

Form **990**

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

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

2021

Department of the Treasury
Internal Revenue Service

▶ Do not enter social security numbers on this form as it may be made public.
▶ Go to www.irs.gov/Form990 for instructions and the latest information.

Open to Public Inspection

A For the 2021 calendar year, or tax year beginning and ending

| | | | |
|--|--|--|--|
| B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending | C Name of organization UNITY HEALTHCARE | | D Employer identification number 42-0680337 |
| | Doing business as TRINITY MUSCATINE | | E Telephone number 309-779-2200 |
| | Number and street (or P.O. box if mail is not delivered to street address) | Room/suite | G Gross receipts \$ 112,090,274. |
| | 1518 MULBERRY AVENUE | | H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | City or town, state or province, country, and ZIP or foreign postal code MUSCATINE, IA 52761 | | H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| F Name and address of principal officer: ROBERT ERICKSON SAME AS C ABOVE | | If "No," attach a list. See instructions | |
| I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527 | | | |
| J Website: WWW.UNITYPOINT.ORG (SEE SCH O) | | | |
| K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other | | L Year of formation: 1941 | M State of legal domicile: IA |

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 <input type="checkbox"/> 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 | 15 |
| | 4 Number of independent voting members of the governing body (Part VI, line 1b) | 4 | 9 |
| | 5 Total number of individuals employed in calendar year 2021 (Part V, line 2a) | 5 | 431 |
| | 6 Total number of volunteers (estimate if necessary) | 6 | 441 |
| | 7 a Total unrelated business revenue from Part VIII, column (C), line 12 | 7a | 0. |
| b Net unrelated business taxable income from Form 990-T, Part I, line 11 | 7b | 0. | |
| Revenue | 8 Contributions and grants (Part VIII, line 1h) | Prior Year 6,909,181. | Current Year 2,458,460. |
| | 9 Program service revenue (Part VIII, line 2g) | 47,812,405. | 55,796,915. |
| | 10 Investment income (Part VIII, column (A), lines 3, 4, and 7d) | 601,216. | 1,109,331. |
| | 11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) | 1,410,544. | 619,640. |
| | 12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12) | 56,733,346. | 59,984,346. |
| | Expenses | 13 Grants and similar amounts paid (Part IX, column (A), lines 1-3) | 7,543. |
| 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) | | 30,590,296. | 32,682,271. |
| 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) | | 20,911,651. | 21,949,584. |
| 18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25) | 51,509,490. | 54,694,373. | |
| 19 Revenue less expenses. Subtract line 18 from line 12 | 5,223,856. | 5,289,973. | |
| Net Assets or Fund Balances | 20 Total assets (Part X, line 16) | Beginning of Current Year 61,157,332. | End of Year 66,493,219. |
| | 21 Total liabilities (Part X, line 26) | 33,504,729. | 34,078,688. |
| | 22 Net assets or fund balances. Subtract line 21 from line 20 | 27,652,603. | 32,414,531. |

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 | | |
| | KATHERINE MARCHIK, SR 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 <input type="checkbox"/> | PTIN |
| | Firm's name | Firm's EIN | | Phone no. | |
| | Firm's address | | | | |

May the IRS discuss this return with the preparer shown above? See instructions Yes No

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission: THE MISSION OF TRINITY-MUSCATINE 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

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

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses.

4a (Code:) (Expenses \$ 49,343,771. including grants of \$ 0.) (Revenue \$ 56,229,232.)

HEALTH-CARE SERVICES

UNITY HEALTHCARE IS AN IMPORTANT ELEMENT OF THE HEALTH-CARE DELIVERY SYSTEM THAT THE MUSCATINE COMMUNITIES RELY ON EVERY DAY. IT IS COMMITTED TO PROVIDING QUALITY HEALTH CARE AND TO USING ITS RESOURCES TO THE GREATEST COMMUNITY BENEFIT.

UNITY HEALTHCARE 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, HANDICAP, AGE OR ABILITY TO COMPENSATE FOR SERVICES RENDERED. THESE INCLUDE, BUT

4b (Code:) (Expenses \$ 1,762,957. including grants of \$ 62,518.) (Revenue \$ 0.)

COMMUNITY BENEFIT, INCLUDING CHARITY CARE

CHARITY CARE AND MEANS-TESTED PROGRAMS: UNITY HEALTHCARE 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 AT A VALUE OF \$387,200 IN 2021. OFTENTIMES, UNITY HEALTHCARE RECEIVES PAYMENTS FROM PAYORS OR PATIENTS THAT ARE LESS THAN IT CHARGES FOR SERVICES. UNITY HEALTHCARE PARTICIPATES IN MEDICAID AND OTHER GOVERNMENT-SPONSORED HEALTH-CARE PROGRAMS. UNITY HEALTHCARE'S NET COST OF PROVIDING CARE FOR WHICH IT RECEIVES PAYMENT

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

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

4e Total program service expenses 51,106,728.

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

| | Yes | No |
|---|-----|----|
| 22 Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i> | | 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? <i>If "Yes," complete Schedule J</i> | 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? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i> | X | |
| b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? | | X |
| 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? | | X |
| d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? | | X |
| 25a Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i> | | 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? <i>If "Yes," complete Schedule L, Part I</i> | | X |
| 26 Did the organization report any amount on Part X, line 5 or 22, for receivables from or payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part II</i> | | X |
| 27 Did the organization provide a grant or other assistance to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity (including an employee thereof) or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i> | | X |
| 28 Was the organization a party to a business transaction with one of the following parties (see the Schedule L, Part IV, instructions for applicable filing thresholds, conditions, and exceptions): | | |
| a A current or former officer, director, trustee, key employee, creator or founder, or substantial contributor? <i>If "Yes," complete Schedule L, Part IV</i> | X | |
| b A family member of any individual described in line 28a? <i>If "Yes," complete Schedule L, Part IV</i> | | X |
| c A 35% controlled entity of one or more individuals and/or organizations described in line 28a or 28b? <i>If "Yes," complete Schedule L, Part IV</i> | | X |
| 29 Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i> | | X |
| 30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i> | | X |
| 31 Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i> | | X |
| 32 Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i> | | 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? <i>If "Yes," complete Schedule R, Part I</i> | | X |
| 34 Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i> | X | |
| 35a Did the organization have a controlled entity within the meaning of section 512(b)(13)? | X | |
| b If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i> | | X |
| 36 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i> | | 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? <i>If "Yes," complete Schedule R, Part VI</i> | | X |
| 38 Did the organization complete Schedule O and provide explanations on Schedule O for Part VI, lines 11b and 19? | X | |

Note: All Form 990 filers are required to complete Schedule O

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

| | Yes | No |
|---|-----|----|
| 1a Enter the number reported in box 3 of Form 1096. Enter -0- if not applicable | | |
| b Enter the number of Forms W-2G included on line 1a. Enter -0- if not applicable | | |
| c Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? | | |

Part V Statements Regarding Other IRS Filings and Tax Compliance (continued)

Table with columns for question number, question text, and Yes/No response boxes. Includes questions 2a through 17 regarding employee counts, tax filings, and organizational activities.

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 on Schedule O. See instructions.

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

Section A. Governing Body and Management

| | | Yes | No |
|-----------|--|-----|----|
| 1a | Enter the number of voting members of the governing body at the end of the tax year If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain on Schedule O. | | |
| | 1a | 15 | |
| b | Enter the number of voting members included on line 1a, above, who are independent | | |
| | 1b | 9 | |
| 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? | | X |
| 3 | Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, trustees, or key employees to a management company or other person? | | X |
| 4 | Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? | | X |
| 5 | Did the organization become aware during the year of a significant diversion of the organization's assets? | | X |
| 6 | Did the organization have members or stockholders? | 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? | 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? | X | |
| 8 | Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: | | |
| a | The governing body? | X | |
| b | Each committee with authority to act on behalf of the governing body? | 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 on Schedule O | | 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? | | 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? | X | |
| b | Describe on 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 | X | |
| b | Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? | X | |
| c | Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe on Schedule O how this was done | X | |
| 12c | | | |
| 13 | Did the organization have a written whistleblower policy? | X | |
| 14 | Did the organization have a written document retention and destruction policy? | 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 | X | |
| b | Other officers or key employees of the organization | X | |
| | If "Yes" to line 15a or 15b, describe the process on 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? | | 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 | | | |

Section C. Disclosure

- 17** List the states with which a copy of this Form 990 is required to be filed **NONE**
- 18** Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A, 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.
 Own website Another's website Upon request Other (explain on Schedule O)
- 19** Describe on Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
- 20** State the name, address, and telephone number of the person who possesses the organization's books and records **DAVE DELLITT, DIR OF FINANCE/CONTROLLER - 309-779-2200**
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 or note to any line in this Part VII

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

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

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
 - List all of the organization's **current** key employees, if any. See the 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, Form 1099-MISC, and/or box 1 of Form 1099-NEC) 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.
- See the instructions for the order in which to list the persons above.

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

| (A) Name and title | (B) Average hours per week (list any hours for related organizations below line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W-2/1099-MISC/1099-NEC) | (E) Reportable compensation from related organizations (W-2/1099-MISC/1099-NEC) | (F) Estimated amount of other compensation from the organization and related organizations |
|---|---|---|-----------------------|---------|--------------|------------------------------|--------|---|--|---|
| | | Individual trustee or director | Institutional trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| JOHN SHEEHAN (TO 9/19) FORMER BD MEMBER/INTERIM PRES/CEO | 0.00 40.00 | | | | | | X | 0. | 928,920. | 169,378. |
| ROBERT ERICKSON BOARD MEMBER/PRESIDENT/CEO | 1.00 40.00 | X | | X | | | | 0. | 696,665. | 154,427. |
| TOYOSI OLUTADE, MD CHIEF MEDICAL OFFICER | 1.00 40.00 | | | X | | | | 0. | 804,731. | 37,765. |
| RHONDA SOWARDS MEDICAL DIRECTOR | 40.00 0.00 | | | | X | | | 0. | 647,483. | 37,679. |
| KATHERINE MARCHIK SR VP FINANCE/CFO | 1.00 40.00 | | | X | | | | 0. | 451,012. | 107,046. |
| JOY LEDBETTER (FR 5/21) VP HUMAN RESOURCES | 1.00 40.00 | | | | X | | | 0. | 522,510. | 34,928. |
| YACOB ZAYADIN, MD (FR 8/21) BOARD MEMBER | 1.00 0.00 | X | | | | | | 0. | 391,983. | 23,718. |
| RICHARD SEIDLER (TO 5/19) FORMER BD MEMBER/PRESIDENT/CEO | 0.00 0.00 | | | | | | X | 0. | 411,367. | 0. |
| ROBERT WEIS, MD BOARD MEMBER | 1.00 40.00 | X | | | | | | 0. | 320,342. | 36,124. |
| ANGELA JOHNSON (TO 10/21) VP HR/VP OPERATIONS | 40.00 1.00 | | | X | | | | 249,873. | 39,882. | 34,081. |
| ROBERT CARLSON, MD (FR 1/21- TO 5/21) BOARD MEMBER | 1.00 0.00 | X | | | | | | 0. | 271,951. | 23,831. |
| JASON THORNBURG, PA-C PHYSICIANS ASSISTANT | 40.00 0.00 | | | | X | | | 228,207. | 0. | 37,319. |
| JENNY OLSON, DNP NURSE PRACTITIONER | 40.00 0.00 | | | | X | | | 208,658. | 0. | 29,932. |
| PEGGY CREAMER, ARNP NURSE PRACTITIONER | 40.00 0.00 | | | | X | | | 193,474. | 0. | 26,134. |
| MARIA-TERESA GALOSO, MD BOARD MEMBER | 1.00 0.00 | X | | | | | | 0. | 183,638. | 34,374. |
| ASHLEY WELLER, PA-C PHYSICIANS ASSISTANT | 40.00 0.00 | | | | X | | | 174,123. | 0. | 25,331. |
| ANDREA WALSH, PA-C PHYSICIANS ASSISTANT | 40.00 0.00 | | | | X | | | 170,901. | 0. | 23,367. |

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

| (A) Name and title | (B) Average hours per week (list any hours for related organizations below line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W-2/1099-MISC/1099-NEC) | (E) Reportable compensation from related organizations (W-2/1099-MISC/1099-NEC) | (F) Estimated amount of other compensation from the organization and related organizations |
|--|---|---|-----------------------|---------|--------------|------------------------------|--------|---|--|---|
| | | Individual trustee or director | Institutional trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| PAMELA F. ASKEW VP PATIENT CARE | 40.00 0.00 | | | | X | | | 163,901. | 0. | 20,113. |
| BENJAMIN POHL, PA-C (FR 1/21) BOARD MEMBER | 40.00 0.00 | X | | | | | | 153,431. | 0. | 14,039. |
| CLINT CHRISTOPHER (FR 1/21) BOARD MEMBER | 1.00 0.00 | X | | | | | | 0. | 0. | 0. |
| TONI ELLER, OD BOARD MEMBER | 1.00 1.00 | X | | | | | | 0. | 0. | 0. |
| TROY FRIDLEY BOARD MEMBER | 1.00 0.00 | X | | | | | | 0. | 0. | 0. |
| SCOTT NATVIG BOARD SECRETARY | 1.00 0.00 | X | | X | | | | 0. | 0. | 0. |
| MARK PETERSON BOARD MEMBER | 1.00 0.00 | X | | | | | | 0. | 0. | 0. |
| CHARLA SCHAFFER BOARD VICE CHAIR | 1.00 0.00 | X | | X | | | | 0. | 0. | 0. |
| DANIEL STEIN BOARD CHAIR | 1.00 1.00 | X | | X | | | | 0. | 0. | 0. |
| 1b Subtotal | | | | | | | | 1,542,568. | 5,670,484. | 869,586. |
| c Total from continuation sheets to Part VII, Section A | | | | | | | | 0. | 0. | 0. |
| d Total (add lines 1b and 1c) | | | | | | | | 1,542,568. | 5,670,484. | 869,586. |

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 **22**

| | Yes | No |
|--|-----|----|
| 3 Did the organization list any former officer, director, trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual | 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 | 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 | | 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 |
|---|--------------------------------|---------------------|
| RIVERBEND ANESTHESIA P.C. 1710 COBBLESTONE DR, MUSCATINE, IA 52761 | ANESTHESIA/CRNA SERVICES | 1,771,275. |
| ESTES COMPANY LLC, 220 SW 9TH ST SUITE 180, DES MOINES, IA 50309 | CONSTRUCTION SERVICES | 1,192,062. |
| AYA LOCUMS LLC, 5930 CORNERSTONE CT W SUITE 300, SAN DIEGO, CA 92121 | EMPLOYMENT SERVICES | 685,854. |
| ARAMARK SERVICES INC 27310 NETWORK PLACE, CHICAGO, IL 60673 | FOOD & FACILITY SVCS | 529,761. |
| PEORIA TAZEWELL PATHOLOGY GROUP 221 NE GLEN OAK, PEORIA, IL 61636 | MEDICAL SERVICES | 274,823. |

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 **9**

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 (list any hours for related organizations below line) | (C) Position (check all that apply) | | | | | | (D) Reportable compensation from the organization (W-2/1099-MISC) | (E) Reportable compensation from related organizations (W-2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|---|---|--|-----------------------|---------|--------------|------------------------------|--------|--|---|---|
| | | Individual trustee or director | Institutional trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| CANDACE TERRILL BOARD TREASURER | 1.00 0.00 | | X | | X | | | 0. | 0. | 0. |
| GUADALUPE VAZQUEZ (TO 8/21) BOARD MEMBER | 1.00 0.00 | | X | | | | | 0. | 0. | 0. |
| CAROL WEBB BOARD MEMBER | 1.00 0.00 | | X | | | | | 0. | 0. | 0. |
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| | | | | | | | | | | |
| Total to Part VII, Section A, line 1c | | | | | | | | | | |

