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Form 990

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

OMB No 1545-0047

2011

Open to Public Inspection

A For the 2011 calendar year, or tax year beginning 07-01-2011 and ending 06-30-2012

B Check if applicable

☐ Address change

☐ Name change

☐ Initial return

☐ Terminated

☐ Amended return

☐ Application pending

C Name of organization

MOUNT CARMEL HEALTH SYSTEM

Doing Business As

Number and street (or P O box if mail is not delivered to street address)

Room/suite

6150 EAST BROAD STREET

City or town, state or country, and ZIP + 4

COLUMBUS, OH 432131574

F Name and address of principal officer

CLAUS VON ZYCHLIN

6150 EAST BROAD STREET

COLUMBUS, OH 432131574

D Employer identification number

31-1439334

E Telephone number

(614) 546-4300

G Gross receipts \$ 204,653,044

I Tax-exempt status

☒ 501(c)(3) ☐ 501(c) () ☐ (Insert no) ☐ 4947(a)(1) or ☐ 527

J Website:

WWW.MOUNTCARMELHEALTH.COM

K Form of organization

☒ Corporation ☐ Trust ☐ Association ☐ Other

L Year of formation

1995

M State of legal domicile

OH

| Part I | Summary |
|-----------------------------|---|
| Activities & Governance | <div>1 Briefly describe the organization's mission or most significant activities</div> <div>HEALTHCARE SYSTEM MANAGEMENT AND SUPPORT</div> |
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| | |
| | <div>2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets</div> <div>3 Number of voting members of the governing body (Part VI, line 1a)</div> <div>4 Number of independent voting members of the governing body (Part VI, line 1b)</div> <div>5 Total number of individuals employed in calendar year 2011 (Part V, line 2a)</div> <div>6 Total number of volunteers (estimate if necessary)</div> <div>7a Total unrelated business revenue from Part VIII, column (C), line 12</div> <div>7b Net unrelated business taxable income from Form 990-T, line 34</div> |
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| | |
| | |
| Revenue | <div>8 Contributions and grants (Part VIII, line 1h)</div> <div>9 Program service revenue (Part VIII, line 2g)</div> <div>10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)</div> <div>11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)</div> <div>12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)</div> |
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| | |
| Expenses | <div>13 Grants and similar amounts paid (Part IX, column (A), lines 1–3)</div> <div>14 Benefits paid to or for members (Part IX, column (A), line 4)</div> <div>15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)</div> <div>16a Professional fundraising fees (Part IX, column (A), line 11e)</div> <div>16b Total fundraising expenses (Part IX, column (D), line 25) ▶⁰</div> <div>17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)</div> <div>18 Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)</div> <div>19 Revenue less expenses Subtract line 18 from line 12</div> |
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| | |
| | |
| | |
| Net Assets or Fund Balances | <div>Beginning of Current Year</div> <div>End of Year</div> |
| | |
| | |
| | |

Part II

Signature Block

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

Sign Here

Signature of officer

2013-05-13

Date

KEITH COLEMAN SVP & CFO

Type or print name and title

Paid Preparer's Use Only

Preparer's signature

Date

Check if self-employed ☐

Preparer's taxpayer identification number (see instructions)

Firm's name (or yours if self-employed), address, and ZIP + 4

EIN

Phone no

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

For Paperwork Reduction Act Notice, see the separate instructions.

Cat No 11282Y

Form 990 (2011)

Part III

Statement of Program Service Accomplishments

Check if Schedule O contains a response to any question in this Part III ☐ Yes ☒ No

1

Briefly describe the organization's mission

MOUNT CARMEL HEALTH SYSTEM'S PURPOSE IS TO GOVERN,MANAGE AND PROVIDE ADMINISTRATIVE SERVICES TO ITS SUBSIDIARIES THE ADMINISTRATIVE SERVICES PROVIDED BY MOUNT CARMEL HEALTH SYSTEM FOR THE SUBSIDIARIES ALLOW FOR ECONOMIES OF SCALE THAT PERMIT THE SUBSIDIARIES TO PROVIDE HEALTHCARE SERVICES TO PATIENTS AT A REASONABLE COST

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 and section 4947(a)(1) trusts are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported

4a

(Code) (Expenses \$ 168,137,720 including grants of \$ 741,954) (Revenue \$ 182,606,940)

MOUNT CARMEL HEALTH SYSTEM, AN OHIO NOT-FOR-PROFIT CORPORATION, OWNS AND/OR OPERATES FIVE HOSPITALS IN THE COLUMBUS, OHIO AREA CONTAINING 1,195 BEDS AND VARIOUS OTHER ACUTE AND NONACUTE HEALTH SERVICE PROVIDERS AS WELL AS A LICENSED HEALTH MAINTENANCE ORGANIZATION THE HEALTH SYSTEM PROVIDES SERVICES TO PATIENTS WHO RESIDE IN CENTRAL OHIO OHIO NOT-FOR-PROFIT MEMBER ORGANIZATIONS INCLUDE MOUNT CARMEL HEALTH, SAINT ANN'S HOSPITAL, MOUNT CARMEL NEW ALBANY SURGICAL HOSPITAL, DILEY RIDGE MEDICAL CENTER, MOUNT CARMEL CARE CONTINUUM SERVICES CORPORATION, MOUNT CARMEL COLLEGE OF NURSING, MOUNT CARMEL HEALTH SYSTEM FOUNDATION, MOUNT CARMEL HEALTH PLAN, INC , AND MOUNT CARMEL HEALTH INSURANCE COMPANY OHIO FOR-PROFIT MEMBER ORGANIZATIONS INCLUDE MOUNT CARMEL HEALTH PROVIDERS, INC AND MOUNT CARMEL BEHAVIORAL HEALTHCARE SERVICES MOUNT CARMEL HEALTH SYSTEM IS A MEMBER OF TRINITY HEALTH FOR MORE INFORMATION ON SPECIFIC SERVICES PROVIDED, PLEASE SEE MOUNT CARMEL HEALTH SYSTEM'S WEBSITE AT WWW.MOUNTCARMELHEALTH.COM

4b

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

MISSIONTHE MISSION STATEMENT FOR MOUNT CARMEL HEALTH SYSTEM IS AS FOLLOWS WE SERVE TOGETHER IN TRINITY HEALTHIN THE SPIRIT OF THE GOSPELTO HEAL BODY, MIND AND SPIRITTO IMPROVE THE HEALTH OF OUR COMMUNITIESAND TO STEWARD THE RESOURCES ENTRUSTED TO US

4c

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

4d

Other program services (Describe in Schedule O)


















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

4e

Total program service expenses \$ 168,137,720

Part IV

Checklist of Required Schedules

| | | Yes | No |
|-----|--|-----|-----|
| 1 | Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? <i>If "Yes," complete Schedule A.</i>  | 1 | Yes |
| 2 | Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> (see instructions)? . . . | 2 | No |
| 3 | Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I.</i>  | 3 | No |
| 4 | Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? <i>If "Yes," complete Schedule C, Part II.</i>  | 4 | Yes |
| 5 | Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? <i>If "Yes," complete Schedule C, Part III.</i>  | 5 | No |
| 6 | Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? <i>If "Yes," complete Schedule D, Part I.</i>  | 6 | No |
| 7 | Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas or historic structures? <i>If "Yes," complete Schedule D, Part II.</i>  | 7 | No |
| 8 | Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III.</i>  | 8 | No |
| 9 | Did the organization report an amount in Part X, line 21, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? <i>If "Yes," complete Schedule D, Part IV.</i>  | 9 | No |
| 10 | Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? <i>If "Yes," complete Schedule D, Part V.</i>  | 10 | No |
| 11 | If the organization's answer to any of the following questions is 'Yes,' then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable | | |
| a | Did the organization report an amount for land, buildings, and equipment in Part X, line 10? <i>If "Yes," complete Schedule D, Part VI.</i>  | 11a | Yes |
| b | Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VII.</i>  | 11b | Yes |
| c | Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VIII.</i>  | 11c | No |
| d | Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part IX.</i>  | 11d | Yes |
| e | Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X.</i>  | 11e | Yes |
| f | Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? <i>If "Yes," complete Schedule D, Part X.</i>  | 11f | No |
| 12a | Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI, XII, and XIII.</i>  | 12a | No |
| b | Was the organization included in consolidated, independent audited financial statements for the tax year? <i>If "Yes," and if the organization answered 'No' to line 12a, then completing Schedule D, Parts XI, XII, and XIII is optional.</i>  | 12b | Yes |
| 13 | Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E.</i> | 13 | No |
| 14a | Did the organization maintain an office, employees, or agents outside of the United States? . . . | 14a | No |
| b | Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? <i>If "Yes," complete Schedule F, Part I.</i> . . . | 14b | No |
| 15 | Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or assistance to any organization or entity located outside the U S ? <i>If "Yes," complete Schedule F, Part II and IV.</i> . . . | 15 | No |
| 16 | Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or assistance to individuals located outside the U S ? <i>If "Yes," complete Schedule F, Part III and IV.</i> . . . | 16 | No |
| 17 | Did the organization report a total of more than \$15,000, of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? <i>If "Yes," complete Schedule G, Part I.</i> | 17 | No |
| 18 | Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? <i>If "Yes," complete Schedule G, Part II.</i> . . . | 18 | No |
| 19 | Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III.</i> . . . | 19 | No |
| 20a | Did the organization operate one or more hospitals? <i>If "Yes," complete Schedule H.</i> . . . | 20a | No |
| b | If "Yes" to line 20a, did the organization attach its audited financial statement to this return? Note. All Form 990 filers that operated one or more hospitals must attach audited financial statements . . . | 20b | |

Part IV

Checklist of Required Schedules (continued)

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

| | | | | | | |
|---|--|------------|-----------|--|--|----|
| Part V Statements Regarding Other IRS Filings and Tax Compliance | | | | | | |
| Check if Schedule O contains a response to any question in this Part V <input type="checkbox"/> | | | | | | |
| | | Yes | No | | | |
| 1a | Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable. . | 1a | 1,527 | | | |
| b | Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable. | 1b | 0 | | | |
| c | Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? | 1c | Yes | | | |
| 2a | Enter the number of employees reported on Form W-3, <i>Transmittal of Wage and Tax Statements</i> filed for the calendar year ending with or within the year covered by this return. | 2a | 9,681 | | | |
| b | If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions). | 2b | Yes | | | |
| 3a | Did the organization have unrelated business gross income of \$1,000 or more during the year? | 3a | Yes | | | |
| b | If "Yes," has it filed a Form 990-T for this year? If "No," provide an explanation in Schedule O. | 3b | Yes | | | |
| 4a | At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account or securities account)? | 4a | | | | No |
| b | If "Yes," enter the name of the foreign country: _____ See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts. | | | | | |
| 5a | Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? | 5a | | | | No |
| b | Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? | 5b | | | | No |
| c | If "Yes" to line 5a or 5b, did the organization file Form 8886-T? | 5c | | | | |
| 6a | Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible? | 6a | | | | No |
| b | If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? | 6b | | | | |
| 7 | Organizations that may receive deductible contributions under section 170(c). | | | | | |
| a | Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor? | 7a | | | | No |
| b | If "Yes," did the organization notify the donor of the value of the goods or services provided? | 7b | | | | |
| c | Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? | 7c | | | | No |
| d | If "Yes," indicate the number of Forms 8282 filed during the year. | 7d | | | | |
| e | Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? | 7e | | | | No |
| f | Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? | 7f | | | | No |
| g | If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? | 7g | | | | |
| h | If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? | 7h | | | | |
| 8 | Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations. Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year? | 8 | | | | No |
| 9 | Sponsoring organizations maintaining donor advised funds. | | | | | |
| a | Did the organization make any taxable distributions under section 4966? | 9a | | | | |
| b | Did the organization make a distribution to a donor, donor advisor, or related person? | 9b | | | | |
| 10 | Section 501(c)(7) organizations. Enter | | | | | |
| a | Initiation fees and capital contributions included on Part VIII, line 12. | 10a | | | | |
| b | Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities. | 10b | | | | |
| 11 | Section 501(c)(12) organizations. Enter | | | | | |
| a | Gross income from members or shareholders. | 11a | | | | |
| b | Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them). | 11b | | | | |
| 12a | Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041? | 12a | | | | |
| b | If "Yes," enter the amount of tax-exempt interest received or accrued during the year. | 12b | | | | |
| 13 | Section 501(c)(29) qualified nonprofit health insurance issuers. | | | | | |
| a | Is the organization licensed to issue qualified health plans in more than one state? Note. All 501(c)(29) organizations must list in Schedule O each state in which they are licensed to issue qualified health plans, the amount of reserves required by each state, and the amount of reserves the organization allocated to each state. | 13a | | | | |
| b | Enter the aggregate amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans. | 13b | | | | |
| c | Enter the aggregate amount of reserves on hand. | 13c | | | | |
| 14a | Did the organization receive any payments for indoor tanning services during the tax year? | 14a | | | | No |
| b | If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O. | 14b | | | | |

Part VI

Governance, Management, and Disclosure

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

Section A. Governing Body and Management

| | | | |
|----|---|-----|-----|
| | | Yes | No |
| 1a | Enter the number of voting members of the governing body at the end of the tax year | | |
| 1a | 13 | | |
| b | Enter the number of voting members included in line 1a, above, who are independent | 1b | 7 |
| 2 | Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee? | 2 | No |
| 3 | Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? | 3 | No |
| 4 | Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? | 4 | No |
| 5 | Did the organization become aware during the year of a significant diversion of the organization's assets? | 5 | Yes |
| 6 | Did the organization have members or stockholders? | 6 | Yes |
| 7a | Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? | 7a | Yes |
| b | Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? | 7b | Yes |
| 8 | Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following | | |
| a | The governing body? | 8a | Yes |
| b | Each committee with authority to act on behalf of the governing body? | 8b | Yes |
| 9 | Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O | 9 | No |

Section B. Policies

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

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

Section C. Disclosure

| | |
|----|---|
| 17 | List the States with which a copy of this Form 990 is required to be filed |
| 18 | Section 6104 requires an organization to make its Form 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply. <input type="checkbox"/> Own website <input type="checkbox"/> Another's website <input checked="" type="checkbox"/> Upon request |
| 19 | Describe in Schedule O whether (and if so, how), the organization made its governing documents, conflict of interest policy, and financial statements available to the public. See Additional Data Table. |
| 20 | State the name, physical address, and telephone number of the person who possesses the books and records of the organization. CAROLYN WHITE 6150 EAST BROAD STREET COLUMBUS, OH 43213 (614) 546-4130 |

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

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

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

[illegible]

Part VII

| | | | | |
|-----------|--|-----------|------------|-----------|
| 1b | Sub-Total | | | |
| c | Total from continuation sheets to Part VII, Section A | | | |
| d | Total (add lines 1b and 1c) | 1,453,536 | 14,062,310 | 1,546,863 |

2 Total number of individuals (including but not limited to those listed in Item 1) who received more than \$100,000 of reportable compensation from the organization. 307

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

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than \$100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

| (A) Name and business address | (B) Description of services | (C) Compensation |
|--|--------------------------------|---------------------|
| COMTEX 575 HARMON AVE COLUMBUS, OH 43223 | LAUNDRY SERVICES | 5,311,790 |
| BRUNER CORPORATION PO BOX 75683 CLEVELAND, OH 44101 | CONSTRUCTION SERVICES | 3,941,198 |
| DAWSON HEALTHCARE 3650 OLENTANGY RIVER ROAD COLUMBUS, OH 43214 | TEMPORARY SERVICES | 3,873,589 |
| BVK DIRECT 250 WEST COVENTRY CT STE 300 MILWAUKEE, WI 53217 | MARKETING & ADVERTISING | 2,417,232 |
| PREMIER COURIER INC 3687 INTERCHANGE ROAD COLUMBUS, OH 43204 | DELIVERY SERVICES | 1,090,542 |

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 ▶55

Part VIII

Statement of Revenue

| | | | | (A) Total revenue | (B) Related or exempt function revenue | (C) Unrelated business revenue | (D) Revenue excluded from tax under sections 512, 513, or 514 | |
|---|---|---|----------------|----------------------|--|---|---|--|
| Contributions, gifts, grants and other similar amounts | 1a | Federated campaigns . . . | 1a | | | | | |
| | b | Membership dues | 1b | | | | | |
| | c | Fundraising events | 1c | | | | | |
| | d | Related organizations | 1d | | | | | |
| | e | Government grants (contributions) | 1e | | | | | |
| | f | All other contributions, gifts, grants, and similar amounts not included above | 1f | | | | | |
| | g | Noncash contributions included in lines 1a-1f \$ _____ | | | | | | |
| | h | Total. Add lines 1a-1f | | | | | | |
| Program Service Revenue | | | Business Code | | | | | |
| | 2a | SUBSIDIARY FEES | 900099 | 170,109,932 | 170,109,932 | | | |
| | b | GIFT SHOPS | 453220 | 1,439,380 | | | 1,439,380 | |
| | c | | | | | | | |
| | d | | | | | | | |
| | e | | | | | | | |
| | f | All other program service revenue | | | | | | |
| | g | Total. Add lines 2a-2f | | 171,549,312 | | | | |
| Other Revenue | 3 | Investment income (including dividends, interest and other similar amounts) | | 8,855,005 | | | 8,855,005 | |
| | 4 | Income from investment of tax-exempt bond proceeds . . | | | | | | |
| | 5 | Royalties | | | | | | |
| | 6a | Gross rents | (i) Real | (ii) Personal | | | | |
| | | | 3,754,504 | | | | | |
| | | | 0 | | | | | |
| | | | 3,754,504 | | | | | |
| | d | Net rental income or (loss) | | 3,754,504 | | | 3,754,504 | |
| | 7a | Gross amount from sales of assets other than inventory | (i) Securities | (ii) Other | | | | |
| | | | 5,194,930 | | | | | |
| | | | 0 | | | | | |
| | | | 5,194,930 | | | | | |
| | d | Net gain or (loss) | | 5,194,930 | | | 5,194,930 | |
| | 8a | Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18 | a | | | | | |
| | b | Less direct expenses | b | | | | | |
| | c | Net income or (loss) from fundraising events . . | | | | | | |
| | 9a | Gross income from gaming activities See Part IV, line 19 | a | | | | | |
| | b | Less direct expenses | b | | | | | |
| | c | Net income or (loss) from gaming activities . . | | | | | | |
| | 10a | Gross sales of inventory, less returns and allowances | a | | | | | |
| | b | Less cost of goods sold | b | | | | | |
| | c | Net income or (loss) from sales of inventory . . | | | | | | |
| | Miscellaneous Revenue | | Business Code | | | | | |
| 11a | MANAGEMENT FEES | 561499 | 4,717,196 | 4,162,587 | 554,609 | | | |
| b | PROFESSIONAL FEES | 900099 | 1,410,234 | 420,898 | 989,336 | | | |
| c | | | | | | | | |
| d | All other revenue | | 9,171,863 | 7,913,523 | 1,258,340 | | | |
| e | Total. Add lines 11a-11d | | 15,299,293 | | | | | |
| 12 | Total revenue. See Instructions | | 204,653,044 | 182,606,940 | 2,802,285 | 19,243,819 | | |

