

**ELO Prof LLC  
PO Box 249  
Mitchell, SD 57301  
605-996-7717**

May 13, 2022

**CONFIDENTIAL**

HURON REGIONAL MEDICAL CENTER INC  
172 4TH ST SE  
HURON, SD 57350

Dear Marcia:

We have prepared the enclosed returns from information you provided; we suggest that you examine these returns carefully to fully acquaint yourself with all items contained therein to ensure that there are no omissions or misstatements.

**Federal Filing Instructions**

Your Form 990 for the year ended 6/30/21 shows no balance due.

Your return is being filed electronically with the IRS and is not required to be mailed. If you mail a paper copy of your return to the IRS it will delay the processing of your return. Your electronically filed return is not complete without your signature. You are using a Personal Identification Number (PIN) for signing your return electronically. Form 8879-EO, IRS *e-file* Signature Authorization for an Exempt Organization should be signed and dated by an authorized officer of the organization and returned as soon as possible to:

ELO Prof LLC  
PO Box 249  
Mitchell, SD 57301

***Important:* Your return will not be filed with the IRS until the signed Form 8879-EO has been received by this office.**

Your Form 990-T for the tax year ended 6/30/21 shows no balance due. The return should be signed and dated on Page 2 by an officer representing the organization.

Your Form 990-T is being filed electronically with the IRS and is not required to be mailed. If you mail a paper copy of your return to the IRS it will delay the processing of your return.

Your electronically filed 990-T is not complete without your signature. Form 8453-EO, Exempt Organization Declaration and Signature for Electronic Filing should be signed and dated by an authorized officer of the organization. The form will be included as an attachment to the electronic file and therefore must be signed and returned before the electronic file is transmitted to the IRS.

Return the signed Form 8453-EO as soon as possible to:

ELO Prof LLC  
PO Box 249

Mitchell, SD 57301

Also enclosed is any material you furnished for use in preparing the returns. If any of the returns are examined by taxing authorities, requests may be made for supporting documentation. Therefore, we recommend that you retain all pertinent records for at least seven years.

In order that we may properly advise you of tax considerations, please keep us informed of any significant changes in your financial affairs or of any correspondence received from taxing authorities.

If you have any questions, or if we can be of assistance in any way, please call.

Thank you for the opportunity to provide you with our services.

Form **8453-EO**

**Exempt Organization Declaration and Signature for Electronic Filing**

OMB No. 1545-0047

For calendar year 2020, or tax year beginning 07/01/20, and ending 06/30/21

**2020**

For use with Forms 990, 990-EZ, 990-PF, 990-T, 1120-POL, 4720, and 8868

Go to [www.irs.gov/Form8453EO](http://www.irs.gov/Form8453EO) for the latest information.

Department of the Treasury  
Internal Revenue Service

Name of exempt organization or person subject to tax

Taxpayer identification number

**HURON REGIONAL MEDICAL CENTER INC**

**46-0345312**

**Part I Type of Return and Return Information (Whole Dollars Only)**

Check the box for the type of return being filed with Form 8453-EO and enter the applicable amount, if any, from the return. If you check the box on line 1a, 2a, 3a, 4a, 5a, 6a, or 7a below, and the amount on that line of the return being filed with this form was blank, then leave line 1b, 2b, 3b, 4b, 5b, 6b, or 7b, whichever is applicable, blank (do not enter -0-). If you entered -0- on the return, then enter -0- on the applicable line below. Do not complete more than one line in Part I.

1a Form 990 check here <input type="checkbox"/>	1b Total revenue, if any (Form 990, Part VIII, column (A), line 12)	1b
2a Form 990-EZ check here <input type="checkbox"/>	2b Total revenue, if any (Form 990-EZ, line 9)	2b
3a Form 1120-POL check here <input type="checkbox"/>	3b Total tax (Form 1120-POL, line 22)	3b
4a Form 990-PF check here <input type="checkbox"/>	4b Tax based on investment income (Form 990-PF, Part VI, line 5)	4b
5a Form 8868 check here <input type="checkbox"/>	5b Balance due (Form 8868, line 3c)	5b
6a Form 990-T check here <input checked="" type="checkbox"/>	6b Total tax (Form 990-T, Part III, line 4)	6b
7a Form 4720 check here <input type="checkbox"/>	7b Total tax (Form 4720, Part III, line 1)	7b

**Part II Declaration of Officer or Person Subject to Tax**

- 8  I authorize the U.S. Treasury and its designated Financial Agent to initiate an Automated Clearing House (ACH) electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment.
- If a copy of this return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I certify that I executed the electronic disclosure consent contained within this return allowing disclosure by the IRS of this Form 990/990-EZ/990-PF (as specifically identified in Part I above) to the selected state agency(ies).

Under penalties of perjury, I declare that  I am an officer of the above named organization or  I am the person subject to tax with respect to \_\_\_\_\_, (EIN) \_\_\_\_\_,

and that I have examined a copy of the 2020 electronic return and accompanying schedules and statements, and, to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the return to the IRS and to receive from the IRS (a) an acknowledgement of receipt or reason for rejection of the transmission, (b) the reason for any delay in processing the return or refund, and (c) the date of any refund.

**Sign Here**      
 Date Title, if applicable

**Part III Declaration of Electronic Return Originator (ERO) and Paid Preparer (see instructions)**

I declare that I have reviewed the above return and that the entries on Form 8453-EO are complete and correct to the best of my knowledge. If I am only a collector, I am not responsible for reviewing the return and only declare that this form accurately reflects the data on the return. The organization officer or person subject to tax will have signed this form before I submit the return. I will give a copy of all forms and information to be filed with the IRS to the officer or person subject to tax, and have followed all other requirements in Pub. 4163, Modernized e-File (MeF) Information for Authorized IRS e-file Providers for Business Returns. If I am also the Paid Preparer, under penalties of perjury I declare that I have examined the above return and accompanying schedules and statements, and, to the best of my knowledge and belief, they are true, correct, and complete. This Paid Preparer declaration is based on all information of which I have any knowledge.

<b>ERO's Use Only</b>	ERO's signature <input type="text" value="JAY TOLSMAN, CPA"/>	Date <input type="text" value="05/13/22"/>	Check if also paid preparer <input checked="" type="checkbox"/>	Check if self-employed <input type="checkbox"/>	ERO's SSN or PTIN <input type="text" value="P00736087"/>
	Firm's name (or yours if self-employed), address, and ZIP code <input type="text" value="ELO PROF LLC PO BOX 249 MITCHELL SD 57301"/>	EIN <input type="text" value="46-0434947"/>	Phone no. <input type="text" value="605-996-7717"/>		

Under penalties of perjury, I declare that I have examined the above return and accompanying schedules and statements, and, to the best of my knowledge and belief, they are true, correct, and complete. Declaration of preparer is based on all information of which the preparer has any knowledge.

<b>Paid Preparer Use Only</b>	Print/Type preparer's name <input type="text"/>	Preparer's signature <input type="text"/>	Date <input type="text"/>	Check if self-employed <input type="checkbox"/>	PTIN <input type="text"/>
	Firm's name <input type="text"/>	Firm's EIN <input type="text"/>			
	Firm's address <input type="text"/>	Phone no. <input type="text"/>			

For Privacy Act and Paperwork Reduction Act Notice, see back of form.

Form **8453-EO** (2020)

Form **8879-EO**

### IRS e-file Signature Authorization for an Exempt Organization

OMB No. 1545-0047

For calendar year 2020, or fiscal year beginning 7/01, 2020, and ending 6/30, 20 21.

# 2020

Department of the Treasury  
Internal Revenue Service

**u Do not send to the IRS. Keep for your records.**  
**u Go to [www.irs.gov/Form8879EO](http://www.irs.gov/Form8879EO) for the latest information.**

Name of exempt organization or person subject to tax

**HURON REGIONAL MEDICAL CENTER INC**

Taxpayer identification number

**46-0345312**

Name and title of officer or person subject to tax

**JUSTIN PICEK  
SECRETARY**

#### Part I Type of Return and Return Information (Whole Dollars Only)

Check the box for the return for which you are using this Form 8879-EO and enter the applicable amount, if any, from the return. If you check the box on line 1a, 2a, 3a, 4a, 5a, 6a, or 7a below, and the amount on that line for the return being filed with this form was blank, then leave line 1b, 2b, 3b, 4b, 5b, 6b, or 7b, whichever is applicable, blank (do not enter -0-). But, if you entered -0- on the return, then enter -0- on the applicable line below. Do not complete more than one line in Part I.

<b>1a</b> Form 990 check here <input checked="" type="checkbox"/>	<b>b</b> Total revenue, if any (Form 990, Part VIII, column (A), line 12)	<b>1b</b> <u>50,307,849</u>
<b>2a</b> Form 990-EZ check here <input type="checkbox"/>	<b>b</b> Total revenue, if any (Form 990-EZ, line 9)	<b>2b</b> _____
<b>3a</b> Form 1120-POL check here <input type="checkbox"/>	<b>b</b> Total tax (Form 1120-POL, line 22)	<b>3b</b> _____
<b>4a</b> Form 990-PF check here <input type="checkbox"/>	<b>b</b> Tax based on investment income (Form 990-PF, Part VI, line 5)	<b>4b</b> _____
<b>5a</b> Form 8868 check here <input type="checkbox"/>	<b>b</b> Balance due (Form 8868, line 3c)	<b>5b</b> _____
<b>6a</b> Form 990-T check here <input type="checkbox"/>	<b>b</b> Total tax (Form 990-T, Part III, line 4)	<b>6b</b> _____
<b>7a</b> Form 4720 check here <input type="checkbox"/>	<b>b</b> Total tax (Form 4720, Part III, line 1)	<b>7b</b> _____

#### Part II Declaration and Signature Authorization of Officer or Person Subject to Tax

Under penalties of perjury, I declare that  I am an officer of the above organization of  I am a person subject to tax with respect to (name of organization) \_\_\_\_\_, (EIN) \_\_\_\_\_ and that I have examined a copy of the 2020 electronic return and accompanying schedules and statements, and, to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the return to the IRS and to receive from the IRS (a) an acknowledgement of receipt or reason for rejection of the transmission, (b) the reason for any delay in processing the return or refund, and (c) the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the electronic return and, if applicable, the consent to electronic funds withdrawal.

#### PIN: check one box only

I authorize ELO PROF LLC to enter my PIN 34266 as my signature  
ERO firm name Enter five numbers, but do not enter all zeros

on the tax year 2020 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

As an officer or person subject to tax with respect to the organization, I will enter my PIN as my signature on the tax year 2020 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Signature of officer or person subject to tax

Date } 05/14/22

#### Part III Certification and Authentication

**ERO's EFIN/PIN.** Enter your six-digit electronic filing identification number (EFIN) followed by your five-digit self-selected PIN.

**46034977174**

Do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2020 electronically filed return indicated above. I confirm that I am submitting this return in accordance with the requirements of Pub. 4163, Modernized e-File (MeF) Information for Authorized IRS e-file Providers for Business Returns.

ERO's signature } JAY TOLSMA, CPA

Date } 05/14/22

**ERO Must Retain This Form — See Instructions  
Do Not Submit This Form to the IRS Unless Requested To Do So**

For Paperwork Reduction Act Notice, see back of form.

Form **8879-EO** (2020)

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

**2020**  
**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](http://www.irs.gov/Form990) for instructions and the latest information.

