

For Paperwork Reduction Act Notice, see the separate instructions. Cat No 11282Y Form **990** (2016)

**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:

WE, MERCY HEALTH SERVICES-IOWA AND TRINITY HEALTH, SERVE TOGETHER IN THE SPIRIT OF THE GOSPEL AS A COMPASSIONATE AND TRANSFORMING HEALING PRESENCE WITHIN OUR COMMUNITIES. MERCY HEALTH SERVICES-IOWA IS A MEMBER OF TRINITY HEALTH.

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

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

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

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

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

<b>4a</b>	(Code )	(Expenses \$ 687,365,099	including grants of \$ 5,629,417 )	(Revenue \$ 685,006,703 )
	See Additional Data			

<b>4b</b>	(Code )	(Expenses \$	including grants of \$	(Revenue \$ )
-----------	---------	--------------	------------------------	---------------

<b>4c</b>	(Code )	(Expenses \$	including grants of \$	(Revenue \$ )
-----------	---------	--------------	------------------------	---------------

<b>4d</b>	Other program services (Describe in Schedule O )	(Expenses \$	including grants of \$	(Revenue \$ )
-----------	--	--------------	------------------------	---------------

<b>4e</b>	Total program service expenses ▶	687,365,099
-----------	----------------------------------	-------------

**Part IV Checklist of Required Schedules**

	Yes	No
<b>1</b> Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A	<b>1</b> Yes	
<b>2</b> Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?	<b>2</b> Yes	
<b>3</b> 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	<b>3</b>	No
<b>4 Section 501(c)(3) organizations.</b> Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II	<b>4</b> Yes	
<b>5</b> 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	<b>5</b>	No
<b>6</b> 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	<b>6</b>	No
<b>7</b> 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	<b>7</b>	No
<b>8</b> Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III	<b>8</b>	No
<b>9</b> 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	<b>9</b>	No
<b>10</b> 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	<b>10</b> Yes	
<b>11</b> 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		
<b>a</b> Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI	<b>11a</b> Yes	
<b>b</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	<b>11b</b> Yes	
<b>c</b> 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	<b>11c</b>	No
<b>d</b> 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	<b>11d</b> Yes	
<b>e</b> Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	<b>11e</b> Yes	
<b>f</b> 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 X	<b>11f</b>	No
<b>12a</b> Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII	<b>12a</b>	No
<b>b</b> 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	<b>12b</b> Yes	
<b>13</b> Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	<b>13</b>	No
<b>14a</b> Did the organization maintain an office, employees, or agents outside of the United States?	<b>14a</b>	No
<b>b</b> Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV	<b>14b</b>	No
<b>15</b> 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	<b>15</b>	No
<b>16</b> 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	<b>16</b>	No
<b>17</b> 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)	<b>17</b>	No
<b>18</b> 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	<b>18</b>	No
<b>19</b> 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	<b>19</b>	No

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

	Yes	No
<b>20a</b> Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H . . . . .	20a Yes	
<b>b</b> If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? . . . . .	20b Yes	
<b>21</b> 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 Yes	
<b>22</b> 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 Yes	
<b>23</b> 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	
<b>24a</b> 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>b</b> Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? . . . . .	24b	
<b>c</b> 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	
<b>d</b> Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? . . . . .	24d	
<b>25a 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>b</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
<b>26</b> 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
<b>27</b> 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
<b>28</b> 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) <b>a</b> A current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV . . . . . <b>b</b> A family member of a current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV . . . . . <b>c</b> 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 . . . . .	28a 28b 28c	No Yes Yes
<b>29</b> Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M . . . . .	29	No
<b>30</b> Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? If "Yes," complete Schedule M . . . . .	30	Yes
<b>31</b> Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, Part I . . . . .	31	No
<b>32</b> 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
<b>33</b> 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	Yes
<b>34</b> 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
<b>35a</b> Did the organization have a controlled entity within the meaning of section 512(b)(13)? <b>b</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 . . . . .	35a 35b	Yes Yes
<b>36 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
<b>37</b> 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
<b>38</b> 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>	983
<b>b</b>	Enter the number of Forms W-2G included in line 1a Enter -0- if not applicable . . . . .	<b>1b</b>	52
<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>	5,998
<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? If "No" to line 3b, provide an explanation in Schedule O . . . . .	<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 <b>▶</b> _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)		
<b>5a</b>	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . . . . .	<b>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>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>7a</b>	No
<b>b</b>	If "Yes," did the organization notify the donor of the value of the goods or services provided? . . . . .	<b>7b</b>	
<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>7c</b>	No
<b>d</b>	If "Yes," indicate the number of Forms 8282 filed during the year . . . . .	<b>7d</b>	
<b>e</b>	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? . . . . .	<b>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>a</b>	Initiation fees and capital contributions included on Part VIII, line 12 . . . . .	<b>10a</b>	
<b>b</b>	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities . . . . .	<b>10b</b>	
<b>11</b>	<b>Section 501(c)(12) organizations.</b> Enter		
<b>a</b>	Gross income from members or shareholders . . . . .	<b>11a</b>	
<b>b</b>	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them ) . . . . .	<b>11b</b>	
<b>12a</b>	<b>Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041? . . . . .	<b>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>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>13a</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>13b</b>	
<b>c</b>	Enter the amount of reserves on hand . . . . .	<b>13c</b>	
<b>14a</b>	Did the organization receive any payments for indoor tanning services during the tax year? . . . . .	<b>14a</b>	No
<b>b</b>	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O . . . . .	<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	5	
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	4	
<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?	Yes	
<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?	Yes	
<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?	Yes	
<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?	Yes	
<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?	Yes	
<b>b</b>	Each committee with authority to act on behalf of the governing body?	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.		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?	Yes	
<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.	Yes	
<b>b</b>	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	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.	Yes	
<b>13</b>	Did the organization have a written whistleblower policy?	Yes	
<b>14</b>	Did the organization have a written document retention and destruction policy?	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.		No
<b>b</b>	Other officers or key employees of the organization.		No
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?	Yes	
<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?	Yes	

**Section C. Disclosure**

**17** List the States with which a copy of this Form 990 is required to be filed: \_\_\_\_\_

**18** Section 6104 requires an organization to make its Form 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

☐ 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:  
 ► BETH GDOWIK 20555 VICTOR PARKWAY LIVONIA, MI 481527018 (734) 343-1000

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

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

Form **990** (2016)

[illegible]

**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 ► 309

## Section B. Independent Contractors

(A) Name and business address	(B) Description of services	(C) Compensation
MASON CITY CLINIC PC 250 S CRESCENT DRIVE MASON CITY, IA 50401	MEDICAL SERVICES	11,477,842
UNITED CLINICAL LABORATORIES 205 BLUFF STREET DUBUQUE, IA 52001	LABORATORY SERVICES	7,987,014
CONLON CONSTRUCTION PO BOX 3400 DUBUQUE, IA 52004	CONSTRUCTION SERVICES	4,004,145
STRATEGIC STAFFING SOLUTIONS 645 GRISWOLD ST STE 2900 DETROIT, MI 48226	STAFFING SERVICES	3,563,176
HENKEL CONSTRUCTION COMPANY 208 E STATE STREET MASON CITY, IA 50402	CONSTRUCTION SERVICES	2,962,093

<p><b>2</b> Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization ► 100</p>	
--	--



**Part VIII** Statement of RevenueCheck 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>	3,466,458				
	<b>e</b> Government grants (contributions)	<b>1e</b>	1,433,921				
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above	<b>1f</b>	333,455				
	<b>g</b> Noncash contributions included in lines 1a-1f \$ _____	20,000					
	<b>h Total.</b> Add lines 1a-1f . . . . .			5,233,834			
<b>Program Service Revenue</b>			Business Code				
	<b>2a</b> NET PATIENT SERVICE REVENUE		622110	614,559,569	614,559,569		
	<b>b</b> PHARMACY REVENUE		446110	60,659,837	30,770,791	29,889,046	
	<b>c</b> LABORATORY REVENUE		621500	1,456,510		1,456,510	
	<b>d</b> _____						
	<b>e</b> _____						
	<b>f</b> All other program service revenue						
	<b>g Total.</b> Add lines 2a-2f . . . . .			676,675,916			
<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts) . . . . .			3,222,580			3,222,580
	<b>4</b> Income from investment of tax-exempt bond proceeds						
	<b>5</b> Royalties . . . . .						
	<b>6a</b> Gross rents	(i) Real	(ii) Personal				
		1,066,354					
	<b>b</b> Less rental expenses	1,010,739					
	<b>c</b> Rental income or (loss)	55,615					
	<b>d</b> Net rental income or (loss) . . . . .			55,615			55,615
	<b>7a</b> Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other				
		2,698,372	48,185				
	<b>b</b> Less cost or other basis and sales expenses	0	107,765				
	<b>c</b> Gain or (loss)	2,698,372	-59,580				
	<b>d</b> Net gain or (loss) . . . . .			2,638,792			2,638,792
	<b>8a</b> Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18 . . . . .	<b>a</b>					
	<b>b</b> Less direct expenses . . . . .	<b>b</b>					
	<b>c</b> Net income or (loss) from fundraising events . . . . .						
	<b>9a</b> Gross income from gaming activities See Part IV, line 19 . . . . .	<b>a</b>					
<b>b</b> Less direct expenses . . . . .	<b>b</b>						
<b>c</b> Net income or (loss) from gaming activities . . . . .							
<b>10a</b> Gross sales of inventory, less returns and allowances . . . . .	<b>a</b>						
	1,580,880						
<b>b</b> Less cost of goods sold . . . . .	<b>b</b>	762,486					
<b>c</b> Net income or (loss) from sales of inventory . . . . .			818,394		615,791	202,603	
Miscellaneous Revenue		Business Code					
<b>11a</b> MANAGEMENT REVENUE		541618	4,182,146	2,755,257	1,426,889		
<b>b</b> CAFETERIA REVENUE		722514	3,403,622			3,403,622	
<b>c</b> GOV'T SUBSIDY-EHR		622110	774,398	774,398			
<b>d</b> All other revenue . . . . .			36,925,285	36,146,688	701,552	77,045	
<b>e Total.</b> Add lines 11a-11d . . . . .			45,285,451				
<b>12 Total revenue.</b> See Instructions . . . . .			733,930,582	685,006,703	34,089,788	9,600,257	

**Part IX Statement of Functional Expenses**

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

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

**Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.**

	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21.	5,556,101	5,556,101		
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22.	73,316	73,316		
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.				
<b>4</b> Benefits paid to or for members.				
<b>5</b> Compensation of current officers, directors, trustees, and key employees.	3,925,344		3,925,344	
<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).	928,369	23,992	904,377	
<b>7</b> Other salaries and wages.	270,303,519	252,203,693	18,099,826	
<b>8</b> Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions).	11,436,303	10,641,725	794,578	
<b>9</b> Other employee benefits.	27,217,156	25,191,648	2,025,508	
<b>10</b> Payroll taxes.	17,969,491	16,495,010	1,474,481	
<b>11</b> Fees for services (non-employees):				
<b>a</b> Management.	3,300,164	3,029,370	270,794	
<b>b</b> Legal.	204,342		204,342	
<b>c</b> Accounting.	6,833		6,833	
<b>d</b> Lobbying.	2,500		2,500	
<b>e</b> Professional fundraising services. See Part IV, line 17.				
<b>f</b> Investment management fees.	371,786		371,786	
<b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	75,638,766	70,386,960	5,251,806	
<b>12</b> Advertising and promotion.	3,092,417	2,838,670	253,747	
<b>13</b> Office expenses.	9,020,419	8,280,252	740,167	
<b>14</b> Information technology.	33,729,043	30,961,417	2,767,626	
<b>15</b> Royalties.				
<b>16</b> Occupancy.	13,401,073	12,301,452	1,099,621	
<b>17</b> Travel.	845,336	775,972	69,364	
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials.				
<b>19</b> Conferences, conventions, and meetings.	421,154	386,596	34,558	
<b>20</b> Interest.	7,217,495	7,217,495		
<b>21</b> Payments to affiliates.				
<b>22</b> Depreciation, depletion, and amortization.	40,301,547	36,994,617	3,306,930	
<b>23</b> Insurance.	3,843,376	3,528,009	315,367	
<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):				
<b>a</b> MEDICAL SUPPLIES	145,649,183	145,649,183		
<b>b</b> UBI TAXES	650,000	650,000		
<b>c</b> INTERCO PURCHASED SVCS	25,115,945	23,055,064	2,060,881	
<b>d</b> BAD DEBT EXPENSE	14,920,550	14,920,550		
<b>e</b> All other expenses	17,298,628	16,204,007	1,094,621	
<b>25</b> Total functional expenses. Add lines 1 through 24e.	732,440,156	687,365,099	45,075,057	0
<b>26</b> Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

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

				(A) Beginning of year		(B) End of year
<b>Assets</b>	<b>1</b>	Cash—non-interest-bearing . . . . .		4,731,541	<b>1</b>	4,120,480
	<b>2</b>	Savings and temporary cash investments . . . . .		395,119	<b>2</b>	68,867
	<b>3</b>	Pledges and grants receivable, net . . . . .			<b>3</b>	
	<b>4</b>	Accounts receivable, net . . . . .		82,168,618	<b>4</b>	88,336,248
	<b>5</b>	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L			<b>5</b>	
	<b>6</b>	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			<b>6</b>	
	<b>7</b>	Notes and loans receivable, net . . . . .		2,471,252	<b>7</b>	2,513,815
	<b>8</b>	Inventories for sale or use . . . . .		17,017,543	<b>8</b>	17,885,990
	<b>9</b>	Prepaid expenses and deferred charges . . . . .		2,068,095	<b>9</b>	1,781,302
	<b>10a</b>	Land, buildings, and equipment—cost or other basis. Complete Part VI of Schedule D	<b>10a</b> 656,120,338			
	<b>b</b>	Less: accumulated depreciation	<b>10b</b> 431,536,662	230,021,086	<b>10c</b>	224,583,676
	<b>11</b>	Investments—publicly traded securities . . . . .		132,934,523	<b>11</b>	147,492,747
	<b>12</b>	Investments—other securities. See Part IV, line 11 . . . . .		118,625,384	<b>12</b>	122,001,747
	<b>13</b>	Investments—program-related. See Part IV, line 11 . . . . .			<b>13</b>	
	<b>14</b>	Intangible assets . . . . .			<b>14</b>	
	<b>15</b>	Other assets. See Part IV, line 11 . . . . .		74,302,914	<b>15</b>	82,627,090
<b>16</b>	<b>Total assets.</b> Add lines 1 through 15 (must equal line 34) . . . . .		664,736,075	<b>16</b>	691,411,962	
<b>Liabilities</b>	<b>17</b>	Accounts payable and accrued expenses . . . . .		65,339,480	<b>17</b>	62,044,254
	<b>18</b>	Grants payable . . . . .			<b>18</b>	
	<b>19</b>	Deferred revenue . . . . .		1,445,068	<b>19</b>	537,295
	<b>20</b>	Tax-exempt bond liabilities . . . . .			<b>20</b>	
	<b>21</b>	Escrow or custodial account liability. Complete Part IV of Schedule D			<b>21</b>	
	<b>22</b>	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L . . . . .			<b>22</b>	
	<b>23</b>	Secured mortgages and notes payable to unrelated third parties . . . . .		4,087,923	<b>23</b>	4,270,948
	<b>24</b>	Unsecured notes and loans payable to unrelated third parties . . . . .			<b>24</b>	
	<b>25</b>	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D		210,019,889	<b>25</b>	227,040,434
	<b>26</b>	<b>Total liabilities.</b> Add lines 17 through 25 . . . . .		280,892,360	<b>26</b>	293,892,931
<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>					
	<b>27</b>	Unrestricted net assets		383,498,186	<b>27</b>	397,162,746
	<b>28</b>	Temporarily restricted net assets . . . . .		320,529	<b>28</b>	331,285
	<b>29</b>	Permanently restricted net assets		25,000	<b>29</b>	25,000
	<b>Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.</b>					
	<b>30</b>	Capital stock or trust principal, or current funds . . . . .			<b>30</b>	
	<b>31</b>	Paid-in or capital surplus, or land, building or equipment fund . . . . .			<b>31</b>	
	<b>32</b>	Retained earnings, endowment, accumulated income, or other funds			<b>32</b>	
	<b>33</b>	<b>Total net assets or fund balances</b> . . . . .		383,843,715	<b>33</b>	397,519,031
	<b>34</b>	<b>Total liabilities and net assets/fund balances</b> . . . . .		664,736,075	<b>34</b>	691,411,962

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

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	733,930,582
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	732,440,156
<b>3</b>	Revenue less expenses Subtract line 2 from line 1	<b>3</b>	1,490,426
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	383,843,715
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	22,770,212
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	-10,585,322
<b>10</b>	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	<b>10</b>	397,519,031

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

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

# Additional Data

**Software ID:**  
**Software Version:**  
**EIN:** 31-1373080  
**Name:** MERCY HEALTH SERVICES - IOWA CORP

Form 990 (2016)

**Form 990, Part III, Line 4a:**

MERCY HEALTH SERVICES-IOWA (MHS-IA) IS COMPRISED OF FOUR HOSPITAL DIVISIONS IN THE STATE OF IOWA THAT PROVIDED OVER 147,000 PATIENT DAYS OF HEALTH CARE SERVICES TO THEIR COMMUNITIES THROUGHOUT THE STATE OF IOWA AND SURROUNDING STATES PLEASE VISIT SCHEDULE H AND OUR WEBSITE FOR ADDITIONAL INFORMATION ABOUT OUR SERVICES, RECOGNITIONS, AND AWARDS [WWW.TRINITY-HEALTH.ORG/IOWA](http://WWW.TRINITY-HEALTH.ORG/IOWA)

(A) Name and Title	(B) Average hours per week (list any hours)	(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	(E) Reportable compensation from other organizations
-----------------------	--	---	--	---

(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			
DAVID VELLINGA ..... DIRECTOR, REGIONAL PRESIDENT & CEO	1 00 .....	X		X				0	0	0
MILTON AVERY ..... DIRECTOR, CHAIR	1 00 .....	X		X				0	0	0
MARY CORITA HEID RSM ..... DIRECTOR, VICE CHAIR	1 00 .....	X		X				0	0	0
MAURITA SOUKUP RSM ..... DIRECTOR	1 00 .....	X						0	0	0
JAMES CODDINGTON MD ..... DIRECTOR THROUGH 7/16	1 00 .....	X						0	0	0
LAMETTA WYNN ..... DIRECTOR THROUGH 7/16	1 00 .....	X						0	0	0
MARK NIEMER MD ..... DIRECTOR THROUGH 7/16	1 00 .....	X						0	0	0
MARTI RODAMAKER ..... DIRECTOR THROUGH 7/16	1 00 .....	X						0	0	0
RALPH REEDER MD ..... DIRECTOR	1 00 .....	X						0	0	0
CLAYTON FITZHUGH ..... DIR & TRINITY EVP CHRO THROUGH 7/16	1 00 ..... 54 00	X						0	1,005,114	32,084

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors			
(A)	(B)	(C)	(D)
1. Name of the officer, director, trustee, key employee, highest compensated employee, or independent contractor	2. Title	3. Compensation for services rendered in the capacity of officer, director, trustee, key employee, highest compensated employee, or independent contractor	4. Compensation for services rendered in the capacity of officer, director, trustee, key employee, highest compensated employee, or independent contractor
		(a) Salary or fixed compensation	(b) Other compensation
		(c) Total compensation	(d) Compensation for services rendered in the capacity of officer, director, trustee, key employee, highest compensated employee, or independent contractor

(A) Compensated Employees, and Independent Contractors		(B) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(C)	(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
Name and Title	Average hours per week (list any hours for related organizations below dotted line)	Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former				
RODNEY SCHLADER ..... TREASURER, REGIONAL CFO	49 00 ..... 1 00			X				0	363,443	49,503	
MARCIA SMITH ..... SECRETARY, ASSOCIATE COUNSEL	1 00 ..... 44 00			X				0	281,518	38,595	
JAMES FITZPATRICK ..... PRESIDENT & CEO SIOUX CITY	53 00 ..... 2 00				X			0	749,043	34,546	
DANIEL VARNUM ..... CEO NORTH IOWA	55 00 ..... 0 00				X			0	667,498	45,617	
PAUL MANTERNACH ..... SVP PHYS INTEGRATION/CMO NORTH IOWA	50 00 ..... 0 00				X			0	420,866	39,985	
KAY TAKES ..... PRESIDENT DUBUQUE	54 00 ..... 1 00				X			0	351,876	46,674	
DIANE FISCHELS ..... VP COO NORTH IOWA	50 00 ..... 0 00				X			0	341,192	37,925	
HUGH DEPAULIS ..... VP FINANCE SIOUX CITY	46 00 ..... 4 00				X			0	256,825	36,413	
DANETTE ZOOK ..... VP FINANCE NORTH IOWA	48 00 ..... 2 00				X			0	219,923	37,371	
KIM DUWE ..... VP FINANCE DUBUQUE	48 00 ..... 2 00				X			0	196,959	29,685	

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	Former			
MARK HAGANMAN ..... PHYSICIAN, FAMILY MEDICINE NORTH IA	50 00 ..... 0 00					X		722,845	0	48,487
MICHAEL LAMPE ..... PHYSICIAN, FAMILY MEDICINE NORTH IA	50 00 ..... 0 00					X		681,454	0	30,417
YEN LIU ..... PHYSICIAN, DERMATOLOGY NORTH IOWA	50 00 ..... 0 00					X		678,625	0	29,257
BRENT OWEN ..... PHYSICIAN, FAMILY MEDICINE NORTH IA	50 00 ..... 0 00					X		645,810	0	36,969
ALIREZA YARAHMADI ..... PHYSICIAN, NEUROLOGY NORTH IOWA	50 00 ..... 0 00					X		644,475	0	40,470
JUDITH PERSICHILLI ..... FORMER OFFICER	0 00 ..... 0 00						X	0	2,115,151	0
PAUL NEUMANN ..... FORMER OFFICER, TRIN CHIEF LEGAL CNSL	0 00 ..... 55 00						X	0	1,070,455	43,694
JENNIFER BARNETT ..... FORMER OFFICER	0 00 ..... 0 00						X	0	392,595	17,120
AGNES HAGERTY ..... FORMER OFFICER	0 00 ..... 0 00						X	0	437,158	33,742
BENJAMIN CARTER ..... FORMER OFFICER, TRINITY HEALTH CFO	0 00 ..... 55 00						X	0	1,306,307	48,877