Part VIII Statement of Revenue

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

| | | | (A) | (B) | (C) | (D) | |
|---|---|----------------------|----------------|------------------------------------|----------------------------|--|--|
| | | | Total revenue | Related or exempt function revenue | Unrelated business revenue | Revenue excluded from tax under sections 512 - 514 | |
| Contributions, Gifts, Grants and Other Similar Amounts | 1 a Federated campaigns | 1a | | | | | |
| | b Membership dues | 1b | | | | | |
| | c Fundraising events | 1c | | | | | |
| | d Related organizations | 1d | 44,985. | | | | |
| | e Government grants (contributions) | 1e | 2,208,309. | | | | |
| | f All other contributions, gifts, grants, and similar amounts not included above | 1f | 205,166. | | | | |
| | g Noncash contributions included in lines 1a-1f | 1g | \$ | | | | |
| | h Total. Add lines 1a-1f | | | 2,458,460. | | | |
| Program Service Revenue | 2 a NET PATIENT REVENUE | Business Code | 900099 | 55,523,540. | 55523540. | | |
| | b RENTAL INCOME | | 531390 | 224,209. | 224,209. | | |
| | c MGMT & SUPPORT SVCS | | 561000 | 49,166. | 49,166. | | |
| | d | | | | | | |
| | e | | | | | | |
| | f All other program service revenue | | | | | | |
| | g Total. Add lines 2a-2f | | | 55,796,915. | | | |
| Other Revenue | 3 Investment income (including dividends, interest, and other similar amounts) | | | 440,467. | | 440,467. | |
| | 4 Income from investment of tax-exempt bond proceeds | | | | | | |
| | 5 Royalties | | | | | | |
| | 6 a Gross rents | 6a | (i) Real | | | | |
| | | | (ii) Personal | | | | |
| | | | | | | | |
| | b Less: rental expenses | 6b | | | | | |
| | c Rental income or (loss) | 6c | | | | | |
| | d Net rental income or (loss) | | | | | | |
| | 7 a Gross amount from sales of assets other than inventory | 7a | (i) Securities | 52,729,315. | 45,477. | | |
| | | | (ii) Other | | | | |
| | | | | | | | |
| | b Less: cost or other basis and sales expenses | 7b | 52,023,964. | 81,964. | | | |
| c Gain or (loss) | 7c | 705,351. | -36,487. | | | | |
| d Net gain or (loss) | | | 668,864. | | 668,864. | | |
| 8 a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18 | 8a | | | | | | |
| | | | | | | | |
| | | | | | | | |
| b Less: direct expenses | 8b | | | | | | |
| c Net income or (loss) from fundraising events | | | | | | | |
| 9 a Gross income from gaming activities. See Part IV, line 19 | 9a | | | | | | |
| | | | | | | | |
| | | | | | | | |
| b Less: direct expenses | 9b | | | | | | |
| c Net income or (loss) from gaming activities | | | | | | | |
| 10 a Gross sales of inventory, less returns and allowances | 10a | | | | | | |
| | | | | | | | |
| | | | | | | | |
| b Less: cost of goods sold | 10b | | | | | | |
| c Net income or (loss) from sales of inventory | | | | | | | |
| Miscellaneous Revenue | 11 a MISCELLANEOUS | Business Code | 900099 | 605,663. | 605,663. | | |
| | b CAFETERIA/FOOD SVCS | | 722210 | 187,323. | | 187,323. | |
| | c SHARED SAVINGS REVENUE | | 900099 | -173,346. | -173,346. | | |
| | d All other revenue | | | | | | |
| | e Total. Add lines 11a-11d | | | 619,640. | | | |
| 12 Total revenue. See instructions | | | 59,984,346. | 56229232. | 0. | 1296654. | |

Part IX Statement of Functional Expenses

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

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

| Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII. | (A) Total expenses | (B) Program service expenses | (C) Management and general expenses | (D) Fundraising expenses |
|--|-----------------------|---------------------------------|--|-----------------------------|
| 1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 ... | 62,518. | 62,518. | | |
| 2 Grants and other assistance to domestic individuals. See Part IV, line 22 | | | | |
| 3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16 | | | | |
| 4 Benefits paid to or for members | | | | |
| 5 Compensation of current officers, directors, trustees, and key employees | 628,570. | 167,470. | 461,100. | |
| 6 Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) | 113,066. | 113,066. | | |
| 7 Other salaries and wages | 25,906,218. | 23,767,697. | 2,138,521. | |
| 8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions) | 716,348. | 657,215. | 59,133. | |
| 9 Other employee benefits | 3,794,466. | 3,481,238. | 313,228. | |
| 10 Payroll taxes | 1,523,603. | 1,397,832. | 125,771. | |
| 11 Fees for services (nonemployees): | | | | |
| a Management | 6,710,428. | 6,710,428. | | |
| b Legal | 104,035. | | 104,035. | |
| c Accounting | | | | |
| d Lobbying | | | | |
| e Professional fundraising services. See Part IV, line 17 | | | | |
| f Investment management fees | 101,217. | 57,139. | 44,078. | |
| g Other. (If line 11g amount exceeds 10% of line 25, column (A), amount, list line 11g expenses on Sch O.) | 3,924,325. | 3,863,884. | 60,441. | |
| 12 Advertising and promotion | 22,228. | 806. | 21,422. | |
| 13 Office expenses | 412,548. | 403,385. | 9,163. | |
| 14 Information technology | | | | |
| 15 Royalties | | | | |
| 16 Occupancy | 2,007,411. | 1,972,979. | 34,432. | |
| 17 Travel | 35,545. | 35,082. | 463. | |
| 18 Payments of travel or entertainment expenses for any federal, state, or local public officials ... | | | | |
| 19 Conferences, conventions, and meetings | 592. | 242. | 350. | |
| 20 Interest | 597,924. | 597,924. | | |
| 21 Payments to affiliates | | | | |
| 22 Depreciation, depletion, and amortization | 1,742,042. | 1,738,044. | 3,998. | |
| 23 Insurance | 947,532. | 947,532. | | |
| 24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses on line 24e. If line 24e amount exceeds 10% of line 25, column (A), amount, list line 24e expenses on Schedule O.) | | | | |
| a MEDICAL SUPPLIES | 5,226,699. | 5,042,212. | 184,487. | |
| b MISCELLANEOUS EXPENSE | 118,744. | 90,621. | 28,123. | |
| c BAD DEBT EXPENSE | -385. | -385. | | |
| d INCOME TAXES | -1,301. | -201. | -1,100. | |
| e All other expenses | | | | |
| 25 Total functional expenses. Add lines 1 through 24e | 54,694,373. | 51,106,728. | 3,587,645. | 0. |
| 26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. | | | | |

Check here if following SOP 98-2 (ASC 958-720)

Part X Balance Sheet

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

| | | (A) Beginning of year | | (B) End of year |
|---|--|--------------------------|-------------|--------------------|
| Assets | 1 Cash - non-interest-bearing | 6,914,444. | 1 | 7,035,550. |
| | 2 Savings and temporary cash investments | 1,912,909. | 2 | 3,376,608. |
| | 3 Pledges and grants receivable, net | | 3 | |
| | 4 Accounts receivable, net | 8,333,161. | 4 | 7,703,217. |
| | 5 Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons | | 5 | |
| | 6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B) | | 6 | |
| | 7 Notes and loans receivable, net | 2,267,175. | 7 | 1,717,971. |
| | 8 Inventories for sale or use | 924,321. | 8 | 852,261. |
| | 9 Prepaid expenses and deferred charges | 124,939. | 9 | 124,074. |
| | 10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D | 10a 78,878,009. | | |
| | b Less: accumulated depreciation | 10b 53,848,463. | 10c | 25,029,546. |
| | 11 Investments - publicly traded securities | 16,576,010. | 11 | 20,653,992. |
| | 12 Investments - other securities. See Part IV, line 11 | | 12 | |
| | 13 Investments - program-related. See Part IV, line 11 | | 13 | |
| | 14 Intangible assets | | 14 | |
| | 15 Other assets. See Part IV, line 11 | | 15 | |
| 16 Total assets. Add lines 1 through 15 (must equal line 33) | 61,157,332. | 16 | 66,493,219. | |
| Liabilities | 17 Accounts payable and accrued expenses | 2,754,218. | 17 | 3,884,664. |
| | 18 Grants payable | | 18 | |
| | 19 Deferred revenue | 4,110,523. | 19 | 2,432,531. |
| | 20 Tax-exempt bond liabilities | 2,430,000. | 20 | 2,265,000. |
| | 21 Escrow or custodial account liability. Complete Part IV of Schedule D | | 21 | |
| | 22 Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons | | 22 | |
| | 23 Secured mortgages and notes payable to unrelated third parties | | 23 | 356,289. |
| | 24 Unsecured notes and loans payable to unrelated third parties | 266,097. | 24 | 715,260. |
| | 25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D | 23,943,891. | 25 | 24,424,944. |
| | 26 Total liabilities. Add lines 17 through 25 | 33,504,729. | 26 | 34,078,688. |
| Net Assets or Fund Balances | Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33. | | | |
| | 27 Net assets without donor restrictions | 27,652,603. | 27 | 32,406,926. |
| | 28 Net assets with donor restrictions | | 28 | 7,605. |
| | Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> and complete lines 29 through 33. | | | |
| | 29 Capital stock or trust principal, or current funds | | 29 | |
| | 30 Paid-in or capital surplus, or land, building, or equipment fund | | 30 | |
| | 31 Retained earnings, endowment, accumulated income, or other funds | | 31 | |
| | 32 Total net assets or fund balances | 27,652,603. | 32 | 32,414,531. |
| | 33 Total liabilities and net assets/fund balances | 61,157,332. | 33 | 66,493,219. |

Part XI Reconciliation of Net Assets

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

| | | | |
|-----------|--|-----------|-------------|
| 1 | Total revenue (must equal Part VIII, column (A), line 12) | 1 | 59,984,346. |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 54,694,373. |
| 3 | Revenue less expenses. Subtract line 2 from line 1 | 3 | 5,289,973. |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A)) | 4 | 27,652,603. |
| 5 | Net unrealized gains (losses) on investments | 5 | 376,605. |
| 6 | Donated services and use of facilities | 6 | |
| 7 | Investment expenses | 7 | |
| 8 | Prior period adjustments | 8 | |
| 9 | Other changes in net assets or fund balances (explain on Schedule O) | 9 | -904,650. |
| 10 | Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B)) | 10 | 32,414,531. |

Part XII Financial Statements and Reporting

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

- 1** Accounting method used to prepare the Form 990: Cash Accrual Other _____
If the organization changed its method of accounting from a prior year or checked "Other," explain on Schedule O.
- 2a** Were the organization's financial statements compiled or reviewed by an independent accountant?
If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both:
 Separate basis Consolidated basis Both consolidated and separate basis
- b** Were the organization's financial statements audited by an independent accountant?
If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both:
 Separate basis Consolidated basis Both consolidated and separate basis
- c** If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?
If the organization changed either its oversight process or selection process during the tax year, explain on Schedule O.
- 3a** As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?
- 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 on Schedule O and describe any steps taken to undergo such audits

| | Yes | No |
|-----------|-----|----|
| | | |
| 2a | | X |
| | | |
| 2b | X | |
| | | |
| 2c | X | |
| | | |
| 3a | X | |
| | | |
| 3b | X | |

SCHEDULE A
(Form 990)

Public Charity Status and Public Support

OMB No. 1545-0047

2021

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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.
Go to www.irs.gov/Form990 for instructions and the latest information.

Name of the organization: UNITY HEALTHCARE
Employer identification number: 42-0680337

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

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

- 1 [] A church, convention of churches, or association of churches described in section 170(b)(1)(A)(i).
2 [] A school described in section 170(b)(1)(A)(ii). (Attach Schedule E (Form 990).)
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 agricultural research organization described in section 170(b)(1)(A)(ix) operated in conjunction with a land-grant college or university or a non-land-grant college of agriculture (see instructions). Enter the name, city, and state of the college or university:
10 [] An organization that normally receives (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions, subject to certain exceptions; and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See section 509(a)(2). (Complete Part III.)
11 [] An organization organized and operated exclusively to test for public safety. See section 509(a)(4).
12 [] An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2). See section 509(a)(3). Check the box on lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.
a [] Type I. A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. You must complete Part IV, Sections A and B.
b [] Type II. A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). You must complete Part IV, Sections A and C.
c [] Type III functionally integrated. A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). You must complete Part IV, Sections A, D, and E.
d [] Type III non-functionally integrated. A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). You must complete Part IV, Sections A and D, and Part V.
e [] Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.
f Enter the number of supported organizations
g Provide the following information about the supported organization(s).

Table with 6 main columns: (i) Name of supported organization, (ii) EIN, (iii) Type of organization, (iv) Is the organization listed in your governing document?, (v) Amount of monetary support, (vi) Amount of other support. Includes a Total row at the bottom.

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) 2017 | (b) 2018 | (c) 2019 | (d) 2020 | (e) 2021 | (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) 2017 | (b) 2018 | (c) 2019 | (d) 2020 | (e) 2021 | (f) Total |
|---|----------|----------|----------|----------|----------|--------------------------|
| 7 Amounts from line 4 | | | | | | |
| 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources | | | | | | |
| 9 Net income from unrelated business activities, whether or not the business is regularly carried on | | | | | | |
| 10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) | | | | | | |
| 11 Total support. Add lines 7 through 10 | | | | | | |
| 12 Gross receipts from related activities, etc. (see instructions) | | | | | 12 | |
| 13 First 5 years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here | | | | | | <input type="checkbox"/> |

Section C. Computation of Public Support Percentage

| | | |
|---|----|--------------------------|
| 14 Public support percentage for 2021 (line 6, column (f), divided by line 11, column (f)) | 14 | % |
| 15 Public support percentage from 2020 Schedule A, Part II, line 14 | 15 | % |
| 16a 33 1/3% support test - 2021. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization | | <input type="checkbox"/> |
| b 33 1/3% support test - 2020. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization | | <input type="checkbox"/> |
| 17a 10% -facts-and-circumstances test - 2021. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and stop here. Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization | | <input type="checkbox"/> |
| b 10% -facts-and-circumstances test - 2020. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and stop here. Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization | | <input type="checkbox"/> |
| 18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions | | <input type="checkbox"/> |

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

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

Section A. Public Support

| Calendar year (or fiscal year beginning in) ► | (a) 2017 | (b) 2018 | (c) 2019 | (d) 2020 | (e) 2021 | (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) 2017 | (b) 2018 | (c) 2019 | (d) 2020 | (e) 2021 | (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 on line 10b, whether or not the business is regularly carried on | | | | | | |
| 12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) | | | | | | |
| 13 Total support. (Add lines 9, 10c, 11, and 12.) | | | | | | |

14 First 5 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 2021 (line 8, column (f), divided by line 13, column (f)) | 15 | % |
| 16 Public support percentage from 2020 Schedule A, Part III, line 15 | 16 | % |

Section D. Computation of Investment Income Percentage

| | | |
|--|-----------|---|
| 17 Investment income percentage for 2021 (line 10c, column (f), divided by line 13, column (f)) | 17 | % |
| 18 Investment income percentage from 2020 Schedule A, Part III, line 17 | 18 | % |

19a 33 1/3% support tests - 2021. 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 - 2020. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ►

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

| | Yes | No |
|--|-----|----|
| 11 Has the organization accepted a gift or contribution from any of the following persons? | | |
| a A person who directly or indirectly controls, either alone or together with persons described on lines 11b and 11c below, the governing body of a supported organization? | | |
| b A family member of a person described on line 11a above? | | |
| c A 35% controlled entity of a person described on line 11a or 11b above? <i>If "Yes" to line 11a, 11b, or 11c, provide detail in Part VI.</i> | | |
| 11a | | |
| 11b | | |
| 11c | | |

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally Integrated Supporting Organizations

| | | | |
|---|--|--|--|
| 1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions). | | | |
| a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below. | | | |
| b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below. | | | |
| c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a governmental entity (see instructions). | | | |
| 2 Activities Test. Answer lines 2a and 2b below. | | | |
| a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <i>If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.</i> | | | |
| b Did the activities described on line 2a, above, constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? <i>If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.</i> | | | |
| 3 Parent of Supported Organizations. Answer lines 3a and 3b below. | | | |
| a Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>If "Yes" or "No" provide details in Part VI.</i> | | | |
| b Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i> | | | |
| 2a | | | |
| 2b | | | |
| 3a | | | |
| 3b | | | |