**A For the 2020 calendar year, or tax year beginning 07/01/20, and ending 06/30/21**

<b>B</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	<b>C</b> Name of organization <p align="center"><b>HURON REGIONAL MEDICAL CENTER INC</b></p> Doing business as Number and street (or P.O. box if mail is not delivered to street address) Room/suite <p><b>172 4TH ST SE</b></p> City or town, state or province, country, and ZIP or foreign postal code <p><b>HURON SD 57350</b></p>	<b>D</b> Employer identification number <p align="center"><b>46-0345312</b></p> <b>E</b> Telephone number <p align="center"><b>605-353-6545</b></p> <b>G</b> Gross receipts \$ <b>50,454,324</b>
<b>F</b> Name and address of principal officer: <p><b>JUSTIN PICEK</b></p>		<b>H(a)</b> Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>H(b)</b> Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. See instructions
<b>I</b> Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) ( ) t (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527		<b>H(c)</b> Group exemption number <b>u</b>
<b>J</b> Website: <b>u WWW.HURONREGIONAL.ORG</b>		<b>L</b> Year of formation: <b>1978</b> <b>M</b> State of legal domicile: <b>SD</b>
<b>K</b> Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other <b>u</b>		

**Part I Summary**

	<b>1</b> Briefly describe the organization's mission or most significant activities: <p align="center"><b>THE MISSION OF HURON REGIONAL MEDICAL CENTER IS TO WORK TOGETHER WITH EACH INDIVIDUAL AND ORGANIZATION IN THE REGION TO PROMOTE AND IMPROVE COMMUNITY HEALTH.</b></p>		
<b>Activities &amp; Governance</b>	<b>2</b> Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	<b>3</b> Number of voting members of the governing body (Part VI, line 1a)	<b>3</b>	<b>11</b>
	<b>4</b> Number of independent voting members of the governing body (Part VI, line 1b)	<b>4</b>	<b>7</b>
	<b>5</b> Total number of individuals employed in calendar year 2020 (Part V, line 2a)	<b>5</b>	<b>409</b>
	<b>6</b> Total number of volunteers (estimate if necessary)	<b>6</b>	<b>41</b>
	<b>7a</b> Total unrelated business revenue from Part VIII, column (C), line 12	<b>7a</b>	<b>101,566</b>
<b>b</b> Net unrelated business taxable income from Form 990-T, Part I, line 11	<b>7b</b>	<b>0</b>	
<b>Revenue</b>	<b>8</b> Contributions and grants (Part VIII, line 1h)	<b>2,832,163</b>	<b>6,204,338</b>
	<b>9</b> Program service revenue (Part VIII, line 2g)	<b>37,876,440</b>	<b>40,639,590</b>
	<b>10</b> Investment income (Part VIII, column (A), lines 3, 4, and 7d)	<b>2,854,658</b>	<b>2,844,155</b>
	<b>11</b> Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	<b>434,518</b>	<b>619,766</b>
	<b>12</b> Total revenue – add lines 8 through 11 (must equal Part VIII, column (A), line 12)	<b>43,997,779</b>	<b>50,307,849</b>
<b>Expenses</b>	<b>13</b> Grants and similar amounts paid (Part IX, column (A), lines 1–3)		<b>0</b>
	<b>14</b> Benefits paid to or for members (Part IX, column (A), line 4)		<b>0</b>
	<b>15</b> Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	<b>22,233,934</b>	<b>23,998,709</b>
	<b>16a</b> Professional fundraising fees (Part IX, column (A), line 11e)		<b>0</b>
	<b>b</b> Total fundraising expenses (Part IX, column (D), line 25) <b>u</b>	<b>0</b>	
	<b>17</b> Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	<b>19,691,410</b>	<b>20,661,604</b>
	<b>18</b> Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	<b>41,925,344</b>	<b>44,660,313</b>
<b>Net Assets or Fund Balances</b>	<b>19</b> Revenue less expenses. Subtract line 18 from line 12	<b>2,072,435</b>	<b>5,647,536</b>
	<b>20</b> Total assets (Part X, line 16)	<b>106,593,716</b>	<b>110,947,457</b>
	<b>21</b> Total liabilities (Part X, line 26)	<b>15,613,098</b>	<b>14,319,303</b>
	<b>22</b> Net assets or fund balances. Subtract line 21 from line 20	<b>90,980,618</b>	<b>96,628,154</b>

**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.

<b>Sign Here</b>	Signature of officer <p align="center"><b>JUSTIN PICEK</b></p>	Date <p align="center"><b>SECRETARY</b></p>			
	Type or print name and title				
<b>Paid Preparer Use Only</b>	Print/Type preparer's name <b>JAY TOLSMA, CPA</b>	Preparer's signature <b>JAY TOLSMA, CPA</b>	Date <b>05/13/22</b>	Check <input type="checkbox"/> if self-employed	PTIN <b>P00736087</b>
	Firm's name } <b>ELO PROF LLC</b>	Firm's EIN } <b>46-0434947</b>			
	Firm's address } <b>PO BOX 249 MITCHELL, SD 57301</b>	Phone no. <b>605-996-7717</b>			

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

For Paperwork Reduction Act Notice, see the separate instructions.

**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 HURON REGIONAL MEDICAL CENTER IS TO WORK TOGETHER WITH EACH INDIVIDUAL AND ORGANIZATION IN THE REGION TO PROMOTE AND IMPROVE COMMUNITY HEALTH.**

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

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

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

If "Yes," describe these changes on Schedule O.

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

4a (Code: ) (Expenses \$ **44,660,313** including grants of\$ ) (Revenue \$ **40,639,590** )

**PROVIDED MEDICAL SERVICES AS FOLLOWS:**

**INPATIENT ADMISSIONS 892**

**OUTPATIENT VISITS 60,147**

**SWING BED ADMISSIONS 101**

**HURON REGIONAL MEDICAL CENTER, INC. PROVIDED COMMUNITY BENEFIT IN THE AMOUNT OF \$10,902,069 FOR 2020-2021 \$11,630,595 FOR 2018-2019.**

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

**N/A**

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

**N/A**

4d Other program services (Describe on Schedule O.)

(Expenses \$ including grants of\$ ) (Revenue \$ )

4e Total program service expenses **u 44,660,313**

**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> (see instructions)?	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	<b>Section 501(c)(3) organizations.</b> Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? <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 donor-restricted endowments or in 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> See instructions		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
20a	Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	X	
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>		X

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

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

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

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

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



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

		Yes	No
<b>2a</b>	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return <b>2a</b> <b>409</b>		
<b>b</b>	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? <b>Note:</b> If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	<b>X</b>	
<b>3a</b>	Did the organization have unrelated business gross income of \$1,000 or more during the year?	<b>X</b>	
<b>b</b>	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation on Schedule O	<b>X</b>	
<b>4a</b>	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?		<b>X</b>
<b>b</b>	If "Yes," enter the name of the foreign country <b>u</b> See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).		
<b>5a</b>	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		<b>X</b>
<b>b</b>	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		<b>X</b>
<b>c</b>	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?		
<b>6a</b>	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?		<b>X</b>
<b>b</b>	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		
<b>7</b>	<b>Organizations that may receive deductible contributions under section 170(c).</b>		
<b>a</b>	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?		<b>X</b>
<b>b</b>	If "Yes," did the organization notify the donor of the value of the goods or services provided?		
<b>c</b>	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		<b>X</b>
<b>d</b>	If "Yes," indicate the number of Forms 8282 filed during the year <b>7d</b>		
<b>e</b>	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		<b>X</b>
<b>f</b>	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		<b>X</b>
<b>g</b>	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		
<b>h</b>	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		
<b>8</b>	<b>Sponsoring organizations maintaining donor advised funds.</b> Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?		
<b>9</b>	<b>Sponsoring organizations maintaining donor advised funds.</b>		
<b>a</b>	Did the sponsoring organization make any taxable distributions under section 4966?		
<b>b</b>	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?		
<b>10</b>	<b>Section 501(c)(7) organizations.</b> Enter:		
<b>a</b>	Initiation fees and capital contributions included on Part VIII, line 12 <b>10a</b>		
<b>b</b>	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities <b>10b</b>		
<b>11</b>	<b>Section 501(c)(12) organizations.</b> Enter:		
<b>a</b>	Gross income from members or shareholders <b>11a</b>		
<b>b</b>	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.) <b>11b</b>		
<b>12a</b>	<b>Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?		
<b>b</b>	If "Yes," enter the amount of tax-exempt interest received or accrued during the year <b>12b</b>		
<b>13</b>	<b>Section 501(c)(29) qualified nonprofit health insurance issuers.</b>		
<b>a</b>	Is the organization licensed to issue qualified health plans in more than one state? <b>Note:</b> See the instructions for additional information the organization must report on Schedule O.		
<b>b</b>	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans <b>13b</b>		
<b>c</b>	Enter the amount of reserves on hand <b>13c</b>		
<b>14a</b>	Did the organization receive any payments for indoor tanning services during the tax year?		<b>X</b>
<b>b</b>	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation on Schedule O		
<b>15</b>	Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see instructions and file Form 4720, Schedule N.		<b>X</b>
<b>16</b>	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O.		<b>X</b>

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

**Section A. Governing Body and Management**

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

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

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

**Section C. Disclosure**

- 17** List the states with which a copy of this Form 990 is required to be filed **u NONE**
- 18** Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A, if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.  
 Own website  Another's website  Upon request  Other (explain on Schedule O)
- 19** Describe on Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
- 20** State the name, address, and telephone number of the person who possesses the organization's books and records **u**

**MARCIA ZWANZIGER**

**172 4TH ST SE**

**HURON**

**SD 57350**

**605-353-6545**

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

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

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

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

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

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

(A) Name and title	(B) Average hours per week per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) DR. ELYSE BROCK ..... MD	40.00 0.00					X	451,771	0	26,896	
(2) SARA CASTELLANOS ..... DIRECTOR/HCE	40.00 0.00	X					342,671	0	26,793	
(3) DR ALESE FOX ..... DIRECTOR/HCE	40.00 0.00	X					293,400	0	17,813	
(4) DR TODD ANDERSON ..... MD	40.00 0.00					X	265,705	0	17,983	
(5) MARK BELYEA ..... MD	40.00 0.00					X	247,102	0	505	
(6) SAMMUEL JANES ..... CRNA	40.00 0.00					X	203,393	0	24,069	
(7) JASON BARNHARD ..... CRNA	40.00 0.00					X	205,803	0	13,588	
(8) DENIS DRAKE ..... DIRECTOR	0.00 0.00	X					0	0	0	
(9) TOM HANSEN ..... TREASURER	0.00 0.00	X					0	0	0	
(10) GARY HARRINGTON ..... DIRECTOR	0.00 0.00	X					0	0	0	
(11) DR NATHAN LOEWEN ..... BOARD VICE CHAIR	0.00 0.00	X					0	0	0	

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

(A) Name and title	(B) Average hours per week per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(12) DAVID MCGIRR	0.00									
DIRECTOR	0.00	X					0	0	0	
(13) JUSTIN PICEK	0.00									
SECRETARY	0.00	X					0	0	0	
(14) LAURIE SOLEM	0.00									
BOARD CHAIR	0.00	X					0	0	0	
(15) ANGIE UTTECHT	0.00									
DIRECTOR	0.00	X					0	0	0	
(16) LAURA WILLEMSEN	0.00									
DIRECTOR	0.00	X					0	0	0	
(17) ERICK LARSON	50.00									
PRESIDENT/CEO	0.00			X			0	0	0	
(18) MARCIA ZWANZIGER	50.00									
VP - FINANCE	0.00			X			0	0	0	
<b>1b Subtotal</b>							<b>2,009,845</b>		<b>127,647</b>	
<b>c Total from continuation sheets to Part VII, Section A</b>										
<b>d Total (add lines 1b and 1c)</b>							<b>2,009,845</b>		<b>127,647</b>	

**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 **u24**

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

**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
FOCUS ONE SOLUTIONS LLC OMAHA NE 68103-0037	PO BOX 3037 MEDICAL SERVICE	1,696,698
QUORUM HEALTH RESOURCES LLC BRENTWOOD TN 37027	1573 MOLLORY LANE HOSPITAL MGMT	1,118,714
WAPITI MEDICAL GROUP LLC MILBANK SD 57252	107 FLYNN DRIVE MEDICAL SERVICE	490,707
WEATHERBY LOCUMS INC DALLAS TX 75397-2633	PO BOX 972633 MEDICAL SERVICE	350,047
DR RICHARD ELLISON LUXEMBURG WI 54217	E 918 CHERNEYVILLE RD MEDICAL SERVICE	231,138

