** PUBLIC DISCLOSURE COPY **

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except black lung benefit trust or private foundation)

▶ The organization may have to use a copy of this return to satisfy state reporting requirements.

OMB No. 1545-0047

2011

Open to Public Inspection

A For the 2011 calendar year, or tax year beginning and ending

B Check if applicable: ☐ Address change ☐ Name change ☐ Initial return ☐ Terminated ☐ Amended return ☐ Application pending

C Name of organization: TRINITY MEDICAL CENTER

Doing Business As

Number and street (or P.O. box if mail is not delivered to street address): 2701 17TH ST — Room/suite

City or town, state or country, and ZIP + 4: ROCK ISLAND, IL 61201

D Employer identification number: 36-2739299

E Telephone number: 309-779-5000

G Gross receipts $ 410,573,249.

F Name and address of principal officer: RICHARD SEIDLER
SAME AS C ABOVE

H(a) Is this a group return for affiliates? ☐ Yes ☒ No

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

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

J Website: ▶ WWW.TRINITYQC.COM

H(c) Group exemption number ▶

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1969 **M** State of legal domicile: IL

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities: IMPROVE THE HEALTH OF THE PEOPLE AND COMMUNITIES WE SERVE.

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

3	Number of voting members of the governing body (Part VI, line 1a)	3	19
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	12
5	Total number of individuals employed in calendar year 2011 (Part V, line 2a)	5	3162
6	Total number of volunteers (estimate if necessary)	6	490
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	98,398.
b	Net unrelated business taxable income from Form 990-T, line 34	7b	1,959.

			Prior Year	Current Year
Revenue	8	Contributions and grants (Part VIII, line 1h)	4,557,383.	3,124,407.
	9	Program service revenue (Part VIII, line 2g)	327,767,972.	326,497,284.
	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	9,729,087.	6,208,675.
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	2,704,090.	3,293,825.
	12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	344,758,532.	339,124,191.
Expenses	13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	2,856,454.	2,361,256.
	14	Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
	15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	136,467,919.	156,553,893.
	16a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
	b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 0.		
	17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	187,923,285.	168,463,077.
	18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	327,247,658.	327,378,226.
	19	Revenue less expenses. Subtract line 18 from line 12	17,510,874.	11,745,965.
			Beginning of Current Year	**End of Year**
Net Assets or Fund Balances	20	Total assets (Part X, line 16)	346,938,374.	364,192,128.
	21	Total liabilities (Part X, line 26)	177,254,174.	188,506,032.
	22	Net assets or fund balances. Subtract line 21 from line 20	169,684,200.	175,686,096.

Part II Signature Block

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

Sign Here

▶ Signature of officer — Date

▶ GREG PAGLIUZZA, JR., VP FINANCE/CFO
Type or print name and title

Paid Preparer Use Only

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

Firm's name ▶ — Firm's EIN ▶

Firm's address ▶ — Phone no.

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

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response to any question in this Part III [X]

1 Briefly describe the organization's mission:
THE MISSION OF TRINITY MEDICAL CENTER IS TO IMPROVE THE HEALTH OF THE PEOPLE AND COMMUNITIES WE SERVE.

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 [X] 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 [X] 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 and section 4947(a)(1) trusts 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 $ 257,451,104. including grants of $ 1,979,196.) (Revenue $ 329,523,224.)
HEALTH-CARE SERVICES

TRINITY MEDICAL CENTER IS AN IMPORTANT ELEMENT OF THE HEALTH-CARE DELIVERY SYSTEM THAT THE QUAD CITY COMMUNITIES RELY ON EVERY DAY. IT IS COMMITTED TO PROVIDING QUALITY HEALTH CARE AND TO USING ITS RESOURCES TO THE GREATEST COMMUNITY BENEFIT.

TRINITY MEDICAL CENTER PROVIDES INPATIENT AND OUTPATIENT MEDICAL SERVICES TO TREAT INDIVIDUALS WITH DISEASES, ILLNESS AND INJURIES WITH VARYING COMPLEXITIES. IT PROVIDES SERVICES TO IMPROVE THE HEALTH OF PATIENTS AND TO BETTER THEIR QUALITY OF LIFE. ALL SERVICES ARE PROVIDED REGARDLESS OF AN INDIVIDUAL'S RACE, CREED, SEX, NATIONALITY,

4b (Code:) (Expenses $ 25,854,200. including grants of $ 382,060.) (Revenue $)
COMMUNITY BENEFIT, INCLUDING CHARITY CARE

CHARITY CARE AND MEANS-TESTED PROGRAMS: TRINITY MEDICAL CENTER PROVIDES CHARITY CARE AND OTHER MEANS-TESTED PROGRAMS WITH THE GOAL TO IMPROVE THE COMMUNITY'S OVERALL HEALTH AND ACCESS TO CARE. THIS INCLUDES HEALTH-CARE SERVICES REGARDLESS OF THE PATIENT'S INSURANCE COVERAGE OR FINANCIAL STATUS. CHARITY CARE AND PARTIAL TO FULL FINANCIAL ASSISTANCE IS PROVIDED TO PATIENTS ON A CASE-BY-CASE BASIS. CHARITY CARE WAS MADE AVAILABLE TO 19,977 PEOPLE AT A VALUE OF $7,190,321 IN 2011. OFTENTIMES, TRINITY MEDICAL CENTER RECEIVES PAYMENTS FROM PAYORS OR PATIENTS THAT ARE LESS THAN IT CHARGES FOR SERVICES. TRINITY MEDICAL CENTER PARTICIPATES IN MEDICAID AND OTHER

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

4d Other program services (Describe in Schedule O.)
(Expenses $ including grants of $) (Revenue $)

4e **Total program service expenses** ▶ 283,305,304.

SEE SCHEDULE O FOR CONTINUATION(S)

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	X	
2	Is the organization required to complete *Schedule B, Schedule of Contributors*?	2	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		X
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	X	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		X
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		X
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		X
9	Did the organization report an amount in Part X, line 21; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		X
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10	X	
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI*	11a	X	
b	Did the organization report an amount for investments - other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b		X
c	Did the organization report an amount for investments - program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		X
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d		X
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	X	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f	X	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI, XII, and XIII*	12a		X
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI, XII, and XIII is optional*	12b	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		X
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		X
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b		X
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or assistance to any organization or entity located outside the United States? *If "Yes," complete Schedule F, Parts II and IV*	15		X
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or assistance to individuals located outside the United States? *If "Yes," complete Schedule F, Parts III and IV*	16		X
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I*	17		X
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18	X	
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		X
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	X	

Part IV Checklist of Required Schedules *(continued)*

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

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

Check if Schedule O contains a response to any question in this Part V ☐

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a 290			
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	X	
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 3162			
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?		2b	X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)				
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?		3a	X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No," provide an explanation in Schedule O*		3b	X	
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		X
b	If "Yes," enter the name of the foreign country: ▶				
	See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		5a		X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		5b		X
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?		6a		X
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		X
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		X
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		X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		7f		X
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 and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?		8		
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the organization make any taxable distributions under section 4966?		9a		
b	Did the 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?		13a		
	Note. See the instructions for additional information the organization must report on Schedule O.				
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		X
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 line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.*

Check if Schedule O contains a response to any question in this Part VI [X]

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a	19		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.				
b	Enter the number of voting members included in line 1a, above, who are independent	1b	12		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2		X	
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person?	3			X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4			X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5			X
6	Did the organization have members or stockholders?	6		X	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a		X	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b		X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:				
a	The governing body?	8a		X	
b	Each committee with authority to act on behalf of the governing body?	8b		X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9			X

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

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

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed ▶ IL,IA

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

[X] Own website [ ] Another's website [X] Upon request

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, physical address, and telephone number of the person who possesses the books and records of the organization: ▶

SUSAN M. KAISER, DIR OF FINANCE - 309-779-2895
2701 17TH ST, ROCK ISLAND, IL 61201

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

Check if Schedule O contains a response to any question in this Part VII ☐

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee): Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former	(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
STEPHANIE ACRI TRUSTEE - CHAIR	1.00	X		X				0.	0.	0.
KIM ARMSTRONG TRUSTEE	1.00	X						0.	0.	0.
DUNCAN CAMERON TRUSTEE	1.00	X						0.	0.	0.
DR. RAJENDRA DAHAL TRUSTEE	1.00	X						0.	0.	0.
JAMES HASS TRUSTEE	1.00	X						0.	0.	0.
KEN KOUPAL TRUSTEE	1.00	X						0.	0.	0.
DR. FARAZ MANAZIR TRUSTEE	1.00	X						0.	0.	0.
KENNY MASSEY TRUSTEE	1.00	X						0.	0.	0.
PETER MCLAUGHLIN TRUSTEE	1.00	X						0.	14,855.	0.
LINDA NEWBORN TRUSTEE	1.00	X						0.	14,437.	0.
DR. AHMED OKBA TRUSTEE	1.00	X						0.	0.	0.
DR. WILLIAM OLSON (FR 9/11) TRUSTEE	40.00	X						711,517.	0.	39,391.
DR. ALEX PAREIGIS TRUSTEE	1.00	X						0.	0.	0.
KATHY PULLEY TRUSTEE	1.00	X						0.	0.	0.
MARK SCHWIEBERT TRUSTEE	1.00	X						0.	0.	0.
RICK SEIDLER TRUSTEE/PRESIDENT/CEO	40.00	X		X				727,601.	0.	95,987.
KARLA STEELE TRUSTEE - VICE CHAIR	1.00	X		X				0.	0.	0.

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

(A) Name and title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee): Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former	(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
HEIDI STORL TRUSTEE	1.00	X						0.	0.	0.
KAI SWANSON (TO 2/11) TRUSTEE	1.00	X						0.	0.	0.
DR. MATTHEW WILBER TRUSTEE	1.00	X						0.	0.	0.
TAMARA BYRAM CORP VP	40.00			X				187,286.	0.	33,053.
DAVID DEOPERE PRESIDENT RYC	1.00			X				291,100.	0.	31,908.
MYKL GARRETT (TO 11/11) EXEC VP/COO	40.00			X				304,989.	0.	33,387.
DR. PAUL MCLOONE VPMA/CHIEF MED DIR	40.00			X				96,671.	165,459.	33,408.
GREG PAGLIUZZA JR. VP FINANCE/CFO	40.00			X				343,298.	0.	58,672.
JAY WILLSHER (FR 11/11) INTERIM VP OPERATIONS/CHIEF ADMIN	40.00			X				279,425.	0.	89,547.
1b Sub-total ▶								2,941,887.	194,751.	415,353.
c Total from continuation sheets to Part VII, Section A ▶								4,652,892.	2,973,303.	1056922.
d Total (add lines 1b and 1c) ▶								7,594,779.	3,168,054.	1472275.

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 ▶ 141

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

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
METROPOLITAN MEDICAL LAB 1814 E LOCUST ST, DAVENPORT, IA 52803	LAB SERVICES	8,541,868.
MISSIPPI VALLEY REGIONAL PO BOX 3655, DAVENPORT, IA 52808	BLOOD CENTER	2,167,416.
TAG COMMUNICATIONS 230 E SECOND ST, DAVENPORT, IA 52801	HEALTHCARE MARKETING	1,402,824.
METRO MRI CENTER LIMITED PART 615 VALLEY VIEW DR, MOLINE, IL 61265	ADVANCED RADIOLOGY	1,223,451.
DIVERSIFIED CLINICAL SERVICES PO BOX 636981, CINCINNATI, OH 45263-6981	WOUND CARE SERVICES	1,158,690.

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 ▶ 68

SEE PART VII, SECTION A CONTINUATION SHEETS

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

(A) Name and title	(B) Average hours per week	(C) Position (check all that apply): Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former	(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
DR. PAUL BOLGER MED DIR ED	40.00				X			514,762.	0.	44,913.
KATHLEEN CUNNINGHAM (TO 5/11) VP QUALITY	40.00				X			141,715.	134,211.	27,745.
JON HONSEY (TO 6/11) VP STRATEGIC DEVELOP & PHY	40.00				X			178,585.	0.	23,608.
RICHARD MURPHY VP FINANCE/CFO RYC	40.00				X			150,217.	0.	32,873.
BOBETTE PATTERSON DIR OPERATIONS/INTERIM DIR CARDIO	40.00				X			155,846.	0.	27,012.
MICHAEL PATTERSON VP OPERATIONS - PATIENT CA	40.00				X			355,244.	0.	39,353.
KATHERINE PEARSON VP MARKETING & BUS DEVELOP	40.00				X			215,096.	0.	34,827.
JEFFREY STOLZE CORP VP	40.00				X			274,609.	0.	86,854.
DR. RANDALL BAY PHYSICIAN-ER/TRAUMA	40.00					X		466,570.	0.	42,222.
DR. GREGORY BOHN PHYSICIAN SURG PARTNER CL	40.00					X		596,387.	0.	39,052.
DR. MARK BUETTNER PHYSICIAN-ER/TRAUMA	40.00					X		540,627.	0.	45,617.
DR. KEVIN KURTH PHYSICIAN-ER/TRAUMA	40.00					X		474,960.	66,875.	38,436.
DR. CHAD VANDERLINDEN PHYSICIAN-ER/TRAUMA	40.00					X		464,371.	0.	40,111.
ANDREA COLEMAN (TO 11/09) FORMER PRESIDENT/CEO	0.00						X	123,903.	0.	8,049.
WILLIAM LEAVER (TO 12/07) FORMER PRESIDENT/CEO	0.00						X	0.	1,341,336.	307,059.
TOM TIBBITTS (TO 6/10) FORMER INTERIM PRESIDENT/CEO	0.00						X	0.	758,496.	24,275.
KEVIN VERMEER (TO 5/09) FORMER VP FINANCE/CFO	0.00						X	0.	672,385.	194,916.
Total to Part VII, Section A, line 1c								4,652,892.	2,973,303	1,056,922.

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Part VIII Statement of Revenue

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514
Contributions, Gifts, Grants and Other Similar Amounts					
1 a Federated campaigns	1a				
b Membership dues	1b				
c Fundraising events	1c	24,890.			
d Related organizations	1d	2,886,903.			
e Government grants (contributions)	1e	48,519.			
f All other contributions, gifts, grants, and similar amounts not included above	1f	164,095.			
g Noncash contributions included in lines 1a-1f: $ 5,595.					
h **Total.** Add lines 1a-1f ▶		3,124,407.			
Program Service Revenue	Business Code				
2 a NET PATIENT REVENUE	900099	317588206.	317588206.		
b EDUCATION & RESEARCH	900099	2,783,073.	2,783,073.		
c RENTAL REVENUE	531100	2,058,949.	2,058,949.		
d MGMT & SUPPORT SVCS	561000	1,402,472.	1,309,202.	93,270.	
e MISCELLANEOUS REVENUE	900099	1,382,467.	1,377,339.	5,128.	
f All other program service revenue	900099	1,282,117.	1,282,117.		
g **Total.** Add lines 2a-2f ▶		326497284.			
Other Revenue					
3 Investment income (including dividends, interest, and other similar amounts) ▶		2,909,917.			2909917.
4 Income from investment of tax-exempt bond proceeds ▶					
5 Royalties ▶					
	(i) Real / (ii) Personal				
6 a Gross rents					
b Less: rental expenses					
c Rental income or (loss)					
d Net rental income or (loss) ▶					
	(i) Securities / (ii) Other				
7 a Gross amount from sales of assets other than inventory	74327054 / 61,429.				
b Less: cost or other basis and sales expenses	71045432 / 44,293.				
c Gain or (loss)	3281622. / 17,136.				
d Net gain or (loss) ▶		3,298,758.			3298758.
8 a Gross income from fundraising events (not including $ 24,890. of contributions reported on line 1c). See Part IV, line 18	a 14,137.				
b Less: direct expenses	b 17,935.				
c Net income or (loss) from fundraising events ▶		-3,798.			-3,798.
9 a Gross income from gaming activities. See Part IV, line 19	a				
b Less: direct expenses	b				
c Net income or (loss) from gaming activities ▶					
10 a Gross sales of inventory, less returns and allowances	a 613,081.				
b Less: cost of goods sold	b 341,398.				
c Net income or (loss) from sales of inventory ▶		271,683.			271,683.
Miscellaneous Revenue	Business Code				
11 a CAFETERIA/FOOD SVCS	722210	1,576,450.	1,576,450.		
b MISCELLANEOUS REVENUE	900099	1,449,490.	1,449,490.		
c					
d All other revenue					
e **Total.** Add lines 11a-11d ▶		3,025,940.			
12 **Total revenue.** See instructions. ▶		339124191.	329424826.	98,398.	6476560.

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) but are not required to complete columns (B), (C), and (D).

Check if Schedule O contains a response to any question 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 governments and organizations in the United States. See Part IV, line 21	2,361,256.	2,361,256.		
2 Grants and other assistance to individuals in the United States. See Part IV, line 22				
3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	4,134,526.		4,134,526.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	156,956.		156,956.	
7 Other salaries and wages	120,766,548.	110,666,428.	10,100,120.	
8 Pension plan accruals and contributions (include section 401(k) and section 403(b) employer contributions)	5,391,271.	4,940,380.	450,891.	
9 Other employee benefits	18,663,535.	17,102,640.	1,560,895.	
10 Payroll taxes	7,441,057.	6,818,736.	622,321.	
11 Fees for services (non-employees):				
a Management	3,815,149.	1,287,728.	2,527,421.	
b Legal	1,750.		1,750.	
c Accounting				
d Lobbying	25,000.		25,000.	
e Professional fundraising services. See Part IV, line 17				
f Investment management fees	592,486.	1,669.	590,817.	
g Other	30,863,303.	27,646,470.	3,216,833.	
12 Advertising and promotion	103,930.	47,494.	56,436.	
13 Office expenses	10,816,088.	10,064,974.	751,114.	
14 Information technology	13,831,930.	11,727,730.	2,104,200.	
15 Royalties				
16 Occupancy	6,294,834.	6,150,008.	144,826.	
17 Travel	362,423.	303,465.	58,958.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	536,005.	302,085.	233,920.	
20 Interest	6,968,664.		6,968,664.	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	14,845,508.	5,331,365.	9,514,143.	
23 Insurance	286,202.	-570,650.	856,852.	
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLIES	67,647,679.	67,589,943.	57,736.	
b MISCELLANEOUS EXPENSE	11,455,152.	11,533,583.	-78,431.	
c INCOME TAXES	16,974.		16,974.	
d				
e All other expenses				
25 **Total functional expenses.** Add lines 1 through 24e	327,378,226.	283,305,304.	44,072,922.	0.
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

			(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing	15,304.	1	13,582,026.
	2	Savings and temporary cash investments	34,436,245.	2	42,454,498.
	3	Pledges and grants receivable, net		3	
	4	Accounts receivable, net	38,016,303.	4	43,576,214.
	5	Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5	
	6	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)		6	
	7	Notes and loans receivable, net	12,666,600.	7	13,294,650.
	8	Inventories for sale or use	8,306,448.	8	7,654,536.
	9	Prepaid expenses and deferred charges	1,248,670.	9	1,386,933.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a 306,022,909.			
	b	Less: accumulated depreciation — 10b 176,203,884.	132,402,000.	10c	129,819,025.
	11	Investments - publicly traded securities	109,467,727.	11	102,081,001.
	12	Investments - other securities. See Part IV, line 11		12	
	13	Investments - program-related. See Part IV, line 11	8,798,316.	13	8,821,284.
	14	Intangible assets	1,580,761.	14	1,521,961.
	15	Other assets. See Part IV, line 11		15	
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	346,938,374.	16	364,192,128.
Liabilities	17	Accounts payable and accrued expenses	25,153,133.	17	29,382,527.
	18	Grants payable		18	
	19	Deferred revenue	385,567.	19	-96,455.
	20	Tax-exempt bond liabilities		20	
	21	Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22	Payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		22	
	23	Secured mortgages and notes payable to unrelated third parties		23	
	24	Unsecured notes and loans payable to unrelated third parties	7,139,000.	24	7,285,611.
	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	144,576,474.	25	151,934,349.
	26	**Total liabilities.** Add lines 17 through 25	177,254,174.	26	188,506,032.
Net Assets or Fund Balances		**Organizations that follow SFAS 117, check here ▶ [X] and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	166,128,273.	27	172,005,553.
	28	Temporarily restricted net assets	2,229,989.	28	2,324,364.
	29	Permanently restricted net assets	1,325,938.	29	1,356,179.
		Organizations that do not follow SFAS 117, check here ▶ [ ] and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	169,684,200.	33	175,686,096.
	34	Total liabilities and net assets/fund balances	346,938,374.	34	364,192,128.