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

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

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

| Section B - Minimum Asset Amount | | (A) Prior Year | (B) Current Year (optional) |
|---|---|----------------|-----------------------------|
| 1 | Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year): | | |
| a | Average monthly value of securities | 1a | |
| b | Average monthly cash balances | 1b | |
| c | Fair market value of other non-exempt-use assets | 1c | |
| d | Total (add lines 1a, 1b, and 1c) | 1d | |
| e | Discount claimed for blockage or other factors (<i>explain in detail in Part VI</i>): | | |
| 2 | Acquisition indebtedness applicable to non-exempt-use assets | 2 | |
| 3 | Subtract line 2 from line 1d. | 3 | |
| 4 | Cash deemed held for exempt use. Enter 0.015 of line 3 (for greater amount, see instructions). | 4 | |
| 5 | Net value of non-exempt-use assets (subtract line 4 from line 3) | 5 | |
| 6 | Multiply line 5 by 0.035. | 6 | |
| 7 | Recoveries of prior-year distributions | 7 | |
| 8 | Minimum Asset Amount (add line 7 to line 6) | 8 | |

| Section C - Distributable Amount | | | Current Year |
|---|---|---|--------------|
| 1 | Adjusted net income for prior year (from Section A, line 8, column A) | 1 | |
| 2 | Enter 0.85 of line 1. | 2 | |
| 3 | Minimum asset amount for prior year (from Section B, line 8, column A) | 3 | |
| 4 | Enter greater of line 2 or line 3. | 4 | |
| 5 | Income tax imposed in prior year | 5 | |
| 6 | Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions). | 6 | |
| 7 | <input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally integrated Type III supporting organization (see instructions). | | |

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

| Section D - Distributions | | Current Year |
|----------------------------------|---|---------------------|
| 1 | Amounts paid to supported organizations to accomplish exempt purposes | 1 |
| 2 | Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity | 2 |
| 3 | Administrative expenses paid to accomplish exempt purposes of supported organizations | 3 |
| 4 | Amounts paid to acquire exempt-use assets | 4 |
| 5 | Qualified set-aside amounts (prior IRS approval required - <i>provide details in Part VI</i>) | 5 |
| 6 | Other distributions (<i>describe in Part VI</i>). See instructions. | 6 |
| 7 | Total annual distributions. Add lines 1 through 6. | 7 |
| 8 | Distributions to attentive supported organizations to which the organization is responsive (<i>provide details in Part VI</i>). See instructions. | 8 |
| 9 | Distributable amount for 2021 from Section C, line 6 | 9 |
| 10 | Line 8 amount divided by line 9 amount | 10 |

| Section E - Distribution Allocations (see instructions) | (i) Excess Distributions | (ii) Underdistributions Pre-2021 | (iii) Distributable Amount for 2021 |
|--|-------------------------------------|---|--|
| 1 Distributable amount for 2021 from Section C, line 6 | | | |
| 2 Underdistributions, if any, for years prior to 2021 (reasonable cause required - <i>explain in Part VI</i>). See instructions. | | | |
| 3 Excess distributions carryover, if any, to 2021 | | | |
| a From 2016 | | | |
| b From 2017 | | | |
| c From 2018 | | | |
| d From 2019 | | | |
| e From 2020 | | | |
| f Total of lines 3a through 3e | | | |
| g Applied to underdistributions of prior years | | | |
| h Applied to 2021 distributable amount | | | |
| i Carryover from 2016 not applied (see instructions) | | | |
| j Remainder. Subtract lines 3g, 3h, and 3i from line 3f. | | | |
| 4 Distributions for 2021 from Section D, line 7: \$ | | | |
| a Applied to underdistributions of prior years | | | |
| b Applied to 2021 distributable amount | | | |
| c Remainder. Subtract lines 4a and 4b from line 4. | | | |
| 5 Remaining underdistributions for years prior to 2021, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, <i>explain in Part VI</i> . See instructions. | | | |
| 6 Remaining underdistributions for 2021. Subtract lines 3h and 4b from line 1. For result greater than zero, <i>explain in Part VI</i> . See instructions. | | | |
| 7 Excess distributions carryover to 2022. Add lines 3j and 4c. | | | |
| 8 Breakdown of line 7: | | | |
| a Excess from 2017 | | | |
| b Excess from 2018 | | | |
| c Excess from 2019 | | | |
| d Excess from 2020 | | | |
| e Excess from 2021 | | | |

Schedule B
(Form 990)

Department of the Treasury
Internal Revenue Service

Schedule of Contributors

▶ Attach to Form 990 or Form 990-PF.
▶ Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2021

Name of the organization

UNITY HEALTHCARE

Employer identification number

42-0680337

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

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

For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, contributions totaling \$5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.

Special Rules

For an organization described in section 501(c)(3) 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), that checked Schedule A (Form 990), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions 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 an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than \$1,000 exclusively for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals. Complete Parts I (entering "N/A" in column (b) instead of the contributor name and address), II, and III.

For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc., purposes, but no such contributions totaled 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. Don't complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions totaling \$5,000 or more during the year ▶ \$ _____

Caution: An organization that isn't covered by the General Rule and/or the Special Rules doesn't file Schedule B (Form 990), 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 its Form 990-PF, Part I, line 2, to certify that it doesn't meet the filing requirements of Schedule B (Form 990).

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

Schedule B (Form 990) (2021)

| | |
|---|---|
| Name of organization UNITY HEALTHCARE | Employer identification number 42-0680337 |
|---|---|

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 | <hr/> <hr/> <hr/> | \$ <u>626,594.</u> | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.) |
| 2 | <hr/> <hr/> <hr/> | \$ <u>278,616.</u> | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.) |
| 3 | <hr/> <hr/> <hr/> | \$ <u>432,247.</u> | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.) |
| 4 | <hr/> <hr/> <hr/> | \$ <u>554,580.</u> | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.) |
| 5 | <hr/> <hr/> <hr/> | \$ <u>312,773.</u> | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.) |
| 6 | <hr/> <hr/> <hr/> | \$ <u>205,166.</u> | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.) |

| | |
|---|---|
| Name of organization UNITY HEALTHCARE | Employer identification number 42-0680337 |
|---|---|

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 | <hr/> <hr/> <hr/> | \$ <u>44,985.</u> | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.) |
| | <hr/> <hr/> <hr/> | \$ _____ | Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.) |
| | <hr/> <hr/> <hr/> | \$ _____ | Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.) |
| | <hr/> <hr/> <hr/> | \$ _____ | Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.) |
| | <hr/> <hr/> <hr/> | \$ _____ | Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.) |
| | <hr/> <hr/> <hr/> | \$ _____ | Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.) |
| | <hr/> <hr/> <hr/> | \$ _____ | Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.) |

| | |
|---|---|
| Name of organization UNITY HEALTHCARE | Employer identification number 42-0680337 |
|---|---|

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 |
|------------------------------|--|---|----------------------|
| _____ | _____ _____ _____ | \$ _____ | _____ |
| _____ | _____ _____ _____ | \$ _____ | _____ |
| _____ | _____ _____ _____ | \$ _____ | _____ |
| _____ | _____ _____ _____ | \$ _____ | _____ |
| _____ | _____ _____ _____ | \$ _____ | _____ |
| _____ | _____ _____ _____ | \$ _____ | _____ |
| _____ | _____ _____ _____ | \$ _____ | _____ |

| | |
|---|---|
| Name of organization UNITY HEALTHCARE | Employer identification number 42-0680337 |
|---|---|

Part III Exclusively religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than \$1,000 for the year from any one contributor. 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 info. 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 D (Form 990)

Department of the Treasury Internal Revenue Service

Supplemental Financial Statements

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

Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2021

Open to Public Inspection

Name of the organization UNITY HEALTHCARE Employer identification number 42-0680337

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows include: 1 Total number at end of year, 2 Aggregate value of contributions to (during year), 3 Aggregate value of grants from (during year), 4 Aggregate value at end of year, 5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? (Yes/No), 6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? (Yes/No)

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

Table with 2 columns: Held at the End of the Tax Year. Rows include: 1 Purpose(s) of conservation easements held by the organization (check all that apply): Preservation of land for public use, Protection of natural habitat, Preservation of open space, Preservation of a historically important land area, Preservation of a certified historic structure; 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: a Total number of conservation easements, b Total acreage restricted by conservation easements, c Number of conservation easements on a certified historic structure included in (a), d Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register; 3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year; 4 Number of states where property subject to conservation easement is located; 5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? (Yes/No); 6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year; 7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year; 8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? (Yes/No); 9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets. Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

Table with 2 columns: \$. Rows include: 1a If the organization elected, as permitted under FASB ASC 958, not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide in Part XIII the text of the footnote to its financial statements that describes these items.; 1b If the organization elected, as permitted under FASB ASC 958, to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items: (i) Revenue included on Form 990, Part VIII, line 1; (ii) Assets included in Form 990, Part X; 2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under FASB ASC 958 relating to these items: a Revenue included on Form 990, Part VIII, line 1; b Assets included in Form 990, Part X

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

- 3 Using the organization's acquisition, accession, and other records, check any of the following that make 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 program
 - e Other _____
- 4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.
- 5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? Yes No

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

- 1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? Yes No
- b If "Yes," explain the arrangement in Part XIII and complete the following table:
- | | Amount |
|---------------------------------|--------|
| c Beginning balance | 1c |
| 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, for escrow or custodial account liability? Yes No
- b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided on Part XIII

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

| | (a) Current year | (b) Prior year | (c) Two years back | (d) Three years back | (e) Four years back |
|--|------------------|----------------|--------------------|----------------------|---------------------|
| 1a Beginning of year balance | 11,146,962. | 10,324,907. | 9,040,114. | 9,363,115. | 8,281,100. |
| b Contributions | | | | | |
| c Net investment earnings, gains, and losses | 1,489,320. | 853,622. | 1,316,530. | -292,398. | 1,109,105. |
| d Grants or scholarships | | | | | |
| e Other expenditures for facilities and programs | | | | | |
| f Administrative expenses | 35,036. | 31,567. | 31,737. | 30,603. | 27,090. |
| g End of year balance | 12,601,246. | 11,146,962. | 10,324,907. | 9,040,114. | 9,363,115. |

- 2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
- a Board designated or quasi-endowment 100 %
 - b Permanent endowment .0000 %
 - c Term endowment .0000 %
- The percentages on lines 2a, 2b, and 2c should equal 100%.
- 3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
- | | Yes | No |
|-----------------------------|-----|----|
| (i) Unrelated organizations | | X |
| (ii) Related organizations | X | |
- b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R?
- 4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment.

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

| Description of property | (a) Cost or other basis (investment) | (b) Cost or other basis (other) | (c) Accumulated depreciation | (d) Book value |
|--|--------------------------------------|---------------------------------|------------------------------|----------------|
| 1a Land | | 741,056. | | 741,056. |
| b Buildings | | 46,355,542. | 27,688,114. | 18,667,428. |
| c Leasehold improvements | | 1,848,599. | 1,826,435. | 22,164. |
| d Equipment | | 27,899,874. | 24,252,742. | 3,647,132. |
| e Other | | 2,032,938. | 81,172. | 1,951,766. |
| Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.) | | | | 25,029,546. |

Part VII Investments - Other Securities.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

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

Part VIII Investments - Program Related.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

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

Part IX Other Assets.

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

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

Part X Other Liabilities.

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

| 1. (a) Description of liability | (b) Book value |
|---|----------------|
| (1) Federal income taxes | |
| (2) DUE TO AFFILIATES | 21,149,458. |
| (3) SELF-INSURANCE RESERVE | 2,320,615. |
| (4) HEALTH AND WELFARE BENEFITS | |
| (5) RESERVE | 176,358. |
| (6) LONG-TERM RETENTION INCENTIVES | 479,389. |
| (7) MISCELLANEOUS LIABILITY | 299,124. |
| (8) | |
| (9) | |
| Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶ | 24,424,944. |

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

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

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

| | | | | |
|---|---|----|----------|-------------|
| 1 | Total revenue, gains, and other support per audited financial statements | | 1 | 60,192,000. |
| 2 | Amounts included on line 1 but not on Form 990, Part VIII, line 12: | | | |
| a | Net unrealized gains (losses) on investments | 2a | 376,605. | |
| b | Donated services and use of facilities | 2b | | |
| c | Recoveries of prior year grants | 2c | | |
| d | Other (Describe in Part XIII.) | 2d | 6,993. | |
| e | Add lines 2a through 2d | 2e | | 383,598. |
| 3 | Subtract line 2e from line 1 | | 3 | 59,808,402. |
| 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 | 44,078. | |
| b | Other (Describe in Part XIII.) | 4b | 131,866. | |
| c | Add lines 4a and 4b | 4c | | 175,944. |
| 5 | Total revenue. Add lines 3 and 4c. (This must equal Form 990, Part I, line 12.) | | 5 | 59,984,346. |

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

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

| | | | | |
|---|--|----|---------|-------------|
| 1 | Total expenses and losses per audited financial statements | | 1 | 54,657,000. |
| 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 XIII.) | 2d | 6,881. | |
| e | Add lines 2a through 2d | 2e | | 6,881. |
| 3 | Subtract line 2e from line 1 | | 3 | 54,650,119. |
| 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 | 44,078. | |
| b | Other (Describe in Part XIII.) | 4b | 176. | |
| c | Add lines 4a and 4b | 4c | | 44,254. |
| 5 | Total expenses. Add lines 3 and 4c. (This must equal Form 990, Part I, line 18.) | | 5 | 54,694,373. |

Part XIII Supplemental Information.

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

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:

UNITYPOINT HEALTH 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 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

Part XIII Supplemental Information (continued)

STATE INCOME TAXES TO THE EXTENT THEY HAVE UNRELATED BUSINESS INCOME AS DESCRIBED UNDER PROVISIONS OF SECTION 511 OF THE CODE.

THE 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 2018. THE 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, IF ANY, DURING THE CARRYFORWARD PERIOD. DEFERRED TAX ASSETS AND LIABILITIES RELATED TO THESE SUBSIDIARIES WERE NOT MATERIAL.

PART XI, LINE 2D - OTHER ADJUSTMENTS:

| | |
|---------------------------------------|--------|
| EXPENSES NETTED IN REVENUES | 6,881. |
| ROUNDING | 112. |
| TOTAL TO SCHEDULE D, PART XI, LINE 2D | 6,993. |

PART XI, LINE 4B - OTHER ADJUSTMENTS:

| | |
|---|----------|
| REVENUES IN NET ASSETS WITHOUT DONOR RESTRICTIONS | 124,261. |
| REVENUES IN NET ASSETS WITH DONOR RESTRICTIONS | 7,605. |
| TOTAL TO SCHEDULE D, PART XI, LINE 4B | 131,866. |

PART XII, LINE 2D - OTHER ADJUSTMENTS:

| | |
|-----------------------------|--------|
| EXPENSES NETTED IN REVENUES | 6,881. |
|-----------------------------|--------|

PART XII, LINE 4B - OTHER ADJUSTMENTS:

**SCHEDULE H
(Form 990)**

Department of the Treasury
Internal Revenue Service

Hospitals

- ▶ Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
- ▶ Attach to Form 990.
- ▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2021

Open to Public Inspection

| | |
|--|--|
| Name of the organization UNITY HEALTHCARE | Employer identification number 42-0680337 |
|--|--|

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 | <input checked="" type="checkbox"/> | |
| b If "Yes," was it a written policy? | 1b | <input checked="" type="checkbox"/> | |
| 2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. | | | |
| <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities | | | |
| <input type="checkbox"/> Applied uniformly to most hospital facilities | | | |
| <input type="checkbox"/> Generally tailored to individual hospital facilities | | | |
| 3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year. | | | |
| a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? | | | |
| If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: | 3a | <input checked="" type="checkbox"/> | |
| <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ % | | | |
| b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: | 3b | <input checked="" type="checkbox"/> | |
| <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other <u>600</u> % | | | |
| c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care. | | | |
| 4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"? | 4 | <input checked="" type="checkbox"/> | |
| 5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? | 5a | <input checked="" type="checkbox"/> | |
| b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? | 5b | | <input checked="" type="checkbox"/> |
| 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 | <input checked="" type="checkbox"/> | |
| b If "Yes," did the organization make it available to the public? | 6b | <input checked="" type="checkbox"/> | |

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

| | (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 |
|--|---|-------------------------------|-------------------------------------|-------------------------------|-----------------------------------|------------------------------|
| Financial Assistance and Means-Tested Government Programs | | | | | | |
| a Financial Assistance at cost (from Worksheet 1) | | | 387,200. | | 387,200. | .71% |
| b Medicaid (from Worksheet 3, column a) | | | 11889411. | 11180884. | 708,527. | 1.30% |
| c Costs of other means-tested government programs (from Worksheet 3, column b) | | | | | | |
| d Total. Financial Assistance and Means-Tested Government Programs | | | 12276611. | 11180884. | 1095727. | 2.01% |
| Other Benefits | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4) | | | 3363885. | 2889586. | 474,299. | .87% |
| f Health professions education (from Worksheet 5) | | | | | | |
| g Subsidized health services (from Worksheet 6) | | | | | | |
| h Research (from Worksheet 7) | | | | | | |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | | | 192,931. | | 192,931. | .35% |
| j Total. Other Benefits | | | 3556816. | 2889586. | 667,230. | 1.22% |
| k Total. Add lines 7d and 7j | | | 15833427. | 14070470. | 1762957. | 3.23% |

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? 1

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

1 TRINITY MUSCATINE
1518 MULBERRY AVENUE
MUSCATINE, IA 52761
WWW.UNITYPOINT.ORG/QUADCITIES/TRINITY-700005H

Table with 9 columns: Licensed hospital, gen. medical & surgical, Children's hospital, Teaching hospital, Critical access hospital, Research facility, ER-24 hours, ER-other, Other (describe), Facility reporting group. Row 1 contains 'X' marks in the first two and seventh columns.