**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 **u**

12

**Part VIII Statement of Revenue**

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514	
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<b>1a</b> Federated campaigns	<b>1a</b>					
	<b>b</b> Membership dues	<b>1b</b>					
	<b>c</b> Fundraising events	<b>1c</b>					
	<b>d</b> Related organizations	<b>1d</b>					
	<b>e</b> Government grants (contributions)	<b>1e</b>	<b>6,146,337</b>				
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above	<b>1f</b>	<b>58,001</b>				
	<b>g</b> Noncash contributions included in lines 1a-1f	<b>1g</b>	\$				
	<b>h Total.</b> Add lines 1a-1f	<b>u</b>	<b>6,204,338</b>				
<b>Program Service Revenue</b>	<b>2a</b> <b>ROUTINE SERVICES</b>	Business Code	<b>40,639,590</b>	<b>40,639,590</b>			
	<b>b</b>						
	<b>c</b>						
	<b>d</b>						
	<b>e</b>						
	<b>f</b> All other program service revenue						
	<b>g Total.</b> Add lines 2a-2f	<b>u</b>	<b>40,639,590</b>				
<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts)	<b>u</b>	<b>2,844,155</b>	<b>2,844,155</b>			
	<b>4</b> Income from investment of tax-exempt bond proceeds	<b>u</b>					
	<b>5</b> Royalties	<b>u</b>					
	<b>6a</b> Gross rents	(i) Real	(ii) Personal				
		<b>6a</b>	<b>248,041</b>				
		<b>b</b> Less: rental expenses	<b>6b</b>	<b>146,475</b>			
	<b>c</b> Rental inc. or (loss)	<b>6c</b>	<b>101,566</b>				
	<b>d</b> Net rental income or (loss)	<b>u</b>	<b>101,566</b>		<b>101,566</b>		
	<b>7a</b> Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other				
		<b>7a</b>					
		<b>b</b> Less: cost or other basis and sales exps.	<b>7b</b>				
	<b>c</b> Gain or (loss)	<b>7c</b>					
	<b>d</b> Net gain or (loss)	<b>u</b>					
	<b>8a</b> Gross income from fundraising events (not including \$ of contributions reported on line 1c). See Part IV, line 18	<b>8a</b>					
<b>b</b> Less: direct expenses		<b>8b</b>					
<b>c</b> Net income or (loss) from fundraising events	<b>u</b>						
<b>9a</b> Gross income from gaming activities. See Part IV, line 19	<b>9a</b>						
	<b>b</b> Less: direct expenses	<b>9b</b>					
<b>c</b> Net income or (loss) from gaming activities	<b>u</b>						
<b>10a</b> Gross sales of inventory, less returns and allowances	<b>10a</b>						
	<b>b</b> Less: cost of goods sold	<b>10b</b>					
<b>c</b> Net income or (loss) from sales of inventory	<b>u</b>						
<b>Miscellaneous Revenue</b>	<b>11a</b> <b>OTHER OPERATING REVENUE</b>	Business Code	<b>518,200</b>	<b>518,200</b>			
	<b>b</b>						
	<b>c</b>						
	<b>d</b> All other revenue						
	<b>e Total.</b> Add lines 11a-11d	<b>u</b>	<b>518,200</b>				
<b>12 Total revenue.</b> See instructions	<b>u</b>	<b>50,307,849</b>	<b>44,001,945</b>	<b>101,566</b>	<b>0</b>		

**Part IX Statement of Functional Expenses**

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21				
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22				
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
<b>4</b> Benefits paid to or for members				
<b>5</b> Compensation of current officers, directors, trustees, and key employees				
<b>6</b> Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
<b>7</b> Other salaries and wages	<b>19,606,876</b>	<b>19,606,876</b>		
<b>8</b> Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)				
<b>9</b> Other employee benefits	<b>4,391,833</b>	<b>4,391,833</b>		
<b>10</b> Payroll taxes				
<b>11</b> Fees for services (nonemployees):				
<b>a</b> Management				
<b>b</b> Legal				
<b>c</b> Accounting				
<b>d</b> Lobbying				
<b>e</b> Professional fundraising services. See Part IV, line 17				
<b>f</b> Investment management fees				
<b>g</b> Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.)				
<b>12</b> Advertising and promotion				
<b>13</b> Office expenses				
<b>14</b> Information technology				
<b>15</b> Royalties				
<b>16</b> Occupancy				
<b>17</b> Travel				
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials				
<b>19</b> Conferences, conventions, and meetings				
<b>20</b> Interest				
<b>21</b> Payments to affiliates				
<b>22</b> Depreciation, depletion, and amortization	<b>2,478,107</b>	<b>2,478,107</b>		
<b>23</b> Insurance	<b>343,799</b>	<b>343,799</b>		
<b>24</b> Other expenses. Itemize expenses not covered above (List miscellaneous expenses on line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
<b>a</b> <b>SUPPLIES</b>	<b>6,698,728</b>	<b>6,698,728</b>		
<b>b</b> <b>PURCHASED SERVICES &amp; FEES</b>	<b>5,987,956</b>	<b>5,987,956</b>		
<b>c</b> <b>MEDICAL SPECIALIST FEES</b>	<b>1,615,610</b>	<b>1,615,610</b>		
<b>d</b> <b>OTHER EXPENSES</b>	<b>1,497,087</b>	<b>1,497,087</b>		
<b>e</b> All other expenses	<b>2,040,317</b>	<b>2,040,317</b>		
<b>25</b> Total functional expenses. Add lines 1 through 24e	<b>44,660,313</b>	<b>44,660,313</b>	<b>0</b>	<b>0</b>
<b>26</b> Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)				

**Part X Balance Sheet**

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

		(A) Beginning of year		(B) End of year
<b>Assets</b>	<b>1</b> Cash—non-interest-bearing .....		<b>1</b>	
	<b>2</b> Savings and temporary cash investments .....	<b>23,938,664</b>	<b>2</b>	<b>23,960,177</b>
	<b>3</b> Pledges and grants receivable, net .....		<b>3</b>	
	<b>4</b> Accounts receivable, net .....	<b>5,788,334</b>	<b>4</b>	<b>8,539,743</b>
	<b>5</b> Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons .....			
		<b>10,833</b>	<b>5</b>	<b>6,292</b>
	<b>6</b> Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B) .....		<b>6</b>	
	<b>7</b> Notes and loans receivable, net .....	<b>1,261,197</b>	<b>7</b>	
	<b>8</b> Inventories for sale or use .....	<b>799,405</b>	<b>8</b>	<b>859,072</b>
	<b>9</b> Prepaid expenses and deferred charges .....	<b>709,214</b>	<b>9</b>	<b>466,018</b>
	<b>10a</b> Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D .....	<b>10a 68,628,162</b>		
	<b>b</b> Less: accumulated depreciation .....	<b>10b 46,457,713</b>	<b>18,855,312</b>	<b>10c 22,170,449</b>
	<b>11</b> Investments—publicly traded securities .....		<b>11</b>	
	<b>12</b> Investments—other securities. See Part IV, line 11 .....	<b>53,365,044</b>	<b>12</b>	<b>52,231,580</b>
	<b>13</b> Investments—program-related. See Part IV, line 11 .....		<b>13</b>	
	<b>14</b> Intangible assets .....		<b>14</b>	
<b>15</b> Other assets. See Part IV, line 11 .....	<b>1,865,713</b>	<b>15</b>	<b>2,714,126</b>	
<b>16 Total assets.</b> Add lines 1 through 15 (must equal line 33) .....	<b>106,593,716</b>	<b>16</b>	<b>110,947,457</b>	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses .....	<b>13,322,361</b>	<b>17</b>	<b>13,054,321</b>
	<b>18</b> Grants payable .....		<b>18</b>	
	<b>19</b> Deferred revenue .....	<b>2,080,737</b>	<b>19</b>	<b>700,000</b>
	<b>20</b> Tax-exempt bond liabilities .....		<b>20</b>	
	<b>21</b> Escrow or custodial account liability. Complete Part IV of Schedule D .....		<b>21</b>	
	<b>22</b> Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons .....		<b>22</b>	
	<b>23</b> Secured mortgages and notes payable to unrelated third parties .....		<b>23</b>	
	<b>24</b> Unsecured notes and loans payable to unrelated third parties .....	<b>210,000</b>	<b>24</b>	<b>564,982</b>
	<b>25</b> Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D .....		<b>25</b>	
	<b>26 Total liabilities.</b> Add lines 17 through 25 .....	<b>15,613,098</b>	<b>26</b>	<b>14,319,303</b>
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33.</b>			
	<b>27</b> Net assets without donor restrictions .....	<b>90,980,618</b>	<b>27</b>	<b>96,628,154</b>
	<b>28</b> Net assets with donor restrictions .....		<b>28</b>	
	<b>Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> and complete lines 29 through 33.</b>			
	<b>29</b> Capital stock or trust principal, or current funds .....		<b>29</b>	
	<b>30</b> Paid-in or capital surplus, or land, building, or equipment fund .....		<b>30</b>	
	<b>31</b> Retained earnings, endowment, accumulated income, or other funds .....		<b>31</b>	
<b>32</b> Total net assets or fund balances .....	<b>90,980,618</b>	<b>32</b>	<b>96,628,154</b>	
<b>33</b> Total liabilities and net assets/fund balances .....	<b>106,593,716</b>	<b>33</b>	<b>110,947,457</b>	

**Part XI Reconciliation of Net Assets**

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

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	<b>50,307,849</b>
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	<b>44,660,313</b>
<b>3</b>	Revenue less expenses. Subtract line 2 from line 1	<b>3</b>	<b>5,647,536</b>
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	<b>4</b>	<b>90,980,618</b>
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	
<b>9</b>	Other changes in net assets or fund balances (explain on Schedule O)	<b>9</b>	
<b>10</b>	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	<b>10</b>	<b>96,628,154</b>

**Part XII Financial Statements and Reporting**

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

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



**SCHEDULE A**  
(Form 990 or 990-EZ)

Department of the Treasury  
Internal Revenue Service

**Public Charity Status and Public Support**

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

**U Attach to Form 990 or Form 990-EZ.**

**U Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.**

OMB No. 1545-0047

**2020**

**Open to Public Inspection**

Name of the organization <b>HURON REGIONAL MEDICAL CENTER INC</b>	Employer identification number <b>46-0345312</b>
--	---

**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 331/3% 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		
(A)						
(B)						
(C)						
(D)						
(E)						
<b>Total</b>						

**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) <b>u</b>	(a) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
<b>2</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
<b>3</b> The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>4 Total.</b> Add lines 1 through 3						
<b>5</b> 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)						
<b>6</b> Public support. Subtract line 5 from line 4.						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) <b>u</b>	(a) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(f) Total
<b>7</b> Amounts from line 4						
<b>8</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
<b>9</b> Net income from unrelated business activities, whether or not the business is regularly carried on						
<b>10</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
<b>11 Total support.</b> Add lines 7 through 10						

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

**13 First 5 years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here**

**Section C. Computation of Public Support Percentage**

<b>14</b> Public support percentage for 2020 (line 6, column (f) divided by line 11, column (f))	<b>14</b>	%
<b>15</b> Public support percentage from 2019 Schedule A, Part II, line 14	<b>15</b>	%

**16a 33 1/3% support test—2020.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization

**b 33 1/3% support test—2019.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization

**17a 10%-facts-and-circumstances test—2020.** 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

**b 10%-facts-and-circumstances test—2019.** 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

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

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

(Complete only if you checked the box on line 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) <b>u</b>	(a) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
<b>2</b> Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
<b>3</b> Gross receipts from activities that are not an unrelated trade or business under section 513						
<b>4</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
<b>5</b> The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>6 Total.</b> Add lines 1 through 5						
<b>7a</b> Amounts included on lines 1, 2, and 3 received from disqualified persons						
<b>b</b> Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
<b>c</b> Add lines 7a and 7b						
<b>8 Public support.</b> (Subtract line 7c from line 6.)						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) <b>u</b>	(a) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(f) Total
<b>9</b> Amounts from line 6						
<b>10a</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
<b>b</b> Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
<b>c</b> Add lines 10a and 10b						
<b>11</b> Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
<b>12</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
<b>13 Total support.</b> (Add lines 9, 10c, 11, and 12.)						

