Explanation
PART VI, LINE 4	<p>) ALSO FROM SG2, OUR TOTAL SERVICE AREA'S INCOME BY HOUSEHOLD IS AS FOLLOWS INCOME RANGE 2016 HOUSEHOLDS\$ < \$ 9,999 7,480 \$ 10,000 - \$ 14,999 5,401\$ 15,000 - \$ 19,999 5,103\$ 20,000 - \$ 24,999 4,904\$ 25,000 - \$ 29,999 4,460\$ 30,000 - \$ 39,999 4,632\$ 35,000 - \$ 39,999 4, 564 \$ 40,000 - \$ 44,999 4,510\$ 45,000 - \$ 49,999 4,261\$ 50,000 - \$ 59,999 7,513\$ 60,000 - \$ 74,999 10,027\$ 75,000 - \$ 99,999 12,180\$100,000 - \$124,999 7,911\$125,000 - \$149,999 4,238 \$150,000 - \$199,999 3,069\$ > \$200,000 3,243</p> <p>ACCORDING TO THE WEBSITE FOR HEALTH RESOURCES AND SERVICES ADMINISTRATION, THE FOLLOWING AREAS IN OUR SERVICE AREA ARE MUA'S NORTH DAKOTA BENSON COUNTY BENSON SERVICE AREACAVALIER COUNTY CAVALIER SERVICE AREAGRAND FORKS COUNTY NORTHWOOD SERVICE AREA, GRAND FORKS SERVICE AREANELSON COUNTY NELSON SERVICE AREAPEMBI NA COUNTY WALHALLA SERVICE AREAROLETTE COUNTY ROLETTE SERVICE AREATOWNER COUNTY CANDO CITY SERVICE AREATRAILL COUNTY TRAILL SERVICE AREAWALSH COUNTY PARK RIVER CITY SERVICE AREA MINNESOTA KITTSON COUNTY KITTSON SERVICE AREAMARSHALL COUNTY MARSHALL SERVICE AREAPOLK COUNTY POLK SERVICE AREARED LAKE COUNTY RED LAKE SERVICE AREAROSEAU COUNTY ROSEAU SERVICE AREA</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 5	ALL OF ALTRU'S RESOURCES ARE DEVOTED TO IMPROVING HEALTH IN THE COMMUNITIES WE SERVE TO DO SO, WE KNOW THAT NOT ALL MEDICAL SERVICES WILL COME FROM STAFF EMPLOYED BY ALTRU HEALTH SYSTEM ALTRU EXTENDS MEDICAL STAFF PRIVILEGES TO ALL QUALIFIED PHYSICIANS IN OUR COMMUNITY FOR NEARLY ALL DEPARTMENTS ALSO, OUR BOARD OF DIRECTORS IS MADE UP OF INDIVIDUALS FROM OUTSIDE ALTRU HEALTH SYSTEM THESE PEOPLE ARE VOLUNTEERS WHO HAVE THE SAME DEDICATION AND FOCUS ON ALTRU'S MISSION AS OUR OWN STAFF

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 6	ALTRU HEALTH SYSTEM IS PART OF AN AFFILIATED HEALTH CARE SYSTEM IN SEPTEMBER 2011, ALTRU HEALTH SYSTEM BECAME THE FIRST MEMBER OF THE MAYO CLINIC CARE NETWORK THIS IS A NON-OWNERSHIP RELATIONSHIP THAT BENFITS THE ORGANIZATION'S PHYSICIANS AND PATIENTS FROM ENHANCED ACCESS TO MAYO PHYSICIANS AND CLINICAL RESOURCES MORE SPECIFICALLY, PHYSICIANS HAVE ACCESS TO MAYO CLINIC'S EVIDENCE-BASED DISEASE MANAGEMENT PROTOCOLS, CLINIC CARE GUIDELINES, AND TREATMENT RECOMMENDATIONS AND REFERENCE MATERIALS FOR COMPLEX MEDICAL CONDITIONS PART VI, LINE 7 ALTRU HEALTH SYSTEM IS NOT REQUIRED TO FILE OUR COMMUNITY BENEFIT REPORT WITH ANY OUTSIDE ORGANIZATIONS BUT HAS MADE OUR REPORT AVAILABLE TO ANYONE ON OUR WEB SITE

Additional Data

Software ID:
Software Version:
EIN: 45-0310462
Name: ALTRU HEALTH SYSTEM

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? 3											
Name, address, primary website address, and state license number											
1	ALTRU HOSPITAL 1200 S COLUMBIA RD GRAND FORKS, ND 582066002	X	X					X			
2	ALTRU REHABILITATION CENTER 1300 S COLUMBIA RD GRAND FORKS, ND 582066002	X									
3	ALTRU SPECIALTY CENTER 4500 S WASHINGTON ST GRAND FORKS, ND 58201	X	X								