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns
All other organizations must complete column (A) but are not required to complete columns (B), (C), and (D)
Check if Schedule O contains a response to any question in this Part IX

| Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII. | | (A) Total expenses | (B) Program service expenses | (C) Management and general expenses | (D) Fundraising expenses |
|--|---|-----------------------|---------------------------------|--|-----------------------------|
| 1 | Grants and other assistance to governments and organizations in the United States See Part IV, line 21 | 741,954 | 741,954 | | |
| 2 | Grants and other assistance to individuals in the United States See Part IV, line 22 | | | | |
| 3 | Grants and other assistance to governments, organizations, and individuals outside the United States See Part IV, lines 15 and 16 | | | | |
| 4 | Benefits paid to or for members | | | | |
| 5 | Compensation of current officers, directors, trustees, and key employees | 6,573,176 | | 6,573,176 | |
| 6 | Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) | 110,301 | 110,301 | | |
| 7 | Other salaries and wages | 60,181,637 | 38,521,112 | 21,660,525 | |
| 8 | Pension plan contributions (include section 401(k) and section 403(b) employer contributions) | 2,485,674 | 1,569,869 | 915,805 | |
| 9 | Other employee benefits | 6,550,909 | 3,892,279 | 2,658,630 | |
| 10 | Payroll taxes | 4,404,528 | 2,558,590 | 1,845,938 | |
| 11 | Fees for services (non-employees) | | | | |
| a | Management | | | | |
| b | Legal | 1,283,024 | 1,283,024 | | |
| c | Accounting | | | | |
| d | Lobbying | 143,000 | | 143,000 | |
| e | Professional fundraising See Part IV, line 17 | | | | |
| f | Investment management fees | | | | |
| g | Other | 9,338,988 | 9,336,978 | 2,010 | |
| 12 | Advertising and promotion | 4,619,435 | 4,619,435 | | |
| 13 | Office expenses | 5,453,854 | 5,372,973 | 80,881 | |
| 14 | Information technology | 48,739,692 | 48,736,491 | 3,201 | |
| 15 | Royalties | | | | |
| 16 | Occupancy | 3,236,788 | 2,801,919 | 434,869 | |
| 17 | Travel | 539,997 | 537,912 | 2,085 | |
| 18 | Payments of travel or entertainment expenses for any federal, state, or local public officials | | | | |
| 19 | Conferences, conventions, and meetings | 98,733 | 98,160 | 573 | |
| 20 | Interest | | | | |
| 21 | Payments to affiliates | | | | |
| 22 | Depreciation, depletion, and amortization | 18,801,797 | 18,523,607 | 278,190 | |
| 23 | Insurance | 850,438 | 850,438 | | |
| 24 | Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24f If line 24f amount exceeds 10% of line 25, column (A) amount, list line 24f expenses on Schedule O) | | | | |
| a | INTERCO PURCHASED SERV | 22,916,408 | 19,208,098 | 3,708,310 | |
| b | CONTRACT LABOR | 8,179,796 | 5,120,685 | 3,059,111 | |
| c | MEDICAL SUPPLIES | 3,109,696 | 3,109,696 | | |
| d | UBI TAXES | 450,303 | 450,303 | | |
| e | | | | | |
| f | All other expenses | 4,582,189 | 693,896 | 3,888,293 | |
| 25 | Total functional expenses. Add lines 1 through 24f | 213,392,317 | 168,137,720 | 45,254,597 | 0 |
| 26 | Joint costs. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720) Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation | | | | |

Part X

Balance Sheet

| | | | | | (A) | | (B) |
|-----------------------------|---|---|-----|-------------|-------------------|-----|-------------|
| | | | | | Beginning of year | | End of year |
| Assets | 1 | Cash—non-interest-bearing | | | 650 | 1 | 260 |
| | 2 | Savings and temporary cash investments | | | 17,372,206 | 2 | 30,938,512 |
| | 3 | Pledges and grants receivable, net | | | | 3 | |
| | 4 | Accounts receivable, net | | | | 4 | |
| | 5 | Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L | | | | 5 | |
| | 6 | Receivables from other disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B). Complete Part II of Schedule L | | | | 6 | |
| | 7 | Notes and loans receivable, net | | | 23,206,731 | 7 | 19,974,968 |
| | 8 | Inventories for sale or use | | | 858,455 | 8 | 1,022,678 |
| | 9 | Prepaid expenses and deferred charges | | | 1,505,706 | 9 | 1,240,400 |
| | 10a | Land, buildings, and equipment, cost or other basis. Complete Part VI of Schedule D | 10a | 237,941,751 | | | |
| | b | Less: accumulated depreciation | 10b | 144,066,243 | 85,510,055 | 10c | 93,875,508 |
| | 11 | Investments—publicly traded securities | | | 233,014,438 | 11 | 199,459,321 |
| | 12 | Investments—other securities. See Part IV, line 11 | | | 272,793,665 | 12 | 324,201,601 |
| | 13 | Investments—program-related. See Part IV, line 11 | | | | 13 | |
| | 14 | Intangible assets | | | 1,077,614 | 14 | 1,003,295 |
| | 15 | Other assets. See Part IV, line 11 | | | 166,711,046 | 15 | 203,648,261 |
| | 16 | Total assets. Add lines 1 through 15 (must equal line 34) | | | 802,050,566 | 16 | 875,364,804 |
| Liabilities | 17 | Accounts payable and accrued expenses | | | 58,789,074 | 17 | 63,901,458 |
| | 18 | Grants payable | | | | 18 | |
| | 19 | Deferred revenue | | | 313 | 19 | 5,740 |
| | 20 | Tax-exempt bond liabilities | | | | 20 | |
| | 21 | Escrow or custodial account liability. Complete Part IV of Schedule D | | | | 21 | |
| | 22 | Payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L | | | | 22 | |
| | 23 | Secured mortgages and notes payable to unrelated third parties | | | | 23 | |
| | 24 | Unsecured notes and loans payable to unrelated third parties | | | | 24 | |
| | 25 | Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D | | | 414,778,847 | 25 | 467,712,874 |
| | 26 | Total liabilities. Add lines 17 through 25 | | | 473,568,234 | 26 | 531,620,072 |
| Net Assets or Fund Balances | Organizations that follow SFAS 117, check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34. | | | | | | |
| | 27 | Unrestricted net assets | | | 328,482,332 | 27 | 343,744,732 |
| | 28 | Temporarily restricted net assets | | | | 28 | |
| | 29 | Permanently restricted net assets | | | | 29 | |
| | Organizations that do not follow SFAS 117, check here <input type="checkbox"/> and complete lines 30 through 34. | | | | | | |
| | 30 | Capital stock or trust principal, or current funds | | | | 30 | |
| | 31 | Paid-in or capital surplus, or land, building or equipment fund | | | | 31 | |
| | 32 | Retained earnings, endowment, accumulated income, or other funds | | | | 32 | |
| | 33 | Total net assets or fund balances | | | 328,482,332 | 33 | 343,744,732 |
| | 34 | Total liabilities and net assets/fund balances | | | 802,050,566 | 34 | 875,364,804 |

Part XI Reconciliation of Net Assets

Check if Schedule O contains a response to any question in this Part XI ☒

| | | | |
|----------|---|----------|-------------|
| 1 | Total revenue (must equal Part VIII, column (A), line 12) | 1 | 204,653,044 |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 213,392,317 |
| 3 | Revenue less expenses Subtract line 2 from line 1 | 3 | -8,739,273 |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | 328,482,332 |
| 5 | Other changes in net assets or fund balances (explain in Schedule O) | 5 | 24,001,673 |
| 6 | Net assets or fund balances at end of year Combine lines 3, 4, and 5 (must equal Part X, line 33, column (B)) | 6 | 343,744,732 |

Part XII Financial Statements and Reporting

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

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

SCHEDULE A
(Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

► Attach to Form 990 or Form 990-EZ. ► See separate instructions.

OMB No 1545-0047

2011

Open to Public Inspection

Name of the organization
MOUNT CARMEL HEALTH SYSTEM

Employer identification number
31-1439334

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

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

1

☐

A church, convention of churches, or association of churches **section 170(b)(1)(A)(i).**

2

☐

A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E)

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 organization that normally receives (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2).** (Complete Part III)

10

☐

An organization organized and operated exclusively to test for public safety Sees**section 509(a)(4).**

11

☒

An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2) See **section 509(a)(3).** Check the box that describes the type of supporting organization and complete lines 11e through 11h

a

☒

Type I

b

☐

Type II

c

☐

Type III - Functionally integrated

d

☐

Type III - Other

e

☒

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

f

☐

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

g

☐

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

(i)

a person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the the supported organization?

(ii)

a family member of a person described in (i) above?

(iii)

a 35% controlled entity of a person described in (i) or (ii) above?

h

☐

Provide the following information about the supported organization(s)

| | Yes | No |
|----------|-----|----|
| 11g(i) | | No |
| 11g(ii) | | No |
| 11g(iii) | | No |

| (i) Name of supported organization | (ii) EIN | (iii) Type of organization (described on lines 1- 9 above or IRC section (see instructions)) | (iv) Is the organization in col (i) listed in your governing document? | | (v) Did you notify the organization in col (i) of your support? | | (vi) Is the organization in col (i) organized in the U S ? | | (vii) Amount of support? |
|---|-------------|---|---|----|--|----|---|----|-----------------------------|
| | | | Yes | No | Yes | No | Yes | No | |
| (A) MOUNT CARMEL NEW ALBANY SURGICAL HOSPITAL | 870790288 | 3 | | No | Yes | | Yes | | 0 |
| (B) MOUNT CARMEL HEALTH | 314379602 | 3 | | No | Yes | | Yes | | 0 |
| (C) ST ANN'S HOSPITAL | 314412701 | 3 | | No | Yes | | Yes | | 0 |
| (D) TRINITY HEALTH CORPORATION | 351443425 | 11 | Yes | | Yes | | Yes | | 13,914,000 |
| (E) DILEY RIDGE MEDICAL CENTER | 342032340 | 3 | | No | Yes | | Yes | | 0 |
| Total | | | | | | | | | 13,914,000 |

Part II

Support Schedule for Organizations Described in IRC 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)
(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

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

| Section B. Total Support | | | | | | | |
|---|--|----------|----------|----------|----------|----------|-----------|
| Calendar year (or fiscal year beginning in) | | (a) 2007 | (b) 2008 | (c) 2009 | (d) 2010 | (e) 2011 | (f) Total |
| 7 | Amounts from line 4 | | | | | | |
| 8 | Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources | | | | | | |
| 9 | Net income from unrelated business activities, whether or not the business is regularly carried on | | | | | | |
| 10 | Other income (Explain in Part IV) Do not include gain or loss from the sale of capital assets | | | | | | |
| 11 | Total support (Add lines 7 through 10) | | | | | | |
| 12 | Gross receipts from related activities, etc (See instructions) | | | | | 12 | |
| 13 | First Five Years If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a 501(c)(3) organization, check this box and stop here | | | | | | |

| Section C. Computation of Public Support Percentage | | | |
|---|--|----|--|
| 14 | Public Support Percentage for 2011 (line 6 column (f) divided by line 11 column (f)) | 14 | |
| 15 | Public Support Percentage for 2010 Schedule A, Part II, line 14 | 15 | |
| 16a | 33 1/3% support test—2011. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization  | | |
| b | 33 1/3% support test—2010. If the organization did not check the box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization  | | |
| 17a | 10%-facts-and-circumstances test—2011. If the organization did not check a box on line 13, 16a, or 16b and line 14 is 10% or more, and if the organization meets the "facts and circumstances" test, check this box and stop here. Explain in Part IV how the organization meets the "facts and circumstances" test The organization qualifies as a publicly supported organization  | | |
| b | 10%-facts-and-circumstances test—2010. If the organization did not check a box on line 13, 16a, 16b, or 17a and line 15 is 10% or more, and if the organization meets the "facts and circumstances" test, check this box and stop here. Explain in Part IV how the organization meets the "facts and circumstances" test The organization qualifies as a publicly supported organization  | | |
| 18 | Private Foundation If the organization did not check a box on line 13, 16a, 16b, 17a or 17b, check this box and see instructions  | | |

Part IIIPart III

Support Schedule for Organizations Described in IRC 509(a)(2)
(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

| Section A. Public Support | | | | | | |
|--|----------|----------|----------|----------|----------|-----------|
| Calendar year (or fiscal year beginning in) | (a) 2007 | (b) 2008 | (c) 2009 | (d) 2010 | (e) 2011 | (f) Total |
| 1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.") | | | | | | |
| 2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose | | | | | | |
| 3 Gross receipts from activities that are not an unrelated trade or business under section 513 | | | | | | |
| 4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf | | | | | | |
| 5 The value of services or facilities furnished by a governmental unit to the organization without charge | | | | | | |
| 6 Total. Add lines 1 through 5 | | | | | | |
| 7a Amounts included on lines 1, 2, and 3 received from disqualified persons | | | | | | |
| b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year | | | | | | |
| c Add lines 7a and 7b | | | | | | |
| 8 Public Support (Subtract line 7c from line 6.) | | | | | | |

| Section B. Total Support | | | | | | |
|--|----------|----------|----------|----------|----------|-----------|
| Calendar year (or fiscal year beginning in) | (a) 2007 | (b) 2008 | (c) 2009 | (d) 2010 | (e) 2011 | (f) Total |
| 9 Amounts from line 6 | | | | | | |
| 10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources | | | | | | |
| b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975 | | | | | | |
| c Add lines 10a and 10b | | | | | | |
| 11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on | | | | | | |
| 12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.) | | | | | | |
| 13 Total support (Add lines 9, 10c, 11 and 12.) | | | | | | |
| 14 First Five Years If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a 501(c)(3) organization, check this box and stop here | | | | | | |

| Section C. Computation of Public Support Percentage | | |
|---|----|--|
| 15 Public Support Percentage for 2011 (line 8 column (f) divided by line 13 column (f)) | 15 | |
| 16 Public support percentage from 2010 Schedule A, Part III, line 15 | 16 | |

| Section D. Computation of Investment Income Percentage | | |
|--|----|--|
| 17 Investment income percentage for 2011 (line 10c column (f) divided by line 13 column (f)) | 17 | |
| 18 Investment income percentage from 2010 Schedule A, Part III, line 17 | 18 | |
| 19a 33 1/3% support tests—2011. If the organization did not check the box on line 14, and line 15 is more than 33 1/3% and line 17 is not more than 33 1/3%, check this box and stop here . The organization qualifies as a publicly supported organization | | |
| b 33 1/3% support tests—2010. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and stop here . The organization qualifies as a publicly supported organization | | |
| 20 Private Foundation If the organization did not check a box on line 14, 19a or 19b, check this box and see instructions | | |

Part IV **Supplemental Information.** Supplemental Information. Complete this part to provide the explanation required by Part II, line 10; Part II, line 17a or 17b; or Part III, line 12. Also complete this part for any additional information. (See instructions).

| |
|------------------------------|
| Facts And Circumstances Test |
| |

| |
|-------------|
| Explanation |
| |
| |
| |
| |

SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527
▶ **Complete if the organization is described below.**
▶ **Attach to Form 990 or Form 990-EZ.** ▶ **See separate instructions.**

OMB No 1545-0047

2011

Open to Public Inspection

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

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

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

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

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

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

| | |
|--|--|
| Name of the organization MOUNT CARMEL HEALTH SYSTEM | Employer identification number 31-1439334 |
|--|--|

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

| | | |
|---|--|------------|
| 1 | Provide a description of the organization's direct and indirect political campaign activities on behalf of or in opposition to candidates for public office in Part IV | |
| 2 | Political expenditures | ▶ \$ _____ |
| 3 | Volunteer hours | _____ |

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

| | | |
|----|---|--|
| 1 | Enter the amount of any excise tax incurred by the organization under section 4955 | ▶ \$ _____ |
| 2 | Enter the amount of any excise tax incurred by organization managers under section 4955 | ▶ \$ _____ |
| 3 | If the organization incurred a section 4955 tax, did it file Form 4720 for this year? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4a | Was a correction made? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b | If "Yes," describe in Part IV | |

