

Public Disclosure Copy

TAX RETURN FILING INSTRUCTIONS

FORM 990

FOR THE YEAR ENDING
September 30, 2018

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| Prepared for | Mobridge Regional Hospital 1401 10th Ave W Mobridge, SD 57601 |
| Prepared by | EIDE BAILLY LLP 200 EAST 10TH ST, PO BOX 5125 SIOUX FALLS, SD 57117-5125 |
| Amount due or refund | Not applicable |
| Make check payable to | Not applicable |
| Mail tax return and check (if applicable) to | Not applicable |
| Return must be mailed on or before | Not applicable |
| Special Instructions | This return has qualified for electronic filing. After you have reviewed the return for completeness and accuracy, please sign, date and return Form 8879-EO to our office. We will transmit the return electronically to the IRS and no further action is required. Return Form 8879-EO to us by August 15, 2019. |

EXTENDED TO AUGUST 15, 2019

Form **990**

Return of Organization Exempt From Income Tax
Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

OMB No. 1545-0047

2017

Open to Public Inspection

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.

A For the 2017 calendar year, or tax year beginning OCT 1, 2017 and ending SEP 30, 2018

| | | |
|--|---|---|
| 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 MOBRIDGE REGIONAL HOSPITAL Doing business as Number and street (or P.O. box if mail is not delivered to street address) Room/suite 1401 10TH AVE W City or town, state or province, country, and ZIP or foreign postal code MOBRIDGE, SD 57601 F Name and address of principal officer: JOHN AYOUB SAME AS C ABOVE | D Employer identification number 46-0255944 E Telephone number 605-845-3692 G Gross receipts \$ 23,731,347. H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions) H(c) Group exemption number ▶ |
| 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.MOBRIDGEHOSPITAL.ORG | | |
| 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: 1959 | | M State of legal domicile: SD |

Part I Summary

| | | | |
|------------|---|----------------------------------|---------------------|
| 1 | Briefly describe the organization's mission or most significant activities: PROVIDING HEALTHCARE TO PEOPLE THROUGHOUT THE REGION. | | |
| 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 | 12 |
| 4 | Number of independent voting members of the governing body (Part VI, line 1b) | 4 | 10 |
| 5 | Total number of individuals employed in calendar year 2017 (Part V, line 2a) | 5 | 210 |
| 6 | Total number of volunteers (estimate if necessary) | 6 | 200 |
| 7a | Total unrelated business revenue from Part VIII, column (C), line 12 | 7a | 0. |
| 7b | Net unrelated business taxable income from Form 990-T, line 34 | 7b | 0. |
| 8 | Contributions and grants (Part VIII, line 1h) | Prior Year | Current Year |
| 9 | Program service revenue (Part VIII, line 2g) | 211,528. | 78,345. |
| 10 | Investment income (Part VIII, column (A), lines 3, 4, and 7d) | 23,495,918. | 23,442,190. |
| 11 | Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) | 62,146. | 131,365. |
| 12 | Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12) | 95,289. | 79,447. |
| 13 | Grants and similar amounts paid (Part IX, column (A), lines 1-3) | 23,864,881. | 23,731,347. |
| 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) | 0. | 0. |
| 16a | Professional fundraising fees (Part IX, column (A), line 11e) | 11,759,009. | 12,957,400. |
| 16b | Total fundraising expenses (Part IX, column (D), line 25) ▶ 0. | 0. | 0. |
| 17 | Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e) | 9,658,822. | 9,647,298. |
| 18 | Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25) | 21,417,831. | 22,604,698. |
| 19 | Revenue less expenses. Subtract line 18 from line 12 | 2,447,050. | 1,126,649. |
| 20 | Total assets (Part X, line 16) | Beginning of Current Year | End of Year |
| 21 | Total liabilities (Part X, line 26) | 26,787,293. | 27,184,101. |
| 22 | Net assets or fund balances. Subtract line 21 from line 20 | 8,398,854. | 7,632,575. |
| 22 | | 18,388,439. | 19,551,526. |

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 JOHN AYOUB, CEO Type or print name and title | Date |
| Paid Preparer Use Only | Print/Type preparer's name LAURIE HANSON | Preparer's signature LAURIE HANSON |
| | Date 08/12/19 | Check if self-employed <input type="checkbox"/> PTIN P00851848 |
| | Firm's name ▶ EIDE BAILLY LLP | Firm's EIN ▶ 45-0250958 |
| | Firm's address ▶ 200 EAST 10TH ST, PO BOX 5125 SIOUX FALLS, SD 57117-5125 | Phone no. 605-339-1999 |

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

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission: THE MISSION OF MOBRIDGE REGIONAL HOSPITAL IS TO PROVIDE HIGH QUALITY HEALTHCARE SERVICES IN A COMPASSIONATE AND PROFESSIONAL MANNER FOR PEOPLE THROUGHOUT THE REGION.

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

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

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

4a (Code:) (Expenses \$ 20,290,273. including grants of \$) (Revenue \$ 23,521,637.) MOBRIDGE REGIONAL HOSPITAL (MRH), A 25-BED CRITICAL ACCESS HOSPITAL, 16 BED ASSISTED LIVING CENTER, 8 BED SENIOR HOUSING CENTER, AND MEDICAL CLINICS, PROVIDES HEALTHCARE SERVICES TO PERSONS THROUGHOUT THE REGION. DURING THE FISCAL YEAR ENDED SEPTEMBER 30, 2018, THE HOSPITAL PROVIDED CARE TO THE NORTH CENTRAL REGION OF SOUTH DAKOTA, AND THE SOUTH CENTRAL REGION OF NORTH DAKOTA. THE HOSPITAL HAD: 1,557 PATIENT DAYS 1,442 ACUTE CARE DAYS 989 SWING BED CARE DAYS 4,167 EMERGENCY ROOM VISITS 20,173 RURAL HEALTH CLINIC VISITS 7,125 ASSISTED LIVING DAYS (PRAIRIE SUNSET VILLAGE)

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

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

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

4e Total program service expenses 20,290,273.

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> | X | |
| 2 Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> ? | | X |
| 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> | | X |
| 4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? <i>If "Yes," complete Schedule C, Part II</i> | | X |
| 5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? <i>If "Yes," complete Schedule C, Part III</i> | | X |
| 6 Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? <i>If "Yes," complete Schedule D, Part I</i> | | X |
| 7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? <i>If "Yes," complete Schedule D, Part II</i> | | X |
| 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> | | X |
| 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> | | X |
| 10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? <i>If "Yes," complete Schedule D, Part V</i> | | X |
| 11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable. | | |
| a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? <i>If "Yes," complete Schedule D, Part VI</i> | X | |
| b Did the organization report an amount for investments - other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VII</i> | X | |
| c Did the organization report an amount for investments - program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VIII</i> | | X |
| d Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part IX</i> | | X |
| e Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i> | X | |
| f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? <i>If "Yes," complete Schedule D, Part X</i> | X | |
| 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> | X | |
| 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> | | X |
| 13 Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i> | | X |
| 14a Did the organization maintain an office, employees, or agents outside of the United States? | | X |
| b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? <i>If "Yes," complete Schedule F, Parts I and IV</i> | | X |
| 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> | | X |
| 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> | | X |
| 17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? <i>If "Yes," complete Schedule G, Part I</i> | | X |
| 18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? <i>If "Yes," complete Schedule G, Part II</i> | | X |
| 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> | | X |

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Part IV Checklist of Required Schedules (continued)

| | Yes | No |
|--|-------------------------------------|-------------------------------------|
| 20a Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i> | <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 type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 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> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 26 Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? <i>If "Yes," complete Schedule L, Part II</i> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 27 Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 28 Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions): | | |
| a A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| b A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| c An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV</i> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 29 Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 31 Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 35a Did the organization have a controlled entity within the meaning of section 512(b)(13)? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 38 Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

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

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

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

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

Section A. Governing Body and Management

| | | Yes | No |
|-----------|--|-----|----|
| 1a | Enter the number of voting members of the governing body at the end of the tax year If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O. | | |
| | 1a 12 | | |
| b | Enter the number of voting members included in line 1a, above, who are independent | | |
| | 1b 10 | | |
| 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, or 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 in 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 in Schedule O the process, if any, used by the organization to review this Form 990. | | |
| 12a | Did the organization have a written conflict of interest policy? If "No," go to line 13 | 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 in Schedule O how this was done | X | |
| 12c | | X | |
| 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 in Schedule O (see instructions). | | |
| 16a | Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year? | | 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 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
 Own website Another's website Upon request Other (explain in Schedule O)
- 19** Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
- 20** State the name, address, and telephone number of the person who possesses the organization's books and records: **RENAE TISDALL - 605-845-8164**
PO BOX 580, MOBRIDGE, SD 57601

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent ContractorsCheck if Schedule O contains a response or note to any line in this Part VII **Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees****1a** Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

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

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

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

| (A) Name and Title | (B) Average hours per week (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) | (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 | | | |
| (1) BILL BACHMEIER CHAIRMAN | 1.00 0.00 | X | | X | | | | 0. | 0. | 0. |
| (2) DELPHINE STEUCK VICE CHAIR/DIRECTOR UNTIL 02/2018 | 1.00 0.00 | X | | X | | | | 0. | 0. | 0. |
| (3) LORI HEIL VICE CHAIR FROM 02/2018 | 1.00 0.00 | X | | X | | | | 0. | 0. | 0. |
| (4) HEIDI ROSHAU TREASURER | 1.00 0.00 | X | | X | | | | 0. | 0. | 0. |
| (5) DR. TOM SWANSON SECRETARY | 1.00 0.00 | X | | X | | | | 0. | 0. | 0. |
| (6) CHRISTOPHER BOHLANDER DIRECTOR FROM 05/2018 | 1.00 0.30 | X | | | | | | 0. | 0. | 0. |
| (7) DR. LEONARD LINDE DIRECTOR | 1.00 0.00 | X | | | | | | 0. | 0. | 0. |
| (8) BARB GROSS DIRECTOR | 1.00 0.00 | X | | | | | | 0. | 0. | 0. |
| (9) JAKE KRAFT DIRECTOR | 1.00 0.00 | X | | | | | | 0. | 0. | 0. |
| (10) PATTI SCHMEICHEL DIRECTOR | 1.00 0.00 | X | | | | | | 0. | 0. | 0. |
| (11) PAT FUHRMAN DIRECTOR | 1.00 0.30 | X | | | | | | 0. | 0. | 0. |
| (12) DR. TRAVIS HENDERSON INTERNAL MEDICINE/DIRECTOR | 40.00 0.00 | X | | | | | | 336,552. | 0. | 33,877. |
| (13) DR. ROBERT MARCIANO FAMILY MD/DIRECTOR | 40.00 0.00 | X | | | | | | 363,494. | 0. | 24,947. |
| (14) JOHN AYOUB CEO | 40.00 0.00 | | | X | | | | 0. | 0. | 0. |
| (15) RENAE TISDALL CFO | 40.00 0.00 | | | X | | | | 95,345. | 0. | 23,837. |
| (16) DR. BELA CSAKI SURGEON | 40.00 0.00 | | | | | X | | 315,711. | 0. | 16,096. |
| (17) DR. JOSH HENDERSON INTERNAL MEDICINE | 40.00 0.00 | | | | | X | | 263,235. | 0. | 30,689. |

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) | (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 | | | |
| (18) DEBBIE SMITH CRNA | 40.00 0.00 | | | | | X | | 208,496. | 0. | 15,281. |
| (19) JESSICA NORDER CNP | 40.00 0.00 | | | | | X | | 197,773. | 0. | 21,096. |
| (20) DORIDA VOJTA CNP, CNM | 40.00 0.00 | | | | | X | | 194,517. | 0. | 31,373. |
| | | | | | | | | | | |
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| | | | | | | | | | | |
| 1b Sub-total | | | | | | | | 1,975,123. | 0. | 197,196. |
| c Total from continuation sheets to Part VII, Section A | | | | | | | | 0. | 0. | 0. |
| d Total (add lines 1b and 1c) | | | | | | | | 1,975,123. | 0. | 197,196. |

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 **17**

| | Yes | No |
|--|-----|----|
| 3 Did the organization list any former officer, director, or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i> | | 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? <i>If "Yes," complete Schedule J for such individual</i> | 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? <i>If "Yes," complete Schedule J for such person</i> | | 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 |
|---|---------------------------------------|---------------------|
| CHI ST. ALEXIUS HEALTH 900 EAST BROADWAY, BISMARCK, ND 58501 | IT SERVICES, CEO SALARY, SUPPLIES, ET | 231,753. |
| NORTHERN PLAINS LAB PO BOX 2036, BISMARCK, ND 58502 | OUTSOURCE LABORATORY SERVICES | 171,809. |
| | | |
| | | |
| | | |