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

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 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
ALTRU HOSPITAL	
ALTRU REHABILITATION CENTER	PART V, SECTION B, LINE 5 ALTRU HEALTH SYSTEM AND THE GRAND FORKS PUBLIC HEALTH DEPARTMENT T ENGAGED MULTIPLE PARTNERS TO CONDUCT SURVEYS AND FOCUS GROUPS WITH COMMUNITY LEADERS TO GET THEIR INSIGHT ABOUT THE HEALTH OF THE COMMUNITY AND HOW IT CAN BE IMPROVED IT WAS AGR EED TO USE THE PROCESS FROM THE ASSOCIATION FOR COMMUNITY HEALTH IMPROVEMENT (SIX STEP COM MUNITY HEALTH ASSESSMENT PROCESS) A COMMUNITY-BASED ADVISORY COMMITTEE WAS FORMED TO WORK WITH ALTRU AND GRAND FORKS PUBLIC HEALTH ON THE ASSESSMENT LEADERSHIP FROM ALTRU AND GRAN D FORKS PUBLIC HEALTH SERVED ON THE ADVISORY COMMITTEE, ALONG WITH INDIVIDUALS REPRESENTIN G THE FOLLOWING AGENCIES/ORGANIZATIONS COMMUNITY VIOLENCE INTERVENTION CENTERUNITED WAYGRA ND FORKS PUBLIC SCHOOLSUNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINEUNIVERSITY OF NORTH DA KOTANORTHEAST HUMAN SERVICE CENTERGRAND FORKS POLICE DEPARTMENTGRAND FORKS FIRE DEPARTMENT ALTRU FAMILY YMCAGRAND FORKS PARK DISTRICTGRAND FORKS AIR FORCE BASELIPP, CARLSON, WITUCKI & ASSOCIATESGRAND FORKS SENIOR CENTERTHIRD STREET CLINICGRAND FORKS CITY COUNCILFAITH COM MUNITYGLOBAL FRIENDS COALITIONVALLEY COMMUNITY HEALTH CENTERPOLK COUNTY PUBLIC HEALTHGRAND FORKS COUNTY COMMISSIONTHE ADVISORY COMMITTEE ENGAGED STUDENTS FROM THE UNIVERSITY OF NOR TH DAKOTA'S MASTER OF PUBLIC HEALTH PROGRAM WITH THE ASSISTANCE OF DR RAYMOND GOLDSTEEN, PROFESSOR AND DIRECTOR OF THE DEPARTMENT OF POPULATION HEALTH THE STUDENT TEAM CONDUCTED A COMMUNITY SURVEY ALONG WITH FOCUS GROUPS WITH COMMUNITY LEADERS TO GET THEIR INSIGHT ABO UT THE HEALTH OF GRAND FORKS AND POLK COUNTY COMMUNITIES AND HOW IT CAN BE IMPROVED
ALTRU HOSPITAL	PART V, SECTION B, LINE 6A ALTRU REHABILITATION CENTER
ALTRU REHABILITATION CENTER	PART V, SECTION B, LINE 6A ALTRU HEALTH SYSTEM
ALTRU HOSPITAL	PART V, SECTION B, LINE 6B GRAND FORKS PUBLIC HEALTH

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
ALTRU REHABILITATION CENTER	PART V, SECTION B, LINE 6B GRAND FORKS PUBLIC HEALTH
ALTRU HOSPITAL	PART V, SECTION B, LINE 11 ALTRU HEALTH SYSTEM DEVELOPED A LIST OF APPROXIMATELY SIXTY SIGNIFICANT ISSUES/NEEDS WITH THE INPUT OF THE ADVISORY COMMITTEE FROM THIS LIST, THE HEALTH ISSUES WERE RANKED BY PRIORITY, AND THE TOP 5 AREAS WERE IDENTIFIED FOR AREAS OF IMPROVEMENT LIMITED FINANCIAL, COMMUNITY, AND PERSONNEL RESOURCES DID NOT ALLOW ALTRU HEALTH SYSTEM TO ADDRESS ALL OF THE IDENTIFIED NEEDS FOR THE 2016 CHNA THE IMPLEMENTATION STRATEGY ADDRESSING THE NEEDS IDENTIFIED IN THE 2016 CHNA WILL BE ADOPTED IN 2017
ALTRU REHABILITATION CENTER	PART V, SECTION B, LINE 11 ALTRU HEALTH SYSTEM DEVELOPED A LIST OF APPROXIMATELY SIXTY SIGNIFICANT ISSUES/NEEDS WITH THE INPUT OF THE ADVISORY COMMITTEE FROM THIS LIST, THE HEALTH ISSUES WERE RANKED BY PRIORITY, AND THE TOP 5 AREAS WERE IDENTIFIED FOR AREAS OF IMPROVEMENT LIMITED FINANCIAL, COMMUNITY, AND PERSONNEL RESOURCES DID NOT ALLOW ALTRU HEALTH SYSTEM TO ADDRESS ALL OF THE IDENTIFIED NEEDS FOR THE 2016 CHNA THE IMPLEMENTATION STRATEGY ADDRESSING THE NEEDS IDENTIFIED IN THE 2016 CHNA WILL BE ADOPTED IN 2017
ALTRU HOSPITAL	PART V, SECTION B, LINE 24 ALL PATIENTS ARE CHARGED THE GROSS CHARGE REGARDLESS OF INSURANCE STATUS ADJUSTMENTS MAY BE APPLIED PROVIDING THE PATIENTS APPLY FOR AND QUALIFY FOR CHAIRTY CARE
ALTRU REHABILITATION CENTER	PART V, SECTION B, LINE 24 ALL PATIENTS ARE CHARGED THE GROSS CHARGE REGARDLESS OF INSURANCE STATUS ADJUSTMENTS MAY BE APPLIED PROVIDING THE PATIENTS APPLY FOR AND QUALIFY FOR CHAIRTY CARE