**14 First 5 years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here**

**Section C. Computation of Public Support Percentage**

<b>15</b> Public support percentage for 2020 (line 8, column (f), divided by line 13, column (f))	<b>15</b>	%
<b>16</b> Public support percentage from 2019 Schedule A, Part III, line 15	<b>16</b>	%

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

<b>17</b> Investment income percentage for 2020 (line 10c, column (f), divided by line 13, column (f))	<b>17</b>	%
<b>18</b> Investment income percentage from 2019 Schedule A, Part III, line 17	<b>18</b>	%

**19a 33 1/3% support tests—2020.** 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—2019.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization

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

**Part IV Supporting Organizations**

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

**Section A. All Supporting Organizations**

	Yes	No
1 Are all of the organization's supported organizations listed by name in the organization's governing documents? <i>If "No," describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.</i>		
2 Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? <i>If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).</i>		
3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? <i>If "Yes," answer lines 3b and 3c below.</i>		
b Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? <i>If "Yes," describe in Part VI when and how the organization made the determination.</i>		
c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? <i>If "Yes," explain in Part VI what controls the organization put in place to ensure such use.</i>		
4a Was any supported organization not organized in the United States ("foreign supported organization")? <i>If "Yes," and if you checked 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 lines 5b and 5c below (if applicable). Also, provide detail in Part VI, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).</i>		
b <b>Type I or Type II only.</b> Was any added or substituted supported organization part of a class already designated in the organization's organizing document?		
c <b>Substitutions only.</b> Was the substitution the result of an event beyond the organization's control?		
6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? <i>If "Yes," provide detail in Part VI.</i>		
7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (as defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? <i>If "Yes," complete Part I of Schedule L (Form 990 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 line 10b below.</i>		
b Did the organization have any excess business holdings in the tax year? <i>(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)</i>		

**Part IV Supporting Organizations** *(continued)*

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

**Section B. Type I Supporting Organizations**

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

**Section C. Type II Supporting Organizations**

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

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

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

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

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

**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.

<b>Section A – Adjusted Net Income</b>		(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	<b>Adjusted Net Income</b> (subtract lines 5, 6, and 7 from line 4)	8	
<b>Section B – Minimum Asset Amount</b>		(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	<b>Total</b> (add lines 1a, 1b, and 1c)	1d	
e	<b>Discount</b> 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 0.015 of line 3 (for greater amount, see instructions).	4	
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5	
6	Multiply line 5 by 0.035.	6	
7	Recoveries of prior-year distributions	7	
8	<b>Minimum Asset Amount</b> (add line 7 to line 6)	8	
<b>Section C – Distributable Amount</b>			Current Year
1	Adjusted net income for prior year (from Section A, line 8, column A)	1	
2	Enter 0.85 of line 1.	2	
3	Minimum asset amount for prior year (from Section B, line 8, column A)	3	
4	Enter greater of line 2 or line 3.	4	
5	Income tax imposed in prior year	5	
6	<b>Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions).	6	
7	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally integrated Type III supporting organization (see instructions).		

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

Section D – Distributions	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required—provide details in Part VI)	
6 Other distributions (describe in Part VI). See instructions.	
7 <b>Total annual distributions.</b> 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 2020 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-2020	(iii) Distributable Amount for 2020
1 Distributable amount for 2020 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2020 (reasonable cause required—explain in Part VI). See instructions.			
3 Excess distributions carryover, if any, to 2020			
a From 2015 .....			
b From 2016 .....			
c From 2017 .....			
d From 2018 .....			
e From 2019 .....			
f <b>Total</b> of lines 3a through 3e			
g Applied to underdistributions of prior years			
h Applied to 2020 distributable amount			
i Carryover from 2015 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from line 3f.			
4 Distributions for 2020 from Section D, line 7: \$			
a Applied to underdistributions of prior years			
b Applied to 2020 distributable amount			
c Remainder. Subtract lines 4a and 4b from line 4.			
5 Remaining underdistributions for years prior to 2020, 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 2020 Subtract lines 3h and 4b from line 1. For result greater than zero, explain in Part VI. See instructions.			
7 <b>Excess distributions carryover to 2021.</b> Add lines 3j and 4c.			
8 Breakdown of line 7:			
a Excess from 2016 .....			
b Excess from 2017 .....			
c Excess from 2018 .....			
d Excess from 2019 .....			
e Excess from 2020 .....			





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

**Schedule of Contributors**

OMB No. 1545-0047

**2020**

u Attach to Form 990, Form 990-EZ, or Form 990-PF.  
 u Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

Name of the organization  <b>HURON REGIONAL MEDICAL CENTER INC</b>	Employer identification number  <b>46-0345312</b>
--	---

Organization type (check one):

**Filers of:**

**Section:**

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

Check if your organization is covered by the **General Rule** or a **Special Rule**.

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

**General Rule**

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

**Special Rules**

- For an organization described in section 501(c)(3) filing Form 990 or 990-EZ that met the 33<sup>1</sup>/<sub>3</sub>% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), that checked Schedule A (Form 990 or 990-EZ), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions of the greater of **(1)** \$5,000; or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h; or (ii) Form 990-EZ, line 1. Complete Parts I and II.
- For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than \$1,000 *exclusively* for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals. Complete Parts I (entering "N/A" in column (b) instead of the contributor name and address), II, and III.
- For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc., purposes, but no such contributions totaled more than \$1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Don't complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions totaling \$5,000 or more during the year ..... ▶ \$ .....

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

Name of organization

Employer identification number

**HURON REGIONAL MEDICAL CENTER INC**

**46-0345312**

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	HRMC FOUNDATION 1104TH STREET SE HURON SD 57350	\$ 31,133	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
.....	.....	\$ .....	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
.....	.....	\$ .....	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
.....	.....	\$ .....	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
.....	.....	\$ .....	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
.....	.....	\$ .....	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
.....	.....	\$ .....	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

SCHEDULE D (Form 990)

Department of the Treasury Internal Revenue Service

Supplemental Financial Statements
u 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.
u Attach to Form 990.

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

OMB No. 1545-0047

2020

Open to Public Inspection

Name of the organization

Employer identification number

HURON REGIONAL MEDICAL CENTER INC

46-0345312

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

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

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

Part II Conservation Easements.

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

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

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.

Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

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

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

- 3** Using the organization's acquisition, accession, and other records, check any of the following that make significant use of its collection items (check all that apply):
- a**  Public exhibition
  - b**  Scholarly research
  - c**  Preservation for future generations
  - d**  Loan or exchange program
  - e**  Other .....
- 4** Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.
- 5** During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection?  Yes  No

**Part IV Escrow and Custodial Arrangements.**

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

- 1a** Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?  Yes  No
- b** If "Yes," explain the arrangement in Part XIII and complete the following table:
- |  | Amount    |
|--|-----------|
| <b>c</b> Beginning balance .....             | <b>1c</b> |
| <b>d</b> Additions during the year .....     | <b>1d</b> |
| <b>e</b> Distributions during the year ..... | <b>1e</b> |
| <b>f</b> Ending balance .....                | <b>1f</b> |
- 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  Yes  No

**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 |
|---|------------------|----------------|--------------------|----------------------|---------------------|
| <b>1a</b> Beginning of year balance .....                     |                  |                |                    |                      |                     |
| <b>b</b> Contributions .....                                  |                  |                |                    |                      |                     |
| <b>c</b> Net investment earnings, gains, and losses .....     |                  |                |                    |                      |                     |
| <b>d</b> Grants or scholarships .....                         |                  |                |                    |                      |                     |
| <b>e</b> Other expenditures for facilities and programs ..... |                  |                |                    |                      |                     |
| <b>f</b> Administrative expenses .....                        |                  |                |                    |                      |                     |
| <b>g</b> 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 **u** .....
  - b** Permanent endowment **u** .....
  - c** Term endowment **u** .....
- 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 |
|---|---------------|----|
| <b>(i)</b> Unrelated organizations .....  | <b>3a(i)</b>  |    |
| <b>(ii)</b> Related organizations .....   | <b>3a(ii)</b> |    |
| <b>b</b> If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R? ..... | <b>3b</b>     |    |
- 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
<b>1a</b> Land .....		<b>1,208,491</b>		<b>1,208,491</b>
<b>b</b> Buildings .....		<b>35,029,411</b>	<b>22,815,089</b>	<b>12,214,322</b>
<b>c</b> Leasehold improvements .....				
<b>d</b> Equipment .....		<b>32,390,260</b>	<b>23,642,624</b>	<b>8,747,636</b>
<b>e</b> Other .....				
<b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.) .....				<b>u 22,170,449</b>

**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 <b>INVESTMENTS</b> .....	<b>52,231,580</b>	<b>COST</b>
(A) .....		
(B) .....		
(C) .....		
(D) .....		
(E) .....		
(F) .....		
(G) .....		
(H) .....		
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 12.) ... <b>u</b>	<b>52,231,580</b>	

**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) .....		
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 13.) ... <b>u</b>		

**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) .....	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 15.) ... <b>u</b>	

**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) .....	
(3) .....	
(4) .....	
(5) .....	
(6) .....	
(7) .....	
(8) .....	
(9) .....	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 25.) ... <b>u</b>	

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





**SCHEDULE H  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

Name of the organization

**Hospitals**

u Complete if the organization answered "Yes" on Form 990, Part IV, question 20.

u Attach to Form 990.

u Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

**2020**

**Open to Public Inspection**

**HURON REGIONAL MEDICAL CENTER INC**

Employer identification number

**46-0345312**

**Part I Financial Assistance and Certain Other Community Benefits at Cost**

	Yes	No
<b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	<input checked="" type="checkbox"/>	
<b>1b</b> If "Yes," was it a written policy?	<input checked="" type="checkbox"/>	
<b>2</b> 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 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		
<b>3</b> 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.		
<b>a</b> Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other <u>125</u> %	<input checked="" type="checkbox"/>	
<b>b</b> Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input checked="" type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____%	<input checked="" type="checkbox"/>	
<b>c</b> 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.		
<b>4</b> 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"/>	
<b>5a</b> 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>b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?		<input checked="" type="checkbox"/>
<b>c</b> 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?		
<b>6a</b> Did the organization prepare a community benefit report during the tax year?	<input checked="" type="checkbox"/>	
<b>b</b> If "Yes," did the organization make it available to the public?	<input checked="" type="checkbox"/>	

**7 Financial Assistance and Certain Other Community Benefits at Cost**

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
<b>a</b> Financial Assistance at cost (from Worksheet 1)			57,521		57,521	0.13
<b>b</b> Medicaid (from Worksheet 3, column a)			597,678	713,393	0	0.00
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b)			501,414	411,181	90,233	0.20
<b>d</b> <b>Total.</b> Financial Assistance and Means-Tested Government Programs			1,156,613	1,124,574	147,754	0.33
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4)			306,684	63,117	243,567	0.55
<b>f</b> Health professions education (from Worksheet 5)			153,000		153,000	0.34
<b>g</b> Subsidized health services (from Worksheet 6)			22,981,223	20,744,273	2,236,950	5.01
<b>h</b> Research (from Worksheet 7)					0	0.00
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8)			98,436		98,436	0.22
<b>j</b> <b>Total.</b> Other Benefits			23,539,343	20,807,390	2,731,953	6.12
<b>k</b> <b>Total.</b> Add lines 7d and 7j			24,695,956	21,931,964	2,879,707	6.45