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	Former			
RICHARD GILFILLAN MD ..... FORMER OFFICER, TRINITY HEALTH CEO	0 00 ..... 55 00						X	0	2,458,370	46,513
RICHARD O'CONNELL ..... FORMER KE, TRINITY EVP THR 11/16	0 00 ..... 55 00						X	0	1,545,409	47,362
JEROME PIERSON MD ..... FORMER KE, MERCY SC PHYSICIAN	49 00 ..... 1 00						X	676,165	0	32,425
RUSSELL KNIGHT ..... FORMER KEY EMPLOYEE	0 00 ..... 0 00						X	0	202,853	4,364
TERESA MOCK MD ..... FORMER KE,SVP CCO AND CPHO N IOWA	50 00 ..... 0 00						X	0	360,986	39,947
LINDA KREI ..... FORMER KEY EMPLOYEE	0 00 ..... 0 00						X	0	275,751	133,667
GARY GUETZKO ..... FORMER KE,VP BUS DEVELOPMENT DUBUQUE	49 00 ..... 1 00						X	0	256,808	38,128
BRIAN MONSMA ..... FORMER KE,VP NTKW DVLPMNT SIOUX CITY	48 00 ..... 2 00						X	0	220,817	37,777
TRACY LARSON ..... FORMER KEY EMPLOYEE, CNO SIOUX CITY	49 00 ..... 1 00						X	0	222,789	32,496
KIMBERLY CHAMBERLIN ..... FORMER KEY EMPLOYEE, CNO NORTH IOWA	49 00 ..... 1 00						X	0	214,446	24,540

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	Former			
SUE MEADE ..... FORMER KE, VP PROF SVCS DUBUQUE	50 00 ..... 0 00						X	0	184,407	24,667
LARRY SELLERS ..... FORMER KE, CLINIC PHYS SIOUX CITY	50 00 ..... 0 00						X	100,035	0	32,028

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

Department of the Treasury  
Internal Revenue Service

**Name of the organization**  
MERCY HEALTH SERVICES - IOWA CORP

**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.**

OMB No 1545-0047

**2016**

**Open to Public  
Inspection**

**Employer identification number**

31-1373080

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

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

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

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1- 10 above (see instructions))	(iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
<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, 8, or 9 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)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 Public support. Subtract line 5 from line 4						
Section B. Total Support						
Calendar year (or fiscal year beginning in) ▶	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and <b>stop here</b> . . . . . ▶ <input type="checkbox"/>						
Section C. Computation of Public Support Percentage						
14 Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f))					14	
15 Public support percentage for 2015 Schedule A, Part II, line 14					15	
16a 33 1/3% support test—2016. 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 ▶ <input type="checkbox"/>						
b 33 1/3% support test—2015. 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 ▶ <input type="checkbox"/>						
17a 10%-facts-and-circumstances test—2016. 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 ▶ <input type="checkbox"/>						
b 10%-facts-and-circumstances test—2015. 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 ▶ <input type="checkbox"/>						
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ <input type="checkbox"/>						

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

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

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ►	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
<b>1</b> Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
<b>2</b> Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
<b>3</b> Gross receipts from activities that are not an unrelated trade or business under section 513						
<b>4</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
<b>5</b> The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>6</b> <b>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</b> <b>Public support.</b> (Subtract line 7c from line 6.)						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
<b>9</b> Amounts from line 6						
<b>10a</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
<b>b</b> Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
<b>c</b> Add lines 10a and 10b						
<b>11</b> Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
<b>12</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
<b>13</b> <b>Total support.</b> (Add lines 9, 10c, 11, and 12.)						

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

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

<b>15</b> Public support percentage for 2016 (line 8, column (f) divided by line 13, column (f))	<b>15</b>	
<b>16</b> Public support percentage from 2015 Schedule A, Part III, line 15	<b>16</b>	

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

<b>17</b> Investment income percentage for <b>2016</b> (line 10c, column (f) divided by line 13, column (f))	<b>17</b>	
<b>18</b> Investment income percentage from <b>2015</b> Schedule A, Part III, line 17	<b>18</b>	

**19a** **33 1/3% support tests—2016.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ☐

**b** **33 1/3% support tests—2015.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ☐

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

**Part IV Supporting Organizations**

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

**Section A. All Supporting Organizations**

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

**Part IV Supporting Organizations** (continued)

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

**Section B. Type I Supporting Organizations**

	Yes	No
<b>1</b> 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? <i>If "No," describe in Part VI how the supported organization(s) effectively operated, supervised, or controlled the organization's activities. If the organization had more than one supported organization, describe how the powers to appoint and/or remove directors or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year.</i>		
<b>1</b>		
<b>2</b> Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? <i>If "Yes," explain in Part VI how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised or controlled the supporting organization.</i>		
<b>2</b>		

**Section C. Type II Supporting Organizations**

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

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

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

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

<b>1</b> Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions)		
<b>a</b> <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.		
<b>b</b> <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
<b>c</b> <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).		
<b>2</b> Activities Test <b>Answer (a) and (b) below.</b>		
<b>a</b> Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <i>If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.</i>		
<b>2a</b>		
<b>b</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? <i>If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.</i>		
<b>2b</b>		
<b>3</b> Parent of Supported Organizations <b>Answer (a) and (b) below.</b>		
<b>a</b> Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>Provide details in Part VI.</i>		
<b>3a</b>		
<b>b</b> Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i>		
<b>3b</b>		

**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**

	(A) Prior Year	(B) Current Year (optional)
<b>1</b> Net short-term capital gain	<b>1</b>	
<b>2</b> Recoveries of prior-year distributions	<b>2</b>	
<b>3</b> Other gross income (see instructions)	<b>3</b>	
<b>4</b> Add lines 1 through 3	<b>4</b>	
<b>5</b> Depreciation and depletion	<b>5</b>	
<b>6</b> 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)	<b>6</b>	
<b>7</b> Other expenses (see instructions)	<b>7</b>	
<b>8 Adjusted Net Income</b> (subtract lines 5, 6 and 7 from line 4)	<b>8</b>	

**Section B - Minimum Asset Amount**

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

**Section C - Distributable Amount**

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



Part V

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

Section D - Distributions	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI) See instructions	
7 Total annual distributions. Add lines 1 through 6	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI) See instructions	
9 Distributable amount for 2016 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2016	(iii) Distributable Amount for 2016
1 Distributable amount for 2016 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2016 (reasonable cause required--see instructions)			
3 Excess distributions carryover, if any, to 2016			
a			
b			
c From 2013. . . . .			
d From 2014. . . . .			
e From 2015. . . . .			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2016 distributable amount			
i Carryover from 2011 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2016 from Section D, line 7 \$			
a Applied to underdistributions of prior years			
b Applied to 2016 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2016, if any Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions)			
6 Remaining underdistributions for 2016 Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions)			
7 Excess distributions carryover to 2017. Add lines 3j and 4c			
8 Breakdown of line 7			
a			
b Excess from 2013. . . . .			
c Excess from 2014. . . . .			
d Excess from 2015. . . . .			
e Excess from 2016. . . . .			

**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).

<b>Facts And Circumstances Test</b>

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

Department of the Treasury  
Internal Revenue Service

**Political Campaign and Lobbying Activities**

For Organizations Exempt From Income Tax Under section 501(c) and section 527  
▶Complete if the organization is described below. ▶Attach to Form 990 or Form 990-EZ.  
▶Information about Schedule C (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047

**2016**

**Open to Public Inspection**

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

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

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

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

If the organization answered "Yes" on Form 990, Part IV, Line 5 (Proxy Tax) (see separate instructions) or Form 990-EZ, Part V, line 35c (Proxy Tax) (see separate instructions), then

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

Name of the organization MERCY HEALTH SERVICES - IOWA CORP	Employer identification number 31-1373080
---	--

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

1	Provide a description of the organization's direct and indirect political campaign activities in Part IV	
2	Political expenditures	▶ \$
3	Volunteer hours	

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

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

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

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

(a) Name	(b) Address	(c) EIN	(d) Amount paid from filing organization's funds If none, enter -0-	(e) Amount of political contributions received and promptly and directly delivered to a separate political organization If none, enter -0-
2				
3				
4				
5				
6				

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

**A** Check ☒ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures)

**B** Check ☐ if the filing organization checked box A and "limited control" provisions apply

**Limits on Lobbying Expenditures**  
(The term "expenditures" means amounts paid or incurred.)**(a)** Filing  
organization's  
totals**(b)** Affiliated  
group totals

**1a** Total lobbying expenditures to influence public opinion (grass roots lobbying)

**b** Total lobbying expenditures to influence a legislative body (direct lobbying)

**c** Total lobbying expenditures (add lines 1a and 1b)

**d** Other exempt purpose expenditures

**e** Total exempt purpose expenditures (add lines 1c and 1d)

**f** Lobbying nontaxable amount Enter the amount from the following table in both columns

If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:
Not over \$500,000	20% of the amount on line 1e
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000
Over \$17,000,000	\$1,000,000

**g** Grassroots nontaxable amount (enter 25% of line 1f)

**h** Subtract line 1g from line 1a If zero or less, enter -0-

**i** Subtract line 1f from line 1c If zero or less, enter -0-

**j** If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?

☐ Yes ☐ No**4-Year Averaging Period Under section 501(h)**

(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the separate instructions for lines 2a through 2f.)

**Lobbying Expenditures During 4-Year Averaging Period**

Calendar year (or fiscal year beginning in)	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) Total
<b>2a</b> Lobbying nontaxable amount					
<b>b</b> Lobbying ceiling amount (150% of line 2a, column(e))					
<b>c</b> Total lobbying expenditures					
<b>d</b> Grassroots nontaxable amount					
<b>e</b> Grassroots ceiling amount (150% of line 2d, column (e))					
<b>f</b> Grassroots lobbying expenditures					

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

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity

		(a)		(b)
		Yes	No	Amount
<b>1</b>	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
<b>a</b>	Volunteers?		No	
<b>b</b>	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?	Yes		
<b>c</b>	Media advertisements?		No	
<b>d</b>	Mailings to members, legislators, or the public?		No	
<b>e</b>	Publications, or published or broadcast statements?		No	
<b>f</b>	Grants to other organizations for lobbying purposes?	Yes		117,500
<b>g</b>	Direct contact with legislators, their staffs, government officials, or a legislative body?	Yes		2,500
<b>h</b>	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
<b>i</b>	Other activities?		No	
<b>j</b>	Total. Add lines 1c through 1i			120,000
<b>2a</b>	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
<b>b</b>	If "Yes," enter the amount of any tax incurred under section 4912			
<b>c</b>	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
<b>d</b>	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

**Part III-A** Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).

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

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

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

**Part IV** Supplemental Information

Provide the descriptions required for Part I-A, line 1, Part I-B, line 4, Part I-C, line 5, Part II-A (affiliated group list), Part II-A, lines 1 and 2 (see instructions), and Part II-B, line 1. Also, complete this part for any additional information.

Return Reference	Explanation
PART II-B, LINE 1	MERCY HEALTH SERVICES - IOWA (MHS-IA) HAS MADE GRANTS TO OTHER ORGANIZATIONS FOR LOBBYING PURPOSES. THESE GRANTS HAVE BEEN IN THE FORM OF MEMBERSHIP DUES PAID TO REGIONAL AND NATIONAL HEALTH CARE ORGANIZATIONS, WHERE THE ORGANIZATIONS HAVE PROVIDED MHS-IA WITH AN ESTIMATED PERCENTAGE OF DUES PAYMENTS WHICH ARE USED FOR LOBBYING ACTIVITIES. SIMILARLY, THESE HEALTH CARE ORGANIZATIONS WILL ARRANGE CONFERENCES AND SEMINARS FOR MEMBER ORGANIZATIONS AND THEIR EXECUTIVES WHICH INVOLVE LEGISLATORS OR OTHER POLITICAL FIGURES AS GUEST SPEAKERS. OUR SYSTEM'S 2016 FEDERAL AND STATE ADVOCACY GOALS AND PRIORITIES INCLUDED: GOAL 1: ENACT POLICIES THAT SUPPORT BETTER HEALTH, BETTER CARE AND LOWER COST-FURTHER PEOPLE CENTERED 2020 -MEDICARE DELIVERY AND PAYMENT REFORM, INCLUDING MEDICARE SHARED SAVINGS PROGRAM (MSSP) & BUNDLED PAYMENT -"VALUE" NETWORKS (NARROW NETWORKS) -HEALTH INFORMATION TECHNOLOGY (HIT)/INTEROPERABILITY -STATE INNOVATION MODELS (SIM) -MEDICAID INNOVATION -BEHAVIORAL HEALTH -WORKFORCE, INCLUDING INTERSTATE COMPACT -TELEHEALTH -PALLIATIVE CARE GOAL 2: SECURE COVERAGE EXPANSION -PROTECT RECENT MEDICAID EXPANSION -PUSH FOR MEDICAID EXPANSION IN STATES YET TO ACT -IMPROVE HEALTH INSURANCE EXCHANGE (HIX) ENROLLMENT, PLAN OVERSIGHT, AND OPERABILITY GOAL 3: SUSTAIN CATHOLIC HEALTH MINISTRY, INCLUDING FAIR PAYMENT AND TAX EXEMPTION -PREVENT ARBITRARY MEDICARE & MEDICAID CUTS -PROTECT DISPROPORTIONATE SHARE PAYMENTS -ENACT POLICIES THAT SUPPORT BETTER HEALTH, BETTER CARE, AND LOWER COST -ENSURE MAXIMUM COVERAGE AND ACCESS, INCLUDING MEDICAID EXPANSION -DRIVE QUALITY AND EFFICIENCY ACROSS THE CONTINUUM OF CARE WITH VALUE-BASED, SUSTAINABLE PAYMENT MODELS -STRENGTHEN TRINITY HEALTH'S POSITION AS A RESPECTED POLICY PARTNER -BOLSTER OUR ADVOCACY VOICE THROUGH EFFECTIVE SYSTEM-WIDE ENGAGEMENT - LEAD THE WAY OUR SYSTEM'S 2017 FEDERAL AND STATE ADVOCACY GOALS AND PRIORITIES INCLUDE: GOAL 1: IMPROVE THE HEALTH OF INDIVIDUALS AND COMMUNITIES -COVERAGE AND ACCESS TO MENTAL AND PHYSICAL HEALTH SERVICES -INSURANCE PROTECTIONS -MEDICAID EXPANSION -HIX SUSTAINABILITY -BEHAVIORAL HEALTH INTEGRATION -PALLIATIVE CARE -SUBSTANCE ABUSE / OPIOIDS -TOBACCO -OBESITY / NUTRITION -HEALTH EQUITY GOAL 2: SUSTAIN CATHOLIC HEALTH MINISTRY, INCLUDING FAIR PAYMENT AND TAX EXEMPTION -INNOVATIVE DELIVERY AND PAYMENT MODELS -ALTERNATIVE PAYMENT MODELS (SIM / MACRA) -HIT / INTEROPERABILITY -WORKFORCE -MEDICAID INNOVATION -MEANINGFUL & STANDARD MEASURERS -TELEHEALTH -TRANSPARENCY

efile GRAPHIC print - DO NOT PROCESS		As Filed Data -		DLN: 93493135006218	
<div>SCHEDULE D (Form 990)</div> <div>Department of the Treasury Internal Revenue Service</div>		<div>Supplemental Financial Statements</div> <div>► Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b. ► Attach to Form 990.</div> <div>Information about Schedule D (Form 990) and its instructions is at <a href="http://www.irs.gov/form990">www.irs.gov/form990</a>.</div>			<div>OMB No 1545-0047</div> <div>2016</div> <div>Open to Public Inspection</div>
<div>Name of the organization</div> MERCY HEALTH SERVICES - IOWA CORP				<div>Employer identification number</div> 31-1373080	
<div>Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.</div> <div>Complete if the organization answered "Yes" on Form 990, Part IV, line 6.</div>					
		(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? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>					
6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds 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? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>					
<div>Part II Conservation Easements.</div> <div>Complete if the organization answered "Yes" on Form 990, Part IV, line 7.</div>					
1 Purpose(s) of conservation easements held by the organization (check all that apply) <div><input type="checkbox"/> Preservation of land for public use (e g , recreation or education) <input type="checkbox"/> Preservation of an historically important land area</div> <div><input type="checkbox"/> Protection of natural habitat <input type="checkbox"/> Preservation of a certified historic structure</div> <div><input type="checkbox"/> Preservation of open space</div>					
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					
				Held at the End of the Year	
a Total number of conservation easements				2a	
b Total acreage restricted by conservation easements				2b	
c Number of conservation easements on a certified historic structure included in (a)				2c	
d Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register				2d	
3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ►					
4 Number of states where property subject to conservation easement is located ►					
5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>					
6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ►					
7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ► \$					
8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>					
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					
<div>Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.</div> <div>Complete if the organization answered "Yes" on Form 990, Part IV, line 8.</div>					
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 on Form 990, Part VIII, line 1				► \$	
(ii) Assets included in Form 990, Part X				► \$	
2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items					
a Revenue included on Form 990, Part VIII, line 1				► \$	
b Assets included in Form 990, Part X				► \$	
For Paperwork Reduction Act Notice, see the Instructions for Form 990.					
			Cat No 52283D Schedule D (Form 990) 2016		

Part III

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

3

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

a

☐

Public exhibition

b

☐

Scholarly research

c

☐

Preservation for future generations

d

☐

Loan or exchange programs

e

☐

Other

4

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

5

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

☐ Yes

☐ No

Part IV

Escrow and Custodial Arrangements.

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

1a

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

☐ Yes

☐ No

b

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

c

Beginning balance

d

Additions during the year

e

Distributions during the year

f

Ending balance

	Amount
1c	
1d	
1e	
1f	

2a

Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability?

☐ Yes

☐ No

b

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

☐

Part V

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

	(a)Current year	(b)Prior year	(c)Two years back	(d)Three years back	(e)Four years back
1a Beginning of year balance . . . . .	25,000	25,000	25,000	25,000	25,000
b Contributions . . . . .					
c Net investment earnings, gains, and losses					
d Grants or scholarships . . . . .					
e Other expenditures for facilities and programs . . . . .					
f Administrative expenses . . . . .					
g End of year balance . . . . .	25,000	25,000	25,000	25,000	25,000

2

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

a

Board designated or quasi-endowment ▶

0 %

b

Permanent endowment ▶

100 000 %

c

Temporarily restricted endowment ▶

0 %

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

3a

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

(i) unrelated organizations . . . . .

(ii) related organizations . . . . .

b

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

. . . . .

	Yes	No
3a(i)	Yes	
3a(ii)	Yes	
3b	Yes	

4

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

Part VI

Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land . . . . .		10,328,607		10,328,607
b Buildings		403,552,824	263,649,149	139,903,675
c Leasehold improvements				
d Equipment . . . . .		226,352,327	167,529,722	58,822,605
e Other . . . . .		15,886,580	357,791	15,528,789
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c)) . . . ▶				224,583,676

Schedule D (Form 990) 2016

Part VII

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

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1) Financial derivatives . . . . .		
(2) Closely-held equity interests . . . . .		
(3) Other _____		
(A) COMMINGLED FUNDS DIRECTLY HOLDING SECURITIES	54,511,419	F
(B) EQUITY METHOD INVESTMENTS	41,532,510	C
(C) HEDGE FUNDS	25,957,818	F
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Column (b) must equal Form 990, Part X, col (B) line 12 ) ▶	122,001,747	

Part VIII

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

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

Part IX

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

(a) Description	(b) Book value
(1) OTHER RECEIVABLES	20,718,633
(2) INTERCOMPANY ACCOUNTS RECEIVABLE	3,919,422
(3) INVESTMENT IN AFFILIATES	15,211,043
(4) OTHER ASSETS	2,990,644
(5) INTERCOMPANY LT PREPAID INFO SYSTEMS	39,787,348
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 15 ) . . . . . ▶	82,627,090

Part X

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
INTERCOMPANY ACCOUNTS PAYABLE	9,265,800
DEFERRED COMPENSATION	8,894,694
LONG TERM ASSET RETIREMENT OBLIGATION (FIN 47)	4,315,149
INTERCOMPANY NOTES PAYABLE	203,161,035
ANNUITY PAYABLE	46,841
OTHER CURRENT LIABILITIES	891,943
INTERCOMPANY OTHER LIABILITIES	386,441
OTHER LONG-TERM LIABILITIES	78,531
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 25 ) ▶	227,040,434

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



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

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

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

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

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

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

**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
See Additional Data Table	

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

Return Reference	Explanation

Additional Data

Software ID:  
Software Version:  
EIN: 31-1373080  
Name: MERCY HEALTH SERVICES - IOWA CORP

Form 990, Schedule D, Part X, - Other Liabilities

1	(a) Description of Liability	(b) Book Value
	INTERCOMPANY ACCOUNTS PAYABLE	9,265,800
	DEFERRED COMPENSATION	8,894,694
	LONG TERM ASSET RETIREMENT OBLIGATION (FIN 47)	4,315,149
	INTERCOMPANY NOTES PAYABLE	203,161,035
	ANNUITY PAYABLE	46,841
	OTHER CURRENT LIABILITIES	891,943
	INTERCOMPANY OTHER LIABILITIES	386,441
	OTHER LONG-TERM LIABILITIES	78,531

Supplemental Information	
Return Reference	Explanation
PART V, LINE 4	THE ENDOWMENT FUNDS OF MERCY HEALTH SERVICES - IOWA INCLUDE \$25,000 KNOWN AS THE VIANNA HO LSCHLAG SCHOLARSHIP FUND INTEREST INCOME FROM THE FUND IS MADE AVAILABLE FOR NURSING SCHOLARSHIPS PART V, LINE 3A ENDOWMENTS HELD BY DUBUQUE MERCY HEALTH FOUNDATION AND DYERSVILLE HEALTH FOUNDATION FOR THE BENEFIT OF MERCY HEALTH SERVICES - IOWA ARE REPORTED ON THE FORM 990'S OF THE RESPECTIVE FOUNDATIONS

efile GRAPHIC print - DO NOT PROCESSAs Filed Data -DLN: 93493135006218

SCHEDULE H  
(Form 990)

Hospitals

OMB No 1545-0047

2016

Open to Public Inspection

Department of the Treasury

Internal Revenue Service

Complete if the organization answered "Yes" on Form 990, Part IV, question 20.  
Attach to Form 990.  
Information about Schedule H (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

Name of the organization

Employer identification number

MERCY HEALTH SERVICES - IOWA CORP

31-1373080

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

1a

Yes

1b

If "Yes," was it a written policy?