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

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

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

Name and address	Type of Facility (describe)
1 1 - ALTRU MAIN CLINIC 1000 S COLUMBIA RD GRAND FORKS, ND 582066003	OUTPATIENT DEPT OF ALTRU HOSP - CLINIC
1 2 - ALTRU CANCER CENTER 960 S COLUMBIA RD GRAND FORKS, ND 582066003	OUTPATIENT DEPT OF ALTRU HOSP - CLINIC
2 3 - TRUYU AESTHETIC CENTER 3165 DEMERS AVE GRAND FORKS, ND 582066003	OUTPATIENT DEPT OF ALTRU HOSP - CLINIC
3 4 - ALTRU FAMILY MEDICINE CENTER 1380 S COLUMBIA RD GRAND FORKS, ND 582066003	OUTPATIENT DEPT OF ALTRU HOSP - CLINIC
4 5 - ALTRU FAMILY MEDICINE RESIDENCY 725 HAMLINE STREET GRAND FORKS, ND 58203	OUTPATIENT CLINIC
5 6 - ALTRU FAMILY MEDICINE RESIDENCY PHARMACY 725 HAMLINE STREET GRAND FORKS, ND 58203	OUTPATIENT PHARMACY
6 7 - ALTRU CLINIC - DRAYTON 1003 N MAIN DRAYTON, ND 582254650	OUTPATIENT CLINIC/THERAPY
7 8 - ALTRU PSYCHIATRY CENTER 860 S COLUMBIA RD GRAND FORKS, ND 582066002	OUTPATIENT DEPARTMENT - PSYCH SERVICES
8 9 - ALTRU HOSPITAL - CENTER COURT FITNESS 1600 32ND AVE S GRAND FORKS, ND 58201	OUTPATIENT THERAPY
9 10 - ALTRU OUTPATIENT CENTER 411 2ND ST NW EAST GRAND FORKS, MN 56721	OUTPATIENT THERAPY
10 11 - ALTRU CLINIC - CAVALIER 201 E 3RD AVE S CAVALIER, ND 582200040	OUTPATIENT CLINIC
11 12 - ALTRU CLINIC - DEVILS LAKE 1001 7TH STREET NE DEVILS LAKE, ND 583012719	OUTPATIENT CLINIC
12 13 - ALTRU CLINIC - CROOKSTON 400 SOUTH MINNESOTA CROOKSTON, MN 567160606	OUTPATIENT DEPT OF ALTRU HOSP - CLINIC
13 14 - ALTRU CLINIC - RED LAKE FALLS 312 INTERNATIONAL DRIVE RED LAKE FALLS, MN 567504662	OUTPATIENT DEPT OF ALTRU HOSP - CLINIC
14 15 - ALTRU CLINIC - ERSKINE 23076 347TH ST SE ERSKINE, MN 565354201	OUTPATIENT DEPT OF ALTRU HOSP - CLINIC

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

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

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

Name and address	Type of Facility (describe)
16 16 - ALTRU CLINIC - FERTILE MILL STREET MAIN FERTILE, MN 565404215	OUTPATIENT DEPT OF ALTRU HOSP - CLINIC
1 17 - ALTRU CLINIC - ROSEAU 711 DELMORE DRIVE ROSEAU, MN 567511534	OUTPATIENT CLINIC
2 18 - ALTRU CLINIC - WARROAD 412 MAIN AVE NE WARROAD, MN 567632342	OUTPATIENT CLINIC
3 19 - ALTRU CLINIC - GREENBUSH 19120 200TH ST GREENBUSH, MN 567269280	OUTPATIENT CLINIC
4 20 - UNITY MEDICAL CENTER 164 WEST 13TH STREET GRAFTON, ND 58237	HOME HEALTH/HOSPICE
5 21 - FIRST CARE HEALTH CENTER PO BOX I PARK RIVER, ND 58270	HOME HEALTH/HOSPICE/THERAPY
6 22 - NELSON COUNTY HEALTH SYSTEM BOX 367 MCVILLE, ND 58254	HOME HEALTH/HOSPICE
7 23 - CO CAVALIER CLINIC 201 E 3RD AVE S CAVALIER, ND 58220	HOME HEALTH/HOSPICE
8 24 - ALTRU HOME SVCS-NORTH VALLEY HOME HEALTH 109 S MINNESOTA ST WARREN, MN 56762	HOME HEALTH/HOSPICE
9 25 - ANETA PARKVIEW HEALTH CENTER BOX 287 ANETA, ND 58212	OUTREACH CLINIC
10 26 - CAVALIER COUNTY MEMORIAL 909 2ND ST LANGDON, ND 58249	OUTREACH CLINIC
11 27 - CENTRAL BOILER 20502 160TH ST GREENBUSH, MN 56726	OUTREACH CLINIC
12 28 - COOPERSTOWN MEDICAL CENTER 1200 ROBERTS ST COOPERSTOWN, ND 58425	OUTREACH CLINIC
13 29 - DEVILS LAKE GOOD SAMARITAN 302 7TH AVE DEVILS LAKE, ND 58301	OUTREACH CLINIC
14 30 - FIRST CARE HEALTH CENTER 115 VIVIAN ST PARK RIVER, ND 58270	OUTREACH CLINIC

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

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

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

Name and address	Type of Facility (describe)
31 31 - FRIENDSHIP 554 W 12TH ST GRAFTON, ND 58327	OUTREACH CLINIC
1 32 - 4TH CORP 120 11TH ST NEW ROCKFORD, ND 58356	OUTREACH CLINIC
2 33 - GRIGGS COUNTY HOSPITAL 1200 ROBERTS AVE NE COOPERSTOWN, ND 58425	OUTREACH CLINIC
3 34 - HATTON PRAIRIE VILLAGE 930 DAKOTA AVE HATTON, ND 58240	OUTREACH CLINIC
4 35 - HEARTLAND CARE CENTER 620 14TH AVE NE DEVILS LAKE, ND 58301	OUTREACH CLINIC
5 36 - KARLSTAD HEALTH CARE 304 WASHINGTON AVE W KARLSTAD, MN 56732	OUTREACH CLINIC
6 37 - KITTSON MEMORIAL HEALTH CARE CENTER 1010 S BIRCH HALLOCK, MN 56728	OUTREACH CLINIC
7 38 - KITTSON MEMORIAL CLINIC OF KARLSTAD 1ST AND ROOSEVELT KARLSTAD, MN 56732	OUTREACH CLINIC
8 39 - LAKE REGION CORP 224 3TH ST NW DEVILS LAKE, ND 583012908	OUTREACH CLINIC
9 40 - LAKOTA GOOD SAMARITAN 608 4TH AVE SW HWY 2 LAKOTA, ND 583447500	OUTREACH CLINIC
10 41 - MAPLE MANOR CARE CENTER 1116 9TH AVE LANGDON, ND 58249	OUTREACH CLINIC
11 42 - MCINTOSH MANOR NURSING HOME 600 RIVERSIDE AVE NE MCINTOSH, MN 56556	OUTREACH CLINIC
12 43 - NELSON COUNTY CARE CENTER 108 E NYHUS AVE MCVILLE, ND 58254	OUTREACH CLINIC
13 44 - NELSON COUNTY HEALTH SYSTEM 200 NORTH MAIN MCVILLE, ND 58254	OUTREACH CLINIC
14 45 - NORTHWOOD DEACONESS 4 N PART ST NORTHWOOD, ND 58267	OUTREACH CLINIC