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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing					0	0.00
2 Economic development					0	0.00
3 Community support			5,000		5,000	0.01
4 Environmental improvements					0	0.00
5 Leadership development and training for community members			91,450		91,450	0.20
6 Coalition building					0	0.00
7 Community health improvement advocacy					0	0.00
8 Workforce development			136,810		136,810	0.31
9 Other					0	0.00
10 Total			233,260		233,260	0.52

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

**Section A. Bad Debt Expense**

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

**Section B. Medicare**

5 Enter total revenue received from Medicare (including DSH and IME)	<b>5</b>	16,632,827
6 Enter Medicare allowable costs of care relating to payments on line 5	<b>6</b>	16,460,713
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	<b>7</b>	172,114
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other		

**Section C. Collection Practices**

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

**Part IV Management Companies and Joint Ventures** (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

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

**Part V Facility Information**

**Section A. Hospital Facilities**

(list in order of size, from largest to smallest—see instructions)  
How many hospital facilities did the organization operate during the tax year? 1

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

1	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
HURON REGIONAL MEDICAL CENTER  172 4TH STREET HURON SD 57350	<b>X</b>	<b>X</b>			<b>X</b>		<b>X</b>			

**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 **HURON REGIONAL MEDICAL CENTER**

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

	Yes	No
<b>Community Health Needs Assessment</b>		
<b>1</b> Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? .....		<b>X</b>
<b>2</b> Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C .....		<b>X</b>
<b>3</b> During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 .....	<b>X</b>	
If "Yes," indicate what the CHNA report describes (check all that apply):		
<b>a</b> <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b> <input checked="" type="checkbox"/> Demographics of the community		
<b>c</b> <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b> <input checked="" type="checkbox"/> How data was obtained		
<b>e</b> <input type="checkbox"/> The significant health needs of the community		
<b>f</b> <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b> <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b> <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b> <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA: <b>19</b>		
<b>5</b> In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted .....	<b>X</b>	
<b>6a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C .....		<b>X</b>
<b>6b</b> Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C .....	<b>X</b>	
<b>7</b> Did the hospital facility make its CHNA report widely available to the public? .....	<b>X</b>	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):		
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url): <b>WWW.HURONREGIONAL.ORG</b>		
<b>b</b> <input type="checkbox"/> Other website (list url):		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input type="checkbox"/> Other (describe in Section C)		
<b>8</b> Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 .....	<b>X</b>	
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy: <b>19</b>		
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? .....	<b>X</b>	
<b>a</b> If "Yes," (list url): <b>WWW.HURONREGIONAL.ORG</b>		
<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? .....		<b>X</b>
<b>11</b> Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
<b>12a</b> Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? .....		<b>X</b>
<b>b</b> If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? .....		
<b>c</b> 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? <b>\$</b>		

**Part V Facility Information (continued)**

**Financial Assistance Policy (FAP)**

Name of hospital facility or letter of facility reporting group **HURON REGIONAL MEDICAL CENTER**

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
<b>13</b>	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? .....	<b>X</b>	
If "Yes," indicate the eligibility criteria explained in the FAP:			
<b>a</b>	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care <u>125</u> % and FPG family income limit for eligibility for discounted care of <u>200</u> %		
<b>b</b>	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b>	<input checked="" type="checkbox"/> Asset level		
<b>d</b>	<input type="checkbox"/> Medical indigency		
<b>e</b>	<input checked="" type="checkbox"/> Insurance status		
<b>f</b>	<input checked="" type="checkbox"/> Underinsurance status		
<b>g</b>	<input type="checkbox"/> Residency		
<b>h</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>14</b>	Explained the basis for calculating amounts charged to patients? .....	<b>X</b>	
<b>15</b>	Explained the method for applying for financial assistance? .....	<b>X</b>	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
<b>a</b>	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</b>	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
<b>c</b>	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
<b>d</b>	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>16</b>	Was widely publicized within the community served by the hospital facility? .....	<b>X</b>	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
<b>a</b>	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>WWW.HURONREGIONAL.ORG</u>		
<b>b</b>	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>WWW.HURONREGIONAL.ORG</u>		
<b>c</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>WWW.HURONREGIONAL.ORG</u>		
<b>d</b>	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b>	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>f</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>g</b>	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
<b>h</b>	<input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b>	<input type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information** (continued)

**Billing and Collections**

Name of hospital facility or letter of facility reporting group **HURON REGIONAL MEDICAL CENTER**

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

**Policy Relating to Emergency Medical Care**

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

**Part V Facility Information** *(continued)*

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

Name of hospital facility or letter of facility reporting group **HURON REGIONAL MEDICAL CENTER**

		Yes	No
<b>22</b>	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.		
<b>a</b>	<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>b</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		
<b>c</b>	<input checked="" 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		
<b>d</b>	<input type="checkbox"/> The hospital facility used a prospective Medicare or Medicaid method		
<b>23</b>	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.		<b>X</b>
<b>24</b>	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.		<b>X</b>

**Part V Facility Information** (continued)

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

**FACILITY 1, HURON REGIONAL MEDICAL CENTER - PART V, LINE 5**

**TWO ROUNDS OF WRITTEN SURVEYS WERE COMPLETED BY 26 LOCAL EXPERTS ALONG WITH 3 FOCUS GROUP LISTENING SESSIONS. LOCAL EXPERTS INCLUDED PERSONS WHO REPRESENT THE BROAD INTEREST OF THE COMMUNITY INCLUDING THOSE WITH EXPERTISE RELEVANT TO THE HEALTH NEEDS OF THE COMMUNITY, MEMBERS OF MEDICALLY UNDERSERVED, LOW-INCOME, MINORITY AND MENTALLY ILL POPULATIONS. FOCUS GROUPS WERE CONDUCTED BY LOCAL UNIVERSITY NURSING STUDENTS AND A COMMUNITY SURVEY WAS ANSWERED ONLINE BY 196 RESPONDENTS.**

**FACILITY 1, HURON REGIONAL MEDICAL CENTER - PART V, LINE 6B**

**OTHER ORGANIZATIONS WITH WHICH THE HOSPITAL FACILITY CONDUCTED ITS CHNA: QUORUM HEALTH RESOURCES (QHR) - HOSPITAL FACILITY MANAGEMENT COMPANY FACILITATED CHNA.**

**JAMES VALLEY COMMUNITY HEALTH CLINIC AND COMMUNITY COUNSELING SERVICES PARTICIPATED IN CONFIRMING SIGNIFICANT NEEDS AND DEVELOPING IMPLEMENTATION STRATEGY.**

**PART V, SECTION B, LINE 11 FACILITY 1 - HRMC**

**SEE ATTACHED FACILITY 1 - HRMC - HRMC COMMUNITY HEALTH NEEDS ASSESSMENT GRID**

**PART V, SECTION B, LINE 20(D)**

**HRMC IN PROCESS OF OBTAINING AND MEETING PRESUMPTIVE ELIGIBILITY REQUIREMENTS OF STATE OF SOUTH DAKOTA.**

**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? **0**

Name and address	Type of Facility (describe)



**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 7G - SUBSIDIZED HEALTH SERVICES EXPLANATION****COSTS ATTRIBUTABLE TO PHYSICIAN CLINIC AS SUBSIDIZED HEALTH SERVICES**

**ORTHOPEDIC CLINIC \$511,630, OB/GYN CLINIC \$1,906,137, FAMILY MEDICINE CLINIC \$1,879,931, SURGICAL CLINIC \$543,585, UROLOGY CLINIC \$351,954 AND IM CLINIC \$449,935 FOR A TOTAL OF \$5,643,172. BAD DEBT EXPENSE NOT REPORTED ON LINE 7G WAS \$6,844.**

**PART I, LINE 7 - COSTING METHODOLOGY EXPLANATION**

**WORKSHEET 2 WAS USED TO CALCULATE THE COST AMOUNTS REPORTED IN THE TABLES ALONG WITH COST REPORT AMOUNTS WHEN APPLICABLE.**

**PART II - COMMUNITY BUILDING ACTIVITIES**

**SEE ATTACHED**

**PART III, LINE 2 - BAD DEBT EXPENSE METHODOLOGY**

**ACCOUNTS RECEIVABLE FROM PATIENTS CONSIST OF THE FOLLOWING: ACCOUNTS RECEIVABLE AS OF JUNE 30, 2020 AND 2021 WERE \$8,183,696 AND \$11,908,899. ALLOWANCE FOR DOUBTFUL ACCOUNTS AS OF JUNE 30, 2020 AND 2021 WERE**

**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.

\$ (2,395,362) AND \$ (3,369,156). ACCOUNTS RECEIVABLE, NET AS OF JUNE 30, 2020 AND 2021 WERE \$5,788,334 AND \$8,539,743. THE ALLOWANCE FOR DOUBTFUL ACCOUNTS IS BASED ON AN ESTIMATE USING PAST COLLECTION EXPERIENCE, FINANCIAL CLASS, AND AGE FOR THE PATIENT ACCOUNT. ESTIMATED BAD DEBTS EXPENSE REFLECTS THIS PROVISION FOR ACTUAL OR EXPECTED DOUBTFUL ACCOUNTS. DISCOUNTS AND PAYMENTS ON ACCOUNTS REDUCES ACCOUNTS RECEIVABLE BALANCES THEREFORE REDUCING BAD DEBTS EXPENSE. A STUDY OF FINANCIAL ASSISTANCE APPLICATIONS AND EXPERIENCE OF FINANCIAL ASSISTANCE STAFF WAS USED TO REASONABLY ESTIMATE THE PERCENTAGE OF BAD DEBT FOR PATIENTS WHO WOULD HAVE QUALIFIED FOR ASSISTANCE IF THEY APPLIED. SEE FOOTNOTE #1 PATIENT ACCOUNTS RECEIVABLES SECTION AND FOOTNOTE #4 OF AUDITED FINANCIAL STATEMENTS.

PART VI, LINE 2 - NEEDS ASSESSMENT

SEE ATTACHED #2

PART VI, LINE 3 - PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

SEE ATTACHED #3

**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 VI, LINE 4 - COMMUNITY INFORMATION**

**SEE ATTACHED #4**

**PART VI, LINE 5 - PROMOTION OF COMMUNITY HEALTH**

**SEE ATTACHED #5**

**ADDITIONAL INFORMATION**

**SEE ATTACHED #1**

**SCHEDULE J  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Compensation Information**  
For certain Officers, Directors, Trustees, Key Employees, and Highest  
Compensated Employees  
u Complete if the organization answered "Yes" on Form 990, Part IV, line 23.  
u Attach to Form 990.  
u Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

**2020**

**Open to Public  
Inspection**

Name of the organization

**HURON REGIONAL MEDICAL CENTER INC**

Employer identification number

**46-0345312**

**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 checked="" 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 .....

	Yes	No
<b>1b</b>	<b>X</b>	
<b>2</b>	<b>X</b>	
<b>4a</b>		<b>X</b>
<b>4b</b>		<b>X</b>
<b>4c</b>		<b>X</b>
<b>5a</b>		<b>X</b>
<b>5b</b>		<b>X</b>
<b>6a</b>		<b>X</b>
<b>6b</b>		<b>X</b>
<b>7</b>		<b>X</b>
<b>8</b>		<b>X</b>
<b>9</b>		

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

- |   |   |
|---|---|
| <input checked="" type="checkbox"/> Compensation committee              | <input type="checkbox"/> Written employment contract                                |
| <input checked="" type="checkbox"/> Independent compensation consultant | <input checked="" type="checkbox"/> Compensation survey or study                    |
| <input checked="" 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)? .....