1b

Yes

2

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

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

3a

Yes

☐ 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

3b

Yes

☐ 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

Yes

5a

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

5a

Yes

5b

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

5b

Yes

5c

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

5c

No

6a

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

6a

Yes

6b

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

6b

Yes

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

7 Financial Assistance and Certain Other Community Benefits at Cost						
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)	3	3,877	6,803,186		6,803,186	0 950 %
b Medicaid (from Worksheet 3, column a)	34	46,579	77,808,493	63,841,494	13,966,999	1 950 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs	37	50,456	84,611,679	63,841,494	20,770,185	2 900 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	71	78,019	2,632,654	150,534	2,482,120	0 350 %
f Health professions education (from Worksheet 5)	11	1,608	3,918,543	1,064,961	2,853,582	0 400 %
g Subsidized health services (from Worksheet 6)	27	43,487	19,297,976	11,261,127	8,036,849	1 120 %
h Research (from Worksheet 7)	3	44	32,833		32,833	0 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)	47	61,219	1,142,240	53,590	1,088,650	0 150 %
j Total. Other Benefits	159	184,377	27,024,246	12,530,212	14,494,034	2 020 %
k Total. Add lines 7d and 7j	196	234,833	111,635,925	76,371,706	35,264,219	4 920 %

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

Cat No 50192T

Schedule H (Form 990) 2016

Part III

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	1	30	719		719	0 %
3 Community support	3	137	3,753	75	3,678	0 %
4 Environmental improvements	2	83	966		966	0 %
5 Leadership development and training for community members	1	1,255	6,299		6,299	0 %
6 Coalition building						
7 Community health improvement advocacy	1	1,500	1,774		1,774	0 %
8 Workforce development	2	393	1,896		1,896	0 %
9 Other						
10 Total	10	3,398	15,407	75	15,332	0 %

Part III

Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

		Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1		No
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	14,920,550	
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	0	
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	228,266,879
6 Enter Medicare allowable costs of care relating to payments on line 5.	6	250,898,599
7 Subtract line 6 from line 5. This is the surplus (or shortfall).	7	-22,631,720
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used.		
<input type="checkbox"/> Cost accounting system	<input checked="" type="checkbox"/> Cost to charge ratio	<input type="checkbox"/> Other

Section C. Collection Practices

9a Did the organization have a written debt collection policy during the tax year?	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 1 FOREST PARK IMAGING LLC	IMAGING SERVICES	52 890 %		47 110 %
2 2 MAGNETIC RESONANCE SERVICES LLC	MRI SERVICES	49 000 %		51 000 %
3 3 MASON CITY AMBULATORY SURGERY CENTER LLC	AMBULATORY SURGICAL SERVICES	51 000 %		49 000 %
4 4 MERCY HEART CENTER OUTPATIENT SERVICES LLC	OUTPATIENT ECHOCARDIOGRAPHY AND NUCLEAR MEDICINE SERVICES	51 000 %		49 000 %
5 5 SURGICAL CENTER BUILDING ASSOCIATES LLC	OWNS AND LEASES SURGICAL CENTER BUILDING	35 000 %		65 000 %
6 6 SIOUXLAND SURGERY CENTER LLP (DBA DUNES SURGICAL HOSPITAL)	AMBULATORY SURGICAL SERVICES	30 940 %		44 460 %
7 7 HEALTH MANAGEMENT SERVICES LLC	AMBULATORY SURGICAL SVCS, OCCUPATIONAL HLTH SVCS AND PRIMARY CARE PHYS SVCS	50 000 %		50 000 %
8 8 NORTH IOWA COMMUNITY HEALTHCARE LLC	HEALTHCARE PROVIDERS AND MANAGEMENT SERVICES	20 500 %		41 000 %
9 9 PREFERRED HEALTH CHOICES LLC	MANAGEMENT SERVICES	50 000 %		50 000 %
10 10 UNITED CLINICAL LABORATORIES INC	MEDICAL LABORATORY	33 330 %		33 330 %
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?

**6**

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)

		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (Describe)	Facility reporting group
	See Additional Data Table										

**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 MEDICAL CENTER-NORTH IOWA

**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

**Community Health Needs Assessment**

	Yes	No
<b>1</b> Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? . . . . .	<b>1</b>	No
<b>2</b> Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C . . . . .	<b>2</b>	No
<b>3</b> During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 . . . . . If "Yes," indicate what the CHNA report describes (check all that apply)	<b>3</b>	Yes
<b>a</b> <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b> <input checked="" type="checkbox"/> Demographics of the community		
<b>c</b> <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b> <input checked="" type="checkbox"/> How data was obtained		
<b>e</b> <input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b> <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b> <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b> <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b> <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C) _____		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA 20 <u>16</u>		
<b>5</b> In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .	<b>5</b>	Yes
<b>6 a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b>	No
<b>b</b> Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C . . . . .	<b>6b</b>	Yes
<b>7</b> 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)	<b>7</b>	Yes
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>SEE SCHEDULE H, PART V, SECTION C</u>		
<b>b</b> <input type="checkbox"/> Other website (list url) _____		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input type="checkbox"/> Other (describe in Section C) _____		
<b>8</b> Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 . . . . .	<b>8</b>	Yes
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u>		
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url) <u>SEE SCHEDULE H, PART V, SECTION C</u>	<b>10</b>	Yes
<b>a</b> _____		
<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b> Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
<b>12a</b> Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .	<b>12a</b>	No
<b>b</b> If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b> If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		



**Part V**

**Facility Information** *(continued)*

**Financial Assistance Policy (FAP)**

MERCY MEDICAL CENTER-NORTH IOWA

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

		Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that		
<b>13</b>	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	Yes	
<b>a</b>	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 000000000000 % and FPG family income limit for eligibility for discounted care of 400 000000000000 %		
<b>b</b>	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b>	<input checked="" type="checkbox"/> Asset level		
<b>d</b>	<input checked="" type="checkbox"/> Medical indigency		
<b>e</b>	<input checked="" type="checkbox"/> Insurance status		
<b>f</b>	<input checked="" type="checkbox"/> Underinsurance discount		
<b>g</b>	<input checked="" type="checkbox"/> Residency		
<b>h</b>	<input checked="" type="checkbox"/> Other (describe in Section C)		
<b>14</b>	Explained the basis for calculating amounts charged to patients? . . . . .	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)	Yes	
<b>a</b>	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</b>	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
<b>c</b>	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
<b>d</b>	<input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>16</b>	Was widely publicized within the community served by the hospital facility? . . . . . If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	Yes	
<b>a</b>	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) WWW MERCYNORTHIOWA COM/BUSINESS-OFFICE		
<b>b</b>	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) WWW MERCYNORTHIOWA COM/BUSINESS-OFFICE		
<b>c</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) WWW MERCYNORTHIOWA COM/BUSINESS-OFFICE		
<b>d</b>	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b>	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>f</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>g</b>	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
<b>h</b>	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b>	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information** (continued)**Billing and Collections**

MERCY MEDICAL CENTER-NORTH IOWA

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

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

**Policy Relating to Emergency Medical Care**

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

**Part V Facility Information** *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

MERCY MEDICAL CENTER-NORTH IOWA

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

- a** ☒ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- c** ☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- d** ☐ The hospital facility used a prospective Medicare or Medicaid method

**23** During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? . . . . .

If "Yes," explain in Section C

**24** During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? . . . . .

If "Yes," explain in Section C

	Yes	No
<b>22</b>		
<b>23</b>		No
<b>24</b>		No

**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 MEDICAL CENTER-SIOUX CITY**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):** \_\_\_\_\_**3****Community Health Needs Assessment**

	Yes	No
<b>1</b> Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? . . . . .	<b>1</b>	No
<b>2</b> Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C . . . . .	<b>2</b>	No
<b>3</b> During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 . . . . . If "Yes," indicate what the CHNA report describes (check all that apply)	<b>3</b>	Yes
<b>a</b> <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b> <input checked="" type="checkbox"/> Demographics of the community		
<b>c</b> <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b> <input checked="" type="checkbox"/> How data was obtained		
<b>e</b> <input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b> <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b> <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b> <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b> <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA <u>20 15</u>		
<b>5</b> In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .	<b>5</b>	Yes
<b>6 a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b>	Yes
<b>b</b> Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C . . . . .	<b>6b</b>	Yes
<b>7</b> 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)	<b>7</b>	Yes
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>SEE SCHEDULE H, PART V, SECTION C</u>		
<b>b</b> <input checked="" type="checkbox"/> Other website (list url) <u>SEE SCHEDULE H, PART V, SECTION C</u>		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input checked="" type="checkbox"/> Other (describe in Section C)		
<b>8</b> Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 . . . . .	<b>8</b>	Yes
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 15</u>		
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url) <u>SEE SCHEDULE H, PART V, SECTION C</u>	<b>10</b>	Yes
<b>a</b>		
<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b> Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
<b>12a</b> Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .	<b>12a</b>	No
<b>b</b> If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b> If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

MERCY MEDICAL CENTER-SIOUX CITY

Name of hospital facility or letter of facility reporting group

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13	Yes	
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 000000000000 % and FPG family income limit for eligibility for discounted care of 400 000000000000 %			
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 checked="" type="checkbox"/> Other (describe in Section C)			
14 Explained the basis for calculating amounts charged to patients?	14	Yes	
15 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)	15	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)			
16 Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	16	Yes	
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) WWW MERCYSIOUXCITY COM/FOR-PATIENTS			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) WWW MERCYSIOUXCITY COM/FOR-PATIENTS			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) WWW MERCYSIOUXCITY COM/FOR-PATIENTS			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j <input checked="" type="checkbox"/> Other (describe in Section C)			

**Part V Facility Information** (continued)**Billing and Collections**

MERCY MEDICAL CENTER-SIOUX CITY

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

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

**Policy Relating to Emergency Medical Care**

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

**Part V Facility Information** (continued)**Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

MERCY MEDICAL CENTER-SIOUX CITY

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

- a** ☒ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- c** ☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- d** ☐ The hospital facility used a prospective Medicare or Medicaid method

**23** During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? . . . . .

If "Yes," explain in Section C

**24** During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? . . . . .

If "Yes," explain in Section C

	Yes	No
<b>22</b>		
<b>23</b>		No
<b>24</b>		No

**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 MEDICAL CENTER-DUBUQUE**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

**Community Health Needs Assessment**

	Yes	No
<b>1</b> Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? . . . . .	<b>1</b>	No
<b>2</b> Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C . . . . .	<b>2</b>	No
<b>3</b> During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 . . . . . If "Yes," indicate what the CHNA report describes (check all that apply)	<b>3</b>	Yes
<b>a</b> <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b> <input checked="" type="checkbox"/> Demographics of the community		
<b>c</b> <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b> <input checked="" type="checkbox"/> How data was obtained		
<b>e</b> <input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b> <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b> <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b> <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b> <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C) _____		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA <u>20 14</u>		
<b>5</b> In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .	<b>5</b>	Yes
<b>6 a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b>	Yes
<b>b</b> Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C . . . . .	<b>6b</b>	Yes
<b>7</b> 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)	<b>7</b>	Yes
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>SEE SCHEDULE H, PART V, SECTION C</u>		
<b>b</b> <input type="checkbox"/> Other website (list url) _____		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input type="checkbox"/> Other (describe in Section C) _____		
<b>8</b> Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 . . . . .	<b>8</b>	Yes
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 14</u>	<b>10</b>	Yes
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url) <u>SEE SCHEDULE H, PART V, SECTION C</u>	<b>10b</b>	
<b>11</b> Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
<b>12a</b> Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .	<b>12a</b>	No
<b>b</b> If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b> If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		



**Part V**

**Facility Information** *(continued)*

**Financial Assistance Policy (FAP)**

MERCY MEDICAL CENTER-DUBUQUE

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

		Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that		
<b>13</b>	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	<b>13</b> Yes	
	<b>a</b> <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 000000000000 % and FPG family income limit for eligibility for discounted care of 400 000000000000 %		
	<b>b</b> <input type="checkbox"/> Income level other than FPG (describe in Section C)		
	<b>c</b> <input checked="" type="checkbox"/> Asset level		
	<b>d</b> <input checked="" type="checkbox"/> Medical indigency		
	<b>e</b> <input checked="" type="checkbox"/> Insurance status		
	<b>f</b> <input checked="" type="checkbox"/> Underinsurance discount		
	<b>g</b> <input checked="" type="checkbox"/> Residency		
	<b>h</b> <input checked="" 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	
	<b>a</b> <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
	<b>b</b> <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
	<b>c</b> <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
	<b>d</b> <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
	<b>e</b> <input type="checkbox"/> Other (describe in Section C)		
<b>16</b>	Was widely publicized within the community served by the hospital facility? . . . . . If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	<b>16</b> Yes	
	<b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) WWW MERCYDUBUQUE COM/PATIENT-FINANCIAL-ASSISTANCE		
	<b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) WWW MERCYDUBUQUE COM/PATIENT-FINANCIAL-ASSISTANCE		
	<b>c</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) WWW MERCYDUBUQUE COM/PATIENT-FINANCIAL-ASSISTANCE		
	<b>d</b> <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
	<b>e</b> <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
	<b>f</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
	<b>g</b> <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
	<b>h</b> <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
	<b>i</b> <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
	<b>j</b> <input checked="" type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information** (continued)**Billing and Collections**

MERCY MEDICAL CENTER-DUBUQUE

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

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

**Policy Relating to Emergency Medical Care**

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

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

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

MERCY MEDICAL CENTER-DUBUQUE

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

**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

- a** ☒ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- c** ☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- d** ☐ The hospital facility used a prospective Medicare or Medicaid method

**23** During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? . . . . .

If "Yes," explain in Section C

**24** During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? . . . . .

If "Yes," explain in Section C

	Yes	No
<b>22</b>		
<b>23</b>		No
<b>24</b>		No

**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)  
DUNES SURGICAL HOSPITAL**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):** \_\_\_\_\_

5

**Community Health Needs Assessment**

	Yes	No
<b>1</b> Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? . . . . .	<b>1</b>	No
<b>2</b> Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C . . . . .	<b>2</b>	No
<b>3</b> During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 . . . . . If "Yes," indicate what the CHNA report describes (check all that apply)	<b>3</b>	Yes
<b>a</b> <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b> <input checked="" type="checkbox"/> Demographics of the community		
<b>c</b> <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b> <input checked="" type="checkbox"/> How data was obtained		
<b>e</b> <input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b> <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b> <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b> <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b> <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA 20 <u>15</u>		
<b>5</b> In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .	<b>5</b>	Yes
<b>6 a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b>	Yes
<b>b</b> Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C . . . . .	<b>6b</b>	Yes
<b>7</b> 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)	<b>7</b>	Yes
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>SEE SCHEDULE H, PART V, SECTION C</u>		
<b>b</b> <input checked="" type="checkbox"/> Other website (list url) <u>SEE SCHEDULE H, PART V, SECTION C</u>		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input checked="" type="checkbox"/> Other (describe in Section C)		
<b>8</b> Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 . . . . .	<b>8</b>	Yes
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>15</u>		
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url) <u>SEE SCHEDULE H, PART V, SECTION C</u>	<b>10</b>	Yes
<b>a</b>		
<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b> Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
<b>12a</b> Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .	<b>12a</b>	No
<b>b</b> If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b> If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V

Facility Information (continued)

Financial Assistance Policy (FAP)

DUNES SURGICAL HOSPITAL																																																																																								
Name of hospital facility or letter of facility reporting group																																																																																								
	<table><tr><td></td><td>Yes</td><td>No</td></tr><tr><td>Did the hospital facility have in place during the tax year a written financial assistance policy that</td><td></td><td></td></tr><tr><td><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</td><td><b>13</b> Yes</td><td></td></tr><tr><td><b>a</b> <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 000000000000 % and FPG family income limit for eligibility for discounted care of 400 000000000000 %</td><td></td><td></td></tr><tr><td><b>b</b> <input type="checkbox"/> Income level other than FPG (describe in Section C)</td><td></td><td></td></tr><tr><td><b>c</b> <input checked="" type="checkbox"/> Asset level</td><td></td><td></td></tr><tr><td><b>d</b> <input checked="" type="checkbox"/> Medical indigency</td><td></td><td></td></tr><tr><td><b>e</b> <input checked="" type="checkbox"/> Insurance status</td><td></td><td></td></tr><tr><td><b>f</b> <input checked="" type="checkbox"/> Underinsurance discount</td><td></td><td></td></tr><tr><td><b>g</b> <input type="checkbox"/> Residency</td><td></td><td></td></tr><tr><td><b>h</b> <input checked="" type="checkbox"/> Other (describe in Section C)</td><td></td><td></td></tr><tr><td><b>14</b> Explained the basis for calculating amounts charged to patients?</td><td><b>14</b> Yes</td><td></td></tr><tr><td><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)</td><td><b>15</b> Yes</td><td></td></tr><tr><td><b>a</b> <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application</td><td></td><td></td></tr><tr><td><b>b</b> <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application</td><td></td><td></td></tr><tr><td><b>c</b> <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process</td><td></td><td></td></tr><tr><td><b>d</b> <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications</td><td></td><td></td></tr><tr><td><b>e</b> <input type="checkbox"/> Other (describe in Section C)</td><td></td><td></td></tr><tr><td><b>16</b> Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)</td><td><b>16</b> Yes</td><td></td></tr><tr><td><b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) WWW.DUNESSURGICALHOSPITAL.COM/FINANCIAL-ASSISTANCE-AND-CHARITY-CARE</td><td></td><td></td></tr><tr><td><b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) WWW.DUNESSURGICALHOSPITAL.COM/FINANCIAL-ASSISTANCE-AND-CHARITY-CARE</td><td></td><td></td></tr><tr><td><b>c</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) WWW.DUNESSURGICALHOSPITAL.COM/FINANCIAL-ASSISTANCE-AND-CHARITY-CARE</td><td></td><td></td></tr><tr><td><b>d</b> <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)</td><td></td><td></td></tr><tr><td><b>e</b> <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)</td><td></td><td></td></tr><tr><td><b>f</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)</td><td></td><td></td></tr><tr><td><b>g</b> <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention</td><td></td><td></td></tr><tr><td><b>h</b> <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP</td><td></td><td></td></tr><tr><td><b>i</b> <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations</td><td></td><td></td></tr><tr><td><b>j</b> <input type="checkbox"/> Other (describe in Section C)</td><td></td><td></td></tr></table>		Yes	No	Did the hospital facility have in place during the tax year a written financial assistance policy that			<b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	<b>13</b> Yes		<b>a</b> <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 000000000000 % and FPG family income limit for eligibility for discounted care of 400 000000000000 %			<b>b</b> <input type="checkbox"/> Income level other than FPG (describe in Section C)			<b>c</b> <input checked="" type="checkbox"/> Asset level			<b>d</b> <input checked="" type="checkbox"/> Medical indigency			<b>e</b> <input checked="" type="checkbox"/> Insurance status			<b>f</b> <input checked="" type="checkbox"/> Underinsurance discount			<b>g</b> <input type="checkbox"/> Residency			<b>h</b> <input checked="" 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		<b>a</b> <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			<b>b</b> <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			<b>c</b> <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			<b>d</b> <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			<b>e</b> <input type="checkbox"/> Other (describe in Section C)			<b>16</b> Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	<b>16</b> Yes		<b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) WWW.DUNESSURGICALHOSPITAL.COM/FINANCIAL-ASSISTANCE-AND-CHARITY-CARE			<b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) WWW.DUNESSURGICALHOSPITAL.COM/FINANCIAL-ASSISTANCE-AND-CHARITY-CARE			<b>c</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) WWW.DUNESSURGICALHOSPITAL.COM/FINANCIAL-ASSISTANCE-AND-CHARITY-CARE			<b>d</b> <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			<b>e</b> <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			<b>f</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			<b>g</b> <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			<b>h</b> <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			<b>i</b> <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			<b>j</b> <input type="checkbox"/> Other (describe in Section C)		
	Yes	No																																																																																						
Did the hospital facility have in place during the tax year a written financial assistance policy that																																																																																								
<b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	<b>13</b> Yes																																																																																							
<b>a</b> <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 000000000000 % and FPG family income limit for eligibility for discounted care of 400 000000000000 %																																																																																								
<b>b</b> <input type="checkbox"/> Income level other than FPG (describe in Section C)																																																																																								
<b>c</b> <input checked="" type="checkbox"/> Asset level																																																																																								
<b>d</b> <input checked="" type="checkbox"/> Medical indigency																																																																																								
<b>e</b> <input checked="" type="checkbox"/> Insurance status																																																																																								
<b>f</b> <input checked="" type="checkbox"/> Underinsurance discount																																																																																								
<b>g</b> <input type="checkbox"/> Residency																																																																																								
<b>h</b> <input checked="" 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																																																																																							
<b>a</b> <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application																																																																																								
<b>b</b> <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application																																																																																								
<b>c</b> <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process																																																																																								
<b>d</b> <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications																																																																																								
<b>e</b> <input type="checkbox"/> Other (describe in Section C)																																																																																								
<b>16</b> Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	<b>16</b> Yes																																																																																							
<b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) WWW.DUNESSURGICALHOSPITAL.COM/FINANCIAL-ASSISTANCE-AND-CHARITY-CARE																																																																																								
<b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) WWW.DUNESSURGICALHOSPITAL.COM/FINANCIAL-ASSISTANCE-AND-CHARITY-CARE																																																																																								
<b>c</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) WWW.DUNESSURGICALHOSPITAL.COM/FINANCIAL-ASSISTANCE-AND-CHARITY-CARE																																																																																								
<b>d</b> <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)																																																																																								
<b>e</b> <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)																																																																																								
<b>f</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)																																																																																								
<b>g</b> <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention																																																																																								
<b>h</b> <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP																																																																																								
<b>i</b> <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations																																																																																								
<b>j</b> <input type="checkbox"/> Other (describe in Section C)																																																																																								

