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Form 990

## Return of Organization Exempt From Income Tax

2014

Open to Public Inspection

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

- Do not enter social security numbers on this form as it may be made public
- Information about Form 990 and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990)

## A For the 2014 calendar year, or tax year beginning 07-01-2014, and ending 06-30-2015

B Check if applicable	C Name of organization MERCY HEALTH SYSTEM CORPORATION		D Employer identification number 39-0816848
<input type="checkbox"/> Address change			
<input type="checkbox"/> Name change	Doing business as		E Telephone number (608) 756-6000
<input type="checkbox"/> Initial return			
<input type="checkbox"/> Final return/terminated	Number and street (or P O box if mail is not delivered to street address) PO BOX 5003 - 1000 MINERAL POINT	Room/suite	
<input type="checkbox"/> Amended return	City or town, state or province, country, and ZIP or foreign postal code JANESVILLE, WI 535475003		G Gross receipts \$ 540,200,479
<input type="checkbox"/> Application pending	F Name and address of principal officer JAVON BEA PO BOX 5003 - 1000 MINERAL POINT JANESVILLE, WI 535475003		H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

I Tax-exempt status  501(c)(3)  501(c) ( ) (insert no)  4947(a)(1) or  527

J Website: ► WWW MERCYHEALTHSYSTEM.ORG

K Form of organization  Corporation  Trust  Association  Other ►H(b) Are all subordinates included?  Yes  No  
If "No," attach a list (see instructions)

H(c) Group exemption number ►

L Year of formation 1972 M State of legal domicile WI

## Part I Summary

1 Briefly describe the organization's mission or most significant activities  
THE MISSION OF MERCY HEALTH SYSTEM IS TO PROVIDE EXCEPTIONAL HEALTH CARE SERVICES RESULTING IN HEALING IN THE BROADEST SENSE

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

3 Number of voting members of the governing body (Part VI, line 1a)	3	10
4 Number of independent voting members of the governing body (Part VI, line 1b)	4	7
5 Total number of individuals employed in calendar year 2014 (Part V, line 2a)	5	3,876
6 Total number of volunteers (estimate if necessary)	6	0
7a Total unrelated business revenue from Part VIII, column (C), line 12	7a	10,543,700
b Net unrelated business taxable income from Form 990-T, line 34	7b	0

		Prior Year	Current Year
8 Contributions and grants (Part VIII, line 1h)	263,821	211,005	
9 Program service revenue (Part VIII, line 2g)	515,758,827	540,911,259	
10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	293,559	1,387,588	
11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	2,856,252	-4,058,585	
12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	519,172,459	538,451,267	

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12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	519,172,459	538,451,267	
13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0	0	
14 Benefits paid to or for members (Part IX, column (A), line 4)	0	0	
15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	297,341,530	310,745,853	
16a Professional fundraising fees (Part IX, column (A), line 11e)	0	0	
b Total fundraising expenses (Part IX, column (D), line 25) ►0			
17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	206,767,003	211,011,871	
18 Total expenses Add lines 13-17 (must equal Part IX, column (A), line 25)	504,108,533	521,757,724	
19 Revenue less expenses Subtract line 18 from line 12	15,063,926	16,693,543	

		Beginning of Current Year	End of Year
20 Total assets (Part X, line 16)	497,525,602	515,850,817	
21 Total liabilities (Part X, line 26)	303,051,697	309,395,101	
22 Net assets or fund balances Subtract line 21 from line 20	194,473,905	206,455,716	

## 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	*****	2016-05-09
	Signature of officer	Date
JAVON BEA CEO	Type or print name and title	

Paid Preparer Use Only	Print/Type preparer's name BRADLEY S MCGUIRE CPA	Preparer's signature BRADLEY S MCGUIRE CPA	Date 2016-05-09	Check <input checked="" type="checkbox"/> if self-employed	PTIN P00643763
	Firm's name ► BAKER TILLY VIRCHOW KRAUSE LLP	Firm's EIN ► 39-0859910			
	Firm's address ► 500 MIDLAND COURT PO BOX 8130 JANESVILLE, WI 535478130	Phone no (608) 752-5835			

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 (2014)

**Part III Statement of Program Service Accomplishments**Check if Schedule O contains a response or note to any line in this Part III **1** Briefly describe the organization's mission

THE MISSION OF MERCY HEALTH SYSTEM IS TO PROVIDE EXCEPTIONAL HEALTH CARE SERVICES RESULTING IN HEALING IN THE BROADEST SENSE

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

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

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

If "Yes," describe these changes on Schedule O

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

**4a** (Code) (Expenses \$ 417,872,148 including grants of \$ ) (Revenue \$ 529,080,363 )

HOSPITAL DISCHARGES 8,600, NURSING HOME ADMISSIONS 294, BIRTHS 1,055, OUTPATIENT VISITS 1,215,194 MERCY HEALTH SYSTEM CONTINUES ITS TRADITION OF GIVING BACK TO EACH OF THE COMMUNITIES WE SERVE IN A WIDE VARIETY OF FASHIONS. ONE OF THE LARGER AREAS OF CONTRIBUTION IS IN THE AREA OF PUBLIC HEALTH SERVICES. THIS INCLUDES EXTENSIVE DONATIONS OF TIME AND SUPPLIES TO HEALTHNET OF ROCK COUNTY, A LARGE FREE PRIMARY CARE CLINIC SERVING THE REGION. MORE THAN EIGHTY PERCENT OF THE PHYSICIAN SERVICES PROVIDED AT THE CLINIC ARE SUPPLIED THROUGH MERCY HEALTH SYSTEM. WE HAVE A SIMILAR COMMITMENT TO OPEN ARMS FREE CLINIC THAT SERVICES LOW INCOME RESIDENTS IN WALWORTH COUNTY. ADDITIONALLY, WE PROVIDE HEALTH SCREENING AND RELATED SERVICES AT NUMEROUS EVENTS IN ROCK AND WALWORTH COUNTIES IN WISCONSIN AND MCHENRY COUNTY IN ILLINOIS. MERCY ALSO PROVIDES FINANCIAL AND IN KIND CONTRIBUTIONS TO OTHER PRIVATE NOT FOR PROFIT HEALTH RELATED AGENCIES AND ORGANIZATION IN OUR SERVICE AREA. BENEFICIARIES INCLUDED BUT ARE NOT LIMITED TO THE AMERICAN HEART ASSOCIATION, AMERICAN CANCER SOCIETY, UNITED WAY ORGANIZATIONS IN ROCK, WALWORTH, AND MCHENRY COUNTIES, YWCA CARE HOUSE, YMCA, AMERICAN LUNG ASSOCIATION, WALWORTH COUNTY ALLIANCE FOR CHILDREN, TURNING POINT WOMEN'S CENTER IN MCHENRY, OPEN ARMS FREE CLINIC, AND THE RED CROSS, TO NAME JUST A FEW. RECIPIENTS MERCY ALSO ENCOURAGES ITS PARTNERS (EMPLOYEES) TO DONATE THEIR TIME AND ENERGY TO SUPPORT A WHOLE HOST OF COMMUNITY BASED CAUSES. THOUSANDS OF HOURS EACH YEAR ARE DONATED TO NOT FOR PROFIT AND PUBLIC AGENCIES THROUGHOUT OUR SERVICE AREA. EXAMPLES OF VOLUNTEER ACTIVITIES BEING SUPPORTED INCLUDE NURSING SERVICES AT COMMUNITY AND FREE CLINICS THROUGHOUT THE REGION, MEALS ON WHEELS DELIVERY ACTIVITIES, ACTIVE INVOLVEMENT AS GOVERNING BOARD MEMBERS FOR SUCH ORGANIZATIONS AS UNITED WAY, CRIME STOPPERS, ROTARY BOTANICAL GARDENS, HEALTHNET, AND MANY OTHER ORGANIZATIONS. ANOTHER EXAMPLE OF MERCY'S COMMITMENT TO COMMUNITY IS ITS SUPPORT OF THE OPERATIONS THROUGH OFFERING SAFE RESIDENCE TO HOMELESS WOMEN AND THEIR CHILDREN AT THE HOUSE OF MERCY HOMELESS CENTER. SINCE ITS OPENING IN 1996, THE CENTER HAS SERVED MORE THAN 5500 PERSONS, MOST OF WHOM ARE UNDER THE AGE OF 18 AT THE CENTER. THE CENTER OFFERS A SAFE HARBOR FOR THESE INDIVIDUALS AS WELL AS CASE MANAGEMENT, ASSISTANCE WITH JOB SEARCHES, FINDING PERMANENT HOUSING AND EDUCATION.

**4b** (Code) (Expenses \$ ) (Revenue \$ )

**4c** (Code) (Expenses \$ ) (Revenue \$ )

**4d** Other program services (Describe in Schedule O )  
(Expenses \$ ) (Revenue \$ )

**4e** Total program service expenses ► 417,872,148

**Part IV Checklist of Required Schedules**

1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A

2 Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)?

3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I

4 **Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II

5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? If "Yes," complete Schedule C, Part III

6 Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes," complete Schedule D, Part I

7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II

8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III

9 Did the organization report an amount in Part X, line 21 for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? If "Yes," complete Schedule D, Part IV

10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? If "Yes," complete Schedule D, Part V

11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable

- a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI
- b Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII
- c Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII
- d Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part IX
- e Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X
- f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part XI

12a Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII

12b Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional

13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E

14a Did the organization maintain an office, employees, or agents outside of the United States?

14b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV

15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? If "Yes," complete Schedule F, Parts II and IV

16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? If "Yes," complete Schedule F, Parts III and IV

17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I (see instructions)

18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II

19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III

20a Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H

b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?

	Yes	No
1	Yes	
2	Yes	
3		No
4		No
5		No
6		No
7		No
8		No
9		No
10		No
11a	Yes	
11b	Yes	
11c		No
11d		No
11e	Yes	
11f		No
12a		No
12b	Yes	
13		No
14a		No
14b		No
15		No
16		No
17		No
18		No
19		No
20a	Yes	
20b	Yes	

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

21	Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? If "Yes," complete Schedule I, Parts I and II	21		No
22	Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? If "Yes," complete Schedule I, Parts I and III	22		No
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? If "Yes," complete Schedule J	23	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? If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a	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	<b>Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.</b> Did the organization engage in an excess benefit transaction with a disqualified person during the year? If "Yes," complete Schedule L, Part 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? If "Yes," complete Schedule L, Part I	25b		No
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? If "Yes," complete Schedule L, Part II	26		No
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? If "Yes," complete Schedule L, Part III	27		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? If "Yes," complete Schedule L, Part IV	28a		No
b	A family member of a current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV	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 direct or indirect owner? If "Yes," complete Schedule L, Part IV	28c		No
29	Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M	29		No
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? If "Yes," complete Schedule M	30		No
31	Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, Part I	31		No
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? If "Yes," complete Schedule N, Part II	32		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? If "Yes," complete Schedule R, Part I	33		No
34	Was the organization related to any tax-exempt or taxable entity? If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1	34	Yes	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	Yes	
b	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? If "Yes," complete Schedule R, Part V, line 2	35b		No
36	<b>Section 501(c)(3) organizations.</b> Did the organization make any transfers to an exempt non-charitable related organization? If "Yes," complete Schedule R, Part V, line 2	36		No
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? If "Yes," complete Schedule R, Part VI	37		No
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? <b>Note.</b> All Form 990 filers are required to complete Schedule O	38	Yes	

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

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

		Yes	No
<b>1a</b> Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable . . .	<b>1a</b>	402	
<b>1b</b> Enter the number of Forms W-2G included in line 1a Enter -0- if not applicable . . .	<b>1b</b>	0	
<b>c</b> Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? . . .	<b>1c</b>	Yes	
<b>2a</b> Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return . . .	<b>2a</b>	3,876	
<b>b</b> If at least one is reported on line 2a, did the organization file all required federal employment tax returns? <b>Note.</b> If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	<b>2b</b>	Yes	
<b>3a</b> Did the organization have unrelated business gross income of \$1,000 or more during the year? . . .	<b>3a</b>	Yes	
<b>b</b> If "Yes," has it filed a Form 990-T for this year? <i>If "No" to line 3b, provide an explanation in Schedule O</i> . . .	<b>3b</b>	Yes	
<b>4a</b> At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . . .	<b>4a</b>	No	
<b>b</b> If "Yes," enter the name of the foreign country ► See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)			
<b>5a</b> Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . . .	<b>5a</b>	No	
<b>b</b> Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? . . .	<b>5b</b>	No	
<b>c</b> If "Yes," to line 5a or 5b, did the organization file Form 8886-T? . . .	<b>5c</b>		
<b>6a</b> Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . .	<b>6a</b>	No	
<b>b</b> If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? . . .	<b>6b</b>		
<b>7</b> <b>Organizations that may receive deductible contributions under section 170(c).</b>	<b>7a</b>	No	
<b>a</b> Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor? . . .	<b>7b</b>		
<b>b</b> If "Yes," did the organization notify the donor of the value of the goods or services provided? . . .	<b>7c</b>	No	
<b>c</b> Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? . . .	<b>7d</b>		
<b>d</b> If "Yes," indicate the number of Forms 8282 filed during the year			
<b>e</b> Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? . . .	<b>7e</b>	No	
<b>f</b> Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . . .	<b>7f</b>	No	
<b>g</b> If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? . . .	<b>7g</b>		
<b>h</b> If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? . . .	<b>7h</b>		
<b>8</b> <b>Sponsoring organizations maintaining donor advised funds.</b> Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	<b>8</b>		
<b>9a</b> Did the sponsoring organization make any taxable distributions under section 4966? . . .	<b>9a</b>		
<b>b</b> Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . .	<b>9b</b>		
<b>10</b> <b>Section 501(c)(7) organizations.</b> Enter	<b>10a</b>		
<b>a</b> Initiation fees and capital contributions included on Part VIII, line 12 . . .	<b>10b</b>		
<b>b</b> Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities			
<b>11</b> <b>Section 501(c)(12) organizations.</b> Enter	<b>11a</b>		
<b>a</b> Gross income from members or shareholders . . .	<b>11b</b>		
<b>b</b> Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them) . . .			
<b>12a</b> <b>Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041? . . .	<b>12a</b>		
<b>b</b> If "Yes," enter the amount of tax-exempt interest received or accrued during the year	<b>12b</b>		
<b>13</b> <b>Section 501(c)(29) qualified nonprofit health insurance issuers.</b>	<b>13a</b>		
<b>a</b> Is the organization licensed to issue qualified health plans in more than one state? <b>Note.</b> See the instructions for additional information the organization must report on Schedule O	<b>13b</b>		
<b>b</b> Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans . . .	<b>13c</b>		
<b>14a</b> Did the organization receive any payments for indoor tanning services during the tax year? . . .	<b>14a</b>	No	
<b>b</b> If "Yes," has it filed a Form 720 to report these payments? <i>If "No," provide an explanation in Schedule O</i> . . .	<b>14b</b>		