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group TRINITY MUSCATINE

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

| | Yes | No |
|--|-----|----|
| Community Health Needs Assessment | | |
| 1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? | | X |
| 2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C | | X |
| 3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 | X | |
| If "Yes," indicate what the CHNA report describes (check all that apply): | | |
| a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility | | |
| b <input checked="" type="checkbox"/> Demographics of the community | | |
| c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | |
| d <input checked="" type="checkbox"/> How data was obtained | | |
| e <input checked="" type="checkbox"/> The significant health needs of the community | | |
| f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | |
| g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs | | |
| h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests | | |
| i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s) | | |
| j <input type="checkbox"/> Other (describe in Section C) | | |
| 4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>21</u> | | |
| 5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted | X | |
| 6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | X | |
| b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C | X | |
| 7 Did the hospital facility make its CHNA report widely available to the public? | X | |
| If "Yes," indicate how the CHNA report was made widely available (check all that apply): | | |
| a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>WWW.UNITYPOINT.ORG/QUADCITIES/TRINITY-MUS</u> | | |
| b <input checked="" type="checkbox"/> Other website (list url): <u>WWW.QUADCITIES.HEALTHFORECAST.NET</u> | | |
| c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility | | |
| d <input type="checkbox"/> Other (describe in Section C) | | |
| 8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 | X | |
| 9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>21</u> | | |
| 10 Is the hospital facility's most recently adopted implementation strategy posted on a website? | X | |
| a If "Yes," (list url): <u>WWW.UNITYPOINT.ORG/QUADCITIES/TRINITY-MUSCATINE</u> | | |
| b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? | | |
| 11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed. | | |
| 12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? | | X |
| b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? | | |
| c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ | | |

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group TRINITY MUSCATINE

| | | Yes | No |
|---|---|----------|----|
| Did the hospital facility have in place during the tax year a written financial assistance policy that: | | | |
| 13 | Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? | X | |
| If "Yes," indicate the eligibility criteria explained in the FAP: | | | |
| a | <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>600</u> % | | |
| b | <input type="checkbox"/> Income level other than FPG (describe in Section C) | | |
| c | <input checked="" type="checkbox"/> Asset level | | |
| d | <input checked="" type="checkbox"/> Medical indigency | | |
| e | <input checked="" type="checkbox"/> Insurance status | | |
| f | <input checked="" type="checkbox"/> Underinsurance status | | |
| g | <input checked="" type="checkbox"/> Residency | | |
| h | <input checked="" type="checkbox"/> Other (describe in Section C) | | |
| 14 | Explained the basis for calculating amounts charged to patients? | X | |
| 15 | Explained the method for applying for financial assistance? | X | |
| If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply): | | | |
| a | <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application | | |
| b | <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | |
| c | <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | |
| d | <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | |
| e | <input checked="" type="checkbox"/> Other (describe in Section C) | | |
| 16 | Was widely publicized within the community served by the hospital facility? | X | |
| If "Yes," indicate how the hospital facility publicized the policy (check all that apply): | | | |
| a | <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>SEE PART V, PAGE 8</u> | | |
| b | <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE PART V, PAGE 8</u> | | |
| c | <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V, PAGE 8</u> | | |
| d | <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| e | <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| f | <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| g | <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention | | |
| h | <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP | | |
| i | <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations | | |
| j | <input type="checkbox"/> Other (describe in Section C) | | |

Part V Facility Information (continued)

Billing and Collections

Name of hospital facility or letter of facility reporting group TRINITY MUSCATINE

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

Name of hospital facility or letter of facility reporting group TRINITY MUSCATINE

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

Part V Facility Information *(continued)*

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

TRINITY MUSCATINE:

PART V, SECTION B, LINE 5: THIS ASSESSMENT INCORPORATES DATA FROM MULTIPLE SOURCES, INCLUDING PRIMARY RESEARCH (THROUGH THE PRC COMMUNITY HEALTH SURVEY), AS WELL AS SECONDARY RESEARCH (VITAL STATISTICS AND OTHER EXISTING HEALTH-RELATED DATA). IT ALSO ALLOWS FOR TRENDING AND COMPARISON TO BENCHMARK DATA AT THE STATE AND NATIONAL LEVELS. SELECT OPERATIONS DATA FROM LOCAL PROVIDERS ALSO WERE SUMMARIZED. QUALITATIVE DATA ON COMMUNITY HEALTH CONCERNS WAS ALSO COLLECTED AND ANALYZED FROM OUR BI-STATE STEERING COMMITTEE, STAKEHOLDERS, AND THROUGH 21 FOCUS GROUPS REACHING 147 INDIVIDUALS FROM 12 SUB-POPULATIONS.

TRINITY MUSCATINE:

PART V, SECTION B, LINE 6A: GENESIS HEALTH SYSTEM AND UNITYPOINT HEALTH-TRINITY MEDICAL CENTER

TRINITY MUSCATINE:

PART V, SECTION B, LINE 6B: COMMUNITY HEALTH CARE, QUAD CITY HEALTH INITIATIVE, MUSCATINE COUNTY PUBLIC HEALTH DEPARTMENT, ROCK ISLAND COUNTY HEALTH DEPARTMENT, SCOTT COUNTY PUBLIC HEALTH DEPARTMENT

TRINITY MUSCATINE:

PART V, SECTION B, LINE 11: THE MOST RECENT ASSESSMENT WAS CONDUCTED IN 2021. BASED ON THE ASSESSMENT, UNITYPOINT HEALTH - TRINITY DEVELOPED A

Part V Facility Information *(continued)*

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

COMMUNITY HEALTH IMPROVEMENT PLAN FOR 2022-2024 FOCUSED ON KEY AREAS

IDENTIFIED THAT WILL GUIDE THE COMMUNITY WORK TRINITY DOES FOR THE NEXT

THREE YEARS. THOSE AREAS INCLUDE HEALTHY LIFESTYLE (HEART DISEASE, STROKE,

DIABETES, NUTRITION, OBESITY/WEIGHT, AND PHYSICAL ACTIVITY); CANCER;

MENTAL HEALTH; AND ACCESS TO HEALTHCARE. SERVICE LINE LEADERS PROVIDED

FEEDBACK ON WHAT WAS TO BE ADDRESSED AND ACCOMPLISHED BASED ON THE

IDENTIFIED NEEDS.

FOR 2021, WE ADDRESSED AREAS OF NEED IDENTIFIED IN THE 2018 CHNA, HEART

DISEASE/STROKE; DIABETES/PHYSICAL ACTIVITY, NUTRITION & OBESITY; MENTAL

HEALTH; CANCER; AND ACCESS TO HEALTHCARE WITH ACTIONS AND RESULTS

DESCRIBED BELOW.

WHILE CREATING THE COMMUNITY HEALTH IMPROVEMENT PLAN, AREAS OF IMPROVEMENT

IDENTIFIED IN THE ASSESSMENT HAD TO BE PRIORITIZED BASED ON WHAT COULD

REALISTICALLY BE ADDRESSED BY THE HOSPITAL SYSTEM, AND WHAT WAS ALREADY

BEING ADDRESSED BY OTHER COMMUNITY ORGANIZATIONS AND CHNA PARTNERS.

CONSIDERATIONS INCLUDED SERVICES THAT COULD BE ACTUALLY PROVIDED BY THE

HOSPITAL RELATED TO THE NEED, THE FINANCIAL MEANS TO HAVE AN IMPACT, THE

STAFFING AVAILABLE TO MEET THE NEED, AND WHAT NEEDS WERE BEING ADDRESSED

BY OTHER ORGANIZATIONS WITHIN OUR COMMUNITY.

HEART DISEASE/STROKE (5) 6-WEEK, EVIDENCE-BASED, PLANT FOCUSED COOKING

CLASS SERIES (34 CLASSES), CALLED COOKING WITH HEART, WERE PRESENTED TO 64

PEOPLE. CONTINUED HEART TO HEART COMMUNITY EDUCATION SERIES WITH 5

PRESENTATIONS BY CARDIOLOGISTS REACHING 200 PEOPLE. THE TRINITY HEALTH

FOUNDATION RAISED MORE THAN \$140,000 FOR CARDIOVASCULAR SERVICES AT THE

UNITYPOINT HEALTH CUP GOLF BENEFIT. TRINITY HIRED A PREVENTION & WELLNESS

STRATEGIST TO THE TEAM, WHO HAS A FOCUS ON HEART HEALTH AND PROVIDES

COMMUNITY EDUCATION AND SUPPORT ON THE TOPICS OF DISEASE PREVENTION,

Part V Facility Information (continued)

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

IMPROVING HEALTH THROUGH NUTRITION, AND OTHER PROVEN WELLNESS TECHNIQUES.

DIABETES/PHYSICAL ACTIVITY, NUTRITION & OBESITY

PRESENTED 4 COOKING WITH HEART FOR DIABETES SERIES (16 CLASSES), A 4-WEEK, EVIDENCE-BASED COOKING CLASS FOR PREVENTION OF DIABETES AND MANAGING BLOOD SUGAR WITH 4 DIETICIANS FROM TRINITY, UNITYPOINT CLINIC AND GENESIS HEALTH SYSTEM. NINETY-NINE PARTICIPANTS LEARNED HOW NUTRITION CAN HELP THEM LIVE WELL AND MANAGE BLOOD SUGARS THROUGH FOOD CHOICES, AND HOW TO PREPARE HEALTHY, DELICIOUS RECIPES. HEALTHY EATING VIDEOS WERE CREATED FOR BIG BROTHERS BIG SISTERS BY WELLNESS COACHES FOR AGES 6-11 AND 12-17. CALLED EAT THE RAINBOW THESE VIDEOS EXPLAINED THE HEALTH BENEFITS OF EATING ALL COLORS OF FRUITS AND VEGETABLES. 500 COMMUNITY MEMBERS WERE PROVIDED NUTRITION AND HEALTHY LIFESTYLE EDUCATION AT SEVEN EVENTS, INCLUDING DIABETES RISK ASSESSMENTS, HEALTHY PLATE TRAINING, AND SODIUM CONSIDERATIONS.

MENTAL HEALTH

ROBERT YOUNG CENTER FOR COMMUNITY MENTAL HEALTH WORKED WITH THE STATE OF IOWA TO OBTAIN CHAPTER 24 ACCREDITATION, WHICH IS A PRECURSOR TO APPLYING FOR DESIGNATION AS A COMMUNITY MENTAL HEALTH CENTER FOR MUSCATINE RYC CLINIC. THE ROBERT YOUNG CENTER'S \$6.7 MILLION DOLLAR PROPOSED FY22 EASTERN IOWA REGION CRISIS SYSTEM CONTRACT WAS APPROVED BY THE REGION GOVERNING BOARD. THE EXPANSION OF CRISIS SERVICES FOR CEDAR, MUSCATINE, SCOTT, JACKSON, AND CLINTON COUNTIES INCLUDES CRISIS STABILIZATION, RESIDENTIAL AND COMMUNITY-BASED SERVICES FOR CHILDREN AND ADULTS, PEER SUPPORT, JAIL-BASED SERVICES, CARE COORDINATION, MEDICATION BRIDGE APPOINTMENTS, TRAINING, AND

Part V Facility Information (continued)

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

OTHER MENTAL HEALTH SERVICES. CADS PROVIDED 847 HOURS OF EDUCATION AND TRAINING TO 2,819 STUDENTS AND ADULTS ON PREVENTION OF GAMBLING, DRUG OVERDOSE, ALCOHOL ABUSE, DRUG ABUSE, TOBACCO USE, PRESCRIPTION DRUG ABUSE, AND VIOLENCE, AS WELL AS SKILLS BUILDING AND A STRONG AFRICAN AMERICAN FAMILIES PROGRAM. RYC'S CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC PARTICIPATED IN THE NAACP RESOURCE FAIR WITH 200 PEOPLE AND PROVIDED A GRIEF AND SUICIDE PREVENTION PRESENTATION AT A HEALTH AND WELLNESS COMMUNITY EVENT.

CANCER

TRINITY AND GILDA'S CLUB PROVIDED FREE, IN-HOME COLON CANCER SCREENING TESTS, THANKS TO A GRANT FROM IOWA CANCER CONSORTIUM. 575 KITS WERE DISTRIBUTED, 68 WERE RETURNED, A 12% RETURN RATE, AND 5 WERE POSITIVE. COORDINATED THE FOLLOW-UP CARE WITH THEIR PRIMARY CARE PROVIDER OR SPECIALTY PROVIDERS. PARTNERED WITH 8 ORGANIZATIONS, PARISH NURSES, LOCAL BARBER SHOPS, AND CHURCHES TO DISTRIBUTE THE KITS. HOSTED 3 COLON CANCER SCREENING WORKSHOPS AND TRAINED STAFF AT COMMUNITY HEALTH CARE ON THE COLON CANCER SCREENING KITS. THREE FREE COOKING WITH HEART FOR CANCER CLASS SERIES (12 CLASSES), WITH 100 PARTICIPANTS WAS PROVIDED. SUSAN G. KOMEN BREAST CANCER FOUNDATION, AFTER RESTRUCTURING, PROVIDED TRINITY HEALTH FOUNDATION WITH \$50,000 FOR BREAST HEALTH SERVICES, PATIENT SERVICES, TECHNOLOGY, ACCESS TO CARE, AND FUTURE INNOVATIONS. VIDEOS ON VAPING FACTS CREATED FOR AGES 6-11 AND 12-17 AT BIG BROTHERS BIG SISTERS EDUCATION ON NUTRITION AND CANCER, SCREENING FOR BREAST, LUNG AND COLON CANCERS, AND BREAST CANCER AWARENESS PROVIDED AT 4 EVENTS FOR 300 PEOPLE.

ACCESS TO HEALTHCARE

Part V Facility Information (continued)

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

TRINITY PARTNERED WITH THE PROJECT OF THE QC TO ENSURE ALL MEMBERS OF OUR COMMUNITY HAVE SAFE, EQUITABLE ACCESS TO HEALTHCARE WITH PLANS FOR LGBTQ SAFE ZONES IN ALL UNITYPOINT CLINICS AND TRAINING TO ALL STAFF MEMBERS. LAUNCHED NEW SOCIAL SERVICES RESOURCE CALLED TOGETHER WE CARE TO HELP PEOPLE FIND ASSISTANCE WITH FOOD, HOUSING, TRANSPORTATION, EMPLOYMENT AND MORE. A \$6 MILLION PROJECT SERVING THE MUSCATINE COMMUNITY PRIORITIZES FACILITY UPGRADES TO ALLOW LOCAL MEDICAL PROVIDERS MORE OF THE RESOURCES THEY NEED TO PROVIDE HIGH-QUALITY, PERSONAL CARE CLOSER TO HOME. HEALTHPARTNERS UNITYPOINT HEALTH BEGAN OFFERING FULL HEALTH INSURANCE PLANS TO SMALL BUSINESSES WITH <50 EMPLOYEES IN SCOTT & MUSCATINE COUNTIES WITH 27 PLAN OPTIONS. PARISH NURSES PROVIDED 537 HOURS OF TRANSPORTATION SERVICES TO 516 PERSONS IN ILLINOIS AND IOWA QUAD CITIES. THE QUAD CITIES REGIONAL SERVICES FOR VETERANS PROJECT WAS HELD VIRTUALLY FROM OCTOBER 1 TO NOVEMBER 19 TO PROVIDE VETERANS ACCESS TO VA, RYC, AND COMMUNITY RESOURCES. FORTY VETERANS WERE SERVED. PROVIDED \$40,573 IN FREE MEDICATIONS TO 662 PATIENTS. REDUCED TOTAL AREA NO-SHOW RATE IN CLINICS BY 3% SINCE 2019. OUTREACH COORDINATOR PROVIDED EDUCATION TO 55 PERSONS ON 5 OCCASIONS AT CHRISTIAN CARE MEN'S HOMELESS SHELTER. 868 HOURS OF ASSISTANCE BY OUR FINANCIAL CONSULTING/MARKETPLACE TEAM WAS PROVIDED TO THE COMMUNITY DURING OPEN ENROLLMENT, AS WELL AS EDUCATION ON INSURANCE COVERAGE OPTIONS THROUGHOUT THE YEAR.