**Part V Facility Information** (continued)**Billing and Collections**

DUNES SURGICAL HOSPITAL

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

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

**Policy Relating to Emergency Medical Care**

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

**Part V Facility Information** *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

DUNES SURGICAL HOSPITAL

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

- a** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- c** ☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- d** ☒ The hospital facility used a prospective Medicare or Medicaid method

**23** During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? . . . . .

If "Yes," explain in Section C

**24** During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? . . . . .

If "Yes," explain in Section C

	Yes	No
<b>23</b>		No
<b>24</b>		No

**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 MEDICAL CENTER-NEW HAMPTON

**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):** \_\_\_\_\_

4

**Community Health Needs Assessment**

	Yes	No
<b>1</b> Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? . . . . .	<b>1</b>	No
<b>2</b> Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C . . . . .	<b>2</b>	No
<b>3</b> During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 . . . . . If "Yes," indicate what the CHNA report describes (check all that apply)	<b>3</b> Yes	
<b>a</b> <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b> <input checked="" type="checkbox"/> Demographics of the community		
<b>c</b> <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b> <input checked="" type="checkbox"/> How data was obtained		
<b>e</b> <input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b> <input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b> <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b> <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b> <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA 20 <u>15</u>		
<b>5</b> In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .	<b>5</b> Yes	
<b>6 a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b>	No
<b>b</b> Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C . . . . .	<b>6b</b>	No
<b>7</b> 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)	<b>7</b> Yes	
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>SEE SCHEDULE H, PART V, SECTION C</u>		
<b>b</b> <input type="checkbox"/> Other website (list url) _____		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input type="checkbox"/> Other (describe in Section C)		
<b>8</b> Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 . . . . .	<b>8</b> Yes	
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>15</u>	<b>10</b>	
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url) <u>SEE SCHEDULE H, PART V, SECTION C</u>	<b>10</b> Yes	
<b>a</b>		
<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b> Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
<b>12a</b> Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .	<b>12a</b>	No
<b>b</b> If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b> If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		



**Part V**

**Facility Information** *(continued)*

**Financial Assistance Policy (FAP)**

MERCY MEDICAL CENTER-NEW HAMPTON

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

		Yes	No
<b>13</b>	Did the hospital facility have in place during the tax year a written financial assistance policy that 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	Yes	
<b>a</b>	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 000000000000 % and FPG family income limit for eligibility for discounted care of 400 000000000000 %		
<b>b</b>	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b>	<input checked="" type="checkbox"/> Asset level		
<b>d</b>	<input checked="" type="checkbox"/> Medical indigency		
<b>e</b>	<input checked="" type="checkbox"/> Insurance status		
<b>f</b>	<input checked="" type="checkbox"/> Underinsurance discount		
<b>g</b>	<input checked="" type="checkbox"/> Residency		
<b>h</b>	<input checked="" type="checkbox"/> Other (describe in Section C)		
<b>14</b>	Explained the basis for calculating amounts charged to patients?	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)	Yes	
<b>a</b>	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</b>	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
<b>c</b>	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
<b>d</b>	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>16</b>	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	Yes	
<b>a</b>	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) WWW.MERCYNEWHAMPTON.COM/BILLING		
<b>b</b>	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) WWW.MERCYNEWHAMPTON.COM/BILLING		
<b>c</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) WWW.MERCYNEWHAMPTON.COM/BILLING		
<b>d</b>	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b>	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>f</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>g</b>	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
<b>h</b>	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b>	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information** (continued)**Billing and Collections**

MERCY MEDICAL CENTER-NEW HAMPTON

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

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

**Policy Relating to Emergency Medical Care**

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

**Part V Facility Information** *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

MERCY MEDICAL CENTER-NEW HAMPTON

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

- a** ☒ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- c** ☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- d** ☐ The hospital facility used a prospective Medicare or Medicaid method

**23** During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? . . . . .

If "Yes," explain in Section C

**24** During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? . . . . .

If "Yes," explain in Section C

	Yes	No
<b>22</b>		
<b>23</b>		No
<b>24</b>		No

**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 MEDICAL CENTER-DYERSVILLE**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):** \_\_\_\_\_

6

**Community Health Needs Assessment**

	Yes	No
<b>1</b> Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? . . . . .	<b>1</b>	No
<b>2</b> Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C . . . . .	<b>2</b>	No
<b>3</b> During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 . . . . . If "Yes," indicate what the CHNA report describes (check all that apply)	<b>3</b>	Yes
<b>a</b> <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b> <input checked="" type="checkbox"/> Demographics of the community		
<b>c</b> <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b> <input checked="" type="checkbox"/> How data was obtained		
<b>e</b> <input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b> <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b> <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b> <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b> <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA 20 <u>14</u>		
<b>5</b> In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .	<b>5</b>	Yes
<b>6 a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b>	Yes
<b>b</b> Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C . . . . .	<b>6b</b>	Yes
<b>7</b> 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)	<b>7</b>	Yes
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>SEE SCHEDULE H, PART V, SECTION C</u>		
<b>b</b> <input type="checkbox"/> Other website (list url) _____		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input type="checkbox"/> Other (describe in Section C)		
<b>8</b> Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 . . . . .	<b>8</b>	Yes
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>14</u>		
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url) <u>SEE SCHEDULE H, PART V, SECTION C</u>	<b>10</b>	Yes
<b>a</b>		
<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b> Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
<b>12a</b> Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .	<b>12a</b>	No
<b>b</b> If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b> If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

MERCY MEDICAL CENTER-DYERSVILLE

Name of hospital facility or letter of facility reporting group

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
<b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	<b>13</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 000000000000 % and FPG family income limit for eligibility for discounted care of 400 000000000000 %			
<b>b</b> <input type="checkbox"/> Income level other than FPG (describe in Section C)			
<b>c</b> <input checked="" type="checkbox"/> Asset level			
<b>d</b> <input checked="" type="checkbox"/> Medical indigency			
<b>e</b> <input checked="" type="checkbox"/> Insurance status			
<b>f</b> <input checked="" type="checkbox"/> Underinsurance discount			
<b>g</b> <input checked="" type="checkbox"/> Residency			
<b>h</b> <input checked="" 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	
<b>a</b> <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
<b>b</b> <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
<b>c</b> <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
<b>d</b> <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
<b>e</b> <input type="checkbox"/> Other (describe in Section C)			
<b>16</b> Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	<b>16</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) WWW MERCYDUBUQUE COM/PATIENT-FINANCIAL-ASSISTANCE			
<b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) WWW MERCYDUBUQUE COM/PATIENT-FINANCIAL-ASSISTANCE			
<b>c</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) WWW MERCYDUBUQUE COM/PATIENT-FINANCIAL-ASSISTANCE			
<b>d</b> <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>e</b> <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>f</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>g</b> <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
<b>h</b> <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
<b>i</b> <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
<b>j</b> <input checked="" type="checkbox"/> Other (describe in Section C)			

**Part V Facility Information** (continued)**Billing and Collections**

MERCY MEDICAL CENTER-DYERSVILLE

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

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

**Policy Relating to Emergency Medical Care**

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

**Part V Facility Information** *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

MERCY MEDICAL CENTER-DYERSVILLE

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

- a** ☒ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- c** ☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- d** ☐ The hospital facility used a prospective Medicare or Medicaid method

**23** During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? . . . . .

If "Yes," explain in Section C

**24** During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? . . . . .

If "Yes," explain in Section C

	Yes	No
<b>22</b>		
<b>23</b>		No
<b>24</b>		No

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

[illegible]



**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? **16**

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

**Part VI Supplemental Information**

Provide the following information

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

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART I, LINE 3C	IN ADDITION TO LOOKING AT A MULTIPLE OF THE FEDERAL POVERTY GUIDELINES, OTHER FACTORS ARE CONSIDERED SUCH AS THE PATIENT'S FINANCIAL STATUS AND/OR ABILITY TO PAY AS DETERMINED THROUGH THE ASSESSMENT PROCESS

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 6A	MERCY HEALTH SERVICES-IOWA (MHS-IA) REPORTS ITS COMMUNITY BENEFIT INFORMATION AS PART OF THE CONSOLIDATED COMMUNITY BENEFIT INFORMATION REPORTED BY TRINITY HEALTH (EIN 35-1443425) IN ITS AUDITED FINANCIAL STATEMENTS, AVAILABLE AT WWW TRINITY-HEALTH ORG IN ADDITION, THE HOSPITAL DIVISIONS OF MHS-IA INCLUDE A COPY OF THEIR MOST RECENT SCHEDULE H ON THEIR RESPECTIVE WEBSITES TRINITY HEALTH ALSO INCLUDES MHS-IA'S MOST RECENTLY FILED SCHEDULE H ON ITS WEBSITE

# 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7	THE BEST AVAILABLE DATA WAS USED TO CALCULATE THE COST AMOUNTS REPORTED IN ITEM 7 FOR CERTAIN CATEGORIES, PRIMARILY TOTAL CHARITY CARE AND MEANS-TESTED GOVERNMENT PROGRAMS, SPECIFIC COST-TO-CHARGE RATIOS WERE CALCULATED AND APPLIED TO THOSE CATEGORIES THE COST-TO-CHARGE RATIO WAS DERIVED FROM WORKSHEET 2, RATIO OF PATIENT CARE COST-TO-CHARGES IN OTHER CATEGORIES, THE BEST AVAILABLE DATA WAS DERIVED FROM THE HOSPITALS' COST ACCOUNTING SYSTEMS

# 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LN 7 COL(F)	THE FOLLOWING NUMBER, \$14,920,550, REPRESENTS THE AMOUNT OF BAD DEBT EXPENSE INCLUDED IN TOTAL FUNCTIONAL EXPENSES IN FORM 990, PART IX, LINE 25 PER IRS INSTRUCTIONS, THIS AMOUNT WAS EXCLUDED FROM THE DENOMINATOR WHEN CALCULATING THE PERCENT OF TOTAL EXPENSE FOR SCHEDULE H, PART I, LINE 7, COLUMN (F)

Form and Line Reference	Explanation
PART II, COMMUNITY BUILDING ACTIVITIES	MERCY MEDICAL CENTER-SIOUX CITY (MERCY SC) ENVIRONMENTAL IMPROVEMENTS A DOWNTOWN GARDEN O F GREEN SPACE WAS DEVELOPED AND MERCY SC CONTRIBUTED FOR THE MAINTENANCE AND IMPROVEMENTS TO THE GARDEN ANNUALLY LEADERSHIP DEVELOPMENT AND TRAINING FOR COMMUNITY MEMBERS MANY COL LEAGUES OF MERCY SC ARE INVOLVED IN COMMUNITY BOARDS THAT HELP DEVELOP LEADERSHIP SKILLS I N INDIVIDUALS IN OUR COMMUNITY, WHICH IS A GREAT BENEFIT TO THE REGION WORKFORCE DEVELOPM ENT ATTENDING LOCAL SCHOOLS IN THE TRISTATE AREA TO GIVE THE STUDENTS AN OPPORTUNITY TO H AVE A CHANCE TO EXPERIENCE THE POSSIBILITY OF GOING INTO A HEALTH CARE CAREER MERCY SC (HU MAN RESOURCES) PARTNERED WITH NATIVE AMERICAN SCHOOLS IN WINNEBAGO, NEBRASKA ON PROJECT SE ARCH THIS JOINT EFFORT ENABLED NATIVE AMERICANS TO PARTICIPATE IN A 5TH YEAR SENIOR JOB T RAINING PROGRAM, WITH GRADUATION THE PROGRAM IS WELL RECEIVED AND PRODUCED GREAT RESULTS FOR TRAINING AND HELPING YOUNG ADULTS BECOME EMPLOYABLE MERCY MEDICAL CENTER-NEW HAMPTON (MERCY NH) AS ONE OF THE LARGEST EMPLOYERS IN THE AREA, MERCY NH TAKES ITS CIVIC RESPONSIB ILITY VERY SERIOUSLY SUPPORT OF, AND CONTRIBUTIONS TO, COMMUNITY ORGANIZATIONS, EVENTS, A ND PROGRAMS, SUCH AS NEW HORIZONS-CHAMBER, AND THE INDUSTRIAL DEVELOPMENT CORPORATION HELP IMPROVE THE ECONOMY OF MERCY NH'S CATCHMENT COUNTIES BY PROMOTING ECONOMIC DEVELOPMENT, MERCY NH HELPS CREATE A COMMUNITY THAT CONTINUES TO BUILD ITSELF THROUGH THE LEADERS WHO W ORK AND VOLUNTEER AT THE HOSPITAL ECONOMIC STABILITY IS INTRINSICALLY LINKED TO THE PREVE NTION OF HEALTH PROBLEMS ASSOCIATED WITH POVERTY, HOMELESSNESS, AND ENVIRONMENTAL CHALLENG ES, AND IS CRUCIAL IF THE COMMUNITY HOPES TO MAINTAIN A VIABLE HOSPITAL COMPLEX WITH A BRO AD SPECTRUM OF ESSENTIAL SERVICES IN ADDITION TO SUPPORTING ECONOMIC DEVELOPMENT IN OUR R EGION, MERCY NH ENCOURAGES ITS LEADERSHIP STAFF TO SUPPORT AND PROVIDE LEADERSHIP TO NON-P ROFIT ORGANIZATIONS THROUGHOUT THE AREA MERCY'S PUBLIC RELATIONS MANAGER SERVES ON THE BO ARD OF DIRECTORS FOR THE INDUSTRIAL DEVELOPMENT CORPORATION AND WORKS TO IMPROVE THE QUALI TY OF LIVING IN THE NEW HAMPTON AREA THE WORK INDUSTRIAL DEVELOPMENT CORPORATION ALSO TIE S INTO WORKFORCE DEVELOPMENT AND PARTNERING WITH OUR AREA COMMUNITY COLLEGES AND INDUSTRIE S TO ENHANCE THEIR WORKFORCE MERCY'S CEO SERVES ON THE NORTHEAST IOWA COMMUNITY COLLEGE S ECTOR BOARD AND THE CNO IS ACTIVELY INVOLVED WITH THE AREA COMMUNITY COLLEGES MENTORING PR OGRAMS WORKING CLOSELY WITH OTHER HEALTH CARE PARTNERS IN OUR COMMUNITY IS A PRIORITY FOR MERCY NH MERCY'S CNO SERVES ON THE PRAIRIE VIEW MANAGEMENT BOARD, WHICH OVERSEES THE HERI TAGE RESIDENCE LOCATED IN NEW HAMPTON THE HERITAGE RESIDENCE IS A 15-BED RESIDENTIAL CARE FACILITY THAT OFFERS ON-SITE PSYCHIATRIC SERVICES, SUBSTANCE ABUSE COUNSELING, AND COMMUN ITY INTEGRATED ACTIVITY PROGRAM THE HERITAGE RESIDENCE ALSO HAS HOME AND COMMUNITY BASED SERVICES FOR THOSE INDIVIDUALS ON ID WAIVER OR HABILITATION SERVICES MERCY NH ALSO IDENTIF IED A NEED FOR MEMBERS OF THE COMMUNITY TO MORE SAFELY DISPOSE OF THEIR SHARPS AND CONTAIN ERS TO REDUCE ENVIRONMENTAL HAZARDS THE HOSPITAL NOW COLLABORATES WITH PHARMACIES IN NEW HAMPTON TO COLLECT THE CONTAINERS MERCY NH PRIDES ITSELF ON BEING COMMUNITY HEALTH IMPROV EMENT ADVOCATES MERCY NH'S COMMUNITY WELLNESS PROGRAM CONTINUES TO EXPAND AND IS CURRENTL Y ACTIVE IN THE WALKING SCHOOL BUS PROGRAM, TOBACCO FREE COALITION, COMMUNITY FOOD & FITNE SS INITIATIVE AND THE LOCAL FAMER'S MARKET MERCY NH PROVIDES SUPPORT AND EXPERTISE TO THE CHICKASAW CONNECTIONS, A COALITION AGAINST UNDERAGE DRINKING THIS PARTNERSHIP INCLUDES A CTIVE INVOLVEMENT FROM ALL OF OUR FAMILY MEDICINE PHYSICIANS AND THE WELLNESS COORDINATOR AND RECENTLY EXPANDED ITS SCOPE OF WORK TO INCLUDE REDUCING DRUG USE IN OUR AREA TEENAGERS AS WELL MERCY NH WORKS CLOSELY WITH NEW HAMPTON COMMUNITY SCHOOLS TO EDUCATE STUDENTS ABO UT HEALTH AND WELLNESS HANDWASHING LESSONS ARE TAUGHT TO ALL PRE-SCHOOL AND KINDERGARTEN CLASSES THOSE AGE GROUPS ALSO TOUR THE HOSPITAL TO BECOME COMFORTABLE WITH OUR ENVIRONMEN T AND KNOW THAT THE HOSPITAL IS NOT A SCARY PLACE MERCY NH ALSO INVITES ALL 8TH GRADE STU DENTS FOR A TOUR IN WHICH THEY LEARN ABOUT THE VARIETY OF HEALTHCARE CAREERS AVAILABLE TO THEM THE HIGH SCHOOL ATHLETES ARE CLOSELY MONITORED BY MERCY NH'S ATHLETIC TRAINER WHO CA RES FOR THE ATHLETES AT THE HIGH SCHOOL THREE TIMES PER WEEK, PLUS IS IN ATTENDANCE AT ALL FOOTBALL AND WRESTLING EVENTS WORKING WITH FAMILIES OF YOUNG CHILDREN IS IMPORTANT TO BU ILD A STRONG FOUNDATION FOR THE CHILD TO GROW PARENT AND CHILD EDUCATION IS OFFERED AT LO W OR NO COST TO AREA FAMILIES MERCY NH HOSTS THE NURTURED HEARTS APPROACH CLASSES TWICE A YEAR AND EACH SUMMER OFFERS A SENSORY MOTOR SKILLS PLAY GROUP FOR TODDLERS WHO NEED TO DE VLOP FINE MOTOR SKILLS MERCY NH PARTNERED WITH CHICKASAW AMBULANCE SERVICE, CHICKASAW CO UNTY RESCUE SQUAD/FIRST RESPONDERS AND MERCY AIR MED, TO HOST A COMMUNITY OPEN HOUSE FAMI LIES ATTENDING WERE ABLE TO VIEW DEMONSTRATIONS, G

Form and Line Reference	Explanation
PART II, COMMUNITY BUILDING ACTIVITIES	ET INFORMATION ON CAR SEAT USE FOR CHILDREN, TOUR THE ER, AND VIEW ALL THE EMERGENCY VEHICLES, INCLUDING THE MERCY AID MED HELICOPTER MERCY NH ALSO PROVIDED A FREE DINNER TO ALL THE VOLUNTEERS SERVING OUR EMS PROGRAMS IN CHICKASAW COUNTY

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 2	METHODOLOGY USED FOR LINE 2 - ANY DISCOUNTS PROVIDED OR PAYMENTS MADE TO A PARTICULAR PATIENT ACCOUNT ARE APPLIED TO THAT PATIENT ACCOUNT PRIOR TO ANY BAD DEBT WRITE-OFF AND ARE THUS NOT INCLUDED IN BAD DEBT EXPENSE AS A RESULT OF THE PAYMENT AND ADJUSTMENT ACTIVITY BEING POSTED TO BAD DEBT ACCOUNTS, WE ARE ABLE TO REPORT BAD DEBT EXPENSE NET OF THESE TRANSACTIONS



**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART III, LINE 3	MHS-IA USES A PREDICTIVE MODEL THAT INCORPORATES THREE DISTINCT VARIABLES IN COMBINATION TO PREDICT WHETHER A PATIENT QUALIFIES FOR FINANCIAL ASSISTANCE (1) SOCIO-ECONOMIC SCORE, (2) ESTIMATED FEDERAL POVERTY LEVEL (FPL), AND (3) HOMEOWNERSHIP BASED ON THE MODEL, CHARITY CARE CAN STILL BE EXTENDED TO PATIENTS EVEN IF THEY HAVE NOT RESPONDED TO FINANCIAL COUNSELING EFFORTS AND ALL OTHER FUNDING SOURCES HAVE BEEN EXHAUSTED FOR FINANCIAL STATEMENT PURPOSES, MHS-IA IS RECORDING AMOUNTS AS CHARITY CARE (INSTEAD OF BAD DEBT EXPENSE) BASED ON THE RESULTS OF THE PREDICTIVE MODEL THEREFORE, MHS-IA IS REPORTING ZERO ON LINE 3, SINCE THEORETICALLY ANY POTENTIAL CHARITY CARE SHOULD HAVE BEEN IDENTIFIED THROUGH THE PREDICTIVE MODEL