**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 or note to any line in this Part VI

### Section A. Governing Body and Management

			Yes	No
<b>1a</b>	Enter the number of voting members of the governing body at the end of the tax year	<b>1a</b>	10	
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O			
<b>b</b>	Enter the number of voting members included in line 1a, above, who are independent	<b>1b</b>	7	
<b>2</b>	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?			No
<b>3</b>	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?			No
<b>4</b>	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?			No
<b>5</b>	Did the organization become aware during the year of a significant diversion of the organization's assets?			No
<b>6</b>	Did the organization have members or stockholders?			No
<b>7a</b>	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?			No
<b>b</b>	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?			No
<b>8</b>	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following			
<b>a</b>	The governing body?	<b>8a</b>	Yes	
<b>b</b>	Each committee with authority to act on behalf of the governing body?	<b>8b</b>	Yes	
<b>9</b>	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O	<b>9</b>		No

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

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

### Section C. Disclosure

- 17 List the States with which a copy of this Form 990 is required to be filed  IL, WI
- 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  
 Own website  Another's website  Upon request  Other (explain in Schedule O)
- 19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year
- 20 State the name, address, and telephone number of the person who possesses the organization's books and records  
 JOHN COOK

1000 MINERAL POINT  
JANESVILLE, WI 535475003 (608) 756-6642

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

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

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

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

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

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

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

<b>(A)</b> Name and Title	<b>(B)</b> Average hours per week (list any hours for related organizations below dotted line)	<b>(C)</b> Position (do not check more than one box, unless person is both an officer and a director/trustee)						<b>(D)</b> Reportable compensation from the organization (W-2/1099-MISC)	<b>(E)</b> Reportable compensation from related organizations (W-2/1099-MISC)	<b>(F)</b> Estimated amount of other compensation from the organization and related organizations
		Individual trustee Or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			

<b>1b Sub-Total</b>			
<b>c Total from continuation sheets to Part VII, Section A</b>			
<b>d Total (add lines 1b and 1c)</b>	17,619,136	0	627,291

**2** Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization **►325**

	Yes	No
<b>3</b> Did the organization list any <b>former</b> officer, director or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual	3	No
<b>4</b> For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? If "Yes," complete Schedule J for such individual	4	Yes
<b>5</b> Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? If "Yes," complete Schedule J for such person	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
EPIC SYSTEMS CORPORATION 1979 MILKY WAY VERONA, WI 53593	SOFTWARE/SYSTEM MAINTENANCE	3,489,643
MAGILL CONSTRUCTION COMPANY 977 KOOPMAN LANE ELKHORN, WI 53121	CONSTRUCTION	2,868,447
HAYES LOCUMS LLC 6700 N ANDREWS AVE STE 600 FORT LAUDERDALE, FL 33309	PHYSICIAN LOCUM	1,907,992
WALSH CONSTRUCTION COMPANY II LLC 929 WEST ADAMS CHICAGO, IL 60607	CONSTRUCTION	1,656,452
CAMELOT RADIOLOGY ASSOCIATES 3849 N PERRYVILLE RD ROCKFORD, IL 61114	PHYSICIAN SERVICES	1,013,916

**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 **►49**

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

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514	
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<b>1a</b> Federated campaigns . . . . .	<b>1a</b>				
	<b>b</b> Membership dues . . . . .	<b>1b</b>				
	<b>c</b> Fundraising events . . . . .	<b>1c</b>				
	<b>d</b> Related organizations . . . . .	<b>1d</b>	119,870			
	<b>e</b> Government grants (contributions)	<b>1e</b>	37,794			
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above	<b>1f</b>	53,341			
	<b>g</b> Noncash contributions included in lines 1a-1f \$					
	<b>h</b> <b>Total.</b> Add lines 1a-1f . . . . .		211,005			
<b>Program Service Revenue</b>		<b>Business Code</b>				
	<b>2a</b> PATIENT SERVICE REVENUE	621110	529,080,363	529,080,363		
	<b>b</b> UNRELATED BUSINESS INCOME	561000	10,543,700	10,543,700		
	<b>c</b> CAFETERIA	722210	1,287,196		1,287,196	
	<b>d</b>					
	<b>e</b>					
	<b>f</b> All other program service revenue					
	<b>g</b> <b>Total.</b> Add lines 2a-2f . . . . .		540,911,259			
<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts) . . . . .		1,365,279		1,365,279	
	<b>4</b> Income from investment of tax-exempt bond proceeds					
	<b>5</b> Royalties . . . . .					
	<b>6a</b> Gross rents	(I) Real	(II) Personal			
	<b>b</b> Less rental expenses					
	<b>c</b> Rental income or (loss)					
	<b>d</b> Net rental income or (loss) . . . . .					
	<b>7a</b> Gross amount from sales of assets other than inventory	(I) Securities	(II) Other			
<b>b</b> Less cost or other basis and sales expenses	1,761,394	10,127				
<b>c</b> Gain or (loss)	1,748,415	797				
<b>d</b> Net gain or (loss) . . . . .	12,979	9,330				
			22,309		22,309	
<b>8a</b> Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18 . . . . .	a					
<b>b</b> Less direct expenses . . . . .	b					
<b>c</b> Net income or (loss) from fundraising events . . . . .						
<b>9a</b> Gross income from gaming activities See Part IV, line 19 . . . . .	a					
<b>b</b> Less direct expenses . . . . .	b					
<b>c</b> Net income or (loss) from gaming activities . . . . .						
<b>10a</b> Gross sales of inventory, less returns and allowances . . . . .	a					
<b>b</b> Less cost of goods sold . . . . .	b					
<b>c</b> Net income or (loss) from sales of inventory . . . . .						
Miscellaneous Revenue	<b>Business Code</b>					
<b>11a</b> MISCELLANEOUS	900099	24,601			24,601	
<b>b</b> OTHER INVESTMENTS	900099	-4,083,186			-4,083,186	
<b>c</b>						
<b>d</b> All other revenue . . . . .						
<b>e</b> <b>Total.</b> Add lines 11a-11d . . . . .		-4,058,585				
<b>12</b> <b>Total revenue.</b> See Instructions . . . . .		538,451,267	529,080,363	10,543,700	-1,383,801	

**Part IX Statement of Functional Expenses**

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

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

<b>Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.</b>	<b>(A) Total expenses</b>	<b>(B) Program service expenses</b>	<b>(C) Management and general expenses</b>	<b>(D) Fundraising expenses</b>
<b>1</b> Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21				
<b>2</b> Grants and other assistance to domestic individuals See Part IV, line 22				
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, lines 15 and 16				
<b>4</b> Benefits paid to or for members				
<b>5</b> Compensation of current officers, directors, trustees, and key employees	11,465,076		11,465,076	
<b>6</b> Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
<b>7</b> Other salaries and wages	245,123,814	198,971,029	46,152,785	
<b>8</b> Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	7,804,014	6,259,599	1,544,415	
<b>9</b> Other employee benefits	31,897,171	24,086,976	7,810,195	
<b>10</b> Payroll taxes	14,455,778	10,776,172	3,679,606	
<b>11</b> Fees for services (non-employees)				
<b>a</b> Management				
<b>b</b> Legal	861,718		861,718	
<b>c</b> Accounting	45,100		45,100	
<b>d</b> Lobbying				
<b>e</b> Professional fundraising services See Part IV, line 17				
<b>f</b> Investment management fees	33,035		33,035	
<b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	28,536,009	16,003,141	12,532,868	
<b>12</b> Advertising and promotion	2,922,634	29,538	2,893,096	
<b>13</b> Office expenses	89,521,539	84,516,705	5,004,834	
<b>14</b> Information technology	1,072,397	364,988	707,409	
<b>15</b> Royalties				
<b>16</b> Occupancy	8,627,984	7,739,906	888,078	
<b>17</b> Travel	1,087,435	493,135	594,300	
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials				
<b>19</b> Conferences, conventions, and meetings	1,504,964	1,082,196	422,768	
<b>20</b> Interest	9,229,088	8,279,138	949,950	
<b>21</b> Payments to affiliates				
<b>22</b> Depreciation, depletion, and amortization	25,883,670	23,197,204	2,686,466	
<b>23</b> Insurance	5,248,405	3,682,329	1,566,076	
<b>24</b> Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24e If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O)	23,755,339	23,755,339		
<b>a</b> BAD DEBTS				
<b>b</b> EQUIPMENT REPAIRS & MAI	8,069,744	5,360,792	2,708,952	
<b>c</b> WI MEDICAID & OTHER TAX	7,825,864	7,825,864		
<b>d</b> INTER-ENTITY TRANSACTION	-7,150,979	-5,527,125	-1,623,854	
<b>e</b> All other expenses	3,937,925	975,222	2,962,703	
<b>25</b> <b>Total functional expenses.</b> Add lines 1 through 24e	521,757,724	417,872,148	103,885,576	0
<b>26</b> <b>Joint costs.</b> Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)				

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

		(A) Beginning of year	(B) End of year
<b>Assets</b>			
1	Cash—non-interest-bearing	24,990	<b>1</b> 26,759
2	Savings and temporary cash investments	19,975,876	<b>2</b> 42,527,506
3	Pledges and grants receivable, net	3	
4	Accounts receivable, net	87,097,875	<b>4</b> 92,564,232
5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L	5	
6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L	6	
7	Notes and loans receivable, net	7	
8	Inventories for sale or use	10,737,552	<b>8</b> 11,486,031
9	Prepaid expenses and deferred charges	5,824,521	<b>9</b> 3,631,138
10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	<b>10a</b> 550,894,358	
b	Less accumulated depreciation	<b>10b</b> 269,989,734	288,590,194 <b>10c</b> 280,904,624
11	Investments—publicly traded securities	11	
12	Investments—other securities See Part IV, line 11	73,661,949	<b>12</b> 72,290,520
13	Investments—program-related See Part IV, line 11	13	
14	Intangible assets	14	
15	Other assets See Part IV, line 11	11,612,645	<b>15</b> 12,420,007
16	<b>Total assets.</b> Add lines 1 through 15 (must equal line 34)	497,525,602	<b>16</b> 515,850,817
<b>Liabilities</b>			
17	Accounts payable and accrued expenses	60,162,338	<b>17</b> 67,931,328
18	Grants payable	18	
19	Deferred revenue	19	
20	Tax-exempt bond liabilities	20	
21	Escrow or custodial account liability Complete Part IV of Schedule D	21	
22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L	22	
23	Secured mortgages and notes payable to unrelated third parties	7,104,728	<b>23</b> 5,942,428
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	235,784,631	<b>25</b> 235,521,345
26	<b>Total liabilities.</b> Add lines 17 through 25	303,051,697	<b>26</b> 309,395,101
<b>Net Assets or Fund Balances</b>			
	<b>Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.</b>		
27	Unrestricted net assets	194,473,905	<b>27</b> 206,455,716
28	Temporarily restricted net assets	28	
29	Permanently restricted net assets	29	
	<b>Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.</b>		
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	194,473,905	<b>33</b> 206,455,716
34	<b>Total liabilities and net assets/fund balances</b>	497,525,602	<b>34</b> 515,850,817

**Part XI Reconciliation of Net Assets**Check if Schedule O contains a response or note to any line in this Part XI 

1	Total revenue (must equal Part VIII, column (A), line 12)	1	538,451,267
2	Total expenses (must equal Part IX, column (A), line 25)	2	521,757,724
3	Revenue less expenses Subtract line 2 from line 1	3	16,693,543
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	194,473,905
5	Net unrealized gains (losses) on investments	5	-1,186,128
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-3,525,604
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	206,455,716

**Part XII Financial Statements and Reporting**Check if Schedule O contains a response or note to any line in this Part XII 

	Yes	No
1 Accounting method used to prepare the Form 990 <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O		
2a Were the organization's financial statements compiled or reviewed by an independent accountant? If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	2a	No
2b Were the organization's financial statements audited by an independent accountant? If 'Yes,' check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	2b	Yes
2c If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O	2c	Yes
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? 3b 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	3a	No
	3b	

## Additional Data

**Software ID:**  
**Software Version:**  
**EIN:** 39-0816848  
**Name:** MERCY HEALTH SYSTEM CORPORATION

**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 (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)					(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee			
(1) ROWLAND MCCLELLAN ..... CHAIRPERSON & DIRECTOR	1 00 .....	X					0	0	0
(1) THOMAS POOL ..... VICE-CHAIRPERSON & DIRECTOR	1 00 .....	X					19,500	0	0
(2) LARRY SQUIRE ..... TREASURER & DIRECTOR	1 00 .....	X					2,333	0	0
(3) ELIZABETH HANSCH ..... DIRECTOR	1 00 .....	X					0	0	0
(4) DAVE SYVERSON ..... DIRECTOR	1 00 .....	X					15,000	0	0
(5) MARK GOELZER MD ..... DIRECTOR/PHYSICIAN	55 00 .....				X		457,757	0	31,022
(6) KATHERINE SCHACK ..... DIRECTOR	1 00 .....	X					664	0	0
(7) MARK KOPP ..... DIRECTOR	1 00 .....	X					1,735	0	0
(8) DENNIS UEHARA ..... DIRECTOR	1 00 55 00 .....	X					0	0	0
(9) CURTIS WORDEN ..... DIRECTOR	1 00 .....	X					0	0	0
(10) BARB BORTNER ..... VICE-PRESIDENT	55 00 .....			X			216,651	0	36,963
(11) DAN COLBY ..... VICE-PRESIDENT	55 00 .....			X			273,892	0	30,198
(12) DAVID KURTZ ..... VICE-PRESIDENT	55 00 .....			X			254,723	0	27,222
(13) JOHN COOK ..... VICE-PRESIDENT	55 00 .....			X			414,941	0	39,695
(14) KATHLEEN HARRIS ..... VICE-PRESIDENT	55 00 .....			X			146,755	0	30,816
(15) RUTH YARBROUGH ..... VICE-PRESIDENT	55 00 .....			X			272,996	0	24,986
(16) RICHARD GRUBER ..... VICE-PRESIDENT	55 00 .....			X			225,377	0	30,391
(17) E PATRICK CRANLEY ..... VICE-PRESIDENT	55 00 .....			X			13,288	0	0
(18) JOANNA BENNING ..... VICE-PRESIDENT	55 00 .....			X			0	0	0
(19) JOSEPH NEMETH ..... VICE-PRESIDENT	55 00 .....			X			229,563	0	28,952
(20) SUE RIPSCH ..... VICE-PRESIDENT	55 00 .....			X			408,512	0	34,595
(21) JENNIFER HALLATT ..... VICE-PRESIDENT	1 00 .....			X			240,824	0	41,637
(22) PAUL VAN DEN HEUVEL ..... VICE-PRESIDENT	1 00 .....			X			321,557	0	39,065
(23) JAVON BEA ..... PRESIDENT & DIRECTOR	55 00 .....	X		X			8,005,192	0	38,785
(24) BRADLEY FIDELER ..... PHYSICIAN	40 00 .....				X		1,389,324	0	44,924

**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 (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)					(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations	
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated				
(26) MERLE RUST ..... PHYSICIAN	40 00 .....					X		1,265,325	0	44,441
(1) ROBB WHINNEY ..... PHYSICIAN	40 00 .....					X		1,188,907	0	34,767
(2) CRAIG LYON ..... PHYSICIAN	40 00 .....					X		1,156,541	0	40,504
(3) JONATHAN EHRHARDT ..... PHYSICIAN	40 00 .....					X		1,097,779	0	28,328

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

► Information about Schedule A (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).**2014****Open to Public  
Inspection**Department of the  
Treasury  
Internal Revenue Service**Name of the organization**