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 **2**

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 | | | | | |
| | e Government grants (contributions) | 1e | 77,520. | | | | |
| | f All other contributions, gifts, grants, and similar amounts not included above | 1f | 825. | | | | |
| | g Noncash contributions included in lines 1a-1f: \$ | | | | | | |
| | h Total. Add lines 1a-1f | | | 78,345. | | | |
| Program Service Revenue | 2 a PATIENT SERVICE REVENUE | Business Code 623110 | 23,169,340. | 23,169,340. | | | |
| | b ANCILLARY CHARGES | 900099 | 272,850. | 272,850. | | | |
| | c | | | | | | |
| | d | | | | | | |
| | e | | | | | | |
| | f All other program service revenue | | | | | | |
| | g Total. Add lines 2a-2f | | | 23,442,190. | | | |
| Other Revenue | 3 Investment income (including dividends, interest, and other similar amounts) | | 124,765. | | | 124,765. | |
| | 4 Income from investment of tax-exempt bond proceeds | | | | | | |
| | 5 Royalties | | | | | | |
| | 6 a Gross rents | (i) Real | 79,447. | | | | |
| | | (ii) Personal | | | | | |
| | | b Less: rental expenses | 0. | | | | |
| | c Rental income or (loss) | | 79,447. | | | | |
| | d Net rental income or (loss) | | | 79,447. | 79,447. | | |
| | 7 a Gross amount from sales of assets other than inventory | (i) Securities | | | | | |
| | | (ii) Other | | 6,600. | | | |
| | | b Less: cost or other basis and sales expenses | | 0. | | | |
| | | c Gain or (loss) | | 6,600. | | | |
| | d Net gain or (loss) | | | 6,600. | | 6,600. | |
| | 8 a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18 | a | | | | | |
| b Less: direct expenses | | b | | | | | |
| c Net income or (loss) from fundraising events | | | | | | | |
| 9 a Gross income from gaming activities. See Part IV, line 19 | a | | | | | | |
| | b Less: direct expenses | b | | | | | |
| | c Net income or (loss) from gaming activities | | | | | | |
| 10 a Gross sales of inventory, less returns and allowances | a | | | | | | |
| | b Less: cost of goods sold | b | | | | | |
| | c Net income or (loss) from sales of inventory | | | | | | |
| Miscellaneous Revenue | | Business Code | | | | | |
| 11 a _____ | | | | | | | |
| | b _____ | | | | | | |
| | c _____ | | | | | | |
| | d All other revenue | | | | | | |
| e Total. Add lines 11a-11d | | | | | | | |
| 12 Total revenue. See instructions. | | | 23,731,347. | 23,521,637. | 0. | 131,365. | |

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 | | | | |
| 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 | 876,276. | 752,714. | 123,562. | |
| 6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) | | | | |
| 7 Other salaries and wages | 9,267,681. | 8,820,546. | 447,135. | |
| 8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions) | 339,267. | 323,459. | 15,808. | |
| 9 Other employee benefits | 1,820,632. | 1,731,291. | 89,341. | |
| 10 Payroll taxes | 653,544. | 615,678. | 37,866. | |
| 11 Fees for services (non-employees): | | | | |
| a Management | | | | |
| b Legal | 16,664. | | 16,664. | |
| c Accounting | 51,215. | | 51,215. | |
| d Lobbying | | | | |
| e Professional fundraising services. See Part IV, line 17 | | | | |
| f Investment management fees | | | | |
| g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.) | 1,177,601. | 869,362. | 308,239. | |
| 12 Advertising and promotion | 85,022. | 6,133. | 78,889. | |
| 13 Office expenses | 161,572. | 83,908. | 77,664. | |
| 14 Information technology | 78,557. | | 78,557. | |
| 15 Royalties | | | | |
| 16 Occupancy | 338,181. | 241,441. | 96,740. | |
| 17 Travel | 89,391. | 67,341. | 22,050. | |
| 18 Payments of travel or entertainment expenses for any federal, state, or local public officials | | | | |
| 19 Conferences, conventions, and meetings | 43,183. | 43,183. | | |
| 20 Interest | 244,611. | | 244,611. | |
| 21 Payments to affiliates | | | | |
| 22 Depreciation, depletion, and amortization | 1,365,184. | 1,365,184. | | |
| 23 Insurance | 71,331. | 43,932. | 27,399. | |
| 24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.) | | | | |
| a MEDICAL SUPPLIES | 2,854,422. | 2,811,469. | 42,953. | |
| b BAD DEBT | 1,855,237. | 1,855,237. | | |
| c EQUIPMENT AND MAINTENAN | 1,119,186. | 598,731. | 520,455. | |
| d DUES AND SUBSCRIPTIONS | 47,684. | 25,174. | 22,510. | |
| e All other expenses | 48,257. | 35,490. | 12,767. | |
| 25 Total functional expenses. Add lines 1 through 24e | 22,604,698. | 20,290,273. | 2,314,425. | 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) | | (B) |
|---|--|------------------------|-------------|-------------|
| | | Beginning of year | | End of year |
| Assets | 1 Cash - non-interest-bearing | | 1 | |
| | 2 Savings and temporary cash investments | 8,582,877. | 2 | 8,340,158. |
| | 3 Pledges and grants receivable, net | | 3 | |
| | 4 Accounts receivable, net | 3,119,753. | 4 | 3,484,114. |
| | 5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L | | 5 | |
| | 6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instr). Complete Part II of Sch L | | 6 | |
| | 7 Notes and loans receivable, net | 251,697. | 7 | 450,847. |
| | 8 Inventories for sale or use | 358,227. | 8 | 429,895. |
| | 9 Prepaid expenses and deferred charges | 142,294. | 9 | 185,858. |
| | 10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D | 10a 32,852,286. | | |
| | b Less: accumulated depreciation | 10b 22,243,809. | | |
| | 11 Investments - publicly traded securities | 1,256,000. | 11 | 1,268,500. |
| | 12 Investments - other securities. See Part IV, line 11 | 1,739,131. | 12 | 1,790,111. |
| | 13 Investments - program-related. See Part IV, line 11 | | 13 | |
| | 14 Intangible assets | | 14 | |
| | 15 Other assets. See Part IV, line 11 | 646,476. | 15 | 626,141. |
| 16 Total assets. Add lines 1 through 15 (must equal line 34) | 26,787,293. | 16 | 27,184,101. | |
| Liabilities | 17 Accounts payable and accrued expenses | 1,402,242. | 17 | 1,376,903. |
| | 18 Grants payable | | 18 | |
| | 19 Deferred revenue | 88,707. | 19 | 0. |
| | 20 Tax-exempt bond liabilities | 2,662,506. | 20 | 2,276,779. |
| | 21 Escrow or custodial account liability. Complete Part IV of Schedule D | | 21 | |
| | 22 Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L | | 22 | |
| | 23 Secured mortgages and notes payable to unrelated third parties | 3,527,964. | 23 | 3,446,268. |
| | 24 Unsecured notes and loans payable to unrelated third parties | | 24 | |
| | 25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D | 717,435. | 25 | 532,625. |
| | 26 Total liabilities. Add lines 17 through 25 | 8,398,854. | 26 | 7,632,575. |
| Net Assets or Fund Balances | Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34. | | | |
| | 27 Unrestricted net assets | 17,451,592. | 27 | 18,680,614. |
| | 28 Temporarily restricted net assets | 936,847. | 28 | 870,912. |
| | 29 Permanently restricted net assets | | 29 | |
| | Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34. | | | |
| | 30 Capital stock or trust principal, or current funds | | 30 | |
| | 31 Paid-in or capital surplus, or land, building, or equipment fund | | 31 | |
| | 32 Retained earnings, endowment, accumulated income, or other funds | | 32 | |
| | 33 Total net assets or fund balances | 18,388,439. | 33 | 19,551,526. |
| 34 Total liabilities and net assets/fund balances | 26,787,293. | 34 | 27,184,101. | |

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 | 23,731,347. |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 22,604,698. |
| 3 | Revenue less expenses. Subtract line 2 from line 1 | 3 | 1,126,649. |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | 18,388,439. |
| 5 | Net unrealized gains (losses) on investments | 5 | |
| 6 | Donated services and use of facilities | 6 | |
| 7 | Investment expenses | 7 | |
| 8 | Prior period adjustments | 8 | |
| 9 | Other changes in net assets or fund balances (explain in Schedule O) | 9 | 36,438. |
| 10 | Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 19,551,526. |

Part XII Financial Statements and Reporting

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

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

SCHEDULE A
(Form 990 or 990-EZ)

Public Charity Status and Public Support

OMB No. 1545-0047

2017

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 **MOBRIDGE REGIONAL HOSPITAL** Employer identification number **46-0255944**

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

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

- 1 A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i)**.
- 2 A school described in **section 170(b)(1)(A)(ii)**. (Attach Schedule E (Form 990 or 990-EZ).)
- 3 A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii)**.
- 4 A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii)**. Enter the hospital's name, city, and state: _____
- 5 An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv)**. (Complete Part II.)
- 6 A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v)**.
- 7 An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 8 A community trust described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 9 An agricultural research organization described in **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 in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.
 - a **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**
 - b **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**
 - c **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**
 - d **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**
 - e Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.
 - f Enter the number of supported organizations
 - g Provide the following information about the supported organization(s).

| (i) Name of supported organization | (ii) EIN | (iii) Type of organization (described on lines 1-10 above (see instructions)) | (iv) Is the organization listed in your governing document? | | (v) Amount of monetary support (see instructions) | (vi) Amount of other support (see instructions) |
|------------------------------------|----------|---|---|----|---|---|
| | | | Yes | No | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Total | | | | | | |

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

(Complete only if you checked the box on line 5, 7, 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) 2013 | (b) 2014 | (c) 2015 | (d) 2016 | (e) 2017 | (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) 2013 | (b) 2014 | (c) 2015 | (d) 2016 | (e) 2017 | (f) Total |
|--|----------|----------|----------|----------|-----------|--------------------------|
| 7 Amounts from line 4 | | | | | | |
| 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources ... | | | | | | |
| 9 Net income from unrelated business activities, whether or not the business is regularly carried on ... | | | | | | |
| 10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) | | | | | | |
| 11 Total support. Add lines 7 through 10 | | | | | | |
| 12 Gross receipts from related activities, etc. (see instructions) | | | | | 12 | |
| 13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here | | | | | | <input type="checkbox"/> |

Section C. Computation of Public Support Percentage

| | | |
|---|-----------|--------------------------|
| 14 Public support percentage for 2017 (line 6, column (f) divided by line 11, column (f)) | 14 | % |
| 15 Public support percentage from 2016 Schedule A, Part II, line 14 | 15 | % |
| 16a 33 1/3% support test - 2017. 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 - 2016. 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 - 2017. 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 - 2016. 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) 2013 | (b) 2014 | (c) 2015 | (d) 2016 | (e) 2017 | (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) 2013 | (b) 2014 | (c) 2015 | (d) 2016 | (e) 2017 | (f) Total |
|--|----------|----------|----------|----------|----------|-----------|
| 9 Amounts from line 6 | | | | | | |
| 10a Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources | | | | | | |
| b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975 | | | | | | |
| c Add lines 10a and 10b | | | | | | |
| 11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on | | | | | | |
| 12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) | | | | | | |
| 13 Total support. (Add lines 9, 10c, 11, and 12.) | | | | | | |

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

Section C. Computation of Public Support Percentage

| | | |
|--|-----------|---|
| 15 Public support percentage for 2017 (line 8, column (f) divided by line 13, column (f)) | 15 | % |
| 16 Public support percentage from 2016 Schedule A, Part III, line 15 | 16 | % |

Section D. Computation of Investment Income Percentage

| | | |
|---|-----------|---|
| 17 Investment income percentage for 2017 (line 10c, column (f) divided by line 13, column (f)) | 17 | % |
| 18 Investment income percentage from 2016 Schedule A, Part III, line 17 | 18 | % |

19a 33 1/3% support tests - 2017. 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 - 2016. 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 12a of Part I, complete Sections A and B. If you checked 12b of Part I, complete Sections A and C. If you checked 12c of Part I, complete Sections A, D, and E. If you checked 12d of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

| | Yes | No |
|--|-----|----|
| 1 Are all of the organization's supported organizations listed by name in the organization's governing documents? <i>If "No," describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.</i> | | |
| 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 (b) and (c) 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 12a or 12b in Part I, answer (b) and (c) 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 (b) and (c) below (if applicable). Also, provide detail in Part VI, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).</i> | | |
| 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 (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i> | | |
| 8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i> | | |
| 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 in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? <i>If "Yes," provide detail in Part VI.</i> | | |
| c Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? <i>If "Yes," provide detail in Part VI.</i> | | |
| 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 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 in (b) and (c) below, the governing body of a supported organization? | | |
| b A family member of a person described in (a) above? | | |
| c A 35% controlled entity of a person described in (a) or (b) above? If "Yes" to a, b, or c, provide detail in Part VI . | | |

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

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? If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s). | | |
| 3 By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? If "Yes," describe in Part VI the role the organization's supported organizations played in this regard. | | |

Section E. Type III Functionally Integrated Supporting Organizations

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

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 (explain in detail in Part VI): | | |
| 2 | Acquisition indebtedness applicable to non-exempt-use assets | 2 | |
| 3 | Subtract line 2 from line 1d | 3 | |
| 4 | Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions) | 4 | |
| 5 | Net value of non-exempt-use assets (subtract line 4 from line 3) | 5 | |
| 6 | Multiply line 5 by .035 | 6 | |
| 7 | Recoveries of prior-year distributions | 7 | |
| 8 | Minimum Asset Amount (add line 7 to line 6) | 8 | |

| Section C - Distributable Amount | | | Current Year |
|---|---|----------|--------------|
| 1 | Adjusted net income for prior year (from Section A, line 8, Column A) | 1 | |
| 2 | Enter 85% of line 1 | 2 | |
| 3 | Minimum asset amount for prior year (from Section B, line 8, Column A) | 3 | |
| 4 | Enter greater of line 2 or line 3 | 4 | |
| 5 | Income tax imposed in prior year | 5 | |
| 6 | Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions) | 6 | |
| 7 | <input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally integrated Type III supporting organization (see instructions). | | |