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

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

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

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

Name and address	Type of Facility (describe)
46 46 - OAKLAND PARK COMMUNITIES INC 123 BAKEN STREET THIEF RIVER FALLS, MN 56701	OUTREACH CLINIC
1 47 - PEMBILIER NURSING CENTER 500 DELANO AVE WALHALLA, ND 58282	OUTREACH CLINIC
2 48 - PEMBINA COUNTY MEMORIAL HOSPITAL 301 MOUNTAIN STREET E CAVALIER, ND 58220	OUTREACH CLINIC
3 49 - PIONEER MEMORIAL CARE CENTER 23028 347TH ST SE ERSKINE, MN 565359466	OUTREACH CLINIC
4 50 - REM-GRAFTON 817 HILL AVE GRAFTON, ND 58327	OUTREACH CLINIC
5 51 - VALLEY 4000 4004 24TH AVE SOUTH GRAND FORKS, ND 58201	OUTREACH CLINIC
6 52 - VALLEY MEMORIAL HOMES 2900 14TH AVE SOUTH GRAND FORKS, ND 58201	OUTREACH CLINIC
7 53 - WEDGEWOOD MANOR 804 MAIN STREET WEST CAVALIER, ND 58220	OUTREACH CLINIC
8 54 - CENTER FOR PREVENTION & GENETICS 4401 S 11TH ST GRAND FORKS, ND 58201	OUTREACH CLINIC
9 55 - ALTRU CLINIC - EAST GRAND FORKS 607 DEMERS AVE EAST GRAND FORKS, MN 56721	OUTPATIENT DEPT OF ALTRU HOSP - CLINIC
10 56 - ALTRU PROFESSIONAL CENTER 4440 S WASHINGTON ST GRAND FORKS, ND 58201	OUTPATIENT CLINIC

Schedule I
(Form 990)

Department of the Treasury
Internal Revenue Service

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

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

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

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
ALTRU HEALTH SYSTEM

Employer identification number
45-0310462

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
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2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table 10

3 Enter total number of other organizations listed in the line 1 table 2

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) SCHOLARSHIPS	14	18,840			
(2) SPONSORSHIPS	3	2,000			
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					

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

Return Reference	Explanation
PART I, LINE 2	UNIVERSITY OF MINNESOTA FOUNDATION - SCHOLARSHIPS ARE DIRECTED BY THE UNIVERSITY OF MINNESOTA FOUNDATION AS PART OF THE SCHOLARSHIP PROGRAM AND ALTRU DOES NOT DIRECTLY DESIGNATE SCHOLARSHIP RECIPIENTS COMMUNITY VIOLENCE INTERVENTION CENTER - FUNDS WERE GRANTED WITH THE DIRECTION THAT CVIC WAS ABLE TO USE FUNDS AS NEEDED CVIC DETERMINES THE RECIPIENTS OF THE ASSISTANCE PROVIDED THROUGH THOSE FUNDS RE ARENA, INC - ALTRU REVIEWS THE SPONSORSHIPS WITH RE ARENA/UNIVERSITY OF NORTH DAKOTA OFFICIALS PRIOR TO THE EVENTS AND HAS REPRESENTATIVES ATTEND THE EVENTS TO ACKNOWLEDGE THE PROPRIETY OF THE ANNOUNCEMENTS MADE REGARDING THE SPONSORSHIP OF THE DAY'S EVENT UNITED WAY GRAND FORKS/EAST GRAND FORKS - FUNDS WERE GRANTED TO THE ANNUAL CAMPAIGN AND UNITED WAY USES THE FUNDS AS NEEDED UND FOUNDATION - SCHOLARSHIPS ARE DIRECTED BY UND AS PART OF THE SCHOLARSHIP PROGRAM AND ALTRU DOES NOT DIRECTLY DESIGNATE SCHOLARSHIP RECIPIENTS GREATER GRAND FORKS YOUNG PROFESSIONALS - FUNDS GRANTED WITH THE DIRECTION THAT THEY WERE ABLE TO USE THE FUNDS AS NEEDED GRAND FORKS PARK DISTRICT FOUNDATION - FUNDS GRANTED WITH THE DIRECTION THAT THEY WERE ABLE TO USE THE FUNDS AS NEEDED TOWARDS THE WELLNESS CENTER FACILITY PROJECT AND THE ICON SPORTS CENTER ICE ARENA ALTRU FAMILY YMCA - FUNDS GRANTED WITH THE DIRECTION THAT THEY WERE ABLE TO USE THE FUNDS AS NEEDED A REPRESENTATIVE ATTENDED THE EVENTS TO ACKNOWLEDGE THE PROPRIETY OF THE ANNOUNCEMENTS MADE REGARDING THE SPONSORSHIP OF THE DAY'S EVENT CITY OF EAST GRAND FORKS - FUNDS GRANTED WITH THE DIRECTION THAT THEY WERE ABLE TO USE THE FUNDS AS NEEDED CITY OF GRAND FORKS - FUNDS GRANTED WITH THE DIRECTION THAT THEY WERE ABLE TO USE THE FUNDS AS NEEDED TOWARDS A SOCIAL DETOX FACILITY LIFECARE MEDICAL CENTER - FUNDS GRANTED WITH THE DIRECTION THAT THEY WERE ABLE TO USE THE FUNDS AS NEEDED A REPRESENTATIVE ATTENDED THE EVENTS TO ACKNOWLEDGE THE PROPRIETY OF THE ANNOUNCEMENTS MADE REGARDING THE SPONSORSHIP OF THE DAY'S EVENT GRAND FORKS DOWNTOWN DEVELOPMENT ASSOCIATION - FUNDS GRANTED WITH THE DIRECTION THAT THEY WERE ABLE TO USE THE FUNDS AS NEEDED