MERCY HEALTH SYSTEM CORPORATION

**Employer identification number**

39-0816848

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

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

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

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

3  A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii)**.

4  A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii)**. Enter the hospital's name, city, and state \_\_\_\_\_

5  An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv)**. (Complete Part II )

6  A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v)**.

7  An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi)**. (Complete Part II )

8  A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II )

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

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

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

a  **Type I**. A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization **You must complete Part IV, Sections A and B**.

b  **Type II**. A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s) **You must complete Part IV, Sections A and C**.

c  **Type III functionally integrated**. A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions) **You must complete Part IV, Sections A, D, and E**.

d  **Type III non-functionally integrated**. A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions) **You must complete Part IV, Sections A and D, and Part V**.

e  Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization

f Enter the number of supported organizations . . . . .

g Provide the following information about the supported organization(s)

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-9 above or IRC section (see instructions))	(iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
<b>Total</b>						

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

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

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ►	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(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 <b>Total.</b> 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 <b>Public support.</b> Subtract line 5 from line 4						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI )						
11 <b>Total support</b> Add lines 7 through 10						
12 Gross receipts from related activities, etc (see instructions)					12	
13 <b>First five years.</b> If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and <b>stop here</b> . . . . . ►						

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

14 Public support percentage for 2014 (line 6, column (f) divided by line 11, column (f))	14	
15 Public support percentage for 2013 Schedule A, Part II, line 14	15	
16a <b>33 1/3% support test—2014.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here</b> . The organization qualifies as a publicly supported organization ►		
b <b>33 1/3% support test—2013.</b> If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and <b>stop here</b> . The organization qualifies as a publicly supported organization ►		
17a <b>10%-facts-and-circumstances test—2014.</b> 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 <b>stop here</b> . Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ►		
b <b>10%-facts-and-circumstances test—2013.</b> 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 <b>stop here</b> . Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ►		
18 <b>Private foundation.</b> If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ►		

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

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

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ►	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(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						
<b>6 Total.</b> Add lines 1 through 5						
<b>7a</b> Amounts included on lines 1, 2, and 3 received from disqualified persons						
<b>b</b> Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
<b>c</b> Add lines 7a and 7b						
<b>8 Public support</b> (Subtract line 7c from line 6 )						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
9 Amounts from line 6						
<b>10a</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
<b>b</b> Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
<b>c</b> Add lines 10a and 10b						
<b>11</b> Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
<b>12</b> Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI )						
<b>13 Total support.</b> (Add lines 9, 10c, 11, and 12 )						
<b>14 First five years.</b> If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and <b>stop here</b> ►						

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

15 Public support percentage for 2014 (line 8, column (f) divided by line 13, column (f))	15
16 Public support percentage from 2013 Schedule A, Part III, line 15	16

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

17 Investment income percentage for 2014 (line 10c, column (f) divided by line 13, column (f))	17
18 Investment income percentage from 2013 Schedule A, Part III, line 17	18
<b>19a 33 1/3% support tests—2014.</b> 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 <b>stop here</b> . The organization qualifies as a publicly supported organization ►	
<b>b 33 1/3% support tests—2013.</b> 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 <b>stop here</b> . The organization qualifies as a publicly supported organization ►	

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

**Part IV Supporting Organizations**

(Complete only if you checked a box on line 11 of Part I. If you checked 11a of Part I, complete Sections A and B. If you checked 11b of Part I, complete Sections A and C. If you checked 11c of Part I, complete Sections A, D, and E. If you checked 11d of Part I, complete Sections A and D, and complete Part V.)

**Section A. All Supporting Organizations**

**1** Are all of the organization's supported organizations listed by name in the organization's governing documents? If "No," describe in **Part VI** how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.

**2** Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? If "Yes," explain in **Part VI** how the organization determined that the supported organization was described in section 509(a)(1) or (2).

**3a** Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? If "Yes," answer (b) and (c) below.

**b** Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? If "Yes," describe in **Part VI** when and how the organization made the determination.

**c** Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? If "Yes," explain in **Part VI** what controls the organization put in place to ensure such use.

**4a** Was any supported organization not organized in the United States ("foreign supported organization")? If "Yes" and if you checked 11a or 11b in Part I, answer (b) and (c) below.

**b** Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? If "Yes," describe in **Part VI** how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations. . . .

**c** Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? If "Yes," explain in **Part VI** what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.

**5a** Did the organization add, substitute, or remove any supported organizations during the tax year? If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in **Part VI**, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed, (ii) the reasons for each such action, (iii) the authority under the organization's organizing document authorizing such action, and (iv) how the action was accomplished (such as by amendment to the organizing document).

**b** **Type I or Type II only.** Was any added or substituted supported organization part of a class already designated in the organization's organizing document?

**c** **Substitutions only.** Was the substitution the result of an event beyond the organization's control?

**6** Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (a) its supported organizations, (b) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (c) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? If "Yes," provide detail in **Part VI**.

**7** Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in IRC 4958(c)(3)(C)), a family member of a substantial contributor, or a 35-percent controlled entity with regard to a substantial contributor? If "Yes," complete Part I of Schedule L (Form 990).

**8** Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? If "Yes," complete Part II of Schedule L (Form 990).

**9a** Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? If "Yes," provide detail in **Part VI**.

**b** Did one or more disqualified persons (as defined in line 9(a)) hold a controlling interest in any entity in which the supporting organization had an interest? If "Yes," provide detail in **Part VI**.

**c** Did a disqualified person (as defined in line 9(a)) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? If "Yes," provide detail in **Part VI**.

**10a** Was the organization subject to the excess business holdings rules of IRC 4943 because of IRC 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? If "Yes," answer b below.

**b** Did the organization have any excess business holdings in the tax year? (Use Schedule C, Form 4720, to determine whether the organization had excess business holdings).

**11** Has the organization accepted a gift or contribution from any of the following persons?

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

**b** A family member of a person described in (a) above?

**c** A 35% controlled entity of a person described in (a) or (b) above? If "Yes" to a, b, or c, provide detail in **Part VI**.

	Yes	No
<b>1</b>		
<b>2</b>		
<b>3a</b>		
<b>3b</b>		
<b>3c</b>		
<b>4a</b>		
<b>4b</b>		
<b>4c</b>		
<b>5a</b>		
<b>5b</b>		
<b>5c</b>		
<b>6</b>		
<b>7</b>		
<b>8</b>		
<b>9a</b>		
<b>9b</b>		
<b>9c</b>		
<b>10a</b>		
<b>10b</b>		
<b>11a</b>		
<b>11b</b>		
<b>11c</b>		

**Part IV Supporting Organizations (continued)****Section B. Type I Supporting Organizations**

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

2 Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? If "Yes," explain in **Part VI** how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised or controlled the supporting organization.

	Yes	No
1		
2		

**Section C. Type II Supporting Organizations**

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

	Yes	No
1		

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

1 Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (1) a written notice describing the type and amount of support provided during the prior tax year, (2) a copy of the Form 990 that was most recently filed as of the date of notification, and (3) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?

2 Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization(s) or (ii) serving on the governing body of a supported organization? If "No," explain in **Part VI** how the organization maintained a close and continuous working relationship with the supported organization(s).

3 By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? If "Yes," describe in **Part VI** the role the organization's supported organizations played in this regard.

	Yes	No
1		
2		
3		

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

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (**see instructions**)

a  The organization satisfied the Activities Test Complete **line 2** below

b  The organization is the parent of each of its supported organizations Complete **line 3** below

c  The organization supported a governmental entity Describe in Part VI how you supported a government entity (**see instructions**)

2 Activities Test **Answer (a) and (b) below.**

a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? If "Yes," then in **Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.**

	Yes	No
2a		

b Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? If "Yes," explain in **Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.**

	Yes	No
2b		
3a		

3 Parent of Supported Organizations **Answer (a) and (b) below.**

a Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? *Provide details in Part VI.*

	Yes	No
3a		
3b		

b Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? If "Yes," describe in Part VI the role played by the organization in this regard.

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

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

**Section A - Adjusted Net Income**

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

	(A) Prior Year	(B) Current Year (optional)
1		
2		
3		
4		
5		
6		
7		
8		

**Section B - Minimum Asset Amount**

1 Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year)  
 a Average monthly value of securities  
 b Average monthly cash balances  
 c Fair market value of other non-exempt-use assets  
 d Total (add lines 1a, 1b, and 1c)  
 e Discount claimed for blockage or other factors (explain in detail in Part VI) \_\_\_\_\_  
 2 Acquisition indebtedness applicable to non-exempt use assets  
 3 Subtract line 2 from line 1d  
 4 Cash deemed held for exempt use Enter 1-1/2% of line 3 (for greater amount, see instructions)  
 5 Net value of non-exempt-use assets (subtract line 4 from line 3)  
 6 Multiply line 5 by 035  
 7 Recoveries of prior-year distributions  
 8 Minimum Asset Amount (add line 7 to line 6)

	(A) Prior Year	(B) Current Year (optional)
1		
1a		
1b		
1c		
1d		
2		
3		
4		
5		
6		
7		
8		

**Section C - Distributable Amount**

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

		Current Year
1		
2		
3		
4		
5		
6		

**Section D - Distributions**

	<b>Current Year</b>
<b>1</b> Amounts paid to supported organizations to accomplish exempt purposes	
<b>2</b> Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
<b>3</b> Administrative expenses paid to accomplish exempt purposes of supported organizations	
<b>4</b> Amounts paid to acquire exempt-use assets	
<b>5</b> Qualified set-aside amounts (prior IRS approval required)	
<b>6</b> Other distributions (describe in Part VI) See instructions	
<b>7 Total annual distributions.</b> Add lines 1 through 6	
<b>8</b> Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI) See instructions	
<b>9</b> Distributable amount for 2014 from Section C, line 6	
<b>10</b> Line 8 amount divided by Line 9 amount	

<b>Section E - Distribution Allocations (see instructions)</b>	<b>(i) Excess Distributions</b>	<b>(ii) Underdistributions Pre-2014</b>	<b>(iii) Distributable Amount for 2014</b>
<b>1</b> Distributable amount for 2014 from Section C, line 6			
<b>2</b> Underdistributions, if any, for years prior to 2014 (reasonable cause required--see instructions)			
<b>3</b> Excess distributions carryover, if any, to 2014			
<b>a</b> From 2009. . . . .			
<b>b</b> From 2010. . . . .			
<b>c</b> From 2011. . . . .			
<b>d</b> From 2012. . . . .			
<b>e</b> From 2013. . . . .			
<b>f Total</b> of lines 3a through e			
<b>g</b> Applied to underdistributions of prior years			
<b>h</b> Applied to 2014 distributable amount			
<b>i</b> Carryover from 2009 not applied (see instructions)			
<b>j</b> Remainder Subtract lines 3g, 3h, and 3i from 3f			
<b>4</b> Distributions for 2014 from Section D, line 7 \$ _____			
<b>a</b> Applied to underdistributions of prior years			
<b>b</b> Applied to 2014 distributable amount			
<b>c</b> Remainder Subtract lines 4a and 4b from 4			
<b>5</b> Remaining underdistributions for years prior to 2014, if any Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions)			
<b>6</b> Remaining underdistributions for 2014 Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions)			
<b>7 Excess distributions carryover to 2015.</b> Add lines 3j and 4c			
<b>8</b> Breakdown of line 7			
<b>a</b> From 2010. . . . .			
<b>b</b> From 2011. . . . .			
<b>c</b> From 2012. . . . .			
<b>d</b> From 2013. . . . .			
<b>e</b> From 2014. . . . .			

**Part VI Supplemental Information.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; Part III, line 12; Part IV, Section A, lines 1, 2, 3b, 3c, 4b, 4c, 5a, 6, 9a, 9b, 9c, 11a, 11b, and 11c; Part IV, Section B, lines 1 and 2; Part IV, Section C, line 1; Part IV, Section D, lines 2 and 3; Part IV, Section E, lines 1c, 2a, 2b, 3a and 3b; Part V, line 1; Part V, Section B, line 1e; Part V Section D, lines 5, 6, and 8; and Part V, Section E, lines 2, 5, and 6. Also complete this part for any additional information. (See instructions).

Facts And Circumstances Test

Return Reference

Explanation

**SCHEDULE D**  
(Form 990)**Supplemental Financial Statements**

OMB No 1545-0047

**2014**

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

► Attach to Form 990.

Information about Schedule D (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).**Open to Public Inspection**Department of the Treasury  
Internal Revenue Service**Name of the organization**

MERCY HEALTH SYSTEM CORPORATION

**Employer identification number**

39-0816848

**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 value of contributions to (during year)		
3 Aggregate value of grants from (during year)		
4 Aggregate value at end of year		

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

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

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

1 Purpose(s) of conservation easements held by the organization (check all that apply)	<input type="checkbox"/> Preservation of land for public use (e.g., recreation or education) <input type="checkbox"/> Preservation of an historically important land area
	<input type="checkbox"/> Protection of natural habitat <input type="checkbox"/> Preservation of a certified historic structure
	<input type="checkbox"/> Preservation of open space
2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year	
a Total number of conservation easements	<b>Held at the End of the Year</b>
b Total acreage restricted by conservation easements	2a
c Number of conservation easements on a certified historic structure included in (a)	2b
d Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2c
3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ► _____	2d
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6 Staff and volunteer hours devoted to monitoring, inspecting, and enforcing conservation easements during the year ► _____	
7 Amount of expenses incurred in monitoring, inspecting, and enforcing conservation easements during the year ► \$ _____	
8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements	

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

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items

(i) Revenue included in Form 990, Part VIII, line 1 ► \$ \_\_\_\_\_

(ii) Assets included in Form 990, Part X ► \$ \_\_\_\_\_

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items

a Revenue included in Form 990, Part VIII, line 1 ► \$ \_\_\_\_\_

b Assets included in Form 990, Part X ► \$ \_\_\_\_\_

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

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

<b>a</b> <input type="checkbox"/> Public exhibition	<b>d</b> <input type="checkbox"/> Loan or exchange programs
<b>b</b> <input type="checkbox"/> Scholarly research	<b>e</b> <input type="checkbox"/> Other
<b>c</b> <input type="checkbox"/> 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 XIII

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

**Part IV Escrow and Custodial Arrangements.** Complete if the organization answered "Yes" 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 XIII and complete the following table

	<b>Amount</b>
<b>1c</b>	
<b>1d</b>	
<b>1e</b>	
<b>1f</b>	

**2a** Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability?  Yes  No

**b** If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII

**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
<b>1a</b> Beginning of year balance . . . . .					
<b>b</b> Contributions . . . . .					
<b>c</b> Net investment earnings, gains, and losses					
<b>d</b> Grants or scholarships . . . . .					
<b>e</b> Other expenditures for facilities and programs . . . . .					
<b>f</b> Administrative expenses . . . . .					
<b>g</b> End of year balance . . . . .					