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

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

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

Part II-A

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

- A
- Check
- ☐
- if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures)
- B
- Check
- ☐
- if the filing organization checked box A and "limited control" provisions apply

| Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.) | | (a) Filing Organization's Totals | (b) Affiliated Group Totals | | | | | | | | | | | | |
|--|---|---|--|--------------------|------------------------------|---|---|---|---|--|--|-------------------|-------------|--|--|
| 1a | Total lobbying expenditures to influence public opinion (grass roots lobbying) | | | | | | | | | | | | | | |
| b | Total lobbying expenditures to influence a legislative body (direct lobbying) | | | | | | | | | | | | | | |
| c | Total lobbying expenditures (add lines 1a and 1b) | | | | | | | | | | | | | | |
| d | Other exempt purpose expenditures | | | | | | | | | | | | | | |
| e | Total exempt purpose expenditures (add lines 1c and 1d) | | | | | | | | | | | | | | |
| f | Lobbying nontaxable amount Enter the amount from the following table in both columns | | | | | | | | | | | | | | |
| <table><tr><td>If the amount on line 1e, column (a) or (b) is:</td><td>The lobbying nontaxable amount is:</td></tr><tr><td>Not over \$500,000</td><td>20% of the amount on line 1e</td></tr><tr><td>Over \$500,000 but not over \$1,000,000</td><td>\$100,000 plus 15% of the excess over \$500,000</td></tr><tr><td>Over \$1,000,000 but not over \$1,500,000</td><td>\$175,000 plus 10% of the excess over \$1,000,000</td></tr><tr><td>Over \$1,500,000 but not over \$17,000,000</td><td>\$225,000 plus 5% of the excess over \$1,500,000</td></tr><tr><td>Over \$17,000,000</td><td>\$1,000,000</td></tr></table> | | If the amount on line 1e, column (a) or (b) is: | The lobbying nontaxable amount is: | Not over \$500,000 | 20% of the amount on line 1e | Over \$500,000 but not over \$1,000,000 | \$100,000 plus 15% of the excess over \$500,000 | Over \$1,000,000 but not over \$1,500,000 | \$175,000 plus 10% of the excess over \$1,000,000 | Over \$1,500,000 but not over \$17,000,000 | \$225,000 plus 5% of the excess over \$1,500,000 | Over \$17,000,000 | \$1,000,000 | | |
| If the amount on line 1e, column (a) or (b) is: | The lobbying nontaxable amount is: | | | | | | | | | | | | | | |
| Not over \$500,000 | 20% of the amount on line 1e | | | | | | | | | | | | | | |
| Over \$500,000 but not over \$1,000,000 | \$100,000 plus 15% of the excess over \$500,000 | | | | | | | | | | | | | | |
| Over \$1,000,000 but not over \$1,500,000 | \$175,000 plus 10% of the excess over \$1,000,000 | | | | | | | | | | | | | | |
| Over \$1,500,000 but not over \$17,000,000 | \$225,000 plus 5% of the excess over \$1,500,000 | | | | | | | | | | | | | | |
| Over \$17,000,000 | \$1,000,000 | | | | | | | | | | | | | | |
| g | Grassroots nontaxable amount (enter 25% of line 1f) | | | | | | | | | | | | | | |
| h | Subtract line 1g from line 1a If zero or less, enter -0- | | | | | | | | | | | | | | |
| i | Subtract line 1f from line 1c If zero or less, enter -0- | | | | | | | | | | | | | | |
| j | If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | |

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

| Lobbying Expenditures During 4-Year Averaging Period | | | | | |
|--|----------|----------|----------|----------|-----------|
| Calendar year (or fiscal year beginning in) | (a) 2008 | (b) 2009 | (c) 2010 | (d) 2011 | (e) Total |
| 2a Lobbying non-taxable amount | | | | | |
| b Lobbying ceiling amount (150% of line 2a, column(e)) | | | | | |
| c Total lobbying expenditures | | | | | |
| d Grassroots non-taxable amount | | | | | |
| e Grassroots ceiling amount (150% of line 2d, column (e)) | | | | | |
| f Grassroots lobbying expenditures | | | | | |

Part II-B

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

| | | (a) | | (b) |
|--|--|-----|----|---------|
| | | Yes | No | Amount |
| 1 | During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of | | | |
| | a Volunteers? | | No | |
| | b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)? | Yes | | |
| | c Media advertisements? | | No | |
| | d Mailings to members, legislators, or the public? | | No | |
| | e Publications, or published or broadcast statements? | | No | |
| | f Grants to other organizations for lobbying purposes? | Yes | | 10,620 |
| | g Direct contact with legislators, their staffs, government officials, or a legislative body? | Yes | | 143,808 |
| | h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means? | | No | |
| | i Other activities? If "Yes," describe in Part IV | | No | |
| | j Total lines 1c through 1i | | | 154,428 |
| | 2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)? | | No | |
| b If "Yes," enter the amount of any tax incurred under section 4912 | | | | |
| c If "Yes," enter the amount of any tax incurred by organization managers under section 4912 | | | | |
| d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year? | | | | |

Part III-A

Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).

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

Part III-B

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

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

Part IV

Supplemental Information

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

| Identifier | Return Reference | Explanation |
|------------------------------------|-------------------|--|
| EXPLANATION OF LOBBYING ACTIVITIES | PART II-B, LINE 1 | MOUNT CARMEL HEALTH SYSTEM HAS MADE GRANTS TO OTHER ORGANIZATIONS IN THE FORM OF MEMBERSHIP DUES PAID TO A NATIONAL HEALTH CARE ORGANIZATION. THIS ORGANIZATION HAS PROVIDED MOUNT CARMEL HEALTH SYSTEM WITH AN ESTIMATED PERCENTAGE OF DUES PAYMENTS WHICH ARE USED FOR LOBBYING ACTIVITIES. IN ADDITION, PAYMENTS WERE MADE TO LOBBYING FIRMS TO ASSIST WITH FEDERAL EARMARK REQUESTS AND STATE LEGISLATIVE ADVOCACY. MOUNT CARMEL HEALTH SYSTEM MADE NO CONTRIBUTIONS TO ANY LEGISLATORS OR CANDIDATES. |

SCHEDULE D
(Form 990)

Supplemental Financial Statements

OMB No 1545-0047

2011

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

| | |
|--|--|
| Name of the organization MOUNT CARMEL HEALTH SYSTEM | Employer identification number 31-1439334 |
|--|--|

Part I

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

| | | |
|---|--|------------------------------|
| | (a) Donor advised funds | (b) Funds and other accounts |
| 1 | Total number at end of year | |
| 2 | Aggregate contributions to (during year) | |
| 3 | Aggregate grants from (during year) | |
| 4 | Aggregate value at end of year | |
| 5 | Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div> | |
| 6 | Did the organization inform all grantees, donors, and donor advisors in writing that grant funds may be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div> | |

Part II

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

1

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

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

2

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

| | |
|---|--|
| | Held at the End of the Year |
| a | Total number of conservation easements |
| b | Total acreage restricted by conservation easements |
| c | Number of conservation easements on a certified historic structure included in (a) |
| d | Number of conservation easements included in (c) acquired after 8/17/06 |

3

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

4

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

5

Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?

☐ Yes ☐ No

6

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

7

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

8

Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and 170(h)(4)(B)(ii)?

☐ Yes ☐ No

9

In Part XIV, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements

Part III

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

1a

If the organization elected, as permitted under SFAS 116, not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education or research in furtherance of public service, provide, in Part XIV, the text of the footnote to its financial statements that describes these items

b

If the organization elected, as permitted under SFAS 116, to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items

(i)

Revenues included in Form 990, Part VIII, line 1

▶ \$ _____

(ii)

Assets included in Form 990, Part X

▶ \$ _____

2

If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 relating to these items

a

Revenues included in Form 990, Part VIII, line 1

▶ \$ _____

b

Assets included in Form 990, Part X

▶ \$ _____

For Privacy Act and Paperwork Reduction Act Notice, see the Intructions for Form 990

Cat No 52283D

Schedule D (Form 990) 2011

Part III

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

3

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

a

☐ Public exhibition

d

☐ Loan or exchange programs

b

☐ Scholarly research

e

☐ Other

c

☐ Preservation for future generations

4

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

5

During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection?

☐ Yes

☐ No

Part IV

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

1a

Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?

☐ Yes

☐ No

b

If "Yes," explain the arrangement in Part XIV and complete the following table

| | |
|----|--------|
| | Amount |
| 1c | |
| 1d | |
| 1e | |
| 1f | |

2a

Did the organization include an amount on Form 990, Part X, line 21?

☐ Yes

☐ No

b

If "Yes," explain the arrangement in Part XIV

Part V

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

| | | | | | |
|----|--|---------------|-------------------|---------------------|--------------------|
| | (a)Current Year | (b)Prior Year | (c)Two Years Back | (d)Three Years Back | (e)Four Years Back |
| 1a | Beginning of year balance | | | | |
| b | Contributions | | | | |
| c | Investment earnings or losses | | | | |
| d | Grants or scholarships | | | | |
| e | Other expenditures for facilities and programs | | | | |
| f | Administrative expenses | | | | |
| g | End of year balance | | | | |

2

Provide the estimated percentage of the year end balance held as

a

Board designated or quasi-endowment ▶

b

Permanent endowment ▶

c

Term endowment ▶

3a

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

(i) unrelated organizations

3a(i)

Yes

No

(ii) related organizations

3a(ii)

b

If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?

3b

4

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

Part VI

Land, Buildings, and Equipment. See Form 990, Part X, line 10.

| | | | | |
|--|--------------------------------------|--------------------------------|------------------------------|----------------|
| Description of property | (a) Cost or other basis (investment) | (b)Cost or other basis (other) | (c) Accumulated depreciation | (d) Book value |
| 1a Land | | 32,742,051 | | 32,742,051 |
| b Buildings | | 75,581,611 | 38,070,828 | 37,510,783 |
| c Leasehold improvements | | | | |
| d Equipment | | 120,414,431 | 105,980,168 | 14,434,263 |
| e Other | 6,930,323 | 2,273,335 | 15,247 | 9,188,411 |
| Total. Add lines 1a-1e (Column (d) should equal Form 990, Part X, column (B), line 10(c).) ▶ | | | | 93,875,508 |

Schedule D (Form 990) 2011

Part XI

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

| | | | |
|----|---|----|--|
| 1 | Total revenue (Form 990, Part VIII, column (A), line 12) | 1 | |
| 2 | Total expenses (Form 990, Part IX, column (A), line 25) | 2 | |
| 3 | Excess or (deficit) for the year Subtract line 2 from line 1 | 3 | |
| 4 | Net unrealized gains (losses) on investments | 4 | |
| 5 | Donated services and use of facilities | 5 | |
| 6 | Investment expenses | 6 | |
| 7 | Prior period adjustments | 7 | |
| 8 | Other (Describe in Part XIV) | 8 | |
| 9 | Total adjustments (net) Add lines 4 - 8 | 9 | |
| 10 | Excess or (deficit) for the year per financial statements Combine lines 3 and 9 | 10 | |

Part XII

Reconciliation of Revenue per Audited Financial Statements With Revenue per Return

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

Part XIII

Reconciliation of Expenses per Audited Financial Statements With Expenses per Return

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

Part XIV

Supplemental Information

Complete this part to provide the descriptions required for Part II, lines 3, 5, and 9, Part III, lines 1a and 4, Part IV, lines 1b and 2b, Part V, line 4, Part X, Part XI, line 8, Part XII, lines 2d and 4b, and Part XIII, lines 2d and 4b. Also complete this part to provide any additional information.

| Identifier | Return Reference | Explanation |
|------------|------------------|-------------|
|------------|------------------|-------------|

Schedule I
(Form 990)

Department of the Treasury
Internal Revenue Service

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

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

OMB No 1545-0047

2011

Open to Public
Inspection

Name of the organization
MOUNT CARMEL HEALTH SYSTEM

Employer identification number
31-1439334

Part I

General Information on Grants and Assistance

- 1

Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance?

Yes

✓

No
- 2

Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States

Part II

Grants and Other Assistance to Governments and Organizations in the United States. Complete if the organization answered "Yes" to Form 990, Part IV, line 21 for any recipient that received more than \$5,000. Check this box if no one recipient received more than \$5,000. Use Part IV and Schedule I-1 (Form 990) if additional space is needed ▶

| (a) Name and address of organization or government | (b) EIN | (c) IRC Code section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
|--|---------|------------------------------------|--------------------------|-----------------------------------|---|--|------------------------------------|
| See Additional Data Table | | | | | | | |
| | | | | | | | |
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2

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

15

3

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

5

Part III

Grants and Other Assistance to Individuals in the United States. Complete if the organization answered "Yes" to Form 990, Part IV, line 22.
Use Schedule I-1 (Form 990) if additional space is needed.

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

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

| Identifier | Return Reference | Explanation |
|--|------------------|--|
| PROCEDURE FOR MONITORING GRANTS IN THE U S | PART I, LINE 2 | SCHEDULE I, PART I, LINE 2 DONATIONS MADE BY MOUNT CARMEL HEALTH SYSTEM TO CHARITABLE ORGANIZATIONS ARE MADE IN FURTHERANCE OF THE RECIPIENT ORGANIZATION'S EXEMPT PURPOSE AND ARE CONSIDERED UNRESTRICTED WITH REGARD TO THE USE OF THE FUNDS |

Software ID:
Software Version:
EIN: 31-1439334
Name: MOUNT CARMEL HEALTH SYSTEM

Form 990, Schedule I, Part II, Grants and Other Assistance to Governments and Organizations in the United States

| (a) Name and address of organization or government | (b) EIN | (c) IRC Code section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
|--|------------|------------------------------------|--------------------------|-----------------------------------|---|--|------------------------------------|
| CAPITAL PARK FAMILY HEALTH CENTER INC882 HAMILTON ROAD WHITEHALL, OH 43213 | 38-3765547 | 501(C)3 | 266,666 | | | | COMMUNITY BENEFIT |
| AMERICAN HEART ASSOCIATION INC 7272 GREENVILLE AVE DALLAS, TX 75231 | 13-5613797 | 501(C)3 | 25,000 | | | | COMMUNITY BENEFIT |

Form 990,Schedule I, Part II, Grants and Other Assistance to Governments and Organizations in the United States

| (a) Name and address of organization or government | (b) EIN | (c) IRC Code section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
|--|------------|------------------------------------|--------------------------|-----------------------------------|---|--|------------------------------------|
| ARTHRITIS FOUNDATION INC 3740 RIDGE MILL DRIVE HILLIARD, OH 43026 | 31-4419290 | 501(C)3 | 5,000 | | | | COMMUNITY BENEFIT |
| WESTERVILLE AREA CHAMBER OF COMMERCE99 COMMERCE PARK DRIVE WESTERVILLE, OH 43082 | 31-0737083 | 501(C)6 | 8,325 | | | | COMMUNITY BENEFIT |

Form 990,Schedule I, Part II, Grants and Other Assistance to Governments and Organizations in the United States

| (a) Name and address of organization or government | (b) EIN | (c) IRC Code section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
|--|------------|------------------------------------|--------------------------|-----------------------------------|---|--|------------------------------------|
| LOWER LIGHTS CHRISTIAN HEALTH CENTER 1251 WEST BROAD STREET COLUMBUS, OH 43222 | 31-1810355 | 501(C)3 | 202,500 | | | | COMMUNITY BENEFIT |
| MARCH OF DIMES FOUNDATION 1275 MAMARONECK AVENUE WHITE PLAINS, NY 10605 | 13-1846366 | 501(C)3 | 5,000 | | | | COMMUNITY BENEFIT |

Form 990,Schedule I, Part II, Grants and Other Assistance to Governments and Organizations in the United States

| (a) Name and address of organization or government | (b) EIN | (c) IRC Code section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
|---|------------|------------------------------------|--------------------------|-----------------------------------|---|--|------------------------------------|
| GAHANNA CONVENTION AND VISITORS BUREAU 181 GRANVILLE STREET GAHANNA, OH 43230 | 80-0322167 | 501(C)6 | 25,020 | | | | COMMUNITY BENEFIT |
| WESTERVILLE PARKS FOUNDATION350 N CLEVELAND AVE WESTERVILLE, OH 43081 | 31-1719247 | 501(C)3 | 7,280 | | | | COMMUNITY BENEFIT |

Form 990, Schedule I, Part II, Grants and Other Assistance to Governments and Organizations in the United States

| (a) Name and address of organization or government | (b) EIN | (c) IRC Code section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
|--|----------------|---|---------------------------------|--|--|---|---|
| COUNCIL ON HEALTHY MOTHERS AND BABIESPO BOX 3384 DUBLIN, OH 43016 | 42-1546970 | 501(C)3 | 7,050 | | | | COMMUNITY BENEFIT |
| WESTERVILLE SUNRISE ROTARY FOUNDATIONPO BOX 1200 WESTERVILLE, OH 43086 | 31-1481931 | 501(C)3 | 10,000 | | | | COMMUNITY BENEFIT |

Form 990,Schedule I, Part II, Grants and Other Assistance to Governments and Organizations in the United States

| (a) Name and address of organization or government | (b) EIN | (c) IRC Code section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
|--|------------|------------------------------------|--------------------------|-----------------------------------|---|--|------------------------------------|
| FOUNDATION OF THE CATHOLIC DIOCESE OF COLUMBUS257 EAST BROAD STREET COLUMBUS, OH 43215 | 31-1116640 | 501(C)3 | 5,500 | | | | COMMUNITY BENEFIT |
| CHARITABLE PHARMACY OF CENTRAL OHIO200 E LIVINGSTON AVE COLUMBUS, OH 43215 | 27-0147099 | 501(C)3 | 25,000 | | | | COMMUNITY BENEFIT |

Form 990, Schedule I, Part II, Grants and Other Assistance to Governments and Organizations in the United States

| (a) Name and address of organization or government | (b) EIN | (c) IRC Code section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
|--|------------|------------------------------------|--------------------------|-----------------------------------|---|--|------------------------------------|
| DRESS FOR SUCCESS COLUMBUS2239 EAST 55TH STREET CLEVELAND, OH 44103 | 20-5112085 | 501(C)3 | 5,000 | | | | COMMUNITY BENEFIT |
| YOUNG MEN'S CHRISTIAN ASSOCIATION OF CENTRAL OHIO40 WEST LONG STREET COLUMBUS, OH 43215 | 31-4379594 | 501(C)3 | 5,000 | | | | COMMUNITY BENEFIT |

Form 990,Schedule I, Part II, Grants and Other Assistance to Governments and Organizations in the United States

| (a) Name and address of organization or government | (b) EIN | (c) IRC Code section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
|--|------------|------------------------------------|--------------------------|-----------------------------------|---|--|------------------------------------|
| NATIONWIDE CHILDREN'S HOSPITAL700 CHILDRENS HOSPITAL COLUMBUS,OH 43205 | 01-0782751 | 501(C)3 | 15,000 | | | | COMMUNITY BENEFIT |
| CHILDREN'S HUNGER ALLIANCE 370 SOUTH FIFTH STREET COLUMBUS,OH 43215 | 23-7303509 | 501(C)3 | 5,000 | | | | COMMUNITY BENEFIT |

Form 990,Schedule I, Part II, Grants and Other Assistance to Governments and Organizations in the United States

| (a) Name and address of organization or government | (b) EIN | (c) IRC Code section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV , appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
|--|------------|------------------------------------|--------------------------|-----------------------------------|--|--|------------------------------------|
| GROVE CITY AREA CHAMBER OF COMMERCE4069 BROADWAY GROVE CITY, OH 43123 | 31-0922925 | 501(C)6 | 15,000 | | | | COMMUNITY BENEFIT |
| ROTARY INTERNATIONAL CLUB OF WESTERVILLEPO BOX 595 WESTERVILLE, OH 43086 | 31-6050404 | 501(C)4 | 7,500 | | | | COMMUNITY BENEFIT |

Form 990, Schedule I, Part II, Grants and Other Assistance to Governments and Organizations in the United States

| (a) Name and address of organization or government | (b) EIN | (c) IRC Code section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
|--|------------|------------------------------------|--------------------------|-----------------------------------|---|--|------------------------------------|
| SIMON KENTON COUNCIL BOYSCOUTS OF AMERICA 1901 E DUBLIN GRANVILLE RD COLUMBUS, OH 43229 | 31-4388520 | 501(C)3 | 6,050 | | | | COMMUNITY BENEFIT |
| VIOLET FESTIVAL INC PO BOX 361 PICKERINGTON, OH 43147 | 31-1518034 | 501(C)4 | 20,000 | | | | COMMUNITY BENEFIT |

Schedule J
(Form 990)

Compensation Information

OMB No 1545-0047

2011

Open to Public Inspection

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

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

▶ Attach to Form 990. ▶ See separate instructions.