Schedule A (Form 990 or 990-EZ) 2017

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

| Section D - Distributions | Current Year |
|---|---------------------|
| 1 Amounts paid to supported organizations to accomplish exempt purposes | |
| 2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity | |
| 3 Administrative expenses paid to accomplish exempt purposes of supported organizations | |
| 4 Amounts paid to acquire exempt-use assets | |
| 5 Qualified set-aside amounts (prior IRS approval required) | |
| 6 Other distributions (describe in Part VI). See instructions. | |
| 7 Total annual distributions. Add lines 1 through 6. | |
| 8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions. | |
| 9 Distributable amount for 2017 from Section C, line 6 | |
| 10 Line 8 amount divided by line 9 amount | |

| Section E - Distribution Allocations (see instructions) | (i) Excess Distributions | (ii) Underdistributions Pre-2017 | (iii) Distributable Amount for 2017 |
|--|-------------------------------------|---|--|
| 1 Distributable amount for 2017 from Section C, line 6 | | | |
| 2 Underdistributions, if any, for years prior to 2017 (reasonable cause required- explain in Part VI). See instructions. | | | |
| 3 Excess distributions carryover, if any, to 2017 | | | |
| a | | | |
| b From 2013 | | | |
| c From 2014 | | | |
| d From 2015 | | | |
| e From 2016 | | | |
| f Total of lines 3a through e | | | |
| g Applied to underdistributions of prior years | | | |
| h Applied to 2017 distributable amount | | | |
| i Carryover from 2012 not applied (see instructions) | | | |
| j Remainder. Subtract lines 3g, 3h, and 3i from 3f. | | | |
| 4 Distributions for 2017 from Section D, line 7: \$ | | | |
| a Applied to underdistributions of prior years | | | |
| b Applied to 2017 distributable amount | | | |
| c Remainder. Subtract lines 4a and 4b from 4. | | | |
| 5 Remaining underdistributions for years prior to 2017, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, explain in Part VI . See instructions. | | | |
| 6 Remaining underdistributions for 2017. Subtract lines 3h and 4b from line 1. For result greater than zero, explain in Part VI . See instructions. | | | |
| 7 Excess distributions carryover to 2018. Add lines 3j and 4c. | | | |
| 8 Breakdown of line 7: | | | |
| a Excess from 2013 | | | |
| b Excess from 2014 | | | |
| c Excess from 2015 | | | |
| d Excess from 2016 | | | |
| e Excess from 2017 | | | |

Schedule A (Form 990 or 990-EZ) 2017

SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No. 1545-0047

2017

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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.

Name of the organization MOBRIDGE REGIONAL HOSPITAL Employer identification number 46-0255944

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 3 columns: Question, (a) Donor advised funds, (b) Funds and other accounts. Rows include total number at end of year, aggregate value of contributions, grants, and end of year, and two yes/no questions about donor property and grant fund usage.

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

Table with 3 columns: Question, (a) Donor advised funds, (b) Funds and other accounts. Rows include purpose of easements, total number and acreage, number of easements on historic structures, and monitoring details.

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 3 columns: Question, (a) Donor advised funds, (b) Funds and other accounts. Rows include reporting requirements for art and historical treasures.

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

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

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

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

5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? Yes No

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

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? Yes No

b If "Yes," explain the arrangement in Part XIII and complete the following table:

| | Amount |
|---------------------------------|--------|
| c Beginning balance | 1c |
| 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 | | | | | |
| b Contributions | | | | | |
| c Net investment earnings, gains, and losses | | | | | |
| d Grants or scholarships | | | | | |
| e Other expenditures for facilities and programs | | | | | |
| f Administrative expenses | | | | | |
| g End of year balance | | | | | |

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

- a Board designated or quasi-endowment _____ %
- b Permanent endowment _____ %
- c Temporarily restricted endowment _____ %

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

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

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

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

Part VI Land, Buildings, and Equipment.

Complete if the organization answered "Yes" 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 | | 95,575. | | 95,575. |
| b Buildings | | 15,900,908. | 9,159,750. | 6,741,158. |
| c Leasehold improvements | | | | |
| d Equipment | | 15,862,265. | 12,573,701. | 3,288,564. |
| e Other | | 993,538. | 510,358. | 483,180. |
| Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.) | | | | 10,608,477. |

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) INTEREST IN MOBRIDGE | | |
| (B) REGIONAL HEALTHCARE | | |
| (C) FOUNDATION | 860,742. | END-OF-YEAR MARKET VALUE |
| (D) ASSETS LIMITED AS TO USE | 929,369. | END-OF-YEAR MARKET VALUE |
| (E) | | |
| (F) | | |
| (G) | | |
| (H) | | |
| Total. (Col. (b) must equal Form 990, Part X, col. (B) line 12.) ▶ | 1,790,111. | |

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) DEFERRED COMPENSATION PLAN PAYABLE | 522,625. |
| (3) PSV DEPOSITS | 10,000. |
| (4) | |
| (5) | |
| (6) | |
| (7) | |
| (8) | |
| (9) | |
| Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶ | 532,625. |

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

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

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

| | | | |
|----------|--|-----------|-------------|
| 1 | Total revenue, gains, and other support per audited financial statements | 1 | 21,978,483. |
| 2 | Amounts included on line 1 but not on Form 990, Part VIII, line 12: | | |
| a | Net unrealized gains (losses) on investments | 2a | |
| b | Donated services and use of facilities | 2b | |
| c | Recoveries of prior year grants | 2c | |
| d | Other (Describe in Part XIII.) | 2d | -1,742,693. |
| e | Add lines 2a through 2d | 2e | -1,742,693. |
| 3 | Subtract line 2e from line 1 | 3 | 23,721,176. |
| 4 | Amounts included on Form 990, Part VIII, line 12, but not on line 1: | | |
| a | Investment expenses not included on Form 990, Part VIII, line 7b | 4a | |
| b | Other (Describe in Part XIII.) | 4b | 10,171. |
| c | Add lines 4a and 4b | 4c | 10,171. |
| 5 | Total revenue. Add lines 3 and 4c . (This must equal Form 990, Part I, line 12.) | 5 | 23,731,347. |

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 | 20,749,461. |
| 2 | Amounts included on line 1 but not on Form 990, Part IX, line 25: | | |
| a | Donated services and use of facilities | 2a | |
| b | Prior year adjustments | 2b | |
| c | Other losses | 2c | |
| d | Other (Describe in Part XIII.) | 2d | |
| e | Add lines 2a through 2d | 2e | 0. |
| 3 | Subtract line 2e from line 1 | 3 | 20,749,461. |
| 4 | Amounts included on Form 990, Part IX, line 25, but not on line 1: | | |
| a | Investment expenses not included on Form 990, Part VIII, line 7b | 4a | |
| b | Other (Describe in Part XIII.) | 4b | 1,855,237. |
| c | Add lines 4a and 4b | 4c | 1,855,237. |
| 5 | Total expenses. Add lines 3 and 4c . (This must equal Form 990, Part I, line 18.) | 5 | 22,604,698. |

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 X, LINE 2:

THE HOSPITAL IS A SOUTH DAKOTA NONPROFIT CORPORATION AND HAS BEEN RECOGNIZED BY THE INTERNAL REVENUE SERVICE (IRS) AS EXEMPT FROM FEDERAL INCOME TAXES UNDER INTERNAL REVENUE CODE SECTION 501(C)(3). THE HOSPITAL IS ANNUALLY REQUIRED TO FILE A RETURN OF ORGANIZATION EXEMPT FROM INCOME TAX (FORM 990) WITH THE IRS. IN ADDITION, THE HOSPITAL IS SUBJECT TO INCOME TAX ON NET INCOME THAT IS DERIVED FROM BUSINESS ACTIVITIES THAT ARE UNRELATED TO ITS EXEMPT PURPOSE. THE HOSPITAL HAS DETERMINED IT IS NOT SUBJECT TO UNRELATED BUSINESS INCOME TAX AND HAS NOT FILED AN EXEMPT ORGANIZATION BUSINESS INCOME TAX RETURN (FORM 990T) WITH THE IRS.

THE HOSPITAL BELIEVES THAT IT HAS APPROPRIATE SUPPORT FOR ANY TAX

Part XIII Supplemental Information (continued)

POSITIONS TAKEN AFFECTING ITS ANNUAL FILING REQUIREMENTS, AND AS SUCH,
DOES NOT HAVE ANY UNCERTAIN TAX POSITIONS THAT ARE MATERIAL TO THE
FINANCIAL STATEMENTS. THE HOSPITAL WOULD RECOGNIZE FUTURE ACCRUED INTEREST
AND PENALTIES RELATED TO UNRECOGNIZED TAX BENEFITS AND LIABILITIES IN
INCOME TAX EXPENSE IF SUCH INTEREST AND PENALTIES ARE INCURRED.

PART XI, LINE 2D - OTHER ADJUSTMENTS:

| | |
|---------------------------------------|-------------|
| BAD DEBT RECLASSIFIED AS EXPENSE | -1,855,237. |
| NET ASSET RELEASED FROM RESTRICTION | 112,544. |
| TOTAL TO SCHEDULE D, PART XI, LINE 2D | -1,742,693. |

PART XI, LINE 4B - OTHER ADJUSTMENTS:

| | |
|-------------------------------------|---------|
| RESTRICTED GRANTS AND CONTRIBUTIONS | 10,171. |
|-------------------------------------|---------|

PART XII, LINE 4B - OTHER ADJUSTMENTS:

| | |
|----------------------------------|------------|
| BAD DEBT RECLASSIFIED AS EXPENSE | 1,855,237. |
|----------------------------------|------------|

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2017

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

- ▶ 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.

Name of the organization **MOBRIDGE REGIONAL HOSPITAL** Employer identification number **46-0255944**

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 | <input checked="" type="checkbox"/> | |
| b If "Yes," was it a written policy? | <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: | <input checked="" type="checkbox"/> | |
| <input checked="" type="checkbox"/> 100% <input type="checkbox"/> 150% <input 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: | <input checked="" type="checkbox"/> | |
| <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input checked="" type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ % | | |
| c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care. | | |
| 4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"? | <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? | <input checked="" type="checkbox"/> | |
| b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? | <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? | | <input checked="" type="checkbox"/> |
| 6a Did the organization prepare a community benefit report during the tax year? | | <input checked="" type="checkbox"/> |
| b If "Yes," did the organization make it available to the public? | | |

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) | | | 135,000. | | 135,000. | .65% |
| b Medicaid (from Worksheet 3, column a) | | | 4788597. | 2933812. | 1854785. | 8.94% |
| c Costs of other means-tested government programs (from Worksheet 3, column b) | | | | | | |
| d Total Financial Assistance and Means-Tested Government Programs | | | 4923597. | 2933812. | 1989785. | 9.59% |
| Other Benefits | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4) | | | | | | |
| f Health professions education (from Worksheet 5) | | | | | | |
| g Subsidized health services (from Worksheet 6) | | | 4283463. | 1562333. | 2721130. | 13.11% |
| h Research (from Worksheet 7) | | | | | | |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | | | | | | |
| j Total. Other Benefits | | | 4283463. | 1562333. | 2721130. | 13.11% |
| k Total. Add lines 7d and 7j | | | 9207060. | 4496145. | 4710915. | 22.70% |

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 MOBRIDGE REGIONAL HOSPITAL

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>15</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>SEE 7D</u> | | |
| b <input type="checkbox"/> Other website (list url): _____ | | |
| c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility | | |
| d <input checked="" 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>15</u> | | |
| 10 Is the hospital facility's most recently adopted implementation strategy posted on a website? | X | |
| a If "Yes," (list url): <u>SEE PART V, LINE 10A NARRATIVE.</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 MOBRIDGE REGIONAL HOSPITAL

| | 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>100</u> % and FPG family income limit for eligibility for discounted care of <u>300</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 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 type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | |
| e <input type="checkbox"/> Other (describe in Section C) | | |
| 16 Was widely publicized within the community served by the hospital facility? | 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 NARRATIVE</u> | | |
| b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE NARRATIVE</u> | | |
| c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE NARRATIVE</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 LEP populations | | |
| j <input checked="" 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 MOBRIDGE REGIONAL HOSPITAL

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

Name of hospital facility or letter of facility reporting group MOBRIDGE REGIONAL HOSPITAL

| | | 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? If "Yes," explain in Section C. | 23 | X |
| 24 | During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C. | 24 | X |

Schedule H (Form 990) 2017

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, 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.

MOBRIDGE REGIONAL HOSPITAL:

PART V, SECTION B, LINE 5: THE FACILITY OBTAINED DATA FOR THE COMMUNITY HEALTH NEEDS ASSESSMENT THROUGH FOCUS GROUPS, SURVEYS AND PERSONAL INTERVIEWS INVOLVING COMMUNITY LEADERS, COMMUNITY HEALTHCARE PROVIDERS, COORDINATING AGENCIES, COMMUNITY MEMBERS AND THE UNDERSERVED POPULATION.