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

**a** Board designated or quasi-endowment

**b** Permanent endowment

**c** Temporarily restricted endowment

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

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

**(i)** unrelated organizations . . . . .

**(ii)** related organizations . . . . .

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

<b>Yes</b>	<b>No</b>
<b>3a(i)</b>	
<b>3a(ii)</b>	
<b>3b</b>	

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

**Part VI Land, Buildings, and Equipment.** Complete if the organization answered 'Yes' to Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

	Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
<b>1a</b> Land . . . . .		27,052,591			27,052,591
<b>b</b> Buildings . . . . .		303,684,416	117,743,138		185,941,278
<b>c</b> Leasehold improvements . . . . .		5,414,556	4,207,254		1,207,302
<b>d</b> Equipment . . . . .		201,330,721	142,793,763		58,536,958
<b>e</b> Other . . . . .		13,412,074	5,245,579		8,166,495
<b>Total.</b> Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c).)					280,904,624

**Part VII Investments—Other Securities.** Complete if the organization answered 'Yes' to Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other		
(A) INVEST - FUTURE REPLACE OF PROP, PLANT & EQUIPMENT	32,902,139	C
(B) ASSETS UNDER BOND INDENTURE AGREEMENT	4,355,413	C
(C) DEFERRED COMPENSATION	12,545,681	C
(D) INVESTMENT IN MERCYCARE	17,732,416	C
(E) INVESTMENTS - OTHER	4,754,871	C
<b>Total. (Column (b) must equal Form 990, Part X, col (B) line 12 )</b>	<b>72,290,520</b>	

**Part VIII Investments—Program Related.** Complete if the organization answered 'Yes' to Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

(a) Description of investment	(b) Book value	(c) Method of valuation Cost or end-of-year market value
<b>Total. (Column (b) must equal Form 990, Part X, col (B) line 13 )</b>		

**Part IX Other Assets.** Complete if the organization answered 'Yes' to Form 990, Part IV, line 11d. See Form 990, Part X, line 15

(a) Description	(b) Book value
<b>Total. (Column (b) must equal Form 990, Part X, col.(B) line 15.)</b>	

**Part X Other Liabilities.** Complete if the organization answered 'Yes' to Form 990, Part IV, line 11e or 11f. See Form 990, Part X, line 25.

1 (a) Description of liability	(b) Book value
Federal income taxes	
DEFERRED COMPENSATION	12,545,681
PENSION LIABILITY	23,408,000
CAPITAL LEASES PAYABLE	119,500
DUE TO RELATED PARTY	198,001,399
DUE TO THIRD PARTIES	1,446,765
<b>Total. (Column (b) must equal Form 990, Part X, col (B) line 25 )</b>	<b>235,521,345</b>

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

**Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return** Complete if the organization answered 'Yes' to Form 990, Part IV, line 12a.

1	Total revenue, gains, and other support per audited financial statements . . . . .	<table border="1" style="margin: auto;"> <tr><td>2a</td><td></td></tr> <tr><td>2b</td><td></td></tr> <tr><td>2c</td><td></td></tr> <tr><td>2d</td><td></td></tr> <tr><td>2e</td><td></td></tr> </table>	2a		2b		2c		2d		2e		1	
2a														
2b														
2c														
2d														
2e														
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12													
a	Net unrealized gains (losses) on investments . . . . .													
b	Donated services and use of facilities . . . . .													
c	Recoveries of prior year grants . . . . .													
d	Other (Describe in Part XIII ) . . . . .	<table border="1" style="margin: auto;"> <tr><td>4a</td><td></td></tr> <tr><td>4b</td><td></td></tr> </table>	4a		4b									
4a														
4b														
e	Add lines 2a through 2d . . . . .													
3	Subtract line 2e from line 1 . . . . .	<table border="1" style="margin: auto;"> <tr><td>3</td><td></td></tr> <tr><td>4a</td><td></td></tr> <tr><td>4b</td><td></td></tr> <tr><td>4c</td><td></td></tr> <tr><td>5</td><td></td></tr> </table>	3		4a		4b		4c		5			
3														
4a														
4b														
4c														
5														
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 . . . . .													
b	Other (Describe in Part XIII ) . . . . .													
c	Add lines 4a and 4b . . . . .													
5	Total revenue Add lines 3 and 4c. (This must equal Form 990, Part I, line 12 ) . . . . .													

**Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.** Complete if the organization answered 'Yes' to Form 990, Part IV, line 12a.

1	Total expenses and losses per audited financial statements . . . . .	<table border="1" style="margin: auto;"> <tr><td>2a</td><td></td></tr> <tr><td>2b</td><td></td></tr> <tr><td>2c</td><td></td></tr> <tr><td>2d</td><td></td></tr> <tr><td>2e</td><td></td></tr> </table>	2a		2b		2c		2d		2e		1	
2a														
2b														
2c														
2d														
2e														
2	Amounts included on line 1 but not on Form 990, Part IX, line 25													
a	Donated services and use of facilities . . . . .													
b	Prior year adjustments . . . . .													
c	Other losses . . . . .													
d	Other (Describe in Part XIII ) . . . . .	<table border="1" style="margin: auto;"> <tr><td>4a</td><td></td></tr> <tr><td>4b</td><td></td></tr> </table>	4a		4b									
4a														
4b														
e	Add lines 2a through 2d . . . . .													
3	Subtract line 2e from line 1 . . . . .	<table border="1" style="margin: auto;"> <tr><td>3</td><td></td></tr> <tr><td>4a</td><td></td></tr> <tr><td>4b</td><td></td></tr> <tr><td>4c</td><td></td></tr> <tr><td>5</td><td></td></tr> </table>	3		4a		4b		4c		5			
3														
4a														
4b														
4c														
5														
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 . . . . .													
b	Other (Describe in Part XIII ) . . . . .													
c	Add lines 4a and 4b . . . . .													
5	Total expenses Add lines 3 and 4c. (This must equal Form 990, Part I, line 18 ) . . . . .													

**Part XIII Supplemental Information**

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

Return Reference	Explanation

**Part XIII** **Supplemental Information (continued)**

Return Reference	Explanation

SCHEDULE H  
(Form 990)

## Hospitals

OMB No 1545-0047

Department of the Treasury  
Internal Revenue Service

► Complete if the organization answered "Yes" to Form 990, Part IV, question 20.

► Attach to Form 990.

► Information about Schedule H (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

2014

Open to Public  
InspectionName of the organization  
MERCY HEALTH SYSTEM CORPORATION

Employer identification number

39-0816848

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

1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a . . . . .

b If "Yes," was it a written policy? . . . . .

2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year

Applied uniformly to all hospital facilities  Applied uniformly to most hospital facilities

Generally tailored to individual hospital facilities

3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year

a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for *free* care

100%  150%  200%  Other \_\_\_\_\_ %

b Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care

200%  250%  300%  350%  400%  Other \_\_\_\_\_ %

c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care

4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"? . . . . .

5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? . . . . .

b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? . . . . .

c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care? . . . . .

6a Did the organization prepare a community benefit report during the tax year? . . . . .

b If "Yes," did the organization make it available to the public? . . . . .

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

	Yes	No
1a	Yes	
1b	Yes	
3a	Yes	
3b	Yes	
4	Yes	
5a	Yes	
5b		No
5c		
6a		No
6b		

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

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1) . . . . .			2,594,823	0	2,594,823	0 520 %
b Medicaid (from Worksheet 3, column a) . . . . .			145,920,882	98,833,216	47,087,666	9 460 %
c Costs of other means-tested government programs (from Worksheet 3, column b) . . . . .			4,736,755	2,818,984	1,917,771	0 390 %
d Total Financial Assistance and Means-Tested Government Programs . . . . .			153,252,460	101,652,200	51,600,260	10 370 %
<b>Other Benefits</b>						
e Community health improvement services and community benefit operations (from Worksheet 4) . . . . .			1,588,117	186,781	1,401,336	0 280 %
f Health professions education (from Worksheet 5) . . . . .			6,205,630	814,443	5,391,187	1 080 %
g Subsidized health services (from Worksheet 6) . . . . .			15,993,759	12,329,893	3,663,866	0 740 %
h Research (from Worksheet 7) . . . . .			0	0		0 %
i Cash and in-kind contributions for community benefit (from Worksheet 8) . . . . .			856,316	0	856,316	0 170 %
j Total. Other Benefits . . . . .			24,643,822	13,331,117	11,312,705	2 270 %
k Total. Add lines 7d and 7j . . . . .			177,896,282	114,983,317	62,912,965	12 640 %

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support			54,100		54,100	0 010 %
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building			33,290		33,290	0 010 %
7 Community health improvement advocacy			20,810		20,810	0 %
8 Workforce development			35,370		35,370	0 010 %
9 Other						
<b>10 Total</b>			143,570		143,570	0 030 %

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

**Section A. Bad Debt Expense**

1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No 15? **1** Yes

2 Enter the amount of the organization's bad debt expense Explain in Part VI the methodology used by the organization to estimate this amount **2** 9,065,269

3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit **3** 1,571,011

4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements

**Section B. Medicare**

5 Enter total revenue received from Medicare (including DSH and IME) **5** 59,026,628

6 Enter Medicare allowable costs of care relating to payments on line 5 **6** 91,163,939

7 Subtract line 6 from line 5 This is the surplus (or shortfall) **7** -32,137,311

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

Cost accounting system

Cost to charge ratio

Other

**Section C. Collection Practices**

9a Did the organization have a written debt collection policy during the tax year? **9a** Yes

b If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI **9b** Yes

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

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

**Part V Facility Information****Section A. Hospital Facilities**

(list in order of size from largest to smallest—see instructions)

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

2

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

See Additional Data Table

Other (describe)

Facility reporting group

**Part V Facility Information (continued)****Section B. Facility Policies and Practices**

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

MERCY HOSPITAL AND TRAUMA CENTER

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

1

	<b>Yes</b>	<b>No</b>
<b>Community Health Needs Assessment</b>		
1 Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year? . . . . .	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C . . . . .	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 . . . . . If "Yes," indicate what the CHNA report describes (check all that apply)	3	Yes
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA 20 13	5	Yes
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .		
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C . . . . .	6b	Yes
7 Did the hospital facility make its CHNA report widely available to the public? . . . . . If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a <input checked="" type="checkbox"/> Hospital facility's website (list url) MERCYHEALTHSYSTEM.ORG		
b <input type="checkbox"/> Other website (list url) _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 . . . . .	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 13		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . .	10	Yes
a If "Yes" (list url) MERCYHEALTHSYSTEM.ORG		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	10b	No
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .	12a	No
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	12b	
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

**Part V Facility Information (continued)**

## MERCY HOSPITAL AND TRAUMA CENTER

Name of hospital facility or letter of facility reporting group \_\_\_\_\_

		Yes	No
<b>Financial Assistance Policy (FAP)</b>			
Did the hospital facility have in place during the tax year a written financial assistance policy that			
<b>13</b>	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	<b>13</b>	Yes
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>150 000000000000%</u> and FPG family income limit for eligibility for discounted care of <u>300 000000000000%</u>		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input checked="" type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance discount		
g	<input checked="" type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
<b>14</b>	Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b>	Yes
<b>15</b>	Explained the method for applying for financial assistance? . . . . . If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	<b>15</b>	Yes
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
<b>16</b>	Included measures to publicize the policy within the community served by the hospital facility? . . . . . If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	<b>16</b>	Yes
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>MERCYHEALTHSYSTEM.ORG</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>MERCYHEALTHSYSTEM.ORG</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>MERCYHEALTHSYSTEM.ORG</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
h	<input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> Other (describe in Section C)		

**Billing and Collections**

<b>17</b>	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment? . . . . .	<b>17</b>	Yes
<b>18</b>	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
a	<input checked="" type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Actions that require a legal or judicial process		
d	<input type="checkbox"/> Other similar actions (describe in Section C)		
e	<input type="checkbox"/> None of these actions or other similar actions were permitted		

**Part V Facility Information (continued)****MERCY HOSPITAL AND TRAUMA CENTER****Name of hospital facility or letter of facility reporting group** \_\_\_\_\_

	<b>Yes</b>	<b>No</b>
<b>19</b> Did the hospital facility or other authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? . . . . .	<b>19</b>	No
If "Yes," check all actions in which the hospital facility or a third party engaged		
a <input type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Actions that require a legal or judicial process		
d <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b> Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (check all that apply)		
a <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission		
b <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge		
c <input type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills		
d <input type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy		
e <input type="checkbox"/> Other (describe in Section C)		
f <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

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

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

<b>22</b> Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care		
a <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged		
b <input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged		
c <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
<b>23</b> During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? . . . . .	<b>23</b>	No
If "Yes," explain in Section C		
<b>24</b> During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? . . . . .	<b>24</b>	No
If "Yes," explain in Section C		

**Part V Facility Information (continued)****Section B. Facility Policies and Practices**

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

MERCY WALWORTH HOSPITAL AND MEDICAL CENT

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

2

	<b>Yes</b>	<b>No</b>
<b>Community Health Needs Assessment</b>		
1	No	
2	No	
3	Yes	
4	Yes	
5	Yes	
6a	Yes	
6b	Yes	
7	Yes	
8	Yes	
9	Yes	
10	Yes	
10b	No	
11	No	
12a	No	
12b	No	

1 Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year? . . . . .

2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C . . . . .

3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 . . . . .  
If "Yes," indicate what the CHNA report describes (check all that apply)

a  A definition of the community served by the hospital facility

b  Demographics of the community

c  Existing health care facilities and resources within the community that are available to respond to the health needs of the community

d  How data was obtained

e  The significant health needs of the community

f  Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups

g  The process for identifying and prioritizing community health needs and services to meet the community health needs

h  The process for consulting with persons representing the community's interests

i  Information gaps that limit the hospital facility's ability to assess the community's health needs

j  Other (describe in Section C)

4 Indicate the tax year the hospital facility last conducted a CHNA 20 13

5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .

6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .

6b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C . . . . .

7 Did the hospital facility make its CHNA report widely available to the public? . . . . .  
If "Yes," indicate how the CHNA report was made widely available (check all that apply)

a  Hospital facility's website (list url) MERCYHEALTHSYSTEM.ORG

b  Other website (list url) \_\_\_\_\_

c  Made a paper copy available for public inspection without charge at the hospital facility

d  Other (describe in Section C)

8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 . . . . .

9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 13

10 Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . .

a If "Yes" (list url) MERCYHEALTHSYSTEM.ORG

b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .

11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed

12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .

b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .

c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ \_\_\_\_\_

**Part V Facility Information (continued)****MERCY WALWORTH HOSPITAL AND MEDICAL CENT**

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_

	<b>Yes</b>	<b>No</b>
<b>Financial Assistance Policy (FAP)</b>		
Did the hospital facility have in place during the tax year a written financial assistance policy that		
<b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	<b>13</b>	Yes
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>150 000000000000%</u> and FPG family income limit for eligibility for discounted care of <u>300 000000000000%</u>		
b <input type="checkbox"/> Income level other than FPG (describe in Section C)		
c <input checked="" type="checkbox"/> Asset level		
d <input checked="" type="checkbox"/> Medical indigency		
e <input checked="" type="checkbox"/> Insurance status		
f <input checked="" type="checkbox"/> Underinsurance discount		
g <input checked="" type="checkbox"/> Residency		
h <input type="checkbox"/> Other (describe in Section C)		
<b>14</b> Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b>	Yes
<b>15</b> Explained the method for applying for financial assistance? . . . . . If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	<b>15</b>	Yes
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e <input type="checkbox"/> Other (describe in Section C)		
<b>16</b> Included measures to publicize the policy within the community served by the hospital facility? . . . . . If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	<b>16</b>	Yes
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>MERCYHEALTHSYSTEM.ORG</u>		
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>MERCYHEALTHSYSTEM.ORG</u>		
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>MERCYHEALTHSYSTEM.ORG</u>		
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f <input type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g <input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
h <input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i <input checked="" type="checkbox"/> Other (describe in Section C)		

**Billing and Collections**

<b>17</b> Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment? . . . . .	<b>17</b>	Yes
<b>18</b> Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
a <input checked="" type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Actions that require a legal or judicial process		
d <input type="checkbox"/> Other similar actions (describe in Section C)		
e <input type="checkbox"/> None of these actions or other similar actions were permitted		

**Part V Facility Information (continued)****MERCY WALWORTH HOSPITAL AND MEDICAL CENT**

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_

	<b>Yes</b>	<b>No</b>
<b>19</b> Did the hospital facility or other authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? . . . . .	<b>19</b>	No
If "Yes," check all actions in which the hospital facility or a third party engaged		
a <input type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Actions that require a legal or judicial process		
d <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b> Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (check all that apply)		
a <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission		
b <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge		
c <input type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills		
d <input type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy		
e <input type="checkbox"/> Other (describe in Section C)		
f <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

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

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

<b>22</b> Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care		
a <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged		
b <input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged		
c <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
<b>23</b> During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? . . . . .	<b>23</b>	No
If "Yes," explain in Section C		
<b>24</b> During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? . . . . .	<b>24</b>	No
If "Yes," explain in Section C		

**Part V Facility Information (continued)**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16l, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

Form and Line Reference	Explanation
See Additional Data Table	

**Part V Facility Information (continued)****Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**  
(list in order of size, from largest to smallest)How many non-hospital health care facilities did the organization operate during the tax year? **51**

Name and address	Type of Facility (describe)
1	See Additional Data Table
2	
3	
4	
5	
6	
7	
8	
9	
10	

**Part VI Supplemental Information**

Provide the following information

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

Form and Line Reference	Explanation
PART I, LINE 6A	MERCY HEALTH SYSTEM, CORP (MHS) SUBMITS AN ANNUAL COMMUNITY BENEFIT STATEMENT TO THE WISCONSIN HOSPITAL ASSOCIATION (WHA) PERIODICALLY, IT PUBLISHES A PAMPHLET EXPLAINING THE COMMUNITY BENEFITS THAT MHS, AND THE RELATED ORGANIZATIONS OF MHS PROVIDE TO THE COMMUNITIES THEY SERVE. MHS HAS SUPPLIED SUPPLEMENTAL COMMUNITY BENEFIT STATEMENT INFORMATION WITH ITS 990 TAX RETURN SINCE FISCAL YEAR 2006 (TAX FORM 2005). MHS ISSUED A PRESS RELEASE RELATING TO THE HEALTH SYSTEM'S PRIOR YEAR'S COMMUNITY BENEFITS AND HAS THE SAME ON ITS WEBSITE, IT FURTHER REFERENCES THE AVAILABILITY OF WHA'S REPORT

Form and Line Reference	Explanation
PART I, LINE 7	A COST-TO-CHARGE RATIO METHODOLOGY WAS USED TO DETERMINE COSTS ASSOCIATED WITH CHARITY CARE, UNREIMBURSED MEDICAID, AND OTHER MEANS TESTED GOVERNMENT PROGRAMS. THE COST-TO-CHARGE RATIO WAS DERIVED FROM IRS WORKSHEET 2. RATIO OF PATIENT CARE COST-TO-CHARGE. THE COST OF THE OTHER BENEFITS REFERENCED IN THE TABLE OF LINE 7 (COMMUNITY HEALTH IMPROVEMENT SERVICES AND COMMUNITY BENEFIT OPERATIONS, HEALTH PROFESSIONS EDUCATION, SUBSIDIZED HEALTH SERVICES, CASH AND IN-KIND CONTRIBUTIONS) WERE DETERMINED USING ACTUAL DEPARTMENT/SERVICE SPECIFIC DATA AND/OR COST ACCOUNTING DERIVED DATA.

Form and Line Reference	Explanation
PART I, LINE 7G	THE SUBSIDIZED HEALTH CARE LINE INCLUDES \$3,446,340 OF EXPENSES (COLUMN C) AND \$1,667,081 OF NET EXPENSES (COLUMN E) ATTRIBUTABLE TO THE COSTS OF TRAUMA SURGEONS THESE SURGEONS STAFF THE LEVEL II TRAUMA PROGRAM OF MERCY HEALTH SYSTEM CORP 24/7 MERCY SOUTH - FAMILY PRACTICE CLINIC WAS ALSO INCLUDED IN THIS LINE EXPENSES IN COLUMN C TOTLED \$3,426,774 AND COLUMN E HAD \$267,858 OF NET EXPENSES

Form and Line Reference	Explanation
PART I, LN 7 COL(F)	BAD DEBT EXPENSE OF \$23,755,339 INCLUDED ON FORM 990, PART IX, LINE 25, WAS EXCLUDED FROM EXPENSES WHEN CALCULATING THE PERCENTAGE IN THIS COLUMN

Form and Line Reference	Explanation
PART II, COMMUNITY BUILDING ACTIVITIES	MERCY'S MANY HEALTH IMPROVEMENT AND BENEFIT SERVICES/OPERATIONS WERE THE RESULT OF MERCY FILLING A COMMUNITY NEED. MERCY'S COLLABORATIVE EFFORTS AND THE EFFORTS OF ITS RELATED ENTITIES HAVE BROUGHT ASSISTANCE TO THE AREA'S UNDERSERVED (AS DETAILED IN #2 ABOVE)

Form and Line Reference	Explanation
PART III, LINE 2	THE COST OF BAD DEBT ON LINE 2, PART III, WAS DETERMINED BY APPLYING THE COST-TO-CHARGE RATIO TO THOSE CHARGES ESTIMATED AND EXPENSED AS UNCOLLECTIBLE

Form and Line Reference	Explanation
PART III, LINE 3	THE ESTIMATE OF BAD DEBT DOLLARS THAT MAY HAVE BEEN COVERED THROUGH MERCY HEALTH SYSTEM CORP'S FINANCIAL ASSISTANCE/CHARITY CARE POLICY (HAD THE PROPER PAPER WORK BEEN COMPLETED BY THE INDIVIDUAL NEEDING ASSISTANCE) IS ESTIMATED AT 17 33% THIS FIGURE WAS BASED ON THE PERCENT OF BAD DEBT ACCOUNT DOLLARS THAT ARE RECLASSIFIED FOR CHARITY AND/OR BANKRUPTCY PURPOSES

Form and Line Reference	Explanation
PART III, LINE 4	<p>BAD DEBT EXPENSE IS ACCOUNTED FOR IN THE FOLLOWING MANNER (AS DETAILED IN NOTE 1 OF THE AUDITED FINANCIAL STATEMENTS OF MERCY ALLIANCE, INC AND AFFILIATES - MERCY ALLIANCE, INC IS THE PARENT COMPANY OF MERCY HEALTH SYSTEM CORP) PATIENT ACCOUNTS RECEIVABLE ARE RECORDED NET OF CONTRACTUAL ADJUSTMENTS AND ALLOWANCE FOR DOUBTFUL ACCOUNTS, WHICH REFLECTS MANAGEMENT'S BEST ESTIMATE OF THE AMOUNTS THAT WILL NOT BE COLLECTED IN EVALUATING THE COLLECTABILITY OF PATIENT ACCOUNTS RECEIVABLE, ALLIANCE ANALYZES HISTORICAL LOSS EXPERIENCE ON REVENUE FOR ALL PAYORS USING THE LOSS EXPERIENCE RATE, ALLIANCE ESTIMATES THE APPROPRIATE ALLOWANCE FOR DOUBTFUL ACCOUNTS AND PROVISION FOR BAD DEBTS. THE DIFFERENCE BETWEEN THE STANDARD RATES (OR THE DISCOUNTED RATES IF NEGOTIATED) AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS CHARGED AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS</p>

Form and Line Reference	Explanation
PART III, LINE 8	DATA FOR LINES 5 & 6 OF PART III AND THE MEDICARE SHORTFALL IS BASED ON MERCY HEALTH SYSTEM CORP'S TWO MEDICARE COST REPORTS (MERCY HOSPITAL AND TRAUMA CENTER-JANESVILLE, AND MERCY WALWORTH HOSPITAL)

Form and Line Reference	Explanation
PART III, LINE 9B	PATIENTS WHO ARE SELF-PAY, REGARDLESS OF WHETHER THEY QUALIFY FOR MERCY HEALTH SYSTEM'S (MHS) COMMUNITY CARE PROGRAM, WILL RECEIVE A 20% DISCOUNT FROM MHS'S STANDARD FEE SCHEDULE. ALL SELF-PAY PATIENTS MEET WITH PATIENT FINANCIAL COUNSELORS AND DISCUSS PAYMENT OPTIONS INCLUDING MHS'S COMMUNITY CARE PROGRAM. PATIENTS MUST APPLY FOR COMMUNITY CARE AND SUPPLY MERCY WITH THE NECESSARY FINANCIAL AND OTHER INFORMATION REQUIRED. PATIENTS WHO QUALIFY FOR COMMUNITY CARE BENEFITS WILL RECEIVE A REDUCTION IN THE BALANCE OWED, EXTENDED PAYMENT TERMS, OR BOTH. THE AMOUNT OF THE COMMUNITY CARE BENEFIT WILL BE BASED ON THE PATIENT'S ABILITY TO PAY AND THE SIZE OF THE OUTSTANDING BALANCE.

Form and Line Reference	Explanation
PART VI, LINE 2	<p>MERCY HEALTH SYSTEM CORP (MHS), ALONG WITH ITS SISTER ORGANIZATION, MERCY HARVARD HOSPITAL (MHH), WORKS IN CONJUNCTION WITH THE PUBLIC HEALTH DEPARTMENTS OF ROCK (WI), WALWORTH (WI) AND MCHENRY (IL) COUNTIES TO COMPLETE MERCY HEALTH SYSTEM CORP HAS DEDICATED STAFF THAT WORKS WITH VARIOUS AGENCIES/PROGRAMS TO ASSESS HEALTH NEEDS IN THE COMMUNITIES THAT MHH AND MHS SERVE. COLLABORATIVE EXAMPLES OF MERCY AND MERCY'S RELATED ENTITIES INCLUDE I) THE COMMUNITY HEALTH CENTER AT MERCY CLINIC SOUTH PARTNERSHIP WITH THE COMMUNITY HEALTH CENTER, INC OF BELOIT, WI IN 2006 MERCY PARTNERED WITH COMMUNITY HEALTH CENTER, INC TO OPEN THIS CLINIC IN JANESVILLE. IT PROVIDES FREE AND LOW-COST CARE TO LOW-INCOME, UNINSURED AND UNDERINSURED PATIENTS. THIS FIRST-OF-ITS-KIND PARTNERSHIP IS THE RESULT OF YEARS OF WORK WITH LOCAL PARTNERS AND THE FEDERAL GOVERNMENT TO DESIGN AND DEBUT A NEW MODEL OF CARE FOR THE UNDERSERVED. THE CLINIC SEES OVER 200 NEW PATIENTS EACH MONTH, HAS SIGNIFICANTLY IMPROVED PATIENT OUTCOMES, AND HAS SAVED MILLION IN UNNECESSARY EMERGENCY DEPARTMENT COSTS. II) HEALTHNET FREE CLINIC IN JANESVILLE MERCY PHYSICIANS VOLUNTEER THEIR SERVICES. MERCY ALSO DONATES LAB, RADIOLOGY AND OTHER ANCILLARY SERVICES TO PATIENTS. III) FAMILY HEALTH PARTNERSHIP CLINIC AND WELL CHILD CLINIC IN WOODSTOCK, IL AND HARVARD FREE CLINIC IN MCHENRY COUNTY, IL. MERCY PHYSICIANS VOLUNTEER THEIR SERVICES. IV) FAMILY HEALTH PARTNERSHIP CLINIC MCHENRY COUNTY DEPARTMENT OF HEALTH COLLABORATION TO PROVIDE MAMMOGRAMS AT MERCY FACILITIES FOR WOMEN WHO CANNOT OTHERWISE AFFORD THE SERVICE. V) ROCK COUNTY HEALTH DEPARTMENT BIOTERRORISM READINESS PROJECT. VI) RED CROSS BLOOD DRIVE AND COOPERATIVE VOLUNTEER EFFORTS. VII) UNITED WAY FUND RAISING CAMPAIGN AND ROCK COUNTY NEEDS ASSESSMENT SURVEY CONTRIBUTOR. VIII) AREA POLICE AND FIRE DEPARTMENTS PROVIDE PORTABLE DEFIBRILLATORS FOR POLICE VEHICLES AND FREE OR REDUCED-COST PARAMEDIC/EMT EDUCATIONAL OPPORTUNITIES. IX) COMMUNITY ACTION, INC. MERCY LEADERSHIP SERVES ON STRATEGIC PLANNING COMMITTEE AND COMMUNITY ACTION DEVELOPMENT BOARD.</p>

Form and Line Reference	Explanation
PART VI, LINE 3	ALL UNINSURED PATIENTS ARE NOTIFIED OF MERCY'S FINANCIAL AIDE POLICY UPON REGISTRATION. INFORMATION IS ALSO AVAILABLE AT THE HEALTH SYSTEM'S WEBSITE, IN OUR EMERGENCY ROOMS, FINANCIAL SERVICES OFFICES, AND WITH THE PATIENT FINANCIAL COUNSELORS. APPROPRIATE PERSONNEL HAVE BEEN TRAINED ON HOW TO INTERACT WITH PATIENTS ABOUT FINANCIAL AID AVAILABILITY, AND HOW TO DIRECT PATIENTS TO APPROPRIATE FINANCIAL AID STAFF. THE HOSPITALS HAVE TRANSLATION SERVICES AVAILABLE AS NEEDED.