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART III, LINE 4	<p>MHS-IA IS INCLUDED IN THE CONSOLIDATED FINANCIAL STATEMENTS OF TRINITY HEALTH THE FOLLOWING IS THE TEXT OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS FOOTNOTE FROM PAGE 14 OF THOSE STATEMENTS "THE CORPORATION RECOGNIZES A SIGNIFICANT AMOUNT OF PATIENT SERVICE REVENUE AT THE TIME THE SERVICES ARE RENDERED EVEN THOUGH THE CORPORATION DOES NOT ASSESS THE PATIENT'S ABILITY TO PAY AT THAT TIME AS A RESULT, THE PROVISION FOR BAD DEBTS IS PRESENTED AS A DEDUCTION FROM PATIENT SERVICE REVENUE (NET OF CONTRACTUAL PROVISIONS AND DISCOUNTS) FOR UNINSURED AND UNDERINSURED PATIENTS THAT DO NOT QUALIFY FOR CHARITY CARE, THE CORPORATION ESTABLISHES AN ALLOWANCE TO REDUCE THE CARRYING VALUE OF SUCH RECEIVABLES TO THEIR ESTIMATED NET REALIZABLE VALUE THIS ALLOWANCE IS ESTABLISHED BASED ON THE AGING OF ACCOUNTS RECEIVABLE AND THE HISTORICAL COLLECTION EXPERIENCE BY THE HEALTH MINISTRIES AND FOR EACH TYPE OF PAYOR A SIGNIFICANT PORTION OF THE CORPORATION'S PROVISION FOR DOUBTFUL ACCOUNTS RELATES TO SELF-PAY PATIENTS, AS WELL AS CO-PAYMENTS AND DEDUCTIBLES OWED TO THE CORPORATION BY PATIENTS WITH INSURANCE "PART III, LINE 5 TOTAL MEDICARE REVENUE REPORTED IN PART III, LINE 5 HAS BEEN REDUCED BY THE TWO PERCENT SEQUESTRATION REDUCTION</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART III, LINE 8	<p>MHS-IA DOES NOT BELIEVE ANY MEDICARE SHORTFALL SHOULD BE TREATED AS COMMUNITY BENEFIT THIS IS SIMILAR TO CATHOLIC HEALTH ASSOCIATION RECOMMENDATIONS, WHICH STATE THAT SERVING MEDICARE PATIENTS IS NOT A DIFFERENTIATING FEATURE OF TAX-EXEMPT HEALTH CARE ORGANIZATIONS AND THAT THE EXISTING COMMUNITY BENEFIT FRAMEWORK ALLOWS COMMUNITY BENEFIT PROGRAMS THAT SERVE THE MEDICARE POPULATION TO BE COUNTED IN OTHER COMMUNITY BENEFIT CATEGORIES</p> <p>PART III, LINE 8 COSTING METHODOLOGY FOR LINE 6 - MEDICARE COSTS WERE OBTAINED FROM THE FILED MEDICARE COST REPORT THE COSTS ARE BASED ON MEDICARE ALLOWABLE COSTS AS REPORTED ON WORKSHEET B, COLUMN 27, WHICH EXCLUDE DIRECT MEDICAL EDUCATION COSTS INPATIENT MEDICARE COSTS ARE CALCULATED BASED ON A COMBINATION OF ALLOWABLE COST PER DAY TIMES MEDICARE DAYS FOR ROUTINE SERVICES AND COST TO CHARGE RATIO TIMES MEDICARE CHARGES FOR ANCILLARY SERVICES OUTPATIENT MEDICARE COSTS ARE CALCULATED BASED ON COST TO CHARGE RATIO TIMES MEDICARE CHARGES BY ANCILLARY DEPARTMENT</p>

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 9B	MHS-IA'S COLLECTION POLICY CONTAINS PROVISIONS ON THE COLLECTION PRACTICES TO BE FOLLOWED FOR PATIENTS WHO ARE KNOWN TO QUALIFY FOR FINANCIAL ASSISTANCE CHARITY DISCOUNTS ARE APPLIED TO THE AMOUNTS THAT QUALIFY FOR FINANCIAL ASSISTANCE COLLECTION PRACTICES FOR THE REMAINING BALANCES ARE CLEARLY OUTLINED IN EACH HOSPITAL'S COLLECTION POLICY THE HOSPITALS HAVE IMPLEMENTED BILLING AND COLLECTION PRACTICES FOR PATIENT PAYMENT OBLIGATIONS THAT ARE FAIR, CONSISTENT AND COMPLIANT WITH STATE AND FEDERAL REGULATIONS

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART VI, LINE 2	<p>NEEDS ASSESSMENT - MHS-IA HOSPITALS ASSESS THE HEALTH STATUS OF THEIR COMMUNITIES, IN PARTNERSHIP WITH COMMUNITY COALITIONS, AS PART OF THE NORMAL COURSE OF OPERATIONS AND IN THE CONTINUOUS EFFORT TO IMPROVE PATIENT CARE AND THE HEALTH OF THE OVERALL COMMUNITY. IN THE ASSESSMENT OF THEIR COMMUNITIES, OUR HOSPITALS MAY USE PATIENT DATA, PUBLIC HEALTH DATA, ANNUAL COUNTY HEALTH RANKINGS, MARKET STUDIES AND GEOGRAPHICAL MAPS SHOWING AREAS OF HIGH UTILIZATION FOR EMERGENCY SERVICES AND INPATIENT CARE, WHICH MAY INDICATE POPULATIONS OF INDIVIDUALS WHO DO NOT HAVE ACCESS TO PREVENTATIVE SERVICES OR ARE UNINSURED. MERCY NI AND MERCY NH EACH HAVE A LOCAL BOARD OF GOVERNANCE COMPOSED OF AREA RESIDENTS, EMPLOYERS AND REPRESENTATIVES OF DEMOGRAPHIC GROUPS. THESE HOSPITALS ALSO COMMUNICATE WITH OTHER AGENCIES ABOUT WHAT SERVICES ARE NEEDED LOCALLY. IN PARTICULAR, OUR PRIMARY CARE PHYSICIANS HAVE A STRONG AWARENESS OF PATIENT NEEDS. A COMMITTEE MEETS QUARTERLY THAT IS COMPRISED OF COMMUNITY MEMBERS AND HOSPITAL PERSONNEL THAT WORK DIRECTLY WITH THE UNINSURED, UNDERINSURED AND UNDERSERVED. THE COMMUNITY BENEFIT MINISTRY OFFICER INTERFACES REGULARLY WITH COMMUNITY HUMAN SERVICE AGENCIES AND COALITIONS. MERCY SC AND DUNES STAFF ROUTINELY (MONTHLY) MEET WITH VARIOUS COMMUNITY AGENCIES, CHURCHES, AND SCHOOLS IN SEARCH OF OPPORTUNITIES TO PARTNER WITH TO ADDRESS (1) ACCESS TO PRIMARY CARE, (2) EXERCISE AND NUTRITION FOR YOUTH, (3) ACCESS TO MENTAL HEALTH SERVICES, AND (4) SOCIAL DETERMINANTS OF HEALTH: GENERAL POVERTY, HOMELESSNESS, EDUCATION AND HUNGER.</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART VI, LINE 3	<p>PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE - MHS-IA HOSPITALS ARE COMMITTED TO - PROVIDING ACCESS TO QUALITY HEALTH CARE SERVICES WITH COMPASSION, DIGNITY AND RESPECT FOR THOSE WE SERVE, PARTICULARLY THE POOR AND THE UNDERSERVED IN OUR COMMUNITIES- CARING FOR ALL PERSONS, REGARDLESS OF THEIR ABILITY TO PAY FOR SERVICES- ASSISTING PATIENTS WHO CANNOT PAY FOR PART OR ALL OF THE CARE THEY RECEIVE - BALANCING NEEDED FINANCIAL ASSISTANCE FOR SOME PATIENTS WITH BROADER FISCAL RESPONSIBILITIES IN ORDER TO SUSTAIN VIABILITY AND PROVIDE THE QUALITY AND QUANTITY OF SERVICES FOR ALL WHO MAY NEED CARE IN A COMMUNITYIN ACCORDANCE WITH AMERICAN HOSPITAL ASSOCIATION RECOMMENDATIONS, MHS-IA HAS ADOPTED THE FOLLOWING GUIDING PRINCIPLES WHEN HANDLING THE BILLING, COLLECTION AND FINANCIAL SUPPORT FUNCTIONS FOR OUR PATIENTS - PROVIDE EFFECTIVE COMMUNICATIONS WITH PATIENTS REGARDING HOSPITAL BILLS- MAKE AFFIRMATIVE EFFORTS TO HELP PATIENTS APPLY FOR PUBLIC AND PRIVATE FINANCIAL SUPPORT PROGRAMS- OFFER FINANCIAL SUPPORT TO PATIENTS WITH LIMITED MEANS- IMPLEMENT POLICIES FOR ASSISTING LOW-INCOME PATIENTS IN A CONSISTENT MANNER- IMPLEMENT FAIR AND CONSISTENT BILLING AND COLLECTION PRACTICES FOR ALL PATIENTS WITH PATIENT PAYMENT OBLIGATIONSTHE HOSPITALS COMMUNICATE EFFECTIVELY WITH PATIENTS REGARDING PATIENT PAYMENT OBLIGATIONS FINANCIAL COUNSELING IS PROVIDED TO PATIENTS ABOUT THEIR PAYMENT OBLIGATIONS AND HOSPITAL BILLS INFORMATION ON HOSPITAL-BASED FINANCIAL SUPPORT POLICIES AND EXTERNAL PROGRAMS THAT PROVIDE COVERAGE FOR SERVICES ARE MADE AVAILABLE TO PATIENTS DURING THE PRE-REGISTRATION AND REGISTRATION PROCESSES AND/OR THROUGH COMMUNICATIONS WITH PATIENTS SEEKING FINANCIAL ASSISTANCE FINANCIAL COUNSELORS MAKE AFFIRMATIVE EFFORTS TO HELP PATIENTS APPLY FOR PUBLIC AND PRIVATE PROGRAMS FOR WHICH THEY MAY QUALIFY AND THAT MAY ASSIST THEM IN OBTAINING AND PAYING FOR HEALTH CARE SERVICES EVERY EFFORT IS MADE TO DETERMINE A PATIENT'S ELIGIBILITY PRIOR TO OR AT THE TIME OF ADMISSION OR SERVICE FINANCIAL ASSISTANCE APPLICATIONS WILL BE ACCEPTED UNTIL ONE YEAR AFTER THE FIRST BILLING STATEMENT TO THE PATIENT THE HOSPITALS OFFER FINANCIAL SUPPORT TO PATIENTS WITH LIMITED MEANS THIS SUPPORT IS AVAILABLE TO UNINSURED AND UNDERINSURED PATIENTS WHO DO NOT QUALIFY FOR PUBLIC PROGRAMS OR OTHER ASSISTANCE NOTIFICATION ABOUT FINANCIAL ASSISTANCE, INCLUDING CONTACT INFORMATION, IS AVAILABLE THROUGH PATIENT BROCHURES, MESSAGES ON PATIENT BILLS, POSTED NOTICES IN PUBLIC REGISTRATION AREAS INCLUDING EMERGENCY ROOMS, ADMITTING AND REGISTRATION DEPARTMENTS, AND OTHER PATIENT FINANCIAL SERVICES OFFICES SUMMARIES OF HOSPITAL PROGRAMS ARE MADE AVAILABLE TO APPROPRIATE COMMUNITY HEALTH AND HUMAN SERVICES AGENCIES AND OTHER ORGANIZATIONS THAT ASSIST PEOPLE IN NEED INFORMATION REGARDING FINANCIAL ASSISTANCE PROGRAMS IS ALSO AVAILABLE ON HOSPITAL WEBSITES IN ADDITION TO ENGLISH, THIS INFORMATION IS ALSO AVAILABLE IN OTHER LANGUAGES AS REQUIRED BY INTERNAL REVENUE CODE SECTION 501(R), REFLECTING OTHER PRIMARY LANGUAGES SPOKEN BY THE POPULATION SERVICED BY OUR HOSPITALS THE HOSPITALS HAVE ESTABLISHED WRITTEN POLICIES FOR THE BILLING, COLLECTION AND SUPPORT FOR PATIENTS WITH PAYMENT OBLIGATIONS THE HOSPITALS MAKE EVERY EFFORT TO ADHERE TO THEIR POLICIES AND ARE COMMITTED TO IMPLEMENTING AND APPLYING THE POLICIES FOR ASSISTING PATIENTS WITH LIMITED MEANS IN A PROFESSIONAL, CONSISTENT MANNER</p>

Form and Line Reference	Explanation
PART VI, LINE 4	<p>COMMUNITY INFORMATION -MERCY NI SERVES 14 COUNTIES IN NORTH CENTRAL IOWA THE PRIMARY SERV ICE AREA INCLUDES CERRO GORDO AND WORTH COUNTIES AND THE SECONDARY SERVICE AREA INCLUDES B UTLER, CHICKASAW, FLOYD, FRANKLIN, HANCOCK, HARDIN, HOWARD, KOSSUTH, MITCHELL, PALO ALTO, WINNEBAGO, AND WRIGHT COUNTIES THE TOTAL POPULATION OF THE 14-COUNTY SERVICE AREA IS 202, 410, REPRESENTING 86,492 HOUSEHOLDS (2014 CENSUS DATA) OF THE PRIMARY SERVICE AREA, 20% A RE OVER AGE 65, AS COMPARED WITH 15% FOR THE STATE OF IOWA AS A WHOLE, AND 14% FOR THE UNI TED STATES TWENTY-THREE PERCENT OF THE PRIMARY SERVICE AREA IS CHILDREN UNDER THE AGE OF 18 NINETY-SEVEN PERCENT OF THE PRIMARY SERVICE AREA IS WHITE, COMPARED WITH 91% FOR IOWA AND 74% FOR THE COUNTRY AS A WHOLE THREE PERCENT OF THE WHITE POPULATION IS HISPANIC IN T HE NORTH IOWA AREA NEARLY 8% OF THE PRIMARY SERVICE AREA IS UNINSURED, COMPARED WITH 8% I N IOWA AND 14% NATIONALLY BROKEN DOWN BY AGE GROUPS, 5% OF CHILDREN UNDER AGE 18, 11% OF ADULTS AGES 18-64, AND 0 13% OF ADULTS AGES 65+ ARE UNINSURED THE UNINSURED BY ETHNICITY, 10% ARE BLACK, 18% ARE NATIVE AMERICAN, 8% ARE ASIAN, 7% ARE WHITE, 10% ARE MULTIPLE RACE S, AND 24% OF UNINSURED ARE "OTHER" MERCY SC AND DUNES SIOUX CITY, IOWA SERVES AS THE REGI ONAL HUB FOR BUSINESS, EMPLOYMENT, INDUSTRY, RETAIL TRADE, MEDICAL CARE, AND EDUCATIONAL O PPORTUNITIES SIX COUNTIES IN THE TRI-STATE AREA OF NORTHWESTERN IOWA, NORTHEASTERN NEBRAS KA, AND SOUTHWESTERN SOUTH DAKOTA ARE INCLUDED IN THE SIOUXLAND COMMUNITY HEALTH NEEDS ASS ESSMENT INDIVIDUALS RESIDING IN THESE COUNTIES LIVE WITHIN A 40-MILE RADIUS OF SIOUX CITY THE AREA INCLUDES THE IOWA COUNTIES OF WOODBURY AND PLYMOUTH, THE NEBRASKA COUNTIES OF D AKOTA, DIXON, AND THURSTON, AND THE SOUTH DAKOTA COUNTY OF UNION THE TOTAL AREA FOR THESE COUNTIES IS 3,354 SQUARE MILES, WITH WOODBURY AND PLYMOUTH REPRESENTING 52% OF THE TOTAL AREA THE SIOUXLAND REGION HAS A TOTAL CURRENT POPULATION OF 177,740 WITH AN ESTIMATED 1% INCREASE BY 2020 ABOUT 22% OF THE POPULATION IS UNDER THE AGE OF 14 YEARS AND 15% OF THE P OPULATION IS OVER THE AGE OF 65 YEARS THE RACE/ETHNICITY DISTRIBUTION IN THE AREA IS 76% WHITE, 15% HISPANIC, 2% BLACK, 2% ASIAN, AND 5% OTHER IN THE AREA, 50% OF THE HOUSEHOLDS A RE IN AN ANNUAL INCOME GROUP OF LESS THAN \$50K THE REGIONAL ECONOMY IS BASED ON FOOD MANU FACTURING, AGRICULTURE, HEALTH CARE AND SOCIAL ASSISTANCE, EDUCATION, AND THE FOOD SERVICE INDUSTRIES THE AUGUST 2015 UNEMPLOYMENT RATE FOR THE LARGEST COUNTIES IN THE REGION - WO ODBURY, PLYMOUTH, AND DAKOTA - WAS 3 5%, 2 5%, AND 3 9% RESPECTIVELY THE UNEMPLOYMENT RAT E FOR THURSTON COUNTY, WITH A POPULATION OF APPROXIMATELY 7,000, HAS RISEN TO 6% WOODBURY COUNTY HAS A POPULATION OF 104,080, WHICH REPRESENTS 59% OF THE SIOUXLAND REGIONAL TOTAL THE COMMUNITY RESIDENTS OF SIOUX CITY AND SERGEANT BLUFF REPRESENT NEARLY 90% OF THE WOOD BURY COUNTY POPULATION PLYMOUTH COUNTY HAS A POPULATION OF 23,085, OR 13% OF THE SIOUXLAN D REGIONAL TOTAL THE LARGEST COMMUNITY IN THE COUNTY IS LEMARS WITH A POPULATION OF 12,60 0 AT 12% OF THE REGIONAL POPULATION, DAKOTA COUNTY HAS A POPULATION OF 21,660 SOUTH SIOU X CITY AND DAKOTA CITY TOTAL RESIDENTS REPRESENT 84% OF THE COUNTY POPULATION UNION COUNT Y HAS A POPULATION OF 16,200, WHICH REPRESENTS 9% OF THE REGIONAL TOTAL NORTH SIOUX CITY AND DAKOTA DUNES TOTAL RESIDENTS REPRESENT 40% OF THE COUNTY POPULATION THE TOTAL RESIDEN TS IN THE COMMUNITIES OF SIOUX CITY, SERGEANT BLUFF, LEMARS, SOUTH SIOUX CITY, DAKOTA CITY , NORTH SIOUX CITY, AND DAKOTA DUNES TOTAL 128,800 COMPLETING THE SIX-COUNTY AREA IS THUR STON COUNTY WITH A POPULATION OF 6,860 AND DIXON COUNTY WITH A POPULATION OF 5,860 REPRESE NTING 7% OF THE REGIONAL TOTAL MERCY DUB AND MERCY DYR'S PRIMARY SERVICE AREA IS DUBUQUE C OUNTY, IOWA, WHICH IS A FEDERALLY DESIGNATED MEDICALLY UNDERSERVED AREA THIS DEFINITION O F THE COMMUNITY IS BASED ON THE RESIDENCE OF THE HOSPITALS' PATIENTS IN CALENDAR YEAR 201 4, 61 6% OF MERCY DUB'S INPATIENT CASES AND 75 2% OF MERCY DUB'S EMERGENCY DEPARTMENT CASE S WERE FOR DUBUQUE COUNTY RESIDENTS, WHILE 93 8% OF MERCY DYR'S INPATIENT CASES AND 77 7% OF MERCY DYR'S EMERGENCY DEPARTMENT CASES WERE FOR DUBUQUE COUNTY RESIDENTS BEYOND DUBUQU E COUNTY, RESIDENTS' USE OF THE HOSPITAL IS MORE SCATTERED IN 2014, FOR EXAMPLE, MERCY DU B AND MERCY DYR DISCHARGED INPATIENTS WHO RESIDED IN 18 DIFFERENT STATES DUBUQUE COUNTY'S POPULATION IN 2012 WAS 95,097 THE POPULATION GREW ABOUT 5% BETWEEN 2000 AND 2010 OF THE POPULATION, 73% IS URBAN AND 27% IS RURAL IT HAS AN AVERAGE POPULATION DENSITY OF 156 PEO PLE PER SQUARE MILE IN MARCH 2012, THE COST OF LIVING INDEX FOR DUBUQUE COUNTY WAS 86 8, COMPARED TO THE US AVERAGE OF 100 WHITE NON-HISPANIC PEOPLE COMPRISE 92 9% OF THE POPULAT ION, BLACK NON-HISPANICS 2 6%, HISPANIC OR LATINO 1 9%, TWO OR MORE RACES 1 2%, AND ASIAN 0 9% THE MEDIAN RESIDENT AGE IS 38 0 YEARS, THE SAME AS IOWA'S IN ADDITION TO MERCY DUB AND MERCY DYR, UNITYPOINT HEALTH FINLEY HOSPITAL I</p>

Form and Line Reference	Explanation
PART VI, LINE 4	<p>S THE THIRD HOSPITAL LOCATED IN DUBUQUE COUNTY MERCY NH SERVES THE CHICKASAW AREA AND SURROUNDING COUNTIES WITHIN A 20-MILE RADIUS STRETCHING IN EVERY DIRECTION FROM NEW HAMPTON. THE PRIMARY SERVICE AREA CONSISTS OF THE TOWNS OF NEW HAMPTON, FREDERICKSBURG, ALTA VISTA, IONIA, ELMA, WAUCOMA, LAWLER AND NASHUA. THE ESTIMATED POPULATION OF THIS AREA IS 13,500. ACCORDING TO THE U.S. CENSUS BUREAU, CHICKASAW COUNTY HAD AN ESTIMATED POPULATION OF 12,097 IN 2015. CHICKASAW COUNTY EXPERIENCED AN ESTIMATED 2.7% PERCENT DECLINE IN POPULATION FROM 2010 TO 2015. THE STRESS THAT THIS TREND PLACES ON THE PROVISION OF SERVICES IS COMPOUNDED BY THE HIGHER THAN AVERAGE PROPORTION OF ELDERLY INDIVIDUALS IN THE AREA. OF THE CHICKASAW POPULATION, 19.4% WERE OVER AGE 65 IN 2015, COMPARED TO 16.1% FOR THE STATE AND 14.9% FOR THE NATION. IOWA RANKS FOURTH IN PERCENTAGE OF POPULATION OVER THE AGE OF 65. THIS LARGE PERCENTAGE FOR THIS AGE GROUP PRESENTS SPECIAL CHALLENGES TO HEALTH CARE PROVIDERS, BECAUSE THIS AGE GROUP HAS THE HIGHEST INCIDENCE OF DISEASE AND MORTALITY IN MOST CATEGORIES AND, CORRESPONDINGLY, REPRESENTS THE BIGGEST USERS OF HEALTH CARE SERVICES. IN ADDITION, MEDICARE PAYMENT SHORTFALLS PRESENT AN ADDITIONAL BURDEN FOR RURAL HEALTH PROVIDERS. FOR FISCAL YEAR 2017, 49.5% OF MERCY NH'S REVENUES (HOSPITAL INPATIENT AND OUTPATIENT) WERE GENERATED FROM MEDICARE PATIENTS. THE MEDIAN HOUSEHOLD INCOME IN CHICKASAW COUNTY WAS ESTIMATED AT \$47,040 IN 2015. INDIVIDUALS BELOW THE POVERTY LEVEL COMPRISE 8.5% OF THE POPULATION. THE FISCAL YEAR 2017 PAYER MIX AT POINT OF REGISTRATION INCLUDES 42.7% COVERED BY MEDICARE, 11.3% COVERED BY MEDICAID AND 3.5% SELF-PAY.</p>