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

Schedule J (Form 990) 2020

**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. ELYSE BROCK MD	(i)	349,888	10,000	91,883	8,400	18,496	478,667	0
	(ii)	0	0	0	0	0	0	0
2 SARA CASTELLANOS DIRECTOR/HCE	(i)	342,671	0	0	8,400	18,393	369,464	0
	(ii)	0	0	0	0	0	0	0
3 DR ALESE FOX DIRECTOR/HCE	(i)	276,965	0	16,435	0	17,813	311,213	0
	(ii)	0	0	0	0	0	0	0
4 DR TODD ANDERSON MD	(i)	253,705	12,000	0	0	17,983	283,688	0
	(ii)	0	0	0	0	0	0	0
5 MARK BELYEA MD	(i)	247,102	0	0	0	505	247,607	0
	(ii)	0	0	0	0	0	0	0
6 SAMMUEL JANES CRNA	(i)	203,393	0	0	6,151	17,918	227,462	0
	(ii)	0	0	0	0	0	0	0
7 JASON BARNHARD CRNA	(i)	205,803	0	0	5,545	8,043	219,391	0
	(ii)	0	0	0	0	0	0	0
8	(i)							
	(ii)							
9	(i)							
	(ii)							
10	(i)							
	(ii)							
11	(i)							
	(ii)							
12	(i)							
	(ii)							
13	(i)							
	(ii)							
14	(i)							
	(ii)							
15	(i)							
	(ii)							
16	(i)							
	(ii)							

**Part III Supplemental Information**

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 III - OTHER ADDITIONAL INFORMATION**

**QUORUM HEALTH RESOURCES (QHR) WHO IS CONTRACTED BY THE BOARD OF DIRECTORS  
TO MANAGE THE HOSPITAL PAYS THE PRES/CEO AND VP-FINANCE SINCE THEY ARE  
EMPLOYEES OF QHR.**

**SCHEDULE L**  
**(Form 990 or 990-EZ)**

Department of the Treasury  
Internal Revenue Service

Name of the organization

**Transactions With Interested Persons**

**U** Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.

**U** Attach to Form 990 or Form 990-EZ.

**U** Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

**2020**

Open To Public Inspection

HURON REGIONAL MEDICAL CENTER INC

Employer identification number

46-0345312

**Part I Excess Benefit Transactions** (section 501(c)(3), section 501(c)(4), and 501(c)(29) organizations only).

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

1	(a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected?	
				Yes	No
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 ..... **U** \$ \_\_\_\_\_

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization ..... **U** \$ \_\_\_\_\_

**Part II Loans to and/or From Interested Persons.**

Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the org.?		(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?		(i) Written agreement?	
			To	From			Yes	No	Yes	No	Yes	No
DR ELYSE BROCK (1) HOUSING ASSISTANCE	HCE			X	50,000	6,292		X	X			X
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												
(8)												
(9)												
(10)												
<b>Total</b> .....						<b>U</b> \$ 6,292						

**Part III Grants or Assistance Benefiting Interested Persons.**

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				
(7)				
(8)				
(9)				
(10)				





**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.

u Attach to Form 990 or 990-EZ.

u Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No. 1545-0047

**2020****Open to Public  
Inspection**

Name of the organization

**HURON REGIONAL MEDICAL CENTER INC**

Employer identification number

**46-0345312****FORM 990, PART VI, LINE 2 - RELATED PARTY INFORMATION AMONG OFFICERS****SEE ATTACHED****FORM 990, PART VI, LINE 3 - MANAGEMENT DELEGATED****HRMC CONTRACTED WITH QUORUM HEALTH RESOURCES (QHR) TO PROVIDE MANAGEMENT SERVICES AS DIRECTED BY THE BOARD. QHR THEN EMPLOYS PRESIDENT/CEO AND VP-FINANCE/CFO.****FORM 990, PART VI, LINE 11B - ORGANIZATION'S PROCESS TO REVIEW FORM 990****ORGANIZATION'S PROCESS IS TO PROVIDE FORM 990 TO THE BOARD OF DIRECTORS PRIOR TO SUBMISSION. FORM 990 ALSO PRESENTED TO BOARD BY AUDITOR/CFO.****FORM 990, PART VI, LINE 12C - ENFORCEMENT OF CONFLICTS POLICY****ENFORCEMENT OF CONFLICTS OF INTEREST POLICY FOR BOARD OF DIRECTORS IS DONE THROUGH THE EXECUTIVE COMMITTEE WHO ACTIVELY MONITORS COMPLIANCE.****FORM 990, PART VI, LINE 15A - COMPENSATION PROCESS FOR TOP OFFICIAL****COMPENSATION COMMITTEE IN CONJUNCTION WITH QHR REVIEWED INDEPENDENT COMPENSATION CONSULTANT'S COMPENSATION SURVEY FOR BOTH CEO AND CFO. BOARD APPROVED EXECUTIVE COMPENSATION POLICY, REQUIRES AN INDEPENDENT COMPENSATION SURVEY EVERY 4 YEARS AND REVIEW OF CEO AND CFO COMPENSATION ANNUALLY.****FORM 990, PART VI, LINE 15B - COMPENSATION PROCESS FOR OFFICERS****COMPENSATION COMMITTEE IN CONJUNCTION WITH QHR REVIEWED INDEPENDENT**

Name of the organization

Employer identification number

HURON REGIONAL MEDICAL CENTER INC

46-0345312

COMPENSATION CONSULTANT'S COMPENSATION SURVEY FOR BOTH CEO AND CFO. BOARD APPROVED EXECUTIVE COMPENSATION POLICY, REQUIRES AND INDEPENDENT COMPENSATION SURVEY EVERY 4 YEARS AND REVIEW OF CEO AND CFO COMPENSATION ANNUALLY.

FORM 990, PART VI, LINE 19 - GOVERNING DOCUMENTS DISCLOSURE EXPLANATION FINANCIAL STATEMENTS, GOVERNING DOCUMENTS, AND CONFLICT OF INTEREST POLICY AVAILABLE FOR PUBLIC INSPECTION AT THE ADMINISTRATION OFFICE OF THE ORGANIZATION. FINANCIAL STATEMENTS MADE PUBLIC AND ANNUAL POSTING OF FORM 990 THROUGH GUIDESTAR AND ON HOSPITAL WEBSITE

**SCHEDULE R  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

Name of the organization

**Related Organizations and Unrelated Partnerships**

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

**u Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.**

OMB No. 1545-0047

**2020**

**Open to Public  
Inspection**

**HURON REGIONAL MEDICAL CENTER INC**

Employer identification number

**46-0345312**

**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
(1)					
(2)					
(3)					
(4)					
(5)					

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) HURON REG MEDICAL CTR FOUNDATION 110 4TH STREET SE 46-0437171 HURON SD 57350	FUNDRAISIN	SD	501C	3	N/A		X
(2)							
(3)							
(4)							
(5)							

**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 alloc.?		(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	
(1) .....												
(2) .....												
(3) .....												
(4) .....												

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
(1) .....									
(2) .....									
(3) .....									
(4) .....									

**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.

	Yes	No
<b>1</b> 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?		
<b>a</b> Receipt of <b>(i)</b> interest, <b>(ii)</b> annuities, <b>(iii)</b> royalties, or <b>(iv)</b> rent from a controlled entity .....	<b>1a</b>	<b>X</b>
<b>b</b> Gift, grant, or capital contribution to related organization(s) .....	<b>1b</b>	<b>X</b>
<b>c</b> Gift, grant, or capital contribution from related organization(s) .....	<b>1c</b>	<b>X</b>
<b>d</b> Loans or loan guarantees to or for related organization(s) .....	<b>1d</b>	<b>X</b>
<b>e</b> Loans or loan guarantees by related organization(s) .....	<b>1e</b>	<b>X</b>
<b>f</b> Dividends from related organization(s) .....	<b>1f</b>	<b>X</b>
<b>g</b> Sale of assets to related organization(s) .....	<b>1g</b>	<b>X</b>
<b>h</b> Purchase of assets from related organization(s) .....	<b>1h</b>	<b>X</b>
<b>i</b> Exchange of assets with related organization(s) .....	<b>1i</b>	<b>X</b>
<b>j</b> Lease of facilities, equipment, or other assets to related organization(s) .....	<b>1j</b>	<b>X</b>
<b>k</b> Lease of facilities, equipment, or other assets from related organization(s) .....	<b>1k</b>	<b>X</b>
<b>l</b> Performance of services or membership or fundraising solicitations for related organization(s) .....	<b>1l</b>	<b>X</b>
<b>m</b> Performance of services or membership or fundraising solicitations by related organization(s) .....	<b>1m</b>	<b>X</b>
<b>n</b> Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) .....	<b>1n</b>	<b>X</b>
<b>o</b> Sharing of paid employees with related organization(s) .....	<b>1o</b>	<b>X</b>
<b>p</b> Reimbursement paid to related organization(s) for expenses .....	<b>1p</b>	<b>X</b>
<b>q</b> Reimbursement paid by related organization(s) for expenses .....	<b>1q</b>	<b>X</b>
<b>r</b> Other transfer of cash or property to related organization(s) .....	<b>1r</b>	<b>X</b>
<b>s</b> Other transfer of cash or property from related organization(s) .....	<b>1s</b>	<b>X</b>

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners section 501(c)(3) organizations?		(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		Yes	No	
(1) .....													
(2) .....													
(3) .....													
(4) .....													
(5) .....													
(6) .....													
(7) .....													
(8) .....													
(9) .....													
(10) .....													
(11) .....													

**Part VII Supplemental Information.**

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

---

[Dotted lines for supplemental information]

Form **990-T**

**Exempt Organization Business Income Tax Return**  
(and proxy tax under section 6033(e))

OMB No. 1545-0047

**2020**

For calendar year 2020 or other tax year beginning **07/01/20**, and ending **06/30/21**

Go to [www.irs.gov/Form990T](http://www.irs.gov/Form990T) for instructions and the latest information.

Department of the Treasury  
Internal Revenue Service

Open to Public Inspection  
for 501(c)(3)  
Organizations Only

Do not enter SSN numbers on this form as it may be made public if your organization is a 501(c)(3).

**A**  Check box if address changed.

**B** Exempt under section  
 501(C)(3) **( 3 )**  
 408(e)  220(e)  
 408A  530(a)  
 529(a)  529A

**Name of organization** (  Check box if name changed and see instructions.)  
**HURON REGIONAL MEDICAL CENTER INC**

**Employer identification number**  
**46-0345312**

**Number, street, and room or suite no. If a P.O. box, see instructions.**  
**172 4TH ST SE**

**Group exemption number (see instructions)**

**City or town, state or province, country, and ZIP or foreign postal code**  
**HURON SD 57350**

**F**  Check box if an amended return.

**C** Book value of all assets at end of year ..... **u 110,947,457**

**G** Check organization type **u**  501(c) corporation  501(c) trust  401(a) trust  Other trust  Applicable reinsurance entity

**H** Check if filing only to **u**  Claim credit from Form 8941  Claim a refund shown on Form 2439

**I** Check if a 501(c)(3) organization filing a consolidated return with a 501(c)(2) titleholding corporation ..... **u**

**J** Enter the number of attached Schedules A (Form 990-T) ..... **u** **1**

**K** During the tax year, was the corporation a subsidiary in an affiliated group or a parent-subsidary controlled group? ..... **u**  Yes  No  
 If "Yes," enter the name and identifying number of the parent corporation  
**u**

**L** The books are in care of **u** **MARCIA ZWANZIGER** Telephone number **u** **605-353-6545**

Part I Total Unrelated Business Taxable income		
1	Total of unrelated business taxable income computed from all unrelated trades or businesses (see instructions)	1 -132,020
2	Reserved	2
3	Add lines 1 and 2	3 -132,020
4	Charitable contributions (see instructions for limitation rules)	4
5	Total unrelated business taxable income before net operating losses. Subtract line 4 from line 3	5 -132,020
6	Deduction for net operating loss. See instructions	6 0
7	Total of unrelated business taxable income before specific deduction and section 199A deduction. Subtract line 6 from line 5	7 -132,020
8	Specific deduction (generally \$1,000, but see instructions for exceptions)	8 1,000
9	Trusts. Section 199A deduction. See instructions	9
10	Total deductions. Add lines 8 and 9	10 1,000
11	Unrelated business taxable income. Subtract line 10 from line 7. If line 10 is greater than line 7, enter zero	11 0
Part II Tax Computation		
1	Organizations taxable as corporations. Multiply Part I, line 11 by 21% (0.21)	1 0
2	Trusts taxable at trust rates. See instructions for tax computation. Income tax on the amount on Part I, line 11 from: <input type="checkbox"/> Tax rate schedule or <input type="checkbox"/> Schedule D (Form 1041)	2 0
3	Proxy tax. See instructions	3
4	Other tax amounts. See instructions	4
5	Alternative minimum tax (trusts only)	5
6	Tax on noncompliant facility income. See instructions	6
7	Total. Add lines 3 through 6 to line 1 or 2, whichever applies	7 0

For Paperwork Reduction Act Notice, see instructions.