Form and Line Reference	Explanation
PART VI, LINE 4	<p>MERCY HOSPITAL AND TRAUMA CENTER IS LOCATED IN JANESVILLE, WI ROCK COUNTY IT IS ONE OF TWO ACUTE CARE HOSPITALS IN JANESVILLE, WI IT IS LICENSED FOR 240 ACUTE BEDS IT HAS 24/7 EMERGENCY SERVICES, WITH A TRAUMA II DESIGNATION IT IS A TEACHING HOSPITAL WITH A RESIDENCY PROGRAM UNEMPLOYMENT IN ROCK COUNTY (2013) WAS AT 8.6% WHILE THE STATE (WI) AND THE NATION WERE AT 7.0% AND 7.5%, RESPECTIVELY MEDIAN HOUSEHOLD INCOME (2012) WAS \$50,316 IN ROCK COUNTY, WHICH IS LOWER THAN BOTH THE STATES \$52,627 AND NATIONAL MEDIAN OF \$53,046 IN 2012, 13.5% OF ROCK COUNTY RESIDENTS LIVED BELOW THE POVERTY LEVEL, THIS IS LARGER THAN THE STATES AVERAGE OF 12.5%, BUT LESS THAN THE NATIONAL AVERAGE OF 14.9% OVER 50% OF STUDENTS IN THE JANESVILLE SCHOOL DISTRICT WERE ECONOMICALLY DISADVANTAGED STUDENTS (SCHOOL YEAR 2012-2013) MERCY WALWORTH HOSPITAL IS LOCATED IN LAKE GENEVA WI WHICH IS IN WALWORTH COUNTY, WI IT IS A CRITICAL ACCESS HOSPITAL LICENSED FOR 25 ACUTE BEDS THAT PROVIDES 24/7 EMERGENCY SERVICES MERCY HEALTH SYSTEM CORP DISTRIBUTED HEALTH QUESTIONNAIRES TO A RANDOM SAMPLE OF WALWORTH COUNTY RESIDENTS THE SURVEY, DISTRIBUTED TO 2000 MEMBERS OF THE COMMUNITY, COVERED VARIOUS TOPICS, INCLUDING ACCESS TO CARE, QUALITY OF LIFE, CHRONIC ILLNESSES, AND LIFESTYLE FACTORS A RESPONSE WAS RECEIVED FROM 14.4% OF HOUSEHOLDS THAT RECEIVED THE SURVEY (288 SURVEYS) ONCE THE SURVEY RESPONSES WERE TABULATED, THE SURVEY RESULTS WERE EVALUATED AND ANALYZED FOR HEALTH AND DEMOGRAPHIC TRENDS IN ADDITION TO THE DATA GATHERED FROM HOUSEHOLD SURVEYS AND FOCUS GROUPS, MERCY HEALTH SYSTEM ANALYZED HEALTH-RELATED DATA FROM A VARIETY OF EXISTING SOURCES, INCLUDING THE UNIVERSITY OF WISCONSIN POPULATION HEALTH INSTITUTES COUNTY HEALTH RANKINGS, WISCONSIN DEPARTMENT OF PUBLIC HEALTH, AND THE UNITED STATES CENSUS BUREAU SECONDARY SOURCE DATA, WHEN COMBINED WITH THE INFORMATION GATHERED FROM THE HOUSEHOLD SURVEYS, PROVIDED A PICTURE OF WHAT IS WORKING WELL IN ADDITION TO IDENTIFYING OPPORTUNITIES FOR IMPROVEMENT FOR THE HEALTHCARE INFRASTRUCTURE OF WALWORTH COUNTY UNEMPLOYMENT IN WALWORTH COUNTY (2013) WAS AT 7.0%, THIS MATCHED THE STATES (WI) RATE AND WAS BETTER THAN THE NATIONAL AVERAGE OF 7.5% APPROXIMATELY 50% OF STUDENTS IN THE LAKE GENEVA J1 SCHOOL DISTRICT WERE ECONOMICALLY DISADVANTAGED STUDENTS (SCHOOL YEAR 2012-2013) MERCY HEALTH SYSTEM CORPS PAYOR DEMOGRAPHICS FOR ITS HOSPITALS INCLUDE 40.49% MEDICARE, AND 15.82% MEDICAID FOR THE FISCAL YEAR OF JULY 1, 2014 JUNE 30, 2015 (AS DETERMINED BY CHARGES BILLED)</p>

Form and Line Reference	Explanation
PART VI, LINE 5	MERCY HEALTH SYSTEM CORP (MHS) HAS AN OPEN MEDICAL STAFF WITH PRIVILEGES AVAILABLE TO ALL QUALIFIED PHYSICIANS IN THE AREAS MHS HAS A GOVERNING BODY COMPRISED OF A MAJORITY OF INDEPENDENT PERSONS REPRESENTATIVE OF THE COMMUNITY

Form and Line Reference	Explanation
PART VI, LINE 6	<p>MERCY HEALTH SYSTEM CORPORATION (MHS) HAS TWO HOSPITALS THAT PROVIDE ACUTE CARE SERVICES IN ROCK AND WALWORTH COUNTIES OF WISCONSIN MHS ALSO OPERATES COMMUNITY CLINICS LOCATED THROUGHOUT SIX COUNTIES OF WISCONSIN AND ILLINOIS IT IS PART OF A LARGER INTEGRATED HEALTHCARE SYSTEM AND IS AFFILIATED WITH OTHER SEPARATELY REPORTED ORGANIZATIONS MERCY ALLIANCE INC IS THE PARENT COMPANY OF MHS, MERCY HARVARD HOSPITAL, INC , AND MERCY ASSISTED CARE INC MERCY HARVARD HOSPITAL PROVIDES ACUTE CARE SERVICES IN MCHENRY COUNTY, ILLINOIS MERCY ASSISTED CARE PROVIDES HOME HEALTH SERVICES, HOSPICE, AND DME (DURABLE MEDICAL EQUIPMENT) SERVICES, THUS PROVIDING CONTINUATION OF CARE TO MHS PATIENTS AND THE COMMUNITY AS A WHOLE MHS WORKS WITH THE MERCY FOUNDATION, INC TO OPERATE A HOMELESS SHELTER IN JANESVILLE, WI THE HOUSE OF MERCY HOMELESS CENTER PROVIDES SHELTER, SUPPORT, AND TRAINING TO WOMEN, CHILDREN, AND FAMILIES TO HELP FIGHT HOMELESSNESS IT OPENED IN 1996, AND NOW SHELTERS AN AVERAGE OF 290 INDIVIDUALS PER YEAR THE LAST THREE YEARS MERCY HOSPITAL ASSOCIATION OF VOLUNTEERS, INC IS THE ORGANIZATION/TAX ENTITY OF MERCYS VOLUNTEERS VOLUNTEERS NUMBERED 1,431 IN CALENDAR YEAR 2014 THIS ORGANIZATION NOT ONLY SUPPORTS MERCYS SERVICES, BUT PROVIDES BENEFITS TO THE COMMUNITY AS A WHOLE IN CONJUNCTION WITH MHS MEAL PREPARATION, THE VOLUNTEERS PARTICIPATE IN AND OVERSEE A MEALS-ON-WHEELS PRO GRAM PARTICIPANT/NUTRITION SPECIFIC MEALS ARE PREPARED AND DELIVERED TO THE ELDERLY NEEDING ASSISTANCE IN JANESVILLE THE VOLUNTEER ASSOCIATION RUNS A HOSPITALITY HOUSE IN WHICH FAMILY MEMBERS OF PATIENTS ARE OFFERED FREE HOUSING DURING THEIR LOVED ONES EXTENDED HOSPITAL STAY AND REHABILITATION</p>

Form and Line Reference	Explanation
PART VI, LINE 7, REPORTS FILED WITH STATES	WI,IL



## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 39-0816848

**Name:** MERCY HEALTH SYSTEM CORPORATION

### Form 990 Part V Section C Supplemental Information for Part V, Section B.

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
MERCY HOSPITAL AND TRAUMA CENTER	PART V, SECTION B, LINE 5 MERCY HEALTH SYSTEM CORP (MHS) SET OUT TO GATHER INFORMATION ON THE COMMUNITY OF ROCK COUNTY, WISCONSIN MHS COLLABORATED WITH BELOIT HEALTH SYSTEM, ROCK COUNTY HEALTH DEPARTMENT, UNIVERSITY OF WISCONSIN - EXTENSION ROCK COUNTY, ROCK COUNTY, HEALTHNET OF ROCK COUNTY, EDGERTON HOSPITAL AND HEALTH SERVICES, SSM HEALTHCARE OF WISCONSIN THE GROUP GATHERED INFORMATION THROUGH HOUSEHOLD SURVEYS AND SECONDARY DATA SOURCES MHS DISTRIBUTED HEALTH QUESTIONNAIRES TO A RANDOM SAMPLE OF ROCK COUNTY RESIDENTS THE FIFTY QUESTION SURVEY WAS DISTRIBUTED TO 2,000 MEMBERS OF THE COMMUNITY AND COVERED VARIOUS TOPICS, INCLUDING ACCESS TO CARE, QUALITY OF LIFE, CHRONIC ILLNESSES, AND LIFESTYLE FACTORS A RESPONSE WAS RECEIVED FROM 32.8% OF HOUSEHOLDS THAT RECEIVED THE SURVEY IN ADDITION TO THE DATA GATHERED FROM HOUSEHOLD SURVEYS AND FOCUS GROUPS, MHS ANALYZED HEALTH-RELATED DATA FROM A VARIETY OF EXISTING SOURCES, INCLUDING WISCONSIN COUNTY HEALTH RANKINGS, WISCONSIN DEPARTMENT OF TRANSPORTATION, DEPARTMENT OF EDUCATION, WISCONSIN DEPARTMENT OF HEALTH SERVICES, U S CENSUS BUREAU, AND OTHERS SECONDARY SOURCE DATA, WHEN COMBINED WITH THE INFORMATION GATHERED FROM THE HOUSEHOLD SURVEYS, PROVIDED A PICTURE OF WHAT IS WORKING WELL IN ADDITION TO IDENTIFYING OPPORTUNITIES FOR IMPROVEMENT FOR THE HEALTHCARE INFRASTRUCTURE OF ROCK COUNTY AND THE COMMUNITY AS A WHOLE

**Form 990 Part V Section C Supplemental Information for Part V, Section B.**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
MERCY WALWORTH HOSPITAL AND MEDICAL CENT	PART V, SECTION B, LINE 5 MERCY HEALTH SYSTEM CORP (MHS) DISTRIBUTED HEALTH QUESTIONNAIRES TO A RANDOM SAMPLE OF WALWORTH COUNTY RESIDENTS. THE SURVEY, DISTRIBUTED TO 2000 MEMBERS OF THE COMMUNITY, COVERED VARIOUS TOPICS, INCLUDING ACCESS TO CARE, QUALITY OF LIFE, CHRONIC ILLNESSES, AND LIFESTYLE FACTORS. A RESPONSE WAS RECEIVED FROM 14.4% OF HOUSEHOLDS THAT RECEIVED THE SURVEY (288 SURVEYS). ONCE THE SURVEY RESPONSES WERE TABULATED, THE SURVEY RESULTS WERE EVALUATED AND ANALYZED FOR HEALTH AND DEMOGRAPHIC TRENDS IN ADDITION TO THE DATA GATHERED FROM HOUSEHOLD SURVEYS AND FOCUS GROUPS, MHS ANALYZED HEALTH-RELATED DATA FROM A VARIETY OF EXISTING SOURCES, INCLUDING THE UNIVERSITY OF WISCONSIN POPULATION HEALTH INSTITUTES COUNTY HEALTH RANKINGS, WISCONSIN DEPARTMENT OF PUBLIC HEALTH, AND THE UNITED STATES CENSUS BUREAU. SECONDARY SOURCE DATA, WHEN COMBINED WITH THE INFORMATION GATHERED FROM THE HOUSEHOLD SURVEYS, PROVIDED A PICTURE OF WHAT IS WORKING WELL IN ADDITION TO IDENTIFYING OPPORTUNITIES FOR IMPROVEMENT FOR THE HEALTHCARE INFRASTRUCTURE OF WALWORTH COUNTY.

**Form 990 Part V Section C Supplemental Information for Part V, Section B.**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
MERCY HOSPITAL AND TRAUMA CENTER	PART V, SECTION B, LINE 6A BELOIT HEALTH SYSTEM, EDGERTON HOSPITAL AND HEALTH SERVICES, SSM HEALTHCARE OF WI

**Form 990 Part V Section C Supplemental Information for Part V, Section B.**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
MERCY WALWORTH HOSPITAL AND MEDICAL CENT	PART V, SECTION B, LINE 6A AURORA LAKELAND MEDICAL CENTER

**Form 990 Part V Section C Supplemental Information for Part V, Section B.**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
MERCY HOSPITAL AND TRAUMA CENTER	PART V, SECTION B, LINE 6B ROCK COUNTY HEALTH DEPARTMENT, UNIVERSITY OF WISCONSIN - EXTENSION ROCK COUNTY, ROCK COUNTY, HEALTH NET OF ROCK COUNTY, ROCK COUNTY HEALTH DEPARTMENT

**Form 990 Part V Section C Supplemental Information for Part V, Section B.**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
MERCY WALWORTH HOSPITAL AND MEDICAL CENT	PART V, SECTION B, LINE 6B DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS), PUBLIC HEALTH, MEDICAL COLLEGE OF WISCONSIN (WALWORTH COUNTY PUBLIC HEALTH STUDENT), DENTAL PERFECTIONS, DUNCAN MEDICATION & CONSULTING SERVICES LLC, ROCK-WALWORTH COMMUNITY ACTION, ST BENEDICT CHURCH, UW-EXTENSION, GODFREY, LEIBSLE, BLACKBURN, & HOWARTH, ELKHORN SCHOOLS, GATEWAY TECHNICAL COLLEGE, AURORA HEALTH CARE EAST TROY, COMMUNITY HEALTH SYSTEMS INC, WALWORTH COUNTY JOB CENTER, FORT HEALTH CARE, ROCK-WALWORTH COMPREHENSIVE FAMILY SERVICES, UW-WHITEWATER, VIP SERVICES INC, UNIV HEALTH & COUNSELING CENTER, FAMILY LIVING EDUCATOR, UW-EXTENSION, PARENT CONNECTIONS-ELKHORN SCHOOL DISTRICT, LAKELAND ANIMAL SHELTER, FRANKLIN HEALTH DEPARTMENT, BENEFIT CONCEPTS INC, AND SEAL A SMILE

**Form 990 Part V Section C Supplemental Information for Part V, Section B.**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
MERCY HOSPITAL AND TRAUMA CENTER	PART V, SECTION B, LINE 11 CONSISTENT WITH THE ROCK AND WALWORTH COUNTY COMMUNITY NEEDS ASSESSMENT ACTION PLANS, MERCY CONTINUES TO ROLL OUT ITS IMPLEMENTATION PLANS PROMOTING HYPERTENSION AWARENESS, SUPPORTING OBESITY EDUCATION AND SMOKING CESSATION PROGRAMS ARE PRIORITIES IN ROCK AND WALWORTH COUNTIES MERCY PARTNERS WITH MULTIPLE COMMUNITY BASED ORGANIZATIONS IN ROCK AND WALWORTH COUNTY TO ACCOMPLISH SUCCESSFUL IMPLEMENTATION OF THESE STRATEGIES DURING THE COURSE OF TAX YEAR 2014 (FISCAL YEAR JULY 1, 2014-JUNE 30, 2015), MERCY PARTICIPATED IN NUMEROUS COMMUNITY HEALTH FAIRS, PROVIDED FREE SCREENINGS AT OUR CLINICS AND IN CONJUNCTION WITH COMMUNITY BASED ORGANIZATIONS, OFFERED SCREENINGS TO FREE AND SLIDING FEE SCHEDULE PRIMARY CARE CLINICS, AND SCHOOL DISTRICTS IN BOTH COUNTIES MERCY ALSO PROVIDES FINANCIAL INCENTIVES FOR THEIR EMPLOYEES TO PARTICIPATE IN SMOKING CESSATION PROGRAMS ALL OF THESE EFFORTS ARE SUPPORTED THROUGH BROAD BASED MARKETING AND ADVERTISING PROGRAMS DIRECTED TO AUDIENCES IN BOTH COUNTIES PROMOTING THESE PROGRAMS IN THE AREA OF OBJECTIVES RELATED TO MENTAL HEALTH CARE, AUTISM SUPPORT AND DECREASING SUBSTANCE ABUSE, MERCY CONTINUES TO ATTEMPT TO BUILD ADDITIONAL CAPACITY FOR OUTPATIENT THERAPY AND EDUCATION MERCY HAS PARTNERED WITH A FOUNDATION IN WALWORTH COUNTY AND BEEN SUCCESSFUL IN GAINING GRANT-IN-AID FUNDING FROM A NEW YORK BASED FOUNDATION TO INCREASE AUTISM SUPPORT PROGRAMS FOR TRAINING, EDUCATION, AND EQUIPMENT AND SERVICES GRANTS TO PARENTS OF AUTISTIC CHILDREN IN ROCK AND WALWORTH COUNTIES THESE OBJECTIVES ARE SCHEDULED FOR IMPLANTATION DURING TAX YEAR 2015 (FISCAL YEAR JULY 1, 2015 - JUNE 30, 2016) AND ARE BEING FURTHER ROLLED OUT IN THE AREA OF DENTAL CARE, MONIES ARE BEING PROVIDED THROUGH GENERAL GRANTS AND SPONSORSHIPS TO THE REGIONAL FREE DENTAL CLINIC FINALLY IN THE AREA OF SCREENINGS, MERCY PARTNERS WITH COMMUNITY AGENCIES AND MERCY STAFF TO OFFER SCREENINGS AT HEALTH FAIRS, MERCY SPONSORED EVENTS, AND THROUGH FREE AND SLIDING FEE SCALE PRIMARY CLINICS IN ROCK AND WALWORTH COUNTIES