Part XI Reconciliation of Net Assets

Check if Schedule O contains a response to any question in this Part XI [X]

1	Total revenue (must equal Part VIII, column (A), line 12)	1	339,124,191.
2	Total expenses (must equal Part IX, column (A), line 25)	2	327,378,226.
3	Revenue less expenses. Subtract line 2 from line 1	3	11,745,965.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	169,684,200.
5	Other changes in net assets or fund balances (explain in Schedule O)	5	-5,744,069.
6	Net assets or fund balances at end of year. Combine lines 3, 4, and 5 (must equal Part X, line 33, column (B))	6	175,686,096.

Part XII Financial Statements and Reporting

Check if Schedule O contains a response to any question in this Part XII [ ]

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

SCHEDULE A
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.
▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

OMB No. 1545-0047

2011

Open to Public Inspection

Name of the organization TRINITY MEDICAL CENTER

Employer identification number 36-2739299

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

The organization is not a private foundation because it is: (For lines 1 through 11, check only one box.)

1 [ ] A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
2 [ ] A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E.)
3 [X] A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
4 [ ] A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state: _____
5 [ ] An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)
6 [ ] A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
7 [ ] An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
8 [ ] A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
9 [ ] An organization that normally receives: (1) more than 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.)
10 [ ] An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**
11 [ ] An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2). See **section 509(a)(3).** Check the box that describes the type of supporting organization and complete lines 11e through 11h.

a [ ] Type I **b** [ ] Type II **c** [ ] Type III - Functionally integrated **d** [ ] Type III - Other

e [ ] By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2).

f If the organization received a written determination from the IRS that it is a Type I, Type II, or Type III supporting organization, check this box ..... [ ]

g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?

			Yes	No
(i)	A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization?	**11g(i)**		
(ii)	A family member of a person described in (i) above?	**11g(ii)**		
(iii)	A 35% controlled entity of a person described in (i) or (ii) above?	**11g(iii)**		

h Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-9 above or IRC section (see instructions))	(iv) Is the organization in col. (i) listed in your governing document?		(v) Did you notify the organization in col. (i) of your support?		(vi) Is the organization in col. (i) organized in the U.S.?		(vii) Amount of support
			Yes	No	Yes	No	Yes	No	
Total									

LHA **For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.**

Schedule A (Form 990 or 990-EZ) 2011

132021
01-24-12

15221024 791930 36-2739299 2011.04040 TRINITY MEDICAL CENTER 36-27391

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(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 IV.)						
11 **Total support.** Add lines 7 through 10						

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

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2011 (line 6, column (f) divided by line 11, column (f)) ..... **14** %

15 Public support percentage from 2010 Schedule A, Part II, line 14 ..... **15** %

16a **33 1/3% support test - 2011.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ..... ▶ ☐

b **33 1/3% support test - 2010.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ..... ▶ ☐

17a **10% -facts-and-circumstances test - 2011.** 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 IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ..... ▶ ☐

b **10% -facts-and-circumstances test - 2010.** 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 IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ..... ▶ ☐

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

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(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) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(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 IV.)						
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 2011 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2010 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for **2011** (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from **2010** Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2011.** 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 - 2010.** 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 ▶ ☐

Schedule B
(Form 990, 990-EZ, or 990-PF)
Department of the Treasury
Internal Revenue Service

Schedule of Contributors

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

OMB No. 1545-0047

2011

Name of the organization	**Employer identification number**
TRINITY MEDICAL CENTER	36-2739299

Organization type (check one):

Filers of:	**Section:**
Form 990 or 990-EZ	[X] 501(c)(3) (enter number) organization
	[ ] 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation
	[ ] 527 political organization
Form 990-PF	[ ] 501(c)(3) exempt private foundation
	[ ] 4947(a)(1) nonexempt charitable trust treated as a private foundation
	[ ] 501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule.**
Note. Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

[X] For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, $5,000 or more (in money or property) from any one contributor. Complete Parts I and II.

Special Rules

[ ] For a section 501(c)(3) organization filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi) and received from any one contributor, during the year, a contribution of the greater of **(1)** $5,000 or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h, or (ii) Form 990-EZ, line 1. Complete Parts I and II.

[ ] For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than $1,000 for use *exclusively* for religious, charitable, scientific, literary, or educational purposes, or the prevention of cruelty to children or animals. Complete Parts I, II, and III.

[ ] For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions for use *exclusively* for religious, charitable, etc., purposes, but these contributions did not total to more than $1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Do not complete any of the parts unless the **General Rule** applies to this organization because it received nonexclusively religious, charitable, etc., contributions of $5,000 or more during the year. ..... ▶ $ _____

Caution. An organization that is not covered by the General Rule and/or the Special Rules does not file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on Part I, line 2 of its Form 990-PF, to certify that it does not meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

LHA **For Paperwork Reduction Act Notice, see the Instructions for Form 990, 990-EZ, or 990-PF.**

Name of organization	Employer identification number
TRINITY MEDICAL CENTER	36-2739299

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1		$ 28,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
2		$ 150,944.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
3		$ 17,442.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
4		$ 5,595.	Person [ ] Payroll [ ] Noncash [X] (Complete Part II if there is a noncash contribution.)
5		$ 130,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
6		$ 31,077.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)

Name of organization	Employer identification number
TRINITY MEDICAL CENTER	36-2739299

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7		$ 1,247,830.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
8		$ 186,222.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
9		$ 1,301,907.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)

Name of organization	Employer identification number
TRINITY MEDICAL CENTER	36-2739299

Part II **Noncash Property** (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
4	MEDICAL LIBRARY BOOKS, STATUE, JOURNALS	$ 5,595.	02/23/11

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

Name of organization: TRINITY MEDICAL CENTER

Employer identification number: 36-2739299

Part III *Exclusively* religious, charitable, etc., individual contributions to section 501(c)(7), (8), or (10) organizations that total more than $1,000 for the year. Complete columns **(a)** through **(e)** and the following line entry. For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of **$1,000 or less** for the year. (Enter this information once.) ▶ $

Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

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

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

OMB No. 1545-0047

2011

Open to Public Inspection

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

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

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

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

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

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

Name of organization	Employer identification number
TRINITY MEDICAL CENTER	36-2739299

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

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

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

1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ $
2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ $
3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? ☐ Yes ☐ No
4a Was a correction made? ☐ Yes ☐ No
b If "Yes," describe in Part IV.

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

1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ $
2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ $
3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b ▶ $
4 Did the filing organization file **Form 1120-POL** for this year? ☐ Yes ☐ No
5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

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

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

Schedule C (Form 990 or 990-EZ) 2011

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

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

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

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

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

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

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

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	**(a)** 2008	**(b)** 2009	**(c)** 2010	**(d)** 2011	**(e)** Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

For each "Yes" response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a) Yes	(a) No	(b) Amount
1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X	
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?	X		25,000.
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?		X	
j Total. Add lines 1c through 1i			25,000.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

Part IV **Supplemental Information**

Complete this part to provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A; and Part II-B, line 1. Also, complete this part for any additional information.

PART II-B, LINE 1, LOBBYING ACTIVITIES:

DENNY JACOBS AND ASSOCIATES ACTS ON TMC'S BEHALF TO PROMOTE AND EDUCATE LEGISLATORS AND STATE GOVERNMENT ABOUT TMC'S POSITION RELATING TO LAWS, BILLS, POLICIES, PROCEDURES AND ETC.

SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047
2011
Open to Public Inspection

Name of the organization TRINITY MEDICAL CENTER

Employer identification number 36-2739299

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

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

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

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

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

Part II Conservation Easements.

Complete if the organization answered "Yes" to Form 990, Part IV, line 7.

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

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

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

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

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

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

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

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

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

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

9 In Part XIV, 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" to 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 XIV, 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) Revenues included in 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 Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

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

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

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

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

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

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" to 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 XIV and complete the following table:

		Amount
c Beginning balance	1c	
d Additions during the year	1d	
e Distributions during the year	1e	
f Ending balance	1f	

2a Did the organization include an amount on Form 990, Part X, line 21? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIV.

Part V Endowment Funds. Complete if the organization answered "Yes" to 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	111,608,387.	98,763,528.	73,344,833.	98,982,185.	
b Contributions	342,481.	368,566.	6,436,324.	582,339.	
c Net investment earnings, gains, and losses	-7,619,436.	13,589,944.	19,425,565.	-26,903,952.	
d Grants or scholarships	610,604.	1,113,651.	443,195.	446,486.	
e Other expenditures for facilities and programs				-1,130,747.	
f Administrative expenses					
g End of year balance	103,720,828.	111,608,387.	98,763,528.	73,344,833.	

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

a Board designated or quasi-endowment ▶ 96.53 %
b Permanent endowment ▶ 1.31 %
c Temporarily restricted endowment ▶ 2.16 %

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

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

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

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

Part VI Land, Buildings, and Equipment. 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		6,322,281.		6,322,281.
b Buildings		199,986,646.	107,449,566.	92,537,080.
c Leasehold improvements				
d Equipment		90,600,952.	64,117,570.	26,483,382.
e Other		9,113,030.	4,636,748.	4,476,282.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				129,819,025.

Part VII Investments - Other Securities. 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)		
(I)		
Total. (Col (b) must equal Form 990, Part X, col (B) line 12.) ▶		

Part VIII Investments - Program Related. See Form 990, Part X, line 13.

(a) Description of investment type	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
(10)		
Total. (Col (b) must equal Form 990, Part X, col (B) line 13.) ▶		

Part IX Other Assets. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
Total. *(Column (b) must equal Form 990, Part X, col (B) line 15.)* ▶	

Part X Other Liabilities. See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) DUE TO AFFILIATES	454,328.
(3) ASBESTOS REMOVAL LIABILITY	1,093,219.
(4) MISCELLANEOUS LIABILITY	165,409.
(5) SELF-INSURANCE RESERVE	12,705,892.
(6) LONG-TERM RETENTION INCENTIVES	1,573,049.
(7) HEALTH AND WELFARE BENEFITS	
(8) RESERVE	1,614,506.
(9) IOWA HEALTH SYSTEM NOTE PAYABLE	134,327,946.
(10)	
(11)	
Total. *(Column (b) must equal Form 990, Part X, col (B) line 25.)* ▶	151,934,349.

2. FIN 48 (ASC 740) Footnote. In Part XIV, 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).

Part XI Reconciliation of Change in Net Assets from Form 990 to Audited Financial Statements

1	Total revenue (Form 990, Part VIII, column (A), line 12)	1	339,124,191.
2	Total expenses (Form 990, Part IX, column (A), line 25)	2	327,378,226.
3	Excess or (deficit) for the year. Subtract line 2 from line 1	3	11,745,965.
4	Net unrealized gains (losses) on investments	4	-5,648,543.
5	Donated services and use of facilities	5	
6	Investment expenses	6	
7	Prior period adjustments	7	
8	Other (Describe in Part XIV.)	8	-95,526.
9	Total adjustments (net). Add lines 4 through 8	9	-5,744,069.
10	Excess or (deficit) for the year per audited financial statements. Combine lines 3 and 9	10	6,001,896.

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

1	Total revenue, gains, and other support per audited financial statements			1	349,068,000.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:				
a	Net unrealized gains on investments	2a	-5,648,543.		
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIV.)	2d	17,383,006.		
e	Add lines **2a** through **2d**			2e	11,734,463.
3	Subtract line **2e** from line **1**			3	337,333,537.
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	397,694.		
b	Other (Describe in Part XIV.)	4b	1,392,960.		
c	Add lines **4a** and **4b**			4c	1,790,654.
5	Total revenue. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 12.)*			5	339,124,191.

Part XIII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return

1	Total expenses and losses per audited financial statements			1	338,339,000.
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 XIV.)	2d	17,388,495.		
e	Add lines **2a** through **2d**			2e	17,388,495.
3	Subtract line **2e** from line **1**			3	320,950,505.
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	397,694.		
b	Other (Describe in Part XIV.)	4b	6,030,027.		
c	Add lines **4a** and **4b**			4c	6,427,721.
5	Total expenses. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 18.)*			5	327,378,226.

Part XIV Supplemental Information

Complete this part to 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, line 8; Part XII, lines 2d and 4b; and Part XIII, lines 2d and 4b. Also complete this part to provide any additional information.

PART V, LINE 4: THE ORGANIZATION RETAINS FUNDS FOR INTENDED FUTURE USES, INCLUDING PURCHASE OF EQUIPMENT, INDIGENT CARE, FUNDING OF MISSION RELATED OPERATIONS, AND HEALTH EDUCATION. IN ADDITION, SOME FUNDS ARE HELD FOR INVESTMENT IN PERPETUITY.

PART X, LINE 2: IOWA HEALTH SYSTEM AND MOST OF ITS SUBSIDIARIES ARE CLASSIFIED AS TAX-EXEMPT ORGANIZATIONS AS DESCRIBED IN SECTIONS 501(C)(3) AND 501(C)(2) OF THE INTERNAL REVENUE CODE (THE CODE). TAX-EXEMPT

Part XIV Supplemental Information *(continued)*

ORGANIZATIONS ARE NOT SUBJECT TO FEDERAL AND STATE INCOME TAXES ON RELATED INCOME, PURSUANT TO SECTION 501(A) OF THE CODE. THESE ORGANIZATIONS ARE SUBJECT TO FEDERAL AND STATE INCOME TAXES TO THE EXTENT THEY HAVE UNRELATED BUSINESS INCOME AS DESCRIBED UNDER PROVISIONS OF SECTION 511 OF THE CODE.

THE HEALTH SYSTEM FILES FORM 990 FOR SUBSTANTIALLY ALL OF ITS OPERATING ENTITIES IN THE U.S. FEDERAL JURISDICTION AND IS NO LONGER SUBJECT TO EXAMINATION BY TAX AUTHORITIES FOR THE YEARS BEFORE 2008. THE HEALTH SYSTEM HAS NO MATERIAL UNCERTAIN TAX POSITIONS.

CERTAIN SUBSIDIARIES ARE SUBJECT TO FEDERAL AND STATE INCOME TAXES. SOME OF THESE CORPORATIONS HAVE ACCUMULATED NET OPERATING LOSS CARRYFORWARDS THAT ARE AVAILABLE TO OFFSET FUTURE TAXABLE INCOME DURING THE CARRYFORWARD PERIOD. NO INCOME TAX BENEFIT HAS BEEN RECOGNIZED FOR THE NET OPERATING LOSS CARRYFORWARDS OR OTHER POTENTIAL DEFERRED TAX ASSETS IN THE CONSOLIDATED FINANCIAL STATEMENTS BECAUSE THE HEALTH SYSTEM BELIEVES REALIZATION OF THESE BENEFITS IS UNLIKELY.

PART XI, LINE 8 - OTHER ADJUSTMENTS:

CHANGE IN BENEFICIAL INTEREST IN TRINITY HEALTH FOUNDATION	149,564.
CHANGES IN PENSION LIABILITY	-245,090.
TOTAL TO SCHEDULE D, PART XI, LINE 8	-95,526.

PART XII, LINE 2D - OTHER ADJUSTMENTS:

SPECIAL EVENT EXPENSES	17,935.
SUBSIDIARY ELIMINATING ENTRIES (PRECEDENCE)	506,534.
SUBSIDIARY ELIMINATING ENTRIES (RYC)	16,517,139.

Part XIV Supplemental Information *(continued)*

COST OF GOODS SOLD	341,398.
TOTAL TO SCHEDULE D, PART XII, LINE 2D	17,383,006.

PART XII, LINE 4B - OTHER ADJUSTMENTS:

REVENUES IN TEMPORARILY RESTRICTED FUND BALANCE	178.
IOWA HEALTH SYSTEM CONTRACTING SERVICES, LC PURCHASE REBATES	1,301,907.
ROUNDING	365.
ELIMINATING ENTRIES	90,510.
TOTAL TO SCHEDULE D, PART XII, LINE 4B	1,392,960.

PART XIII, LINE 2D - OTHER ADJUSTMENTS:

SUBSIDIARY ELIMINATING ENTRIES (PRECEDENCE)	512,023.
SPECIAL EVENT EXPENSES	17,935.
SUBSIDIARY ELIMINATING ENTRIES (RYC)	16,517,139.
COST OF GOODS SOLD	341,398.
TOTAL TO SCHEDULE D, PART XIII, LINE 2D	17,388,495.

PART XIII, LINE 4B - OTHER ADJUSTMENTS:

EXPENSES IN UNRESTRICTED FUND BALANCE	4,632,017.
IOWA HEALTH SYSTEM CONTRACTING SERVICES, LC PURCHASE REBATES	1,301,907.
ROUNDING	103.
ELIMINATING ENTRIES	96,000.
TOTAL TO SCHEDULE D, PART XIII, LINE 4B	6,030,027.

SCHEDULE G
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information Regarding Fundraising or Gaming Activities

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

OMB No. 1545-0047

2011

Open To Public Inspection

Name of the organization: TRINITY MEDICAL CENTER

Employer identification number: 36-2739299

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

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

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

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

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

(i) Name and address of individual or entity (fundraiser)	**(ii)** Activity	**(iii)** Did fundraiser have custody or control of contributions? Yes	No	**(iv)** Gross receipts from activity	**(v)** Amount paid to (or retained by) fundraiser listed in col. **(i)**	**(vi)** Amount paid to (or retained by) organization
Total ..... ▶						

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

LHA **Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.**

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

		(a) Event #1 STYLE SHOW (event type)	(b) Event #2 GARDEN PARTY (event type)	(c) Other events NONE (total number)	(d) Total events (add col. (a) through col. (c))
Revenue	1 Gross receipts	37,537.	1,490.		39,027.
	2 Less: Charitable contributions	21,075.	3,815.		24,890.
	3 Gross income (line 1 minus line 2)	16,462.	-2,325.		14,137.
Direct Expenses	4 Cash prizes				
	5 Noncash prizes				
	6 Rent/facility costs				
	7 Food and beverages				
	8 Entertainment	16,520.	1,415.		17,935.
	9 Other direct expenses				
	10 Direct expense summary. Add lines 4 through 9 in column (d) ▶				(17,935.)
	11 Net income summary. Combine line 3, column (d), and line 10 ▶				-3,798.