Form **990-T** (2020)



**Part III Tax and Payments**

<b>1a</b> Foreign tax credit (corporations attach Form 1118; trusts attach Form 1116) .....	<b>1a</b>		
<b>b</b> Other credits (see instructions) .....	<b>1b</b>		
<b>c</b> General business credit. Attach Form 3800 (see instructions) .....	<b>1c</b>		
<b>d</b> Credit for prior year minimum tax (attach Form 8801 or 8827) .....	<b>1d</b>		
<b>e Total credits.</b> Add lines 1a through 1d .....		<b>1e</b>	
<b>2</b> Subtract line 1e from Part II, line 7 .....		<b>2</b>	
<b>3</b> Other taxes. Check if from: <input type="checkbox"/> Form 4255 <input type="checkbox"/> Form 8611 <input type="checkbox"/> Form 8697 <input type="checkbox"/> Form 8866 <input type="checkbox"/> Other (attach statement) .....		<b>3</b>	
<b>4 Total tax.</b> Add lines 2 and 3 (see instructions) <input type="checkbox"/> Check if includes tax previously deferred under section 1294. Enter tax amount here .....	<b>u</b>	<b>4</b>	<b>0</b>
<b>5</b> 2020 net 965 tax liability paid from Form 965-A or Form 965-B, Part II, column (k), line 4 .....		<b>5</b>	
<b>6a</b> Payments: A 2019 overpayment credited to 2020 .....	<b>6a</b>		
<b>b</b> 2020 estimated tax payments. Check if section 643(g) election applies <b>u</b> <input type="checkbox"/> .....	<b>6b</b>		
<b>c</b> Tax deposited with Form 8868 .....	<b>6c</b>		
<b>d</b> Foreign organizations: Tax paid or withheld at source (see instructions) .....	<b>6d</b>		
<b>e</b> Backup withholding (see instructions) .....	<b>6e</b>		
<b>f</b> Credit for small employer health insurance premiums (attach Form 8941) .....	<b>6f</b>		
<b>g</b> Other credits, adjustments, and payments: <input type="checkbox"/> Form 2439 <input type="checkbox"/> Form 4136 <input type="checkbox"/> Other .....	<b>6g</b>		
<b>7 Total payments.</b> Add lines 6a through 6g .....		<b>7</b>	
<b>8</b> Estimated tax penalty (see instructions). Check if Form 2220 is attached <b>u</b> <input type="checkbox"/> .....	<b>u</b>	<b>8</b>	
<b>9 Tax due.</b> If line 7 is smaller than the total of lines 4, 5, and 8, enter amount owed .....	<b>u</b>	<b>9</b>	<b>0</b>
<b>10 Overpayment.</b> If line 7 is larger than the total of lines 4, 5, and 8, enter amount overpaid .....	<b>u</b>	<b>10</b>	
<b>11</b> Enter the amount of line 10 you want: <b>Credited to 2021 estimated tax u</b> <b>Refunded u</b> .....		<b>11</b>	

**Part IV Statements Regarding Certain Activities and Other Information** (see instructions)

	Yes	No
<b>1</b> At any time during the 2020 calendar year, did the organization have an interest in or a signature or other authority over a financial account (bank, securities, or other) in a foreign country? If "Yes," the organization may have to file FinCEN Form 114, Report of Foreign Bank and Financial Accounts. If "Yes," enter the name of the foreign country here <b>u</b> .....		<b>X</b>
<b>2</b> During the tax year, did the organization receive a distribution from, or was it the grantor of, or transferor to, a foreign trust? .....		<b>X</b>
If "Yes," see instructions for other forms the organization may have to file.		
<b>3</b> Enter the amount of tax-exempt interest received or accrued during the tax year <b>u</b> \$ .....		
<b>4a</b> Did the organization change its method of accounting? (see instructions) .....		<b>X</b>
<b>b</b> If 4a is "Yes," has the organization described the change on Form 990, 990-EZ, 990-PF, or Form 1128? If "No," explain in Part V .....		

**Part V Supplemental Information**

Provide the explanation required by Part IV, line 4b. Also, provide any other additional information. See instructions.

<b>Sign Here</b>	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 taxpayer) is based on all information of which preparer has any knowledge.				
	<b>u</b> _____		<b>u</b> <b>SECRETARY</b>		
	Signature of officer	Date	Title		
<b>Paid Preparer Use Only</b>	Print/Type preparer's name <b>JAY TOLSMA, CPA</b>	Preparer's signature <b>JAY TOLSMA, CPA</b>	Date <b>05/13/22</b>	Check <input checked="" type="checkbox"/> if self-employed	PTIN <b>P00736087</b>
	Firm's name } <b>ELO PROF LLC</b>	Firm's EIN } <b>46-0434947</b>			
	Firm's address } <b>PO BOX 249</b>	Phone no. <b>605-996-7717</b>			
		<b>MITCHELL, SD 57301</b>			

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

**SCHEDULE A  
(Form 990-T)**

**Unrelated Business Taxable Income  
From an Unrelated Trade or Business**

OMB No. 1545-0047

**2020**

Department of the Treasury  
Internal Revenue Service

Go to [www.irs.gov/Form990T](http://www.irs.gov/Form990T) for instructions and the latest information.

Open to Public Inspection for  
501(c)(3) Organizations Only

Do not enter SSN numbers on this form as it may be made public if your organization is a 501(c)(3).

<b>A</b> Name of the organization <b>HURON REGIONAL MEDICAL CENTER INC</b>	<b>B</b> Employer identification number <b>46-0345312</b>
<b>C</b> Unrelated Business Activity Code (see instructions) <b>u531110</b>	<b>D</b> Sequence: <b>1</b> of <b>1</b>

**E** Describe the unrelated trade or business **u UNRELATED BUSINESS ACTIVITY**

Part I Unrelated Trade or Business Income	(A) Income	(B) Expenses	(C) Net
<b>1a</b> Gross receipts or sales			
<b>b</b> Less returns and allowances <b>c</b> Balance <b>u</b>	<b>1c</b>		
<b>2</b> Cost of goods sold (Part III, line 8)	<b>2</b>		
<b>3</b> Gross profit. Subtract line 2 from line 1c	<b>3</b>		
<b>4a</b> Capital gain net income (attach Sch D (Form 1041 or Form 1120)) (see instructions)	<b>4a</b>		
<b>b</b> Net gain (loss) (Form 4797) (attach Form 4797) (see instructions)	<b>4b</b>		
<b>c</b> Capital loss deduction for trusts	<b>4c</b>		
<b>5</b> Income (loss) from partnership and S corporation (attach statement)	<b>5</b>		
<b>6</b> Rent income (Part IV)	<b>6</b>		
<b>7</b> Unrelated debt-financed income (Part V)	<b>7</b>		
<b>8</b> Interest, annuities, royalties, and rents from a controlled organization (Part VI)	<b>8</b>		
<b>9</b> Investment income of section 501(c)(7), (9), or (17) organization (Part VII)	<b>9</b>		
<b>10</b> Exploited exempt activity income (Part VIII)	<b>10</b>		
<b>11</b> Advertising income (Part IX)	<b>11</b>		
<b>12</b> Other income (see instructions; attach statement) <b>SEE STMT 1</b>	<b>12</b> 248,041		248,041
<b>13 Total.</b> Combine lines 3 through 12	<b>13</b> 248,041		248,041

**Part II Deductions Not Taken Elsewhere** (See instructions for limitations on deductions) Deductions must be directly connected with the unrelated business income

<b>1</b> Compensation of officers, directors, and trustees (Part X)		<b>1</b>	
<b>2</b> Salaries and wages		<b>2</b>	
<b>3</b> Repairs and maintenance		<b>3</b>	30,619
<b>4</b> Bad debts		<b>4</b>	
<b>5</b> Interest (attach statement) (see instructions)		<b>5</b>	
<b>6</b> Taxes and licenses		<b>6</b>	33,432
<b>7</b> Depreciation (attach Form 4562) (see instructions)	<b>7</b>		169,535
<b>8</b> Less depreciation claimed in Part III and elsewhere on return	<b>8a</b>	<b>8b</b>	169,535
<b>9</b> Depletion		<b>9</b>	
<b>10</b> Contributions to deferred compensation plans		<b>10</b>	
<b>11</b> Employee benefit programs		<b>11</b>	
<b>12</b> Excess exempt expenses (Part VIII)		<b>12</b>	
<b>13</b> Excess readership costs (Part IX)		<b>13</b>	
<b>14</b> Other deductions (attach statement) <b>SEE STATEMENT 2</b>		<b>14</b>	146,475
<b>15 Total deductions.</b> Add lines 1 through 14		<b>15</b>	380,061
<b>16</b> Unrelated business income before net operating loss deduction. Subtract line 15 from Part I, line 13, column (C)		<b>16</b>	-132,020
<b>17</b> Deduction for net operating loss (see instructions)		<b>17</b>	
<b>18 Unrelated business taxable income.</b> Subtract line 17 from line 16		<b>18</b>	-132,020

For Paperwork Reduction Act Notice, see instructions.

Schedule A (Form 990-T) 2020

Part III Cost of Goods Sold

Enter method of inventory valuation u

Table with 8 rows for Cost of Goods Sold. Rows include: 1 Inventory at beginning of year, 2 Purchases, 3 Cost of labor, 4 Additional section 263A costs, 5 Other costs, 6 Total, 7 Inventory at end of year, 8 Cost of goods sold. Includes Yes/No checkboxes for line 9.

Part IV Rent Income (From Real Property and Personal Property Leased with Real Property)

Table for Rent Income. Line 1: Description of property. Lines 2-5: Rent received or accrued, deductions, and total deductions. Columns A, B, C, D.

Part V Unrelated Debt-Financed Income (see instructions)

Table for Unrelated Debt-Financed Income. Lines 2-7: Gross income, deductions, average acquisition debt, average adjusted basis, and reportable income. Lines 8-11: Total gross income, allocable deductions, and total dividends-received deductions. Columns A, B, C, D.