MOBRIDGE REGIONAL HOSPITAL:

PART V, SECTION B, LINE 7D: THE CHNA REPORT IS AVAILABLE AT [HTTP://WWW.MOBRIDGEHOSPITAL.ORG/ABOUT-US/COMMUNITY-ASSESSMENT-REPORT-990/](http://www.mobridgehospital.org/about-us/community-assessment-report-990/)

MOBRIDGE REGIONAL HOSPITAL:

PART V, SECTION B, LINE 10A
THE HOSPITAL'S IMPLEMENTATION STRATEGY IS POSTED ON THE WEBSITE AT [HTTP://WWW.MOBRIDGEHOSPITAL.ORG/ABOUT-US/COMMUNITY-ASSESSMENT-REPORT-990/](http://www.mobridgehospital.org/about-us/community-assessment-report-990/).
THE IMPLEMENTATION STRATEGY BEGINS ON PAGE 5 OF THE CHNA.

MOBRIDGE REGIONAL HOSPITAL:

PART V, SECTION B, LINE 11: PURSUANT TO THE IMPLEMENTATION STRATEGY ADOPTED BY MOBRIDGE REGIONAL HOSPITAL, THE FOLLOWING ACTIONS PLANS HAVE BEEN DEVELOPED.

MENTAL HEALTH CARE - THE HOSPITAL HAS OPPORTUNITIES TO OFFER ADDITIONAL MENTAL HEALTH SERVICES, BOTH IN PERSON AND ELECTRONICALLY. MRH WILL ALSO CONTINUE TO DEVELOP RELATIONSHIPS WITH MENTAL HEALTH PROFESSIONALS IN THE

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, 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.

AREA. A NURSE PRACTITIONER WITH AN EMPHASIS IN PSYCHOLOGY FOR SERVICES BEGAN IN SEPTEMBER, 2018. OUTREACH SERVICES WITH MENTAL HEALTH PROVIDERS HAVE ALSO BEEN SECURED WITH E-ER SERVICES THROUGH AVERA HEALTH WITH TELEMEDICINE TECHNOLOGY.

URGENT CARE - MRH HAS CHANGED IT'S STAFFING PATTERNS IN CLINIC TO HAVE A PROVIDER AVAILABLE FOR URGENT CARE NEEDS. THIS PROVIDER HAS A CLEAR SCHEDULE AND ONLY SEES URGENT CARE PATIENTS IN THE CLINIC OR THE ER IF NECESSARY.

CANCER TREATMENT CENTER - MRH CONTINUES TO DEVELOP RELATIONSHIPS WITH ONCOLOGISTS IN ORDER TO ENHANCE CANCER CARE OPTIONS IN THE COMMUNITY. OUTREACH SERVICES HAVE BEEN ESTABLISHED WITH AVERA HEALTH ONE DAY PER MONTH.

KIDNEY DIALYSIS AND PEDIATRICS WILL NOT BE ADDRESSED. FINANCIAL FEASIBILITY STUDIES WERE COMPLETED. WE FOUND THE COST TO ADD KIDNEY DIALYSIS WAS FAR TOO GREAT AND WE ARE THEREFORE UNABLE TO PROVIDE THIS PARTICULAR SERVICE. THE COST TO RECRUIT AND RETAIN A PEDIATRICIAN WAS ALSO TOO GREAT. PEDIATRIC NEEDS WERE REFERRED TO BISMARCK, PIERRE, AND SIOUX FALLS.

MOBRIDGE REGIONAL HOSPITAL:

PART V, SECTION B, LINE 13H: PRESUMPTIVE ELIGIBILITY MAY BE USED AS A LAST RESORT.

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, 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.

MOBRIDGE REGIONAL HOSPITAL:

PART V, SECTION B, LINE 16J: PART V, LINE 16A, FAP WEBSITE:

HTTP://WWW.MOBRIDGEHOSPITAL.ORG/PATIENTS-AND-VISITORS/PAY-A-BILL/FINANCIAL-ASSISTANCE/

PART V, LINE 16B, FAP APPLICATION WEBSITE:

HTTP://WWW.MOBRIDGEHOSPITAL.ORG/PATIENTS-AND-VISITORS/PAY-A-BILL/FINANCIAL-ASSISTANCE/

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

HTTP://WWW.MOBRIDGEHOSPITAL.ORG/PATIENTS-AND-VISITORS/PAY-A-BILL/FINANCIAL-ASSISTANCE/

PART V, LINE 16J:

A FINANCIAL ASSISTANCE NOTICE IS MADE PART OF THE BILLING INVOICE. A FINANCIAL ASSISTANCE NOTICE IS POSTED IN THE EMERGENCY ROOM, WAITING ROOMS, AND ADMISSIONS OFFICE, AND THE FULL POLICY IS MADE AVAILABLE UPON REQUEST AND ON THE WEBSITE.

MOBRIDGE REGIONAL HOSPITAL:

PART V, SECTION B, LINE 20E: PROVIDED FINANCIAL ASSISTANCE INFORMATION WITH PATIENT DISCHARGE MATERIALS.

MOBRIDGE REGIONAL HOSPITAL:

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, 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.

PART V, SECTION B, LINE 24: THE HOSPITAL FINANCIAL ASSISTANCE POLICY DOES NOT COVER ELECTIVE PROCEDURES. THE HOSPITAL MAY HAVE CHARGED FAP ELIGIBLE PATIENTS GROSS CHARGES FOR SERVICES THAT ARE NOT COVERED UNDER THE FINANCIAL ASSISTANCE POLICY.

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 MOBRIDGE MEDICAL CLINIC 1309 10TH AVE W MOBRIDGE, SD 57601 | PROVIDER BASED RURAL HEALTH CLINIC |
| 2 WEST RIVER HEALTH CLINIC 103 1ST AVENUE E MCLAUGHLIN, SD 57642 | PROVIDER BASED RURAL HEALTH CLINIC |
| 3 WEST DAKOTA HEALTH CLINIC 906 MAIN TIMBER LAKE, SD 57656 | PROVIDER BASED RURAL HEALTH CLINIC |
| 4 PRAIRIE SUNSET VILLAGE 1320 W GRAND XING MOBRIDGE, SD 57601 | ASSISTED LIVING & SENIOR HOUSING |
| | |
| | |
| | |
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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 3C:

IN ADDITION TO FPG, THE HOSPITAL USES AN ASSET TEST, REVIEWS MEDICAL INDIGENCY, AND CONSIDERS INSURANCE STATUS IN DETERMINING ELIGIBILITY FOR FINANCIAL ASSISTANCE. PRESUMPTIVE ELIGIBILITY MAY BE USED AS A LAST RESORT.

PART I, LINE 7:

CHARITY CARE EXPENSE WAS CONVERTED TO COST ON LINE 7A BASED ON AN OVERALL COST-TO-CHARGE RATIO ADDRESSING ALL PATIENT SEGMENTS. LINE 7B WAS DETERMINED USING THE MEDICAID PS&R REPORT AND THE GENERAL LEDGER ACCOUNTING SYSTEM. LINE 7G WAS DETERMINED USING THE MEDICARE COST REPORT FOR FISCAL YEAR ENDING 9/30/18.

PART I, LINE 7G:

SUBSIDIZED HEALTH SERVICES INCLUDES NET COSTS OF \$2,630,372 ATTRIBUTABLE TO PHYSICIAN CLINICS.

PART I, LN 7 COL(F):

Part VI Supplemental Information (Continuation)

BAD DEBT EXPENSE OF \$1,855,237 WAS SUBTRACTED FROM TOTAL OPERATING EXPENSE.

PART III, LINE 2:

BAD DEBT EXPENSE ON PART III LINES 2 AND 3 IS BASED ON CHARGES. WHEN A PAYMENT IS RECEIVED OR A DISCOUNT GIVEN ON A BAD DEBT ACCOUNT IT OFFSETS THE CURRENT FISCAL YEAR BAD DEBT EXPENSE THROUGH A RECOVERY OF BAD DEBT ACCOUNT.

PART III, LINE 3:

THE ESTIMATED AMOUNT OF THE ORGANIZATION'S BAD DEBT EXPENSE ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE ORGANIZATION'S CHARITY CARE POLICY IS CALCULATED BASED ON THE PERCENTAGE OF INDIVIDUALS LIVING BELOW THE POVERTY LEVEL. THE 13.7% CAN REASONABLY BE CONSIDERED A COMMUNITY BENEFIT AS IT WOULD HAVE BEEN WRITTEN OFF TO CHARITY CARE.

PART III, LINE 4:

THE FOOTNOTE FOR BAD DEBT EXPENSE IS LOCATED ON PAGES 6 AND 7 OF THE ATTACHED AUDITED FINANCIAL STATEMENTS.

PART III, LINE 8:

MEDICARE ALLOWABLE COST OF CARE WAS CALCULATED FROM THE MEDICARE COST REPORT FOR THE FISCAL YEAR ENDING 9/30/2018. MEDICAL SERVICES ARE PROVIDED TO PATIENTS WITH MEDICARE COVERAGE REGARDLESS OF WHETHER OR NOT A SURPLUS OR DEFICIT IS REALIZED. PROVIDING MEDICARE SERVICES PROMOTES ACCESS TO HEALTHCARE SERVICES WHICH ARE VITALLY NEEDED BY OUR COMMUNITY. THE MEDICARE COST REPORT IS COMPLETED BASED ON THE RULES AND REGULATIONS SET FORTH BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES.

Part VI Supplemental Information (Continuation)

PART III, LINE 9B:

THE PATIENT ACCOUNT SPECIALIST AT THE MOBRIDGE REGIONAL HOSPITAL KEEPS ON FILE ALL GUARANTORS WHO HAVE QUALIFIED FOR FINANCIAL ASSISTANCE AND APPLIES THE FINANCIAL ASSISTANCE TO ALL ACCOUNTS WHEN THE GUARANTOR BALANCE BECOMES DUE. UPDATED FINANCIAL INFORMATION IS REQUESTED ANNUALLY FOR ANY CHANGES IN FINANCIAL ASSISTANCE THAT MAY APPLY.

IF AN ACCOUNT GOES TO COLLECTION AND OUR COLLECTION AGENCY IDENTIFIES THAT A PATIENT IS MEETING FINANCIAL ASSISTANCE ELIGIBILITY CRITERIA, THE PATIENT'S ACCOUNT MAY BE CONSIDERED FOR FINANCIAL ASSISTANCE. COLLECTION ACTIVITY WILL BE SUSPENDED ON ACCOUNTS, AND THE FINANCIAL ASSISTANCE APPLICATION WILL BE REVIEWED. IF THE ENTIRE ACCOUNT BALANCE IS ADJUSTED, THE ACCOUNT WILL BE RETURNED. IF A PARTIAL ADJUSTMENT OCCURS, THE PATIENT FAILS TO COOPERATE WITH THE FINANCIAL ASSISTANCE PROCESS, OR IF THE PATIENT IS NOT ELIGIBLE FOR FINANCIAL ASSISTANCE, COLLECTION ACTIVITY WILL RESUME.

PART VI, LINE 2:

MOBRIDGE REGIONAL HOSPITAL (MRH) IS COMMITTED TO PROVIDING HIGH QUALITY HEALTHCARE SERVICES TO ALL PEOPLE THROUGHOUT THE REGION. THE FACILITY PROVIDES FAMILY MEDICINE, INTERNAL MEDICINE, OB, ICU, ALS, AMBULANCE SERVICE, EMERGENCY CARE, AND SURGICAL SERVICES TO ALL PEOPLE WHO ARE IN NEED OF THOSE SERVICES. MRH CURRENTLY IS WORKING IN COLLABORATION WITH WALWORTH COUNTY AND THE STATE OF SOUTH DAKOTA TO PROVIDE COMMUNITY HEALTH SERVICES, INCLUDING FAMILY PLANNING SERVICES, ADULT HEALTH, AND CHILD IMMUNIZATIONS. MRH'S MANAGEMENT STRIVES TO LISTEN TO THE COMMUNITY NEEDS. IF NEW HEALTHCARE NEEDS ARISE, ADMINISTRATION WILL COMPLETE AN ANALYSIS OF

Schedule H (Form 990)

Part VI Supplemental Information (Continuation)

COST/BENEFIT FOR THE NEW SERVICE TO BE OFFERED. MRH'S ADMINISTRATION BELIEVES IN BEING OUT IN THE PUBLIC AT EVENTS TO ANSWER QUESTIONS THAT MAY SURFACE ABOUT THE FACILITY.

PART VI, LINE 3:

MRH POSTS ITS FINANCIAL ASSISTANCE POLICY, OR A SUMMARY THEREOF, AND FINANCIAL ASSISTANCE CONTACT INFORMATION IN THE ADMISSIONS AREAS AND CLINIC AREAS IN WHICH ELIGIBLE PATIENTS ARE LIKELY TO BE PRESENT. THE FACILITY PROVIDES A COPY OF THE POLICY, OR A SUMMARY THEREOF, AND FINANCIAL ASSISTANCE CONTACT INFORMATION TO PATIENTS WITH DISCHARGE MATERIALS. THE PATIENTS ACCOUNT MANAGER DISCUSSES WITH THE PATIENT THE AVAILABILITY OF VARIOUS GOVERNMENT BENEFITS, SUCH AS MEDICAID OR STATE PROGRAMS, AND ASSISTS THE PATIENT WITH QUALIFICATION FOR SUCH PROGRAMS, WHERE APPLICABLE.