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

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

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

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

b If "No," explain: _____

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

b If "Yes," explain: _____

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

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

13 Indicate the percentage of gaming activity operated in:

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

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

Name ▶

Address ▶

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

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

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

Name ▶

Address ▶

16 Gaming manager information:

Name ▶

Gaming manager compensation ▶ $ _____

Description of services provided ▶

☐ Director/officer ☐ Employee ☐ Independent contractor

17 Mandatory distributions:

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

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

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

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

2011

Open to Public Inspection

Name of the organization TRINITY MEDICAL CENTER

Employer identification number 36-2739299

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	X	
b	If "Yes," was it a written policy?	1b	X	
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. [X] 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) to determine eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: [ ] 100% [ ] 150% [X] 200% [ ] Other _____ %	3a	X	
b	Did the organization use FPG to determine eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: [ ] 200% [ ] 250% [ ] 300% [ ] 350% [X] 400% [ ] Other _____ %	3b	X	
c	If the organization did not use FPG to determine eligibility, describe in Part VI the income based criteria 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, to determine eligibility for free or discounted care.			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	X	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	X	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		X
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		
6a	Did the organization prepare a community benefit report during the tax year?	6a	X	
b	If "Yes," did the organization make it available to the public?	6b	X	

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)		19,977	7190321.		7190321.	2.20%
b Medicaid (from Worksheet 3, column a)		29,285	27562888.	14238644.	13324244.	4.07%
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs		49,262	34753209.	14238644.	20514565.	6.27%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)		103,096	1629944.		1629944.	.50%
f Health professions education (from Worksheet 5)		1,062	823,490.		823,490.	.25%
g Subsidized health services (from Worksheet 6)		17,448	2035801.		2035801.	.62%
h Research (from Worksheet 7)		378	476,397.		476,397.	.15%
i Cash and in-kind contributions for community benefit (from Worksheet 8)		22,392	838,542.	419,539.	419,003.	.13%
j **Total.** Other Benefits		144,376	5804174.	419,539.	5384635.	1.65%
k **Total.** Add lines 7d and 7j		193,638	40557383.	14658183.	25899200.	7.92%

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		34,737	278,987.		278,987.	.09%
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		34,737	278,987.		278,987.	.09%

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		X
2 Enter the amount of the organization's bad debt expense	2 8,696,324.			
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy	3 22,861,000.			
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense. In addition, describe the costing methodology used in determining the amounts reported on lines 2 and 3, and rationale for including a portion of bad debt amounts as community benefit.				

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME)	5 109,849,345.
6 Enter Medicare allowable costs of care relating to payments on line 5	6 120,934,942.
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7 -11,085,597.

8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:

☐ Cost accounting system ☒ Cost to charge ratio ☐ Other

Section C. Collection Practices

		Yes	No
9a Did the organization have a written debt collection policy during the tax year?	9a	X	
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	X	

Part IV Management Companies and Joint Ventures (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 QUAD CITY AMBULATORY SURGERY CENTER, L.L.C.	AMBULATORY SURGERY CENTER	50.00%		50.00%
2 TRINITY PHYSICIAN HOSPITAL ORGANIZATION, LTD.	LICENSED PPO PROVIDING HEALTH MGMT SERVICES TO PEOPLE IN IL & IA	49.90%		40.37%
3 TRINITY BETTENDORF ORTHOPEDIC CO-MANAGEMENT COMPANY, LLC	ADMINISTRATION OF ORTHOPEDIC SERVICE LINES	50.00%		50.00%

Part V Facility Information

Section A. Hospital Facilities
(list in order of size, from largest to smallest)

How many hospital facilities did the organization operate during the tax year? 3

Name and address	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)
1 TRINITY MEDICAL CENTER - ROCK ISLAND 2701 17TH ST ROCK ISLAND, IL 61201	X	X					X		
2 TRINITY MEDICAL CENTER - MOLINE 500 JOHN DEERE RD MOLINE, IL 61265	X	X					X		
3 TRINITY MEDICAL CENTER - BETTENDORF 4500 UTICA RIDGE RD BETTENDORF, IA 52722	X	X					X		

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of Hospital Facility: TRINITY MEDICAL CENTER - ROCK ISLAND

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 1

		Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for tax year 2011)			
1 During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8	1	X	
If "Yes," indicate what the Needs Assessment describes (check all that apply):			
a [X] A definition of the community served by the hospital facility			
b [X] Demographics of the community			
c [ ] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d [X] How data was obtained			
e [X] The health needs of the community			
f [X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g [X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h [X] The process for consulting with persons representing the community's interests			
i [ ] Information gaps that limit the hospital facility's ability to assess the community's health needs			
j [ ] Other (describe in Part VI)			
2 Indicate the tax year the hospital facility last conducted a Needs Assessment: 20 11			
3 In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3	X	
4 Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4	X	
5 Did the hospital facility make its Needs Assessment widely available to the public?	5	X	
If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):			
a [X] Hospital facility's website			
b [X] Available upon request from the hospital facility			
c [X] Other (describe in Part VI)			
6 If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):			
a [ ] Adoption of an implementation strategy to address the health needs of the hospital facility's community			
b [ ] Execution of the implementation strategy			
c [X] Participation in the development of a community-wide community benefit plan			
d [ ] Participation in the execution of a community-wide community benefit plan			
e [ ] Inclusion of a community benefit section in operational plans			
f [ ] Adoption of a budget for provision of services that address the needs identified in the Needs Assessment			
g [X] Prioritization of health needs in its community			
h [X] Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i [ ] Other (describe in Part VI)			
7 Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	7	X	
Financial Assistance Policy			
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
8 Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8	X	
9 Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care?	9	X	
If "Yes," indicate the FPG family income limit for eligibility for free care: 200 %			
If "No," explain in Part VI the criteria the hospital facility used.			

Part V Facility Information *(continued)* TRINITY MEDICAL CENTER - ROCK ISLAND

		Yes	No
10 Used FPG to determine eligibility for providing *discounted* care?	10	X	
If "Yes," indicate the FPG family income limit for eligibility for discounted care: 400 %			
If "No," explain in Part VI the criteria the hospital facility used.			
11 Explained the basis for calculating amounts charged to patients?	11	X	
If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a [X] Income level			
b [X] Asset level			
c [X] Medical indigency			
d [ ] Insurance status			
e [ ] Uninsured discount			
f [ ] Medicaid/Medicare			
g [ ] State regulation			
h [ ] Other (describe in Part VI)			
12 Explained the method for applying for financial assistance?	12	X	
13 Included measures to publicize the policy within the community served by the hospital facility?	13	X	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a [X] The policy was posted on the hospital facility's website			
b [X] The policy was attached to billing invoices			
c [ ] The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d [ ] The policy was posted in the hospital facility's admissions offices			
e [ ] The policy was provided, in writing, to patients on admission to the hospital facility			
f [X] The policy was available on request			
g [ ] Other (describe in Part VI)			
Billing and Collections			
14 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 actions the hospital facility may take upon non-payment?	14	X	
15 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 patient's eligibility under the facility's FAP:			
a [X] Reporting to credit agency			
b [X] Lawsuits			
c [X] Liens on residences			
d [ ] Body attachments			
e [X] Other similar actions (describe in Part VI)			
16 Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP?	16	X	
If "Yes," check all actions in which the hospital facility or a third party engaged:			
a [X] Reporting to credit agency			
b [X] Lawsuits			
c [X] Liens on residences			
d [ ] Body attachments			
e [ ] Other similar actions (describe in Part VI)			
17 Indicate which efforts the hospital facility made before initiating any of the actions checked in line 16 (check all that apply):			
a [X] Notified patients of the financial assistance policy on admission			
b [X] Notified patients of the financial assistance policy prior to discharge			
c [X] Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills			
d [X] Documented its determination of whether patients were eligible for financial assistance under the hospital facility's financial assistance policy			
e [ ] Other (describe in Part VI)			

Part V Facility Information *(continued)* TRINITY MEDICAL CENTER - ROCK ISLAND

Policy Relating to Emergency Medical Care

		Yes	No
18 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires 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?	18	X	

If "No," indicate why:

- **a** ☐ The hospital facility did not provide care for any emergency medical conditions
- **b** ☐ The hospital facility's policy was not in writing
- **c** ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)
- **d** ☐ Other (describe in Part VI)

Individuals Eligible for Financial Assistance

19 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.

- **a** ☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- **b** ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- **c** ☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- **d** ☒ Other (describe in Part VI)

20 Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and 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 Part VI.	20		X
21 Did the hospital facility charge any of its FAP-eligible patients an amount equal to the gross charge for any service provided to that patient? If "Yes," explain in Part VI.	21	X	

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of Hospital Facility: TRINITY MEDICAL CENTER - MOLINE

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 2

		Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for tax year 2011)			
1 During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8	1		
If "Yes," indicate what the Needs Assessment describes (check all that apply):			
a ☐ A definition of the community served by the hospital facility			
b ☐ Demographics of the community			
c ☐ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☐ How data was obtained			
e ☐ The health needs of the community			
f ☐ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☐ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☐ The process for consulting with persons representing the community's interests			
i ☐ Information gaps that limit the hospital facility's ability to assess the community's health needs			
j ☐ Other (describe in Part VI)			
2 Indicate the tax year the hospital facility last conducted a Needs Assessment: 20 ____			
3 In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3		
4 Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4		
5 Did the hospital facility make its Needs Assessment widely available to the public?	5		
If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):			
a ☐ Hospital facility's website			
b ☐ Available upon request from the hospital facility			
c ☐ Other (describe in Part VI)			
6 If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):			
a ☐ Adoption of an implementation strategy to address the health needs of the hospital facility's community			
b ☐ Execution of the implementation strategy			
c ☐ Participation in the development of a community-wide community benefit plan			
d ☐ Participation in the execution of a community-wide community benefit plan			
e ☐ Inclusion of a community benefit section in operational plans			
f ☐ Adoption of a budget for provision of services that address the needs identified in the Needs Assessment			
g ☐ Prioritization of health needs in its community			
h ☐ Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i ☐ Other (describe in Part VI)			
7 Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	7		
Financial Assistance Policy			
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
8 Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8	X	
9 Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care?	9	X	
If "Yes," indicate the FPG family income limit for eligibility for free care: 200 %			
If "No," explain in Part VI the criteria the hospital facility used.			

Part V Facility Information *(continued)* TRINITY MEDICAL CENTER - MOLINE

		Yes	No
10 Used FPG to determine eligibility for providing *discounted* care?	10	X	
If "Yes," indicate the FPG family income limit for eligibility for discounted care: 400 %			
If "No," explain in Part VI the criteria the hospital facility used.			
11 Explained the basis for calculating amounts charged to patients?	11	X	
If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a [X] Income level			
b [X] Asset level			
c [X] Medical indigency			
d [ ] Insurance status			
e [ ] Uninsured discount			
f [ ] Medicaid/Medicare			
g [ ] State regulation			
h [ ] Other (describe in Part VI)			
12 Explained the method for applying for financial assistance?	12	X	
13 Included measures to publicize the policy within the community served by the hospital facility?	13	X	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a [X] The policy was posted on the hospital facility's website			
b [X] The policy was attached to billing invoices			
c [ ] The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d [ ] The policy was posted in the hospital facility's admissions offices			
e [ ] The policy was provided, in writing, to patients on admission to the hospital facility			
f [X] The policy was available on request			
g [ ] Other (describe in Part VI)			
Billing and Collections			
14 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 actions the hospital facility may take upon non-payment?	14	X	
15 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 patient's eligibility under the facility's FAP:			
a [X] Reporting to credit agency			
b [X] Lawsuits			
c [X] Liens on residences			
d [ ] Body attachments			
e [X] Other similar actions (describe in Part VI)			
16 Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP?	16	X	
If "Yes," check all actions in which the hospital facility or a third party engaged:			
a [X] Reporting to credit agency			
b [X] Lawsuits			
c [X] Liens on residences			
d [ ] Body attachments			
e [ ] Other similar actions (describe in Part VI)			
17 Indicate which efforts the hospital facility made before initiating any of the actions checked in line 16 (check all that apply):			
a [X] Notified patients of the financial assistance policy on admission			
b [X] Notified patients of the financial assistance policy prior to discharge			
c [X] Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills			
d [X] Documented its determination of whether patients were eligible for financial assistance under the hospital facility's financial assistance policy			
e [ ] Other (describe in Part VI)			

Part V Facility Information *(continued)* TRINITY MEDICAL CENTER - MOLINE

Policy Relating to Emergency Medical Care

		Yes	No
18 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires 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?	18	X	

If "No," indicate why:

- **a** ☐ The hospital facility did not provide care for any emergency medical conditions
- **b** ☐ The hospital facility's policy was not in writing
- **c** ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)
- **d** ☐ Other (describe in Part VI)

Individuals Eligible for Financial Assistance

19 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.

- **a** ☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- **b** ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- **c** ☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- **d** ☒ Other (describe in Part VI)

20 Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and 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 Part VI.	20		X
21 Did the hospital facility charge any of its FAP-eligible patients an amount equal to the gross charge for any service provided to that patient? If "Yes," explain in Part VI.	21	X	

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of Hospital Facility: TRINITY MEDICAL CENTER - BETTENDORF

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 3

		Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for tax year 2011)			
1 During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8	1		
If "Yes," indicate what the Needs Assessment describes (check all that apply):			
a ☐ A definition of the community served by the hospital facility			
b ☐ Demographics of the community			
c ☐ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☐ How data was obtained			
e ☐ The health needs of the community			
f ☐ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☐ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☐ The process for consulting with persons representing the community's interests			
i ☐ Information gaps that limit the hospital facility's ability to assess the community's health needs			
j ☐ Other (describe in Part VI)			
2 Indicate the tax year the hospital facility last conducted a Needs Assessment: 20 ____			
3 In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3		
4 Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4		
5 Did the hospital facility make its Needs Assessment widely available to the public?	5		
If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):			
a ☐ Hospital facility's website			
b ☐ Available upon request from the hospital facility			
c ☐ Other (describe in Part VI)			
6 If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):			
a ☐ Adoption of an implementation strategy to address the health needs of the hospital facility's community			
b ☐ Execution of the implementation strategy			
c ☐ Participation in the development of a community-wide community benefit plan			
d ☐ Participation in the execution of a community-wide community benefit plan			
e ☐ Inclusion of a community benefit section in operational plans			
f ☐ Adoption of a budget for provision of services that address the needs identified in the Needs Assessment			
g ☐ Prioritization of health needs in its community			
h ☐ Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i ☐ Other (describe in Part VI)			
7 Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	7		
Financial Assistance Policy			
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
8 Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8	X	
9 Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care?	9	X	
If "Yes," indicate the FPG family income limit for eligibility for free care: 200 %			
If "No," explain in Part VI the criteria the hospital facility used.			

Part V Facility Information *(continued)* TRINITY MEDICAL CENTER - BETTENDORF

		Yes	No
10 Used FPG to determine eligibility for providing *discounted* care?	10	X	
If "Yes," indicate the FPG family income limit for eligibility for discounted care: 400 %			
If "No," explain in Part VI the criteria the hospital facility used.			
11 Explained the basis for calculating amounts charged to patients?	11	X	
If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a [X] Income level			
b [X] Asset level			
c [X] Medical indigency			
d [ ] Insurance status			
e [ ] Uninsured discount			
f [ ] Medicaid/Medicare			
g [ ] State regulation			
h [ ] Other (describe in Part VI)			
12 Explained the method for applying for financial assistance?	12	X	
13 Included measures to publicize the policy within the community served by the hospital facility?	13	X	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a [X] The policy was posted on the hospital facility's website			
b [X] The policy was attached to billing invoices			
c [ ] The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d [ ] The policy was posted in the hospital facility's admissions offices			
e [ ] The policy was provided, in writing, to patients on admission to the hospital facility			
f [X] The policy was available on request			
g [ ] Other (describe in Part VI)			
Billing and Collections			
14 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 actions the hospital facility may take upon non-payment?	14	X	
15 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 patient's eligibility under the facility's FAP:			
a [X] Reporting to credit agency			
b [X] Lawsuits			
c [X] Liens on residences			
d [ ] Body attachments			
e [X] Other similar actions (describe in Part VI)			
16 Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP?	16	X	
If "Yes," check all actions in which the hospital facility or a third party engaged:			
a [X] Reporting to credit agency			
b [X] Lawsuits			
c [X] Liens on residences			
d [ ] Body attachments			
e [ ] Other similar actions (describe in Part VI)			
17 Indicate which efforts the hospital facility made before initiating any of the actions checked in line 16 (check all that apply):			
a [X] Notified patients of the financial assistance policy on admission			
b [X] Notified patients of the financial assistance policy prior to discharge			
c [X] Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills			
d [X] Documented its determination of whether patients were eligible for financial assistance under the hospital facility's financial assistance policy			
e [ ] Other (describe in Part VI)			

Part V Facility Information *(continued)* TRINITY MEDICAL CENTER - BETTENDORF

Policy Relating to Emergency Medical Care

		Yes	No
18 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires 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?	18	X	
If "No," indicate why:			
a ☐ The hospital facility did not provide care for any emergency medical conditions			
b ☐ The hospital facility's policy was not in writing			
c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)			
d ☐ Other (describe in Part VI)			

Individuals Eligible for Financial Assistance

19 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.			
a ☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged			
b ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged			
c ☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged			
d ☒ Other (describe in Part VI)			
20 Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and 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?	20		X
If "Yes," explain in Part VI.			
21 Did the hospital facility charge any of its FAP-eligible patients an amount equal to the gross charge for any service provided to that patient?	21	X	
If "Yes," explain in Part VI.			

Part V Facility Information *(continued)*

Section C. 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? 3

Name and address	Type of Facility (describe)
1 TRINITY CENTER FOR WOUND CARE 4480 UTICA RIDGE ROAD, SUITE 110 BETTENDORF, IA 52722	OUTPATIENT ONLY
2 TRINITY OUTPATIENT REHABILITATION SERV 4480 UTICA RIDGE ROAD, SUITE 102 BETTENDORF, IA 52722	OUTPATIENT ONLY
3 QUAD CITY AMBULATORY SURGERY CENTER 520 VALLEY VIEW DRIVE, SUITE 300 MOLINE, IL 61265	AMBULATORY SURGERY CENTER

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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.

PART I, LINE 6A: TRINITY MEDICAL CENTER'S COMMUNITY BENEFIT REPORT IS CONTAINED WITHIN THE IOWA HEALTH SYSTEM CONSOLIDATED COMMUNITY BENEFIT REPORT WHICH IS POSTED ON ITS WEBSITE AT WWW.IHS.ORG.

IN ADDITION, THE HOSPITAL AND ITS REGIONAL AFFILIATES PUBLISHES AN ANNUAL COMMUNITY BENEFIT REPORT. THIS REPORT IS POSTED ON ITS WEBSITE AT WWW.TRINITYQC.COM.

PART I, LINE 7G: THE NET COMMUNITY BENEFIT COST OF SUBSIDIZED HEALTH SERVICES OF $2,035,801 IS ATTRIBUTED TO TRINITY AMBULANCE SERVICE.