**Part VI Interest, Annuities, Royalties, and Rents from Controlled Organizations** (see instructions)

1. Name of controlled organization	2. Employer identification number	Exempt/Nonexempt Controlled Organization			
		3. Net unrelated income (loss) (see instructions)	4. Total of specified payments made	5. Part of column 4 that is included in the controlling organization's gross income	6. Deductions directly connected with income in column 5
(1)					
(2)					
(3)					
(4)					

**Nonexempt Controlled Organizations**

7. Taxable income	8. Net unrelated income (loss) (see instructions)	9. Total of specified payments made	10. Part of column 9 that is included in the controlling organization's gross income	11. Deductions directly connected with income in column 10
(1)				
(2)				
(3)				
(4)				

			Add columns 5 and 10. Enter here and on Part I, line 8, column (A)	Add columns 6 and 11. Enter here and on Part I, line 8, column (B)
--	--	--	--	--

**Totals** .....

**u**

**Part VII Investment Income of a Section 501(c)(7), (9), or (17) Organization** (see instructions)

1. Description of income	2. Amount of income	3. Deductions directly connected (attach statement)	4. Set-asides (attach statement)	5. Total deductions and set-asides (add columns 3 and 4)
(1)				
(2)				
(3)				
(4)				

		Add amounts in column 2. Enter here and on Part I, line 9, column (A)			Add amounts in column 5. Enter here and on Part I, line 9, column (B)
--	--	---	--	--	---

**Totals** .....

**u**

**Part VIII Exploited Exempt Activity Income, Other Than Advertising Income** (see instructions)

1	Description of exploited activity:	
2	Gross unrelated business income from trade or business. Enter here and on Part I, line 10, column (A)	<b>2</b>
3	Expenses directly connected with production of unrelated business income. Enter here and on Part I, line 10, column (B)	<b>3</b>
4	Net income (loss) from unrelated trade or business. Subtract line 3 from line 2. If a gain, complete lines 5 through 7	<b>4</b>
5	Gross income from activity that is not unrelated business income	<b>5</b>
6	Expenses attributable to income entered on line 5	<b>6</b>
7	Excess exempt expenses. Subtract line 5 from line 6, but do not enter more than the amount on line 4. Enter here and on Part II, line 12	<b>7</b>

**Part IX Advertising Income**

**1** Name(s) of periodical(s). Check box if reporting two or more periodicals on a consolidated basis.

<b>A</b>	<input type="checkbox"/>	_____
<b>B</b>	<input type="checkbox"/>	_____
<b>C</b>	<input type="checkbox"/>	_____
<b>D</b>	<input type="checkbox"/>	_____

Enter amounts for each periodical listed above in the corresponding column.

	A	B	C	D
<b>2</b> Gross advertising income .....				
<b>a</b> Add columns A through D. Enter here and on Part I, line 11, column (A) .....				<b>u</b> _____
<b>3</b> Direct advertising costs by periodical .....				
<b>a</b> Add columns A through D. Enter here and on Part I, line 11, column (A) .....				<b>u</b> _____
<b>4</b> Advertising gain (loss). Subtract line 3 from line 2. For any column in line 4 showing a gain, complete lines 5 through 8. For any column in line 4 showing a loss or zero, do not complete lines 5 through 7, and enter zero on line 8 .....				
<b>5</b> Readership costs .....				
<b>6</b> Circulation income .....				
<b>7</b> Excess readership costs. If line 6 is less than line 5, subtract line 6 from line 5. If line 5 is less than line 6, enter zero .....				
<b>8</b> Excess readership costs allowed as a deduction. For each column showing a gain on line 4, enter the lesser of line 4 or line 7 .....				
<b>a</b> Add line 8, columns A through D. Enter the greater of the line 8a, columns total or zero here and on Part II, line 13 .....				<b>u</b> _____

**Part X Compensation of Officers, Directors, and Trustees (see instructions)**

1. Name	2. Title	3. Percentage of time devoted to business	4. Compensation attributable to unrelated business
(1)		%	
(2)		%	
(3)		%	
(4)		%	
<b>Total.</b> Enter here and on Part II, line 1 .....			<b>u</b> _____

**Part XI Supplemental Information (see instructions)**

---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---

Form <b>990-T</b>	<b>Schedule A Loss Carryover Calculation</b>	<b>2020</b>
Description <b>UNRELATED BUSINESS ACTIVITY</b>		

Name <b>HURON REGIONAL MEDICAL CENTER INC</b>	Taxpayer Identification Number <b>46-0345312</b>
--	---

Unincorporated Business Income Tax Code: **531110** Activity: **LESSORS OF RESIDENTIAL BUILDINGS**

Each activity may carryforward losses after 2018

1 Activity income .....	1	<b>248,041</b>
2 Activity deductions .....	2	<b>380,061</b>
3 Activities income or loss, after deductions .....	3	<b>-132,020</b>
4 Losses carried over to this year (do not include amounts prior to 2018) .....	4	<b>114,432</b>
5 Enter 100% of the amount on Line 3, if both lines 3 and 4 are positive. ....	5	
6 Take the lesser of Line 4 or Line 5. <b>Enter here and on Line 17 of Form 990-T, Sch A, Part II</b> .....	6	
7 Remaining losses to be carried forward to 2021 (Subtract Line 6 from line 4) .....	7	<b>114,432</b>
8 If line 3 is less than zero, enter that amount here as a positive number .....	8	<b>132,020</b>
9 Total loss carried forward to 2021 (Add lines 7 and 8) .....	9	<b>246,452</b>

Electronic Filing includes the report of additional amounts for this activity

<b>E1</b> Activity loss amounts from 2019 .....	<b>E1</b>	<b>114,432</b>
<b>E2</b> Prior year activity losses included on Schedule A, Line 17 .....	<b>E2</b>	

**Federal Statements****Unrelated Business Activity****Statement 1 - Schedule A (990T), Part I, Line 12 - Other Income**

Description	Amount
RENTAL	\$ 248,041
TOTAL	\$ <u>248,041</u>

**Unrelated Business Activity****Statement 2 - Schedule A (990T), Part II, Line 14 - Other Deductions**

Description	Amount
PURCHASED SERVICES	\$ 6,442
MINOR EQUIPMENT	2,234
SALARIES & WAGES	6,327
RENTALS & LEASES	468
RECRUITING	637
SUPPLIES	9,735
UTILITIES	120,632
TOTAL	\$ <u>146,475</u>

Form <b>990-T</b>	<b>Business Income Activity Summary</b>	<b>2020</b>
-------------------	---	-------------

Name <b>HURON REGIONAL MEDICAL CENTER INC</b>	Taxpayer Identification Number <b>46-0345312</b>
--	---

**Business Activity Income (and allocation of Prior-2018 NOL)**

A. Total Pre-2018 Net Operating Losses Carried Forward .....	A. <u>155,601</u>
B. Total Pre-2018 Net Operating Loss allocated to Sch A activities .....	B. _____
C. Total Pre-2018 Net Operating Loss allocated to Form 990-T, Line 6 .....	C. _____
D. Pre-2018 Applied (Sum of B and C) .....	D. _____
E. Pre-2018 Remaining (Line A minus Line D) .....	E. <u>155,601</u>
F. Pre-2018 Net Operating Losses Expiring this Year .....	F. _____
G. Pre-2018 Net Operating Losses Carried Forward .....	G. <u>155,601</u>

Unrelated Business Income Activity with Income	Code	Net Income	Allocated Pre2018 NOL
1. _____		1. _____	_____
2. _____		2. _____	_____
3. _____		3. _____	_____
4. _____		4. _____	_____
5. _____		5. _____	_____
6. _____		6. _____	_____
7. _____		7. _____	_____
8. _____		8. _____	_____
9. _____		9. _____	_____
10. _____		10. _____	_____
11. _____		11. _____	_____
12. _____		12. _____	_____
13. _____		13. _____	_____
14. _____		14. _____	_____
15. All other revenue _____		15. _____	_____
16. Total taxable income .....		16. _____	_____

**Business Activity Losses**

Unrelated Business Income Activity with Losses	Code	Current Year Loss
1. <b>UNRELATED BUSINESS ACTIVITY</b> .....	<b>531110</b>	1. <u>-132,020</u>
2. _____		2. _____
3. _____		3. _____
4. _____		4. _____
5. All other activities .....		5. _____
6. Totals .....		6. <u>-132,020</u>



Form <b>990/990-PF</b>	<b>Electronic Filing - PDF Attachment Report</b>	<b>2020</b>
For calendar year 2020, or tax year beginning <b>07/01/20</b> , and ending <b>06/30/21</b>		

Name <b>HURON REGIONAL MEDICAL CENTER INC</b>	Taxpayer Identification Number <b>46-0345312</b>
--	---

Title	Attachment Source	Proforma
<p><b>MANUALLY ATTACHED TO RETURN</b></p> <p><b>SCHEDULE H, PART VI - ADDITIONAL INFO</b></p> <p><b>2020 FORM 990, PART VI LINE 2 DISCLOSURES</b></p> <p><b>AUDITED FINANCIAL STATEMENTS</b></p>	<p><b>L:\HURON REGIONAL MEDICAL CENTER\2021\990\2020 SCHEDULE NO H, PART VI - ADDITIONAL INFO.PDF</b></p> <p><b>L:\HURON REGIONAL MEDICAL CENTER\2021\990\2020 FORM 990,NO PART VI LINE 2 DISCLOSURES.PDF</b></p> <p><b>O:\FINANCIAL STATEMENTS IN PROGRESS\HURON REGIONAL MEDICNO AL CENTER\2021- COMPLETE\6-30-21 AUDIT REPORT - FOR 990</b></p>	

Form <b>SchM</b>	<b>Two Year Comparison for Unrelated Business Activity</b>	<b>2019 &amp; 2020</b>
For calendar year 2020, or tax year beginning <b>07/01/20</b> , ending <b>06/30/21</b>		
Organization Name <b>HURON REGIONAL MEDICAL CENTER INC</b>	Taxpayer Identification Number <b>46-0345312</b>	

Unincorporated Business Income Tax Code: **531110** Activity: **UNRELATED BUSINESS ACTIVITY**

		2019	2020	Differences	
<b>R</b> <b>e</b> <b>v</b> <b>e</b> <b>n</b> <b>u</b> <b>e</b>	1. Gross profit/loss on business activities .....	1.			
	2. Capital gains/losses .....	2.			
	3. Income/loss from partnerships and S corporations .....	3.			
	4. Rental income (net of expense) .....	4.			
	5. Unrelated debt-financed income (net of expense) .....	5.			
	6. Interest, and other income from controlled organizations (net of expense) .....	6.			
	7. Investment income of specific organizations (net of expense) .....	7.			
	8. Exploited exempt activity income (net of expense) .....	8.			
	9. Advertising income (net of expense) .....	9.			
	10. Other income .....	10.	247,539	248,041	502
	<b>11. Total trade or business income.</b> Combine lines 1 through 10	<b>11.</b>	<b>247,539</b>	<b>248,041</b>	<b>502</b>
<b>E</b> <b>x</b> <b>p</b> <b>e</b> <b>n</b> <b>s</b> <b>e</b> <b>s</b>	12. Compensation of officers, directors, and trustees .....	12.			
	13. Other salaries and wages .....	13.			
	14. Repairs and maintenance .....	14.	20,204	30,619	10,415
	15. Bad debts .....	15.			
	16. Interest .....	16.			
	17. Taxes and licenses .....	17.	40,998	33,432	-7,566
	18. Depreciation and Depletion .....	18.	181,300	169,535	-11,765
	19. Contributions to deferred compensation plans .....	19.			
	20. Employee benefit programs .....	20.			
	21. Other deductions .....	21.	119,469	146,475	27,006
	<b>22. Total deductions.</b> Add lines 12 through 22	<b>22.</b>	<b>361,971</b>	<b>380,061</b>	<b>18,090</b>
	<b>23. Taxable income before deductions.</b> Subtract line 23 from 11	<b>23.</b>	<b>-114,432</b>	<b>-132,020</b>	<b>-17,588</b>
	24. Deductible losses .....	24.		114,432	114,432
	<b>25. Unrelated business taxable income (loss)</b>	<b>25.</b>	<b>-114,432</b>	<b>-246,452</b>	<b>-132,020</b>