PART VI, LINE 4:

MRH IS LOCATED IN A SMALL RURAL COMMUNITY IN WALWORTH COUNTY, SOUTH DAKOTA, KNOWN AS MOBRIDGE. WALWORTH COUNTY HAS A POPULATION OF 5,443 PEOPLE RACIALLY COMPRISED OF MAINLY CAUCASIAN (82.4%) AND NATIVE AMERICANS/ALASKAN NATIVE (13.6%). THE COMMUNITY BORDERS THE STANDING ROCK RESERVATION AND THE CHEYENNE RIVER RESERVATION WHICH ACCOUNTS FOR THE LARGER NATIVE AMERICAN POPULATION AND RELATIONS WITH INDIAN HEALTH SERVICES. THE MEDIAN HOUSEHOLD INCOME OF MOBRIDGE IS \$41,358, AND THE MEDIAN FAMILY INCOME IS \$52,316. ROUGHLY 11.5% OF THE POPULATION IS BELOW THE POVERTY LINE. THE FACILITY OWNS AND OPERATES CLINICS IN MOBRIDGE, MCLAUGHLIN AND TIMBER LAKE. THE FACILITY SERVES PATIENTS FROM A SIX COUNTY AREA (WALWORTH, ZIEBACH, CORSON, DEWEY, CAMPBELL AND POTTER) AND IS APPROXIMATELY ONE HUNDRED MILES FROM ANOTHER HOSPITAL WITH A HIGHER LEVEL

Part VI Supplemental Information (Continuation)

OF CARE OFFERED. ZIEBACH COUNTY IS THE 6TH POOREST COUNTY IN AMERICA, AND 46% OF PEOPLE LIVING IN THIS COUNTY ARE UNDER FEDERAL POVERTY GUIDELINES.

PART VI, LINE 5:

THE MOBRIDGE REGIONAL HOSPITAL IS COMMITTED TO THE PATIENTS WE SERVE, REGARDLESS OF RACE, COLOR, RELIGION, SEX, DISABILITY, OR ABILITY TO PAY. THE ORGANIZATION'S FINANCIAL ASSISTANCE ADJUSTMENTS HAVE CONTINUED TO TREND UP OVER THE PAST FEW YEARS, AND WE CONTINUE TO FOCUS BUDGET EFFORTS TO CONTINUE THIS TREND. MRH IS 100 MILES FROM ANOTHER HEALTHCARE FACILITY WITH A HIGHER LEVEL OF CARE AND PARTICIPATES IN THE NORTH DAKOTA AND SOUTH DAKOTA TRAUMA SYSTEMS WITH LEVEL III AND LEVEL IV CERTIFICATIONS, RESPECTIVELY. MRH CONTINUES A BROAD LEVEL OF BOARD INVOLVEMENT FOR CORSON, DEWEY, AND WALWORTH COUNTIES TO MONITOR COMMUNITY NEEDS IN THOSE AREAS. MRH CONTINUES TO BE A POPULAR PLACE FOR MEDICAL STUDENTS TO COMPLETE CLINICAL ROTATIONS, AND WE CONTINUE TO OFFER A WIDE VARIETY OF CERTIFICATION CLASSES TO NURSES AND THE MEMBERS OF THE COMMUNITY INCLUDING EMT-B, PALS, ACLS, TNCC, ALSO, NALS, EMT-I, AND CPR.

MRH HAS DEVELOPED A WORKSITE WELLNESS PROGRAM WITHIN THE ORGANIZATION AND HAS GOALS TO WORK WITH OTHER BUSINESSES IN THE COMMUNITY TO PROMOTE OVERALL HEALTHY LIFESTYLES.

MRH PROVIDES VARIOUS HEALTH SCREENINGS AVAILABLE TO THE COMMUNITY AND SURROUNDING COMMUNITIES THROUGHOUT THE YEAR. THE HEALTH SCREENINGS INCLUDE FREE CHOLESTEROL CHECKS, BMI, BLOOD PRESSURE AND WAIST/HIP RATIOS. THESE PREVENTATIVE HEALTH SCREENINGS PROMOTE THE GENERAL HEALTH OF THE COMMUNITY.

Part VI Supplemental Information (Continuation)

THE HOSPITAL HAS A BOARD OF DIRECTORS COMPRISED OF VOLUNTEERS WHO RESIDE
IN THE SERVICE AREA. MEDICAL STAFF PRIVILEGES ARE EXTENDED TO ALL
QUALIFIED PHYSICIANS IN THE AREA. ALL QUALIFIED PHYSICIANS WHO SHOW AN
INTEREST MUST GO THROUGH A CREDENTIAL REVIEW AND BOARD APPROVAL. SURPLUS
FUNDS, IF AVAILABLE, ARE REINVESTED IN THE FACILITIES TO IMPROVE PATIENT
CARE.

**SCHEDULE J
(Form 990)**

Compensation Information

OMB No. 1545-0047

2017

Open to Public Inspection

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.

Department of the Treasury
Internal Revenue Service

Name of the organization: **MOBRIDGE REGIONAL HOSPITAL**
 Employer identification number: **46-0255944**

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 filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.
- | | |
|--|---|
| <input checked="" type="checkbox"/> Compensation committee | <input type="checkbox"/> Written employment contract |
| <input 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) 2017

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 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 | | | | |
| (1) DR. TRAVIS HENDERSON INTERNAL MEDICINE/DIRECTOR | (i) | 254,251. | 37,500. | 44,801. | 10,800. | 23,539. | 370,891. | 0. |
| | (ii) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| (2) DR. ROBERT MARCIANO FAMILY MD/DIRECTOR | (i) | 279,817. | 76,526. | 7,151. | 10,800. | 14,617. | 388,911. | 0. |
| | (ii) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| (3) DR. BELA CSAKI SURGEON | (i) | 307,891. | 0. | 7,820. | 10,800. | 5,824. | 332,335. | 0. |
| | (ii) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| (4) DR. JOSH HENDERSON INTERNAL MEDICINE | (i) | 216,463. | 37,500. | 9,272. | 10,300. | 20,806. | 294,341. | 0. |
| | (ii) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| (5) DEBBIE SMITH CRNA | (i) | 207,262. | 0. | 1,234. | 8,280. | 7,366. | 224,142. | 0. |
| | (ii) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| (6) JESSICA NORDER CNP | (i) | 125,548. | 67,041. | 5,184. | 0. | 21,337. | 219,110. | 0. |
| | (ii) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| (7) DORIDA VOJTA CNP, CNM | (i) | 129,365. | 59,732. | 5,420. | 7,677. | 23,937. | 226,131. | 0. |
| | (ii) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| | (i) | | | | | | | |
| | (ii) | | | | | | | |
| | (i) | | | | | | | |
| | (ii) | | | | | | | |
| | (i) | | | | | | | |
| | (ii) | | | | | | | |
| | (i) | | | | | | | |
| | (ii) | | | | | | | |
| | (i) | | | | | | | |
| | (ii) | | | | | | | |
| | (i) | | | | | | | |
| | (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, LINE 3:

THE CEO IS COMPENSATED THROUGH A MANAGEMENT AGREEMENT WITH ST. ALEXIUS MEDICAL CENTER IN BISMARCK, ND. THE BOARD OF DIRECTORS OF MOBRIDGE REGIONAL HOSPITAL REVIEWS THE MANAGEMENT AGREEMENT AND MAKES A DETERMINATION AS TO WHETHER THE COMPENSATION FOR THE CEO'S SERVICES IS REASONABLE.

PART I, LINE 7:

THE PHYSICIANS ARE PAID BASED ON RELATIVE VALUE UNIT BASED PRODUCTION.

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

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.

OMB No. 1545-0047
2017
 Open to Public Inspection

Name of the organization **MOBRIDGE REGIONAL HOSPITAL** Employer identification number **46-0255944**

| Part I Bond Issues | | | | | | | | | | | |
|--|----------------|-------------|-----------------|-----------------|----------------------------------|--------------|----|-------------------------|----|----------------------|----|
| SEE PART VI FOR COLUMN (F) CONTINUATIONS | | | | | | | | | | | |
| (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 |
| CITY OF MOBRIDGE, SOUTH DAKOTA | 46-6000320 | 607429BA4 | 05/08/07 | 5,773,898. | REFINANCE BONDS ISSUED 1997 USED | | X | | X | | X |
| B | | | | | | | | | | | |
| C | | | | | | | | | | | |
| D | | | | | | | | | | | |

| Part II Proceeds | | | | | | | | | |
|---|------------|----|-----|----|-----|----|-----|----|--|
| | A | | B | | C | | D | | |
| 1 Amount of bonds retired | 3,445,000. | | | | | | | | |
| 2 Amount of bonds legally defeased | | | | | | | | | |
| 3 Total proceeds of issue | 5,773,898. | | | | | | | | |
| 4 Gross proceeds in reserve funds | 265,908. | | | | | | | | |
| 5 Capitalized interest from proceeds | | | | | | | | | |
| 6 Proceeds in refunding escrows | | | | | | | | | |
| 7 Issuance costs from proceeds | 88,005. | | | | | | | | |
| 8 Credit enhancement from proceeds | | | | | | | | | |
| 9 Working capital expenditures from proceeds | | | | | | | | | |
| 10 Capital expenditures from proceeds | 1,000,000. | | | | | | | | |
| 11 Other spent proceeds | 4,416,499. | | | | | | | | |
| 12 Other unspent proceeds | | | | | | | | | |
| 13 Year of substantial completion | 2008 | | | | | | | | |
| | Yes | No | Yes | No | Yes | No | Yes | No | |
| 14 Were the bonds issued as part of a current refunding issue? | | X | | | | | | | |
| 15 Were the bonds issued as part of an advance refunding issue? | X | | | | | | | | |
| 16 Has the final allocation of proceeds been made? | X | | | | | | | | |
| 17 Does the organization maintain adequate books and records to support the final allocation of proceeds? | X | | | | | | | | |

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

Part III Private Business Use (Continued)

| | A | | B | | C | | D | |
|---|-----|-------|-----|----|-----|----|-----|----|
| | Yes | No | Yes | No | Yes | No | Yes | No |
| 3a Are there any management or service contracts that may result in private business use of bond-financed property? | | X | | | | | | |
| b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property? | | | | | | | | |
| c Are there any research agreements that may result in private business use of bond-financed property? | | X | | | | | | |
| d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property? | | | | | | | | |
| 4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government | | .00 % | | % | | % | | % |
| 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 | | .00 % | | % | | % | | % |
| 6 Total of lines 4 and 5 | | .00 % | | % | | % | | % |
| 7 Does the bond issue meet the private security or payment test? | | X | | | | | | |
| 8a Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued? | | X | | | | | | |
| b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of | | % | | % | | % | | % |
| c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2? | | | | | | | | |
| 9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2? | | X | | | | | | |

Part IV Arbitrage

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

Part IV Arbitrage (Continued)

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

Part V Procedures To Undertake Corrective Action

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

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

SCHEDULE K, PART I, BOND ISSUES:

(A) ISSUER NAME: CITY OF MOBRIDGE, SOUTH DAKOTA

(F) DESCRIPTION OF PURPOSE:

REFINANCE BONDS ISSUED 1997 USED FOR CONSTRUCTION; PURCHASE CT, CLINIC & EM

SCHEDULE K, PART IV, ARBITRAGE, LINE 2C:

(A) ISSUER NAME: CITY OF MOBRIDGE, SOUTH DAKOTA

DATE THE REBATE COMPUTATION WAS PERFORMED: 08/15/2017

SCHEDULE O
(Form 990 or 990-EZ)Department of the Treasury
Internal Revenue Service**Supplemental Information to Form 990 or 990-EZ**Complete to provide information for responses to specific questions on
Form 990 or 990-EZ or to provide any additional information.

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2017Open to Public
Inspection

Name of the organization

MOBRIDGE REGIONAL HOSPITAL

Employer identification number

46-0255944

FORM 990, PART VI, SECTION A, LINE 3:

MRH CURRENTLY HAS A MANAGEMENT AGREEMENT WITH ST. ALEXIUS MEDICAL CENTER IN BISMARCK, ND. THE AGREEMENT PROVIDES THE CEO AND INFORMATION TECHNOLOGY SUPPORT AT A COST TO MRH. THE ORIGINAL MANAGEMENT AGREEMENT DATE WAS JANUARY 1, 2000. JOHN AYOUB, CEO, BEGAN WORKING AT MRH JANUARY 2017. JOHN AYOUB, CEO, RECEIVED COMPENSTION OF \$208,919 AND ESTIMATED BENEFITS OF \$21,823. THE CEO OVERSEES ALL DAILY OPERATIONAL ACTIVITIES AND REPORTS TO THE ORGANIZATION'S BOARD OF DIRECTORS. THE CEO WORKS VERY CLOSELY WITH ALL DEPARTMENT SUPERVISORS TO ENSURE THAT ALL AREAS OF THE HOSPITAL ARE RUNNING EFFICIENTLY AND SMOOTHLY. THE CEO IS RESPONSIBLE FOR PHYSICIAN CONTRACTING AND WORKS VERY CLOSELY WITH HUMAN RESOURCES FOR RECRUITMENT OF PROFESSIONAL MEDICAL STAFF.

FORM 990, PART VI, SECTION A, LINE 6:

THERE IS ONLY ONE CLASS OF MEMBER; ALL MEMBERS HAVE ONE VOTE (SAME VOTING RIGHTS). EACH PERSON WHO DONATES \$100 OR MORE IS A MEMBER ENTITLED TO ONE VOTE.