Form and Line Reference	Explanation
PART VI, LINE 5	<p>OTHER INFORMATION - MERCY NI HAS PROVIDED MANAGEMENT SERVICES FOR RURAL HOSPITALS SINCE 19 78 THESE COMMUNITY HOSPITALS OFFER QUALITY HEALTH CARE AND YET ARE STILL ABLE TO TAKE ADV ANTAGE OF ALL THE RESOURCES MERCY NI HAS TO OFFER AS A MAJOR REFERRAL CENTER MERCY NI EXT ENDS MEDICAL STAFF PRIVILEGES TO ALL QUALIFIED COMMUNITY HEALTHCARE PROVIDERS IN ORDER TO BEST MEET THE NEEDS OF THOSE WHO LIVE IN NORTH IOWA COMMUNITIES MERCY NI IS INTENTIONAL I N DEVELOPING TRIPLE-AIM ACCOUNTABLE CARE ORGANIZATION (ACO) RELATIONSHIPS AND COLLABORATIN G WITH COMMUNITY HEALTH PROVIDERS AND SOCIAL SERVICE AGENCIES, IN CREATING A SYSTEM OF CAR E COORDINATION PROCESSES THERE ARE NEARLY 120 PROFESSIONALS REPRESENTING ALL ASPECTS OF H EALTH CARE IN OUR PRIMARY SERVICE AREA PARTICIPATING IN TRANSITIONS OF CARE ITS PURPOSE I S TO IMPROVE COMMUNICATION AND PROCESSES IN ORDER TO IMPROVE QUALITY AND SAFETY OF TRANSIT IONS BETWEEN FACILITIES MERCY NI SUPPORTS THE COMMUNITY BY SPONSORING THE COMMUNITY CARE COORDINATION PROGRAM WITH EFFORTS FOCUSED ON THE SAFETY NET POPULATIONS AS A TEACHING HOSP ITAL, MERCY NI HOSTS A 3-YEAR FAMILY PRACTICE RESIDENCY PROGRAM, PHARMACY RESIDENCY, INTER NAL MEDICINE RESIDENCY, CARDIOLOGY FELLOWSHIP, HOSPICE AND PALLIATIVE CARE FELLOWSHIP, AND A SCHOOL OF RADIOLOGIC TECHNOLOGY THE HOSPITAL SERVES AS A CLINICAL SITE FOR STUDENTS ST UDYING TO BECOME PHYSICIANS, NURSES, PARAMEDICS, PHARMACISTS, MEDICAL ASSISTANTS AND OTHER ALLIED HEALTH PROFESSIONALS IN ADDITION, MERCY NI SUPPORTS HOMELESS SHELTERS FOR MEN AND WOMEN IN COLLABORATION WITH OTHER NON-PROFIT ORGANIZATIONS AS A SOLE COMMUNITY PROVIDER, SPECIALIZED SERVICES INCLUDE A HEART AND VASCULAR INSTITUTE, CANCER CENTER, DIABETES CENTE R, STROKE CENTER, BARIATRIC CENTER, VASCULAR AND WOUND CENTER, LEVEL II BIRTH CENTER AND A LEVEL II EMERGENCY CENTER EMERGENCY SERVICES ARE AVAILABLE TO ALL REGARDLESS OF THEIR AB ILITY TO PAY BECAUSE OF THE NEED BY INDIGENT ADULTS FOR DENTAL CARE, MERCY NI PROVIDES A SUITE WITH TWO FULLY FURNISHED OPERATORIES TO ACCOMMODATE EMERGENT DENTAL NEEDS HALF-DAY CLINICS ARE MANNED BY AREA DENTISTS AND DENTAL ASSISTANTS VOLUNTEERING THEIR TIME AND SKIL LS PARTNERSHIP FOR A TOBACCO FREE CERRO GORDO COUNTY IS A COALITION THAT INCLUDES CERRO G ORDO COUNTY DEPT OF PUBLIC HEALTH, FREEDOM FROM SMOKING PROGRAM (CREATED BY THE AMERICAN LUNG ASSOCIATION), AND SMOKE FREE HOMES PROGRAM WHICH FOCUSED ON COMMUNITY GOALS TARGETING TOBACCO USE AND OBESITY MERCY NI SUPPORTED OVER THE COUNTER NICOTINE REPLACEMENT THERAPY FOR THOSE WITH INCOME LIMITATIONS MERCY NI WORKED WITH WHOLLY OWNED CLINIC NETWORK CLINI CIANS TO SCREEN AND REFER FOR CESSATION MERCY NI SPONSORED FREEDOM FROM SMOKING FACILITAT OR TRAINING FOR TWO COMMUNITY PARTNERS MERCY NI CONTINUES TO COLLABORATE WITH STATE ADVOC ACY REPRESENTATIVES AND OTHER HEALTH MINISTRY'S SURROUNDING TOBACCO 21 LEGISLATION, WHICH ADVOCATES INCREASING THE LEGAL AGE TO PURCHASE TOBACCO FROM 18 TO 21 MERCY NI ALSO PARTIC IPATED IN ADVOCACY EFFORTS TO INCREASE AWARENESS SURROUNDING SMOKE FREE MOVIES MERCY NI B EGAN THE BABY FRIENDLY JOURNEY IN FISCAL YEAR 2016 AND HAS ACCOMPLISHED ADDITIONAL MILESTO NES IN THE IMPLEMENTATION PROCESS AND BREASTFEEDING POLICY DEVELOPMENT IN FISCAL YEAR 2017 BABY FRIENDLY HOSPITALS ARE HOSPITALS THAT ARE RECOGNIZED FOR ENCOURAGING BREASTFEEDING AND MOTHER/BABY BONDING, WHICH IS KNOWN TO PROVIDE HEALTH BENEFITS FOR INFANTS, CHILDREN, AND MOTHERS MERCY NI FURTHER INVESTS IN THE COMMUNITY TO ENHANCE THE HEALTH OF RESIDENTS B Y PROVIDING - PRE-DIABETES CLASSES AND SUPPORT GROUP MEETINGS AT NO CHARGE - SENIOR HEALTH INSURANCE INFORMATION PROGRAM (SHIIP) COUNSELING BY SHIIP VOLUNTEERS- SUPPORT FOR TRANSPO RTATION TO ELIMINATE BARRIERS TO HEALTHCARE- SUPPORT FOR THOSE WHO ARE HOMELESS - COLLABOR ATION TO SUPPORT A SELF-SUFFICIENCY PROGRAM- MERCY FAMILY HEALTH LINE, A 24-HOUR/7-DAY A W EEK TELEPHONE MEDICAL TRIAGE AND INFORMATION SERVICE- PARTICIPATION OF THE HOSPITAL KITCHE N IN PREPARATION OF MEALS ON WHEELS- FIVE HEALTH CAREER SCHOLARSHIPS GIVEN ANNUALLY TO COM MUNITY RECIPIENTS THE HOSPITAL VOLUNTEER AUXILIARYMERCY SC HAS EARNED MORE NATIONAL RECOGN ITION FOR QUALITY PATIENT OUTCOMES THAN ANY OTHER HOSPITAL IN THE REGION THE MEDICAL CENT ER HAS EARNED MULTIPLE HONORS FOR ITS LEADERSHIP AND EXCELLENCE IN SEVERAL CLINICAL AREAS, INCLUDING CARDIAC CARE, ORTHOPEDIC SERVICES, VASCULAR SURGERY, STROKE CARE AND CANCER CAR E MERCY SC IS HOME TO THE ONLY LEVEL II TRAUMA CENTER IN WESTERN IOWA AND PROVIDES A VITAL , LIFESAVING LINK TO RURAL AREAS VIA MERCY AIR CARE, THE HOSPITAL'S HELICOPTER AMBULANCE S ERVICE MERCY SC IS INVOLVED IN A NUMBER OF COMMUNITY VENTURES AND SUPPORTS THE SIOUXLAND M EDICAL EDUCATION FOUNDATION (FAMILY PRACTICE RESIDENCY) WE ALSO WORK CLOSELY WITH WINNEBA GO INDIAN HEALTH SERVICES TO CLOSE HEALTH OUTCOMES DISPARITIES IN ADDITION, MERCY SC COLL ABORATES WITH ST LUKE'S COLLEGE OF NURSING, WITCC SCHOOL OF NURSING AND BRIAR CLIFF UNIVE RSITY SCHOOL OF NURSING MERCY SC IS SHIFTING FOCUS</p>

Form and Line Reference	Explanation
PART VI, LINE 5	<p>AND COMMITTING RESOURCES TO PEOPLE-CENTERED HEALTH CARE MERCY SC HAS RECEIVED BLUE ZONE DISTINCTION AS AN EMPLOYER AND IS WORKING TO ASSIST OTHERS TO RECEIVE THIS RIVERSIDE ELEM ENTARY RECEIVED THIS DISTINCTION, IN PART DUE TO MERCY SC'S SUPPORT OF EXERCISE EQUIPMENT FOR STUDENTS AND PLUMBING TO SUPPORT A COMMUNITY GARDEN MERCY DUB AND MERCY DYC ARE ADVISED BY LOCAL BOARDS AND OPERATE EMERGENCY ROOMS WHICH ARE AVAILABLE TO ALL REGARDLESS OF ABILITY TO PAY MERCY DUB ALSO PROVIDES SEVERAL SERVICES THAT ARE UNIQUE TO THE COMMUNITY, INCLUDING OPEN HEART SURGERY, NEONATAL INTENSIVE CARE AND INPATIENT COMMUNITY PSYCHIATRIC SERVICES MERCY NH IS THE SOLE COMMUNITY PROVIDER OFFERING A RANGE OF SPECIALIZED SERVICES, DIABETES AND NUTRITION EDUCATION, AND AN EMERGENCY CENTER EMERGENCY SERVICES ARE AVAILABLE TO ALL REGARDLESS OF THEIR ABILITY TO PAY EMERGENCY SERVICES ARE PROVIDED AT A FINANCIAL LOSS, BUT ARE A CRITICALLY NEEDED SERVICE MERCY COOPERATES WITH OTHER AGENCIES TO IMPROVE OVERALL COMMUNITY HEALTH AND WELL-BEING FOR EXAMPLE, WE SPONSOR A COMMUNITY GARDEN, AND PRODUCE IS PROVIDED TO THE COMMUNITY'S FOOD PANTRY (WHICH UTILIZES HOSPITAL SPACE, AT NO COST) MERCY NH EXTENDS MEDICAL STAFF PRIVILEGES TO ALL QUALIFIED COMMUNITY HEALTHCARE PROVIDERS, IN ORDER TO BEST MEET THE NEEDS OF OUR NORTHEAST IOWA COMMUNITIES MERCY NH HAS ABOUT 50 IN-HOUSE VOLUNTEERS, WHO SERVE IN NEARLY EVERY DEPARTMENT OF THE MEDICAL CENTER FROM CLERICAL WORK TO PROVIDING PATIENT AND VISITOR SERVICES, MERCY NH VOLUNTEERS TRULY DO MAKE A DIFFERENCE THROUGH FUNDRAISERS, THE VOLUNTEERS ALSO PROVIDE FINANCIAL SUPPORT TO A VARIETY OF AREAS WITHIN THE HOSPITAL MERCY AUXILIARY AWARDS SCHOLARSHIPS TO HIGH SCHOOL AND NON-TRADITIONAL STUDENTS PURSUING EDUCATION IN THE HEALTHCARE FIELD THE AUXILIARY ALSO SPONSORS NUMEROUS BLOOD DRIVES AND LUNCH-AND-LEARN EVENTS ON HEALTHCARE SUBJECTS THEY ALSO PROVIDE WIGS AND TURBANS TO THOSE INDIVIDUALS WHO HAVE LOST THEIR HAIR DUE TO ILLNESS</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART VI, LINE 6	<p>MHS-IA IS A MEMBER OF TRINITY HEALTH, ONE OF THE LARGEST CATHOLIC HEALTH CARE DELIVERY SYSTEMS IN THE COUNTRY. TRINITY HEALTH ANNUALLY REQUIRES THAT ALL MEMBER ORGANIZATIONS DEFINE - AND ACHIEVE - SPECIFIC COMMUNITY HEALTH AND WELL-BEING GOALS. IN FISCAL YEAR 2017, GOALS INCLUDED 1) PARTICIPATING IN LOCAL COALITION AND ADVOCACY EFFORTS AIMED AT CURBING TOBACCO USE AND PREVENTING OBESITY, 2) ASSESSING CAPACITY TO IDENTIFY AND SUPPORT INDIVIDUALS THAT ARE HOUSING INSECURE AND ACKNOWLEDGING OTHER BARRIERS INDIVIDUALS HAVE ACCESSING HEALTH CARE AND 3) EXPANDING ACCESS AND DELIVERY OF DIABETES PREVENTION PROGRAMS. TRINITY HEALTH ACKNOWLEDGES THE IMPACT SOCIAL DETERMINANTS SUCH AS ADEQUATE HOUSING, SAFETY, ACCESS TO FOOD, EDUCATION, INCOME, AND HEALTH COVERAGE HAVE ON THE HEALTH OF THE COMMUNITY. IN FISCAL YEAR 2016, TRINITY HEALTH LAUNCHED THE TRANSFORMING COMMUNITIES INITIATIVE (TCI), AWARDING EIGHT COMMUNITIES FUNDING TO IMPROVE THE HEALTH AND WELL-BEING OF THEIR COMMUNITIES IN PARTNERSHIP WITH THE LOCAL TRINITY HEALTH MEMBER HOSPITAL. THE AWARDED COMMUNITIES FOCUS ON POLICY, SYSTEM, AND ENVIRONMENTAL CHANGES THAT SPECIFICALLY IMPACT COMMUNITY IDENTIFIED NEEDS AND THAT WILL REDUCE CHILDHOOD OBESITY AND YOUTH TOBACCO USE. IN FISCAL YEAR 2017, TRINITY HEALTH INVESTED \$2.7 MILLION IN TCI. AS A NOT-FOR-PROFIT HEALTH SYSTEM, TRINITY HEALTH REINVESTS ITS PROFITS BACK INTO OUR COMMUNITIES THROUGH PROGRAMS SERVING THOSE WHO ARE POOR AND VULNERABLE, HELPING MANAGE CHRONIC CONDITIONS LIKE DIABETES, PROVIDING HEALTH EDUCATION, PROMOTING WELLNESS AND DEVELOPING PROGRAMS AND POLICIES TO SPECIFICALLY SUPPORT VULNERABLE POPULATIONS. ANNUALLY, THE ORGANIZATION INVESTS OVER \$1.1 BILLION IN SUCH COMMUNITY BENEFITS AND WORKS TO ENSURE THAT ITS MEMBER HOSPITALS AND OTHER ENTITIES/AFFILIATES ENHANCE THE OVERALL HEALTH OF THE COMMUNITIES THEY SERVE BY ADDRESSING THE SPECIFIC NEEDS OF EACH COMMUNITY. FOR MORE INFORMATION ABOUT TRINITY HEALTH, VISIT <a href="http://WWW.TRINITY-HEALTH.ORG">WWW.TRINITY-HEALTH.ORG</a>.</p>

Additional Data

Software ID:  
Software Version:  
EIN: 31-1373080  
Name: MERCY HEALTH SERVICES - IOWA CORP

Form 990 Schedule H, Part V Section A. Hospital Facilities

Section A. Hospital Facilities		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER—24 hours	ER—other	Other (Describe)	Facility reporting group
(list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? 6											
1	MERCY MEDICAL CENTER-NORTH IOWA 1000 FOURTH STREET SW MASON CITY, IA 50401 WWW.MERCYNORTHIOWA.COM 170023H	X	X		X		X	X			
2	MERCY MEDICAL CENTER-DUBUQUE 250 MERCY DRIVE DUBUQUE, IA 52001 WWW.MERCYDUBUQUE.COM 310003H	X	X					X		REHAB, LAB, PHARM, X-RAY, HOME CARE	
3	MERCY MEDICAL CENTER-SIOUX CITY 801 FIFTH STREET SIOUX CITY, IA 51102 WWW.MERCYSIOUXCITY.COM 970112H	X	X					X		EMPLOYED PHYSICIANS, SKILLED CARE UNIT	
4	MERCY MEDICAL CENTER-NEW HAMPTON 308 NORTH MAPLE AVE NEW HAMPTON, IA 50659 WWW.MERCYNEWHAMPTON.COM 190022H	X				X		X		EMPLOYED PHYSICIANS	
5	DUNES SURGICAL HOSPITAL 600 N SIOUX POINT ROAD DAKOTA DUNES, SD 57049 WWW.DUNESSURGICALHOSPITAL.COM 10580	X	X								

**Form 990 Schedule H, Part V Section A. Hospital Facilities**

<b>Section A. Hospital Facilities</b>  (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? <b>6</b>		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER—24 hours	ER—other	Other (Describe)	Facility reporting group
6	MERCY MEDICAL CENTER-DYERSVILLE 1111 THIRD STREET SW DYERSVILLE, IA 52040 WWW.MERCYDUBUQUE.COM/MERCY-DYERSVILLE 310181H	X	X			X		X		REHAB, LAB, PHARM, X-RAY, HOME CARE	

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-NORTH IOWA	PART V, SECTION B, LINE 5 DURING THE 2016 CHNA ASSESSMENT PERIOD MERCY MEDICAL CENTER-NORTH IOWA (MERCY NI) WORKED WITH AN INDEPENDENT CONSULTANT TO DESIGN AND COORDINATE THE CHNA PROCESS THE ASSESSMENT PERIOD SPANNED AUGUST 2016 THROUGH JANUARY 2017 WITH ADOPTION OF THE CNHA ON MARCH 1, 2017 BY THE BOARD OF DIRECTORS DURING THE ASSESSMENT PERIOD, MERCY NI'S TRAINED FACILITATOR LEAD A SERIES OF FOCUS GROUPS AND INTERVIEWS WHICH WERE HELD WITH MEMBERS OR REPRESENTATIVES OF THE FOLLOWING GROUPS LA LUZ HISPANA, HAMPTON, IA, WHICH PROVIDES SUPPORT AND RESOURCES TO AN UNDERSERVED HISPANIC COMMUNITY, COMMUNITY KITCHEN, WHICH SERVES FOOD TO THOSE WHO ARE UNDERSERVED AND LIVING IN POVERTY, FREE MEDICAL AND DENTAL CLINICS, WHICH SERVE THOSE WHO ARE UNDERSERVED AND LIVING IN POVERTY, AND THE COMMUNITY CARE COORDINATION PROGRAM, WHICH ASSISTS THOSE WHOM ARE SOCIALLY AND MEDICALLY UNDERSERVED THE FOLLOWING NONPROFIT COMMUNITY AGENCIES ALSO CONTRIBUTED IN THE FOCUS GROUPS AND INTERVIEWS CERRO GORDO COUNTY DEPARTMENT OF PUBLIC HEALTH, NORTH IOWA COMMUNITY ACTION ORGANIZATIONS, PRAIRIE RIDGE INTEGRATED BEHAVIORAL HEALTHCARE, UNITED WAY OF NORTH CENTRAL IOWA, AND WELLSOURCE OF NORTH IOWA, ALL OF WHICH ADDRESS THE NEEDS OF THOSE WHO ARE UNDERSERVED AND LIVING IN POVERTY IN THE COMMUNITY A CHNA STEERING COMMITTEE, COMPRISED OF A REPRESENTATIVE FROM EACH OF THESE COMMUNITY AGENCIES, SUMMARIZED AND ANALYZED DATA THAT WAS OBTAINED FROM THE FOLLOWING THE COUNTY HEALTH RANKINGS FOR THE 14 COUNTIES IN THE MERCY NI SERVICE AREA, THE CENTERS FOR DISEASE CONTROL AND PREVENTION, COMMUNITY COMMONS WEBSITE, CHNA GOALS FROM THE PUBLIC HEALTH DEPARTMENTS IN EACH OF THE 14 COUNTIES, AND A SURVEY MONKEY QUESTIONNAIRE DISTRIBUTED TO MERCY NI EMPLOYEES AND OTHER AGENCIES ALL OF THESE DATA SOURCES WERE SUMMARIZED AND INFORMATION PROVIDED TO A SEPARATE ADVISORY COMMITTEE, A GATHERING OF AGENCY REPRESENTATIVES THE ADVISORY COMMITTEE THEN PRIORITIZED THE IDENTIFIED HEALTH NEEDS, BASED ON THE AVERAGE SCORE GIVEN BY COMMITTEE MEMBERS