PART II: COMMUNITY BUILDING ACTIVITIES ARE ESSENTIAL ROLES FOR HEALTH-CARE ORGANIZATIONS IN THAT THEY ADDRESS MANY OF THE UNDERLYING DETERMINANTS OF HEALTH. RESEARCH HAS CONTINUALLY SHOWN THAT WHEN THE FACTORS INFLUENCING HEALTH ARE EXPLORED, HEALTH CARE ACTUALLY PLAYS THE SMALLEST ROLE PROPORTIONATELY. A REPORT IN THE JOURNAL OF AMERICAN MEDICAL ASSOCIATION AND THE CENTER FOR DISEASE CONTROL (MCGINNIS, 1996) SUGGESTS THAT THE FACTORS IMPACTING HEALTH ARE AS FOLLOWS: LIFESTYLE AND BEHAVIORS, 50%, ENVIRONMENT (HUMAN AND NATURAL), 20%, GENETICS AND HUMAN

Part VI Supplemental Information

BIOLOGY, 20%, AND HEALTH CARE, 10%. COMMUNITY BUILDING ACTIVITIES HELP TO ADDRESS THE OTHER INDICATORS OUTSIDE OF THE ROLE TRADITIONALLY PLAYED BY HEALTH-CARE ORGANIZATIONS. THESE ACTIVITIES ARE ALMOST EXCLUSIVELY DONE IN SOME FORM OF PARTNERSHIP IN WHICH THE COMMUNITY OR OTHER ORGANIZATIONS ARE BETTER SUITED TO ADDRESS. HEALTH-CARE ORGANIZATIONS GENERALLY PROVIDE TIMELY AND SPECIFIC RESOURCES TO HELP THESE ISSUES. HEALTH-CARE ORGANIZATIONS CAN BE A RICH AND VALUABLE COMMUNITY RESOURCE IN WAYS NOT TYPICALLY CONSIDERED. OFTEN THE MOST EFFECTIVE WAY TO HELP IMPACT AND IMPROVE THE COMMUNITY HEALTH STATUS IS TO SUPPORT OTHER AGENCIES AND ORGANIZATIONS IN A VARIETY OF WAYS OUTSIDE OF HEALTH SERVICES. THIS IS OFTEN DONE THROUGH CASH OR IN-KIND SERVICES TO SUPPORT OTHER NON-PROFITS, DONATIONS OF DURABLE MEDICAL EQUIPMENT AND SUPPLIES TO CERTAIN AGENCIES, OR THROUGH LEADERSHIP AND EDUCATIONAL EXPERTISE. TRINITY MEDICAL CENTER CONTRIBUTES FINANCIALLY TO A WIDE VARIETY OF COMMUNITY ORGANIZATIONS THAT ADDRESS THE BROADER NEEDS OF THE COMMUNITY. THESE DONATIONS ALLOW OTHER NON-PROFIT ORGANIZATIONS TO FULFILL THEIR MISSIONS TO IMPROVE THE WELL BEING OF THE COMMUNITY AND CONTRIBUTE TO ITS OVERALL HEALTH STATUS IN WAYS THAT MAY DIFFER FROM THE DIRECT SERVICES OF THE HOSPITAL ORGANIZATION AND MAXIMIZE THE RESOURCES THEY HAVE TO WORK WITH. TRINITY MEDICAL CENTER EMPLOYEES ARE ACTIVE IN EDUCATING PARTNERS ON A WIDE VARIETY OF HEALTH SUBJECTS THAT ADVANCE THEIR WORK. FURTHER, TRINITY MEDICAL CENTER EMPLOYEES ARE MEMBERS OF MANY NON-PROFIT BOARDS TO PROVIDE LEADERSHIP OR COLLABORATE TO ADDRESS COMPLEX HEALTH ISSUES. THESE TYPES OF ACTIVITIES SPEAK TO THE BREADTH AND CAPACITY THAT THE HOSPITAL HAS IN IMPACTING THE HEALTH STATUS OF THE COMMUNITY IN A COMPREHENSIVE AND INTENTIONAL APPROACH.

PART III, LINE 4: THE HEALTH SYSTEM PROVIDES AN ALLOWANCE FOR DOUBTFUL

Part VI Supplemental Information

ACCOUNTS BASED UPON A REVIEW OF OUTSTANDING RECEIVABLES, HISTORICAL COLLECTION INFORMATION AND EXISTING ECONOMIC CONDITIONS. AS A SERVICE TO THE PATIENT, THE HEALTH SYSTEM BILLS THIRD-PARTY PAYERS DIRECTLY AND BILLS THE PATIENT WHEN THE PATIENT'S LIABILITY IS DETERMINED. PATIENT ACCOUNTS RECEIVABLE ARE DUE IN FULL WHEN BILLED. ACCOUNTS ARE CONSIDERED DELINQUENT AND SUBSEQUENTLY WRITTEN OFF AS BAD DEBTS BASED ON INDIVIDUAL CREDIT EVALUATION AND SPECIFIC CIRCUMSTANCES OF THE ACCOUNT.

THE AMOUNT REPORTED ON LINE 2 WAS CALCULATED USING IRS WORKSHEET 2 'RATIO OF PATIENT CARE COST TO CHARGES' TO CALCULATE THE COST TO CHARGE RATIO FOR TRINITY MEDICAL CENTER. THIS RATIO WAS THEN APPLIED AGAINST THE BAD DEBT ATTRIBUTABLE TO PATIENT ACCOUNTS USING IRS WORKSHEET A TO ARRIVE AT THE BAD DEBT EXPENSE AT COST REPORTED ON LINE 2.

PART III, LINE 8: AMOUNTS ON LINE 6 WERE CALCULATED USING IRS WORKSHEET B 'TOTAL MEDICARE ALLOWABLE COSTS.' THE MEDICARE ALLOWABLE COSTS WERE OBTAINED FROM THE MEDICARE COST REPORTS AND THEN REDUCED BY ANY AMOUNTS ALREADY CAPTURED IN COMMUNITY BENEFIT EXPENSE IN PART I ABOVE.

THE HOSPITAL BELIEVES THE ENTIRE AMOUNT OF THE MEDICARE SHORTFALL SHOULD BE TREATED AS COMMUNITY BENEFIT, MORE SPECIFICALLY, AS CHARITY CARE. THE ELDERLY CONSTITUTE A CLEARLY-RECOGNIZED CHARITABLE CLASS, AND MANY MEDICARE BENEFICIARIES, LIKE THEIR MEDICAID COUNTERPARTS, ARE POOR AND THUS WOULD HAVE QUALIFIED FOR THE HOSPITAL'S CHARITY CARE PROGRAM, MEDICAID OR OTHER NEEDS-BASED GOVERNMENT PROGRAMS ABSENT THE MEDICARE PROGRAM. BY ACCEPTING PAYMENT BELOW COST TO TREAT THESE INDIVIDUALS, THE BURDENS OF GOVERNMENT ARE RELIEVED WITH RESPECT TO THESE INDIVIDUALS. ADDITIONALLY, THERE IS A SIGNIFICANT POSSIBILITY THAT CONTINUED REDUCTION

Part VI Supplemental Information

IN REIMBURSEMENT MAY ACTUALLY CREATE DIFFICULTIES IN ACCESS FOR THESE INDIVIDUALS. FINALLY, THE AMOUNT SPENT TO COVER THE MEDICARE SHORTFALL IS MONEY NOT AVAILABLE TO COVER CHARITY CARE AND OTHER COMMUNITY BENEFIT NEEDS.

PART III, LINE 9B: AFTER THE PATIENT MEETS THE QUALIFICATIONS FOR FINANCIAL ASSISTANCE, THE ACCOUNT BALANCE IS PARTIALLY OR ENTIRELY WRITTEN OFF, AS APPROPRIATE. ANY REMAINING BALANCE, IF ANY, WOULD BE COLLECTED UNDER THE NORMAL DEBT COLLECTION POLICY.

TRINITY MEDICAL CENTER - ROCK ISLAND:
PART V, SECTION B, LINE 3: A COMPREHENSIVE AND REPRESENTATIVE COMMUNITY WIDE PHONE SURVEY WAS CONDUCTED AND FOCUS GROUPS WERE CONVENED WITH KEY INFORMANTS OF WHOM SOME WERE USERS.

TRINITY MEDICAL CENTER - ROCK ISLAND:
PART V, SECTION B, LINE 4: GENESIS HEALTH SYSTEM, THE ROCK ISLAND COUNTY HEALTH DEPARTMENT, THE SCOTT COUNTY HEALTH DEPARTMENT, TRINITY MUSCATINE PUBLIC HEALTH, AND THE COMMUNITY HEALTH CARE CENTER.

TRINITY MEDICAL CENTER - ROCK ISLAND:
PART V, SECTION B, LINE 5C: THE HEALTH NEEDS ASSESSMENT WAS RECENTLY COMPLETED. IT WAS POSTED ON OUR HOSPITAL WEBSITE MARCH 21, 2012 AND WILL BE AVAILABLE ON THE WEBSITES OF THE OTHER COMMUNITY HEALTH NEEDS ASSESSMENT PARTNERS.

Part VI Supplemental Information

TRINITY MEDICAL CENTER - ROCK ISLAND:

PART V, SECTION B, LINE 15E: GUARANTORS RECEIVE A CYCLE BILL EERY 30 DAYS FOR THE LIFE OF THE ACCOUNT ON A/R. ON DAY 41, 11 DAYS AFTER THE SECOND BILLING CYCLE, A FIRST COLLECTION ATTEMPT IS MADE FROM THE TELEVOX DIALER. THE SECOND COLLECTION ATTEMPT IS MADE BY THE DIALER ON DAY 71, 11 DAYS AFTER THE THIRD AND FINAL BILLING CYCLE. THE THIRD COLLECTION ATTEMPT IS MADE BY THE DIALER ON DAY 87, E DAYS BEFORE THE ACCOUNT IS REVIEWED FOR COLLECTIONS. ACCOUNTS WITH SATISFACTORY PAYMENTS OR PREARRANGED PAYMENT ARRANGEMENTS THAT ARE CURRENT ARE NOT SENT TO THE DIALER. ACCOUNTS WITH A MENTAL HEALTH DIAGNOSIS, WORKERS COMPENSATION ACCOUNTS, ACCOUNTS WITH SKILLED NURSING FACILITIES, AND ACCOUNTS WITH NO PHONE NUMBER ARE ALSO NOT SENT TO THE DIALER. THESE ACCOUNTS ARE ON A MANUAL LIST WHICH THE COLLECTION TEAM REVIEWS AND MAKES CALLS MANUALLY AS DEEMED APPROPRIATE. WHEN THE ACCOUNTS ARE GREATER THAN OR EQUAL TO $5,000, THE COLLECTION TEAM WILL SEND A FINANCIAL ASSISTANCE APPLICATION IF THEY CANNOT MAKE CONTACT WITH THE GUARANTOR AND 10 BUSINESS DAYS LATER, A PAST LETTER. THEY WILL ALSO CHECK FOR MEDICAID ELIGIBILITY FOR THEIR STATE OF RESIDENCE.

TRINITY MEDICAL CENTER - MOLINE:

PART V, SECTION B, LINE 15E: GUARANTORS RECEIVE A CYCLE BILL EERY 30 DAYS FOR THE LIFE OF THE ACCOUNT ON A/R. ON DAY 41, 11 DAYS AFTER THE SECOND BILLING CYCLE, A FIRST COLLECTION ATTEMPT IS MADE FROM THE TELEVOX DIALER. THE SECOND COLLECTION ATTEMPT IS MADE BY THE DIALER ON DAY 71, 11 DAYS AFTER THE THIRD AND FINAL BILLING CYCLE. THE THIRD COLLECTION ATTEMPT IS MADE BY THE DIALER ON DAY 87, E DAYS BEFORE THE ACCOUNT IS REVIEWED FOR COLLECTIONS. ACCOUNTS WITH SATISFACTORY PAYMENTS OR PREARRANGED PAYMENT ARRANGEMENTS THAT ARE CURRENT ARE NOT SENT TO THE DIALER. ACCOUNTS WITH A

Part VI Supplemental Information

MENTAL HEALTH DIAGNOSIS, WORKERS COMPENSATION ACCOUNTS, ACCOUNTS WITH SKILLED NURSING FACILITIES, AND ACCOUNTS WITH NO PHONE NUMBER ARE ALSO NOT SENT TO THE DIALER. THESE ACCOUNTS ARE ON A MANUAL LIST WHICH THE COLLECTION TEAM REVIEWS AND MAKES CALLS MANUALLY AS DEEMED APPROPRIATE. WHEN THE ACCOUNTS ARE GREATER THAN OR EQUAL TO $5,000, THE COLLECTION TEAM WILL SEND A FINANCIAL ASSISTANCE APPLICATION IF THEY CANNOT MAKE CONTACT WITH THE GUARANTOR AND 10 BUSINESS DAYS LATER, A PAST LETTER. THEY WILL ALSO CHECK FOR MEDICAID ELIGIBILITY FOR THEIR STATE OF RESIDENCE.

TRINITY MEDICAL CENTER - BETTENDORF:

PART V, SECTION B, LINE 15E: GUARANTORS RECEIVE A CYCLE BILL EERY 30 DAYS FOR THE LIFE OF THE ACCOUNT ON A/R. ON DAY 41, 11 DAYS AFTER THE SECOND BILLING CYCLE, A FIRST COLLECTION ATTEMPT IS MADE FROM THE TELEVOX DIALER. THE SECOND COLLECTION ATTEMPT IS MADE BY THE DIALER ON DAY 71, 11 DAYS AFTER THE THIRD AND FINAL BILLING CYCLE. THE THIRD COLLECTION ATTEMPT IS MADE BY THE DIALER ON DAY 87, E DAYS BEFORE THE ACCOUNT IS REVIEWED FOR COLLECTIONS. ACCOUNTS WITH SATISFACTORY PAYMENTS OR PREARRANGED PAYMENT ARRANGEMENTS THAT ARE CURRENT ARE NOT SENT TO THE DIALER. ACCOUNTS WITH A MENTAL HEALTH DIAGNOSIS, WORKERS COMPENSATION ACCOUNTS, ACCOUNTS WITH SKILLED NURSING FACILITIES, AND ACCOUNTS WITH NO PHONE NUMBER ARE ALSO NOT SENT TO THE DIALER. THESE ACCOUNTS ARE ON A MANUAL LIST WHICH THE COLLECTION TEAM REVIEWS AND MAKES CALLS MANUALLY AS DEEMED APPROPRIATE. WHEN THE ACCOUNTS ARE GREATER THAN OR EQUAL TO $5,000, THE COLLECTION TEAM WILL SEND A FINANCIAL ASSISTANCE APPLICATION IF THEY CANNOT MAKE CONTACT WITH THE GUARANTOR AND 10 BUSINESS DAYS LATER, A PAST LETTER. THEY WILL ALSO CHECK FOR MEDICAID ELIGIBILITY FOR THEIR STATE OF RESIDENCE.

Part VI Supplemental Information

TRINITY MEDICAL CENTER - ROCK ISLAND:

PART V, SECTION B, LINE 19D: IF THE INDIVIDUAL APPLIES AND QUALIFIES FOR FINANCIAL ASSISTANCE UNDER THE FACILITY'S FINANCIAL ASSISTANCE POLICY, THE HOSPITAL FACILITY USES THE AVERAGE OF THE THREE LOWEST NEGOTIATED COMMERCIAL INSURANCE RATES FOR THOSE SERVICES AT THE HOSPITAL FACILITY TO DETERMINE THE AMOUNTS BILLED FOR ALL SERVICES, INCLUDING EMERGENCY OR MEDICALLY NECESSARY CARE. THIS OCCURS REGARDLESS WHETHER THE INDIVIDUAL HAS INSURANCE COVERAGE. ALSO, IF THE INDIVIDUAL HAS INSURANCE COVERAGE AND DOES NOT APPLY OR QUALIFY FOR FINANCIAL ASSISTANCE UNDER THE FACILITY'S FINANCIAL ASSISTANCE POLICY, THE HOSPITAL FACILITY USES THE INSURER'S NEGOTIATED RATE FOR THOSE SERVICES AT THE HOSPITAL FACILITY. HOWEVER, IF THE INDIVIDUAL DOES NOT HAVE INSURANCE COVERAGE AND EITHER DOES NOT APPLY OR DOES NOT QUALIFY FOR FINANCIAL ASSISTANCE UNDER THE FACILITY'S FINANCIAL ASSISTANCE POLICY, THE HOSPITAL FACILITY USES THE GROSS RATES FOR THOSE SERVICES TO DETERMINE THE AMOUNTS BILLED. IF THE UNINSURED INDIVIDUAL AGREES TO PAY THE BILL IN FULL, THE HOSPITAL FACILITY WILL PROVIDE A 20%-30% DISCOUNT FROM THE GROSS RATES FOR THOSE INDIVIDUALS.

TRINITY MEDICAL CENTER - MOLINE:

PART V, SECTION B, LINE 19D: IF THE INDIVIDUAL APPLIES AND QUALIFIES FOR FINANCIAL ASSISTANCE UNDER THE FACILITY'S FINANCIAL ASSISTANCE POLICY, THE HOSPITAL FACILITY USES THE AVERAGE OF THE THREE LOWEST NEGOTIATED COMMERCIAL INSURANCE RATES FOR THOSE SERVICES AT THE HOSPITAL FACILITY TO DETERMINE THE AMOUNTS BILLED FOR ALL SERVICES, INCLUDING EMERGENCY OR MEDICALLY NECESSARY CARE. THIS OCCURS REGARDLESS WHETHER THE INDIVIDUAL HAS INSURANCE COVERAGE. ALSO, IF THE INDIVIDUAL HAS INSURANCE COVERAGE AND DOES NOT APPLY OR QUALIFY FOR FINANCIAL ASSISTANCE UNDER THE

Part VI Supplemental Information

FACILITY'S FINANCIAL ASSISTANCE POLICY, THE HOSPITAL FACILITY USES THE INSURER'S NEGOTIATED RATE FOR THOSE SERVICES AT THE HOSPITAL FACILITY. HOWEVER, IF THE INDIVIDUAL DOES NOT HAVE INSURANCE COVERAGE AND EITHER DOES NOT APPLY OR DOES NOT QUALIFY FOR FINANCIAL ASSISTANCE UNDER THE FACILITY'S FINANCIAL ASSISTANCE POLICY, THE HOSPITAL FACILITY USES THE GROSS RATES FOR THOSE SERVICES TO DETERMINE THE AMOUNTS BILLED. IF THE UNINSURED INDIVIDUAL AGREES TO PAY THE BILL IN FULL, THE HOSPITAL FACILITY WILL PROVIDE A 20%-30% DISCOUNT FROM THE GROSS RATES FOR THOSE INDIVIDUALS.