Name of the organization
MOUNT CARMEL HEALTH SYSTEM

Employer identification number

31-1439334

Part I

Questions Regarding Compensation

| | Yes | No |
|---|-----|----|
| <div><div>1a</div><div>Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a Complete Part III to provide any relevant information regarding these items</div><div><div><div><input type="checkbox"/> First-class or charter travel</div><div><input type="checkbox"/> Travel for companions</div><div><input type="checkbox"/> Tax idemnification and gross-up payments</div><div><input type="checkbox"/> Discretionary spending account</div></div><div><div><input type="checkbox"/> Housing allowance or residence for personal use</div><div><input type="checkbox"/> Payments for business use of personal residence</div><div><input type="checkbox"/> Health or social club dues or initiation fees</div><div><input type="checkbox"/> Personal services (e g , maid, chauffeur, chef)</div></div></div></div> | | |
| <div><div>1b</div><div>If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all the expenses described above? If "No," complete Part III to explain</div></div> | | |
| <div><div>2</div><div>Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all officers, directors, trustees, and the CEO/Executive Director, regarding the items checked in line 1a?</div></div> | | |
| <div><div>3</div><div>Indicate which, if any, of the following the organization uses to establish the compensation of the organization's CEO/Executive Director Check all that apply</div><div><div><div><input type="checkbox"/> Compensation committee</div><div><input type="checkbox"/> Independent compensation consultant</div><div><input type="checkbox"/> Form 990 of other organizations</div></div><div><div><input type="checkbox"/> Written employment contract</div><div><input type="checkbox"/> Compensation survey or study</div><div><input type="checkbox"/> Approval by the board or compensation committee</div></div></div></div> | | |
| <div><div>4</div><div>During the year, did any person listed in Form 990, Part VII, Section A, line 1a with respect to the filing organization or a related organization</div></div> | | |
| <div><div>4a</div><div>Receive a severance payment or change-of-control payment?</div></div> | | No |
| <div><div>4b</div><div>Participate in, or receive payment from, a supplemental nonqualified retirement plan?</div></div> | Yes | |
| <div><div>4c</div><div>Participate in, or receive payment from, an equity-based compensation arrangement?</div></div> | | No |
| <div><div></div><div>If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III</div></div> | | |
| <div><div></div><div>Only 501(c)(3) and 501(c)(4) organizations only must complete lines 5-9.</div></div> | | |
| <div><div>5</div><div>For persons listed in form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of</div></div> | | |
| <div><div>5a</div><div>The organization?</div></div> | | No |
| <div><div>5b</div><div>Any related organization?</div></div> | | No |
| <div><div></div><div>If "Yes," to line 5a or 5b, describe in Part III</div></div> | | |
| <div><div>6</div><div>For persons listed in form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of</div></div> | | |
| <div><div>6a</div><div>The organization?</div></div> | | No |
| <div><div>6b</div><div>Any related organization?</div></div> | | No |
| <div><div></div><div>If "Yes," to line 6a or 6b, describe in Part III</div></div> | | |
| <div><div>7</div><div>For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III</div></div> | | No |
| <div><div>8</div><div>Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regs section 53 4958-4(a)(3)? If "Yes," describe in Part III</div></div> | | No |
| <div><div>9</div><div>If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53 4958-6(c)?</div></div> | | |

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

[illegible]

Part III **Supplemental Information**

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

| Identifier | Return Reference | Explanation |
|------------|------------------|---|
| | PART I, LINE 3 | MOUNT CARMEL HEALTH SYSTEM IS A SUBSIDIARY IN THE TRINITY HEALTH SYSTEM. MOUNT CARMEL HEALTH SYSTEM'S CEO IS PAID DIRECTLY BY THE SYSTEM'S PARENT ENTITY, TRINITY HEALTH CORPORATION. TRINITY HEALTH CORPORATION USED THE FOLLOWING METHODS TO ESTABLISH THE COMPENSATION OF MOUNT CARMEL HEALTH SYSTEM'S CEO: - COMPENSATION COMMITTEE - INDEPENDENT COMPENSATION CONSULTANT - FORM 990 OF OTHER ORGANIZATIONS - WRITTEN EMPLOYMENT CONTRACT - COMPENSATION SURVEY OR STUDY, AND - APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE. |
| | PART I, LINE 4B | THE FOLLOWING ARE PARTICIPANTS IN THE TRINITY HEALTH PENSION RESTORATION PLAN, A NONQUALIFIED PLAN, WHICH PROVIDES RETIREMENT BENEFITS FOR CERTAIN ASSOCIATES WITH EARNINGS ABOVE THE IRS PAY CAP FOR QUALIFIED PLANS (\$245,000 FOR 2011). THE FOLLOWING ACCRUALS FOR 2011 FOR THIS PLAN ARE INCLUDED IN COLUMN C OF SCHEDULE J, PART II: KEDRICK ADKINS - \$91,607; MICHAEL MURPHY - \$27,513; J. RICHARD O'CONNELL - \$66,279; JOSEPH SWEDISH - \$255,902; CLAUS VON ZYCHLIN - \$52,433. PART I, LINE 4B: THE FOLLOWING ARE PARTICIPANTS IN A SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN (SERP). THE FOLLOWING SERP ACCRUALS FOR 2011 ARE INCLUDED IN COLUMN C OF SCHEDULE J, PART II: JANET MEEKS - \$46,500; JOSEPH SWEDISH - \$265,000. PART II: THE FOLLOWING INDIVIDUALS BECAME VESTED IN A SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN (SERP) DURING CALENDAR 2011. AS A RESULT, THE VESTED AMOUNTS WERE INCLUDED IN THEIR 2011 TAXABLE INCOMES. THE FOLLOWING VESTED SERP AMOUNTS ARE INCLUDED IN COLUMN B(III) OF SCHEDULE J, PART II: JOSEPH SWEDISH - \$2,740,000; KEDRICK ADKINS - \$220,648; RONALD WHITESIDE - \$1,364,200; CYNTHIA SHEETS - \$539,020. COLUMN F OF SCHEDULE J INCLUDES THE PORTION OF THESE AMOUNTS THAT WERE REPORTED AS DEFERRED COMPENSATION IN PRIOR YEARS. |

Software ID:

Software Version:

EIN: 31-1439334

Name: MOUNT CARMEL HEALTH SYSTEM

Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

| (A) Name | | (B) Breakdown of W-2 and/or 1099-MISC compensation | | | (C) Deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation reported in prior Form 990 or Form 990-EZ |
|---------------------|------|--|-------------------------------------|--------------------------|---------------------------|-------------------------|---------------------------------|--|
| | | (i) Base Compensation | (ii) Bonus & incentive compensation | (iii) Other compensation | | | | |
| CLAUS VON ZYCHLIN | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 482,336 | 173,932 | 86,523 | 72,419 | 28,373 | 843,583 | 0 |
| PHILLIP SHUBERT MD | (i) | 502,329 | 0 | 10,424 | 22,297 | 19,325 | 554,375 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| J RICHARD O'CONNELL | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 571,942 | 230,946 | 140,349 | 85,919 | 32,302 | 1,061,458 | 0 |
| JACQUELINE PRIMEAU | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 366,292 | 65,158 | 3,550 | 30,625 | 9,928 | 475,553 | 0 |
| RONALD WHITESIDE | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 378,136 | 94,027 | 1,369,918 | 36,370 | 20,176 | 1,898,627 | 555,919 |
| CYNTHIA SHEETS | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 319,151 | 75,983 | 540,654 | 35,619 | 9,671 | 981,078 | 83,384 |
| PAULA AUTRY | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 287,579 | 69,138 | 961 | 15,925 | 19,846 | 393,449 | 0 |
| JANET MEEKS | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 304,777 | 71,350 | 2,972 | 69,889 | 20,587 | 469,575 | 0 |
| JOHN HEISLER | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 297,988 | 61,070 | 54,512 | 20,751 | 16,230 | 450,551 | 0 |
| HUGH JONES | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 232,540 | 51,014 | 760 | 19,514 | 16,056 | 319,884 | 0 |
| JOSEPH SWEDISH | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 1,279,458 | 677,642 | 3,229,560 | 548,602 | 27,600 | 5,762,862 | 2,698,342 |
| KEDRICK ADKINS | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 743,978 | 316,652 | 344,596 | 103,857 | 13,263 | 1,522,346 | 143,708 |
| MICHAEL MURPHY | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 402,598 | 0 | 71,772 | 48,365 | 27,173 | 549,908 | 0 |
| RICHARD STRECK | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 404,035 | 103,629 | 3,994 | 20,564 | 20,021 | 552,243 | 0 |
| THOMAS BRONKEN | (i) | 262,523 | 18,583 | 1,140 | 18,856 | 15,879 | 316,981 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| MICHELE HELBIG | (i) | 187,739 | 40,553 | 1,123 | 22,527 | 16,341 | 268,283 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| MARY ANN WOLF | (i) | 199,550 | 26,154 | 1,941 | 28,428 | 9,244 | 265,317 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| GAYLE O'BRIEN | (i) | 176,626 | 21,063 | 3,788 | 15,129 | 8,091 | 224,697 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

| (A) Name | | (B) Breakdown of W-2 and/or 1099-MISC compensation | | | (C) Deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation reported in prior Form 990 or Form 990-EZ |
|-------------------|------|--|-------------------------------------|--------------------------|---------------------------|-------------------------|---------------------------------|--|
| | | (i) Base Compensation | (ii) Bonus & incentive compensation | (iii) Other compensation | | | | |
| MICHAEL SLUBOWSKI | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 13,394 | 0 | 137,444 | 500 | 601 | 151,939 | 136,445 |

Schedule L
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions with Interested Persons

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

OMB No 1545-0047

2011

Open to Public Inspection

Name of the organization
MOUNT CARMEL HEALTH SYSTEM

Employer identification number

31-1439334

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

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

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

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

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

Part II Loans to and/or From Interested Persons.

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

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

Part III Grants or Assistance Benefitting 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 grant or type of assistance |
|-------------------------------|--|--|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Part IV

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

| (a) Name of interested person | (b) Relationship between interested person and the organization | (c) Amount of transaction | (d) Description of transaction | (e) Sharing of organization's revenues? | |
|-------------------------------|---|---------------------------|--------------------------------|---|----|
| | | | | Yes | No |
| See Additional Data Table | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Part V

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

| Identifier | Return Reference | Explanation |
|------------|------------------|-------------|
|------------|------------------|-------------|

Additional Data

Software ID:
Software Version:
EIN: 31-1439334
Name: MOUNT CARMEL HEALTH SYSTEM

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

| (a) Name of interested person | (b) Relationship between interested person and the organization | (c) Amount of transaction \$ | (d) Description of transaction | (e) Sharing of organization's revenues? | |
|---|---|------------------------------|---|---|----|
| | | | | Yes | No |
| NEW ALBANY HOSPITAL MANAGEMENT COMPANY II LLC (NAHMC) | CARL BERASI, MCHS TRUSTEE, IS A PART OWNER, BD MEMBER & EMPLOYEE OF NAHMC | 2,223,168 | NEW ALBANY MANAGEMENT COMPANY II LLC CONTRACTS WITH MOUNT CARMEL HEALTH SYSTEM TO PROVIDE MANAGEMENT SERVICES TO MOUNT CARMEL NEW ALBANY SURGICAL HOSPITAL THESE TRANSACTIONS WERE ALL AT ARMS LENGTH | | No |
| PNC BANK | MICHAEL GONSIOROWSKI, MCHS TRUSTEE, IS REG PRES OF PNC'S CNTRL OH REGION | 227,131 | PNC BANK PROVIDES COMMERCIAL BANKING SERVICES TO MOUNT CARMEL HEALTH SYSTEM | | No |
| ANGELA SMITH | FAMILY MEMBER OF CYNTHIA SHEETS, KEY EMPLOYEE | 99,407 | EMPLOYMENT ARRANGEMENT | | No |
| THERESA ROSE SHUBERT | FAMILY MEMBER OF PHILLIP SHUBERT, MD, TRUSTEE | 10,894 | EMPLOYMENT ARRANGEMENT | | No |
| MCMC PROFESSIONAL OFFICE BUILDING III | DAVID STEWART, MCHS TRUSTEE, HAS A >5% OWNERSHIP INTEREST IN THIS J/V | 250,317 | MCHS RECEIVES INCOME AND DISTRIBUTIONS FROM ITS OWN PARTNERSHIP INTEREST IN MCMC PROF OFFICE BLDG III | | No |
| GREEN STREET SURGERY CENTER | ANANTHA PADMANABHAN, MCHS TRUSTEE, HAS A >5% OWNERSHIP INTEREST IN THIS J/V | 482,950 | MCHS RECEIVES RENTAL INCOME AND DISTRIBUTIONS FROM ITS OWN PARTNERSHIP INTEREST IN GREEN STREET SURGERY CENTER | | No |
| CARDINAL HEALTH INC | JORGE GOMEZ, MCHS TRUSTEE, IS AN OFFICER OF CARDINAL HEALTH | 401,475 | CARDINAL HEALTH PROVIDES MEDICAL PRODUCTS AND SERVICES TO MOUNT CARMEL HEALTH SYSTEM | | No |