TRINITY MUSCATINE:

PART V, SECTION B, LINE 13H: PATIENTS WHO QUALIFY AND ARE RECEIVING BENEFITS FROM THE FOLLOWING PROGRAMS MAY BE PRESUMED ELIGIBLE FOR 100% FINANCIAL ASSISTANCE: THE U.S. DEPARTMENT OF AGRICULTURE FOOD AND

Part V Facility Information *(continued)*

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

NUTRITION SERVICE FOOD STAMP PROGRAM; WOMEN, INFANTS & CHILDREN (WIC); AND VARIOUS COUNTY AND STATE RELIEF PROGRAMS. THIRD PARTY AGENCIES ARE USED TO ASSIST WITH COLLECTIONS AND, IF THOSE AGENCIES PROVIDE A STATEMENT REGARDING A PATIENT'S LIKELY INCOME LEVEL, THAT INFORMATION IS USED IN DETERMINING THE ELIGIBILITY STATUS AND THE LEVEL OF DISCOUNT AVAILABLE. STATE LAW REQUIREMENTS THAT OFFER ADDITIONAL AND/OR MORE STRINGENT ELIGIBILITY REQUIREMENTS WILL BE FOLLOWED FOR THOSE STATES.

TRINITY MUSCATINE

PART V, LINE 16A, FAP WEBSITE:

WWW.UNITYPOINT.ORG/QUADCITIES/FINANCIAL-ASSISTANCE.ASPX

TRINITY MUSCATINE

PART V, LINE 16B, FAP APPLICATION WEBSITE:

WWW.UNITYPOINT.ORG/QUADCITIES/FINANCIAL-ASSISTANCE.ASPX

TRINITY MUSCATINE

PART V, LINE 16C, FAP PLAIN LANGUAGE SUMMARY WEBSITE:

WWW.UNITYPOINT.ORG/QUADCITIES/FINANCIAL-ASSISTANCE.ASPX

Part V Facility Information (continued)

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

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

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

| Name and address | Type of Facility (describe) |
|--|-----------------------------|
| 1 UPH TRINITY EXPRESS CARE- NORTHPORT 3426 NORTH PORT DRIVE MUSCATINE, IA 52761 | OUTPATIENT ONLY |
| 2 UPH TRINITY FAMILY MEDICINE-NORTHPORT 3426 NORTH PORT DRIVE MUSCATINE, IA 52761 | OUTPATIENT ONLY |
| 3 UPH TRINITY FAMILY MEDICINE-WILTON 400 OVESEN RD. WILTON, IA 52778 | OUTPATIENT ONLY |
| 4 TRINITY MUSCATINE OCCUPATIONAL MEDICIN 3426 NORTH PORT DRIVE MUSCATINE, IA 52761 | OUTPATIENT ONLY |
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Part VI Supplemental Information

Provide the following information.

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

PART I, LINE 6A:

UNITY HEALTHCARE'S COMMUNITY BENEFIT REPORT IS CONTAINED WITHIN THE IOWA HEALTH SYSTEM COMMUNITY BENEFIT REPORT WHICH CAN BE LOCATED AT WWW.UNITYPOINT.ORG. THIS SYSTEM-WIDE REPORT IS COMPLETED IN ADDITION TO THE COMMUNITY BENEFIT REPORT FOR THE HOSPITAL AND ITS REGIONAL AFFILIATES.

PART I, LINE 7:

A COST-TO-CHARGE RATIO (FROM WORKSHEET 2) IS USED TO CALCULATE THE AMOUNTS ON LINE 7A. THE AMOUNTS ON LINES 7B-7C (UNREIMBURSED MEDICAID AND OTHER MEANS-TESTED GOVERNMENT PROGRAMS) ARE OBTAINED FROM A COST ACCOUNTING SYSTEM OF APPLICABLE PATIENT SEGMENTS. SEGMENTS NOT PASSED TO COST ACCOUNTING SYSTEM USE COST-TO-CHARGE RATIO. THE AMOUNTS FOR LINES 7E, F, H, AND I WOULD COME FROM THE BOOKS AND RECORDS OF SPECIFIC SEGMENTS OF THE ORGANIZATION AND ARE BASED ON COST. THE AMOUNTS ON 7G ARE DERIVED FROM A COST ACCOUNTING SYSTEM OF APPLICABLE PATIENT SEGMENTS. SEGMENTS NOT PASSED TO A COST ACCOUNTING SYSTEM USE THE COST-TO-CHARGE RATIO.

PART I, LINE 7, COLUMN (F):

Part VI Supplemental Information (Continuation)

THE BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25(A),
BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGE IN
THIS COLUMN IS \$ -385.

PART II, COMMUNITY BUILDING ACTIVITIES:

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 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. COMMUNITY SUPPORT INCLUDES THE HOURS TRINITY
MUSCATINE EMPLOYEES SPENT PARTICIPATING IN THE DAY OF CARING (UNITED WAY).
THESE TYPES OF ACTIVITIES SPEAK TO THE BREADTH AND CAPACITY THAT THE

Part VI Supplemental Information (Continuation)

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 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 MUSCATINE. 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 METHODOLOGY DESCRIBED IN THE INSTRUCTIONS TO SCHEDULE H, PART III,
SECTION B, LINE 6 DOES NOT TAKE INTO ACCOUNT ALL COSTS INCURRED BY THE
HOSPITAL AND DOES NOT REPRESENT THE TOTAL COMMUNITY BENEFIT CONFERRED IN

Part VI Supplemental Information (Continuation)

THIS AREA. THE MEDICARE SURPLUS REFLECTED ON SCHEDULE H, PART III, SECTION B WAS DETERMINED USING INFORMATION FROM THE ORGANIZATION'S MEDICARE COST REPORT. HOWEVER THE MEDICARE COST REPORT DISALLOWS CERTAIN ITEMS THAT WE BELIEVE ARE LEGITIMATE EXPENSES INCURRED IN THE PROCESS OF CARING FOR OUR MEDICARE PATIENTS. EXAMPLES OF THESE ITEMS INCLUDE PROVIDER BASED PHYSICIAN EXPENSE, SELF INSURANCE EXPENSE, HOME OFFICE EXPENSE AND THE SHORTFALL FROM FEE SCHEDULE PAYMENTS.

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 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.

Part VI Supplemental Information (Continuation)

PART VI, LINE 2:

TRINITY MUSCATINE CONTINUALLY WORKS WITH COMMUNITY PARTNERS IN THE MUSCATINE COUNTY AREA TO ASSESS THE HEALTH NEEDS OF THE COMMUNITY. TRINITY MUSCATINE'S PUBLIC HEALTH DEPARTMENT WORKS COLLABORATIVELY WITH THE AREA SCHOOLS, BOARD OF HEALTH, BOARD OF SUPERVISORS, AND OTHER LOCAL AGENCIES TO ASSESS, ADDRESS AND MONITOR THE HEALTH NEEDS OF THE MUSCATINE AREA. TRINITY MUSCATINE ALSO PARTICIPATES AS PART OF THE MUSCATINE COMMUNITY HEALTH ASSOCIATION, EMPOWERING HEALTHY BEHAVIORS COMMITTEE, COMMUNITY FOUNDATION OF GREATER MUSCATINE, AND HEALTHY HOMETOWNS. THESE GROUPS ACTIVELY ADDRESS THE NEED AND STRATEGIES ASSOCIATED WITH OPTIMAL HEALTH OUTCOMES. MORE SPECIFICALLY, THESE GROUPS OFTEN FOCUS 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 MUSCATINE 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, UNITY HEALTHCARE 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:

THE HOSPITAL COMMUNICATES THE AVAILABILITY OF FINANCIAL ASSISTANCE TO ALL PATIENTS AND WITHIN THE COMMUNITY. COPIES OF THE FINANCIAL ASSISTANCE POLICY, FINANCIAL ASSISTANCE APPLICATION AND PLAIN LANGUAGE SUMMARY ARE AVAILABLE BY MAIL, ON EACH HOSPITAL'S WEBSITE, AND IN PERSON AT EACH HOSPITAL. THE CENTRAL BILLING OFFICE IS AVAILABLE BY PHONE TO ANSWER QUESTIONS ABOUT THE POLICY, OR PATIENTS SHOULD GO TO THE CASHIER'S OFFICE

Part VI Supplemental Information (Continuation)

AT THE HOSPITAL TO OBTAIN THIS INFORMATION. THE PLAIN LANGUAGE SUMMARY IS OFFERED AS PART OF THE PATIENT INTAKE AND/OR DISCHARGE PROCESS AND INCLUDED WHEN A PATIENT IS SENT WRITTEN NOTICE THAT EXTRAORDINARY COLLECTION ACTIONS MAY BE TAKEN AGAINST HIM/HER. THE FINANCIAL ASSISTANCE POLICY, THE PLAIN LANGUAGE SUMMARY, AND ALL FINANCIAL ASSISTANCE FORMS ARE AVAILABLE IN ENGLISH AND IN ANY OTHER LANGUAGE IN WHICH LIMITED ENGLISH PROFICIENCY (LEP) POPULATIONS CONSTITUTE THE LESSER OF 1,000 PERSONS OR MORE THAN 5% OF THE COMMUNITY SERVED BY THE HOSPITAL. THESE TRANSLATED DOCUMENTS WILL BE AVAILABLE BY MAIL, ON EACH HOSPITAL'S WEBSITE, AND IN PERSON AT EACH HOSPITAL.

PART VI, LINE 4:

TRINITY MUSCATINE IS AN 80-BED COMMUNITY HOSPITAL SERVING MUSCATINE AREA OF EASTERN IOWA. TRINITY MUSCATINE IS NONDENOMINATIONAL AND SERVES ALL WHO COME HERE, REGARDLESS OF REASON OR CIRCUMSTANCE.

90% OF TRINITY MUSCATINE'S MARKET RESIDENTS LIVE WITHIN THE IOWA COUNTIES OF MUSCATINE AND LOUISA.

TRINITY MUSCATINE ADMITS APPROXIMATELY 1,000 INPATIENTS AND CARES FOR OVER 15,000 EMERGENCY PATIENTS PER YEAR. TRINITY MUSCATINE CARES FOR MORE INPATIENTS, OUTPATIENTS, EMERGENCY PATIENTS AND CARDIAC PATIENTS THAN ANY OTHER HOSPITAL IN THE MUSCATINE AREA OF EASTERN IOWA. THERE ARE NO OTHER HOSPITALS WITHIN THE 2-COUNTY SERVICE AREA.

MEDIAN INDIVIDUAL INCOMES RANGE FROM \$60,435 TO \$63,034 AND THE AVERAGE POVERTY RATE IS 9%.

Part VI Supplemental Information (Continuation)

57% OF TRINITY MUSCATINE INPATIENTS ARE ELIGIBLE FOR MEDICARE OR MEDICAID.
MUSCATINE AND LOUISA COUNTIES ARE ABOUT 79% CAUCASIAN AND 17% HISPANIC.

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 (D/B/A UNITYPOINT HEALTH). AS THE NATION'S 13TH LARGEST NONPROFIT HEALTH SYSTEM, UNITYPOINT HEALTH PROVIDES PROGRESSIVE AND HIGH QUALITY SERVICES ACROSS ITS 9 REGIONS WHICH SPAN IOWA, WESTERN ILLINOIS AND SOUTHERN WISCONSIN. THIS REGIONAL CARE MODEL HAS BEEN SUCCESSFUL IN ACHIEVING STANDARDIZED LEVELS OF PERFORMANCE AND KEEPING CARE LOCAL. WITH \$4.9B IN TOTAL OPERATING REVENUE, UNITYPOINT HEALTH EMPLOYS APPROXIMATELY 33,000 TEAM MEMBERS AND OPERATES 20 REGIONAL HOSPITALS, 19 COMMUNITY NETWORK HOSPITALS AND OVER 435 CLINICS. AS A KEY COMPONENT OF UNITYPOINT HEALTH, UNITYPOINT CLINIC IS A 1,180 PROVIDER MULTISPECIALTY GROUP THAT IS BUILT ON THE FOUNDATION OF CARE DELIVERY,

Part VI Supplemental Information (Continuation)

INNOVATION AND EXPERIENCE. REPRESENTED BY OVER 40 SPECIALTIES, UPC IS A FORWARD-THINKING DELIVERY PROVIDER AND IS ON THE LEADING EDGE OF CARE DELIVERY WITH ITS TELEHEALTH, AMBULATORY AND URGENT CARE PROGRAMS. THE DIVERSIFIED HEALTH SYSTEM ALSO INCLUDES UNITYPOINT ACCOUNTABLE CARE, UNITYPOINT HEALTH COLLEGES, UNITYPOINT AT HOME AND EXTENDS HEALTH COVERAGE THROUGH THE HEALTHPARTNERS UNITYPOINT INSURANCE PLAN.

UNITYPOINT HEALTH AND ITS AFFILIATES ENGAGE IN COMMUNITY HEALTH PROGRAMS AND SERVICES AND WORK WITH VOLUNTEER AND CIVIC ORGANIZATIONS, SCHOOLS, BUSINESSES, INSURERS AND INDIVIDUALS TO SUPPORT ACTIVITIES THAT BENEFIT PEOPLE THROUGHOUT THEIR REGIONS. IN 2021, UNITYPOINT HEALTH AND ITS AFFILIATES PROVIDED MORE THAN \$672 MILLION OF COMMUNITY BENEFIT. THE CONTRIBUTIONS TO THEIR COMMUNITIES BY UNITYPOINT HEALTH 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:

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" on Form 990, Part IV, line 21 or 22.

▶ **Attach to Form 990.**

▶ **Go to www.irs.gov/Form990 for the latest information.**

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Name of the organization **UNITY HEALTHCARE** Employer identification number **42-0680337**

Part I General Information on Grants and Assistance

- 1** Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? **Yes** **No**
- 2** Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

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

| 1 (a) Name and address of organization or government | (b) EIN | (c) IRC section (if applicable) | (d) Amount of cash grant | (e) Amount of noncash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of noncash assistance | (h) Purpose of grant or assistance |
|--|----------------|--|---------------------------------|---|--|--|---|
| EASTERN IOWA COMMUNITY COLLEGE 101 W 3RD ST DAVENPORT , IA 52801 | 42-0924364 | GOVERNMENT | 12,520. | 0. | | | PROGRAM SUPPORT |
| ISU EXTENSION LOUISA COUNTY 317 VAN BUREN ST. WAPELLO, IA 52653 | 42-6004224 | GOVERNMENT | 13,206. | 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) 2021

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

| (a) Type of grant or assistance | (b) Number of recipients | (c) Amount of cash grant | (d) Amount of non-cash assistance | (e) Method of valuation (book, FMV, appraisal, other) | (f) Description of noncash assistance |
|---------------------------------|--------------------------|--------------------------|-----------------------------------|---|---------------------------------------|
| | | | | | |
| | | | | | |
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| | | | | | |

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

PART I, LINE 2:

THE ORGANIZATION REQUIRES EACH RECIPIENT OF THE GRANTS MENTIONED IN PART II & III (OTHER THAN ASSISTANCE TO RELATED ORGANIZATIONS IN THE FORM OF WORKING CAPITAL) TO APPLY FOR THE GRANT AND OUTLINES A SERIES OF ELIGIBILITY STANDARDS THAT ARE REQUIRED TO BE MET. THE ORGANIZATION THEN REVIEWS THESE APPLICATIONS, AND BASED ON NEED AND ELIGIBILITY, A COMMITTEE MAKES THE FINAL DECISION ON ALL GRANT RECIPIENTS.