TRINITY MEDICAL CENTER - BETTENDORF:

PART V, SECTION B, LINE 19D: IF THE INDIVIDUAL APPLIES AND QUALIFIES FOR FINANCIAL ASSISTANCE UNDER THE FACILITY'S FINANCIAL ASSISTANCE POLICY, THE HOSPITAL FACILITY USES THE AVERAGE OF THE THREE LOWEST NEGOTIATED COMMERCIAL INSURANCE RATES FOR THOSE SERVICES AT THE HOSPITAL FACILITY TO DETERMINE THE AMOUNTS BILLED FOR ALL SERVICES, INCLUDING EMERGENCY OR MEDICALLY NECESSARY CARE. THIS OCCURS REGARDLESS WHETHER THE INDIVIDUAL HAS INSURANCE COVERAGE. ALSO, IF THE INDIVIDUAL HAS INSURANCE COVERAGE AND DOES NOT APPLY OR QUALIFY FOR FINANCIAL ASSISTANCE UNDER THE FACILITY'S FINANCIAL ASSISTANCE POLICY, THE HOSPITAL FACILITY USES THE INSURER'S NEGOTIATED RATE FOR THOSE SERVICES AT THE HOSPITAL FACILITY. HOWEVER, IF THE INDIVIDUAL DOES NOT HAVE INSURANCE COVERAGE AND EITHER DOES NOT APPLY OR DOES NOT QUALIFY FOR FINANCIAL ASSISTANCE UNDER THE FACILITY'S FINANCIAL ASSISTANCE POLICY, THE HOSPITAL FACILITY USES THE GROSS RATES FOR THOSE SERVICES TO DETERMINE THE AMOUNTS BILLED. IF THE UNINSURED INDIVIDUAL AGREES TO PAY THE BILL IN FULL, THE HOSPITAL FACILITY WILL PROVIDE A 20%-30% DISCOUNT FROM THE GROSS RATES FOR THOSE INDIVIDUALS.

Part VI Supplemental Information

TRINITY MEDICAL CENTER - ROCK ISLAND:

PART V, SECTION B, LINE 21: AS DESCRIBED IN SCHEDULE H, PART V, LINE 19, IF THE PATIENT DOES NOT APPLY OR QUALIFY FOR FINANCIAL ASSISTANCE AND ALSO IS UNINSURED OR RECEIVES NO BENEFIT FROM THEIR INSURANCE ON A SERVICE PROVIDED BY THE HOSPITAL FACILITY, THEY WOULD BE CHARGED AMOUNTS EQUAL TO GROSS CHARGES FOR THE SERVICES PROVIDED TO THE PATIENT. HOWEVER, IF THE PATIENT AGREES TO PAY IN FULL, THEY WILL RECEIVE A 20%-30% DISCOUNT FROM THE GROSS CHARGES.

TRINITY MEDICAL CENTER - MOLINE:

PART V, SECTION B, LINE 21: AS DESCRIBED IN SCHEDULE H, PART V, LINE 19, IF THE PATIENT DOES NOT APPLY OR QUALIFY FOR FINANCIAL ASSISTANCE AND ALSO IS UNINSURED OR RECEIVES NO BENEFIT FROM THEIR INSURANCE ON A SERVICE PROVIDED BY THE HOSPITAL FACILITY, THEY WOULD BE CHARGED AMOUNTS EQUAL TO GROSS CHARGES FOR THE SERVICES PROVIDED TO THE PATIENT. HOWEVER, IF THE PATIENT AGREES TO PAY IN FULL, THEY WILL RECEIVE A 20%-30% DISCOUNT FROM THE GROSS CHARGES.

TRINITY MEDICAL CENTER - BETTENDORF:

PART V, SECTION B, LINE 21: AS DESCRIBED IN SCHEDULE H, PART V, LINE 19, IF THE PATIENT DOES NOT APPLY OR QUALIFY FOR FINANCIAL ASSISTANCE AND ALSO IS UNINSURED OR RECEIVES NO BENEFIT FROM THEIR INSURANCE ON A SERVICE PROVIDED BY THE HOSPITAL FACILITY, THEY WOULD BE CHARGED AMOUNTS EQUAL TO GROSS CHARGES FOR THE SERVICES PROVIDED TO THE PATIENT. HOWEVER, IF THE PATIENT AGREES TO PAY IN FULL, THEY WILL RECEIVE A 20%-30% DISCOUNT FROM THE GROSS CHARGES.

Part VI Supplemental Information

PART VI, LINE 2: TRINITY MEDICAL CENTER CONTINUALLY WORKS WITH COMMUNITY PARTNERS IN THE QUAD CITY AREA OF IOWA AND ILLINOIS TO ASSESS THE HEALTH NEEDS OF THE COMMUNITY. IT'S PRIMARY "COMMUNITY HEALTH ASSESSMENT" PARTNERS ARE THE SCOTT COUNTY PUBLIC HEALTH DEPARTMENT, THE ROCK ISLAND COUNTY HEALTH DEPARTMENT, THE COMMUNITY HEALTH CARE CENTER (AN FAQC), GENESIS MEDICAL CENTER AND THE QUAD CITY HEALTH INIITIATIVE. (THE QUAD CITY HEALTH INITIATIVE IS JOINTLY SPONSORED BY TRINITY MEDICAL CENTER AND GENESIS MEDICAL CENTER). THIS COLLABORATION CONTINUES AND EXISTS TO FACILITATE COORDINATION AND NON-DUPLICATION OF EFFORT AMONG THE PARTNERS AS WE ALL DEVELOP PROGRAMS AND SERVICES DESIGNED TO RESPOND TO THE NEEDS IDENTIFIED IN THE ASSESSMENT. AS NOTED EARLIER, TRINITY MEDICAL CENTER AND GENESIS HEALTH SYSTEM ARE THE SPONSORING PARTNERS OF THE QUAD CITY HEALTH INITIATIVE (QCHI). QCHI IS A COMMUNITY PARTNERSHIP WORKING TO CREATE A HEALTHY COMMUNITY. IT CONSISTS OF OVER 200 VOLUNTEERS FROM ALL WALKS OF LIFE, AS WELL AS A BOARD OF DIRECTORS WHOSE MEMBERS ARE REPRESENTATIVE OF THE COMMUNITY IN TERMS OF SOCIO-ECONOMIC VARIABLES AND COMMUNITY LEADERSHIP. THE BOARD MEETS QUARTERLY. QCHI IS ONE OF THE RESOURCES THAT TRINITY UTILIZES.WHEN ADDRESSING THE COMMUNIITY'S HEALTH NEEDS.

TRINITY'S MISSION EFFECTIVENESS COMMITTEE WHICH CONSISTS OF AREA CLERGY, PHYSICIANS, REPRESENTATIVES OF THE BUSINESS AND SOCIAL SERVICE COMMUNITIES AND TRINITY SENIOR LEADERSHIP IS ANOTHER INVALUABLE RESOURCE UTILIZED TO DEVELOP AND MONITOR TRINITY'S COMMUNITY BENEFITS PLAN. THE PLAN IDENTIFIES SPECIFIC HEALTH PRIORITIES, STRATEGIES AND PLANS OF ACTION TO ADDRESS THOSE NEEDS WHICH ARE CONSISTENT WITH ITS MISSION AND CAPACITY. TRINITY'S

Part VI Supplemental Information

EFFORTS TO "IMPROVE THE HEALTH OF THE COMMUNITIES WE SERVE" ARE MONITORED IN PART BY THE OTHER PARTNER AGENCIES CITED EARLIER I.E. SCOTT COUNTY PUBLIC HEALTH DEPARTMENT, COMMUNITY HEALTH CARE CENTER, ROCK ISLAND COUNTY PUBLIC HEALTH DEPARTMENT AND GENESIS MEDICAL CENTER AS WELL AS BY THE MISSION EFFECTIVENESS COMMITTEE. THE LATTER IS A STANDING COMMITTEE OF TRINITY REGIONAL HEALTH SYSTEM'S BOARD AND MEETS A MINIMUM OF FOUR TIMES A YEAR. ADDITIONALLY, THE QUAD CITY HEALTH INITIATIVE MONITORS AND REPORTS SPECIFIC INDICATORS TO AID IN THE DEVELOPMENT OF NEW PLANS OR REFINING EXISTING ONES.

TRINITY MEDICAL CENTER ALSO PARTICIPATES AS PART OF THE UNITED WAY COMMUNITY IMPACT COMMITTEE. THIS GROUP ACTIVELY ADDRESSES NEED AND STRATEGIES ASSOCIATED WITH HEALTH. MORE SPECIFICALLY, THIS GROUP OFTEN FOCUSES ON THE SOCIAL DETERMINANTS OF HEALTH AND HOW TO IMPACT THEM IN THE EFFORT TO RAISE THE COMMUNITY HEALTH STATUS. THIS WIDE BASED COLLABORATIVE PROVIDES OPPORTUNITIES FOR TRINITY MEDICAL CENTER TO ENGAGE IN VARIOUS AREAS OF SERVICE TO THE COMMUNITY THAT MAY BE OUTSIDE OF ITS TYPICAL EXPERTISE BUT WITHIN ITS EXISTING RESOURCES. IN ADDITION TO THESE ORGANIZED COMMUNITY EFFORTS, TRINITY MEDICAL CENTER CONTINUALLY MONITORS COMMUNITY NEEDS SPECIFIC TO ITS SERVICE LINES AND THE RESOURCES IT CAN LEVERAGE TO ADDRESS THEM. INDIVIDUAL DEPARTMENTS OFTEN WORK TO IDENTIFY SPECIFIC NEEDS RELATED TO THEIR SERVICES AND THE POPULATION THEY IMPACT.

PART VI, LINE 3: TRINITY MEDICAL CENTER PERFORMS THE FOLLOWING ACTIVITIES TO COMMUNICATE THE AVAILABILITY OF CHARITY CARE AND FINANCIAL ASSISTANCE TO ALL PATIENTS: 1) PLACES SIGNAGE, INFORMATION, AND/OR BROCHURES IN APPROPRIATE AREAS OF THE PROVIDER (E.G., THE EMERGENCY DEPARTMENT, AND REGISTRATION AND CHECK-OUT/CASHIER AREAS) STATING THE

Part VI Supplemental Information

PROVIDER/PHYSICIAN PRACTICE OFFERS CHARITY CARE AND DESCRIBES HOW TO OBTAIN MORE INFORMATION ABOUT FINANCIAL ASSISTANCE, 2) PLACES A NOTE ON THE HEALTH-CARE BILL AND STATEMENTS REGARDING HOW TO REQUEST INFORMATION ABOUT FINANCIAL ASSISTANCE, 3) DESIGNATES INDIVIDUALS WHO CAN EXPLAIN THE PROVIDER'S CHARITY CARE POLICY, AND 4) INSTRUCTS STAFF WHO INTERACT WITH PATIENTS TO DIRECT QUESTIONS REGARDING THE CHARITY CARE POLICY TO THE PROPER PROVIDER REPRESENTATIVE.

PART VI, LINE 4: TRINITY MEDICAL CENTER IS A 515-BED COMMUNITY HOSPITAL SERVING EASTERN IOWA AND WESTERN ILLINOIS. TRINITY MEDICAL CENTER IS NONDENOMINATIONAL AND SERVES ALL WHO COME HERE, REGARDLESS OF REASON OR CIRCUMSTANCE.

80% OF TRINITY MEDICAL CENTER'S MARKET RESIDENTS LIVE WITHIN THE IOWA COUNTIES OF ROCK ISLAND (IL) AND SCOTT (IA).

TRINITY MEDICAL CENTER ADMITS APPROXIMATELY 22,000 INPATIENTS AND CARES FOR 86,000 EMERGENCY PATIENTS PER YEAR.

MEDIAN HOUSEHOLD INCOMES RANGE FROM 46,226 TO 49,964 AND THE AVERAGE POVERTY RATE IS 12%.

62% OF TRINITY MEDICAL CENTER INPATIENTS ARE ELIGIBLE FOR MEDICARE OR MEDICAID. ROCK ISLAND AND SCOTT COUNTIES BOTH HAVE SIGNIFICANT MINORITY POPULATION. ROCK ISLAND IS 82% CAUCASION, 9% AFRICAN AMERICAN, 12% HISPANIC, AND 2% ASIAN. SCOTT IS 86% CAUCASION, 7% AFRICAN AMERICAN, AND 6% HISPANIC.

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PART VI, LINE 5: THE HOSPITAL IS ORGANIZED AND OPERATED EXCLUSIVELY FOR CHARITABLE PURPOSES WITH THE GOAL OF PROMOTING THE HEALTH OF THE COMMUNITIES IT SERVES. THE HOSPITAL SUPPORTS THIS MISSION WITH A COMMUNITY BOARD, OPEN MEDICAL STAFF, AND AN EMERGENCY ROOM AVAILABLE TO PATIENTS REGARDLESS OF ABILITY TO PAY. THE BOARD OF DIRECTORS OF THE HOSPITAL IS COMPOSED OF CIVIC LEADERS WHO RESIDE IN THE SERVICE AREA OF THE HOSPITAL. THE BOARD ACTIVELY DEBATES AND SETS POLICY AND STRATEGIC DIRECTION FOR THE HOSPITAL BUT DOES NOT GET INVOLVED IN ISSUES RELATED TO THE DIRECT OPERATIONS OF THE HOSPITAL. THE BOARD TAKES A BALANCED APPROACH WHEN ADDRESSING COMMUNITY AND BUSINESS/FINANCIAL CONCERNS. THE BOARD IS ALSO THE PRIMARY GROUP FOR DETERMINING THE USE OF HOSPITAL SURPLUS FUNDS, WHICH ARE ALL USED TO FURTHER OUR CHARITABLE PURPOSE.

PART VI, LINE 6: THE HOSPITAL IS PART OF IOWA HEALTH SYSTEM. INITIALLY FORMED IN 1995, IOWA HEALTH SYSTEM IS THE STATE'S FIRST AND LARGEST INTEGRATED HEALTH SYSTEM, SERVING NEARLY ONE OF EVERY THREE PATIENTS IN IOWA. THROUGH RELATIONSHIPS WITH 27 HOSPITALS IN METROPOLITAN AND RURAL COMMUNITIES AND MORE THAN 200 PHYSICIAN CLINICS, IOWA HEALTH SYSTEM PROVIDES CARE THROUGHOUT IOWA AND ILLINOIS.

IOWA HEALTH SYSTEM ENTITIES EMPLOY THE STATE'S LARGEST NONPROFIT WORKFORCE, WITH MORE THAN 24,000 EMPLOYEES WORKING TOWARD INNOVATIVE ADVANCEMENTS TO DELIVER THE BEST OUTCOME FOR EVERY PATIENT EVERY TIME. EACH YEAR, THROUGH MORE THAN 3.1 MILLION PATIENT VISITS, IOWA HEALTH SYSTEM HOSPITALS AND CLINICS PROVIDE A FULL RANGE OF CARE TO PATIENTS AND FAMILIES. WITH ANNUAL REVENUES OF $2.8 BILLION, IOWA HEALTH SYSTEM IS THE FIFTH LARGEST NONDENOMINATIONAL HEALTH SYSTEM IN AMERICA AND PROVIDES COMMUNITY BENEFIT PROGRAMS AND SERVICES TO IMPROVE THE HEALTH OF PEOPLE IN

Part VI Supplemental Information

ITS COMMUNITIES.

IOWA HEALTH SYSTEM AND ITS AFFILIATES ENGAGE IN COMMUNITY HEALTH PROGRAMS AND SERVICES THROUGHOUT IOWA, AND WORK WITH VOLUNTEER AND CIVIC ORGANIZATIONS, SCHOOLS, BUSINESSES, INSURERS AND INDIVIDUALS TO SUPPORT ACTIVITIES THAT BENEFIT PEOPLE THROUGHOUT THE STATE. IN 2011, IOWA HEALTH SYSTEM AND ITS AFFILIATES PROVIDED MORE THAN $387 MILLION OF COMMUNITY BENEFIT. THE CONTRIBUTIONS TO THEIR COMMUNITIES BY IOWA HEALTH SYSTEM AND ITS AFFILIATES ARE REPORTED IN DETAIL IN STATEMENT OF PROGRAM SERVICE ACCOMPLISHMENTS (PART III) OF THE IRS FORM 990 OF THOSE AFFILIATES.

PART VI, LINE 7, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:

IL,IA

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" to Form 990, Part IV, line 21 or 22.
▶ Attach to Form 990.

OMB No. 1545-0047

2011

Open to Public Inspection

Name of the organization: TRINITY MEDICAL CENTER

Employer identification number: 36-2739299

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 Governments and Organizations in the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 21, for any recipient that received more than $5,000. Check this box if no one recipient received more than $5,000. Part II can be duplicated if additional space is needed ▶ ☐

1 (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
ILLINOIS HOSPITAL ASSOCIATION 37092 EAGLE WAY CHICAGO, IL 60679	36-2352486	501(C)(3)	131,490.	0.			PROGRAM SUPPORT
IOWA HEALTH SYSTEM 1200 PLEASANT ST DES MOINES, IA 50309	42-1435199	501(C)(3)	2,155,583.	0.			PROGRAM SUPPORT

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

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

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

Schedule I (Form 990) (2011)

132101 01-27-12

Part III **Grants and Other Assistance to Individuals in the United States.** Complete if the organization answered "Yes" to 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

Part IV **Supplemental Information.** Complete this part to provide the information required in Part I, line 2, and any other additional information.

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" to Form 990, Part IV, line 23.**

▶ **Attach to Form 990.** ▶ **See separate instructions.**

OMB No. 1545-0047

2011

Open to Public Inspection

Name of the organization: TRINITY MEDICAL CENTER

Employer identification number: 36-2739299

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 in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items. ☐ First-class or charter travel ☐ Housing allowance or residence for personal use ☐ Travel for companions ☐ Payments for business use of personal residence ☐ Tax indemnification and gross-up payments ☐ Health or social club dues or initiation fees ☒ Discretionary spending account ☐ Personal services (e.g., maid, chauffeur, chef)			
b	If any of the boxes on 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	X	
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all officers, directors, trustees, and the CEO/Executive Director, regarding the items checked in line 1a?	2	X	
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. Explain in Part III. ☐ Compensation committee ☐ Written employment contract ☐ Independent compensation consultant ☐ Compensation survey or study ☐ Form 990 of other organizations ☐ Approval by the board or compensation committee			
4	During the year, did any person listed in 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	X	
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b	X	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	4c		X
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only section 501(c)(3) and 501(c)(4) organizations must complete lines 5-9.			
5	For persons listed in 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		X
b	Any related organization?	5b		X
	If "Yes" to line 5a or 5b, describe in Part III.			
6	For persons listed in 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		X
b	Any related organization?	6b		X
	If "Yes" to line 6a or 6b, describe in Part III.			
7	For persons listed in 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		X
8	Were any amounts reported in 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		X
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9		

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

Schedule J (Form 990) 2011

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01-23-12

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 in 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		(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 reported as deferred in prior Form 990
			(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1	DR. WILLIAM OLSON (FR 9/11)	(i)	646,580.	0.	64,937.	16,224.	23,167.	750,908.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
2	RICK SEIDLER	(i)	433,126.	166,284.	128,191.	83,659.	12,328.	823,588.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
3	TAMARA BYRAM	(i)	135,915.	36,087.	15,284.	12,629.	20,424.	220,339.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
4	DAVID DEOPERE	(i)	197,279.	53,444.	40,377.	12,781.	19,127.	323,008.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
5	MYKL GARRETT (TO 11/11)	(i)	248,996.	0.	55,993.	33,276.	111.	338,376.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
6	DR. PAUL MCLOONE	(i)	68,463.	24,746.	3,462.	3,590.	2,991.	103,252.	0.
		(ii)	164,779.	605.	75.	9,900.	16,927.	192,286.	0.
7	GREG PAGLIUZZA JR.	(i)	277,559.	39,750.	25,989.	43,062.	15,610.	401,970.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
8	JAY WILLSHER (FR 11/11)	(i)	199,974.	50,635.	28,816.	63,222.	26,325.	368,972.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
9	DR. PAUL BOLGER	(i)	451,696.	0.	63,066.	18,846.	26,067.	559,675.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
10	KATHLEEN CUNNINGHAM (TO 5/11)	(i)	64,461.	48,116.	29,138.	8,995.	5,261.	155,971.	0.
		(ii)	113,153.	17,500.	3,558.	5,660.	7,829.	147,700.	0.
11	JON HONSEY (TO 6/11)	(i)	87,205.	52,241.	39,139.	12,489.	11,119.	202,193.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
12	RICHARD MURPHY	(i)	130,284.	15,142.	4,791.	10,780.	22,093.	183,090.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
13	BOBETTE PATTERSON	(i)	123,865.	18,677.	13,304.	11,134.	15,878.	182,858.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
14	MICHAEL PATTERSON	(i)	233,316.	65,988.	55,940.	18,846.	20,507.	394,597.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
15	KATHERINE PEARSON	(i)	154,132.	41,243.	19,721.	15,075.	19,752.	249,923.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
16	JEFFREY STOLZE	(i)	200,686.	55,042.	18,881.	61,604.	25,250.	361,463.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.