**Form 990 Part V Section C Supplemental Information for Part V, Section B.**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
MERCY WALWORTH HOSPITAL AND MEDICAL CENT	PART V, SECTION B, LINE 11 CONSISTENT WITH THE ROCK AND WALWORTH COUNTY COMMUNITY NEEDS ASSESSMENT ACTION PLANS, MERCY CONTINUES TO ROLL OUT ITS IMPLEMENTATION PLANS PROMOTING HYPERTENSION AWARENESS, SUPPORTING OBESITY EDUCATION AND SMOKING CESSATION PROGRAMS ARE PRIORITIES IN ROCK AND WALWORTH COUNTIES MERCY PARTNERS WITH MULTIPLE COMMUNITY BASED ORGANIZATIONS IN ROCK AND WALWORTH COUNTY TO ACCOMPLISH SUCCESSFUL IMPLEMENTATION OF THESE STRATEGIES DURING THE COURSE OF TAX YEAR 2014 (FISCAL YEAR JULY 1, 2014-JUNE 30, 2015), MERCY PARTICIPATED IN NUMEROUS COMMUNITY HEALTH FAIRS, PROVIDED FREE SCREENINGS AT OUR CLINICS AND IN CONJUNCTION WITH COMMUNITY BASED ORGANIZATIONS, OFFERED SCREENINGS TO FREE AND SLIDING FEE SCHEDULE PRIMARY CARE CLINICS, AND SCHOOL DISTRICTS IN BOTH COUNTIES MERCY ALSO PROVIDES FINANCIAL INCENTIVES FOR THEIR EMPLOYEES TO PARTICIPATE IN SMOKING CESSATION PROGRAMS ALL OF THESE EFFORTS ARE SUPPORTED THROUGH BROAD BASED MARKETING AND ADVERTISING PROGRAMS DIRECTED TO AUDIENCES IN BOTH COUNTIES PROMOTING THESE PROGRAMS IN THE AREA OF OBJECTIVES RELATED TO MENTAL HEALTH CARE, AUTISM SUPPORT AND DECREASING SUBSTANCE ABUSE, MERCY CONTINUES TO ATTEMPT TO BUILD ADDITIONAL CAPACITY FOR OUTPATIENT THERAPY AND EDUCATION MERCY HAS PARTNERED WITH A FOUNDATION IN WALWORTH COUNTY AND BEEN SUCCESSFUL IN GAINING GRANT-IN-AID FUNDING FROM A NEW YORK BASED FOUNDATION TO INCREASE AUTISM SUPPORT PROGRAMS FOR TRAINING, EDUCATION, AND EQUIPMENT AND SERVICES GRANTS TO PARENTS OF AUTISTIC CHILDREN IN ROCK AND WALWORTH COUNTIES THESE OBJECTIVES ARE SCHEDULED FOR IMPLANTATION DURING TAX YEAR 2015 (FISCAL YEAR JULY 1, 2015 - JUNE 30, 2016) AND ARE BEING FURTHER ROLLED OUT IN THE AREA OF DENTAL CARE, MONIES ARE BEING PROVIDED THROUGH GENERAL GRANTS AND SPONSORSHIPS TO THE REGIONAL FREE DENTAL CLINIC FINALLY IN THE AREA OF SCREENINGS, MERCY PARTNERS WITH COMMUNITY AGENCIES AND MERCY STAFF TO OFFER SCREENINGS AT HEALTH FAIRS, MERCY SPONSORED EVENTS, AND THROUGH FREE AND SLIDING FEE SCALE PRIMARY CLINICS IN ROCK AND WALWORTH COUNTIES

**Form 990 Part V Section C Supplemental Information for Part V, Section B.**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
MERCY HOSPITAL AND TRAUMA CENTER	PART V, SECTION B, LINE 16I AVAILABLE THROUGH PATIENT FINANCIAL COUNSELORS WHO DO PRE- OR POST-FOLLOW UP WITH SELF-PAY PATIENTS

**Form 990 Part V Section C Supplemental Information for Part V, Section B.**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
MERCY WALWORTH HOSPITAL AND MEDICAL CENT	PART V, SECTION B, LINE 16I AVAILABLE THROUGH PATIENT FINANCIAL COUNSELORS WHO DO PRE- OR POST-FOLLOW UP WITH SELF-PAY PATIENTS

**Form 990 Part V Section C Supplemental Information for Part V, Section B.**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
MERCY HOSPITAL AND TRAUMA CENTER	PART V, SECTION B, LINE 22D THE HOSPITAL FACILITY USED THE AVERAGE COMMERCIAL CHARGE

**Form 990 Part V Section C Supplemental Information for Part V, Section B.**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
MERCY WALWORTH HOSPITAL AND MEDICAL CENT	PART V, SECTION B, LINE 22D THE HOSPITAL FACILITY USED THE AVERAGE COMMERCIAL CHARGE

**Form 990 Part V Section C Supplemental Information for Part V, Section B.**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
PART V, SECTION B, LINE 16	FINANCIAL ASSISTANCE POLICY WEBSITE AVAILABILITY

**Form 990 Part V Section C Supplemental Information for Part V, Section B.**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
MERCY HOSPITAL AND TRAUMA CENTER PART V, SECTION B, LINE 16A WEBSITE	MERCYHEALTHSYSTEM.ORG

**Form 990 Part V Section C Supplemental Information for Part V, Section B.**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
MERCY HOSPITAL AND TRAUMA CENTER PART V, SECTION B, LINE 16B WEBSITE	MERCYHEALTHSYSTEM.ORG

**Form 990 Part V Section C Supplemental Information for Part V, Section B.**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
MERCY HOSPITAL AND TRAUMA CENTER PART V, SECTION B, LINE 16C WEBSITE	MERCYHEALTHSYSTEM.ORG

**Form 990 Part V Section C Supplemental Information for Part V, Section B.**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
MERCY WALWORTH HOSPITAL AND MEDICAL CENT PART V, SECTION B, LINE 16A WEBSITE	MERCYHEALTHSYSTEM.ORG

**Form 990 Part V Section C Supplemental Information for Part V, Section B.**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
MERCY WALWORTH HOSPITAL AND MEDICAL CENT PART V, SECTION B, LINE 16B WEBSITE	MERCYHEALTHSYSTEM.ORG

**Form 990 Part V Section C Supplemental Information for Part V, Section B.**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
MERCY WALWORTH HOSPITAL AND MEDICAL CENT PART V, SECTION B, LINE 16C WEBSITE	MERCYHEALTHSYSTEM.ORG

**Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility****Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

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

Name and address	Type of Facility (describe)
MERCY MANOR TRANSITION CENTER 1000 MINERAL POINT AVENUE JANESVILLE, WI 53548	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY REGIONAL CANCER CENTER 1000 MINERAL POINT AVENUE JANESVILLE, WI 53548	SKILLED NURSING/SUB-ACUTE CARE FACILITY
HOUSE OF MERCY HOMELESS SHELTER 320 LINCOLN STREET JANESVILLE, WI 53548	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY ALGONQUIN MEDICAL CENTER 2401 HARNISH DRIVE SUITE 101 ALGONQUIN, WI 60102	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY BARIATRIC WELLNESS CENTER 250 E CENTER DRIVE SUITE 201 VERNON HILLS, WI 60061	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY BARRINGTON MEDICAL CENTER 500 WEST HIGHWAY 22 BARRINGTON, WI 60010	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY BELOIT MEDICAL CENTER 2825 PRAIRIE AVENUE BEOLOIT, WI 53511	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY BROADHEAD MEDICAL CENTER 2310 FIRST CENTER AVENUE BROADHEAD, WI 53520	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY CENTER FOR CORRECTIVE EYE SURGERY 5400 W ELM STREET SUITE 120 MCHENRY, IL 60050	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY CENTER FOR CORRECTIVE EYE SURGERY 8780 W GOLF ROAD STE 304 NILES, IL 60714	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY CLINIC EAST 3524 EAST MILWAUKEE STREET JANESVILLE, WI 53546	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY CLINIC EAST PHARMACY 3524 EAST MILWAUKEE STREET JANESVILLE, WI 53546	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY CLINIC SOUTH 849 KELLOGG AVENUE JANESVILLE, WI 53546	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY CLINIC WEST 1000 MINERAL POINT AVENUE JANESVILLE, WI 53548	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY CLINIC WEST PHARMACY 1000 MINERAL POINT AVENUE JANESVILLE, WI 53548	SKILLED NURSING/SUB-ACUTE CARE FACILITY

**Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility****Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

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

Name and address	Type of Facility (describe)
MERCY CRYSTAL LAKE CHIROPRACTIC AND REHA 330 W TERRA COTTA ROAD RTE 176 CRYSTAL LAKE, IL 60014	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY CRYSTAL LAKE MEDICAL CENTER EAST 390 CONGRESS PARKWAY CRYSTAL LAKE, IL 60014	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY CRYSTAL LAKE MEDICAL CENTER WEST 350 CONGRESS PARKWAY CRYSTAL LAKE, IL 60014	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY CRYSTAL LAKE OBGYN 750 E TERRA COTTA STE B CRYSTAL LAKE, IL 60014	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY CRYSTAL LAKE MEDICAL CENTER SOUTH 415-A CONGRESS PARKWAY CRYSTAL LAKE, IL 60014	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY DELAVAN MEDICAL CENTER 1038 E GENEVA ST DELAVAN, WI 53115	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY EDGERTON MEDICAL CENTER 217 N MAIN STREET EDGERTON, WI 53534	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY EVANSVILLE MEDICAL CENTER 300 UNION STREET EVANSVILLE, WI 53536	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY HARVARD CLINIC SOUTH 348 S DIVISION HARVARD, IL 60033	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY HEALTH MALL 1010 NORTH WASHINGTON JANESVILLE, WI 53548	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY HEALTH MALL PHARMACY 1010 NORTH WASHINGTON JANESVILLE, WI 53548	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY LAKE GENEVA MEDICAL CENTER 350 PELLER ROAD LAKE GENEVA, WI 53147	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY LAKESIDE ORTHOPAEDICS 352 PELLER ROAD LAKE GENEVA, WI 53147	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY MCHENRY INTERNAL MEDICINE CENTER 633 RIDGEVIEW DRIVE MCHENRY, IL 60050	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY MCHENRY MEDICAL CENTER 3922 MERCY DRIVE MCHENRY, IL 60050	SKILLED NURSING/SUB-ACUTE CARE FACILITY

**Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility****Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

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

Name and address	Type of Facility (describe)
MERCY MILTON MEDICAL CENTER 725 SOUTH JANESVILLE STREET MILTON, WI 53563	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY MILTON PHARMACY 725 SOUTH JANESVILLE STREET MILTON, WI 53563	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY NORTHWEST WOMEN'S GROUP 47 WEST ACORN LANE LAKE IN THE HILLS, IL 601564804	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY OPTIONS-COOPERATIVE CHILDCARE INST 20 EAST COURT STREET JANESVILLE, WI 53548	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY OPTIONS-JANESVILLE 903 MINERAL POINT AVENUE JANESVILLE, WI 53548	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY REGIONAL DIALYSIS CENTER 903 MINERAL POINT AVENUE JANESVILLE, WI 53548	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY REGIONAL LUNG CENTER 903 MINERAL POINT AVENUE JANESVILLE, WI 53548	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY RICHMOND MEDICAL CENTER 9715 PRAIRIE RIDGE RICHMOND, IL 60071	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY SHARON MEDICAL CENTER 118 PLAIN STREET SHARON, WI 53585	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY SPORTS MEDICINE AND REHABILITATION 557 NORTH WASHINGTON JANESVILLE, WI 53548	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY TERRACE 510 N TERRACE STREET JANESVILLE, WI 53548	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY WALWORTH PHARMACY N2950 STATE ROAD 67 LAKE GENEVA, WI 53147	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY WHITEWATER MEDICAL CENTER 507 WEST MAIN STREET WHITEWATER, WI 53190	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY WHITEWATER SPORTS MEDICINE & REHAB 519 WEST MAIN STREET WHITEWATER, WI 53190	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY WOODSTOCK MEDICAL CENTER 2000 LAKE AVENUE WOODSTOCK, IL 60098	SKILLED NURSING/SUB-ACUTE CARE FACILITY

**Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

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

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

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Name and address	Type of Facility (describe)
MERCY WOODSTOCK PHARMACY 2000 LAKE AVENUE WOODSTOCK, IL 60098	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY WOMEN'S HEALTHCARE CENTER - ALCONQ 2230 N HUNTINGTON DR ALGONQUIN, IL 60102	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY WOMEN'S HEALTHCARE CENTER - ELGIN 750 FLETCHER DR STE 206 ELGIN, IL 60123	SKILLED NURSING/SUB-ACUTE CARE FACILITY
WOMEN'S HEALTH CENTER - HOFFMAN ESTATES 1555 BARRINGTON RD STE 2300A HOFFMAN ESTATES, IL 60169	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCY ELKHORN MEDICAL CENTER 839 N WISCONSIN ST ELKHORN, WI 53121	SKILLED NURSING/SUB-ACUTE CARE FACILITY
MERCYCARE BUILDING 580 N WASHINGTON ST JANESVILLE, WI 53548	SKILLED NURSING/SUB-ACUTE CARE FACILITY

**Schedule J**  
(Form 990)**Compensation Information**

OMB No 1545-0047

Department of the Treasury  
Internal Revenue ServiceFor certain Officers, Directors, Trustees, Key Employees, and Highest  
Compensated Employees

► Complete if the organization answered "Yes" to Form 990, Part IV, line 23.

► Attach to Form 990.