FORM 990, PART VI, SECTION A, LINE 7A:

THE NOMINATING COMMITTEE NOMINATES CANDIDATES FOR ELECTION. THE MEMBERS VOTE ON CANDIDATES AT THE ANNUAL MEETING.

FORM 990, PART VI, SECTION A, LINE 8B:

THERE IS NO COMMITTEE WITH THE AUTHORITY TO ACT ON BEHALF OF THE GOVERNING BODY.

| | |
|--|--|
| Name of the organization MOBRIDGE REGIONAL HOSPITAL | Employer identification number 46-0255944 |
|--|--|

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

THE CEO, CFO, AND BOARD OF DIRECTORS WILL REVIEW THE FORM 990 VIA ELECTRONIC TRANSMISSION PRIOR TO FILING WITH THE IRS.

FORM 990, PART VI, SECTION B, LINE 12C:

THE CONFLICT OF INTEREST POLICY COVERS THE ENTIRE BOARD OF DIRECTORS. IF A CONFLICT SHOULD ARISE, IT WOULD FIRST GO TO THE CEO FOR EVALUATION, THEN TO THE BOARD OF DIRECTORS FOR FINAL EVALUATION. THE BOARD OF DIRECTORS IS RESPONSIBLE FOR MAKING THE FINAL DECISION IN DETERMINING IF A CONFLICT EXISTS. IF A CONFLICT IS FOUND, THE PERSON(S) INVOLVED WOULD BE REQUIRED TO ABSTAIN FROM DISCUSSIONS AND VOTING ON THE ITEM CAUSING THE CONFLICT.

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

THE FINANCE COMMITTEE DETERMINES AND APPROVES THE PHYSICIAN CONTRACTS, INCLUDING COMPENSATION. THE CEO'S SALARY IS DETERMINED USING A SALARY SURVEY AND DISCUSSIONS WITH THE MANAGEMENT COMPANY. THE FINANCE COMMITTEE APPROVES THE SALARY OF THE CEO ANNUALLY. THE BOARD OF DIRECTORS APPROVES THE FINANCE COMMITTEE MINUTES, WHICH INCLUDE DISCUSSIONS REGARDING THE CEO'S SALARY.

SALARIES FOR OTHER OFFICERS OR MEMBERS OF MANAGEMENT ARE DETERMINED BY THE CEO THROUGH THE USE OF SALARY SURVEY INFORMATION FROM SDAHO AND EMPLOYEE SERVICE AND EXPERIENCE FILES.

THIS PROCESS IS UNDERTAKEN ANNUALLY.

FORM 990, PART VI, SECTION C, LINE 19:

DOCUMENTS ARE MADE AVAILABLE UPON REQUEST.

| | |
|---|---|
| Name of the organization MOBRIDGE REGIONAL HOSPITAL | Employer identification number 46-0255944 |
|---|---|

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

CHANGE IN FOUNDATION INTEREST 36,438.

**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

2017

Open to Public Inspection

Name of the organization **MOBRIDGE REGIONAL HOSPITAL** Employer identification number **46-0255944**

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 |
| MOBRIDGE REGIONAL HEALTHCARE FOUNDATION - 46-0416693, PO BOX 580, MOBRIDGE, SD 57601 | OUTREACH FOR MOBRIDGE REGIONAL HOSPITAL | SOUTH DAKOTA | 501(C)(3) | LINE 12C, III-FI | MOBRIDGE REGIONAL HOSPITAL | | X |
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For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule R (Form 990) 2017

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 | |
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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 |
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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?

| | Yes | No |
|--|-----|----|
| a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity | | X |
| b Gift, grant, or capital contribution to related organization(s) | | X |
| c Gift, grant, or capital contribution from related organization(s) | | X |
| d Loans or loan guarantees to or for related organization(s) | | X |
| e Loans or loan guarantees by related organization(s) | | X |
| f Dividends from related organization(s) | | X |
| g Sale of assets to related organization(s) | | X |
| h Purchase of assets from related organization(s) | | X |
| i Exchange of assets with related organization(s) | | X |
| j Lease of facilities, equipment, or other assets to related organization(s) | | X |
| k Lease of facilities, equipment, or other assets from related organization(s) | | X |
| l Performance of services or membership or fundraising solicitations for related organization(s) | | X |
| m Performance of services or membership or fundraising solicitations by related organization(s) | | X |
| n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) | X | |
| o Sharing of paid employees with related organization(s) | X | |
| p Reimbursement paid to related organization(s) for expenses | | X |
| q Reimbursement paid by related organization(s) for expenses | | X |
| r Other transfer of cash or property to related organization(s) | | X |
| s Other transfer of cash or property from related organization(s) | | 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.

Lined area for supplemental information.

Form **8868**
(Rev. January 2017)

Application for Automatic Extension of Time To File an Exempt Organization Return

OMB No. 1545-1709

Department of the Treasury
Internal Revenue Service

► **File a separate application for each return.**

► **Information about Form 8868 and its instructions is at www.irs.gov/form8868.**

Electronic filing (e-file). You can electronically file Form 8868 to request a 6-month automatic extension of time to file any of the forms listed below with the exception of Form 8870, Information Return for Transfers Associated With Certain Personal Benefit Contracts, for which an extension request must be sent to the IRS in paper format (see instructions). For more details on the electronic filing of this form, visit www.irs.gov/efile, click on Charities & Non-Profits, and click on e-file for Charities and Non-Profits.

Automatic 6-Month Extension of Time. Only submit original (no copies needed).

All corporations required to file an income tax return other than Form 990-T (including 1120-C filers), partnerships, REMICs, and trusts must use Form 7004 to request an extension of time to file income tax returns.

| | | Enter filer's identifying number |
|--|---|--|
| Type or print | Name of exempt organization or other filer, see instructions. MOBRIDGE REGIONAL HOSPITAL | Employer identification number (EIN) or 46-0255944 |
| File by the due date for filing your return. See instructions. | Number, street, and room or suite no. If a P.O. box, see instructions. 1401 10TH AVE W | Social security number (SSN) |
| | City, town or post office, state, and ZIP code. For a foreign address, see instructions. MOBRIDGE, SD 57601 | |

Enter the Return Code for the return that this application is for (file a separate application for each return) 0 1

| Application Is For | Return Code | Application Is For | Return Code |
|--|-------------|-----------------------------------|-------------|
| Form 990 or Form 990-EZ | 01 | Form 990-T (corporation) | 07 |
| Form 990-BL | 02 | Form 1041-A | 08 |
| Form 4720 (individual) | 03 | Form 4720 (other than individual) | 09 |
| Form 990-PF | 04 | Form 5227 | 10 |
| Form 990-T (sec. 401(a) or 408(a) trust) | 05 | Form 6069 | 11 |
| Form 990-T (trust other than above) | 06 | Form 8870 | 12 |

RENAE TISDALL

• The books are in the care of ► **PO BOX 580 - MOBRIDGE, SD 57601**
Telephone No. ► **605-845-8164** Fax No. ► _____

- If the organization does not have an office or place of business in the United States, check this box
- If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) _____. If this is for the whole group, check this box . If it is for part of the group, check this box and attach a list with the names and EINs of all members the extension is for.

1 I request an automatic 6-month extension of time until **AUGUST 15, 2019**, to file the exempt organization return for the organization named above. The extension is for the organization's return for:

► calendar year _____ or
 ► tax year beginning **OCT 1, 2017**, and ending **SEP 30, 2018**.

2 If the tax year entered in line 1 is for less than 12 months, check reason: Initial return Final return
 Change in accounting period

| | | | |
|---|-----------|----|----|
| 3a If this application is for Forms 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions. | 3a | \$ | 0. |
| b If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit. | 3b | \$ | 0. |
| c Balance due. Subtract line 3b from line 3a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions. | 3c | \$ | 0. |

Caution: If you are going to make an electronic funds withdrawal (direct debit) with this Form 8868, see Form 8453-EO and Form 8879-EO for payment instructions.

LHA **For Privacy Act and Paperwork Reduction Act Notice, see instructions.**

Form **8868** (Rev. 1-2017)

**MAIL TO: DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE CENTER
OGDEN, UT 84201-0045**

Electronic Filing PDF Attachment



Financial Statements
September 30, 2018 and 2017
Mobridge Regional Hospital

Mobridge Regional Hospital
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September 30, 2018 and 2017

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Financial Statements

 Balance Sheets 2

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 Statements of Changes in Net Assets..... 4

 Statements of Cash Flows 5

 Notes to Financial Statements..... 6



Independent Auditor's Report

The Board of Directors
Mobridge Regional Hospital
Mobridge, South Dakota

Report on the Financial Statements

We have audited the accompanying financial statements of Mobridge Regional Hospital (the "Hospital"), which comprise the balance sheets as of September 30, 2018 and 2017, and the related statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Mobridge Regional Hospital as of September 30, 2018 and 2017, and the results of its operations, changes in net assets, and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Eide Bailly LLP

Sioux Falls, South Dakota
January 22, 2019

(This page left blank intentionally.)

| | 2018 | 2017 |
|---|----------------------|----------------------|
| Assets | | |
| Current Assets | | |
| Cash and cash equivalents | \$ 8,329,988 | \$ 8,470,334 |
| Restricted cash and cash equivalents | 10,170 | 112,543 |
| Assets limited as to use | 518,000 | 517,027 |
| Receivables | | |
| Patient and resident, net | 3,484,114 | 3,119,753 |
| Other | 54,685 | - |
| Related party - Mobridge Regional Healthcare Foundation | 187,341 | - |
| Estimated third-party payor settlements | 103,516 | - |
| Supplies | 429,895 | 358,227 |
| Prepaid expenses | 180,658 | 136,054 |
| Total current assets | <u>13,298,367</u> | <u>12,713,938</u> |
| Assets Limited as to Use | | |
| Designated by board as funded depreciation | 268,905 | 267,825 |
| Under indenture agreements | 142,464 | 129,975 |
| Total assets limited as to use, net of current portion | <u>411,369</u> | <u>397,800</u> |
| Property and Equipment, Net | <u>10,608,477</u> | <u>10,690,838</u> |
| Other Assets | | |
| Other investments | 1,268,500 | 1,256,000 |
| Other receivables | 208,821 | 251,697 |
| Related party - Mobridge Regional Healthcare Foundation | - | 187,341 |
| Prepaid expenses | 5,200 | 6,240 |
| Deferred compensation plan | 522,625 | 459,135 |
| Interest in net assets of Mobridge Regional Healthcare Foundation | 860,742 | 824,304 |
| Total other assets | <u>2,865,888</u> | <u>2,984,717</u> |
| Total assets | <u>\$ 27,184,101</u> | <u>\$ 26,787,293</u> |

See Notes to Financial Statements

Mobridge Regional Hospital
Balance Sheets
September 30, 2018 and 2017

| | 2018 | 2017 |
|---|----------------------|----------------------|
| Liabilities and Net Assets | | |
| Current Liabilities | | |
| Current maturities of long-term debt | \$ 504,500 | \$ 481,700 |
| Accounts payable | | |
| Trade | 398,455 | 470,090 |
| Estimated third-party payor settlements | - | 242,000 |
| Accrued expenses | | |
| Salaries and wages | 373,338 | 338,897 |
| Vacation | 566,610 | 548,088 |
| Interest | 38,500 | 45,167 |
| Deposits | 10,001 | 10,001 |
| Deferred revenue | - | 88,707 |
| | 1,891,404 | 2,224,650 |
| Long-Term Liabilities | | |
| Long-term debt, less current maturities, unamortized premiums, and unamortized debt issuance costs | 5,218,546 | 5,715,069 |
| Deferred compensation payable | 522,625 | 459,135 |
| | 5,741,171 | 6,174,204 |
| | 7,632,575 | 8,398,854 |
| Net Assets | | |
| Unrestricted | 18,680,614 | 17,451,592 |
| Temporarily restricted | 870,912 | 936,847 |
| | 19,551,526 | 18,388,439 |
| | \$ 27,184,101 | \$ 26,787,293 |

Mobridge Regional Hospital
Statements of Operations
Years Ended September 30, 2018 and 2017

| | 2018 | 2017 |
|---|---------------------|---------------------|
| Unrestricted Revenues, Gains, and Other Support | | |
| Net patient and resident service revenue | \$ 23,169,340 | \$ 22,894,158 |
| Provision for bad debts | (1,855,237) | (1,452,179) |
| Net patient and resident service revenue | | |
| less provision for bad debts | 21,314,103 | 21,441,979 |
| Other revenue | 330,939 | 330,080 |
| Electronic health record incentive revenue | 88,707 | 354,830 |
| Net assets released from restrictions for operations | 112,544 | 95,246 |
| Total revenues, gains, and other support | 21,846,293 | 22,222,135 |
| Expenses | | |
| Salaries and wages | 10,068,365 | 9,252,458 |
| Employee benefits | 2,728,208 | 2,506,551 |
| Professional services | 1,177,601 | 1,000,251 |
| Supplies | 3,053,085 | 3,079,667 |
| General and administrative | 401,794 | 424,075 |
| Insurance | 279,715 | 295,055 |
| Utilities and telephone | 302,227 | 294,480 |
| Other | 998,050 | 977,711 |
| Rental | 39,589 | 38,856 |
| Travel, education, and meetings | 91,028 | 65,616 |
| Depreciation | 1,365,184 | 1,716,883 |
| Interest | 244,615 | 290,649 |
| Total expenses | 20,749,461 | 19,942,252 |
| Operating Income | 1,096,832 | 2,279,883 |
| Other Income | | |
| Investment income | 124,765 | 62,146 |
| Unrestricted contributions | 825 | - |
| Gain on the sale of assets | 6,600 | - |
| Total other income | 132,190 | 62,146 |
| Revenues in Excess of Expenses and Change in Unrestricted Net Assets | \$ 1,229,022 | \$ 2,342,029 |