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 in 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		(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 reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 DR. RANDALL BAY	(i)	420,869.	0.	45,701.	18,846.	23,376.	508,792.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
2 DR. GREGORY BOHN	(i)	583,473.	0.	12,914.	18,846.	20,206.	635,439.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
3 DR. MARK BUETTNER	(i)	530,108.	0.	10,519.	18,846.	26,771.	586,244.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
4 DR. KEVIN KURTH	(i)	371,976.	0.	102,984.	17,123.	16,788.	508,871.	0.
	(ii)	54,391.	0.	12,484.	2,692.	1,833.	71,400.	0.
5 DR. CHAD VANDERLINDEN	(i)	453,061.	0.	11,310.	18,846.	21,265.	504,482.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
6 ANDREA COLEMAN (TO 11/09)	(i)	0.	0.	123,903.	0.	8,049.	131,952.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
7 WILLIAM LEAVER (TO 12/07)	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	938,718.	335,170.	67,448.	253,072.	53,987.	1,648,395.	0.
8 TOM TIBBITTS (TO 6/10)	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	197,906.	50,000.	510,590.	12,250.	12,025.	782,771.	456,583.
9 KEVIN VERMEER (TO 5/09)	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	485,743.	135,017.	51,625.	169,053.	25,863.	867,301.	0.
10	(i)							
	(ii)							
11	(i)							
	(ii)							
12	(i)							
	(ii)							
13	(i)							
	(ii)							
14	(i)							
	(ii)							
15	(i)							
	(ii)							
16	(i)							
	(ii)							

Part III Supplemental Information

Complete this part to 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.

PART I, LINE 1A: DISCRETIONARY SPENDING ACCOUNTS:

CERTAIN OFFICERS AND/OR DIRECTORS WERE PROVIDED AN EXECUTIVE ALLOWANCE. THE ALLOWANCES ARE REQUIRED TO BE USED TO COVER CERTAIN TRAVEL, MEALS, HEALTH OR SOCIAL CLUB DUES, ENTERTAINMENT, ETC. EXPENSES INSTEAD OF RECEIVING TAX-EXEMPT REIMBURSEMENT. THE ALLOWANCE IS INCLUDED IN TAXABLE COMPENSATION AND REPORTED ON FORM W-2. THE ALLOWANCE GUIDELINES ARE ADDRESSED IN A WRITTEN POLICY.

PART I, LINES 4A-B: SEVERANCE PAYMENT:

THE FOLLOWING INDIVIDUALS RECEIVED A SEVERANCE PAYMENT DURING THE YEAR THAT WAS INCLUDED IN THEIR TAXABLE INCOME: ANDREA COLEMAN $125,462 AND MYKL GARRETT $23,810.

SUPPLEMENTAL NON-QUALIFIED RETIREMENT PLAN:

THE FOLLOWING INDIVIDUALS PARTICIPATED IN A NON-QUALIFIED RETIREMENT PLAN WITH THE FOLLOWING CHANGES TO THEIR ACCOUNTS: DAVID DEOPERE $-6,065, MYKL GARRETT $14,588, WILLIAM LEAVER $243,630, GREG PAGLIUZZA JR. $26,948, RICHARD SEIDLER $66,665, JEFFREY STOLZE $42,758, KEVIN VERMEER $157,312 AND JAY WILLSHER $44,376.

SCHEDULE L
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.
▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

OMB No. 1545-0047

2011

Open To Public Inspection

Name of the organization: TRINITY MEDICAL CENTER

Employer identification number: 36-2739299

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

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

1 (a) Name of disqualified person	(b) Description of transaction	(c) Corrected? Yes	No

2 Enter the amount of tax imposed on the organization managers or disqualified persons during the year under section 4958 ▶ $

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

Part II Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 26, or Form 990-EZ, Part V, line 38a.

(a) Name of interested person and purpose	(b) Loan to or from the organization? To	From	(c) Original principal amount	(d) Balance due	(e) In default? Yes	No	(f) Approved by board or committee? Yes	No	(g) Written agreement? Yes	No
Total ▶ $										

Part III Grants or Assistance Benefiting Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount and type of assistance

LHA **For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.**

Schedule L (Form 990 or 990-EZ) 2011

132131 01-19-12

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues? Yes	No
AMANDA CROWELL	FAMILY MEMBER OF BO	129,191.	EMPLOYMENT		X
BOBETTE PATTERSON	FAMILY MEMBER OF KE	182,859.	EMPLOYMENT		X
CARDIOVASCULAR MEDICINE, P	COMMON BOARD MEMBER	173,901.	MEDICAL SER		X
MARSHA ROMAN	FAMILY MEMBER OF KE	102,779.	EMPLOYMENT		X
MEDICAL ARTS ASSOCIATES, L	COMMON BOARD MEMBER	791,000.	RENT AND ME		X
METRO MRI CENTER LIMITED P	COMMON BOARD MEMBER	2,092,000.	INVESTMENT		X
MICHAEL PATTERSON	FAMILY MEMBER OF KE	394,596.	EMPLOYMENT		X
QUAD CITY AMBULATORY SURGE	COMMON BOARD MEMBER	3,451,000.	INVESTMENT		X
SNYDER, PARK, NELSON & SCH	COMMON BOARD MEMBER	178,967.	ATTORNEY FE		X
TRINITY BETTENDORF ORTHOPE	COMMON BOARD MEMBER	150,000.	MEDICAL SER		X

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

SCH L, PART IV, BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS:

(A) NAME OF PERSON: AMANDA CROWELL

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

FAMILY MEMBER OF BOARD MEMBER DUNCAN CAMERON

(C) AMOUNT OF TRANSACTION $ 129,191.

(D) DESCRIPTION OF TRANSACTION: EMPLOYMENT

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: BOBETTE PATTERSON

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

FAMILY MEMBER OF KEY EMPLOYEE MICHAEL PATTERSON

(C) AMOUNT OF TRANSACTION $ 182,859.

(D) DESCRIPTION OF TRANSACTION: EMPLOYMENT

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: CARDIOVASCULAR MEDICINE, P.C.

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

COMMON BOARD MEMBER/OFFICER

(C) AMOUNT OF TRANSACTION $ 173,901.

(D) DESCRIPTION OF TRANSACTION: MEDICAL SERVICES

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: MARSHA ROMAN

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

FAMILY MEMBER OF KEY EMPLOYEE MICHAEL PATTERSON

(C) AMOUNT OF TRANSACTION $ 102,779.

(D) DESCRIPTION OF TRANSACTION: EMPLOYMENT

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: MEDICAL ARTS ASSOCIATES, L.T.D., P.C.

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

COMMON BOARD MEMBER/OFFICER

(C) AMOUNT OF TRANSACTION $ 791,000.

(D) DESCRIPTION OF TRANSACTION: RENT AND MEDICAL SERVICES

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: METRO MRI CENTER LIMITED PARTNERSHIP

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

COMMON BOARD MEMBER/OFFICER

(C) AMOUNT OF TRANSACTION $ 2,092,000.

(D) DESCRIPTION OF TRANSACTION: INVESTMENT AND PATIENT SERVICE REVENUE

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: MICHAEL PATTERSON

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

FAMILY MEMBER OF KEY EMPLOYEE BOBETTE PATTERSON

(C) AMOUNT OF TRANSACTION $ 394,596.

(D) DESCRIPTION OF TRANSACTION: EMPLOYMENT

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: QUAD CITY AMBULATORY SURGERY CENTER, L.L.C.

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

COMMON BOARD MEMBER/OFFICER

(C) AMOUNT OF TRANSACTION $ 3,451,000.

(D) DESCRIPTION OF TRANSACTION: INVESTMENT

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: SNYDER, PARK, NELSON & SCHWIEBERT, P.C.

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

COMMON BOARD MEMBER/OFFICER

(C) AMOUNT OF TRANSACTION $ 178,967.

(D) DESCRIPTION OF TRANSACTION: ATTORNEY FEES

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF INTERESTED PERSON:

TRINITY BETTENDORF ORTHOPEDIC CO-MANAGEMENT COMPANY, L.L.C.

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

COMMON BOARD MEMBER/OFFICER

(C) AMOUNT OF TRANSACTION $ 150,000.

(D) DESCRIPTION OF TRANSACTION: MEDICAL SERVICES

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF INTERESTED PERSON:

TRINITY PHYSICIAN HOSPITAL ORGANIZATION, L.T.D.

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

COMMON BOARD MEMBER/OFFICER

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

(C) AMOUNT OF TRANSACTION $ 487,000.

(D) DESCRIPTION OF TRANSACTION: INVESTMENT, RENT, ADMINISTRATIVE FEES, SALARIES/BENEFITS, CREDENTIALING FEES, OTHER PROFESSIONAL FEES

(E) SHARING OF ORGANIZATION REVENUES? = NO

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.
▶ Attach to Form 990 or 990-EZ.

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FORM 990, PART III, LINE 4A, PROGRAM SERVICE ACCOMPLISHMENTS:

HANDICAP, AGE OR ABILITY TO COMPENSATE FOR SERVICES RENDERED. THESE INCLUDE, BUT ARE NOT LIMITED TO GENERAL ACUTE CARE, SURGERIES, INTENSIVE CARE AND CRITICAL CARE, CARDIOLOGY, ONCOLOGY, REHABILITATION, SKILLED NURSING, MATERNAL/CHILD CARE, LABORATORY, PHARMACEUTICAL DRUGS, EMERGENCY SERVICES, OUTPATIENT CLINICS, AND RADIOLOGY. SOME OF THE SERVICES PROVIDED DO NOT GENERATE ENOUGH INCOME TO OFFSET THEIR COST. IN THE FISCAL PERIOD ENDED DECEMBER 31, 2011, TRINITY MEDICAL CENTER ADMITTED 18,994 PATIENTS RESULTING IN A TOTAL OF 80,447 PATIENT DAYS. TOTAL OUTPATIENT SURGERY REGISTRATIONS FOR THE SAME PERIOD WERE 9,338. THERE WERE ALSO 77,732 EMERGENCY ROOM VISITS AND 1,926 BABIES DELIVERED.

FORM 990, PART III, LINE 4B, PROGRAM SERVICE ACCOMPLISHMENTS:

GOVERNMENT-SPONSORED HEALTH-CARE PROGRAMS. TRINITY MEDICAL CENTER'S NET COST OF PROVIDING CARE FOR WHICH IT RECEIVES PAYMENT BELOW ITS COST IS $13,279,244 FOR 2011. TOTAL CHARITY CARE AND MEANS-TESTED PROGRAMS REPORTED VALUE: $20,469,565.

OTHER BENEFITS: TRINITY MEDICAL CENTER PROVIDES SEVERAL OTHER BENEFITS THAT ASSIST THE COMMUNITY. PROGRAMS INCLUDE, BUT ARE NOT LIMITED TO COMMUNITY HEALTH IMPROVEMENT SERVICES AND COMMUNITY BENEFIT OPERATIONS SUCH AS PREVENTION AND HEALTH SCREENINGS; HEALTH PROFESSIONAL'S EDUCATION; SUBSIDIZED HEALTH SERVICES; RESEARCH; AND CASH AND IN-KIND CONTRIBUTIONS TO COMMUNITY GROUPS. TRINITY MEDICAL CENTER COLLABORATES WITH OTHER HOSPITALS, CHURCHES, SCHOOLS, CHAMBERS OF COMMERCE AND

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DAYCARE CENTERS TO IMPROVE COMMUNITY HEALTH AND EXPAND ACCESS TO HEALTH CARE. TRINITY MEDICAL CENTER HAS DEDICATED STAFF TO ASSIST COMMUNITY BENEFIT EFFORTS. APPROXIMATELY 144,376 PERSONS WERE SERVED THROUGH THESE PROGRAMS. TOTAL OTHER BENEFITS REPORTED VALUE: $5,384,635.

FORM 990, PART VI, SECTION A, LINE 2: ALEX PAREIGIS, MD; AHMED OKBA, MD; BUSINESS RELATIONSHIP

FORM 990, PART VI, SECTION A, LINE 2: MICHAEL PATTERSON; BOBETTE PATERSON; FAMILY RELATIONSHIP

FORM 990, PART VI, SECTION A, LINE 6: TRINITY REGIONAL HEALTH SYSTEM, A TAX-EXEMPT ILLINOIS NOT-FOR-PROFIT CORPORATION, IS THE SOLE MEMBER.

FORM 990, PART VI, SECTION A, LINE 7A: TRINITY REGIONAL HEALTH SYSTEM'S MAY APPOINT ONE BOARD MEMBER AND APPROVES ALL OTHERS.

FORM 990, PART VI, SECTION A, LINE 7B: TRINITY REGIONAL HEALTH SYSTEM, AS SOLE MEMBER, APPROVES AMENDMENTS TO ARTICLES, BYLAWS AND MISSION, MAY REMOVE ANY TRUSTEE WITH OR WITHOUT CAUSE, APPOINTS CEO AND VICE PRESIDENT, APPROVES MERGERS, CREATION OF SUBSIDIARY OR AFFILIATE ORGANIZATIONS, AND APPROVES BUDGETS AND LONG-RANGE STRATEGY. TRINITY REGIONAL HEALTH SYSTEM AND IOWA HEALTH SYSTEM MUST APPROVE DISSOLUTION.

FORM 990, PART VI, SECTION B, LINE 11: THE FORM 990 IS PREPARED INTERNALLY BY THE IOWA HEALTH SYSTEM TAX DEPARTMENT USING INFORMATION GATHERED FROM VARIOUS FUNCTIONAL AREAS OF THE ORGANIZATION. EACH SECTION OF THE RETURN IS REVIEWED BY THE RESPONSIBLE FUNCTIONAL AREA ALONG WITH THE TAX

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DEPARTMENT. A DRAFT COPY OF THE RETURN IS PROVIDED TO THE CFO FOR REVIEW. A FULL COPY OF THE FORM 990 IS PROVIDED TO THE BOARD OF DIRECTORS PRIOR TO FILING WITH THE IRS.

FORM 990, PART VI, SECTION B, LINE 12C: THE ORGANIZATION HAS A CONFLICT OF INTEREST POLICY. ANNUALLY ALL OFFICERS, DIRECTORS, KEY EMPLOYEES AND REPORTING PHYSICIANS ARE REQUESTED TO COMPLETE A QUESTIONNAIRE TO REPORT POTENTIAL CONFLICTS OF INTEREST. PERSONS WHO HAVE NOT RETURNED QUESTIONNAIRES ARE CONTACTED ADDITIONAL TIMES IN AN EFFORT TO RECEIVE COMPLETE AND ACCURATE RESPONSES FROM ALL PERSONS.

THE ANNUAL QUESTIONNAIRES INCLUDE AN ACKNOWLEDGEMENT THAT THE OFFICER, DIRECTOR, KEY EMPLOYEE OR REPORTING PHYSICIAN: 1) HAS ACCESS TO A COPY OF THE CONFLICT OF INTEREST POLICY; 2) HAS READ AND UNDERSTANDS THE POLICY; 3) AGREES TO COMPLY WITH THE POLICY; 4) UNDERSTANDS THAT THE POLICY APPLIES TO ALL COMMITTEES AND SUBCOMMITTEES HAVING BOARD-DELEGATED POWERS; AND 5) UNDERSTANDS THAT THE ORGANIZATION IS A CHARITABLE ORGANIZATION AND THAT IN ORDER TO MAINTAIN ITS TAX-EXEMPT STATUS, IT MUST CONTINUOUSLY ENGAGE PRIMARILY IN ACTIVITIES WHICH ACCOMPLISH ONE OR MORE OF ITS TAX-EXEMPT PURPOSES.

SENIOR ADMINISTRATIVE STAFF AT ALL RELATED ORGANIZATIONS PROVIDE INFORMATION TO A CENTRAL COORDINATOR RELATED TO THE IDENTIFICATION OF WHICH INDIVIDUALS SHOULD RECEIVE THE QUESTIONNAIRE FOR COMPLETION. THE RESULTS ARE COMPILED CENTRALLY AND REVIEWED BY THE IOWA HEALTH SYSTEM COMPLIANCE OFFICER AND DIRECTOR OF INTERNAL AUDIT. THE DETAIL RESULTS ARE REPORTED TO A COMMITTEE OF THE SYSTEM BOARD. THE RESULTS RELATED TO SPECIFIC REGIONAL PARENT COMPANIES, THEIR HOSPITALS AND RELATED ORGANIZATIONS, ARE

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DISTRIBUTED IN DETAIL TO THE CHAIRPERSON OF THE REGIONAL PARENT ORGANIZATION, THE CHIEF EXECUTIVE OFFICER, CHIEF FINANCIAL OFFICER AND COMPLIANCE MANAGER. THESE INDIVIDUALS ARE ALSO REMINDED OF THE APPROPRIATE PROCESS TO BE FOLLOWED DURING THE YEAR TO ADDRESS POTENTIAL CONFLICTS OF INTEREST THAT RELATE TO MATTERS THAT ARE BROUGHT TO THE BOARD OF DIRECTORS FOR ACTION.

THE INFORMATION DISCLOSED IS USED TO IDENTIFY POTENTIAL CONFLICTS OF INTEREST AND TO ASSIST IN COMPLETING IRS AND MEDICAID QUESTIONNAIRES.

ANY DUALITY OF INTEREST OR POSSIBLE CONFLICT OF INTEREST ON THE PART OF ANY ORGANIZATIONAL OFFICER, DIRECTOR, KEY EMPLOYEE OR REPORTING PHYSICIAN TOGETHER WITH ALL MATERIAL FACTS, SHOULD BE DISCLOSED TO THE BOARD OF DIRECTORS AND MADE A MATTER OF RECORD, EITHER THROUGH AN ANNUAL PROCEDURE OR WHEN THE INTEREST OCCURS OR BECOMES A MATTER OF BOARD ACTION. ANY ORGANIZATIONAL OFFICER, DIRECTOR, KEY EMPLOYEE OR REPORTING PHYSICIAN HAVING A CONFLICT OF INTEREST IN ANY MATTER SHOULD NOT BE PRESENT DURING GENERAL DISCUSSION NOR VOTE OR USE HIS OR HER PERSONAL INFLUENCE ON THE MATTER, AND HE OR SHE SHOULD NOT BE COUNTED IN DETERMINING THE EXISTENCE OF A QUORUM FOR PURPOSES OF THE MATTER OR ITEM AS TO WHICH A CONFLICT EXISTS. THE BOARD SHOULD EXCLUDE THE INDIVIDUAL FROM ANY DISCUSSION OR VOTE IN WHICH THE BOARD DECIDES WHETHER OR NOT A CONFLICT OF INTEREST EXISTS.