**SCHEDULE J
(Form 990)**

Compensation Information

OMB No. 1545-0047

2021

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees
 ▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23.
 ▶ Attach to Form 990.
 ▶ Go to www.irs.gov/Form990 for instructions and the latest information.

Name of the organization **UNITY HEALTHCARE** Employer identification number **42-0680337**

Part I Questions Regarding Compensation

1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.

- | | |
|--|--|
| <input type="checkbox"/> First-class or charter travel | <input type="checkbox"/> Housing allowance or residence for personal use |
| <input type="checkbox"/> Travel for companions | <input type="checkbox"/> Payments for business use of personal residence |
| <input type="checkbox"/> Tax indemnification and gross-up payments | <input type="checkbox"/> Health or social club dues or initiation fees |
| <input type="checkbox"/> Discretionary spending account | <input type="checkbox"/> Personal services (such as 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

2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked on line 1a?

3 Indicate which, if any, of the following the organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.

- | | |
|---|---|
| <input checked="" type="checkbox"/> Compensation committee | <input checked="" type="checkbox"/> Written employment contract |
| <input checked="" type="checkbox"/> Independent compensation consultant | <input checked="" type="checkbox"/> Compensation survey or study |
| <input type="checkbox"/> Form 990 of other organizations | <input checked="" type="checkbox"/> Approval by the board or compensation committee |

4 During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:

- a** Receive a severance payment or change-of-control payment?
- b** Participate in or receive payment from a supplemental nonqualified retirement plan?
- c** Participate in or receive payment from an equity-based compensation arrangement?
- If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.

Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.

5 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:

- a** The organization?
- b** Any related organization?
- If "Yes" on line 5a or 5b, describe in Part III.

6 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:

- a** The organization?
- b** Any related organization?
- If "Yes" on line 6a or 6b, describe in Part III.

7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described on lines 5 and 6? If "Yes," describe in Part III

8 Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III

9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?

| | Yes | No |
|-----------|-----|----|
| 1b | | |
| 2 | | |
| 4a | X | |
| 4b | X | |
| 4c | | X |
| 5a | | X |
| 5b | | X |
| 6a | | X |
| 6b | | X |
| 7 | | X |
| 8 | | X |
| 9 | | |

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

Schedule J (Form 990) 2021

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

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

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

| (A) Name and Title | | (B) Breakdown of W-2 and/or 1099-MISC and/or 1099-NEC compensation | | | (C) Retirement and other deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation in column (B) reported as deferred on prior Form 990 |
|---|------|--|-------------------------------------|-------------------------------------|--|-------------------------|---------------------------------|---|
| | | (i) Base compensation | (ii) Bonus & incentive compensation | (iii) Other reportable compensation | | | | |
| JOHN SHEEHAN (TO 9/19) FORMER BD MEMBER/INTERIM PRES/CEO | (i) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| | (ii) | 720,400. | 173,872. | 34,648. | 159,544. | 9,834. | 1,098,298. | 0. |
| ROBERT ERICKSON BOARD MEMBER/PRESIDENT/CEO | (i) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| | (ii) | 502,511. | 176,190. | 17,964. | 124,690. | 29,737. | 851,092. | 0. |
| TOYOSI OLUTADE, MD CHIEF MEDICAL OFFICER | (i) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| | (ii) | 708,568. | 89,089. | 7,074. | 14,500. | 23,265. | 842,496. | 0. |
| RHONDA SOWARDS MEDICAL DIRECTOR | (i) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| | (ii) | 596,290. | 26,547. | 24,646. | 14,500. | 23,179. | 685,162. | 0. |
| KATHERINE MARCHIK SR VP FINANCE/CFO | (i) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| | (ii) | 350,964. | 95,061. | 4,987. | 78,062. | 28,984. | 558,058. | 0. |
| JOY LEDBETTER (FR 5/21) VP HUMAN RESOURCES | (i) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| | (ii) | 372,080. | 80,449. | 69,981. | 14,500. | 20,428. | 557,438. | 0. |
| YACOB ZAYADIN, MD (FR 8/21) BOARD MEMBER | (i) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| | (ii) | 386,889. | 4,465. | 629. | 14,500. | 9,218. | 415,701. | 0. |
| RICHARD SEIDLER (TO 5/19) FORMER BD MEMBER/PRESIDENT/CEO | (i) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| | (ii) | 0. | 0. | 411,367. | 0. | 0. | 411,367. | 394,444. |
| ROBERT WEIS, MD BOARD MEMBER | (i) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| | (ii) | 306,834. | 7,328. | 6,180. | 14,500. | 21,624. | 356,466. | 0. |
| ANGELA JOHNSON (TO 10/21) VP HR/VP OPERATIONS | (i) | 175,941. | 71,609. | 2,323. | 12,460. | 14,754. | 277,087. | 0. |
| | (ii) | 39,253. | 0. | 629. | 2,040. | 4,827. | 46,749. | 0. |
| ROBERT CARLSON, MD (FR 1/21- TO 5/21) BOARD MEMBER | (i) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| | (ii) | 258,610. | 7,131. | 6,210. | 13,540. | 10,291. | 295,782. | 0. |
| JASON THORNBURG, PA-C PHYSICIANS ASSISTANT | (i) | 222,934. | 4,979. | 294. | 11,775. | 25,544. | 265,526. | 0. |
| | (ii) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| JENNY OLSON, DNP NURSE PRACTITIONER | (i) | 191,083. | 4,916. | 12,659. | 10,863. | 19,069. | 238,590. | 0. |
| | (ii) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| PEGGY CREAMER, ARNP NURSE PRACTITIONER | (i) | 188,110. | 4,210. | 1,154. | 7,322. | 18,812. | 219,608. | 0. |
| | (ii) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| MARIA-TERESA GALOSO, MD BOARD MEMBER | (i) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| | (ii) | 177,513. | 4,059. | 2,066. | 9,626. | 24,748. | 218,012. | 0. |
| ASHLEY WELLER, PA-C PHYSICIANS ASSISTANT | (i) | 169,917. | 3,913. | 293. | 8,835. | 16,496. | 199,454. | 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 on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that aren't listed on Form 990, Part VII.

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

| (A) Name and Title | | (B) Breakdown of W-2 and/or 1099-MISC and/or 1099-NEC compensation | | | (C) Retirement and other deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation in column (B) reported as deferred on prior Form 990 |
|---|------|--|-------------------------------------|-------------------------------------|--|-------------------------|---------------------------------|---|
| | | (i) Base compensation | (ii) Bonus & incentive compensation | (iii) Other reportable compensation | | | | |
| ANDREA WALSH, PA-C PHYSICIANS ASSISTANT | (i) | 166,947. | 3,624. | 330. | 6,986. | 16,381. | 194,268. | 0. |
| | (ii) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| PAMELA F. ASKEW VP PATIENT CARE | (i) | 143,663. | 19,842. | 396. | 8,308. | 11,805. | 184,014. | 0. |
| | (ii) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| BENJAMIN POHL, PA-C (FR 1/21) BOARD MEMBER | (i) | 147,713. | 3,781. | 1,937. | 8,067. | 5,972. | 167,470. | 0. |
| | (ii) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| | (i) | | | | | | | |
| | (ii) | | | | | | | |
| | (i) | | | | | | | |
| | (ii) | | | | | | | |
| | (i) | | | | | | | |
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| | (ii) | | | | | | | |
| | (i) | | | | | | | |
| | (ii) | | | | | | | |

Part III Supplemental Information

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

PART I, LINES 4A-B:

SEVERANCE PAYMENTS:

THE FOLLOWING INDIVIDUAL(S) RECEIVED SEVERANCE PAYMENTS DURING THE YEAR THAT WERE INCLUDED IN THEIR TAXABLE INCOME: RICHARD SEIDLER \$ 16,923.

NONQUALIFIED RETIREMENT PLAN CONTRIBUTIONS:

THE FOLLOWING INDIVIDUAL(S) PARTICIPATED IN AND RECEIVED CONTRIBUTIONS IN A SUPPLEMENTAL NON-QUALIFIED RETIREMENT PLAN: ROBERT ERICKSON \$110,190 , KATHERINE MARCHIK \$63,562 & JOHN SHEEHAN \$145,044.

NONQUALIFIED RETIREMENT PLAN DISTRIBUTIONS:

THE FOLLOWING INDIVIDUAL(S) PARTICIPATED IN AND RECEIVED PAYMENTS FROM A SUPPLEMENTAL NON-QUALIFIED PLAN: RICHARD SEIDLER \$ 394,444. PAYOUTS ARE MADE WITH VESTED FUNDS, AS ESTABLISHED BY PLAN DOCUMENTS.

Supplemental Information on Tax-Exempt Bonds

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.**
▶ **Attach to Form 990.** ▶ **Go to www.irs.gov/Form990 for instructions and the latest information.**

Name of the organization **UNITY HEALTHCARE** Employer identification number **42-0680337**

| Part I Bond Issues | | | | | | | | | | | |
|----------------------------------|----------------|-------------|-----------------|-----------------|----------------------------|--------------|----|-------------------------|----|----------------------|----|
| (a) Issuer name | (b) Issuer EIN | (c) CUSIP # | (d) Date issued | (e) Issue price | (f) Description of purpose | (g) Defeased | | (h) On behalf of issuer | | (i) Pooled financing | |
| | | | | | | Yes | No | Yes | No | Yes | No |
| A IOWA FINANCE AUTHORITY | 52-1699886 | 46246PKC4 | 02/01/06 | 14505000. | CONSTRUCTION OF FACILITIES | X | | | X | | X |
| B CITY OF MUSCATINE, IOWA | 42-6005008 | NONE | 12/31/05 | 4,000,000. | CONSTRUCTION OF FACILITIES | | X | | X | | X |
| C | | | | | | | | | | | |
| D | | | | | | | | | | | |

| Part II Proceeds | | | | | | | | | | |
|--|-------------|----|------------|----|-----|----|-----|----|--|--|
| | A | | B | | C | | D | | | |
| 1 Amount of bonds retired | 3,027,237. | | 2,300,000. | | | | | | | |
| 2 Amount of bonds legally defeased | 11,410,000. | | | | | | | | | |
| 3 Total proceeds of issue | 15,002,237. | | 4,000,000. | | | | | | | |
| 4 Gross proceeds in reserve funds | | | | | | | | | | |
| 5 Capitalized interest from proceeds | 528,415. | | 273,139. | | | | | | | |
| 6 Proceeds in refunding escrows | | | | | | | | | | |
| 7 Issuance costs from proceeds | | | | | | | | | | |
| 8 Credit enhancement from proceeds | | | | | | | | | | |
| 9 Working capital expenditures from proceeds | | | | | | | | | | |
| 10 Capital expenditures from proceeds | 14,544,238. | | 3,726,861. | | | | | | | |
| 11 Other spent proceeds | | | | | | | | | | |
| 12 Other unspent proceeds | | | | | | | | | | |
| 13 Year of substantial completion | 2007 | | 2007 | | | | | | | |
| | Yes | No | Yes | No | Yes | No | Yes | No | | |
| 14 Were the bonds issued as part of a refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)? | | X | | X | | | | | | |
| 15 Were the bonds issued as part of a refunding issue of taxable bonds (or, if issued prior to 2018, an advance refunding issue)? | | X | | X | | | | | | |
| 16 Has the final allocation of proceeds been made? | X | | X | | | | | | | |
| 17 Does the organization maintain adequate books and records to support the final allocation of proceeds? | X | | X | | | | | | | |

| Part III Private Business Use | | | | | | | | |
|---|-----|----|-----|----|-----|----|-----|----|
| | A | | B | | C | | D | |
| | Yes | No | Yes | No | Yes | No | Yes | No |
| 1 Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds? | | X | | X | | | | |
| 2 Are there any lease arrangements that may result in private business use of bond-financed property? | | X | | X | | | | |
| 3a Are there any management or service contracts that may result in private business use of bond-financed property? | X | | X | | | | | |
| b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property? | X | | X | | | | | |
| c Are there any research agreements that may result in private business use of bond-financed property? | X | | X | | | | | |
| d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property? ... | X | | X | | | | | |
| 4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government | | % | | % | | % | | % |
| 5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government | | % | | % | | % | | % |
| 6 Total of lines 4 and 5 | | % | | % | | % | | % |
| 7 Does the bond issue meet the private security or payment test? | | X | | X | | | | |
| 8a Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued? | | X | | X | | | | |
| b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of | | % | | % | | % | | % |
| c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2? | | | | | | | | |
| 9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2? | X | | X | | | | | |

| Part IV Arbitrage | | | | | | | | |
|---|-----|----|-----|----|-----|----|-----|----|
| | A | | B | | C | | D | |
| | Yes | No | Yes | No | Yes | No | Yes | No |
| 1 Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate? | | X | | X | | | | |
| 2 If "No" to line 1, did the following apply? | | | | | | | | |
| a Rebate not due yet? | | X | | X | | | | |
| b Exception to rebate? | X | | X | | | | | |
| c No rebate due? | | X | | X | | | | |
| If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed | | | | | | | | |
| 3 Is the bond issue a variable rate issue? | X | | X | | | | | |

Part IV Arbitrage (continued)

| | A | | B | | C | | D | |
|--|-----|----|-----|----|-----|----|-----|----|
| | Yes | No | Yes | No | Yes | No | Yes | No |
| 4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue? | | X | | X | | | | |
| b Name of provider | | | | | | | | |
| c Term of hedge | | | | | | | | |
| d Was the hedge superintegrated? | | | | | | | | |
| e Was the hedge terminated? | | | | | | | | |
| 5a Were gross proceeds invested in a guaranteed investment contract (GIC)? | | X | | X | | | | |
| b Name of provider | | | | | | | | |
| c Term of GIC | | | | | | | | |
| d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied? | | | | | | | | |
| 6 Were any gross proceeds invested beyond an available temporary period? | | X | | X | | | | |
| 7 Has the organization established written procedures to monitor the requirements of section 148? | X | | X | | | | | |

Part V Procedures To Undertake Corrective Action

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

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

SCHEDULE K, PART II, LINE 3, COLUMN (A)

THERE IS A DIFFERENCE BETWEEN THE BOND ISSUE PRICE AND THE TOTAL PROCEEDS OF BOND ISSUE DUE TO INVESTMENT EARNINGS OF \$497,237.

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 |
| RACHEL POHL | FAMILY MEMBER OF BO | 113,066. | EMPLOYMENT | | X |
| | | | | | |
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Part V Supplemental Information.

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: RACHEL POHL

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

FAMILY MEMBER OF BOARD MEMBER BENJAMIN POHL, PA-C

(C) AMOUNT OF TRANSACTION \$ 113,066.

(D) DESCRIPTION OF TRANSACTION: EMPLOYMENT

(E) SHARING OF ORGANIZATION REVENUES? = NO

**SCHEDULE O
(Form 990)**

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 Form 990-EZ.

▶ Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2021

Open to Public
Inspection

Name of the organization

UNITY HEALTHCARE

Employer identification number

42-0680337

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

ARE NOT LIMITED TO, GENERAL ACUTE CARE, SURGERIES, INTENSIVE CARE AND

CRITICAL CARE, ONCOLOGY, MATERNAL/CHILD CARE, LABORATORY,

PHARMACEUTICAL DRUGS, EMERGENCY SERVICES, OUTPATIENT CLINICS, CHECK-UPS

AND RADIOLOGY. SOME OF THE SERVICES PROVIDED DO NOT GENERATE ENOUGH

INCOME TO OFFSET THEIR COST. IN THE FISCAL PERIOD ENDED DECEMBER 31,

2021, UNITY HEALTHCARE ADMITTED 900 PATIENTS RESULTING IN A TOTAL OF

2,740 PATIENT DAYS. OUTPATIENT VISITS TOTALED 81,805 AND TOTAL

OUTPATIENT SURGERY REGISTRATIONS FOR THE SAME PERIOD WERE 844. THERE

WERE ALSO 16,868 EMERGENCY ROOM VISITS.