SCHEDULE O

(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

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

OMB No 1545-0047

2011

Open to Public
Inspection

| | |
|--|--|
| Name of the organization MOUNT CARMEL HEALTH SYSTEM | Employer identification number 31-1439334 |
|--|--|

| Identifier | Return Reference | Explanation |
|------------|---|--|
| | FORM 990, PART VI, SECTION A, LINE 5 | A SENIOR MANAGEMENT ASSOCIATE OF MOUNT CARMEL HEALTH SYSTEM (MCHS) DIVERTED MCHS FUNDS TO PURCHASE GOODS AND SERVICES FOR PERSONAL USE THROUGH COLLUSION WITH ONE OR MORE MCHS VENDORS. THE APPROXIMATE VALUE OF THE GOODS AND SERVICES WAS \$863,000. MOUNT CARMEL HEALTH SYSTEM TERMINATED THE EMPLOYEE. THE RESULTS OF MCHS' INVESTIGATION WERE REFERRED TO LAW ENFORCEMENT OFFICIALS. THE FILING OF CRIMINAL CHARGES IS PENDING. |

| Identifier | Return Reference | Explanation |
|------------|--------------------------------------|--|
| | FORM 990, PART VI, SECTION A, LINE 6 | THE SOLE MEMBER OF MOUNT CARMEL HEALTH SYSTEM IS TRINITY HEALTH CORPORATION SEE LINE 7 FOR ADDITIONAL INFORMATION |

| Identifier | Return Reference | Explanation |
|------------|--|--|
| | FORM 990, PART VI, SECTION A, LINE 7A | TRINITY HEALTH CORPORATION IS THE SOLE MEMBER OF MOUNT CARMEL HEALTH SYSTEM. TRINITY HEALTH CORPORATION HAS THE RIGHT TO APPOINT ALL PERSONS TO THE BOARD OF TRUSTEES OF MOUNT CARMEL HEALTH SYSTEM. |

| Identifier | Return Reference | Explanation |
|------------|---------------------------------------|---|
| | FORM 990, PART VI, SECTION A, LINE 7B | AS SOLE MEMBER, TRINITY HEALTH CORPORATION MUST APPROVE CERTAIN DECISIONS OF THE GOVERNING BODY , INCLUDING THE STRATEGIC PLAN, ANNUAL CAPITAL PLAN, AND ANNUAL OPERATING BUDGET TRINITY HEALTH CORPORATION MUST ALSO APPROVE SIGNIFICANT CHANGES SUCH AS A MERGER, DISSOLUTION, SALE OF ASSETS IN EXCESS OF CERTAIN LIMITS, A MATERIAL CHANGE IN MISSION, AND MODIFICATIONS TO GOVERNING DOCUMENTS |

| Identifier | Return Reference | Explanation |
|------------|---------------------------------------|--|
| | FORM 990, PART VI, SECTION B, LINE 11 | PRIOR TO FILING, THE FORM 990 FOR MOUNT CARMEL HEALTH SY STEM IS REVIEWED BY SENIOR MANAGEMENT IN ADDITION, CERTAIN KEY SECTIONS OF THE FORM ARE REVIEWED BY THE FINANCE COMMITTEE AS WELL AS THE BOARD OF TRUSTEES THE BOARD RECEIVES A COPY OF THE RETURN IN ITS FINAL FORM BEFORE IT IS FILED WITH THE INTERNAL REVENUE SERVICE |

| Identifier | Return Reference | Explanation |
|------------|---|---|
| | FORM 990, PART VI, SECTION B, LINE 12C | MOUNT CARMEL HEALTH SYSTEM HAS ADOPTED A CONFLICT OF INTEREST POLICY WHICH CONTAINS THE ELEMENTS IN THE MODEL CONFLICT OF INTEREST POLICY ISSUED BY THE IRS. IT APPLIES TO ALL "INTERESTED PERSONS" OF MOUNT CARMEL HEALTH SYSTEM, WHICH INCLUDES TRUSTEES, PRINCIPAL OFFICERS AND EXECUTIVES, AND MEMBERS OF COMMITTEES WITH BOARD DESIGNATED POWERS. INTERESTED PERSONS ARE REQUIRED TO ACT AT ALL TIMES IN A MANNER CONSISTENT WITH MOUNT CARMEL HEALTH SYSTEM'S CHARITABLE PURPOSE AND SERVICE TO THE COMMUNITY AND TO AVOID CONFLICTS OF INTEREST. INTERESTED PERSONS ARE REQUIRED TO MAKE FULL DISCLOSURE TO MOUNT CARMEL HEALTH SYSTEM OF ANY FINANCIAL OR BUSINESS INTERESTS THAT MIGHT RESULT IN OR HAVE THE APPEARANCE OF A CONFLICT OF INTEREST. INTERESTED PERSONS ARE REQUIRED TO RECUSE THEMSELVES FROM DISCUSSION AND VOTING ON MATTERS INVOLVING A CONFLICT OF INTEREST. THE BOARD OF TRUSTEES OF MOUNT CARMEL HEALTH SYSTEM IS RESPONSIBLE FOR THE REVIEW AND APPROVAL OF TRANSACTIONS WITH INTERESTED PERSONS, INCLUDING DETERMINING THAT SUCH TRANSACTIONS ARE FAIR AND REASONABLE TO MOUNT CARMEL HEALTH SYSTEM ON AN ANNUAL BASIS. INTERESTED PERSONS ARE REQUIRED TO COMPLETE A CONFLICT OF INTEREST DISCLOSURE STATEMENT AND TO AFFIRM THEIR RECEIPT OF THE CONFLICT OF INTEREST POLICY, COMPLIANCE WITH ITS REQUIREMENTS, AND AGREE TO NOTIFY THE ORGANIZATION OF CHANGES IMPACTING THEIR ANNUAL DISCLOSURE IN ACCORDANCE WITH THE POLICY. THE ANNUAL DISCLOSURES ARE REVIEWED WITH THE BOARD OF TRUSTEES OF MOUNT CARMEL HEALTH SYSTEM ON AN ANNUAL BASIS. |

| Identifier | Return Reference | Explanation |
|------------|--|--|
| | FORM 990, PART VI, SECTION B, LINE 15 | TRINITY HEALTH FOLLOWS A PROCESS AND POLICY THAT IS INTENDED TO MIRROR THE IRC SECTION 4958 GUIDELINES FOR OBTAINING A "REBUTTABLE PRESUMPTION OF REASONABLENESS" WITH REGARD TO COMPENSATION AND BENEFITS AS PART OF THAT PROCESS, THE COMPENSATION AND BENEFITS OF CERTAIN OFFICERS AND KEY MANAGEMENT OFFICIALS OF MOUNT CARMEL HEALTH SYSTEM ARE REVIEWED AT LEAST ANNUALLY BY THE TRINITY HEALTH BOARD OR THE TRINITY HEALTH HUMAN RESOURCES AND COMPENSATION COMMITTEE (HRCC) OF THE BOARD, AUTHORIZED TO ACT ON BEHALF OF THE BOARD WITH RESPECT TO CERTAIN COMPENSATION MATTERS AS PART OF ITS REVIEW PROCESS, THE HRCC RETAINS AN INDEPENDENT FIRM EXPERIENCED IN COMPENSATION AND BENEFIT MATTERS FOR NOT-FOR-PROFIT HEALTHCARE ORGANIZATIONS TO ADVISE IT IN THE DETERMINATIONS IT MAKES ON THE REASONABLENESS OF PROPOSED COMPENSATION AND BENEFITS ARRANGEMENTS |

| Identifier | Return Reference | Explanation |
|------------|---------------------------------------|---|
| | FORM 990, PART VI, SECTION C, LINE 19 | MOUNT CARMEL HEALTH SYSTEM IS A SUBSIDIARY ORGANIZATION IN THE TRINITY HEALTH SYSTEM. TRINITY HEALTH MAKES CERTAIN OF ITS KEY DOCUMENTS AVAILABLE TO THE PUBLIC ON ITS WEBSITE, WWW.TRINITY-HEALTH.ORG, IN THE "ABOUT US" SECTION. IN THIS SECTION, THE ANNUAL REPORT (WHICH INCLUDES COMMUNITY BENEFIT MINISTRY INFORMATION) AND CONSOLIDATED AUDITED FINANCIAL STATEMENTS ARE PUBLICLY AVAILABLE. |

| Identifier | Return Reference | Explanation |
|---|---|---|
| ESTIMATE OF THE AVERAGE HOURS PER WEEK DEVOTED TO RELATED ORGANIZATIONS | FORM 990, PART VII, SECTION A, COLUMN B | THE HOURS LISTED IN COLUMN B OF PART VII, SECTION A, LINE 1 REFLECT ONLY THE INDIVIDUALS' AVERAGE WEEKLY HOURS SPENT DIRECTLY ON THE ACTIVITIES OF THE REPORTING ORGANIZATION. IN ADDITION, THESE ARE THE AVERAGE HOURS PER WEEK DEVOTED TO RELATED ORGANIZATIONS: KEDRICK ADKINS - 53 HOURS; PAULA AUTRY - 53 HOURS; JOHN HEISLER - 39 HOURS; HUGH JONES - 39 HOURS; JANET MEEKS - 53 HOURS; MICHAEL MURPHY - 53 HOURS; J. RICHARD O'CONNELL - 53 HOURS; JACQUELINE PRIMEAU - 48 HOURS; CYNTHIA SHEETS - 16 HOURS; PHILLIP SHUBERT, MD - 53 HOURS; JOSEPH SWEDISH - 53 HOURS; CLAUD VON ZYCHLIN - 48 HOURS; RONALD WHITESIDE - 44 HOURS. |

| Identifier | Return Reference | Explanation |
|--|---------------------------|--|
| CHANGES IN NET ASSETS OR FUND BALANCES | FORM 990, PART XI, LINE 5 | NET UNREALIZED LOSSES ON INVESTMENTS -19,027,436 EQUITY TRANSFERS FROM AFFILIATES 34,174,971 OTHER 8,854,138 TOTAL TO FORM 990, PART XI, LINE 5 24,001,673 |

| Identifier | Return Reference | Explanation |
|------------|----------------------------------|---|
| | FORM 990, PART XII, LINE 2 | MOUNT CARMEL HEALTH SYSTEM'S FINANCIAL INFORMATION WAS INCLUDED IN THE FY 12 CONSOLIDATED FINANCIAL STATEMENTS OF MOUNT CARMEL HEALTH SYSTEM, AS WELL AS THE CONSOLIDATED FINANCIAL STATEMENTS OF TRINITY HEALTH BOTH SETS OF CONSOLIDATED FINANCIAL STATEMENTS WERE AUDITED BY AN INDEPENDENT PUBLIC ACCOUNTING FIRM |

SCHEDULE R
(Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No 1545-0047

2011

Open to Public Inspection

Name of the organization
MOUNT CARMEL HEALTH SYSTEM

Employer identification number
31-1439334

Part I

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

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

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512(b)(13) controlled organization | |
|---|-------------------------|--|----------------------------|---|----------------------------------|---|----|
| | | | | | | Yes | No |
| See Additional Data Table | | | | | | | |
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Part III

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Predominant income (related, unrelated, excluded from tax under sections 512- 514) | (f) Share of total income | (g) Share of end-of- year assets | (h) Disproportionate allocations? | | (i) Code V—UBI amount in box 20 of Schedule K-1 (Form 1065) | (j) General or managing partner? | | (k) Percentage ownership |
|---|-------------------------|--|-------------------------------------|---|---------------------------------|---|---|----|---|---|----|--------------------------------|
| | | | | | | | Yes | No | | Yes | No | |
| See Additional Data Table | | | | | | | | | | | | |
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Part IV

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income | (g) Share of end-of-year assets | (h) Percentage ownership |
|---|-------------------------|---|-------------------------------------|--|---------------------------------|--|--------------------------------|
| See Additional Data Table | | | | | | | |
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Part V

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

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

1

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

a

Receipt of (i) interest (ii) annuities (iii) royalties (iv) rent from a controlled entity

b

Gift, grant, or capital contribution to related organization(s)

c

Gift, grant, or capital contribution from related organization(s)

d

Loans or loan guarantees to or for related organization(s)

e

Loans or loan guarantees by related organization(s)

f

Sale of assets to related organization(s)

g

Purchase of assets from related organization(s)

h

Exchange of assets with related organization(s)

i

Lease of facilities, equipment, or other assets to related organization(s)

j

Lease of facilities, equipment, or other assets from related organization(s)

k

Performance of services or membership or fundraising solicitations for related organization(s)

l

Performance of services or membership or fundraising solicitations by related organization(s)

m

Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)

n

Sharing of paid employees with related organization(s)

o

Reimbursement paid to related organization(s) for expenses

p

Reimbursement paid by related organization(s) for expenses

q

Other transfer of cash or property to related organization(s)

r

Other transfer of cash or property from related organization(s)

Yes

No

1a

Yes

1b

Yes

1c

Yes

1d

No

1e

Yes

1f

No

1g

No

1h

No

1i

No

1j

Yes

1k

Yes

1l

Yes

1m

No

1n

No

1o

Yes

1p

Yes

1q

Yes

1r

No

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

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

Schedule R (Form 990) 2011

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

[illegible]

Part VII

Supplemental Information

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

| Identifier | Return Reference | Explanation | |
|------------|------------------|-------------|--|
|------------|------------------|-------------|--|

Software ID:
Software Version:
EIN: 31-1439334
Name: MOUNT CARMEL HEALTH SYSTEM

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

| (a) Name, address, and EIN of related organization | (b) Primary Activity | (c) Legal Domicile (State or Foreign Country) | (d) Exempt Code section | (e) Public charity status (if 501(c) (3)) | (f) Direct Controlling Entity | g Section 512 (b)(13) controlled organization | |
|---|--|--|----------------------------------|--|---|---|----|
| ADVANTAGE HEALTHSAINT MARY'S MEDICAL GROUP 245 STATE ST SE GRAND RAPIDS, MI 49503 27-2491974 | HEALTHCARE SERVICES | MI | 501(C) (3) | 9 | TRINITY HEALTH- MICHIGAN | | No |
| AMICARE HOSPICE SERVICES INC 20555 VICTOR PARKWAY LIVONIA, MI 48152 38-2949053 | PROVIDE HOSPICE SERVICES | MI | 501(C) (3) | 11, TYPE I | TRINITY HOME HEALTH SERVICES INC | | No |
| AUXILIARY OF HOLY ROSARY HOSPITAL 351 SW 9TH STREET ONTARIO, OR 97914 94-3059469 | SUPPORTS SERVICES OF RELATED HOSPITAL | OR | 501(C) (3) | 9 | SAINT ALPHONSUS MEDICAL CENTER- ONTARIO | | No |
| BAUM HARMON MERCY HOSPITAL 255 NORTH WELCH AVENUE PRIMGHAR, IA 51245 42-1500277 | ACUTE/AMBULATORY HEALTHCARE SERVICES | IA | 501(C) (3) | 3 | MERCY HEALTH SERVICES-IOWA CORP | | No |
| BAUM HARMON MERCY HOSPITAL & CLINICS FOUNDATION 255 NORTH WELCH AVENUE PRIMGHAR, IA 51245 26-2973307 | SUPPORT THE SERVICES OF RELATED HOSPITAL | IA | 501(C) (3) | 11, TYPE I | BAUM HARMON MERCY HOSPITAL | | No |
| CATHERINE MCAULEY HEALTH SERVICES CORP PO BOX 995 ANN ARBOR, MI 48106 38-2507173 | FURTHER TRINITY HEALTH ACTIVITIES, ORGANIZE AND DEVELOP MEDICAL SERVICES | MI | 501(C) (3) | 11, TYPE II | TRINITY HEALTH- MICHIGAN | | No |
| COMMUNITY HEALTH PARTNERS OF SOUTH BEND PO BOX 3998 SOUTH BEND, IN 46619 26-3051440 | HEALTHCARE SERVICES | IN | 501(C) (3) | 3 | SAINT JOSEPH REGIONAL MEDICAL CENTER INC | | No |
| CRANBROOK HOSPICE CARE 281 ENTERPRISE COURT BLOOMFIELD HILLS, MI 48302 38-3320699 | PROVIDE HOSPICE HEALTH SERVICES | MI | 501(C) (3) | 11, TYPE I | TRINITY HOME HEALTH SERVICES INC | | No |
| DILEY RIDGE MEDICAL CENTER 6150 EAST BROAD STREET COLUMBUS, OH 43213 34-2032340 | HOSPITAL CAMPUS IN FAIRFIELD COUNTY OHIO | OH | 501(C) (3) | 3 | MOUNT CARMEL HEALTH SYSTEM | Yes | |
| DUBUQUE MERCY HEALTH FOUNDATION INC 250 MERCY DRIVE DUBUQUE, IA 52001 26-2227941 | SUPPORT THE SERVICES OF RELATED HOSPITAL | IA | 501(C) (3) | 11, TYPE I | MERCY HEALTH SERVICES-IOWA CORP | | No |
| DYERSVILLE HEALTH FOUNDATION INC 1111 3RD STREET SW DYERSVILLE, IA 52040 20-5383271 | SUPPORT THE SERVICES OF RELATED HOSPITAL | IA | 501(C) (3) | 11, TYPE I | MERCY HEALTH SERVICES-IOWA CORP | | No |
| GOTTLIEB COMMUNITY HEALTH SERVICES CORPORATION 701 W NORTH AVE MELROSE PARK, IL 60160 36-3332852 | SUPPORT THE SERVICES OF RELATED HOSPITAL | IL | 501(C) (3) | 9 | GOTTLIEB MEMORIAL HOSPITAL | | No |
| GOTTLIEB MEMORIAL FOUNDATION 701 W NORTH AVE MELROSE PARK, IL 60160 74-3260011 | SUPPORT THE SERVICES OF RELATED HOSPITAL | IL | 501(C) (3) | 11, TYPE III-FI | N/A | | No |
| GOTTLIEB MEMORIAL HOSPITAL 701 W NORTH AVE MELROSE PARK, IL 60160 36-2379649 | HEALTHCARE SERVICES | IL | 501(C) (3) | 3 | LOYOLA UNIVERSITY HEALTH SYSTEM | | No |
| HACKLEY HOSPITAL 1700 CLINTON ST PO BOX 3302 MUSKEGON, MI 494433302 38-1358196 | HEALTHCARE SERVICES | MI | 501(C) (3) | 3 | MERCY HEALTH PARTNERS | | No |
| HACKLEY HOSPITAL SELF INSURANCE PROFESSIONAL LIABILITY TRUST PO BOX 3302 MUSKEGON, MI 494433302 38-2299878 | SELF INSURANCE FOR GENERAL AND MALPRACTICE LIABILITY | MI | 501(C) (3) | 11, TYPE III-FI | MERCY HEALTH PARTNERS | | No |
| HACKLEY LIFE COUNSELING 1352 TERRACE ST MUSKEGON, MI 494423545 38-1386362 | COUNSELING, EDUCATION, AND SUPPORT | MI | 501(C) (3) | 9 | MERCY HEALTH PARTNERS | | No |
| HACKLEY VISITING NURSE SERVICES AND HOSPICE INC 888 TERRACE ST MUSKEGON, MI 49440 38-1359598 | PROVIDE HOME HEALTH CARE SERVICES | MI | 501(C) (3) | 7 | MERCY HEALTH PARTNERS | | No |
| HOLY CROSS CARENET INC PO BOX 9184 FARMINGTON HILLS, MI 48333 52-1945054 | LONG-TERM CARE AND REHABILITATION FOR THE ELDERLY | MD | 501(C) (3) | 9 | TRINITY CONTINUING CARE SERVICES | | No |
| HOLY CROSS HOSPITAL FOUNDATION INC 11801 TECH ROAD SILVER SPRING, MD 20904 20-8428450 | CHARITABLE FUNDRAISING | MD | 501(C) (3) | 11, TYPE I | HOLY CROSS HOSPITAL OF SILVER SPRING | | No |