Additional Data

Software ID:
Software Version:
EIN: 45-0310462
Name: ALTRU HEALTH SYSTEM

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
COMMUNITY VIOLENCE INTERVENTION CENTER 211 S 4TH ST STE 207 GRAND FORKS, ND 58201	45-0359167	501(C)(3)	25,000				2016 SUPPORT
UNIVERSITY OF MINNESOTA FOUNDATION 200 OAK ST SE STE 500 MINNEAPOLIS, MN 55455	41-6042488	501(C)(3)	20,000				STUDENT SCHOLARSHIP FUND

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
RE ARENA INC ONE RALPH ENGLESTAD DR GRAND FORKS, ND 58203	11-3666663	501(C)(3)	98,500				GAME DAY SPONSORSHIPS
UNITED WAY GRAND FORKSEAST GRAND FORKS 1407 24TH AVE S STE 400 GRAND FORKS, ND 58201	45-0255772	501(C)(3)	10,500				CORPORATE GIFT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
UND FOUNDATION 3100 UNIVERSITY AVE STOP 8157 GRAND FORKS, ND 58202	45-0348296	501(C)(3)	435,838				UND ATHLETICS HIGH PERFORMANCE CENTER, ALTRU TURF FUND
GREATER GRAND FORKS YOUNG PROFESSIONALS 202 NORTH 3RD ST GRAND FORKS, ND 58203	32-0134204	501(C)(6)	11,000				GGFYP VISIONARY SPONSORSHIP

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
GRAND FORKS PARK DISTRICT FOUNDATION 1060 47TH AVE S GRAND FORKS, ND 58201	26-0625504	501(C)(3)	195,500				WELLNESS CENTER PROJECT, LEGENDS & HEROES PLEDGE
ALTRU FAMILY YMCA 215 N 7TH ST GRAND FORKS, ND 58203	45-0226434	501(C)(3)	72,000				YMCA PLAYGROUND, FIRECRACKER ROAD RACE

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CITY OF EAST GRAND FORKS 600 DEMERS AVE NW EAST GRAND FORKS, MN 56721	41-6005112	EAST GRAND FORKS, MN	45,000				WELLNESS PROGRAM
CITY OF GRAND FORKS 255 N 4TH ST GRAND FORKS, ND 58203	45-6002085	GRAND FORKS, ND	21,000				SOCIAL DETOX FACILITY

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
LIFECARE MEDICAL CENTER 715 DELMORE DR ROSEAU, MN 56751	41-1804205	501(C)(3)	5,000				2016 PARTNERS FOR HEALTH EVENT SPONSORSHIP
GRAND FORKS DOWNTOWN DEVELOPMENT ASSOCIATION 23 N 3RD ST STE 2 GRAND FORKS, ND 58203	46-4711617	501(C)(6)	5,000				SUPPORT

Schedule J
(Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

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

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

OMB No 1545-0047

2015

Open to Public Inspection

Name of the organization ALTRU HEALTH SYSTEM	Employer identification number 45-0310462
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Part I

Questions Regarding Compensation

	Yes	No
1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items. <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 If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	1b	
2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?	2	
3 Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III. <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>		
4 During the year, did any person listed on Form 990, Part VII, Section A, line 1a with respect to the filing organization or a related organization: a Receive a severance payment or change-of-control payment?	4a	No
b Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b	No
c Participate in, or receive payment from, an equity-based compensation arrangement? If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.	4c	No
Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.		
5 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of: a The organization?	5a	No
b Any related organization? If "Yes," on line 5a or 5b, describe in Part III.	5b	No
6 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of: a The organization?	6a	No
b Any related organization? If "Yes," on line 6a or 6b, describe in Part III.	6b	No
7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III.	7	No
8 Were any amounts reported on Form 990, Part VII, paid or 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.	8	No
9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9	

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

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

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

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

Part III **Supplemental Information**

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

Return Reference	Explanation
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Additional Data

Software ID:

Software Version:

EIN: 45-0310462

Name: ALTRU HEALTH SYSTEM

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				
1MATTHEW ROLLER MD BOARD MEMBER/PHYSICIAN	(i)	490,136	0	36,523	24,055	17,249	567,963	0
	(ii)	0	0	0	0	0	0	0
1BRADLEY BELLUK MD BOARD MEMBER/PHYSICIAN	(i)	499,088	0	43,058	24,055	24,140	590,341	0
	(ii)	0	0	0	0	0	0	0
2ERIC LUNN MD BOARD MEMBER/PRESIDENT/PHY	(i)	410,473	193,500	43,858	104,347	8,535	760,713	0
	(ii)	0	0	0	0	0	0	0
3DAVID MOLMEN BOARD MEMBER/CEO	(i)	571,772	268,200	94,416	133,224	22,407	1,090,019	0
	(ii)	0	0	0	0	0	0	0
4BRADLEY WEHE BOARD MEMBER/COO	(i)	335,331	177,016	42,918	100,426	22,407	678,098	0
	(ii)	0	0	0	0	0	0	0
5DWIGHT THOMPSON CFO/TREASURER	(i)	341,888	134,566	152,137	118,640	15,966	763,197	0
	(ii)	0	0	0	0	0	0	0
6RENEE M AXTMAN RN ADMIN DIR PRIMARY CARE	(i)	204,441	61,088	9,977	46,981	23,935	346,422	0
	(ii)	0	0	0	0	0	0	0
7KERRY P CARLSON FORMER ADM DIR MEDICAL SPECIALTY	(i)	25,847	48,373	239,485	17,568	4,747	336,020	0
	(ii)	0	0	0	0	0	0	0
8SCOTT CHARETTE MD MEDICAL DIRECTOR SURGICAL	(i)	588,820	18,730	25,242	46,597	22,239	701,628	0
	(ii)	0	0	0	0	0	0	0
9JOSHUA DEERE MEDICAL DIRECTOR	(i)	370,717	33,340	18,317	43,977	22,006	488,357	0
	(ii)	0	0	0	0	0	0	0
10KELLEE FISK CHIEF PEOPLE OFFICER	(i)	283,074	132,604	27,966	100,408	18,076	562,128	0
	(ii)	0	0	0	0	0	0	0
11YVONNE GOMEZ MEDICAL DIRECTOR	(i)	282,767	39,888	25,224	54,196	8,261	410,336	0
	(ii)	0	0	0	0	0	0	0
12KELLY HAGEN RN ADM DIR CARDIOLOGY & MUSCU	(i)	207,239	54,097	1,094	41,419	23,878	327,727	0
	(ii)	0	0	0	0	0	0	0
13LAURA LIZAKOWSKI PAST MEDICAL DIRECTOR	(i)	267,209	18,452	17,418	39,320	15,586	357,985	0
	(ii)	0	0	0	0	0	0	0
14WILLIAM MCKINNON MD MEDICAL DIRECTOR	(i)	244,401	32,068	27,448	59,349	17,840	381,106	0
	(ii)	0	0	0	0	0	0	0
15MARGARET REED RN CHIEF NURSE OFFICER	(i)	262,279	0	55,044	19,571	2,255	339,149	0
	(ii)	0	0	0	0	0	0	0
16DENNIS REISNOUR CHIEF STRATEGY OFFICER	(i)	235,686	88,125	18,464	73,625	2,880	418,780	0
	(ii)	0	0	0	0	0	0	0
17HEATHER STRANDELL ADMINISTRATIVE DIRECTOR	(i)	180,398	42,450	7,750	67,690	3,794	302,082	0
	(ii)	0	0	0	0	0	0	0
18COLLEEN SWANK MD CHIEF MEDICAL OFFICER	(i)	322,986	127,125	18,520	98,490	24,549	591,670	0
	(ii)	0	0	0	0	0	0	0
19KENNETH VEIN ADM DIR PLANT SERVICES	(i)	202,114	61,595	64,496	71,294	17,506	417,005	0
	(ii)	0	0	0	0	0	0	0

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				
21MARK WAIND ADM DIR INFORMATION SERVIC	(i)	346,690	0	20,128	96,807	19,368	482,993	0
	(ii)	0	0	0	0	- 0	- 0	0
1JILL WILSON ADMIN DIRECTOR	(i)	194,057	37,000	25,602	64,048	21,287	341,994	0
	(ii)	0	0	0	0	- 0	- 0	0
2RABEEA ABOUFAKHER PHYSICIAN	(i)	935,287	0	18,540	24,055	22,239	1,000,121	0
	(ii)	0	0	0	0	- 0	- 0	0
3ABDEL AHMEDPHYSICIAN	(i)	0	0	911,630	0	0	911,630	0
	(ii)	0	0	0	0	- 0	- 0	0
4IKECHUKWU ONYEKA PHYSICIAN	(i)	1,300,268	0	18,742	24,055	24,789	1,367,854	0
	(ii)	0	0	0	0	- 0	- 0	0
5DARIN LEETUNPHYSICIAN	(i)	850,896	0	46,484	24,055	16,998	938,433	0
	(ii)	0	0	0	0	- 0	- 0	0
6ATILLA DALMIPHYSICIAN	(i)	888,746	0	35,810	24,055	24,789	973,400	0
	(ii)	0	0	0	0	- 0	- 0	0

Schedule K
(Form 990)

Department of the Treasury
Internal Revenue Service
Name of the organization
ALTRU HEALTH SYSTEM

Supplemental Information on Tax Exempt Bonds

► Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
► Attach to Form 990.
► Information about Schedule K (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2016

Open to Public Inspection

Employer identification number

45-0310462

Part I

Bond Issues

(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pool financing	
						Yes	No	Yes	No	Yes	No
A CITY OF GRAND FORKS	45-6002085	38546WAW0	12-01-2005	40,000,000	CAPITAL EXPENDITURES, FUND DEBT SERVICE FUND		X		X		X
B CITY OF GRAND FORKS	45-6002085	38546WAZ3	08-15-2007	30,755,173	REFUND BONDS ISSUED JUNE 17, 1997 AND MARCH 23, 2000		X		X		X
C CITY OF GRAND FORKS	45-6002085		08-02-2011	23,620,000	REFUND BONDS ISSUED MAY 19, 1994 AND JUNE 17, 1997		X		X		X
D CITY OF GRAND FORKS	45-6002085	38546WCC2	05-01-2012	112,375,000	REFUND BONDS ISSUED 1992, 1997, AND 2010A/2010B, INFRASTRUCTURE, EQUIPMENT		X		X		X

Part II

Proceeds

		A		B		C		D	
1	Amount of bonds retired	11,700,000		5,470,173		11,880,000		1,495,000	
2	Amount of bonds legally defeased								
3	Total proceeds of issue	40,000,000		30,755,173		23,620,000		112,375,000	
4	Gross proceeds in reserve funds	3,530,586		3,075,517					
5	Capitalized interest from proceeds								
6	Proceeds in refunding escrows			27,283,893		23,487,901		49,370,134	
7	Issuance costs from proceeds	425,000		395,763		103,099		2,487,053	
8	Credit enhancement from proceeds	1,506,870							
9	Working capital expenditures from proceeds								
10	Capital expenditures from proceeds	34,537,534							
11	Other spent proceeds								
12	Other unspent proceeds								
13	Year of substantial completion	2007		2007		2011		2012	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue?		X	X		X		X	
15	Were the bonds issued as part of an advance refunding issue?		X		X		X		X
16	Has the final allocation of proceeds been made?	X		X		X		X	
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X		X	

Part III

Private Business Use

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

Part III Private Business Use (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?								
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
c Are there any research agreements that may result in private business use of bond-financed property?								
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶								
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶								
6 Total of lines 4 and 5								
7 Does the bond issue meet the private security or payment test? . . .								
8a Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?								
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of . .								
c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?								