Mobridge Regional Hospital
Statements of Changes in Net Assets
Years Ended September 30, 2018 and 2017

| | 2018 | 2017 |
|--|---------------|---------------|
| Unrestricted Net Assets | | |
| Revenues in excess of expenses and change in unrestricted net assets | \$ 1,229,022 | \$ 2,342,029 |
| Temporarily Restricted Net Assets | | |
| Change in interest in net assets of foundation | 36,438 | 144,059 |
| Restricted grants and contributions | 10,171 | 56,208 |
| Net assets released from restrictions | (112,544) | (95,246) |
| Change in temporarily restricted net assets | (65,935) | 105,021 |
| Change in Net Assets | 1,163,087 | 2,447,050 |
| Net Assets, Beginning of Year | 18,388,439 | 15,941,389 |
| Net Assets, End of Year | \$ 19,551,526 | \$ 18,388,439 |

Mobridge Regional Hospital
Statements of Cash Flows
Years Ended September 30, 2018 and 2017

| | 2018 | 2017 |
|--|--------------|--------------|
| Operating Activities | | |
| Change in net assets | \$ 1,163,087 | \$ 2,447,050 |
| Adjustments to reconcile change in net assets to net cash from operating activities | | |
| Depreciation | 1,365,184 | 1,716,883 |
| Interest expense attributable to amortization of deferred financing costs and bond premium | 7,974 | 7,973 |
| Gain on the sale of assets | (6,600) | - |
| Provision for bad debts | 1,855,237 | 1,452,179 |
| Undistributed portion of change in interest in net assets of Mobridge Regional Healthcare Foundation | (36,438) | (144,059) |
| Restricted grants and contributions | (10,171) | (56,208) |
| Changes in assets and liabilities | | |
| Patient and resident receivables | (2,219,598) | (1,938,316) |
| Other and related party receivables | (11,809) | (106,041) |
| Supplies | (71,668) | (5,243) |
| Prepaid expenses | (43,564) | (72,629) |
| Accounts payable | (71,635) | 27,400 |
| Due to third party payors | (345,516) | 748,175 |
| Accrued expenses | 46,296 | 33,581 |
| Deferred revenue | (88,707) | (354,830) |
| Deposits | - | (1,499) |
| Net Cash from Operating Activities | 1,532,072 | 3,754,416 |
| Investing Activities | | |
| Purchase of property and equipment | (1,276,223) | (756,398) |
| Purchase of assets limited as to use and other investments | (27,042) | (1,261,148) |
| Change in restricted cash and cash equivalents | 102,373 | 39,038 |
| Net Cash used for Investing Activities | (1,200,892) | (1,978,508) |
| Financing Activities | | |
| Principal payments on long-term debt | (481,697) | (635,112) |
| Restricted grants and contributions | 10,171 | 56,208 |
| Net Cash used for Financing Activities | (471,526) | (578,904) |
| Net Change in Cash and Cash Equivalents | (140,346) | 1,197,004 |
| Cash and Cash Equivalents, Beginning of Year | 8,470,334 | 7,273,330 |
| Cash and Cash Equivalents, End of Year | \$ 8,329,988 | \$ 8,470,334 |
| Supplemental Disclosure of Cash Flow Information | | |
| Cash paid during the year for interest | \$ 243,308 | \$ 289,009 |

Note 1 - Organization and Significant Accounting Policies**Organization**

Mobridge Regional Hospital (Hospital) operates a 25-bed critical access hospital, a 16-bed assisted living center, an 8-bed senior housing center in Mobridge, South Dakota, and medical clinics located in Mobridge, Timber Lake, and McLaughlin, South Dakota.

Income Taxes

The Hospital is a South Dakota nonprofit corporation and has been recognized by the Internal Revenue Service (IRS) as exempt from federal income taxes under Internal Revenue Code Section 501(c)(3). The Hospital is annually required to file a Return of Organization Exempt from Income Tax (Form 990) with the IRS. In addition, the Hospital is subject to income tax on net income that is derived from business activities that are unrelated to its exempt purpose. The Hospital has determined it is not subject to unrelated business income tax and has not filed an Exempt Organization Business Income Tax Return (Form 990T) with the IRS.

The Hospital believes that it has appropriate support for any tax positions taken affecting its annual filing requirements, and as such, does not have any uncertain tax positions that are material to the financial statements. The Hospital would recognize future accrued interest and penalties related to unrecognized tax benefits and liabilities in income tax expense if such interest and penalties are incurred.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents include highly liquid investments with an original maturity of three months or less, excluding assets limited as to use. Restricted cash and cash equivalents represents proceeds received under grant agreements that have not been expended as of the balance sheet date.

Patient and Resident Receivables

Patient and resident receivables are uncollateralized patient, resident, and third-party payor obligations. The Hospital does not charge interest on delinquent accounts. Payments of patient and resident receivables are allocated to the specific claims identified on the remittance advice or, if unspecified, are applied to the earliest unpaid claim.

Patient and resident accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, the Hospital analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts.

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For receivables associated with services provided to patients who have third party coverage, the Hospital analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary. For receivables associated with self-pay patients, which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill, the Hospital records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or discounted rates, if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

The Hospital's process for calculating the allowance for doubtful accounts for self-pay patients has not significantly changed from September 30, 2017 to September 30, 2018. The Hospital does not maintain a material allowance for doubtful accounts from third-party payors, nor did it have significant write offs from third-party payors. The Hospital has not significantly changed its charity care or uninsured discount policies during fiscal years 2018 or 2017. Patient and resident receivables are shown net of estimated uncollectibles, charity care, and other allowances of approximately \$3,356,000 and \$2,900,000 as of September 30, 2018 and 2017, of which approximately \$432,000 and \$465,000 was recorded for the allowance for doubtful accounts.

Physician and Employee Notes Receivable

The Hospital issues notes to physicians and employees as part of its recruitment process. Notes are repayable over a minimum of a two-year period to a maximum of a three-year period. The notes are issued with forgiveness provisions over the life of the note to encourage retention. Based on historical analysis, it is anticipated that the balance of the notes will be forgiven. At September 30, 2018 and 2017, notes receivable from physicians and employees were \$450,846 and \$251,697. The physician and employee notes receivable are included in other receivables on the balance sheets.

Supplies

Supplies are stated at lower of cost or net realizable value on a first-in, first-out basis.

Assets Limited as to Use

Assets limited as to use include assets held by trustees under indenture agreements and assets set aside by the board for funded depreciation. Assets limited as to use that are required for obligations classified as current liabilities are reported in current assets.

Investments and Investment Income

Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the balance sheets. Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in revenues in excess of expenses unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are excluded from revenues in excess of expenses unless the investments are trading securities.

Short-term certificates of deposit have original maturities from 3 months to 12 months. Long-term certificates of deposit have maturities greater than 12 months. Investments in certificates of deposit that are not publicly traded are recorded at cost.

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Fair Value Measurements

The Hospital has determined the fair value of certain assets and liabilities in accordance with generally accepted accounting principles, which provides a framework for measuring fair value.

Fair value is defined as the exchange price that would be received for an asset or paid to transfer a liability (an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. Valuation techniques should maximize the use of observable inputs and minimize the use of unobservable inputs.

A fair value hierarchy has been established, which prioritizes the valuation inputs into three broad levels. Level 1 inputs consist of quoted prices in active markets for identical assets or liabilities that the Hospital has the ability to access at the measurement date. Level 2 inputs are inputs other than quoted prices included within Level 1 that are observable for the related asset or liability. Level 3 inputs are unobservable inputs related to the asset or liability.

Property and Equipment

Property and equipment acquisitions in excess of \$5,000 are capitalized and recorded at cost. Depreciation is provided over the estimated useful life of each depreciable asset and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Amortization is included in depreciation and amortization in the financial statements. The estimated useful lives of property and equipment are as follows:

| | |
|----------------------------|---------------|
| Land improvements | 8 - 20 years |
| Buildings and improvements | 10 - 40 years |
| Equipment | 3 - 25 years |

Gifts of long-lived assets such as land, buildings, or equipment are reported as additions to unrestricted net assets, and are excluded from revenues in excess of expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted net assets. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when donated or when acquired long-lived assets are placed in service.

Impairment of Long-lived Assets

The Hospital considers whether indicators of impairment are present and performs the necessary analysis to determine if the carrying values of assets are appropriate. No impairment was identified for the years ended September 30, 2018 and 2017.

Debt Issuance Costs

Unamortized debt issuance costs are deferred and amortized using the straight-line method over the term of the related obligation, which is a reasonable approximation of the effective interest method. Unamortized debt issuance costs are included within the long-term debt on the balance sheets. Amortization of debt issuance costs is included in interest expense in the accompanying financial statements.

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Donor-Restricted Gifts

Unconditional promises to give cash and other assets to the Hospital are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When donor stipulated time restrictions or purpose restrictions are met or accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the statement of operations as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reflected as unrestricted contributions in the statement of operations.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Hospital has been limited by donors to a specific time period or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Hospital in perpetuity. At September 30, 2018 and 2017, the Hospital did not have any permanently restricted net assets.

Net Patient and Resident Service Revenue

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. Payment arrangements include prospectively determined rates, reimbursed costs, discounted charges, and per diem payments. Net patient and resident service revenue is reported at the estimated net realizable amounts from patients, residents, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

The Hospital recognizes patient and resident service revenue associated with services provided to patients and residents who have third-party payor coverage on the basis of contractual rates for the services rendered, as noted above. For uninsured patients that do not qualify for charity care, the Hospital recognizes revenue on the basis of its standard rates for services provided. On the basis of historical experience, a significant portion of the Hospital's uninsured patients and residents will be unable or unwilling to pay for the services provided. Thus, the Hospital records a significant provision for bad debts related to uninsured patients and residents in the period the services are provided. Net patient and resident service revenue before the provision for bad debts recognized for the years ended September 30, 2018 and 2017 from these major payor sources is as follows:

| | 2018 | 2017 |
|--|---------------|---------------|
| Net patient and resident service revenue | | |
| Third-party payors | \$ 20,827,385 | \$ 20,516,792 |
| Uninsured patients | 2,341,955 | 2,377,366 |
| Total all payors | \$ 23,169,340 | \$ 22,894,158 |

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Revenues in Excess of Expenses

Revenues in excess of expenses excludes transfers of assets to and from related parties for other than goods and services, and contributions of long-lived assets, including assets acquired using contributions which were restricted by donors.

Charity Care

To fulfill its mission of community service, the Hospital provides care to patients and residents who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Since the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient and resident service revenue. The estimated cost of providing these services was \$135,000 and \$141,000 for the years ended September 30, 2018 and 2017, calculated by multiplying the ratio of cost to gross charges for the Hospital by the gross uncompensated charges associated with providing charity care to its patients.

Advertising Costs

Costs incurred for producing and distributing advertising are expensed as incurred. The Hospital incurred \$85,023 and \$80,073 for advertising costs for the years ended September 30, 2018 and 2017.

Electronic Health Record Incentive Payments

The American Recovery and Reinvestment Act of 2009 (ARRA) amended the Social Security Act to establish incentive payments under the Medicare and Medicaid programs for certain hospitals and professionals that meaningfully use certified Electronic Health Records (EHR) technology.

Medicare

To qualify for the Medicare EHR incentive payments, hospitals and physicians must meet designated EHR meaningful use criteria. In addition, hospitals must attest that they have used certified EHR technology, satisfied the meaningful use objectives, and specify the Medicare EHR reporting period. This attestation is subject to audit by the federal government or its designee. The Medicare EHR incentive payment to hospitals for each payment year is calculated as a product of (1) allowable costs as defined by the Centers for Medicare & Medicaid Services (CMS) and (2) the Medicare share. For Medicare, once the initial attestation of meaningful use is completed, critical access hospitals receive the entire Medicare EHR incentive payment for submitted allowable costs of the respective periods in a lump sum, subject to a final adjustment on the cost report.

As the entire Medicare EHR incentive payment is received in a lump sum for critical access hospitals and the Hospital must annually attest to increasingly stringent meaningful use criteria, the Medicare EHR incentive payment is first recognized as a deferred revenue with a ratable recognition of revenue over the life of the qualifying assets. During the year ended September 30, 2013, the Hospital received approximately \$1.8 million as a lump sum incentive payment related to Medicare EHR. The Hospital is recognizing the revenue ratably over the useful life of the respective EHR assets from the date that they became meaningful users of EHR technology. The Hospital recognized revenue of \$88,707 and \$354,830 for the Medicare EHR incentive program for the years ended September 30, 2018 and 2017, respectively.