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

| (a) Name, address, and EIN of related organization | (b) Primary Activity | (c) Legal Domicile (State or Foreign Country) | (d) Exempt Code section | (e) Public charity status (if 501(c) (3)) | (f) Direct Controlling Entity | (g) Section 512 (b)(13) controlled organization | |
|---|--|--|----------------------------------|--|--|---|----|
| HOLY CROSS HOSPITAL OF SILVER SPRING INC 1500 FOREST GLEN RD SILVER SPRING, MD 209101484 52-0738041 | HEALTHCARE SERVICES | MD | 501(C) (3) | 3 | TRINITY HEALTH CORPORATION | | No |
| HOLY CROSS MEDICAL CENTER 20555 VICTOR PARKWAY LIVONIA, MI 48152 95-1985442 | HEALTHCARE SERVICES (FORMERLY) | CA | 501(C) (3) | 3 | TRINITY HEALTH CORPORATION | | No |
| HOSPICE OF NORTH IOWA 232 SECOND STREET SE MASON CITY, IA 504016208 42-1173708 | HOSPICE HEALTH CARE SERVICES | IA | 501(C) (3) | 7 | MERCY HEALTH SERVICES-IOWA CORP | | No |
| HOSPICE OF WASHTENAW II 806 AIRPORT BLVD ANN ARBOR, MI 48108 38-3320707 | HOSPICE HEALTH CARE SERVICES | MI | 501(C) (3) | 11, TYPE I | TRINITY HEALTH- MICHIGAN | | No |
| HPCN 1675 LEAHY STREET MUSKEGON, MI 49442 30-0207909 | HEALTHCARE SERVICES | MI | 501(C) (3) | 11, TYPE II | MERCY HEALTH PARTNERS | | No |
| IHA HEALTH SERVICES CORPORATION 24 FRANK LLOYD WRIGHT DR LOBBY J ANN ARBOR, MI 48106 38-3316559 | PROVIDES OFFICE- BASED MEDICAL CARE | MI | 501(C) (3) | 9 | TRINITY HEALTH- MICHIGAN | | No |
| LAKESHORE COMMUNITY HOSPITAL INC 72 S STATE STREET SHELBY, MI 494551228 38-2549295 | ACUTE HEALTHCARE SERVICES | MI | 501(C) (3) | 3 | MERCY HEALTH PARTNERS | | No |
| LOYOLA UNIVERSITY HEALTH SYSTEM 2160 SOUTH FIRST AVENUE MAYWOOD, IL 60153 36-3342448 | HEALTHCARE SYSTEM MANAGEMENT AND SUPPORT | IL | 501(C) (3) | 11, TYPE II | TRINITY HEALTH CORPORATION | | No |
| LOYOLA UNIVERSITY MEDICAL CENTER 2160 SOUTH FIRST AVENUE MAYWOOD, IL 60153 36-4015560 | HEALTHCARE SERVICES | IL | 501(C) (3) | 3 | LOYOLA UNIVERSITY HEALTH SYSTEM | | No |
| MARIAN HOME HEALTHCARE 801 5TH STREET SIOUX CITY, IA 51101 38-3320705 | PROVIDE HOME HEALTH CARE SERVICES | IA | 501(C) (3) | 11, TYPE I | MERCY HEALTH SERVICES-IOWA CORP | | No |
| MCAULEY CLINIC CORPORATION PO BOX 992 ANN ARBOR, MI 48106 38-2561013 | HEALTHCARE SERVICES (FORMERLY) | MI | 501(C) (3) | 3 | CATHERINE MCAULEY HEALTH SERVICES CORP | | No |
| MERCY AMICARE HOME HEALTHCARE OAKLAND 281 ENTERPRISE COURT BLOOMFIELD HILLS, MI 483020312 38-3320698 | PROVIDE HOME HEALTH CARE SERVICES | MI | 501(C) (3) | 11, TYPE I | TRINITY HOME HEALTH SERVICES INC | | No |
| MERCY AMICARE HOME HEALTHCARE PORT HURON 505 HURON AVENUE PORT HURON, MI 48060 38-3320701 | PROVIDE HOME HEALTH CARE SERVICES | MI | 501(C) (3) | 11, TYPE I | TRINITY HOME HEALTH SERVICES INC | | No |
| MERCY FOUNDATION INC 2525 SOUTH MICHIGAN AVENUE CHICAGO, IL 60616 36-3227350 | SUPPORTS THE SERVICES OF RELATED HEALTH CARE SYSTEM | IL | 501(C) (3) | 11, TYPE I | MERCY HEALTH SYSTEM OF CHICAGO | | No |
| MERCY GENERAL HEALTH PARTNERS AMICARE HOMECARE 684 HARVEY STREET MUSKEGON, MI 49442 38-3321856 | PROVIDE HOME HEALTH CARE SERVICES | MI | 501(C) (3) | 11, TYPE I | TRINITY HOME HEALTH SERVICES INC | | No |
| MERCY HEALTH PARTNERS 1415 LEAHY STREET MUSKEGON, MI 49442 38-2589966 | HEALTHCARE SYSTEM SUPPORT | MI | 501(C) (3) | 11, TYPE I | TRINITY HEALTH- MICHIGAN | | No |
| MERCY HEALTH SERVICES - IOWA CORP 1000 4TH STREET SW MASON CITY, IA 50401 31-1373080 | HEALTHCARE SERVICES | DE | 501(C) (3) | 3 | TRINITY HEALTH- MICHIGAN | | No |
| MERCY HEALTH SYSTEM OF CHICAGO 2525 SOUTH MICHIGAN AVENUE CHICAGO, IL 60616 36-3163327 | HEALTHCARE SYSTEM MANAGEMENT AND SUPPORT | IL | 501(C) (3) | 11, TYPE I | TRINITY HEALTH CORPORATION | | No |
| MERCY HEALTH SYSTEM OF CHICAGO LIABILITY SELF INSURANCE TRUST BK OF AMERICA 231 S LASALLE CHICAGO, IL 60697 91-2092113 | SELF INSURANCE FOR PROFESSIONAL AND COMPREHENSIVE LIABILITY | IL | 501(C) (3) | 11, TYPE III-FI | MERCY HEALTH SYSTEM OF CHICAGO | | No |
| MERCY HEALTHCARE FOUNDATION 1410 N 4TH ST CLINTON, IA 52732 42-1316126 | FUNDRAISING AND FINANCIAL ASSISTANCE FOR HOSPITAL CHARITABLE SERVICES | IA | 501(C) (3) | 11, TYPE I | MERCY MEDICAL CENTER-CLINTON | | No |

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

| (a) Name, address, and EIN of related organization | (b) Primary Activity | (c) Legal Domicile (State or Foreign Country) | (d) Exempt Code section | (e) Public charity status (if 501(c) (3)) | (f) Direct Controlling Entity | (g) Section 512 (b)(13) controlled organization | |
|---|---|--|----------------------------------|--|--|---|----|
| MERCY HOSPITAL AND MEDICAL CENTER 2525 SOUTH MICHIGAN AVENUE CHICAGO, IL 60616 36-2170152 | HEALTHCARE SERVICES | IL | 501(C) (3) | 3 | MERCY HEALTH SYSTEM OF CHICAGO | | No |
| MERCY HOSPITAL CADILLAC FOUNDATION 400 HOBART CADILLAC, MI 496012331 20-3357131 | SUPPORT THE SERVICES OF RELATED HOSPITAL | MI | 501(C) (3) | 11, TYPE I | TRINITY HEALTH- MICHIGAN | | No |
| MERCY HOSPITAL GIFT SHOP 2601 ELECTRIC AVE PORT HURON, MI 48060 38-1630480 | VOLUNTEER SERVICE AUXILIARY | MI | 501(C) (3) | 11, TYPE I | TRINITY HEALTH- MICHIGAN | | No |
| MERCY MEDICAL CENTER - CLINTON INC 1410 NORTH 4TH ST CLINTON, IA 527322940 42-1336618 | TO PROVIDE QUALITY HEALTH CARE | DE | 501(C) (3) | 3 | MERCY HEALTH SERVICES-IOWA CORP | | No |
| MERCY MEDICAL CENTER - SIOUX CITY FOUNDATION 801 5TH STREET SIOUX CITY, IA 51102 14-1880022 | SUPPORT THE SERVICES OF RELATED HOSPITAL | IA | 501(C) (3) | 7 | MERCY HEALTH SERVICES-IOWA CORP | | No |
| MERCY MEDICAL CENTER FOUNDATION - NORTH IOWA 1000 4TH STREET SW MASON CITY, IA 504012800 42-1229151 | SUPPORT THE SERVICES OF RELATED HOSPITAL | IA | 501(C) (3) | 11, TYPE III-FI | MERCY HEALTH SERVICES-IOWA CORP | | No |
| MERCY NORTH HOMECARE AND HOSPICE 7985 MACKINAW TRAIL CADILLAC, MI 49601 38-3313897 | HOME HEALTH AND HOSPICE SERVICES | MI | 501(C) (3) | 11, TYPE I | TRINITY HOME HEALTH SERVICES INC | | No |
| MERCY PHYSICIAN GROUP INC 1512 12TH AVENUE ROAD NAMPA, ID 83686 20-8192593 | TO PROVIDE QUALITY HEALTH CARE | ID | 501(C) (3) | 9 | SAINT ALPHONSUS MEDICAL CENTER- NAMPA | | No |
| MERCY SERVICES FOR AGING NON-PROFIT HOUSING CORPORATION PO BOX 9184 FARMINGTON HILLS, MI 483339184 38-2719605 | PROVIDES LONG- TERM CARE FOR THE ELDERLY | MI | 501(C) (3) | 11, TYPE II | TRINITY CONTINUING CARE SERVICES INC | | No |
| MIDWEST MEDFLIGHT 1300 VICTORS WAY ANN ARBOR, MI 48108 38-2684671 | AEROMEDICAL TRANSPORT | MI | 501(C) (3) | 9 | TRINITY HEALTH- MICHIGAN | | No |
| MOUNT CARMEL CARE CONTINUUM SERVICES CORP 793 WEST STATE STREET COLUMBUS, OH 43222 31-1126211 | COOPERATIVE HOSPITAL SERVICE ORGANIZATION | OH | 501(C) (3) | 3 | MOUNT CARMEL HEALTH SYSTEM | Yes | |
| MOUNT CARMEL COLLEGE OF NURSING 6150 EAST BROAD STREET COLUMBUS, OH 43213 31-1308555 | COLLEGE OF NURSING | OH | 501(C) (3) | 2 | MOUNT CARMEL HEALTH | Yes | |
| MOUNT CARMEL HEALTH 6150 EAST BROAD STREET COLUMBUS, OH 43213 31-4379602 | HEALTHCARE SERVICES | OH | 501(C) (3) | 3 | MOUNT CARMEL HEALTH SYSTEM | Yes | |
| MOUNT CARMEL HEALTH INSURANCE COMPANY 6150 EAST BROAD STREET COLUMBUS, OH 43213 25-1912781 | HEALTH INSURANCE | OH | 501(C) (4) | N/A | MOUNT CARMEL HEALTH SYSTEM | Yes | |
| MOUNT CARMEL HEALTH PLAN INC 6150 EAST BROAD STREET COLUMBUS, OH 43213 31-1471229 | MEDICARE HMO FOR SENIORS | OH | 501(C) (4) | N/A | MOUNT CARMEL HEALTH SYSTEM | Yes | |
| MOUNT CARMEL HEALTH SYSTEM 6150 EAST BROAD STREET COLUMBUS, OH 43213 31-1439334 | HEALTHCARE SYSTEM MANAGEMENT AND SUPPORT | OH | 501(C) (3) | 11, TYPE I | TRINITY HEALTH CORPORATION | Yes | |
| MOUNT CARMEL HEALTH SYSTEM FOUNDATION 6150 EAST BROAD STREET COLUMBUS, OH 43213 31-1113966 | SUPPORT THE SERVICES OF RELATED HOSPITAL | OH | 501(C) (3) | 11, TYPE I | MOUNT CARMEL HEALTH SYSTEM | Yes | |
| MOUNT CARMEL HOME CARE LLC 1144 DUBLIN ROAD SUITE B COLUMBUS, OH 43215 26-2729300 | PROVIDE HOME HEALTH CARE SERVICES | OH | 501(C) (3) | 9 | TRINITY HOME HEALTH SERVICES INC | | No |
| MOUNT CARMEL NEW ALBANY SURGICAL HOSPITAL 7333 SMITHS MILL RD NEW ALBANY, OH 43054 87-0790288 | HEALTHCARE SERVICES | OH | 501(C) (3) | 3 | MOUNT CARMEL HEALTH SYSTEM | Yes | |
| MRI MOBILE SERVICES OF WEST MICHIGAN 1820 - 44TH STREET KENTWOOD, MI 49508 38-3073745 | OPERATE MAGNETIC IMAGING RESONANCE (FORMERLY) | MI | 501(C) (3) | 9 | TRINITY HEALTH- MICHIGAN | | No |

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

| (a) Name, address, and EIN of related organization | (b) Primary Activity | (c) Legal Domicile (State or Foreign Country) | (d) Exempt Code section | (e) Public charity status (if 501(c) (3)) | (f) Direct Controlling Entity | g Section 512 (b)(13) controlled organization | |
|---|---|--|----------------------------------|--|---|---|----|
| MUSKEGON COMMUNITY HEALTH PROJECT 565 W WESTERN AVENUE MUSKEGON, MI 49440 91-1932918 | FACILITATE AND COORDINATE HEALTHCARE AND RELATED SERVICES | MI | 501(C)(3) | 7 | MERCY HEALTH PARTNERS | | No |
| OAKLAND MERCY HOSPITAL 601 EAST 2ND STREET OAKLAND, NE 68045 20-8072234 | HEALTHCARE SERVICES | NE | 501(C)(3) | 3 | MERCY HEALTH SERVICES-IOWA CORP | | No |
| OAKLAND MERCY HOSPITAL FOUNDATION 601 E 2ND STREET OAKLAND, NE 68045 31-1678345 | SUPPORTS SERVICES OF RELATED HOSPITAL | NE | 501(C)(3) | 11, TYPE III-FI | OAKLAND MERCY HOSPITAL | | No |
| PORT HURON MERCY FAMILY CARE INC 2601 ELECTRIC AVE PORT HURON, MI 48060 20-1855647 | HEALTHCARE SERVICES | MI | 501(C)(3) | 11, TYPE I | TRINITY HEALTH-MICHIGAN | | No |
| PROFESSIONAL MED TEAM 965 FORK STREET MUSKEGON, MI 494423257 38-2638284 | MEDICAL CARE, TRANSPORTATION AND EDUCATION | MI | 501(C)(3) | 9 | TRINITY HEALTH-MICHIGAN | | No |
| PROFESSIONAL OFFICE CORPORATION 1303 EAST HERNDON AVE FRESNO, CA 93720 94-2839324 | HEALTHCARE SERVICES | CA | 501(C)(3) | 11, TYPE I | SAINT AGNES MEDICAL CENTER | | No |
| SAINT AGNES MEDICAL CENTER 1303 EAST HERNDON AVE FRESNO, CA 93720 94-1437713 | HEALTHCARE SERVICES | CA | 501(C)(3) | 3 | TRINITY HEALTH CORPORATION | | No |
| SAINT ALPHONSUS BUILDING COMPANY INC 1055 NORTH CURTIS RD BOISE, ID 83706 82-0401011 | SUPPORTS SERVICES OF RELATED HOSPITAL | ID | 501(C)(3) | 11, TYPE I | SAINT ALPHONSUS REGIONAL MEDICAL CENTER INC | | No |
| SAINT ALPHONSUS DIVERSIFIED CARE INC 1055 NORTH CURTIS RD BOISE, ID 83706 94-3028978 | SUPPORTS SERVICES OF RELATED HOSPITAL | ID | 501(C)(3) | 11, TYPE I | SAINT ALPHONSUS REGIONAL MEDICAL CENTER INC | | No |
| SAINT ALPHONSUS FOUNDATION-BAKER CITY INC 3325 POCAHONTAS ROAD BAKER CITY, OR 97814 94-3164869 | SUPPORT THE SERVICES OF RELATED HOSPITAL | OR | 501(C)(3) | 7 | SAINT ALPHONSUS MEDICAL CENTER - BAKER CITY | | No |
| SAINT ALPHONSUS FOUNDATION-ONTARIO INC 351 SW 9TH STREET ONTARIO, OR 97914 20-2683560 | SUPPORT THE SERVICES OF RELATED HOSPITAL | OR | 501(C)(3) | 11, TYPE I | SAINT ALPHONSUS MEDICAL CENTER-ONTARIO | | No |
| SAINT ALPHONSUS HEALTH SYSTEM INC 1055 N CURTIS ROAD BOISE, ID 83706 27-1929502 | HEALTHCARE SYSTEM MANAGEMENT AND SUPPORT | ID | 501(C)(3) | 11, TYPE I | TRINITY HEALTH CORPORATION | | No |
| SAINT ALPHONSUS MEDICAL CENTER-BAKER CITY 3325 POCAHONTAS ROAD BAKER CITY, OR 97814 27-1790052 | TO PROVIDE QUALITY HEALTH CARE | OR | 501(C)(3) | 3 | SAINT ALPHONSUS HEALTH SYSTEM INC | | No |
| SAINT ALPHONSUS MEDICAL CENTER-NAMPA 1512 12TH AVENUE ROAD NAMPA, ID 83686 82-0200896 | TO PROVIDE QUALITY HEALTH CARE | ID | 501(C)(3) | 3 | SAINT ALPHONSUS HEALTH SYSTEM INC | | No |
| SAINT ALPHONSUS MEDICAL CENTER-NAMPA HEALTH FOUNDATION INC 1512 12TH AVENUE ROAD NAMPA, ID 83686 26-1737256 | SUPPORT THE SERVICES OF RELATED HOSPITAL | ID | 501(C)(3) | 7 | SAINT ALPHONSUS MEDICAL CENTER-NAMPA | | No |
| SAINT ALPHONSUS MEDICAL CENTER-ONTARIO 351 SW 9TH STREET ONTARIO, OR 97914 27-1789847 | TO PROVIDE QUALITY HEALTH CARE | OR | 501(C)(3) | 3 | SAINT ALPHONSUS HEALTH SYSTEM INC | | No |
| SAINT ALPHONSUS REGIONAL MEDICAL CENTER 1055 NORTH CURTIS RD BOISE, ID 83706 82-0200895 | HEALTHCARE SERVICES | ID | 501(C)(3) | 3 | SAINT ALPHONSUS HEALTH SYSTEM INC | | No |
| SAINT JOSEPH REGIONAL MEDICAL CENTER - PLYMOUTH CAMPUS INC 1915 LAKE AVENUE PO BOX 670 PLYMOUTH, IN 46563 35-1142669 | HEALTHCARE SERVICES | IN | 501(C)(3) | 3 | SAINT JOSEPH REGIONAL MEDICAL CENTER INC | | No |
| SAINT JOSEPH REGIONAL MEDICAL CENTER - SOUTH BEND CAMPUS INC PO BOX 1935 SOUTH BEND, IN 466341935 35-0868157 | HEALTHCARE SERVICES | IN | 501(C)(3) | 3 | SAINT JOSEPH REGIONAL MEDICAL CENTER INC | | No |
| SAINT JOSEPH REGIONAL MEDICAL CENTER MISHAWAKA AUXILIARY INC 5215 HOLY CROSS PARKWAY MISHAWAKA, IN 46545 35-6033285 | HOSPITAL SERVICE AUXILIARY | IN | 501(C)(4) | N/A | SAINT JOSEPH REGIONAL MEDICAL CENTER-S BEND | | No |