► Information about Schedule J (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).**2014****Open to Public  
Inspection**Name of the organization  
MERCY HEALTH SYSTEM CORPORATION

Employer identification number

39-0816848

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

<input type="checkbox"/> First-class or charter travel	<input checked="" type="checkbox"/> Housing allowance or residence for personal use
<input type="checkbox"/> Travel for companions	<input checked="" type="checkbox"/> Payments for business use of personal residence
<input type="checkbox"/> Tax indemnification and gross-up payments	<input checked="" type="checkbox"/> Health or social club dues or initiation fees
<input type="checkbox"/> Discretionary spending account	<input checked="" type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)

**b** 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 of the expenses described above? If "No," complete Part III to explain**2** Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?**3** Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III

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

**4** During the year, did any person listed in Form 990, Part VII, Section A, line 1a with respect to the filing organization or a related organization**a** Receive a severance payment or change-of-control payment?**b** Participate in, or receive payment from, a supplemental nonqualified retirement plan?**c** Participate in, or receive payment from, an equity-based compensation arrangement?

If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III

**Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.****5** For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of**a** The organization?**b** Any related organization?

If "Yes," to line 5a or 5b, describe in Part III

**6** For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of**a** The organization?**b** Any related organization?

If "Yes," to line 6a or 6b, describe in Part III

**7** For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III**8** Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III**9** If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?

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

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

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

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

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column(B) reported as deferred in prior Form 990
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
See Additional Data Table							

**Part III Supplemental Information**

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

Return Reference	Explanation
PART I, LINE 1A	RESIDENCE FOR PERSONAL USE - THE CEO IS PROVIDED WITH A RESIDENCE THE COST OF RENTING THE RESIDENCE IS TREATED AS TAXABLE COMPENSATION PAYMENTS FOR BUSINESS USE OF PERSONAL RESIDENCE - THE CEO IS REIMBURSED FOR INTERNET ACCESS AND COMMUNICATION COSTS USED FOR BUSINESS PURPOSES AT HIS PERSONAL RESIDENCE THE REIMBURSEMENT IS TREATED AS TAXABLE COMPENSATION HEALTH CLUB DUES - THE CEO IS REIMBURSED FOR HEALTH CLUB DUES THIS IS TREATED AS TAXABLE COMPENSATION PERSONAL SERVICES - THE CEO IS REIMBURSED FOR INCOME TAX PREPARATION SERVICES THIS IS TREATED AS TAXABLE COMPENSATION

**Additional Data**

**Software ID:**  
**Software Version:**  
**EIN:** 39-0816848  
**Name:** MERCY HEALTH SYSTEM CORPORATION

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

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred in prior Form 990
	(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
MARK GOELZER MD, DIRECTOR/PHYSICIAN	(i) 453,043 (ii) 0	0 0	4,714 0	17,160 0	13,862 0	488,779 0	0 0
BARB BORTNER, VICE-PRESIDENT	(i) 138,043 (ii) 0	75,288 0	3,320 0	14,119 0	22,844 0	253,614 0	0 0
DAN COLBY, VICE-PRESIDENT	(i) 182,449 (ii) 0	82,473 0	8,970 0	17,160 0	13,038 0	304,090 0	0 0
DAVID KURTZ, VICE-PRESIDENT	(i) 135,957 (ii) 0	103,889 0	14,877 0	11,346 0	15,876 0	281,945 0	0 0
JOHN COOK, VICE-PRESIDENT	(i) 268,004 (ii) 0	140,656 0	6,281 0	17,160 0	22,535 0	454,636 0	0 0
KATHLEEN HARRIS, VICE-PRESIDENT	(i) 88,158 (ii) 0	51,942 0	6,655 0	8,780 0	22,036 0	177,571 0	0 0
RUTH YARBROUGH, VICE-PRESIDENT	(i) 168,823 (ii) 0	91,244 0	12,929 0	17,160 0	7,826 0	297,982 0	0 0
RICHARD GRUBER, VICE-PRESIDENT	(i) 130,941 (ii) 0	82,314 0	12,122 0	14,517 0	15,874 0	255,768 0	0 0
JOSEPH NEMETH, VICE-PRESIDENT	(i) 139,639 (ii) 0	80,675 0	9,249 0	14,731 0	14,221 0	258,515 0	0 0
SUE RIPSCH, VICE-PRESIDENT	(i) 252,313 (ii) 0	132,817 0	23,382 0	17,160 0	17,435 0	443,107 0	0 0
JENNIFER HALLATT, VICE-PRESIDENT	(i) 152,798 (ii) 0	83,905 0	4,121 0	16,082 0	25,555 0	282,461 0	0 0
PAUL VAN DEN HEUVEL, VICE-PRESIDENT	(i) 224,270 (ii) 0	84,375 0	12,912 0	16,037 0	23,028 0	360,622 0	0 0
JAVON BEA, PRESIDENT & DIRECTOR	(i) 1,076,489 (ii) 0	3,313,796 0	3,614,907 0	17,160 0	21,625 0	8,043,977 0	0 0
BRADLEY FIDELER, PHYSICIAN	(i) 1,388,496 (ii) 0	0 0	828 0	17,160 0	27,764 0	1,434,248 0	0 0
MERLE RUST, PHYSICIAN	(i) 1,264,497 (ii) 0	0 0	828 0	17,160 0	27,281 0	1,309,766 0	0 0
ROBB WHINNEY, PHYSICIAN	(i) 1,188,367 (ii) 0	0 0	540 0	17,160 0	17,607 0	1,223,674 0	0 0
CRAIG LYON, PHYSICIAN	(i) 1,156,217 (ii) 0	0 0	324 0	17,085 0	23,419 0	1,197,045 0	0 0
JONATHAN EHRHARDT, PHYSICIAN	(i) 1,097,419 (ii) 0	0 0	360 0	17,160 0	11,168 0	1,126,107 0	0 0

**Schedule L**  
(Form 990 or 990-EZ)**Transactions with Interested Persons**

OMB No 1545-0047

**2014****Open to Public  
Inspection**Department of the Treasury  
Internal Revenue Service

► 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, line 38a or 40b.

► Attach to Form 990 or Form 990-EZ.

► Information about Schedule L (Form 990 or 990-EZ) and its instructions is at  
[www.irs.gov/form990](http://www.irs.gov/form990).Name of the organization  
MERCY HEALTH SYSTEM CORPORATION

Employer identification number

39-0816848

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

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

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

2 Enter the amount of tax incurred by 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-EZ, Part V, line 38a, or Form 990, Part IV, line 26, or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization?	(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?		(i) Written agreement?	
						To	From	Yes	No	Yes	No

Total

► \$

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

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose 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
(1) KRISTEN GOELZER	FAMILY MEMBER OF MARK GOELZER, DIRECTOR	355,171	EMPLOYMENT - PHYSICIAN		No
(2) JAMIE KURTZ	FAMILY MEMBER OF DAVID KURTZ, OFFICER	37,858	EMPLOYMENT - PATIENT ACCOUNT REPRESENTATIVE		No
(3) JOANNA BENNING	FAMILY MEMBER OF JAVON BEA, PRESIDENT & DIRECTOR	106,032	EMPLOYMENT - DIRECTOR		No
(4) MEGAN KRAUSE	FAMILY MEMBER OF SUE RIPSCH, OFFICER	100,243	EMPLOYMENT - MANAGER		No
(5) LAUREN GRUBER	FAMILY MEMBER OF RICHARD GRUBER, OFFICER	24,956	EMPLOYMENT - RN/HIB		No

**Part V Supplemental Information**

Provide additional information for responses to questions on Schedule L (see instructions)

Return Reference

Explanation

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

► Attach to Form 990 or 990-EZ.

► Information about Schedule O (Form 990 or 990-EZ) and its instructions is at  
[www.irs.gov/form990](http://www.irs.gov/form990).**2014****Open to Public  
Inspection**Name of the organization  
MERCY HEALTH SYSTEM CORPORATION**Employer identification number**

39-0816848

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11	MANAGEMENT REVIEWS THE FORM 990 BEFORE FILING AND IT IS AVAILABLE TO THE BOARD OF DIRECTORS
FORM 990, PART VI, SECTION B, LINE 12C	OFFICERS, DIRECTORS, AND KEY EMPLOYEES ARE REQUIRED TO REPORT ALL CONFLICTS OF INTEREST T HE COMPLIANCE OFFICER IS RESPONSIBLE FOR INVESTIGATING ALL CONFLICTS AND REPORTING TO THE BOARD
FORM 990, PART VI, SECTION B, LINE 15	THE MERCY ALLIANCE COMPENSATION COMMITTEE IS COMPRISED OF THE BOARD CHAIRPERSON, SECRETARY , AND THE TREASURER THE COMPENSATION COMMITTEE IS ASSISTED BY INDEPENDENT LEGAL COUNCIL A ND AN INDEPENDENT COMPENSATION CONSULTANT THE COMPENSATION COMMITTEE, LEGAL COUNCIL, AND THE COMPENSATION CONSULTANT MEET THROUGHOUT THE YEAR AND REPORT DIRECTLY TO THE BOARD OF D IRECTORS ANNUALLY THIS PROCESS WAS COMPLETED FOR 2014
FORM 990, PART VI, SECTION C, LINE 19	GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY & FINANCIAL STATEMENTS ARE AVAILABLE UPON REQUEST
FORM 990, PART XI, LINE 9	CHANGES IN PENSION OBLIGATIONS -3,552,000 OTHER 26,396

SCHEDULE R  
(Form 990)

## Related Organizations and Unrelated Partnerships

OMB No 1545-0047

2014

Open to Public  
Inspection

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

► Attach to Form 990.

► Information about Schedule R (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).Department of the Treasury  
Internal Revenue ServiceName of the organization  
MERCY HEALTH SYSTEM CORPORATION

Employer identification number

39-0816848

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

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

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

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

**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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of- year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity?	
								Yes	No
(1) JANESVILLE MEDICAL CENTER INC  1000 MINERAL POINT AVE JANESVILLE, WI 53548 39-1520130	MANAGEMENT OF UNION EMPLOYEES	WI	MERCY HEALTH SYSTEM CORPORATION	C		200	100 000 %	Yes	
(2) MERCYCARE INSURANCE COMPANY  580 N WASHINGTON ST JANESVILLE, WI 53546 39-1768192	INSURANCE	WI	MERCY HEALTH SYSTEM CORPORATION	C	101,883,691	46,162,778	100 000 %	Yes	
(3) MERCYCARE HMO INC - CONSOLIDATED WITH MERCYCARE INSURANCE CO  580 N WASHINGTON ST JANESVILLE, WI 53546 20-1482553	INSURANCE	WI	MERCY HEALTH SYSTEM CORPORATION	C			100 000 %	Yes	
(4) ROCKFORD HEALTH INSURANCE LTD  WELLESLEY HOUSE SO 2ND FL PEMBROOK, HM BD	INSURANCE	BD	N/A	C					No

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

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

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

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

	Yes	No
1a	Yes	
1b	Yes	
1c		No
1d		No
1e	Yes	
1f		No
1g		No
1h		No
1i		No
1j	Yes	
1k	Yes	
1l		No
1m		No
1n	Yes	
1o	Yes	
1p	Yes	
1q	Yes	
1r		No
1s		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 related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) MERCYCARE INSURANCE COMPANY	Q	7,663,492	COST OF SERVICES PROVIDED

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

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

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

**Part VII Supplemental Information**

Provide additional information for responses to questions on Schedule R (see instructions)

Return Reference	Explanation
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Schedule R (Form 990) 2014

**Additional Data**

**Software ID:**  
**Software Version:**  
**EIN:** 39-0816848  
**Name:** MERCY HEALTH SYSTEM CORPORATION

**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 section 501(c) (3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?
(1) MERCY ALLIANCE INC  1000 MINERAL POINT AVE JANESVILLE, WI 53548 39-1679859	SUPPORT OF HEALTHCARE	WI	501(C)(3)	LINE 11A, I	MERCY ROCKFORD HEALTH SYSTEM CORPORATION	Yes No
(1) MERCY FOUNDATION INC  1000 MINERAL POINT AVE JANESVILLE, WI 53548 23-7275336	SUPPORT OF HEALTHCARE	WI	501(C)(3)	LINE 11A, I	MERCY HEALTH SYSTEM CORPORATION	No
(2) MERCY HEALTH SYSTEM ASSOCIATION OF VOLUNTEERS  1000 MINERAL POINT AVE JANESVILLE, WI 53548 39-0912682	SUPPORT OF HEALTHCARE	WI	501(C)(3)	LINE 11C, III-FI	MERCY HEALTH SYSTEM CORPORATION	No
(3) MERCY ASSISTED CARE INC  901 MINERAL POINT AVE JANESVILLE, WI 53548 39-1035110	HEALTHCARE	WI	501(C)(3)	LINE 9	MERCY ALLIANCE INC	No
(4) MERCY HARVARD HOSPITAL INC  901 GRANT STREET HARVARD, IL 60033 31-1551871	HEALTHCARE	IL	501(C)(3)	LINE 3	MERCY ALLIANCE INC	No
(5) HARVARD MEMORIAL HOSPITAL FOUNDATION  901 GRANT STREET HARVARD, IL 60033 36-4308662	SUPPORT OF HEALTHCARE	IL	501(C)(3)	LINE 11A, I	MERCY HARVARD HOSPITAL INC	No
(6) MERCY CRYSTAL LAKE HOSPITAL AND MEDICAL CENTER  1000 MINERAL POINT AVE JANESVILLE, WI 535475003 20-1673011	NONE	IL	501(C)(3)	LINE 3	MERCY ALLIANCE INC	No
(7) MERCY ROCKFORD HEALTH SYSTEM CORPORATION  2400 N ROCKTON AVE ROCKFORD, IL 61103 47-2158680	SUPPORT OF HEALTHCARE	IL	501(C)(3)	LINE 11A, I	N/A	No
(8) ROCKFORD MEMORIAL HOSPITAL  2400 N ROCKTON AVE ROCKFORD, IL 61103 36-2167847	HEALTHCARE	IL	501(C)(3)	LINE 3	ROCKFORD HEALTH SYSTEM	No
(9) ROCKFORD HEALTH SYSTEM  2400 N ROCKTON AVE ROCKFORD, IL 61103 36-3197915	SUPPORT OF HEALTHCARE	IL	501(C)(3)	LINE 11C, III-FI	MERCY ROCKFORD HEALTH SYSTEM CORPORATION	No
(10) ROCKFORD MEMORIAL DEVELOPMENT FOUNDATION  2400 N ROCKTON AVE ROCKFORD, IL 61103 36-3197918	SUPPORT OF HEALTHCARE	IL	501(C)(3)	LINE 11A, I	ROCKFORD HEALTH SYSTEM	No
(11) VISITING NURSES ASSN OF THE ROCKFORD AREA  4223 E STATE STREET ROCKFORD, IL 61108 36-2167945	HEALTHCARE	IL	501(C)(3)	LINE 9	ROCKFORD HEALTH SYSTEM	No
(12) ROCKFORD HEALTH PHYSICIANS  2400 N ROCKTON AVE ROCKFORD, IL 61103 36-3097436	HEALTHCARE	IL	501(C)(3)	LINE 3	ROCKFORD HEALTH SYSTEM	No