Medicaid

The Medicaid EHR incentive payments are paid out based on state-specific legislation and are not to exceed 50% of the entire Medicaid EHR incentive payment in any one year, and 90% of the entire Medicaid EHR incentive payment in any 2-year period. The incentives are paid over a minimum of a 3-year period and a maximum of a 6-year period. To qualify for the first Medicaid EHR incentive payment, the hospital must be in the Adopt, Implement, and Upgrade stages of the meaningful use criteria. To qualify for the second and third Medicaid EHR incentive payments, hospitals must satisfy the meaningful use criteria that are outlined within the Medicare EHR objectives. The Medicaid EHR incentive payments to hospitals for each payment year is calculated as a product of (1) an initial amount; (2) the Medicaid share; and (3) a transition factor applicable to that payment year. The Hospital recognizes Medicaid EHR incentive payments in the year received.

The amount of EHR incentive payments recognized are based on management's best estimate and those amounts are subject to change with such changes impacting the period in which they occur.

Subsequent Events

The Hospital has evaluated subsequent events through January 22, 2019, the date which the financial statements were available to be issued.

Note 2 - Net Patient and Resident Service Revenue

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare – Hospital: The Hospital is licensed as a Critical Access Hospital (CAH). The Hospital is reimbursed for most inpatient and outpatient services at cost with final settlement determined after submission of annual cost reports by the Hospital and are subject to audits thereof by the Medicare intermediary. The Hospital's Medicare cost reports have been audited by the Medicare fiscal intermediary through the year ended September 30, 2016.

Medicare – Clinics: The Mobridge Medical Clinic (Mobridge, SD), West Dakota Health Center (Timber Lake, SD) and West River Health Clinic (McLaughlin, SD) are designated as provider-based rural health clinics (RHC) by the Medicare program. As a result, clinical services rendered to Medicare program beneficiaries are reimbursed at cost.

Medicaid: Inpatient acute care services rendered to Medicaid program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Clinical and outpatient services rendered to Medicaid program beneficiaries are reimbursed under a historical cost-based reimbursement methodology adjusted annually. The Hospital is reimbursed for Medicaid assisted living resident services at established billing rates as prescribed by the South Dakota Department of Social Services regulations.

Wellmark Blue Cross and Blue Shield: Services rendered to Blue Cross and Blue Shield subscribers are reimbursed under a prospectively determined percentage of charges methodology.

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The Hospital has also entered into payment agreements with certain commercial and managed care insurance carriers and other organizations. The basis for payment to the Hospital under these agreements includes prospectively determined rates and discounts from established charges.

Revenue from the Medicare and Medicaid programs accounted for approximately 39% and 20% of the Hospital's gross patient service revenue for the year ended September 30, 2018 and 40% and 19% for the year ended September 30, 2017. Laws and regulations governing the Medicare, Medicaid, and other programs are extremely complex and subject to interpretation. As a result, there is an ongoing level of uncertainty relative to the estimated liability for prior period cost reports. There is a reasonable possibility that recorded estimates will change by a material amount in the near term. The net patient service revenue for the years ended September 30, 2018 and 2017 increased approximately \$7,000 and decreased approximately \$81,000 due to removal of allowances previously estimated that are no longer necessary as a result of final settlements, adjustments to amounts previously estimated and years that are no longer likely subject to audits, reviews, and investigations.

Note 3 - Investments and Investment Income

Assets Limited as to Use

The composition of assets limited as to use at September 30, 2018 and 2017, is shown in the following table.

| | 2018 | 2017 |
|--|------------|------------|
| Under bond indenture agreement - held by trustee | | |
| Bond sinking fund - Cash and cash equivalents | \$ 267,750 | \$ 379,252 |
| Bond reserve fund - Cash and cash equivalents | 392,714 | 267,750 |
| | 660,464 | 647,002 |
| Less amount shown as current | 518,000 | 517,027 |
| | \$ 142,464 | \$ 129,975 |
| Designated by board as funded depreciation | | |
| Cash and cash equivalents | \$ 268,905 | \$ 267,825 |
| | | |

Other Investments

Long-term investments include certificates of deposit of \$1,268,000 and \$1,256,000 as of September 30, 2018 and 2017.

Other assets also include deferred compensation assets which are invested in mutual funds and totaled \$522,625 and \$459,135 as of September 30, 2018 and 2017.

Investment Income

Investment income and gains and losses on assets limited as to use, cash equivalents, short-term investments, and other investments consists of the following for the years ended September 30, 2018 and 2017:

| | 2018 | 2017 |
|------------------------------|------------|-----------|
| Interest and dividend income | \$ 124,765 | \$ 62,146 |
| | | |

Mobridge Regional Hospital
Notes to Financial Statements
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Note 4 - Fair Value Measurements

Fair Values of Assets and Liabilities

Assets measured at fair value on a recurring basis at September 30, 2018 and 2017, respectively, are as follows:

| | Carrying Value | Quoted Prices in Active Markets (Level 1) | Other Observable Inputs (Level 2) | Unobservable Inputs (Level 3) |
|--|-------------------|---|--|-------------------------------------|
| September 30, 2018 | | | | |
| Deferred compensation plan Mutual funds | \$ 522,625 | \$ 522,625 | \$ - | \$ - |
| September 30, 2017 | | | | |
| Deferred compensation plan Mutual funds | \$ 459,135 | \$ 459,135 | \$ - | \$ - |

The fair value for these securities is determined by reference to quoted market prices.

Financial Instruments

The Hospital considers the carrying amount of significant classes of financial instruments on the balance sheets, including cash and cash equivalents, net accounts receivable, assets limited as to use, other assets, accounts payable, accrued liabilities, and other current and long-term liabilities to be reasonable estimates of fair value due to the length of maturity underlying such financial instruments that approximate prevailing market rates at September 30, 2018 and 2017.

As of September 30, 2018 and 2017, the Hospital had fixed-rate bonds with a carrying amount that differed from its estimated fair value. The fair value of the Hospital's fixed rate debt with a carrying amount of \$2,710,000 was estimated to be \$2,259,827 as of September 30, 2018. The fair value of the Hospital's fixed rate debt with a carrying amount of \$2,710,000 was estimated to be \$2,709,783 as of September 30, 2017. The fair value of the Hospital's fixed rate long-term debt is estimated using discounted cash flow analyses, based on the Hospital's effective borrowing rates at respective reporting dates for similar types of arrangements.

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Note 5 - Property and Equipment

A summary of property and equipment at September 30, 2018 and 2017, is as follows:

| | 2018 | | 2017 | |
|----------------------------|----------------------|-----------------------------|----------------------|-----------------------------|
| | Cost | Accumulated Depreciation | Cost | Accumulated Depreciation |
| Land | \$ 95,575 | \$ - | \$ 95,575 | \$ - |
| Land improvements | 823,667 | 510,358 | 823,667 | 458,314 |
| Buildings and improvements | 15,900,908 | 9,159,750 | 15,900,908 | 8,696,920 |
| Equipment | 15,862,265 | 12,573,701 | 14,738,626 | 11,712,704 |
| Construction in progress | 169,871 | - | - | - |
| | <u>\$ 32,852,286</u> | <u>\$ 22,243,809</u> | <u>\$ 31,558,776</u> | <u>\$ 20,867,938</u> |
| Net property and equipment | | <u>\$ 10,608,477</u> | | <u>\$ 10,690,838</u> |

Note 6 - Leases

The Hospital leases certain equipment under various operating leases with terms of less than one year or cancellable upon written notice. Total lease expense for the years ended September 30, 2018 and 2017, for all operating leases was \$39,589 and \$38,856, respectively.

Note 7 - Long-Term Debt

| | 2018 | 2017 |
|---|---------------------|---------------------|
| City of Mobridge, South Dakota Health Care Facilities Revenue Bonds, Series 2007, 5.00% (effective interest rate of 5.1%) with varying annual sinking fund requirements, interest due semi-annually and principal due annually until December 1, 2022 | \$ 2,310,000 | \$ 2,710,000 |
| Unamortized bond premium | 5,080 | 6,300 |
| Unamortized debt issuance costs | (38,301) | (47,494) |
| USDA Rural Development Program mortgage notes payable, 3.75%, due in monthly installments of \$16,625, including interest, through June 26, 2052 | <u>3,446,267</u> | <u>3,527,963</u> |
| | 5,723,046 | 6,196,769 |
| Less current maturities | <u>(504,500)</u> | <u>(481,700)</u> |
| | <u>\$ 5,218,546</u> | <u>\$ 5,715,069</u> |

Mobridge Regional Hospital
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Long-term debt maturities are as follows:

Years Ending September 30,

| | |
|--------------------------------------|----------------------------|
| 2019 | \$ 504,500 |
| 2020 | 522,400 |
| 2021 | 550,400 |
| 2022 | 578,500 |
| 2023 | 606,700 |
| Thereafter | 2,993,767 |
| Unamortized bond premium | 5,080 |
| Less unamortized debt issuance costs | <u>(38,301)</u> |
| | <u><u>\$ 5,723,046</u></u> |

Substantially all of the Hospital's assets at September 30, 2018 and 2017, are pledged as collateral for debt obligations. Various debt agreements of the Hospital contain certain restrictive covenants, including the maintenance of specific financial ratios and amounts.

Under the terms of the revenue refunding bonds loan agreement, the Hospital is required to maintain certain deposits with a trustee. Such deposits are included with assets limited as to use in the financial statements. The loan agreement also places limits on the incurrence of additional borrowings and requires that the Hospital satisfy certain measures of financial performance including a covenant that income available for debt service coverage must equal at least 120 percent of annual debt service requirements on all funded debt.

Note 8 - Temporarily Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at September 30, 2018 and 2017:

| | 2018 | 2017 |
|--|--------------------------|--------------------------|
| Interest in net assets of foundation - funds held by foundation for health care programs and services | \$ 860,742 | \$ 824,304 |
| Grants restricted for capital purchases and specific programs | <u>10,170</u> | <u>112,543</u> |
| | <u><u>\$ 870,912</u></u> | <u><u>\$ 936,847</u></u> |

Note 9 - Benefit Plans

Employee 401(k) Retirement Plan

The Hospital has a defined contribution 401(k) plan which is administered by Mutual of America. Full time employees may participate upon reaching age 18 and completion of one year of service. Part time employees may participate upon reaching age 18 and completion of 1,080 hours of service. Employer contributions of up to 4 percent of annual compensation are deposited with the plan trustee who invests the plan assets. Total pension plan expense for the years ended September 30, 2018 and 2017, was \$320,170 and \$313,839. Participants are immediately 100 percent vested in employer contributions and actual earnings thereon.

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Deferred Compensation Agreement

Effective January 1, 2008, the Hospital adopted the Mobridge Regional Hospital 457(b) Deferred Compensation Plan (the Plan) for certain key employees. The Hospital's Board of Directors designates the participants under the Plan and the Plan is a salary reduction agreement only. As of September 30, 2018 and 2017, the Plan had three participants and a balance of \$522,625 and \$459,135, respectively.

Note 10 - Commitments and Contingencies**Malpractice Insurance**

The Hospital has malpractice insurance coverage to provide protection for professional liability losses on a claims-made basis subject to a limit of \$1 million per claim and \$3 million annual aggregate. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims based on occurrences during its term, but reported subsequently, would be uninsured.

Litigations, Claims, and Assessments

The Hospital is subject to the usual contingencies in the normal course of operations relating to the performance of its tasks under its various programs. In the opinion of management, the ultimate settlement of litigations, claims, and disputes in process will not be material to the financial position of the Hospital.

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations, specifically those relating to the Medicare and Medicaid programs, can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Federal government activity has increased with respect to investigations and allegations concerning possible violations by health care providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments of previously billed and collected revenues from patient services. Management believes that the Hospital is in substantial compliance with current laws and regulations.

Note 11 - Related Party Transactions

Mobridge Regional Hospital Foundation (Foundation) is organized to solicit contributions and hold funds on behalf of the Hospital. Funds are distributed to the hospital as determined by the Foundation's Board of Directors. The Hospital's interest in the net assets of the foundation is reported as a noncurrent asset in the accompanying balance sheets. The amount recorded in the balance sheet is equal to the net assets held by the Foundation that are for the benefit of the Hospital.

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Note 12 - Functional Expenses

The Hospital provides health care services to residents within its geographic location. Expenses related to providing these services by functional class for the years ended September 30, 2018 and 2017, are as follows:

| | 2018 | 2017 |
|----------------------------|---------------|---------------|
| Health care services | \$ 18,444,229 | \$ 17,980,853 |
| General and administrative | 2,305,232 | 1,961,399 |
| | \$ 20,749,461 | \$ 19,942,252 |

Note 13 - Management Agreement – CHI St. Alexius Health

During 2017, the Hospital signed a new management agreement with CHI St. Alexius Health. The management agreement provides that CHI St. Alexius Health will provide management and administrative services. The agreement remains in effect in perpetuity but may be cancelled by the Hospital following a 90-day notice.

Note 14 - Concentrations of Credit Risk

The Hospital grants credit without collateral to its patients and residents, most of who are insured under third-party payor agreements. The Hospital's composition of receivables from third-party payors, patients, and residents at September 30, 2018 and 2017, was as follows:

| | 2018 | 2017 |
|-------------------------------------|------|------|
| Medicare | 27% | 31% |
| Wellmark Blue Cross and Blue Shield | 17% | 20% |
| Medicaid | 11% | 10% |
| U.S. Public Health Service | 17% | 15% |
| Commercial insurance | 13% | 10% |
| Self pay and other | 15% | 14% |
| | 100% | 100% |

The Hospital's cash balances are maintained in various bank deposit accounts. At various times during the years ended September 30, 2018 and 2017, the balances of these deposits were in excess of federally-insured limits.