Part IV Arbitrage

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

Part IV Arbitrage (Continued)

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

Part V Procedures To Undertake Corrective Action

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

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

Return Reference	Explanation
DATE REBATE COMPUTATION PERFORMED	ISSUER NAME CITY OF GRAND FORKS DATE THE REBATE COMPUTATION WAS PERFORMED 12/01/2016 ISSUER NAME CITY OF GRAND FORKS DATE THE REBATE COMPUTATION WAS PERFORMED 12/01/2016

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service
Name of the organization
ALTRU HEALTH SYSTEM

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**

45-0310462

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	FORM 990 IS REVIEWED AND APPROVED BY THE BOARD OF DIRECTORS PRIOR TO FILING

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	CONFLICT OF INTEREST POLICY IS REVIEWED AND SIGNED OFF ANNUALLY BY ALL MEMBERS OF THE BOARD OF DIRECTORS THESE FORMS ARE COLLECTED AND REVIEWED BY THE SECRETARY

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15	DETERMINATION OF THE COMPENSATION FOR THE PRESIDENT AND CEO ARE DETERMINED BY THE BOARD SUBSTANTIATION OF THESE DISCUSSIONS APPEAR IN THE BOARD MINUTES COMPENSATION OF KEY EMPLOYEES ARE DETERMINED BY A COMPENSATION COMMITTEE FORMED OF PHYSICIANS THAT REPORT TO THE BOARD OF DIRECTORS

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 18	THE ORGANIZATIONS 990 AND 990-T PUBLIC INSPECTION COPIES ARE AVAILABLE UPON REQUEST FORM 1023 IS AVAILABLE UPON REQUEST

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	THE ORGANIZATION'S FINANCIAL STATEMENTS ARE MADE AVAILABLE TO THE PUBLIC THROUGH PUBLISHED ANNUAL REPORTS AND VIA ITS WEB SITE GOVERNING DOCUMENTS AND CONFLICT OF INTEREST POLICY ARE AVAILABLE UPON REQUEST

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9	APPLICATION OF FASB ASC TOPIC 715 -7,543,207 UNRELATED BUSINESS INCOME TAX EXPENSE - ACCRUED 195,631

990 Schedule O, Supplemental Information

Return Reference	Explanation
990, PAGE 1, HEADING ITEM C	ALTRU CLINIC-MAIN, ALTRU REHAB CENTER, ALTRU CANCER CENTER, ALTRU FAMILY MEDICINE CENTER, ALTRU FAMILY MEDICINE RESIDENCY, TRUYU AESTHETIC CENTER, ALTRU CLINIC-LAKE REGION, ALTRU CLINIC-CAVALIER, ALTRU CLINIC-DRAYTON, ALTRU CLINIC-CROOKSTON, ALTRU CLINIC-RED LAKE FALLS, ALTRU CLINIC-FERTILE, ALTRU CLINIC-ERSKINE, ALTRU CLINIC-ROSEAU, ALTRU CLINIC-WARROAD, ALTRU CLINIC-GREENBUSH, ALTRU CLINIC-KARLSTAD

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VIII, LINE 2B & 2D	EXCLUSION AMOUNT BIOMED SERVICES \$32,830 SITE SERVICE FEES \$7,166 SUBTOTAL \$39,996 PHARMACY SALES TO EMPLOYEES \$7,695 HOUSING/SPACE RENTALS \$486,782 VENDING MACHINE INCOME \$91,883 SALE OF SCRAP/OTHER \$1,106 SUBTOTAL \$587,466 TOTAL EXCLUSION AMOUNT \$627,462 RELATED OR EXEMPT FUNCTION INCOME CEPT REVENUE \$219,175 HEARING CENTER \$1,027,630 OCCUPATIONAL HEALTH \$610,170 VHA SUPPLY CO - DISTRIBUTION \$1,112,026 PURCHASE DISCOUNTS \$246,545 REBATES \$213,625 CONTRACT SERVICES, OUTREACH, EDUCATION \$3,436,523 MEDICAL RECORDS TRANSCRIPT FEES \$208,487 AFFILIATED OTHER REVENUE \$266,202 MISCELLANEOUS REVENUE \$12,607,638 TOTAL RELATED/EXEMPT INCOME \$19,948,021