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-SIOUX CITY	PART V, SECTION B, LINE 5 IN 2015 DUNES SURGICAL HOSPITAL (DUNES), MERCY MEDICAL CENTER-SIOUX CITY (MERCY SC), SIOUXLAND DISTRICT HEALTH DEPARTMENT (SDHD), AND UNITYPOINT HEALTH - ST LUKE'S PARTNERED TOGETHER TO COMPLETE THE FIRST EVER JOINT CHNA TO DETERMINE THE COMMUNITY'S GREATEST HEALTH NEEDS AND TO COORDINATE EFFORTS TO IMPROVE POPULATION HEALTH OUTCOMES FOR THE SIOUXLAND AREA THE YEAR-LONG PROCESS INCLUDED COLLABORATION OF REPRESENTATIVES FROM EACH ORGANIZATION, KNOWN AS THE CHNA PLANNING COMMITTEE, AS WELL AS ENGAGEMENT FROM THE COMMUNITY PARTNERS LISTED ON LINE 6B BEGINNING IN EARLY 2015, PRIMARY AND SECONDARY DATA WAS COLLECTED THROUGH SEVERAL SOURCES, AND ANALYZED BY THE CHNA PLANNING COMMITTEE A COMMUNITY INPUT MEETING WAS HELD DURING THE SUMMER OF 2015, WHILE FINAL SUBMISSION OF THE CHNA OCCURRED EARLY 2016 THE JOINT CHNA LOOKED AT DATA FROM THE FOLLOWING SIX COUNTIES IN THE TRI-STATE SIOUXLAND AREA, AS EACH HOSPITAL SERVES A LARGER TERRITORY OUTSIDE OF JUST WOODBURY COUNTY -UNION, SD-DAKOTA, DIXON, AND THURSTON, NE-PLYMOUTH AND WOODBURY, IA

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-DUBUQUE	<p>PART V, SECTION B, LINE 5 INPUT FROM THE COMMUNITY WAS GATHERED THROUGH THE FOLLOWING THE INVOLVEMENT OF THE CHNA STEERING COMMITTEE MEMBERS AND THE PROMOTING HEALTH BEHAVIORS TASK FORCE, A SURVEY, AND THREE PUBLIC INPUT SESSIONS THE CHNA STEERING COMMITTEE MET MULTIPLE TIMES, APPROXIMATELY MONTHLY FROM SEPTEMBER 2014 THROUGH MAY 2015 THE PROMOTING HEALTHY BEHAVIORS TASK FORCE MET IN DECEMBER 2014, FEBRUARY 2015, AND MARCH 2015 ORGANIZATIONS PARTICIPATING ON THESE COMMITTEES REPRESENTED BROAD INTERESTS OF THE COMMUNITY, INCLUDING RACIAL AND ETHNIC MINORITIES, A VARIETY OF AGE AND INCOME GROUPS, AND PEOPLE WITH SPECIFIC HEALTH CARE ISSUES ALL OF THE ORGANIZATIONS LISTED ON LINE 6B, PLUS MERCY MEDICAL CENTER - DYERSVILLE (MERCY DYR), PARTICIPATED IN DEVELOPMENT OF THE PROCESS, ANALYSIS OF DATA, CONTRIBUTION OF ADDITIONAL DATA, IDENTIFICATION OF NEEDS, PRIORITIZATION OF NEEDS, AND STRATEGY DEVELOPMENT MANY OF THEM SERVE POPULATIONS AT RISK IN THE COMMUNITY, INCLUDING LOW INCOME AND MINORITY POPULATIONS, AND SPOKE OF THEIR NEEDS THE PROCESS VARIED BY ORGANIZATION, BUT MANY OF THESE TASK FORCE MEMBERS TOOK THE INFORMATION BACK TO THEIR ORGANIZATIONS, DISCUSSED IT, AND RETURNED WITH ADDITIONAL INPUT OR IDEAS THE DUBUQUE COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT SURVEY WAS FIELDED BETWEEN DECEMBER 2014 AND MARCH 2015 THE SURVEY'S BASIC RACIAL/ETHNIC DEMOGRAPHICS ARE REASONABLY REPRESENTATIVE OF THE COMMUNITY AT LARGE THE SURVEY RESPONDENTS WERE 95 1% WHITE, NON-HISPANIC, COMPARED TO 92 9% FOR DUBUQUE COUNTY IN 2012 TO ACCOMMODATE LOW-INCOME HOUSEHOLDS THAT LACKED ACCESS TO THE INTERNET, SOME PAPER VERSIONS OF THE SURVEY WERE MADE AVAILABLE AS NOTED IN THE SURVEY FINDINGS, THERE WERE OCCASIONAL DIFFERENCES IN THE OPINIONS OF WHITE NON-HISPANIC COMPARED TO OTHER SURVEY RESPONDENTS THE THIRD WAY OF SOLICITING INPUT FROM PERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY WERE THE THREE PUBLIC INPUT SESSIONS CONDUCTED IN LATE APRIL AND EARLY MAY 2015 TO ACCOMMODATE WORK SCHEDULES AND TO ENCOURAGE DIVERSITY AMONG THOSE ATTENDING, THE SESSIONS OCCURRED ON DIFFERENT DAYS, IN DIFFERENT LOCATIONS, AND AT DIFFERENT TIMES OF DAY THE CITY OF DUBUQUE, ONE OF THE PARTNERS IN THIS ASSESSMENT PROJECT, HAS BEEN USING AN INFORMAL "COMMUNITY CAFE" FORMAT FOR INCREASING COMMUNITY ENGAGEMENT IN A VARIETY OF COMMUNITY PROJECTS BASED ON THEIR SUCCESS AND THE FAMILIARITY OF THE COMMUNITY WITH THIS CONCEPT, WE CHOSE TO EMPLOY IT FOR THE CHNA</p>



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

Form and Line Reference	Explanation
DUNES SURGICAL HOSPITAL	PART V, SECTION B, LINE 5 IN 2015 DUNES, MERCY SC, SDHD, AND UNITYPOINT HEALTH - ST LUKE'S PARTNERED TOGETHER TO COMPLETE THE FIRST EVER JOINT CHNA TO DETERMINE THE COMMUNITY'S GREATEST HEALTH NEEDS AND TO COORDINATE EFFORTS TO IMPROVE POPULATION HEALTH OUTCOMES FOR THE SIOUXLAND AREA THE YEAR-LONG PROCESS INCLUDED COLLABORATION OF REPRESENTATIVES FROM EACH ORGANIZATION, KNOWN AS THE CHNA PLANNING COMMITTEE, AS WELL AS ENGAGEMENT FROM THE COMMUNITY PARTNERS LISTED ON LINE 6B BEGINNING IN EARLY 2015, PRIMARY AND SECONDARY DATA WAS COLLECTED THROUGH SEVERAL SOURCES, AND ANALYZED BY THE CHNA PLANNING COMMITTEE A COMMUNITY INPUT MEETING WAS HELD DURING THE SUMMER OF 2015, WHILE FINAL SUBMISSION OF THE CHNA OCCURRED EARLY 2016 THE JOINT CHNA LOOKED AT DATA FROM THE FOLLOWING SIX COUNTIES IN THE TRI-STATE SIOUXLAND AREA, AS EACH HOSPITAL SERVES A LARGER TERRITORY OUTSIDE OF JUST WOODBURY COUNTY -UNION, SD-DAKOTA, DIXON, AND THURSTON, NE-PLYMOUTH AND WOODBURY, IA

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-NEW HAMPTON	PART V, SECTION B, LINE 5 THE ASSESSMENT PROCESS WAS INITIATED BY MERCY MEDICAL CENTER-NEW HAMPTON (MERCY NH) A PLANNING TEAM WAS FORMED CONSISTING OF REPRESENTATIVES FROM HOSPITAL GOVERNANCE, LEADERSHIP AND MEDICAL STAFF, AREA EMPLOYERS, SCHOOL DISTRICTS, AND AREA HEALTH PROFESSIONALS FACILITATED BY AN OUTSIDE CONSULTANT, THREE SEPARATE DISCUSSION GROUPS WERE HELD LOCALLY IN DECEMBER 2015 THE GROUPS REPRESENTED VARYING SECTORS IN THE COMMUNITY (1) SOCIAL SERVICE PARTNERS, (2) PATIENTS, AND (3) COMMUNITY/BUSINESS REPRESENTATIVES THERE WAS A 72% RESPONSE TO INVITATIONS TO PARTICIPATE THE PATIENT GROUP WAS PULLED RANDOMLY FROM A PATIENT LISTING OVER THE PRECEDING SIX MONTHS, SOCIAL SERVICE PARTNERS WERE A CROSS-SECTION OF THE AGENCIES MERCY NH WORKS CLOSELY WITH, AND COMMUNITY LEADERS/BUSINESS OWNERS WERE SELECTED FOR THEIR KNOWLEDGE OF THE COMMUNITY SEVEN PARTICIPANTS WERE FROM OUTSIDE NEW HAMPTON (FREDERICKSBURG, LAWLER AND ALTA VISTA), ALL OTHERS WERE FROM NEW HAMPTON THE OUTSIDE CONSULTANT COLLATED AND ANALYZED THE FOCUS GROUP RESULTS WITH SUPPORT FROM MERCY NH'S PLANNING & MARKETING TEAM IN MASON CITY MERCY NH ALSO USED OTHER MECHANISMS TO GATHER COMMUNITY INPUT ON SERVICES SURVEYS, PATIENT FEEDBACK, AND SERVICE UTILIZATION DATA DATA SOURCES INCLUDED COUNTY HEALTH RANKINGS, THE IOWA HOSPITAL ASSOCIATION, THE ADVISORY BOARD AND THE DEPARTMENT OF HEALTH & HUMAN SERVICES MERCY NH WAS CAREFUL TO GATHER INPUT FROM REPRESENTATIVES OF VARIOUS MINORITY AND UNDERSERVED INDIVIDUALS INCLUDING LOW INCOME/UNDERSERVED (SALVATION ARMY, PUBLIC HEALTH AND HERITAGE RESIDENCE REPRESENTATIVES), CHRONIC CONDITIONS (AREA NURSING HOME, MENTAL HEALTH AND HOSPICE REPRESENTATIVES), AND RACIAL/ETHNIC MINORITY (HISPANIC MINISTER FROM HOLY FAMILY)

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-DYERSVILLE	PART V, SECTION B, LINE 5 INPUT FROM THE COMMUNITY WAS GATHERED THROUGH THE FOLLOWING THE INVOLVEMENT OF THE CHNA STEERING COMMITTEE MEMBERS AND THE PROMOTING HEALTH BEHAVIORS TASK FORCE, A SURVEY, AND THREE PUBLIC INPUT SESSIONS THE CHNA STEERING COMMITTEE MET MULTIPLE TIMES, APPROXIMATELY MONTHLY FROM SEPTEMBER 2014 THROUGH MAY 2015 THE PROMOTING HEALTHY BEHAVIORS TASK FORCE MET IN DECEMBER 2014, FEBRUARY 2015, AND MARCH 2015 ORGANIZATIONS PARTICIPATING ON THESE COMMITTEES REPRESENTED BROAD INTERESTS OF THE COMMUNITY, INCLUDING RACIAL AND ETHNIC MINORITIES, A VARIETY OF AGE AND INCOME GROUPS, AND PEOPLE WITH SPECIFIC HEALTH CARE ISSUES ALL OF THE ORGANIZATIONS LISTED ON LINE 6B, PLUS MERCY MEDICAL CENTER - DUBUQUE (MERCY DUB) PARTICIPATED IN DEVELOPMENT OF THE PROCESS, ANALYSIS OF DATA, CONTRIBUTION OF ADDITIONAL DATA, IDENTIFICATION OF NEEDS, PRIORITIZATION OF NEEDS, AND STRATEGY DEVELOPMENT MANY OF THEM SERVE POPULATIONS AT RISK IN THE COMMUNITY, INCLUDING LOW INCOME AND MINORITY POPULATIONS, AND SPOKE OF THEIR NEEDS THE PROCESS VARIED BY ORGANIZATION, BUT MANY OF THESE TASK FORCE MEMBERS TOOK THE INFORMATION BACK TO THEIR ORGANIZATIONS, DISCUSSED IT, AND RETURNED WITH ADDITIONAL INPUT OR IDEAS THE DUBUQUE COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT SURVEY WAS FIELDIED BETWEEN DECEMBER 2014 AND MARCH 2015 THE SURVEY'S BASIC RACIAL/ETHNIC DEMOGRAPHICS ARE REASONABLY REPRESENTATIVE OF THE COMMUNITY AT LARGE THE SURVEY RESPONDENTS WERE 95 1% WHITE, NON-HISPANIC, COMPARED TO 92 9% FOR DUBUQUE COUNTY IN 2012 TO ACCOMMODATE LOW-INCOME HOUSEHOLDS THAT LACKED ACCESS TO THE INTERNET, SOME PAPER VERSIONS OF THE SURVEY WERE MADE AVAILABLE AS NOTED IN THE SURVEY FINDINGS, THERE WERE OCCASIONAL DIFFERENCES IN THE OPINIONS OF WHITE NON-HISPANIC COMPARED TO OTHER SURVEY RESPONDENTS THE THIRD WAY OF SOLICITING INPUT FROM PERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY WERE THE THREE PUBLIC INPUT SESSIONS CONDUCTED IN LATE APRIL AND EARLY MAY 2015 TO ACCOMMODATE WORK SCHEDULES AND TO ENCOURAGE DIVERSITY AMONG THOSE ATTENDING, THE SESSIONS OCCURRED ON DIFFERENT DAYS, IN DIFFERENT LOCATIONS, AND AT DIFFERENT TIMES OF DAY THE CITY OF DUBUQUE, ONE OF THE PARTNERS IN THIS ASSESSMENT PROJECT, HAS BEEN USING AN INFORMAL "COMMUNITY CAFE" FORMAT FOR INCREASING COMMUNITY ENGAGEMENT IN A VARIETY OF COMMUNITY PROJECTS BASED ON THEIR SUCCESS AND THE FAMILIARITY OF THE COMMUNITY WITH THIS CONCEPT, WE CHOSE TO EMPLOY IT FOR THE CHNA

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-SIOUX CITY	PART V, SECTION B, LINE 6A MERCY SC'S CHNA WAS CONDUCTED WITH ST LUKE'S REGIONAL MEDICAL CENTER AND DUNES SURGICAL HOSPITAL

<b>Form 990 Part V Section C Supplemental Information for Part V, Section B.</b>	
<b>Section C. Supplemental Information for Part V, Section B.</b> Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.	
Form and Line Reference	Explanation
MERCY MEDICAL CENTER-DUBUQUE	PART V, SECTION B, LINE 6A MERCY DUB CONDUCTED ITS CHNA WITH MERCY DYN AND UNITYPOINT HEALTH-FINLEY HOSPITAL, DUBUQUE

<b>Form 990 Part V Section C Supplemental Information for Part V, Section B.</b>	
<b>Section C. Supplemental Information for Part V, Section B.</b> Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.	
Form and Line Reference	Explanation
DUNES SURGICAL HOSPITAL	PART V, SECTION B, LINE 6A DUNES' CHNA WAS CONDUCTED WITH MERCY SC AND ST LUKE'S REGIONAL MEDICAL CENTER

<b>Form 990 Part V Section C Supplemental Information for Part V, Section B.</b>	
<b>Section C. Supplemental Information for Part V, Section B.</b> Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.	
Form and Line Reference	Explanation
MERCY MEDICAL CENTER-DYERSVILLE	PART V, SECTION B, LINE 6A MERCY DYR CONDUCTED ITS CHNA WITH MERCY DUB AND UNITYPOINT HEALTH-FINLEY HOSPITAL, DUBUQUE

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-NORTH IOWA	PART V, SECTION B, LINE 6B MERCY NI CONDUCTED ITS CHNA WITH THE FOLLOWING NON-HOSPITAL ORGANIZATIONS CERRO GORDO COUNTY DEPARTMENT OF PUBLIC HEALTH, NORTH IOWA COMMUNITY ACTION ORGANIZATIONS, PRAIRIE RIDGE INTEGRATED BEHAVIORAL HEALTHCARE, UNITED WAY OF NORTH CENTRAL IOWA, WELLSOURCE OF NORTH IOWA, LA LUZ HISPANA, COMMUNITY KITCHEN OF NORTH IOWA, NORTH IOWA DENTAL CLINIC FOR THE UNINSURED AND UNDERINSURED, CERRO GORDO COUNTY FREE HEALTH CARE CLINIC, MASON CITY AREA CHAMBER OF COMMERCE, NORTH IOWA VOCATIONAL CENTER, WELLSOURCE OF NORTH IOWA, MASON CITY PUBLIC LIBRARY, MASON CITY YMCA, NORTH IOWA COMMUNITY ACTION ORGANIZATION, BLUE ZONES PROJECT, NORTH IOWA TRANSITION CENTER, ELDERBRIDGE AGENCY ON AGING, KIMT TELEVISION STATION, RHYTHM CHURCH, MASON CITY YOUTH TASK FORCE, PRAIRIE RIDGE INTEGRATED BEHAVIORAL HEALTHCARE, CENTRAL PARK DENTISTRY, MASON CITY SCHOOL SYSTEM, SALVATION ARMY OF MASON CITY, HY-VEE PHARMACY, CERRO GORDO COUNTY LAW ENFORCEMENT CENTER, NORTHERN LIGHTS ALLIANCE FOR THE HOMELESS, IOWA WORKFORCE DEVELOPMENT, NEWMAN CATHOLIC SCHOOL, FIRST CITIZENS NATIONAL BANK, PROBATION/PAROLE MANAGER 2ND JUDICIAL DISTRICT, MASON CITY POLICE DEPARTMENT, MASON CITY PARATRANSIT, CHARLIE BROWN PRESCHOOL, IOWA SPECIALTY HOSPITAL, FAMILIES FIRST, IOWA LEGAL AID, AND NORTH IOWA YOUTH FOR CHRIST



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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-SIOUX CITY	PART V, SECTION B, LINE 6B MERCY SC CONDUCTED ITS CHNA IN COLLABORATION WITH BOYS TOWN, CENTER FOR SIOUXLAND, COMMUNITY ACTION AGENCY OF SIOUXLAND, CENTER FOR SEXUAL ABUSE & DOMESTIC VIOLENCE, JACKSON RECOVERY CENTERS (SUBSTANCE ABUSE), JACKSON RECOVERY CENTERS SPF-SIG (UNDERAGE), MERCY HOME CARE, MERCY MEDICAL CENTER, MERCY CHILD ADVOCACY CENTER, PLANNED PARENTHOOD - NAVIGATOR (ELDERLY), POISON CENTER, SIMPCO (PHYSICALLY CHALLENGED/GENERAL POPULATION), CONNECTION AREA AGENCY ON AGING, SIOUXLAND CARES, SIOUXLAND COMMUNITY HEALTH CENTER, SIOUXLAND DISTRICT HEALTH CENTER, SIOUXLAND DISTRICT HEALTH DEPARTMENT, SIOUXLAND HUMAN INVESTMENT PARTNERSHIP, SIOUXLAND MENTAL HEALTH CENTER, UNITY POINT - ST LUKE'S, SUSAN G KOMEN (CANCER), AND THE FOODBANK OF SIOUXLAND

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-DUBUQUE	PART V, SECTION B, LINE 6B MERCY DUB CONDUCTED ITS CHNA WITH THE FOLLOWING NON-HOSPITAL ORGANIZATIONS - CITY OF DUBUQUE HEALTH SERVICES- DUBUQUE COUNTY HEALTH DEPARTMENT- CRESCENT COMMUNITY HEALTH CENTER- CITY OF DUBUQUE LEISURE SERVICES- YMCA/YWCA- HOLY FAMILY SCHOOL DISTRICT- HYVEE DIETITIAN SERVICES- WIC- HILLCREST FAMILY SERVICES- HELPING SERVICES OF NE IOWA- DUBUQUE COMMUNITY SCHOOLS- VISITING NURSE ASSOCIATION- MEDICAL ASSOCIATES CLINIC- CITY OF DUBUQUE HUMAN RIGHTS DEPARTMENT- ISU EXTENSION- CITY OF ASBURY CITY PARKS

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

Form and Line Reference	Explanation
DUNES SURGICAL HOSPITAL	PART V, SECTION B, LINE 6B DUNES CONDUCTED ITS CHNA IN COLLABORATION WITH BOYS TOWN, CENTER FOR SIOUXLAND, COMMUNITY ACTION AGENCY OF SIOUXLAND, CENTER FOR SEXUAL ABUSE & DOMESTIC VIOLENCE, JACKSON RECOVERY CENTERS (SUBSTANCE ABUSE), JACKSON RECOVERY CENTERS SPF-SIG (UNDERAGE), MERCY HOME CARE, MERCY MEDICAL CENTER, MERCY CHILD ADVOCACY CENTER, PLANNED PARENTHOOD - NAVIGATOR (ELDERLY), POISON CENTER, SIMPCO (PHYSICALLY CHALLENGED/GENERAL POPULATION), CONNECTION AREA AGENCY ON AGING, SIOUXLAND CARES, SIOUXLAND COMMUNITY HEALTH CENTER, SIOUXLAND DISTRICT HEALTH CENTER, SIOUXLAND DISTRICT HEALTH DEPARTMENT, SIOUXLAND HUMAN INVESTMENT PARTNERSHIP, SIOUXLAND MENTAL HEALTH CENTER, UNITY POINT - ST LUKE'S, SUSAN G KOMEN (CANCER), AND THE FOODBANK OF SIOUXLAND

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-DYERSVILLE	PART V, SECTION B, LINE 6B MERCY DYR CONDUCTED ITS CHNA WITH THE FOLLOWING NON-HOSPITAL ORGANIZATIONS - CITY OF DUBUQUE HEALTH SERVICES- DUBUQUE COUNTY HEALTH DEPARTMENT- CRESCENT COMMUNITY HEALTH CENTER- CITY OF DUBUQUE LEISURE SERVICES- YMCA/YWCA- HOLY FAMILY SCHOOL DISTRICT- HYVEE DIETITIAN SERVICES- WIC- HILLCREST FAMILY SERVICES- HELPING SERVICES OF NE IOWA- DUBUQUE COMMUNITY SCHOOLS- VISITING NURSE ASSOCIATION- MEDICAL ASSOCIATES CLINIC- CITY OF DUBUQUE HUMAN RIGHTS DEPARTMENT- ISU EXTENSION- CITY OF ASBURY CITY PARKS