IN CASES IN WHICH AN OFFICER, DIRECTOR, KEY EMPLOYEE, REPORTING PHYSICIAN OR THE INDIVIDUAL'S HOUSEHOLD MEMBER HAS A CONFLICT OF INTEREST IN AN ARRANGEMENT OR TRANSACTION, THE FOLLOWING ADDITIONAL STEPS MAY BE TAKEN AT THE DIRECTION OF THE BOARD OF DIRECTORS: 1) AFTER DISCLOSURE OF THE FINANCIAL INTEREST AND ALL MATERIAL FACTS, AND AFTER ANY DISCUSSION WITH

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THE INTERESTED PERSON, HE OR SHE SHALL LEAVE THE BOARD OR COMMITTEE MEETING WHILE THE DETERMINATION OF A CONFLICT OF INTEREST IS DISCUSSED AND VOTED UPON. THE REMAINING BOARD OR COMMITTEE MEMBERS SHALL 1) DECIDE IF A CONFLICT OF INTEREST EXISTS, 2) A DISINTERESTED PERSON OR COMMITTEE MAY BE APPOINTED TO INVESTIGATE ALTERNATIVES TO THE PROPOSED ARRANGEMENT OR TRANSACTION; 3) IN ORDER TO APPROVE THE ARRANGEMENT OR TRANSACTION, THE BOARD MUST FIRST FIND, BY MAJORITY VOTE OF DISINTERESTED MEMBERS, THAT THE ARRANGEMENT OR TRANSACTION IS IN THE ORGANIZATION'S BEST INTEREST, IS FAIR AND REASONABLE TO THE ORGANIZATION, AND, AFTER REASONABLE INVESTIGATION, THE DISINTERESTED MEMBERS HAVE DETERMINED THAT A MORE ADVANTAGEOUS TRANSACTION OR ARRANGEMENT CANNOT BE OBTAINED WITH REASONABLE EFFORTS UNDER THE CIRCUMSTANCES;

THE MINUTES OF THE BOARD AND ALL COMMITTEES WITH BOARD-DELEGATED POWERS SHALL CONTAIN: 1) THE NAMES OF THE PERSONS WHO DISCLOSED OR OTHERWISE WERE FOUND TO HAVE A FINANCIAL INTEREST IN CONNECTION WITH AN ACTUAL OR POSSIBLE CONFLICT OF INTEREST, THE NATURE OF THE FINANCIAL INTEREST, ANY ACTION TAKEN TO DETERMINE WHETHER A CONFLICT OF INTEREST WAS PRESENT, AND THE BOARD'S OR COMMITTEE'S DECISION AS TO WHETHER A CONFLICT OF INTEREST IN FACT EXISTED; 2) THE NAMES OF THE PERSONS WHO WERE PRESENT FOR DISCUSSIONS AND VOTES RELATING TO THE TRANSACTION OR ARRANGEMENT, THE CONTENT OF THE DISCUSSION, INCLUDING ANY ALTERNATIVES TO THE PROPOSED TRANSACTION OR ARRANGEMENT, AND A RECORD OF ANY VOTES TAKEN IN CONNECTION THEREWITH;

IN ORDER TO PROTECT THE ORGANIZATION'S BEST INTERESTS, APPROPRIATE DISCIPLINARY ACTION MAY BE TAKEN WITH RESPECT TO AN OFFICER, DIRECTOR, KEY EMPLOYEE OR REPORTING PHYSICIAN WHO VIOLATES THE CONFLICT OF INTEREST POLICY.

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Employer identification number: 36-2739299

FORM 990, PART VI, SECTION B, LINE 15: THE EXECUTIVE COMMITTEE OF THE IOWA HEALTH SYSTEM BOARD OF DIRECTORS ("COMMITTEE") CONDUCTS A COMPREHENSIVE ANNUAL REVIEW OF ALL COMPENSATION AND BENEFITS PROVIDED TO THE ORGANIZATION'S OFFICERS AND KEY EMPLOYEES, INCLUDING THE IHS CHIEF EXECUTIVE OFFICER (THE "CEO"). THIS ANNUAL REVIEW COMPARES THE TOTAL COMPENSATION AND VALUE OF BENEFITS PROVIDED TO EACH EXECUTIVE, ON A POSITION BY POSITION BASIS, TO THAT PROVIDED TO FUNCTIONALLY SIMILAR POSITIONS IN SIMILARLY SITUATED ORGANIZATIONS. THIS REVIEW IS CONDUCTED BY THE COMMITTEE WITH THE ASSISTANCE OF A NATIONAL, INDEPENDENT COMPENSATION CONSULTANT REPORTING DIRECTLY TO THE COMMITTEE. THE COMMITTEE HAS BEEN DELEGATED THE RESPONSIBILITY FOR OVERSIGHT OF EXECUTIVE COMPENSATION AND IS MADE UP ENTIRELY OF INDEPENDENT DIRECTORS WITHIN THE MEANING OF THE "REBUTTABLE PRESUMPTION OF REASONABLENESS" UNDER THE FEDERAL INCOME TAX INTERMEDIATE SANCTIONS RULES. THE COMPENSATION CONSULTANT HOLDS ITSELF OUT TO THE PUBLIC AS A COMPENSATION CONSULTANT, PERFORMS THESE VALUATIONS ON A REGULAR BASIS, IS QUALIFIED TO MAKE THE VALUATIONS OF THE SERVICES INVOLVED, AND HAS SO INDICATED IN A WRITTEN CERTIFICATION TO THE COMMITTEE.

BASED UPON THE ADVICE OF THE COMPENSATION CONSULTANT, AND APPLYING THE BOARD'S COMPENSATION PHILOSOPHY, THE COMMITTEE ESTABLISHES THE OVERALL ADJUSTMENT IN COMPENSATION AND BENEFITS FOR APPROXIMATELY THE TOP FIFTY EXECUTIVES IN THE ENTIRE HEALTH SYSTEM (SEVERAL OF WHICH ARE EMPLOYEES OF THE FILING ORGANIZATION) AND DELEGATES TO THE CEO THE AUTHORITY TO MAKE ADJUSTMENTS, CONSISTENT WITH THE COMMITTEE'S DIRECTION, FOR THE OTHER EXECUTIVES. THE COMMITTEE DETERMINES ALL ASPECTS OF THE COMPENSATION AND BENEFITS OF THE CEO. THE COMMITTEE INTENTIONALLY TAKES ALL THE STEPS NECESSARY TO QUALIFY FOR THE REBUTTABLE PRESUMPTION OF REASONABLENESS UNDER

Name of the organization: TRINITY MEDICAL CENTER

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THE FEDERAL INCOME TAX LAW INTERMEDIATE SANCTIONS RULES, INCLUDING CONTEMPORANEOUS SUBSTANTIATION OF ALL COMMITTEE MEETINGS AND ACTIONS. THE ORGANIZATION BELIEVES IT IS IN FULL COMPLIANCE WITH SECTION 4958 OF THE IRC, PROVIDES NO MORE THAN REASONABLE AND FAIR MARKET VALUE COMPENSATION AND BENEFITS FOR ITS EMPLOYEES AND DOES NOT PROVIDE ANY EXCESS COMPENSATION OR BENEFITS AS PROHIBITED BY SECTION 4958.

THE ANNUAL REVIEW OF COMPENSATION AND BENEFITS WAS LAST PERFORMED IN DECEMBER 2011 FOR THE FOLLOWING INDIVIDUALS: DAVID DEOPERE, MYKL GARRETT, WILLIAM LEAVER, GREG PAGLIUZZA, JR., RICHARD SEIDLER, JEFFREY STOLZE, KEVIN VERMEER, AND JAY WILLSHER.

THE COMPENSATION AND BENEFITS OF THE OTHER PERSONS LISTED ON FORM 990, PART VII WAS ESTABLISHED BY AN INDEPENDENT PERSON/COMMITTEE USING AN INDEPENDENT COMPENSATION CONSULTANT AND/OR COMPENSATION SURVEY OR STUDY FOR SIMILARLY QUALIFED PERSONS IN FUNCTIONALLY COMPARABLE POSITIONS AT SIMILARLY SITUATED ORGANIZATIONS. COMPENSATION AND BENEFITS ARE BASED ON THE FAIR MARKET VALUE OF THE SERVICES PROVIDED TO THE ORGANIZATION.

FORM 990, PART VI, SECTION C, LINE 19: IOWA HEALTH SYSTEM, OUR PARENT ORGANIZATION, HAS VOLUNTARILY ADOPTED MANY OF OUR INDUSTRY'S GOVERNANCE "BEST PRACTICES." IOWA HEALTH SYSTEM HAS DONE SO TO FURTHER ASSURE OUR STAKEHOLDERS THAT OUR GOVERNANCE AND MANAGEMENT IS CONDUCTED RESPONSIBLY AND WARRANTS THE TRUST YOU PLACE IN US.

IN SEPTEMBER 2003, THE IOWA HEALTH SYSTEM BOARD OF DIRECTORS VOLUNTARILY ADOPTED OVER 40 CHANGES TO ITS GOVERNANCE STRUCTURE TO BETTER COMPLY WITH GOVERNANCE BEST PRACTICES AND THE INTENT AND APPLICABLE REQUIREMENTS OF THE

Name of the organization: TRINITY MEDICAL CENTER

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SARBANES-OXLEY ACT OF 2003. IN ADDITION, GOVERNANCE POLICIES AND RELATED INFORMATION HAS BEEN ADDED TO THE IOWA HEALTH SYSTEM WEBSITE, WWW.IHS.ORG, INCLUDING BUT NOT LIMITED TO: OVER 130 CORPORATE COMPLIANCE POLICIES, INCLUDING CHARITY CARE AND CONFLICTS OF INTEREST POLICIES; GOVERNANCE BEST PRACTICE POLICIES; THE IDENTIFICATION OF BOARD MEMBERS AND BOARD COMMITTEES; COMPENSATION FOR HOSPITAL CEO'S; AND FINANCIAL INFORMATION FOR THE PAST SEVEN YEARS.

FORM 990, PART XI, LINE 5, CHANGES IN NET ASSETS:

NET UNREALIZED LOSSES ON INVESTMENTS:	-5,648,543.
CHANGE IN BENEFICIAL INTEREST IN TRINITY HEALTH FOUNDATION	149,564.
CHANGES IN PENSION LIABILITY	-245,090.
TOTAL TO FORM 990, PART XI, LINE 5	-5,744,069.

SCHEDULE R (Form 990)
Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 33, 34, 35, 36, or 37.
▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047
2011
Open to Public Inspection

Name of the organization: TRINITY MEDICAL CENTER

Employer identification number: 36-2739299

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

(a) Name, address, and EIN 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" to 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
ALLEN COLLEGE - 42-1351526 1825 LOGAN AVENUE WATERLOO, IA 50703	EDUCATE AND DEVELOP HEALTHCARE PROFESSIONALS	IOWA	501(C)(3)	170(B)(1)(A)(II)	ALLEN HEALTH SYSTEMS, INC.	X	
ALLEN HEALTH SYSTEMS, INC. - 42-1201924 1825 LOGAN AVENUE WATERLOO, IA 50703	SUPPORT AFFILIATES' MISSION TO IMPROVE HEALTH CARE	IOWA	501(C)(3)	509(A)(3), TYPE II	IOWA HEALTH SYSTEM	X	
ALLEN MEMORIAL HOSPITAL CORPORATION - 42-0698265, 1825 LOGAN AVENUE, WATERLOO, IA 50703	HOSPITAL	IOWA	501(C)(3)	170(B)(1)(A)(III)	ALLEN HEALTH SYSTEMS, INC.	X	
ANAMOSA AREA AMBULANCE SERVICE - 42-1466284 101 GRANT WOOD DRIVE ANAMOSA, IA 52205	PROVIDE AMBULANCE SERVICES	IOWA	501(C)(3)	509(A)(2)	ST. LUKE'S/JONES REGIONAL MEDICAL CENTER	X	

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

Part II **Continuation of Identification of Related Tax-Exempt Organizations**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled organization? Yes	No
CENTRAL IOWA HEALTH PROPERTIES CORPORATION - 42-1233759, 1200 PLEASANT STREET, DES MOINES, IA 50309	PROPERTY HOLDING COMPANY	IOWA	501(C)(2)		CENTRAL IOWA HEALTH SYSTEM	X	
CENTRAL IOWA HEALTH SYSTEM - 42-1189791 1200 PLEASANT STREET DES MOINES, IA 50309	SUPPORT AFFILIATES' MISSION TO IMPROVE HEALTH CARE	IOWA	501(C)(3)	509(A)(3), TYPE II	IOWA HEALTH SYSTEM	X	
CENTRAL IOWA HOSPITAL CORPORATION - 42-0680452, 1200 PLEASANT STREET, DES MOINES, IA 50309	HOSPITAL	IOWA	501(C)(3)	170(B)(1) (A)(III)	CENTRAL IOWA HEALTH SYSTEM	X	
FINLEY TRI-STATES HEALTH GROUP, INC. - 42-1307495, 350 NORTH GRANDVIEW AVENUE, DUBUQUE, IA 52001	SUPPORT AFFILIATES' MISSION TO IMPROVE HEALTH CARE	IOWA	501(C)(3)	509(A)(3), TYPE II	IOWA HEALTH SYSTEM	X	
HNC SERVICES - 27-0987243 1200 PLEASANT STREET DES MOINES, IA 50309	SUPPORT AFFILIATES' MISSION TO IMPROVE HEALTH CARE	IOWA	501(C)(3)	509(A)(2)	IOWA HEALTH SYSTEM	X	
INTEGRATED CARE ORGANIZATION - 27-4665007 1200 PLEASANT STREET DES MOINES, IA 50309	PROMOTE, SUPPPORT THE INTERESTS AND PURPOSES OF AFFILIATES' HOSPITALS	IOWA	501(C)(3)	509(A)(2)	IOWA HEALTH SYSTEM	X	
INTRUST - 42-1477471 11333 AURORA AVENUE URBANDALE, IA 50322	HOME HEALTH CARE	IOWA	501(C)(3)	509(A)(2)	IOWA HEALTH SYSTEM	X	
IOWA HEALTH FOUNDATION - 42-1467682 2700 GRAND AVE., SUITE 109 DES MOINES, IA 50312	CHARITABLE FUNDRAISING	IOWA	501(C)(3)	509(A)(3), TYPE III	CENTRAL IOWA HEALTH SYSTEM	X	
IOWA HEALTH SYSTEM - 42-1435199 1200 PLEASANT STREET DES MOINES, IA 50309	SUPPORT AFFILIATES' MISSION TO IMPROVE HEALTH CARE	IOWA	501(C)(3)	509(A)(3), TYPE III		X	
IOWA PHYSICIANS CLINIC MEDICAL FOUNDATION - 42-1411630, 8101 BIRCHWOOD COURT, JOHNSTON, IA 50131	PRIMARY HEALTH CARE SERVICES	IOWA	501(C)(3)	170(B)(1) (A)(III)	IOWA HEALTH SYSTEM	X	
MEMORIAL FOUNDATION OF ALLEN HOSPITAL - 42-1201138, 1825 LOGAN AVENUE, WATERLOO, IA 50703	CHARITABLE FUNDRAISING	IOWA	501(C)(3)	170(B)(1) (A)(VI)	ALLEN HEALTH SYSTEMS, INC.	X	
METHODIST HEALTH SERVICES CORPORATION - 37-1111135, 221 NORTHEAST GLEN OAK AVENUE, PEORIA, IL 61636	HEALTHCARE	ILLINOIS	501(C)(3)	509(A)(3), TYPE III	IOWA HEALTH SYSTEM	X	

Part II **Continuation of Identification of Related Tax-Exempt Organizations**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled organization? Yes	No
METHODIST MEDICAL CENTER FOUNDATION - 51-0186460, 221 NORTHEAST GLEN OAK AVENUE, PEORIA, IL 61636	FUNDRAISING	ILLINOIS	501(C)(3)	170(B)(1)(A)(VI)	METHODIST HEALTH SERVICES CORPORATION	X	
METHODIST MEDICAL CENTER OF ILLINOIS - 37-0661223, 221 NORTHEAST GLEN OAK AVENUE, PEORIA, IL 61636	HEALTHCARE	ILLINOIS	501(C)(3)	170(B)(1)(A)(III)	METHODIST HEALTH SERVICES CORPORATION	X	
METHODIST SERVICES, INC. - 37-1111134 221 NORTHEAST GLEN OAK AVENUE PEORIA, IL 61636	OFFICE RENTAL	ILLINOIS	501(C)(3)	509(A)(2)	METHODIST HEALTH SERVICES CORPORATION	X	
NELLIE R. SHERWOOD TRUST - 42-6061621 1026 A AVENUE NE CEDAR RAPIDS, IA 52402	PAY MEDICAL BILLS OF RETIRED TEACHERS UNABLE TO PAY	IOWA	501(C)(3)	509(A)(3), TYPE I	ST. LUKE'S METHODIST HOSPITAL	X	
NORTH CENTRAL IOWA MENTAL HEALTH CENTER, INCORPORATED - 42-0937390, 720 KENYON DRIVE, FORT DODGE, IA 50501	MENTAL HEALTH CARE	IOWA	501(C)(3)	170(B)(1)(A)(III)	TRINITY HEALTH SYSTEMS, INC.	X	
NORTHWEST IOWA HOSPITAL CORPORATION - 42-1019872, 2720 STONE PARK BLVD., SIOUX CITY, IA 51104	HOSPITAL	IOWA	501(C)(3)	170(B)(1)(A)(III)	IOWA HEALTH SYSTEM	X	
SELF INSURANCE TRUST AGREEMENT EST. BY METHODIST MEDICAL CENTER OF ILLINOIS , 221 NORTHEAST GLEN OAK AVENUE, PEORIA, IL 61636	FUND SELF-INSURANCE PLAN	ILLINOIS	501(C)(3)	509(A)(3), TYPE III	METHODIST MEDICAL CENER OF ILLINOIS	X	
SIOUXLAND PACE, INC. - 26-1120134 313 COOK STREET SIOUX CITY, IA 51103	ALL-INCLUSIVE CARE FOR THE ELDERLY	IOWA	501(C)(3)	170(B)(1)(A)(III)	ST. LUKE'S HEALTH SYSTEM, INC.	X	
ST. LUKE'S HEALTH RESOURCES - 42-1059182 2720 STONE PARK BLVD. SIOUX CITY, IA 51104	OUTPATIENT CLINICS AND HEALTHCARE SERVICES	IOWA	501(C)(3)	509(A)(2)	ST. LUKE'S HEALTH SYSTEM, INC.	X	
ST. LUKE'S HEALTH SYSTEM, INC. - 42-1294091 2720 STONE PARK BLVD. SIOUX CITY, IA 51104	SUPPORT AFFILIATES' MISSION TO IMPROVE HEALTH CARE	IOWA	501(C)(3)	509(A)(3), TYPE III	IOWA HEALTH SYSTEM	X	
ST. LUKE'S HEALTHCARE - 42-1487968 1026 A AVENUE NE CEDAR RAPIDS, IA 52402	SUPPORT AFFILIATES' MISSION TO IMPROVE HEALTH CARE	IOWA	501(C)(3)	509(A)(3), TYPE II	IOWA HEALTH SYSTEM	X	
ST. LUKE'S METHODIST HOSPITAL - 42-0504780 1026 A AVENUE NE CEDAR RAPIDS, IA 52402	HOSPITAL	IOWA	501(C)(3)	170(B)(1)(A)(III)	ST. LUKE'S HEALTHCARE	X	