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VIII, LINE 2B & 2D	<p>1 BIOMED SERVICES REVENUE EARNED THROUGH THE PROVISION OF SERVICES TO AREA HEALTH CARE FACILITIES NEEDING TO KEEP THEIR EQUIPMENT IN OPERATION IN ORDER TO PROVIDE THEIR PATIENTS WITH THEIR SERVICE THE BIOMED PROGRAM PROVIDES SMALL REGIONAL HOSPITALS WITH A SERVICE OTHERWISE UNOBTAINABLE FROM ANYONE IN THE LOCAL AREA, IT IS OFTEN ON A PRIORITY BASIS 2 SITE SERVICE FEES FEES CHARGED FOR PROVIDING GROUNDS AND MAINTENANCE FOR THE AREA SURROUNDING THE UNITED HOSPITAL, INCLUDING FEES FOR SUCH SERVICES AS MAINTENANCE OF HOSPITAL PARKING LOT, SNOW SHOVELING, AND SNOW REMOVAL 3 PHARMACY SALES TO EMPLOYEES REVENUE INCURRED IN SALES STRICTLY FOR THE CONVENIENCE OF EMPLOYEES 4 HOUSING/SPACE RENTALS INCOME INCURRED THROUGH THE RENTAL OF SPACE TO THE AREA HEALTH EDUCATION CENTER WHICH IS REQUIRED TO BE ON-SITE TO WORK WITH OUR PHYSICIANS PROVIDING HEALTH CARE TO PATIENTS 5 VENDING MACHINE INCOME INCOME EARNED THROUGH THE OPERATION OF VENDING MACHINES IN THE BUILDINGS 6 SALE OF SCRAP INCOME EARNED THROUGH THE SALE OF ITEMS THAT ARE NOT FIXED ASSETS AND ARE OF DIMINISHED USE TO THE ORGANIZATION 7 CEPT REVENUE REVENUE EARNED FROM THE EVALUATION AND TREATMENT OF ADOLESCENTS THROUGH A MULTIDISCIPLINARY APPROACH INCLUDING PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH PATHOLOGY, AND PSYCHOLOGY 8 HEARING CENTER REVENUE FROM THE PROVISION OF AUDIOLOGICAL SERVICES AND HEARING AIDS TO PATIENTS 9 OCCUPATIONAL HEALTH FEES FOR PROVIDING DRUG SCREENINGS FOR REGIONAL EMPLOYERS 10 VHA SUPPLY DISTRIBUTION REBATE RECEIVED BASED ON VOLUME OF SUPPLY PURCHASES 11 PURCHASE DISCOUNTS THIS FIGURE REPRESENTS COST SAVINGS ON PURCHASES FROM SUPPLIERS FOR GOODS USED IN THE PROVISION OF HEALTH CARE SERVICES 12 REBATES REBATES RECEIVED BASED ON VOLUME OF PHARMACY PURCHASES 13 CONTRACT SERVICES, OUTREACH, EDUCATION REVENUES EARNED IN THE PROVISION OF COMMUNITY EDUCATION/ WELLNESS PROGRAMS, PASTORAL COUNSELING SERVICES, AND CONTRACTED SERVICES WITH REGIONAL HEALTHCARE SYSTEMS TO BRING OUTREACH SERVICES INTO THEIR COMMUNITIES 14 CPE FUND CLINICAL PASTORAL EDUCATION INCOME FROM PASTORAL RESIDENTS PROGRAM SPONSORED BY THE ASSOCIATION OF CLINICAL PASTORAL EDUCATION 15 MEDICAL RECORD TRANSCRIPTION FEES INCOME EARNED THROUGH THE CHARGING OF VARIOUS THIRD PARTY PAYERS FOR THE PHOTOCOPYING OF PATIENT RECORDS INSURANCE COMPANIES AND PAYERS ARE CHARGED TO OFFSET THE COST OF COPYING 16 OTHER REVENUE CHARGED TO AFFILIATED CORPORATIONS REVENUE FROM THE PROVISION OF PATIENT SERVICES, SUCH AS PSYCH OR LABORATORY, TO THE PATIENTS OF OTHER CORPORATIONS, WHICH ARE AFFILIATED TO ALTRUS HEALTH SYSTEM 17 MISCELLANEOUS INCOME INCLUDES PRINCIPALLY MONIES FROM MEDICARE & MEDICAID FOR UPGRADING EPIC AND MANDATED ELECTRONIC HEALTH RECORDS SOFTWARE SYSTEMS INCLUDES A RETURN OF EXPENSES FROM AN INSURANCE POOL ALSO INCLUDES INCOME EARNED THROUGH THE PROVISION OF SERVICES THAT ARE OPERATING IN THE HOSPITAL IN NATURE, BUT HAVE NO SPECIFIC COST CENTER IDENTIFICATIONS A</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VIII, LINE 2B & 2D	N EXAMPLE OF THIS WOULD BE IF THE DIRECTOR OF THE COMMUNICATIONS DEPARTMENT RECEIVED A SMA LL TOKEN AMOUNT FOR FILLING OUT A SURVEY FROM SOME HEALTH CARE ORGANIZATION

SCHEDULE R
(Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

► Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.

► Attach to Form 990. ► Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
ALTRU HEALTH SYSTEM

Employer identification number
45-0310462

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1)ALTRU HEALTH FOUNDATION 2501 DEMERS AVE GRAND FORKS, ND 58201 45-0368330	FUNDRAISING	ND	501(C)(3)	LINE 12A, I N/A			No
(2)ALTRU HEALTH RESOURCES 1200 S COLUMBIA RD GRAND FORKS, ND 58201 45-0368332	CONGREGATE HOUSING, ASSISTED LIVING	ND	501(C)(3)	LINE 12A, I N/A			No
(3)DAK-MINN BLOOD BANK 1200 S COLUMBIA RD GRAND FORKS, ND 58201 36-3453164	BLOOD BANK	ND	501(C)(3)	LINE 12D, III-O N/A			No
(4)ALTRU ALLIANCE 1200 S COLUMBIA RD GRAND FORKS, ND 58201 23-7389089	SUPPORT HOSPITAL AND AFFILIATES	ND	501(C)(3)	LINE 12B, II N/A			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.

(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.

(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) ALTRU SPECIALTY SERVICES INC 1200 S COLUMBIA RD GRAND FORKS, ND 58201 45-0395652	DME SALES, RETAIL PHARMACY	ND	N/A	C					No

Part V Transactions With Related Organizations Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.**Note.** Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule**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
1a	Yes	
1b		No
1c	Yes	
1d		No
1e		No
1f		No
1g		No
1h		No
1i		No
1j		No
1k		No
1l		No
1m	Yes	
1n		No
1o	Yes	
1p	Yes	
1q	Yes	
1r		No
1s		No

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

See Additional Data Table

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

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: 45-0310462
Name: ALTRU HEALTH SYSTEM

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

(a) Name of related organization		(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
(1)	ALTRU HEALTH FOUNDATION	C	1,631,175	CASH DONATED
(1)	ALTRU HEALTH FOUNDATION	O	3,136,877	COMPENSATION TO RELATED ORG
(2)	ALTRU SPECIALTY SERVICES	A	146,279	RENT PAYMENT RECEIVED
(3)	DAK-MINN BLOOD BANK	O	394,655	COMPENSATION TO RELATED ORG
(4)	ALTRU ALLIANCE	Q	72,787	AMOUNT REIMBURSED
(5)	ALTRU HEALTH RESOURCES	P	6,000	AMOUNT REIMBURSED
(6)	ALTRU HEALTH RESOURCES	O	2,270,235	COMPENSATION TO RELATED ORG