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

BELOW ITS COST IS \$708,527 FOR 2021. TOTAL CHARITY CARE AND

MEANS-TESTED PROGRAMS REPORTED VALUE: \$1,095,727.

OTHER BENEFITS: UNITY HEALTHCARE PROVIDES SEVERAL OTHER BENEFITS THAT

ASSIST THE COMMUNITY. PROGRAMS MAY INCLUDE, BUT ARE NOT LIMITED TO,

COMMUNITY HEALTH IMPROVEMENT SERVICES AND COMMUNITY BENEFIT OPERATIONS

SUCH AS PREVENTION AND HEALTH SCREENINGS; CONTINUING EDUCATION FOR

HEALTH PROFESSIONALS; SUBSIDIZED HEALTH SERVICES; RESEARCH; AND CASH

AND IN-KIND CONTRIBUTIONS TO COMMUNITY GROUPS. UNITY HEALTHCARE

COLLABORATES WITH OTHER HOSPITALS, CHURCHES, SCHOOLS, CHAMBERS OF

COMMERCE AND DAYCARE CENTERS TO IMPROVE COMMUNITY HEALTH AND EXPAND

ACCESS TO HEALTH CARE. UNITY HEALTHCARE HAS DEDICATED STAFF TO ASSIST

COMMUNITY BENEFIT EFFORTS. TOTAL OTHER BENEFITS REPORTED VALUE:

\$667,230.

Name of the organization

UNITY HEALTHCARE

Employer identification number

42-0680337

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 THREE BOARD MEMBERS 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 APPOINTS CEO.

FORM 990, PART VI, SECTION B, LINE 11B:

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 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 V, LINES 1A & 1B

CASH DISBURSEMENTS ARE CENTRALIZED THROUGH THE PARENT ORGANIZATION, IOWA HEALTH SYSTEM (D/B/A UNITYPOINT HEALTH). THE PARENT MAKES THE PAYMENTS AND FILES THE RELATED FORMS 1099 AND 1096 ON BEHALF OF ALL UNITYPOINT HEALTH SYSTEM RELATED ORGANIZATIONS.

Name of the organization

UNITY HEALTHCARE

Employer identification number

42-0680337

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 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

Name of the organization

UNITY HEALTHCARE

Employer identification number

42-0680337

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 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

| | |
|--|--|
| Name of the organization UNITY HEALTHCARE | Employer identification number 42-0680337 |
|--|--|

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.

FORM 990, PART VI, SECTION B, LINE 15:

THE EXECUTIVE COMMITTEE OF THE IOWA HEALTH SYSTEM BOARD OF DIRECTORS ("COMMITTEE") CONDUCTS A COMPREHENSIVE REVIEW OF ALL COMPENSATION AND BENEFITS PROVIDED TO THE ORGANIZATION'S OFFICERS AND KEY EMPLOYEES,

| | |
|--|--|
| Name of the organization UNITY HEALTHCARE | Employer identification number 42-0680337 |
|--|--|

INCLUDING THE IHS CHIEF EXECUTIVE OFFICER (THE "CEO"). THIS 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 THE TOP 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 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

Name of the organization

UNITY HEALTHCARE

Employer identification number

42-0680337

ITS EMPLOYEES AND DOES NOT PROVIDE ANY EXCESS COMPENSATION OR BENEFITS AS PROHIBITED BY SECTION 4958.

THE REVIEW OF COMPENSATION AND BENEFITS WAS LAST PERFORMED IN DECEMBER 2021 FOR THE FOLLOWING INDIVIDUALS:

ROBERT ERICKSON, ANGELA JOHNSON, JOY LEDBETTER, KATIE MARCHIK, TOYOSI OLUFADE, MD, & JOHN SHEEHAN.

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 QUALIFIED 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:

THE ORGANIZATION'S GOVERNING DOCUMENTS ARE AVAILABLE UPON REQUEST THROUGH THE IOWA HEALTH SYSTEM, OUR PARENT ORGANIZATION, LEGAL DEPARTMENT. THE ORGANIZATION'S CONFLICT OF INTEREST POLICY AND FINANCIAL STATEMENTS ARE PUBLICLY AVAILABLE ON THE IOWA HEALTH SYSTEM WEBSITE, WWW.UNITYPOINT.ORG.

FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

FUND BALANCE TRANSFER TO TRINITY MEDICAL CENTER -904,650.

FORM 990, LINE J, WEBSITE:

WWW.UNITYPOINT.ORG/QUADCITIES/TRINITY-MUSCATINE.ASPX

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

▶ Attach to Form 990.

▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2021

Open to Public Inspection

Name of the organization

UNITY HEALTHCARE

Employer identification number

42-0680337

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

| (a) Name, address, and EIN (if applicable) of disregarded entity | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Total income | (e) End-of-year assets | (f) Direct controlling entity |
|--|-------------------------|---|---------------------|---------------------------|-------------------------------------|
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Part II Identification of Related Tax-Exempt Organizations. Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it had one or more related tax-exempt organizations during the tax year.

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512(b)(13) controlled entity? | |
|--|--|---|-------------------------------|---|-------------------------------------|--|----|
| | | | | | | Yes | No |
| ABBE CENTER FOR COMMUNITY MENTAL HEALTH, INC. - 42-1045257, 740 N 15TH AVE., NO. A, HIAWATHA, IA 52233 | MENTAL HEALTH CARE | IOWA | 501(C)(3) | 509(A)(2) | ABBEHEALTH, INC. | | X |
| ABBEHEALTH, INC. - 42-1373123 740 N 15TH AVE., NO. A HIAWATHA, IA 52233 | SUPPORT AFFILIATES' MISSION TO IMPROVE HEALTH CARE | IOWA | 501(C)(3) | 509(A)(3), TYPE III | ST. LUKE'S HEALTHCARE | | X |
| AGING SERVICES, INC. - 23-7085316 740 N 15TH AVE., NO. A HIAWATHA, IA 52233 | SENIOR SERVICES | IOWA | 501(C)(3) | 170(B)(1) (A)(VI) | ABBEHEALTH, INC. | | X |
| 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 |

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

Schedule R (Form 990) 2021

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 |
| 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)(3), TYPE III | ST. LUKE'S/JONES REGIONAL MEDICAL CENTER | | X |
| BLACK HAWK-GRUNDY MENTAL HEALTH CENTER, INC. - 42-0733463, 3251 WEST NINTH STREET, WATERLOO, IA 50702 | MENTAL HEALTH CARE | IOWA | 501(C)(3) | 170(B)(1) (A)(VI) | ALLEN HEALTH SYSTEMS, INC. | | X |
| CENTER FOR ALCOHOL AND DRUG SERVICES, INC. - 42-1134273, 4869 FOREST GROVE DRIVE, BETTENDORF, IA 52722 | SUBSTANCE ABUSE SERVICES | IOWA | 501(C)(3) | 170(B)(1) (A)(VI) | THE ROBERT YOUNG CENTER FOR COMMUNITY MENTAL | | X |
| 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 |
| CHATHAM OAKS - 42-1302928 740 N 15TH AVE., NO. A HIAWATHA, IA 52233 | MENTAL HEALTH AND/OR DISABILITY RESIDENTIAL TREATMENT SERVICES | IOWA | 501(C)(3) | 509(A)(2) | ABBEHEALTH, INC. | | X |
| DES MOINES AREA MEDICAL EDUCATION CONSORTIUM, INC. - 42-1412497, 1415 WOODLAND AVE., SUITE 130, DES MOINES, IA 50309 | COORDINATION OF MEDICAL EDUCATION PROGRAMS | IOWA | 501(C)(3) | 509(A)(3), TYPE III | | | X |
| EYERLY-BALL COMMUNITY MENTAL HEALTH SERVICES - 42-0942273, 945 19TH STREET, DES MOINES, IA 50314 | MENTAL HEALTH CARE | IOWA | 501(C)(3) | 509(A)(2) | 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 |

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 |
| FRIENDS OF THE BLACK HAWK-GRUNDY MENTAL HEALTH CENTER - 42-1372380, 3820 HILLSIDE DRIVE, CEDAR FALLS, IA 50613 | CHARITABLE FUNDRAISING | IOWA | 501(C)(3) | 170(B)(1) (A)(VI) | ALLEN HEALTH SYSTEMS, INC. | | X |
| GRINNELL REGIONAL MEDICAL CENTER - 42-0933383, 210 FOURTH AVENUE, GRINNELL, IA 50112 | HOSPITAL | IOWA | 501(C)(3) | 170(B)(1) (A)(III) | CENTRAL IOWA HEALTH SYSTEM | | X |
| GRINNELL REGIONAL MEDICAL CENTER AUXILIARY - 23-7075505, 210 FOURTH AVENUE, GRINNELL, IA 50112 | CHARITABLE FUNDRAISING AND VOLUNTEER SERVICES | IOWA | 501(C)(3) | 509(A)(3), TYPE I | GRINNELL REGIONAL MEDICAL CENTER | | X |
| GRINNELL REGIONAL MEDICAL CENTER FOUNDATION - 42-1454737, 210 FOURTH AVENUE, GRINNELL, IA 50112 | CHARITABLE FUNDRAISING | IOWA | 501(C)(3) | 509(A)(3), TYPE I | GRINNELL REGIONAL MEDICAL CENTER | | X |
| HULT CENTER FOR HEALTHY LIVING, INC. - 36-3510390, 5409 N KNOXVILLE AVE, PEORIA, IL 61614 | HEALTH EDUCATION TO THE COMMUNITY | ILLINOIS | 501(C)(3) | 170(B)(1) (A)(VI) | PROCTOR HOSPITAL | | X |
| HUMAN SERVICE CENTER - 37-1004882 600 FAYETTE, PO BOX 1346 PEORIA, IL 61654 | MENTAL HEALTH CARE | ILLINOIS | 501(C)(3) | 170(B)(1) (A)(VI) | UNITYPOINT HEALTH - UNITYPLACE | | X |
| IOWA HEALTH FOUNDATION - 42-1467682 1415 WOODLAND AVE., SUITE E-200 DES MOINES, IA 50309 | CHARITABLE FUNDRAISING | IOWA | 501(C)(3) | 170(B)(1) (A)(VI) | CENTRAL IOWA HEALTH SYSTEM | | X |
| IOWA HEALTH SYSTEM - 42-1435199 1776 WEST LAKES PKWY, #400 WEST DES MOINES, IA 50266 | SUPPORT AFFILIATES' MISSION TO IMPROVE HEALTH CARE | IOWA | 501(C)(3) | 509(A)(3), TYPE III | | | X |
| IOWA PHYSICIANS CLINIC MEDICAL FOUNDATION - 42-1411630, 1776 WEST LAKES PKWY, #400, WEST DES MOINES, IA 50266 | 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 |
| MERITER FOUNDATION, INC. - 23-7098688 202 SOUTH PARK STREET MADISON, WI 53715 | CHARITABLE FUNDRAISING | WISCONSIN | 501(C)(3) | 170(B)(1) (A)(VI) | MERITER HEALTH SERVICES, INC. | | X |
| MERITER HEALTH SERVICES, INC. - 39-1412318 202 SOUTH PARK STREET MADISON, WI 53715 | SUPPORT AFFILIATES' MISSION TO IMPROVE HEALTH CARE | WISCONSIN | 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 |
| MERITER HOSPITAL, INC. - 39-0806367 202 SOUTH PARK STREET MADISON, WI 53715 | HOSPITAL | WISCONSIN | 501(C)(3) | 170(B)(1) (A)(III) | MERITER HEALTH SERVICES, INC. | | X |
| METHODIST HEALTH SERVICES CORPORATION - 37-1111135, 221 NORTHEAST GLEN OAK AVENUE, PEORIA, IL 61636 | SUPPORT AFFILIATES' MISSION TO IMPROVE HEALTH CARE | ILLINOIS | 501(C)(3) | 509(A)(3), TYPE III | IOWA HEALTH SYSTEM | | X |
| METHODIST MEDICAL CENTER FOUNDATION - 51-0186460, 221 NORTHEAST GLEN OAK AVENUE, PEORIA, IL 61636 | CHARITABLE 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 | HOSPITAL | 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) | ST. LUKE'S HEALTH SYSTEM, INC. | | X |
| PARK COURT LIMITED - 37-1178386 600 SOUTH 13TH STREET PEKIN, IL 61554 | SUPPORT AFFILIATES' MISSION TO IMPROVE HEALTH CARE | ILLINOIS | 501(C)(3) | 509(A)(3), TYPE II | METHODIST HEALTH SERVICES CORPORATION | | X |
| PEKIN MEMORIAL HOSPITAL - 37-0692351 600 SOUTH 13TH STREET PEKIN, IL 61554 | HOSPITAL | ILLINOIS | 501(C)(3) | 170(B)(1) (A)(III) | METHODIST HEALTH SERVICES CORPORATION | | X |
| PENN CENTER, INC. - 42-1421803 740 N 15TH AVE., NO. A HIAWATHA, IA 52233 | RESIDENTIAL TREATMENT SERVICES FOR INDEPENDENT LIVING | IOWA | 501(C)(3) | 509(A)(2) | ABBEHEALTH, INC. | | X |
| PRAIRIE VIEW VILLAS NO. 1 - 26-1755679 1900 SPRING ROAD, STE 300 OAK BROOK, IL 60523 | MENTAL HEALTH AND/OR DISABILITY RESIDENTIAL TREATMENT SERVICES | ILLINOIS | 501(C)(3) | 170(B)(1) (A)(VI) | TAZWOOD MENTAL HEALTH CENTER, INC. | | 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 |
| PROCTOR HEALTH SYSTEMS - 36-4147437 5409 N KNOXVILLE AVE PEORIA, IL 61614 | PRIMARY HEALTH CARE SERVICES | ILLINOIS | 501(C)(3) | 170(B)(1) (A)(III) | METHODIST HEALTH SERVICES CORPORATION | | X |
| PROCTOR HOSPITAL - 37-0681540 5409 N KNOXVILLE AVE PEORIA, IL 61614 | HOSPITAL | ILLINOIS | 501(C)(3) | 170(B)(1) (A)(III) | METHODIST HEALTH SERVICES CORPORATION | | 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 I | METHODIST MEDICAL CENTER OF ILLINOIS | | X |
| SIouxLAND PACE, INC. - 26-1120134 1200 TRI VIEW AVE 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 |
| 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 |
| TAZWOOD MENTAL HEALTH CENTER, INC. - 37-1278969, 3248 VANDEVER AVE, PEKIN, IL 61554 | MENTAL HEALTH CARE | ILLINOIS | 501(C)(3) | 170(B)(1) (A)(VI) | UNITYPOINT HEALTH - UNITYPLACE | | 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 |

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 |
| 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 |
| TRIMARK PHYSICIANS GROUP - 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 COLLEGE OF NURSING & HEALTH SCIENCES - 81-0994377, 2122 25TH AVE, ROCK ISLAND, IL 61201 | EDUCATE AND DEVELOP HEALTHCARE PROFESSIONALS | ILLINOIS | 501(C)(3) | 170(B)(1) (A)(II) | TRINITY MEDICAL CENTER | | 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 |
| 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 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 |
| UNITY HEALTHCARE FOUNDATION - 42-1525031 1518 MULBERRY AVENUE MUSCATINE, IA 52761 | SUPPORT AFFILIATES' MISSION TO IMPROVE HEALTH CARE | IOWA | 501(C)(3) | 509(A)(3), TYPE I | UNITY HEALTHCARE | X | |
| UNITYPOINT HEALTH - MARSHALLTOWN - 81-5034179, 1825 LOGAN AVENUE, WATERLOO, IA 50703 | HOSPITAL | IOWA | 501(C)(3) | 170(B)(1) (A)(III) | ALLEN HEALTH SYSTEMS, INC. | | X |
| UNITYPOINT HEALTH - MARSHALLTOWN FOUNDATION - 42-1388518, 3 SOUTH 4TH AVE, MARSHALLTOWN, IA 50158 | CHARITABLE FUNDRAISING | IOWA | 501(C)(3) | 170(B)(1) (A)(VI) | ALLEN HEALTH SYSTEMS, INC. | | X |
| UNITYPOINT HEALTH - UNITYPLACE - 83-4051901 221 NORTHEAST GLEN OAK AVENUE PEORIA, IL 61636 | SUPPORT AFFILIATES' MISSION TO IMPROVE HEALTH CARE | ILLINOIS | 501(C)(3) | 509(A)(3), TYPE II | METHODIST HEALTH SERVICES CORPORATION | | X |
| UNITYPOINT AT HOME - 42-1477471 1776 WEST LAKES PKWY, #400 WEST DES MOINES, IA 50266 | HOME HEALTH CARE | IOWA | 501(C)(3) | 509(A)(2) | IOWA HEALTH SYSTEM | | X |
| UNITYPOINT HEALTH AT WORK - 81-0872241 1776 WEST LAKES PKWY, #400 WEST DES MOINES, IA 50266 | EMPLOYER ONSITE MEDICAL SERVICES AND OCCUPATIONAL MEDICINE | IOWA | 501(C)(3) | 170(B)(1) (A)(III) | IOWA HEALTH SYSTEM | | X |
| WISCONSIN DIALYSIS, INC. - 30-0072647 3034 FISH HATCHERY ROAD MADISON, WI 53713 | OUTPATIENT KIDNEY DIALYSIS | WISCONSIN | 501(C)(3) | 509(A)(3), TYPE III | | | X |
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Part III Identification of Related Organizations Taxable as a Partnership. Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it had one or more related organizations treated as a partnership during the tax year.