Part II **Continuation of Identification of Related Tax-Exempt Organizations**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled organization? Yes	No
ST. LUKE'S/JONES REGIONAL MEDICAL CENTER - 42-1487967, 1795 HIGHWAY 64 EAST, ANAMOSA, IA 52205	HOSPITAL	IOWA	501(C)(3)	170(B)(1)(A)(III)	ST. LUKE'S HEALTHCARE	X	
STL CARE COMPANY - 42-1276632 1026 A AVENUE NE CEDAR RAPIDS, IA 52402	IMPROVE PUBLIC HEALTH SERVICES	IOWA	501(C)(3)	509(A)(2)	ST. LUKE'S HEALTHCARE	X	
THE DUBUQUE VISITING NURSE ASSOCIATION - 42-0680410, 350 NORTH GRANDVIEW AVENUE, DUBUQUE, IA 52001	PUBLIC HEALTH SERVICES/HOME CARE	IOWA	501(C)(3)	509(A)(2)	FINLEY TRI-STATES HEALTH GROUP, INC.	X	
THE FINLEY HOSPITAL - 42-0680354 350 NORTH GRANDVIEW AVENUE DUBUQUE, IA 52001	HOSPITAL	IOWA	501(C)(3)	170(B)(1)(A)(III)	FINLEY TRI-STATES HEALTH GROUP, INC.	X	
THE ROBERT YOUNG CENTER FOR COMMUNITY MENTAL HEALTH - 36-3678909, 2701 17TH STREET, ROCK ISLAND, IL 61201	MENTAL HEALTH CARE	ILLINOIS	501(C)(3)	170(B)(1)(A)(VI)	TRINITY REGIONAL HEALTH SYSTEM	X	
TPG HEALTH - 45-3791448 802 KENYON ROAD FORT DODGE, IA 50501	SUPPORT SERVICES FOR MEDICAL CARE AND HEALTH SERVICES	IOWA	501(C)(3)	170(B)(1)(A)(III)	TRINITY HEALTH SYSTEMS, INC.	X	
TRINITY BUILDING CORPORATION - 42-1376187 802 KENYON ROAD FORT DODGE, IA 50501	PROPERTY HOLDING COMPANY	IOWA	501(C)(2)		TRINITY HEALTH SYSTEMS, INC.	X	
TRINITY HEALTH FOUNDATION - 42-1222381 802 KENYON ROAD FORT DODGE, IA 50501	CHARITABLE FUNDRAISING	IOWA	501(C)(3)	170(B)(1)(A)(VI)	TRINITY HEALTH SYSTEMS, INC.	X	
TRINITY HEALTH FOUNDATION - 36-3321751 2701 17TH STREET ROCK ISLAND, IL 61201	CHARITABLE FUNDRAISING	ILLINOIS	501(C)(3)	170(B)(1)(A)(VI)	TRINITY REGIONAL HEALTH SYSTEM	X	
TRINITY HEALTH SYSTEMS, INC. - 42-1222877 802 KENYON ROAD FORT DODGE, IA 50501	SUPPORT AFFILIATES' MISSION TO IMPROVE HEALTH CARE	IOWA	501(C)(3)	509(A)(3), TYPE II	IOWA HEALTH SYSTEM	X	
TRINITY MEDICAL CENTER - 36-2739299 2701 17TH STREET ROCK ISLAND, IL 61201	HOSPITAL	ILLINOIS	501(C)(3)	170(B)(1)(A)(III)	TRINITY REGIONAL HEALTH SYSTEM	X	
TRINITY REGIONAL HEALTH SYSTEM - 36-3351952 2701 17TH STREET ROCK ISLAND, IL 61201	SUPPORT AFFILIATES' MISSION TO IMPROVE HEALTH CARE	ILLINOIS	501(C)(3)	509(A)(3), TYPE II	IOWA HEALTH SYSTEM	X	

Part II **Continuation of Identification of Related Tax-Exempt Organizations**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled organization? Yes	No
TRINITY REGIONAL HOSPITAL AUXILIARY - 42-6081474, 802 KENYON ROAD, FORT DODGE, IA 50501	CHARITABLE FUNDRAISING AND VOLUNTEER SERVICES	IOWA	501(C)(3)	509(A)(2)	TRINITY REGIONAL MEDICAL CENTER	X	
TRINITY REGIONAL MEDICAL CENTER - 42-1009175 802 KENYON ROAD FORT DODGE, IA 50501	HOSPITAL	IOWA	501(C)(3)	170(B)(1)(A)(III)	TRINITY HEALTH SYSTEMS, INC.	X	
UNITY HEALTHCARE - 42-0680337 1518 MULBERRY AVENUE MUSCATINE, IA 52761	HOSPITAL	IOWA	501(C)(3)	170(B)(1)(A)(III)	TRINITY REGIONAL HEALTH SYSTEM	X	

Part III **Identification of Related Organizations Taxable as a Partnership** (Complete if the organization answered "Yes" to 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? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
1776 WESTLAKES PARKWAY, L.C. - 20-5031651, 4949 WESTOWN PARKWAY, SUITE 200, WEST DES MOINES, IA 50266	OWNERSHIP/RENTA OF 2 COMMERCIAL OFFICE BUILDINGS	IA	N/A	UNRELATED	229,642.	12,309,952.		X	N/A	X		33.33%
ALLEN MEMORIAL HOSPITAL ORTHOPEDIC CO-MANAGEMENT CO., LLC - 45-3237125, 1825 LOGAN AVE, WATERLOO, IA 50703	ORTHOPEDIC MANAGEMENT & ADMINISTRATIVE SERVICES	IA	N/A	RELATED	22,920.	39,683.		X	N/A		X	20.00%
CENTRAL ILLINOIS CANCER CARE CENTER, L.L.C. - 26-1128108, 7309 N. KNOXVILLE, PEORIA, IL 61614	RADIATION THERAPY	IL	N/A	RELATED	1,031,613.	1,886,570.		X	N/A	X		50.00%
CENTRAL IOWA CARDIOVASCULAR CO-MANAGEMENT CO., L.L.C. - 27-3625869, 1200 PLEASANT ST, DES MOINES, IA 50309	CARDIOVASCULAR MANAGEMENT & ADMINISTRATIVE SERVICES	IA	N/A	RELATED	281,022.	87,957.		X	N/A		X	20.00%

Part IV **Identification of Related Organizations Taxable as a Corporation or Trust** (Complete if the organization answered "Yes" to 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
BROADBAND, INC. - 27-3819741 1200 PLEASANT ST DES MOINES, IA 50309	INFORMATION TECHNOLOGY MGMT.	IA	IHS	C CORP	338,870.	13,238,641.	100%
CHARITABLE REMAINDER UNITRUST #1	INVESTMENT	IA	SLHCF	TRUST			
CHARITABLE REMAINDER UNITRUST #2	INVESTMENT	IA	SLHCF	TRUST			
CHARITABLE REMAINDER UNITRUST #3	INVESTMENT	IA	SLHCF	TRUST			
CHARITABLE REMAINDER UNITRUST #6	INVESTMENT	IA	SLHCF	TRUST			

Part III **Continuation of Identification of Related Organizations Taxable as a Partnership**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
DES MOINES PARKING ASSOCIATES - 38-2622972, 1200 PLEASANT ST, DES MOINES, IA 50309	PARKING DECK OPERATIONS	IA	CENTRAL IA HEALTH PROP CORP	RELATED	540,801.	3,772,221.		X	N/A	X		100%
DUBUQUE ENDOSCOPY CENTER, L.C. - 20-1597161, 1515 DELHI STREET, SUITE 500, DUBUQUE, IA 52001	AMBULATORY SURGERY CENTER	IA	THE FINLEY HOSPITAL	RELATED	660,133.	210,769.		X	N/A	X		51.00%
ENSEVA - HIAWATHA, L.L.C. - 45-3437363, 524 PARK ROAD, WATERLOO, IA 50704	COLLOCATION FACILITY	IA	IOWA HEALTH SYSTEM	RELATED	2,624.	2,203,353.		X	N/A		X	52.00%
FINLEY DEPT. OF SURGERY CO-MGMT. CO,, LLC - 42-2808785, 350 N GRANDVIEW AVE, DUBUQUE, IA 52001	SURGERY DEPARTMENT MANAGEMENT SERVICES	IA	N/A	RELATED	101,716.	208,966.		X	N/A		X	50.00%
FINLEY/HARTIG HOMECARE, L.L.C. - 42-1487138, 703 MAIN ST, DUBUQUE, IA 52001	SALE/RENTAL OF MEDICAL EQUIPMENT	IA	N/A	RELATED	132,479.	842,404.		X	N/A	X		50.00%
HEALTH CARE AFFILIATES OF THE TRI-STATES, L.L.C. - 42-1428503, 350 N. GRANDVIEW AVE, DUBUQUE, IA 52001	PROVIDE ACCESS TO LICENSED SOFTWARE	IA	N/A	RELATED	0.	14,037.		X	N/A	X		50.00%
HEALTH ENTERPRISES VENTURES, L.C. - 39-1894290, 4250 GLASS ROAD NE, CEDAR RAPIDS, IA 52402	INVESTMENT VEHICLE OWNING CLINICAL JVS	IA	N/A	UNRELATED	89,797.	817,011.		X	57,299.		X	55.67%
HY-VEE/IOWA HEALTH, L.C. - 26-3293530, 5820 WESTOWN PARKWAY, WEST DES MOINES, IA 50266	PRIMARY CARE CLINIC	IA	N/A	RELATED	-175,705.	44,300.		X	N/A	X		50.00%
IOWA DIAGNOSTIC IMAGING AND PROCEDURE CENTER, L.C. - 03-0482623, 1200 PLEASANT STREET, DES MOINES, IA 50309	OUTPATIENT DIAGNOSTIC IMAGING	IA	N/A	RELATED	1,323,429.	2,917,182.		X	N/A	X		50.00%

Part III **Continuation of Identification of Related Organizations Taxable as a Partnership**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
IOWA HEALTH SYSTEM CONTRACTING SERVICES LC - 42-1511142, 1200 PLEASANT STREET, DES MOINES, IA 50309	GROUP PURCHASING	IA	N/A	RELATED	4,775,894.	15,888,961.		X	N/A	X		100%
LAKEVIEW SURGERY CENTER, L.C. - 42-1516120, 1200 PLEASANT STREET, DES MOINES, IA 50309	SURGERY CENTER	IA	N/A	RELATED	3,443,692.	4,825,696.		X	N/A	X		50.00%
MEDICAL LABORATORIES OF EASTERN IOWA, L.C. - 42-1359640, 1026 A AVE NE, CEDAR RAPIDS, IA 52402	MEDICAL LABORATORY SERVICES	IA	N/A	RELATED	664,320.	870,817.		X	N/A	X		50.00%
METRO MRI CENTER LIMITED PARTNERSHIP - 36-3710164, 615 VALLEY VIEW DRIVE, SUITE 102, MOLINE, IL 61265	PROVIDE MRI AND OTHER MEDICAL SERVICES	IL	N/A	RELATED	600,876.	1,499,952.		X	N/A	X		33.97%
MR ASSOCIATES, LLP - 42-1260463, 1455 SHERMAN ROAD, HIAWATHA, IA 52233	OWN AND OPERATE MR UNIT	IA	N/A	RELATED	2,540,143.	1,416,839.		X	N/A	X		33.33%
NE IA PHYSICAL THERAPY AND SPORTS MEDICINE, L.L.C. - 20-2124978, 1825 LOGAN AVE, WATERLOO, IA 50703	ATHLETIC TRAINING AND SPORTS MEDICINE	IA	N/A	RELATED	-41,070.	0.		X	N/A	X		.00%
ORTHOPAEDIC OUTPATIENT SURGERY CENTER, L.C. - 42-1508092, 1200 PLEASANT STREET, DES MOINES, IA 50309	AMBULATORY SURGERY CENTER	IA	N/A	RELATED	3,314,858.	3,461,181.		X	N/A	X		50.00%
PIERCE STREET SAME DAY SURGERY, L.C. - 20-5895205, 2730 PIERCE STREET, SIOUX CITY, IA 51104	AMBULATORY SURGERY CENTER	IA	N/A	RELATED	931,816.	3,357,708.		X	N/A	X		50.00%
QUAD CITY AMBULATORY SURGERY CENTER, L.L.C. - 36-4471903, 520 VALLEY VIEW DRIVE, SUITE 300, MOLINE, IL 61265	AMBULATORY SURGERY CENTER.	IL	N/A	RELATED	255,765.	3,500,259.		X	N/A	X		50.00%

Part III **Continuation of Identification of Related Organizations Taxable as a Partnership**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
REHABILITATION THERAPY SERVICES, L.L.C. - 81-0584193, 416 ST. MARK'S CT, #110, PEORIA, IL 61603	REHABILATION THERAPY	IL	METHODIST MEDICAL CENTER OF ILLINOIS	RELATED	448,732.	1,397,476.		X	N/A	X		60.03%
THE OUTPATIENT SURGERY CENTER OF CEDAR RAPIDS, L.L.C. - 72-1550812, 1075 FIRST AVENUE SE, CEDAR RAPIDS, IA 52403	AMBULATORY SURGERY CENTER.	IA	N/A	RELATED	3,310,383.	7,115,889.		X	N/A	X		50.00%
TRINITY BETTENDORF ORTHOPEDIC CO-MANAGEMENT COMPANY, LLC - 27-2562753, 4500 UTICA RIDGE RD, BETTENDORF, IA 52722	ORTHOPEDIC SERVICE LINES ADMINISTRATIVE SERVICES	IA	N/A	RELATED	175,377.	118,891.		X	N/A	X		50.00%
TRI-WEBSTER, L.C. - 01-0740062, 1610 COLLINS ST, WEBSTER CITY, IA 50595	MEDICAL BUILDING AND SURROUNDING PROPERTY	IA	N/A	RELATED	110,738.	1,715,230.		X	N/A	X		50.00%
WEST HOSPITAL ORTHOPEDIC CO-MANAGEMENT COMPANY, LLC - 27-1414600, 1660 60TH STREET, WEST DES MOINES, IA 50266	ORTHOPEDIC SERVICE LINES MANAGEMENT	IA	N/A	RELATED	244,306.	26,600.		X	N/A	X		20.00%
WEST LAKES MEDICAL EQUIPMENT, LLC - 26-3300536, 5950 UNIVERSITY AVENUE SUITE 321, WEST DES MOINES, IA 50266	MEDICAL EQUIPMENT SALES AND RENTAL	IA	N/A	UNRELATED	59,770.	171,967.		X	59,770.	X		50.00%
WEST LAKES SLEEP CENTER, LLC - 26-3193923, 5950 UNIVERSITY AVENUE SUITE 2, WEST DES MOINES, IA 50266	SLEEP DISORDER DIAGNOSTIC TESTING FACILITY	IA	N/A	RELATED	92,541.	318,508.		X	N/A	X		50.00%

Part IV **Continuation of Identification of Related Organizations Taxable as a Corporation or Trust**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership
IOWA HEALTH SYSTEM 457 DEF COMP PLAN - 42-1435199 1415 WOODLAND AVE, 2ND FL. DES MOINES, IA 50309	INVESTMENT	IA	IHS	TRUST	266,087.	4,546,270.	100%
METHODIST HEALTH VENTURES, INC. - 37-1140939 P.O. BOX 87 PEORIA, IL 61650	PHARMACY/OFFICE STAFFING	IL	MHSC	C CORP	868,566.	2,437,393.	100%
MEDIMORE, INC. - 42-1414390 1200 PLEASANT ST DES MOINES, IA 50309	MANAGED CARE	IA	IHS	C CORP	210,170.	0.	100%
METHODIST PHYSICIAN SERVICES, INC. - 36-3858550 P.O. BOX 87 PEORIA, IL 61650	MEDICAL SERVICES	IL	MHVI	C CORP	11,908,671.	1,305,915.	100%
PRECEDENCE, INC. - 37-1288604 4622 PROGRESS DRIVE, STE A DAVENPORT, IA 52807	MANAGED MENTAL CARE	IA	RYC	C CORP	506,534.	435,657.	100%
PROVIDER RESOURCE MANAGEMENT, INC. - 37-1223550 P.O. BOX 87 PEORIA, IL 61650	RESOURCE MANAGEMENT	IL	MHSC	C CORP	0.	57,427.	100%
RURAL IOWA SPECIALTY PHYSICIAN CONSORTIUM, INC. - 26-1271143, 700 E UNIVERSITY AVE, DES MOINES, IA 50316	SPECIALTY PHYSICIANS MEDICAL CARE	IA	CIHC	C CORP	481,860.	198,055.	57.00%
STL HEALTH RESOURCES CO. - 42-1193499 1026 A AVE NE CEDAR RAPIDS, IA 52402	PHYSICIAN OFFICE RENTAL	IA	SLMH	C CORP	322,129.	5,577,505.	100%
TRIMARK PHYSICIANS GROUP, INC. - 42-1335554 802 KENYON ROAD FORT DODGE, IA 50501	MEDICAL CLINICS	IA	THS	C CORP	44,216,247.	0.	100%
TRINITY HEALTH ENTERPRISES, INC. - 36-3320141 2701 17TH ST ROCK ISLAND, IL 61201	RETAIL DURABLE MEDICAL EQUIPMENT & PHARMACY	IL	TRHS	C CORP	3,295,832.	2,957,465.	100%

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

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

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

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

	(a) Name of other organization	**(b)** Transaction type (a-r)	**(c)** Amount involved	**(d)** Method of determining amount involved
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				

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

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

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

Part VII Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule R (see instructions).

SCHEDULE R, PART II, COLUMN (G)

SECTION 512(B)(13) CONTROLLED ENTITY

THE ORGANIZATION IS A MEMBER OF A CONSOLIDATED HEALTH SYSTEM AND HAS A COMMON PARENT ORGANIZATION, "IOWA HEALTH SYSTEM." FOR ENTITIES THAT ARE PART OF THE CONSOLIDATED HEALTH SYSTEM (WITH COMMON CONTROL) THE ATTRIBUTION RULES OF IRC SECTION 318 APPLY; MEANING THAT ALL ORGANIZATIONS ARE DEEMED TO HAVE CONTROL OF THE ORGANIZATIONS OWNED BY THE CONTROLLING ORGANIZATION. AS SUCH, WE ARE REPORTING ALL RELATED ORGANIZATIONS OF THE HEALTH SYSTEM IN PARTS II, III & IV. FOR PART V REPORTING, THE TRANSACTIONS DISCLOSED ARE THOSE BETWEEN THE DIRECTLY CONTROLLED PARENT-SUBSIDIARY ONLY.