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

| (a) Name, address, and EIN of related organization | (b) Primary Activity | (c) Legal Domicile (State or Foreign Country) | (d) Exempt Code section | (e) Public charity status (if 501(c) (3)) | (f) Direct Controlling Entity | g Section 512 (b)(13) controlled organization | |
|--|--|--|----------------------------------|--|---|---|----|
| SAINT JOSEPH REGIONAL MEDICAL CENTER PLYMOUTH AUXILIARY INC 1915 LAKE AVENUE PLYMOUTH, IN 46563 35-6043563 | HOSPITAL SERVICE AUXILIARY | IN | 501(C) (3) | 11, TYPE II | SAINT JOSEPH REGIONAL MEDICAL CENTER- PLYMOUTH | | No |
| SAINT JOSEPH REGIONAL MEDICAL CENTER INC 801 EAST LASALLE AVE SOUTH BEND, IN 46617 35-1568821 | HEALTHCARE SYSTEM MANAGEMENT AND SUPPORT | IN | 501(C) (3) | 11, TYPE I | TRINITY HEALTH CORPORATION | | No |
| SAINT JOSEPH'S TOWER INC PO BOX 9184 FARMINGTON HILLS, MI 483339184 31-1040468 | PROVIDES HOUSING FOR LOW INCOME ELDERLY INDIVIDUALS | IN | 501(C) (3) | 9 | TRINITY CONTINUING CARE SERVICES- INDIANA | | No |
| SAINT MARY'S AMICARE HOME HEALTHCARE 1430 MONROE NW GRAND RAPIDS, MI 49505 38-3320700 | PROVIDE HOME HEALTH CARE SERVICES | MI | 501(C) (3) | 11, TYPE I | TRINITY HOME HEALTH SERVICES INC | | No |
| SAINT MARY'S FOUNDATION (FKA SAINT MARY'S DORAN FOUNDATION) 200 JEFFERSON ST SE GRAND RAPIDS, MI 49503 38-1779602 | SUPPORTS SERVICES OF RELATED HOSPITAL | MI | 501(C) (3) | 7 | TRINITY HEALTH- MICHIGAN | | No |
| ST JOSEPH MERCY OAKLAND FOUNDATION 44405 WOODWARD AVE PONTIAC, MI 48341 35-2356789 | SUPPORTS SERVICES OF RELATED HOSPITAL | MI | 501(C) (3) | 11, TYPE I | TRINITY HEALTH- MICHIGAN | | No |
| ST ANN'S HOSPITAL 500 SOUTH CLEVELAND AVE WESTERVILLE, OH 43081 31-4412701 | HEALTHCARE SERVICES | OH | 501(C) (3) | 3 | MOUNT CARMEL HEALTH SYSTEM | Yes | |
| THE FOUNDATION OF SAINT JOSEPH REGIONAL MEDICAL CENTER 4215 EDISON LAKES PARKWAY MISHAWAKA, IN 46545 35-1654543 | SUPPORTS SERVICES OF RELATED HOSPITAL | IN | 501(C) (3) | 11, TYPE I | SAINT JOSEPH REGIONAL MEDICAL CENTER INC | | No |
| TRI-HOSPITAL MRI CENTER 4190 24TH AVENUE FORT GRATIOT, MI 48054 38-2884297 | MRI SERVICES | MI | 501(C) (3) | 3 | TRINITY HEALTH- MICHIGAN | | No |
| TRINITY CONTINUING CARE SERVICES PO BOX 9184 FARMINGTON HILLS, MI 483339184 38-2559656 | MANAGEMENT SERVICES FOR LONG TERM CARE AND SENIOR LIVING FACILITIES | MI | 501(C) (3) | 11, TYPE I | TRINITY HEALTH CORPORATION | | No |
| TRINITY CONTINUING CARE SERVICES - INDIANA INC PO BOX 9184 FARMINGTON HILLS, MI 483339184 93-0907047 | PROVIDES LONG- TERM CARE AND RESIDENTIAL HOUSING | IN | 501(C) (3) | 9 | TRINITY CONTINUING CARE SERVICES | | No |
| TRINITY HEALTH - MICHIGAN 20555 VICTOR PARKWAY LIVONIA, MI 48152 38-2113393 | HEALTHCARE SERVICES | MI | 501(C) (3) | 3 | TRINITY HEALTH CORPORATION | | No |
| TRINITY HEALTH CORPORATION 20555 VICTOR PARKWAY LIVONIA, MI 48152 35-1443425 | HEALTHCARE SYSTEM MANAGEMENT AND SUPPORT | IN | 501(C) (3) | 11, TYPE I | N/A | | No |
| TRINITY HEALTH INTERNATIONAL 20555 VICTOR PARKWAY LIVONIA, MI 48152 42-1253527 | HEALTHCARE TRAINING AND SUPPORT SERVICES | MI | 501(C) (3) | 11, TYPE I | TRINITY HEALTH CORPORATION | | No |
| TRINITY HEALTH WELFARE BENEFIT TRUST 20555 VICTOR PARKWAY LIVONIA, MI 48152 20-8151733 | RETIREE MEDICAL AND RETIREE LIFE INSURANCE COVERAGE | MI | 501(C) (9) | N/A | TRINITY HEALTH CORPORATION | | No |
| TRINITY HOME HEALTH SERVICES INC 17410 COLLEGE PARKWAY LIVONIA, MI 48152 38-2621935 | HOME HEALTH CARE SYSTEM MANAGEMENT SERVICES | MI | 501(C) (3) | 11, TYPE I | TRINITY HEALTH CORPORATION | | No |

Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal Domicile (State or Foreign Country) | (d) Direct Controlling Entity | (e) Predominant income (related, unrelated, excluded from tax under sections 512-514) | (f) Share of total income (\$) | (g) Share of end-of-year assets (\$) | (h) Disproportionate allocations? | | (i) Code V-UBI amount on Box 20 of K-1 (\$) | (j) General or Managing Partner? | | (k) Percentage ownership |
|---|-----------------------------------|--|----------------------------------|--|-----------------------------------|---|--------------------------------------|----|--|-------------------------------------|----|-----------------------------|
| | | | | | | | Yes | No | | Yes | No | |
| ADVENT REHABILITATION LLC 607 DEWEY AVENUE SUITE 300 GRAND RAPIDS, MI 49504 38-3306673 | REHABILITATION THERAPY SERVICES | MI | N/A | N/A | | | | No | | | No | |
| BIG RUN MEDICAL OFFICE BUILDING LIMITED PARTNERSHIP 793 W STATE STREET COLUMBUS, OH 43222 31-1608125 | MEDICAL OFFICE BUILDING RENTAL | OH | MOUNT CARMEL HEALTH SYSTEM | RELATED | 42,976 | 598,695 | | No | | Yes | | 50 000 % |
| CENTER FOR DIGESTIVE CARE LLC 5300 ELLIOTT DRIVE YPSILANTI, MI 48197 03-0447062 | PROVIDE GASTROINTESTINAL SERVICES | MI | N/A | N/A | | | | No | | | No | |
| CENTRAL OHIO SLEEP MEDICINE LTD 6150 EAST BROAD STREET COLUMBUS, OH 43213 31-1701029 | SLEEP MEDICINE SERVICES | OH | MOUNT CARMEL HEALTH SYSTEM | RELATED | 102,989 | 329,966 | | No | | | No | 60 000 % |
| CLINTON IMAGING SERVICES LLC 615 VALLEY VIEW DR STE 202 MOLINE, IL 61265 41-2044739 | MRI DIAGNOSTIC SERVICES | IA | N/A | N/A | | | | No | | | No | |
| FOREST PARK IMAGING LLC 1000 4TH STREET SW MASON CITY, IA 50401 13-4365966 | X-RAY AND MAMMOGRAPHY SERVICES | IA | N/A | N/A | | | | No | | | No | |
| FRANCES WARDE MEDICAL LABORATORY 300 WEST TEXTILE ROAD ANN ARBOR, MI 48104 38-2648446 | LABORATORY | MI | N/A | N/A | | | | No | | | No | |
| FRESNO IMAGING CENTER 1303 E HERNDON AVE FRESNO, CA 93720 77-0363563 | DIAGNOSTIC IMAGING | CA | N/A | N/A | | | | No | | | No | |
| HAWARDEN REGIONAL HEALTH CLINICS LLC 1122 AVENUE L HAWARDEN, IA 51023 20-1444339 | MEDICAL CLINIC | IA | N/A | N/A | | | | No | | | No | |
| IDAHO GYNONCOLOGY SERVICES LLC 1055 N CURTIS RD BOISE, ID 83706 20-2975807 | PROVIDE GYN ONCOLOGY SERVICES | ID | N/A | N/A | | | | No | | | No | |
| INTERMOUNTAIN MEDICAL IMAGING LLC 877 WEST MAIN ST STE 603 BOISE, ID 83702 82-0514422 | PROVIDE IMAGING SERVICES | ID | N/A | N/A | | | | No | | | No | |
| LOYOLA AMBULATORY SURGERY CENTER 1S224 SUMMIT AVE STE 201 OAKBROOK TERRACE, IL 60181 36-4119522 | SURGICAL SERVICES | IL | N/A | N/A | | | | No | | | No | |
| MAGNETIC RESONANCE SERVICES PARTNERSHIP 1416 SIXTH STREET SW MASON CITY, IA 50401 42-1328388 | MRI SERVICES | IA | N/A | N/A | | | | No | | | No | |
| MASON CITY AMBULATORY SURGERY CENTER LLC 990 4TH STREET SW MASON CITY, IA 50401 20-1960348 | SURGERY-SAME DAY | IA | N/A | N/A | | | | No | | | No | |
| MCE MOB IV LIMITED PARTNERSHIP 793 W STATE STREET COLUMBUS, OH 43222 42-1544707 | MEDICAL OFFICE BUILDING RENTAL | OH | MOUNT CARMEL HEALTH SYSTEM | RELATED | 282,087 | 4,211,737 | | No | | Yes | | 49 890 % |

Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal Domicile (State or Foreign Country) | (d) Direct Controlling Entity | (e) Predominant income (related, unrelated, excluded from tax under sections 512-514) | (f) Share of total income (\$) | (g) Share of end- of-year assets (\$) | (h) Disproportionate allocations? | | (i) Code V - UBI amount on Box 20 of K-1 (\$) | (j) General or Managing Partner? | | (k) Percentage ownership |
|--|--|---|--|--|---|--|---|----|--|--|----|--------------------------------|
| | | | | | | | Yes | No | | Yes | No | |
| MCMC POB III LIMITED PARTNERSHIP 793 W STATE STREET COLUMBUS, OH 43222 31-1392994 | MEDICAL OFFICE BUILDING RENTAL | OH | MOUNT CARMEL HEALTH SYSTEM | RELATED | 128,938 | 1,208,982 | | No | | Yes | | 25 430 % |
| MEDILUCENT MOBI 793 W STATE STREET COLUMBUS, OH 43222 20-4911370 | MEDICAL OFFICE BUILDING RENTAL | OH | MOUNT CARMEL HEALTH SYSTEM | RELATED | 81,730 | 2,032,526 | | No | | Yes | | 25 200 % |
| MERCY ADVANCED MRI LLC 2525 SOUTH MICHIGAN AVE CHICAGO, IL 60616 26-2116721 | SUBLEASE MRI EQUIPMENT | IL | N/A | N/A | | | | No | | | No | |
| MERCY HEART & VASCULAR LLC 2525 SOUTH MICHIGAN AVE CHICAGO, IL 60616 20-5272726 | SUBLEASE CT EQUIPMENT | IL | N/A | N/A | | | | No | | | No | |
| MERCY HEART CTR OP SERVICES LLC 1000 4TH STREET SW MASON CITY, IA 50401 13-4237594 | CARDIOVASCULAR SERVICES | IA | N/A | N/A | | | | No | | | No | |
| MERCY OUTPATIENT SURGERY CENTER LLC 1512 12TH AVENUE ROAD NAMPA, ID 83686 84-1380439 | OUTPATIENT SURGERY | ID | N/A | N/A | | | | No | | | No | |
| MICHIANA HEALTH INFORMATION NETWORK LLC 215 WEST MADISON STREET SOUTH BEND, IN 46601 35-2050128 | COMMUNITY BASED CLINICAL INFO SYS & DATA DEPOSITORY | IN | N/A | N/A | | | | No | | | No | |
| MOUNT CARMEL EAST POB III LIMITED PARTNERSHIP 793 W STATE STREET COLUMBUS, OH 43222 31-1369473 | MEDICAL OFFICE BUILDING RENTAL | OH | MOUNT CARMEL HEALTH SYSTEM | RELATED | 124,955 | 1,863,873 | | No | | Yes | | 29 640 % |
| NEWCO AMBULATORY SURGERY CTR LLP 4190 24TH AVENUE FORT GRATIOT, MI 48059 30-0136708 | OUTPATIENT SURGERY CENTER | MI | N/A | N/A | | | | No | | | No | |
| RIVERVIEW MEDICAL OFFICE BUILDING LIMITED PARTNERSHIP 793 W STATE STREET COLUMBUS, OH 43222 31-1531135 | MEDICAL OFFICE BUILDING RENTAL | OH | MOUNT CARMEL HEALTH SYSTEM | RELATED | 456 | 6,080 | | No | | Yes | | 12 977 % |
| SARMED OUTPATIENT PHARMACY LLC 999 N CURTIS RD STE 102 BOISE, ID 83706 51-0483218 | PHARMACY | ID | N/A | N/A | | | | No | | | No | |
| SIXTY FOURTH STREET LLC 2373 64TH ST STE 2200 BYRON CENTER, MI 49315 20-2443646 | PROVIDE OUTPATIENT SURGICAL CARE | MI | N/A | N/A | | | | No | | | No | |
| ST ALPHONSUS CALDWELL CANCER CTR LLC 3123 MEDICAL DR CALDWELL, ID 83605 82-0526861 | RADIATION ONCOLOGY | ID | N/A | N/A | | | | No | | | No | |
| ST ANN'S MEDICAL OFFICE BLDG II LIMITED PARTNERSHIP 793 W STATE STREET COLUMBUS, OH 43222 31-1603660 | MEDICAL OFFICE BUILDING RENTAL | OH | MOUNT CARMEL HEALTH SYSTEM | RELATED | 150,308 | 1,826,597 | | No | | Yes | | 47 010 % |
| TAMARACK MEDICAL CLINIC LLC 610 VILLAGE DRIVE DONNELLY, ID 83615 20-1637921 | OUTPATIENT MEDICAL SERVICES | ID | N/A | N/A | | | | No | | | No | |

Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal Domicile (State or Foreign Country) | (d) Direct Controlling Entity | (e) Predominant income (related, unrelated, excluded from tax under sections 512-514) | (f) Share of total income (\$) | (g) Share of end- of-year assets (\$) | (h) Dispropportionate allocations? | | (i) Code V- UBI amount on Box 20 of K-1 (\$) | (j) General or Managing Partner? | | (k) Percentage ownership |
|---|-----------------------------------|---|--|--|---|--|--|----|---|--|----|--------------------------------|
| | | | | | | | | | | | | |
| WESTAR MEDICAL OFFICE BUILDING LIMITED PARTNERSHIP 793 W STATE STREET COLUMBUS, OH 43222 31-1784409 | MEDICAL OFFICE BUILDING RENTAL | OH | MOUNT CARMEL HEALTH SYSTEM | RELATED | 194,175 | 1,955,755 | | No | | Yes | | 47 920 % |
| WOODLAND IMAGING CENTER LLC 5301 E HURON RIVER DR ANN ARBOR, MI 48106 76-0820959 | RADIOLOGY/IMAGING | MI | N/A | N/A | | | | No | | | No | |

Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal Domicile (State or Foreign Country) | (d) Direct Controlling Entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income (\$) | (g) Share of end-of-year assets (\$) | (h) Percentage ownership |
|---|---------------------------------|--|--|--|---|--|--------------------------------|
| COMMUNITY HEALTH VENTURES INC 565 W WESTERN AVE MUSKEGON, MI 49440 38-3522260 | SOFTWARE MARKETING | MI | N/A | C | | | |
| GOTTLIEB MANAGEMENT SERVICES INC 701 W NORTH AVE MELROSE PARK, IL 60160 36-3330529 | MANAGEMENT SERVICES | IL | N/A | C | | | |
| HACKLEY HEALTH MANAGEMENT CENTER 1415 LEAHY ST MUSKEGON, MI 49442 38-2961814 | WEIGHT MANAGEMENT | MI | N/A | C | | | |
| HACKLEY HEALTH VENTURES INC 1415 LEAHY ST MUSKEGON, MI 49442 38-2589959 | OTHER MEDICAL SERVICES | MI | N/A | C | | | |
| HACKLEY HEALTHCARE EQUIPMENT 1415 LEAHY ST MUSKEGON, MI 49442 38-2578569 | HOME MEDICAL EQUIPMENT | MI | N/A | C | | | |
| HACKLEY PROFESSIONAL CENTER 1415 LEAHY ST MUSKEGON, MI 49442 38-3024797 | REAL ESTATE RENTAL | MI | N/A | C | | | |
| HACKLEY PROFESSIONAL PHARMACY 1415 LEAHY ST MUSKEGON, MI 49442 38-2447870 | PHARMACY | MI | N/A | C | | | |
| HEF INC 1415 LEAHY ST MUSKEGON, MI 49442 38-3086401 | OFFICE STAFFING | MI | N/A | C | | | |
| HOLY CROSS PRIVATE HOME SERVICES CORP 11801 TECH ROAD SILVER SPRING, MD 20904 52-1986562 | HOME CARE SERVICES | MD | N/A | C | | | |
| HPC CO-OWNERS ASSOCIATION 1700 CLINTON MUSKEGON, MI 49442 27-0734448 | CONDOMINIUM ASSOCIATION | MI | N/A | C | | | |
| HURON ARBOR CORPORATION 5301 EAST HURON RIVER DR PO BOX 992 ANN ARBOR, MI 48106 38-2475644 | PROVIDES OFFICE RENTAL SPACE | MI | N/A | C | | | |
| IHA AFFILIATION CORPORATION 24 FRANK LLOYD WRIGHT DR LOBBY J ANN ARBOR, MI 48106 38-3188895 | MEDICAL MANAGEMENT | MI | N/A | C | | | |
| LOYOLA UNIVERSITY OF CHICAGO INSURANCE CO LTD 23 LIME TREE BAY AVENUE GRAND CAYMAN CJ | PROVISION OF INSURANCE COVERAGE | CJ | N/A | C | | | |
| MARYLAND CARE GROUP INC 11801 TECH ROAD SILVER SPRING, MD 20904 52-1815313 | HEALTHCARE HOLDING | MD | N/A | C | | | |
| MEDNOW INC 1512 12TH AVENUE ROAD NAMPA, ID 83686 82-0389927 | OUTPATIENT PHARMACY | ID | N/A | C | | | |
| MERCY MEDICAL SERVICES 801 5TH STREET SIOUX CITY, IA 51101 42-1283849 | PRIMARY CARE PHYSICIANS | IA | N/A | C | | | |
| MERCY SERVICES CORPORATION 2525 SOUTH MICHIGAN AVENUE CHICAGO, IL 60616 36-3227348 | DORMANT | IL | N/A | C | | | |
| MICHIGAN ATHLETIC CLUB 2500 BURTON GRAND RAPIDS, MI 49546 38-2647304 | ATHLETIC CLUB | MI | N/A | C | | | |
| MOUNT CARMEL BEHAVIORAL HEALTHCARE SERVICES INC 6150 EAST BROAD STREET COLUMBUS, OH 43213 31-0971510 | BEHAVIORAL HEALTHCARE SERVICES | OH | MOUNT CARMEL HEALTH SYSTEM | C | | | 100 000 % |
| MOUNT CARMEL HEALTH PROVIDERS INC 6150 EAST BROAD STREET COLUMBUS, OH 43213 31-1382442 | MEDICAL SERVICES | OH | MOUNT CARMEL HEALTH SYSTEM | C | | | 100 000 % |

Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal Domicile (State or Foreign Country) | (d) Direct Controlling Entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income (\$) | (g) Share of end-of-year assets (\$) | (h) Percentage ownership |
|---|--|--|--|--|---|--|--------------------------------|
| NORTH IOWA MERCY MEDICAL SERVICES INC 1000 4TH ST SW MASON CITY, IA 50401 42-1382308 | MEDICAL SERVICES | IA | N/A | C | | | |
| PRIORITY PLUS OF CALIFORNIA PO BOX 27230 FRESNO, CA 93729 77-0395267 | FORMERLY HLTH MGMT NOW DISCONTINUED OPERATIONS | CA | N/A | C | | | |
| SAINT ALPHONSUS PHYSICIANS PA 1055 NORTH CURTIS ROAD BOISE, ID 837061370 33-1078261 | PHYSICIANS | ID | N/A | C | | | |
| SAINT MARY'S HEALTH MANAGEMENT COMPANY 1640 EAST PARIS SE GRAND RAPIDS, MI 49546 38-3450733 | ATHLETIC CLUB | MI | N/A | C | | | |
| SURGERY CENTER FINANCING CORPORATION 6150 EAST BROAD STREET COLUMBUS, OH 43213 31-1531102 | FINANCE, INSURANCE AND REAL ESTATE | OH | MOUNT CARMEL HEALTH SYSTEM | C | | | 100 000 % |
| THRE SERVICES LLC 20555 VICTOR PARKWAY LIVONIA, MI 48152 45-2603654 | REAL ESTATE BROKERAGE SERVICES | MI | N/A | C | | | |
| TRINITY HEALTH EMPLOYEE BENEFIT TRUST 20555 VICTOR PARKWAY LIVONIA, MI 48152 38-3410377 | GRANTOR TRUST | MI | N/A | T | | | |
| VENZKE INSURANCE COMPANY LTD PO BOX 1051 GRAND CAYMAN GRAND CAYMAN CJ 98-0453602 | PROVISION OF INSURANCE COVERAGE | CJ | N/A | C | | | |
| WESTSHORE HEALTH NETWORK 1820 44TH STREET KENTWOOD, MI 49508 38-3280200 | PHYSICIAN HOSPITAL ORGANIZATION | MI | N/A | C | | | |
| WORKPLACE HEALTH OF GRAND HAVEN 1415 LEAHY ST MUSKEGON, MI 49442 38-3112035 | OCCUPATIONAL HEALTH | MI | N/A | C | | | |

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

| (a) Name of other organization | (b) Transaction type(a-r) | (c) Amount Involved (\$) | (d) Method of determining amount involved |
|--|---------------------------------|-----------------------------------|---|
| (1) TRINITY HEALTH CORPORATION | E | 11,527,642 | PER BOOKS |
| (2) TRINITY HEALTH CORPORATION | J | 18,133,453 | PER BOOKS |
| (3) TRINITY HEALTH CORPORATION | O | 47,167,901 | PER BOOKS |
| (4) TRINITY HEALTH CORPORATION | P | 1,565,722 | PER BOOKS |
| (5) TRINITY HEALTH CORPORATION | Q | 2,660,455 | PER BOOKS |
| (6) TRINITY HEALTH CORPORATION | L | 78,052,124 | PER BOOKS |
| (7) TRINITY HEALTH CORPORATION | B | 13,914,000 | PER BOOKS |
| (8) MOUNT CARMEL COLLEGE OF NURSING | B | 843,240 | PER BOOKS |
| (9) MOUNT CARMEL COLLEGE OF NURSING | J | 196,668 | PER BOOKS |
| (10) MOUNT CARMEL CARE CONTINUUM SERVICES CORP | C | 2,255,484 | PER BOOKS |
| (11) MOUNT CARMEL HEALTH SYSTEM FOUNDATION | B | 693,100 | PER BOOKS |
| (12) MOUNT CARMEL HEALTH SYSTEM FOUNDATION | K | 705,403 | PER BOOKS |
| (13) DILEY RIDGE MEDICAL CENTER | A | 505,229 | PER BOOKS |
| (14) DILEY RIDGE MEDICAL CENTER | K | 1,272,687 | PER BOOKS |
| (15) MOUNT CARMEL HEALTH PROVIDERS INC | A | 871,318 | PER BOOKS |
| (16) MOUNT CARMEL HEALTH PROVIDERS INC | K | 3,244,042 | PER BOOKS |
| (17) MOUNT CARMEL HEALTH PROVIDERS INC | L | 1,201,242 | PER BOOKS |
| (18) MOUNT CARMEL HEALTH | A | 153,340 | PER BOOKS |
| (19) MOUNT CARMEL HEALTH | C | 2,512,859 | PER BOOKS |
| (20) MOUNT CARMEL HEALTH | O | 56,274 | PER BOOKS |

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

| (a) Name of other organization | (b) Transaction type(a-r) | (c) Amount Involved (\$) | (d) Method of determining amount involved |
|---|---------------------------------|-----------------------------------|---|
| (21) ST ANN'S HOSPITAL | C | 7,443,034 | PER BOOKS |
| (22) SAINT JOSEPH REGIONAL MEDICAL CENTER - PLYMOUTH CAMPUS INC | K | 151,010 | PER BOOKS |
| (23) SAINT JOSEPH REGIONAL MEDICAL CENTER - SOUTH BEND CAMPUS INC | K | 778,876 | PER BOOKS |
| (24) MOUNT CARMEL NEW ALBANY SURGICAL HOSPITAL | C | 37,413,934 | PER BOOKS |
| (25) SAINT ALPHONSUS REGIONAL MEDICAL CENTER | K | 272,876 | PER BOOKS |
| (26) MCE MOB IV LIMITED PARTNERSHIP | C | 212,384 | PER TAX RETURN |
| (27) MCMC POB III LIMITED PARTNERSHIP | C | 88,158 | PER TAX RETURN |
| (28) CENTRAL OHIO SLEEP MEDICINE LTD | C | 52,200 | PER TAX RETURN |
| (29) WESTAR MEDICAL OFFICE BUILDING LIMITED PARTNERSHIP | C | 127,575 | PER TAX RETURN |
| (30) MOUNT CARMEL EAST POB III LIMITED PARTNERSHIP | C | 138,173 | PER TAX RETURN |
| (31) ST ANN'S HOSPITAL | K | 41,429,719 | PER BOOKS |
| (32) MOUNT CARMEL HEALTH PLAN INC | K | 7,025,944 | PER BOOKS |
| (33) MOUNT CARMEL COLLEGE OF NURSING | K | 1,476,450 | PER BOOKS |
| (34) MOUNT CARMEL CARE CONTINUUM SERVICES CORP | K | 1,580,908 | PER BOOKS |
| (35) MOUNT CARMEL HEALTH | K | 102,284,842 | PER BOOKS |
| (36) MOUNT CARMEL NEW ALBANY SURGICAL HOSPITAL | K | 9,323,213 | PER BOOKS |
| (37) MOUNT CARMEL HEALTH PROVIDERS INC | K | 6,565,168 | PER BOOKS |
| (38) ST ANN'S MEDICAL OFFICE BLDG II LIMITED PARTNERSHIP | C | 83,226 | PER TAX RETURN |
| (39) MOUNT CARMEL HEALTH PLAN INC | C | 5,000,000 | PER BOOKS |
| (40) TRINITY HEALTH - MICHIGAN | K | 103,420 | PER BOOKS |

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

| (a) Name of other organization | | (b) Transaction type(a-r) | (c) Amount Involved (\$) | (d) Method of determining amount involved |
|-----------------------------------|---------------------------|---------------------------------|-----------------------------------|---|
| (41) | TRINITY HEALTH - MICHIGAN | L | 2,151,244 | PER BOOKS |
| (42) | MEDILUCENT MOBI | C | 166,728 | PER TAX RETURN |

Additional Data

Software ID:

Software Version:

EIN: 31-1439334

Name: MOUNT CARMEL HEALTH SYSTEM

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

| (A) Name and Title | (B) Average hours per week | (C) Position (check all that apply) | | | | | | (D) Reportable compensation from the organization (W-2/1099-MISC) | (E) Reportable compensation from related organizations (W-2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|--|-------------------------------|--|-----------------------|---------|--------------|------------------------------|--------|--|---|---|
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| MATTHEW HABASH CHAIR | 2 00 | X | | X | | | | 0 | 0 | 0 |
| STAMPP CORBIN VICE CHAIR | 2 00 | X | | X | | | | 0 | 0 | 0 |
| JOHN PEREZ SECRETARY | 2 00 | X | | X | | | | 0 | 0 | 0 |
| SR RUTH M NICKERSON CSC TREASURER | 2 00 | X | | X | | | | 0 | 0 | 0 |
| DAVID STEWART MD TRUSTEE | 2 00 | X | | | | | | 0 | 0 | 0 |
| CLAUS VON ZYCHLIN PRES & CEO, TRUSTEE | 16 00 | X | | X | | | | 0 | 742,791 | 100,792 |
| MICHAEL GONSIOROWSKI TRUSTEE UNTIL 12/11 | 2 00 | X | | | | | | 0 | 0 | 0 |
| PHILLIP SHUBERT MD TRUSTEE TIL 12/11, DIR, PERINATOLOGY | 2 00 | X | | | | | | 512,753 | 0 | 41,622 |
| SUSAN TOMASKY TRUSTEE | 2 00 | X | | | | | | 0 | 0 | 0 |
| J RICHARD O'CONNELL TRUSTEE, TRINITY EVP, COO-HOSP NTWKS | 2 00 | X | | | | | | 0 | 943,237 | 118,221 |
| CARL BERASI DO TRUSTEE | 2 00 | X | | | | | | 0 | 0 | 0 |
| JORGE GOMEZ TRUSTEE | 2 00 | X | | | | | | 0 | 0 | 0 |
| VALERIANA MOELLER TRUSTEE UNTIL 12/11 | 2 00 | X | | | | | | 0 | 0 | 0 |
| SR JOY O'GRADY TRUSTEE | 2 00 | X | | | | | | 0 | 0 | 0 |
| ANANTHA PADMANABHAN MD TRUSTEE | 2 00 | X | | | | | | 0 | 0 | 0 |
| LISA STEIN TRUSTEE AS OF 1/12 | 2 00 | X | | | | | | 0 | 0 | 0 |
| JACQUELINE PRIMEAU SVP & CFO | 16 00 | | | X | | | | 0 | 435,000 | 40,553 |
| RONALD WHITESIDE EXEC VP & SYSTEM COO | 15 00 | | | X | | | | 0 | 1,842,081 | 56,546 |
| CYNTHIA SHEETS SVP & CIO | 40 00 | | | | X | | | 0 | 935,788 | 45,290 |
| PAULA AUTRY PRESIDENT & COO, MCE UNTIL 4/12 | 2 00 | | | | X | | | 0 | 357,678 | 35,771 |
| JANET MEEKS PRESIDENT & COO, ST ANNS | 2 00 | | | | X | | | 0 | 379,099 | 90,476 |
| JOHN HEISLER SVP HUMAN AFFAIRS | 13 00 | | | | X | | | 0 | 413,570 | 36,981 |
| HUGH JONES SVP STRATEGY & SYSTEM DEV | 13 00 | | | | X | | | 0 | 284,314 | 35,570 |
| JOSEPH SWEDISH TRINITY HEALTH PRES & CEO | 2 00 | | | | X | | | 0 | 5,186,660 | 576,202 |
| KEDRICK ADKINS TRINITY PRES INTEGRATED SVCS | 2 00 | | | | X | | | 0 | 1,405,226 | 117,120 |

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

| (A) Name and Title | (B) Average hours per week | (C) Position (check all that apply) | | | | | | (D) Reportable compensation from the organization (W-2/1099-MISC) | (E) Reportable compensation from related organizations (W-2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|--|-------------------------------|--|-----------------------|---------|--------------|------------------------------|--------|--|---|---|
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| MICHAEL MURPHY TRINITY EVP, HEALTH NTWKS UNTIL 4/12 | 2 00 | | | | X | | | 0 | 474,370 | 75,538 |
| RICHARD STRECK CHIEF MEDICAL OFFICER | 50 00 | | | | | X | | 0 | 511,658 | 40,585 |
| THOMAS BRONKEN CHIEF MED INFO OFFICER | 50 00 | | | | | X | | 282,246 | 0 | 34,735 |
| MICHELE HELBIG EXEC DIR HEALTH PARTNERS | 50 00 | | | | | X | | 229,415 | 0 | 38,868 |
| MARY ANN WOLF VP, HUMAN RESOURCES | 50 00 | | | | | X | | 227,645 | 0 | 37,672 |
| GAYLE O'BRIEN VP QUALITY & SAFETY | 50 00 | | | | | X | | 201,477 | 0 | 23,220 |
| MICHAEL SLUBOWSKI FORMER KEY EMPLOYEE | 0 00 | | | | | | X | 0 | 150,838 | 1,101 |

Additional Data

Software ID:
Software Version:
EIN: 31-1439334
Name: MOUNT CARMEL HEALTH SYSTEM

Form 990, Schedule A, Part I, Line 11h - Provide the following information about the organizations the organization supports.

| (i) Name of Supported Organization | (ii) EIN | (iii) Type of organization (described on lines 1- 9 above or IRC section) | (iv) Is the organization in (i) listed in your governing document? | | (v) Did you notify the organization in (i) of your support? | | (vi) Is the organization in (i) organized in the U S ? | | (vii) Amount of support? |
|---|-------------|---|---|----|---|----|--|----|-----------------------------|
| | | | Yes | No | Yes | No | Yes | No | |
| (A) MOUNT CARMEL NEW ALBANY SURGICAL HOSPITAL | 870790288 | 3 | | No | Yes | | Yes | | 0 |
| (B) MOUNT CARMEL HEALTH | 314379602 | 3 | | No | Yes | | Yes | | 0 |
| (C) ST ANN'S HOSPITAL | 314412701 | 3 | | No | Yes | | Yes | | 0 |
| (D) TRINITY HEALTH CORPORATION | 351443425 | 11 | Yes | | Yes | | Yes | | 13914000 |
| (E) DILEY RIDGE MEDICAL CENTER | 342032340 | 3 | | No | Yes | | Yes | | 0 |