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Predominant income (related, unrelated, excluded from tax under sections 512-514) | (f) Share of total income | (g) Share of end-of-year assets | (h) Disproportionate allocations? | | (i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065) | (j) General or managing partner? | | (k) Percentage ownership |
|---|--|---|-------------------------------------|---|---------------------------------|--|---|----|---|---|----|--------------------------------|
| | | | | | | | Yes | No | | Yes | No | |
| ADVANCED IMAGING CENTER, LLC - 36-4356301, 615 VALLEY VIEW DRIVE, MOLINE, IL 61265 | DIAGNOSTIC RADIOLOGY CENTER | IA | N/A | N/A | N/A | N/A | | X | N/A | X | | N/A |
| ANKENY MEDICAL PARK SURGERY CENTER, L.C. - 83-1281114, 3625 NORTH ANKENY BLVD., STE. J, ANKENY, IA 50021 | AMBULATORY SURGERY CENTER | IA | N/A | N/A | N/A | N/A | | X | N/A | X | | N/A |
| 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 | N/A | N/A | N/A | | X | N/A | X | | N/A |
| CENTRAL IOWA ONCOLOGY CO-MANAGEMENT COMPANY - 45-3017991, 1200 PLEASANT STREET, DES MOINES, IA 50309 | ONCOLOGY MANAGEMENT & ADMINISTRATIVE SERVICES | IA | N/A | N/A | N/A | N/A | | X | N/A | X | | N/A |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income | (g) Share of end-of-year assets | (h) Percentage ownership | (i) Section 512(b)(13) controlled entity? | |
|--|---------------------------------|---|-------------------------------------|--|---------------------------------|--|--------------------------------|---|----|
| | | | | | | | | Yes | No |
| ABBE MANAGEMENT CORPORATION - 42-1361755 740 N 15TH AVE., NO. A HIAWATHA, IA 52233 | MANAGEMENT SERVICES | IA | N/A | C CORP | N/A | N/A | N/A | | X |
| BELCREST SERVICES LTD - 37-1196307 5409 N KNOXVILLE AVE PEORIA, IL 61614 | MEDICAL SERVICES | IL | N/A | C CORP | N/A | N/A | N/A | | X |
| BROADBAND, INC. - 27-3819741 1776 WEST LAKES PKWY. #400 WEST DES MOINES, IA 50266 | INFORMATION TECHNOLOGY MGMT. | IA | N/A | C CORP | N/A | N/A | N/A | | X |
| DELHI POINT CONDO ASSOCIATION - 42-1467002 350 N. GRANDVIEW DUBUQUE, IA 52001 | REAL ESTATE MANAGEMENT | IA | N/A | C CORP | N/A | N/A | N/A | | X |
| HCP CORPORATION - 39-1177562 202 SOUTH PARK STREET MADISON, WI 53715 | REAL ESTATE RENTAL | WI | N/A | C CORP | N/A | N/A | N/A | | X |

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) Disproportion- ate allocations? | | (i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065) | (j) General or managing partner? | | (k) Percentage ownership |
|---|--|--|-------------------------------------|---|---------------------------------|--|---|----|---|---|----|--------------------------------|
| | | | | | | | Yes | No | | Yes | No | |
| CENTRAL IOWA PHYSIO, LLC - 36-4799633, 4714 GETTYSBURG ROAD, MECHANICSBURG, PA 17055 | PHYSICAL THERAPY SERVICES | IA | N/A | N/A | N/A | N/A | X | | N/A | X | | N/A |
| CENTRAL IOWA SURGICAL SERVICES CO-MANAGEMENT CO., L.L.C. - 47-1608704, 1200 PLEASANT ST, DES MOINES, IA | SURGICAL MANAGEMENT & ADMINISTRATIVE SERVICES | IA | N/A | N/A | N/A | N/A | X | | N/A | X | | N/A |
| DUBUQUE ENDOSCOPY CENTER, L.C. - 20-1597161, 1515 DELHI STREET, SUITE 500, DUBUQUE, IA 52001 | AMBULATORY SURGERY CENTER | IA | N/A | N/A | N/A | N/A | X | | N/A | X | | N/A |
| EASTERN IOWA SLEEP SUPPLY, LLC - 85-1990451, 275 10TH STREET SE, STE 1130-B, CEDAR RAPIDS, IA 52403 | MEDICAL EQUIPMENT RETAIL SALES | IA | N/A | N/A | N/A | N/A | X | | N/A | X | | N/A |
| 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 | N/A | N/A | N/A | X | | N/A | X | | N/A |
| IOWA DIAGNOSTIC IMAGING AND PROCEDURE CENTER, L.C. - 03-0482623, 1200 PLEASANT STREET, DES MOINES, IA 50309 | OUTPATIENT DIAGNOSTIC IMAGING | IA | N/A | N/A | N/A | N/A | X | | N/A | X | | N/A |
| IOWA HEALTH SYSTEM CONTRACTING SERVICES LC - 42-1511142, 1776 WEST LAKES PKWY, #400, WEST DES MOINES, | GROUP PURCHASING | IA | N/A | N/A | N/A | N/A | X | | N/A | X | | N/A |
| LAKEVIEW SURGERY CENTER, L.C. - 42-1516120, 1200 PLEASANT STREET, DES MOINES, IA 50309 | SURGERY CENTER | IA | N/A | N/A | N/A | N/A | X | | N/A | X | | N/A |
| MIDWEST ORTHOPAEDIC HOSPITAL AT UNITYPOINT HEALTH-PROCTOR, LLC - 84-3733879, 5409 N. KNOXVILLE AVE, PEORIA, IL | OUTPATIENT ORTHOPEDIC SERVICE LINE MANAGEMENT | IL | N/A | N/A | N/A | N/A | X | | N/A | X | | N/A |

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) Disproportion- ate allocations? | | (i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065) | (j) General or managing partner? | | (k) Percentage ownership |
|---|---|--|-------------------------------------|---|---------------------------------|--|---|----|---|---|----|--------------------------------|
| | | | | | | | Yes | No | | Yes | No | |
| MR ASSOCIATES, LLP - 42-1260463, 1956 1ST AVENUE NE, CEDAR RAPIDS, IA 52402 | OWN AND OPERATE MR UNIT | IA | N/A | N/A | N/A | N/A | X | | N/A | X | | N/A |
| ORTHOPAEDIC OUTPATIENT SURGERY CENTER, L.C. - 42-1508092, 1200 PLEASANT STREET, DES MOINES, IA 50309 | AMBULATORY SURGERY CENTER | IA | N/A | N/A | N/A | N/A | X | | N/A | X | | N/A |
| REHABILITATION THERAPY SERVICES, L.L.C. - 81-0584193, 416 ST. MARK'S CT, #110, PEORIA, IL 61603 | REHABILITATION THERAPY | IL | N/A | N/A | N/A | N/A | X | | N/A | X | | N/A |
| 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 | N/A | N/A | N/A | X | | N/A | X | | N/A |
| UNITED MEDICAL PARK ASC, LLC D/B/A THE SURGERY CENTER AT UNITED MEDICAL PARK, 1825 LOGAN AVE, WATERLOO, IA | AMBULATORY SURGERY CENTER | IA | N/A | N/A | N/A | N/A | X | | N/A | X | | N/A |
| UPHT-SCA HOLDINGS, LLC - 47-3564984, 569 BROOKWOOD VILLAGE, SUITE 901, BIRMINGHAM, AL 35209 | AMBULATORY SURGERY CENTER INVESTMENT | DE | N/A | N/A | N/A | N/A | X | | N/A | X | | N/A |
| WEST HOSPITAL ORTHOPEDIC CO-MANAGEMENT COMPANY, LLC - 27-1414600, 1660 60TH STREET, WEST DES MOINES, IA 50266 | ORTHOPEDIC SERVICE LINES MANAGEMENT | IA | N/A | N/A | N/A | N/A | X | | N/A | X | | N/A |
| 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 | N/A | N/A | N/A | X | | N/A | X | | N/A |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |

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 | (i) Section 512(b)(13) controlled entity? | |
|---|---------------------------------|---|-------------------------------------|--|---------------------------------|--|--------------------------------|---|----|
| | | | | | | | | Yes | No |
| HANSEN CHARITABLE REMAINDER ANNUITY TRUST - 39-6770806, 210 FOURTH AVENUE, GRINNELL, IA 50112 | INVESTMENT | IA | N/A | TRUST | N/A | N/A | N/A | | X |
| HANSEN CHARITABLE REMAINDER UNITRUST - 39-6770807, 210 FOURTH AVENUE, GRINNELL, IA 50112 | INVESTMENT | IA | N/A | TRUST | N/A | N/A | N/A | | X |
| HEALTH ADVANTAGE PLUS, INC. - 42-1436490 210 4TH AVENUE GRINNELL, IA 50112 | PHYSICAL THERAPY | IA | N/A | C CORP | N/A | N/A | N/A | | X |
| HEALTH PLUS INC - 37-1295532 5409 N KNOXVILLE AVE PEORIA, IL 61614 | MANAGED CARE ADMINISTRATION | IL | N/A | C CORP | N/A | N/A | N/A | | X |
| HNC SERVICES - 27-0987243 1776 WEST LAKES PKWY, #400 WEST DES MOINES, IA 50266 | FIBER OPTIC NETWORK SERVICES | IA | N/A | C CORP | N/A | N/A | N/A | | X |
| HOME HEALTH PLUS SERVICES, INC. - 36-4053068 P.O. BOX 87 PEORIA, IL 61650 | HOME HEALTH SERVICES | IL | N/A | C CORP | N/A | N/A | N/A | | X |
| MARIGOLD CITY LAND TRUST NO. ONE - 27-2750273, 2956 COURT STREET, PEKIN, IL 61554 | PROPERTY MANAGEMENT | IL | N/A | TRUST | N/A | N/A | N/A | | X |
| MEDIMORE, INC. - 42-1414390 1776 WEST LAKES PKWY. #400 WEST DES MOINES, IA 50266 | MANAGED CARE | IA | N/A | C CORP | N/A | N/A | N/A | | X |
| MERITER HEALTH ENTERPRISES, INC. - 39-1293620, 202 SOUTH PARK STREET, MADISON, WI 53715 | MANAGEMENT SERVICES | WI | N/A | C CORP | N/A | N/A | N/A | | X |
| MERITER MANAGEMENT SERVICES, INC. - 39-1458235, 202 SOUTH PARK STREET, MADISON, WI 53715 | ADMINISTRATIVE SERVICES | WI | N/A | C CORP | N/A | N/A | N/A | | X |
| METHODIST HEALTH VENTURES, INC. & SUB - 37-1140939, P.O. BOX 87, PEORIA, IL 61650 | PHARMACY/OFFICE STAFFING | IL | N/A | C CORP | N/A | N/A | N/A | | X |
| OPTIMUM HEALTH SOLUTIONS, INC. - 20-5430137 221 NORTHEAST GLEN OAK AVE PEORIA, IL 61636 | HEALTH & WELLNESS CONSULTING | IA | N/A | C CORP | N/A | N/A | N/A | | X |

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

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

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

- a** Receipt of **(i)** interest, **(ii)** annuities, **(iii)** royalties, or **(iv)** rent from a controlled entity
- b** Gift, grant, or capital contribution to related organization(s)
- c** Gift, grant, or capital contribution from related organization(s)
- d** Loans or loan guarantees to or for related organization(s)
- e** Loans or loan guarantees by related organization(s)
- f** Dividends from related organization(s)
- g** Sale of assets to related organization(s)
- h** Purchase of assets from related organization(s)
- i** Exchange of assets with related organization(s)
- j** Lease of facilities, equipment, or other assets to related organization(s)
- k** Lease of facilities, equipment, or other assets from related organization(s)
- l** Performance of services or membership or fundraising solicitations for related organization(s)
- m** Performance of services or membership or fundraising solicitations by related organization(s)
- n** Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)
- o** Sharing of paid employees with related organization(s)
- p** Reimbursement paid to related organization(s) for expenses
- q** Reimbursement paid by related organization(s) for expenses
- r** Other transfer of cash or property to related organization(s)
- s** Other transfer of cash or property from related organization(s)

| | Yes | No |
|-----------|-----|----|
| 1a | | X |
| 1b | | X |
| 1c | X | |
| 1d | | X |
| 1e | X | |
| 1f | | X |
| 1g | | X |
| 1h | | X |
| 1i | X | |
| 1j | | X |
| 1k | | X |
| 1l | | X |
| 1m | X | |
| 1n | | X |
| 1o | X | |
| 1p | X | |
| 1q | X | |
| 1r | | X |
| 1s | | 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 related organization | (b) Transaction type (a-s) | (c) Amount involved | (d) Method of determining amount involved |
|------------|-------------------------------------|-------------------------------|------------------------|--|
| (1) | | | | |
| (2) | | | | |
| (3) | | | | |
| (4) | | | | |
| (5) | | | | |
| (6) | | | | |

Part VII Supplemental Information

Provide additional information for responses to questions on Schedule R. See instructions.

SCHEDULE R, PARTS I - IV:

IOWA HEALTH SYSTEM AND SUBSIDIARIES (D/B/A UNITYPOINT HEALTH)

THIS ENTITY IS PART OF IOWA HEALTH SYSTEM (D/B/A UNITYPOINT HEALTH).

AS THE NATION'S 13TH LARGEST NONPROFIT HEALTH SYSTEM, UNITYPOINT HEALTH

PROVIDES PROGRESSIVE AND HIGH QUALITY SERVICES ACROSS ITS 9 REGIONS

WHICH SPAN IOWA, WESTERN ILLINOIS AND SOUTHERN WISCONSIN. THIS REGIONAL

CARE MODEL HAS BEEN SUCCESSFUL IN ACHIEVING STANDARDIZED LEVELS OF

PERFORMANCE AND KEEPING CARE LOCAL. WITH \$4.9B IN TOTAL OPERATING

REVENUE, UNITYPOINT HEALTH EMPLOYS APPROXIMATELY 33,000 TEAM MEMBERS

AND OPERATES 20 REGIONAL HOSPITALS, 19 COMMUNITY NETWORK HOSPITALS AND

OVER 435 CLINICS. AS A KEY COMPONENT OF UNITYPOINT HEALTH, UNITYPOINT

CLINIC IS A 1,180 PROVIDER MULTISPECIALTY GROUP THAT IS BUILT ON THE

FOUNDATION OF CARE DELIVERY, INNOVATION AND EXPERIENCE. REPRESENTED BY

OVER 40 SPECIALTIES, UPC IS A FORWARD-THINKING DELIVERY PROVIDER AND IS

ON THE LEADING EDGE OF CARE DELIVERY WITH ITS TELEHEALTH, AMBULATORY

AND URGENT CARE PROGRAMS. THE DIVERSIFIED HEALTH SYSTEM ALSO INCLUDES

UNITYPOINT ACCOUNTABLE CARE, UNITYPOINT HEALTH COLLEGES, UNITYPOINT AT

HOME AND EXTENDS HEALTH COVERAGE THROUGH THE HEALTHPARTNERS UNITYPOINT

INSURANCE PLAN.