<b>Form 990 Part V Section C Supplemental Information for Part V, Section B.</b>	
<b>Section C. Supplemental Information for Part V, Section B.</b> Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.	
Form and Line Reference	Explanation
MERCY MEDICAL CENTER-SIOUX CITY	PART V, SECTION B, LINE 7D PAPER COPIES OF THE CHNA WERE MADE AVAILABLE TO THE COLLABORATIVE PARTNERS LISTED ON LINE 6B

<b>Form 990 Part V Section C Supplemental Information for Part V, Section B.</b>	
<b>Section C. Supplemental Information for Part V, Section B.</b> Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.	
Form and Line Reference	Explanation
DUNES SURGICAL HOSPITAL	PART V, SECTION B, LINE 7D PAPER COPIES OF THE CHNA WERE MADE AVAILABLE TO THE COLLABORATIVE PARTNERS LISTED ON LINE 6B

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-NORTH IOWA	<p>PART V, SECTION B, LINE 11 MERCY NI ADDRESSED THE FOLLOWING SIGNIFICANT HEALTH NEEDS WITH IN ITS IMPLEMENTATION STRATEGY IN TAX YEAR 2016 LACK OF MENTAL HEALTH PROVIDERS/SUPPORT SERVICES TO ADDRESS THE LACK OF MENTAL HEALTH PROVIDERS, MERCY NI HIRED ONE ADVANCED REGISTERED NURSE PRACTITIONER (ARNP) SPECIFICALLY TO SUPPORT BEHAVIORAL HEALTH SERVICES ADDITIONALLY, ONE LICENSED INDEPENDENT SOCIAL WORKER (LISW) WAS EMPLOYED TO PROVIDE SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT) TELEMEDICINE SERVICES TO FURTHER ADDRESS MENTAL HEALTH SUPPORT SERVICES, MERCY NI BEGAN PROJECT PREPARATION AND PLANNING SURROUNDING NEW CONSTRUCTION OF A BEHAVIORAL HEALTH CENTER THAT BROKE GROUND IN OCTOBER 2017 LACK OF SOCIAL AND EMOTIONAL SUPPORT GROUND BREAKING FOR THE NEW BEHAVIORAL HEALTH CENTER TO OK PLACE OCTOBER 4TH, 2017 WITH THE PLANNING FOR A BEHAVIORAL HEALTH CENTER, STRATEGIES WILL BE IMPLEMENTED IN THE UPCOMING THREE YEARS WITH A GOAL TO MAXIMIZE SERVICE AVAILABILITY FOR THOSE WITH SOCIAL/EMOTIONAL NEEDS, INCREASING ACCESS AND QUALITY OF SUPPORT SERVICES COMMUNITY HEALTH COORDINATORS, PEER SUPPORTS, HEALTH COACHES AND VOLUNTEER SERVICE PROVIDERS HAVE UNIFIED IN COLLABORATION TO REMOVE SOCIAL AND EMOTIONAL BARRIERS AND PROVIDE SOLUTIONS FOR THOSE AT RISK OF ISOLATION DIABETES A PROJECT MODEL WHICH BEGAN AS A PILOT WITHIN THE PREVIOUS CHNA CYCLE HAS NOW BECOME ROUTINE PRACTICE FOR THE MANAGEMENT OF DIABETIC PATIENTS WITHIN ONE PRIMARY CARE CLINIC THIS WAS DONE BY INTEGRATING A PHARMACIST INTO THE CARE TEAM STUDY ANALYSIS INDICATES AN OUTCOME OF A 1% DECREASE IN A1C AND AN OVERALL RISK REDUCTION OF 40% THIS ALLOWS FOR PATIENT CENTERED GOAL SETTING, PROMOTED BY HEALTH COACHES, WHICH HAS ENHANCED AND EMPOWERED PATIENT CENTERED SELF-MANAGEMENT CARE MERCY NI ENTERED INTO A COLLABORATIVE PARTNERSHIP IN 2017 WITH THE CERRO GORDO COUNTY DEPARTMENT OF PUBLIC HEALTH AND THE FAMILY YMCA TO INCREASE AWARENESS BY EDUCATING CITIZENS ON THE PREVENTION OF DIABETES USING LIFE COACHES THIS IS ALSO AN IOWA STATEWIDE INITIATIVE IN WHICH CERRO GORDO COUNTY AND COLLABORATIVE PARTNERS ARE TAKING PART MERCY NI IS NOT DIRECTLY ADDRESSING THE FOLLOWING LISTED NEEDS IN THIS CHNA CYCLE BECAUSE OF COMPETING PRIORITIES, LACK OF RESOURCES, AND DUE TO THE FACT THAT OTHER AGENCIES ARE ALREADY ADDRESSING THESE ISSUES COST OF HEALTH CARE ALTHOUGH MERCY NI WILL NOT TAKE ADDITIONAL STEPS TO ADDRESS THE COST OF HEALTH CARE, IT WILL CONTINUE TO SUPPORT AND SUSTAIN THE SAFETY NET CARE COORDINATION MODEL INITIATED IN EARLY 2014 IN PARTNERSHIP WITH IOWA PRIMARY CARE ASSOCIATION, IOWA DEPARTMENT OF PUBLIC HEALTH AND LOCAL COMMUNITY PARTNERS (CERRO GORDO COUNTY DEPARTMENT OF PUBLIC HEALTH, PRAIRIE RIDGE INTEGRATED BEHAVIORAL HEALTHCARE, NORTH IOWA COMMUNITY ACTION ORGANIZATION, AND WELLSOURCE) OBESITY ALTHOUGH MERCY NI WILL NOT TAKE ADDITIONAL STEPS TO ADDRESS OBESITY, CURRENT BLUE ZONE EFFORTS ACROSS THE COMMUNITY, COUPLED WITH EMPLOYER SPONSORED WELLNESS INITIATIVES HAS</p>

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-NORTH IOWA	VE INCREASED AWARENESS OF DIETARY MODIFICATION BY EATING MORE WHOLE FOODS, INCREASING MOVE MENT AND GETTING ENOUGH REST THERE HAVE ALSO BEEN SIGNIFICANT IMPROVEMENTS WITHIN CERRO G ORDO COUNTY OF WALKING AND BIKE PATHS AND PARK ENHANCEMENTS PENDING DIABETES PREVENTION P ROGRAMMING WILL DUPLICATE EFFORTS IN THIS ARENA FOR THE ADULT POPULATIONS AND PUBLIC AND P RIVATE SCHOOLS ARE LEADING EFFORTS FOR CHILDHOOD OBESITY, OF WHICH MERCY NI WILL HELP SUPP ORT EFFORTS TO ADDRESS HEALTHY FOOD NOT AVAILABLE ALTHOUGH MERCY NI WILL NOT TAKE ADDITION AL STEPS TO ADDRESS HEALTHY, UNPROCESSED, FRESH, NUTRITIOUS, NATURAL FOODS AT THIS TIME, M ERCY NI WILL CONTINUE PARTNERING WITH THE FOLLOWING COMMUNITY COLLABORATIVE EVENTS SUCH AS FARMERS MARKETS, COMMUNITY SUPPORTED AGRICULTURE, MEALS ON WHEELS, AND COMMUNITY KITCHEN ELDER CARE ALTHOUGH MERCY NI WILL NOT TAKE ADDITIONAL STEPS TO ADDRESS ELDER CARE, MERCY N I CONTINUES TO COLLABORATE WITH THE FOLLOWING COMMUNITY PARTNERS AGING SERVICES COALITION , ELDERBRIDGE AGENCY ON AGING, LOCAL NURSING HOMES, COMMUNITY CARE COORDINATION PROGRAM, M ERCY HOME CARE, AREA PUBLIC HEALTH DEPARTMENTS, NORTH IOWA COMMUNITY ACTION ORGANIZATION, AND NORTH IOWA AREA COMMUNITY COLLEGE TRANSPORTATION TO HEALTH APPOINTMENTS ALTHOUGH MERCY NI WILL NOT TAKE ADDITIONAL STEPS TO ADDRESS TRANSPORTATION TO HEALTH APPOINTMENTS, MERCY NI SUPPORTS AND CONTRIBUTES FINANCIALLY TO OUR COMMUNITY PARTNER, THE SALVATION ARMY THE SALVATION ARMY PROVIDES LEADERSHIP AND OVERSIGHT IN PARTNERSHIP WITH OTHER LOCAL COMMUNIT Y AGENCIES WITHIN CERRO GORDO COUNTY MERCY NI, THE CITY OF MASON CITY, REGION II TRANSIT, AND THE NORTH IOWA AREA COUNCIL OF GOVERNMENTS COLLABORATIVELY ADDRESS THIS SOCIAL DETERM INATE OF HEALTH THAT AFFECTS MANY CITIZENS ACROSS OUR LOCAL AND 14-COUNTY REGION LACK OF MEDICAL PROVIDERS ALTHOUGH MERCY NI WILL NOT TAKE ADDITIONAL STEPS TO ADDRESS THE LACK OF MEDICAL PROVIDERS, MERCY NI HAS RECRUITMENT INITIATIVES IN PLACE TO RECRUIT AND RETAIN MED ICAL PROVIDERS WITHIN THE COMMUNITY, OF WHICH IT WILL SUSTAIN WHILE FOCUSING ON PROVIDER S ATISFACTION



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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-SIOUX CITY	<p>PART V, SECTION B, LINE 11 AFTER REVIEWING ALL INFORMATION AND DATA AVAILABLE FOR THE 2016 CHNA, THE FOLLOWING SEVEN NEEDS WERE IDENTIFIED FOR THE SIOUXLAND AREA</p> <p>TOBACCO/SUBSTANCE ABUSE, OBESITY, TEEN BIRTHS, ACCESS TO CARE, MENTAL ILLNESS, CANCER SCREENINGS, AND HOUSING BOTH MERCY SC AND DUNES TOGETHER HAVE ADDRESSED THESE NEEDS WITHIN THE PAST YEAR FOR YEARS, SEVERAL AGENCIES HAVE BEEN WORKING ON TOBACCO AND SUBSTANCE ABUSE SIOUXLAND CARES HAS FOCUSED ON YOUTH PREVENTION FOR NEARLY 25 YEARS, AND HAS POSITIVELY IMPACTED THE SUBSTANCE ABUSE NUMBERS LOCALLY IN COLLABORATION WITH SIOUXLAND CARES, WE HAVE PROVIDED SEVERAL MEDIA CAMPAIGNS ABOUT DRINKING AND DRIVING MERCY SC ALSO COLLABORATED WITH THE SIOUXLAND DISTRICT HEALTH DEPARTMENT (SDHD) AND WORKED TO PROMOTE QUITLINE IOWA, 2A'S AND R (ASK, ADVICE, REFER) TRAINING FOR CLINIC STAFF, AND TO PROMOTE SMOKE FREE MULTI-UNIT HOUSING COMPLEXES, EVENTS, WORKSITES, AND PARKS MERCY SC IS PARTNERING WITH THE SIOUXLAND TOBACCO COALITION, THROUGH THE PARTICIPATION OF THREE MERCY SC BOARD MEMBERS, AND IN PROGRAMS TO CURB TOBACCO USE INCLUDING LOCALLY PRODUCED TV PUBLIC SERVICE ANNOUNCEMENTS SDHD, MERCY SC, AND DUNES HAVE COLLABORATED TO OFFER THE FOLLOWING PROGRAMS IN FISCAL YEAR 2017 TOBACCO/SUBSTANCE ABUSE SIOUXLAND COMMUNITY HEALTH AND JACKSON RECOVERY PARTICIPATED IN A TRAINING PROVIDED BY MERCY SC, THROUGH THE SOCIETY OF PUBLIC HEALTH EDUCATORS, FOR SMOKING CESSATION &amp; REDUCTION IN PREGNANCY TREATMENT (SCRIPT) SCRIPT IS AN AWARD-WINNING, EVIDENCE-BASED PROGRAM SHOWN TO BE EFFECTIVE IN HELPING THOUSANDS OF PREGNANT WOMEN QUIT SMOKING IT'S DESIGNED TO BE A COMPONENT OF A PATIENT EDUCATION PROGRAM FOR PRENATAL CARE PROVIDERS, AND IS CITED BY THE AGENCY FOR HEALTHCARE RESEARCH &amp; QUALITY'S SMOKING CESSATION CLINICAL PRACTICE GUIDELINES CATCH MY BREATH IS A YOUTH E-CIGARETTE PREVENTION PROGRAM, WHOSE GOAL IS TO INCREASE STUDENTS' KNOWLEDGE OF E-CIGARETTES, NICOTINE AND ADDICTION DANGERS THE AIM IS TO INFORM AND EDUCATE TEACHERS, PARENTS, AND HEALTH PROFESSIONALS IN THE SCHOOL/AFTER-SCHOOL SETTING TO EQUIP STUDENTS WITH ANSWERS ABOUT E-CIGARETTES TO MAKE INFORMED DECISIONS CURRICULUM LICENSES WERE PURCHASED AND PROVIDED TO 3 MIDDLE SCHOOLS AND 12 ELEMENTARY SCHOOLS IN SIOUX CITY THE PROGRAM TARGETED TO 11-14 YEAR OLDS DURING FISCAL YEAR 2017, THE CURRICULUM WAS AVAILABLE TO ALL MIDDLE AND ELEMENTARY SCHOOLS TWENTY LANDLORDS WERE TRAINED FOR SMOKE FREE HOUSING REGARDING CLEAN INDOOR AIR AND ADDED A LEASE ADDENDUM PROHIBITING SMOKING IN THE HOUSING THEY PROVIDE THESE LANDLORDS ATTENDED A FOUR HOUR SEMINAR ABOUT TOBACCO AND NICOTINE FREE HOUSING, LEASING, FINDING A GOOD TENANT, APPLICANTS/APPLICATION PROCESS, AND BACKGROUND CHECKS EACH LANDLORD THAT ATTENDED RECEIVED A COPY OF "AN APARTMENT MANAGER'S GUIDE", A SAMPLE LEASE ADDENDUM, QUITLINE IOWA PRODUCTS THAT PROMOTE THE PROGRAM, AND INFORMATION ABOUT CESSATION PROGRAMS IN SIOUX CITY ALL THE INFORMATION THAT WAS PROVIDED AT THE SEMINAR WAS GIVEN</p>

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-SIOUX CITY	<p>N TO THE SIOUXLAND RENTAL ASSOCIATION LEADERSHIP TO BE PROVIDED TO INTERESTED MEMBERS OBE SITY FROM 2012 THROUGH 2017, MUCH WORK HAS BEGUN IN THE AREA OF OBESITY PREVENTION SEVERA L WORKSITES HAVE IMPLEMENTED WELLNESS POLICIES AND A VARIETY OF PROGRAMMING FOR THEIR EMPL OYEES BLUEZONES PROVIDED TECHNICAL ASSISTANCE IN AIDING SIOUX CITY TO BECOME A CERTIFIED BLUEZONE COMMUNITY WITH CHANGES TO RESTAURANTS, SCHOOLS, WORKPLACES AND THE COMMUNITY SDH D HAS PROVIDED TECHNICAL ASSISTANCE TO SEVERAL WORKSITES, CHILD- CARE CENTERS, SCHOOLS, CLI NICS AND COMMUNITIES ON IMPLEMENTING POLICY, SYSTEM, AND ENVIRONMENTAL CHANGES TO IMPROVE THE HEALTH OF SIOUXLAND RESIDENTS SEVERAL OTHER ENTITIES IN THE COMMUNITY, INCLUDING BOTH HOSPITALS, HAVE ALSO IMPLEMENTED A VARIETY OF PROGRAMS, INCLUDING BUT NOT LIMITED TO COMM UNITY GARDENS, COMPLETE STREET RESOLUTIONS, WALKING SCHOOL BUSES, AND FARM TO SCHOOL PROGR AMS IN AN EFFORT TO CURB THE PREVALENCE OF OBESITY, MERCY SC EXECUTED KIDSHAPE, AN 8-WEEK PROGRAM, WHICH INVOLVED LIFESTYLE MODIFICATION FOR BOTH CHILDREN AND FAMILIES, WAS OFFERE D IN TWO MAJOR ELEMENTARY SCHOOLS, WITH ASSISTANCE IN DIET EDUCATION, EXERCISE AND RECIPE DEVELOPMENT WE HAVE ALSO BEEN COLLABORATING WITH THE SIOUXLAND Y FOR "HEALTHY WEIGHT &amp; YO UR CHILD", A FAMILY FOCUSED PROGRAM THAT HELPS KIDS AGES 7-13 YEARS OLD REACH A HEALTHY WE IGH T AND LIVE A HEALTHIER LIFESTYLE ACCESS TO CARE THROUGHOUT THE YEAR, SIOUXLAND COMMUNI TY HEALTH CENTER STAFFED CERTIFIED APPLICATION COUNSELORS TO ASSIST PATIENTS AT THE HEALTH CENTER AS WELL AS LOCATIONS AROUND THE SIOUXLAND COMMUNITY TO ANSWER QUESTIONS REGARDING THE AFFORDABLE CARE ACT AND ALSO ASSIST CONSUMERS WITH THE ENROLLMENT PROCESS' COMMUNITY C LINICS' RECRUITMENT OF ADVANCED PRACTICE PROVIDERS SUPPLEMENT NEEDS FOR PRIMARY CARE PHYSI CIANS AND SPECIALISTS IN THE SERVICE AREA MERCY SC IS LOCATED IN A MEDICALLY UNDERSERVED AREA WHICH ENABLES THE HOSPITAL TO RECRUIT PHYSICIANS WITH J1 WAIVERS COMMUNITY HOSPITALS SUPPORT/SUBSIDIZE THE SIOUXLAND MEDICAL EDUCATION FOUNDATION RESIDENCY PROGRAM FOR FAMILY PRACTICE PHYSICIANS MANY OF THESE PHYSICIANS STAY IN THE LOCAL COMMUNITIES UPON GRADUATI ON COMMUNITY URGENT CARE CLINICS AND SIOUXLAND COMMUNITY HEALTH CENTER HAVE EXTENDED HOUR S TO ACCOMMODATE NEEDS OF THE PATIENTS' SCHEDULES IN ADDITION, MERCY SC HAS LED EFFORTS T O ENROLL PEOPLE IN THE INSURANCE EXCHANGE, AS WELL AS PARTNERING WITH SOCIAL SERVICES AGEN CIES AND OTHER NON-PROFIT ORGANIZATIONS TO PROVIDE COMMUNITY MEMBERS WITH EASY ACCESS TO V IABLE INSURANCE OPTIONS HOUSING MERCY SC AND DUNES COLLABORATED WITH THE SIOUXLAND STREET PROJECT TO ADDRESS HOMELESSNESS IN THE SIOUXLAND AREA FROM THIS LARGE GROUP, SUB-COMMITT EES WERE FORMED THAT SEEK TO CONCENTRATE IN A SPECIFIC AREA OF FOCUS TO ADDRESS THE FACETS THAT ARISE FROM CHRONIC HOMELESSNESS DETOXIFICATION/MENTAL ILLNESS, SHELTER, ORGANIZATIO N REPORTING AND RETOOLING, SCREENING AND INTAKE, RESEARCH, EDUCATION AND COMMUNITY AWARENE SS THE CONSENSUS IS THAT THE</p>

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-SIOUX CITY	<p>WARMING SHELTER, WHICH OPERATES NIGHTS ONLY, IS NOT SUFFICIENT DURING WINTER TO MEET THE G ROWING DEMANDS OF THE HOMELESS A SHELTER THAT OPERATES 24/7, 365 DAYS A YEAR IS IN NEED THIS REQUIRES COLLABORATION AND FUNDING FROM ALL AGENCIES INVOLVED FROM THESE MEETINGS A ONE-MONTH TRIAL RUN WAS FUNDED BY MERCY SC FOR A DAY SHELTER THAT HAS PROVEN TO MEET A DIR E NEED THE WARMING SHELTER WILL BE OPERATIVE DAY AND NIGHT DURING THE WINTER MONTHS TRAN SPORTATION WILL BE PROVIDED BY A COMMUNITY PARTNER TO AND FROM THE WARMING SHELTER TO THE SOUP KITCHEN MERCY SC AND DUNES COORDINATED A PRESENTATION OF DR WITHERS FROM PITTSBURGH MERCY TO PRESENT STREET MEDICINE, WHICH RESULTED IN A GROUP OF COMMUNITY PARTNERS TO CHAM PION THE STREET MEDICINE PROJECT, LED BY SUNNYBROOK CHURCH MERCY SC HAS SUPPORTED THIS EF FORT IN BRINGING ACCESS TO CARE FOR THE HOMELESS AT FOUR LOCATIONS OVER 50 COMMUNITY PART NERS MEET TO CONTINUE THE WORK FOR THE PLANNING OF THE SIOUXLAND STREET PROJECT THE OVERA RCHING STRATEGIC FOCUS OF THE SESSIONS IS TO BRING A SUPER SHELTER THAT CAN ADDRESS ALL TH E NEEDS OF THE HOMELESS POPULATION IN ONE CENTRALIZED LOCATION MENTAL ILLNESS THROUGHOUT THE YEAR, COLLABORATION HAS OCCURRED TO IMPROVE THE MENTAL ILLNESS THAT IS PREVALENT IN TH E SIOUXLAND AREA SIOUXLAND MENTAL HEALTH HAS BEGUN BOTH THE PEDIATRIC AND ADULT INTEGRATE D HOME HEALTH PROGRAM FOR INDIVIDUALS WITH MENTAL HEALTH DIAGNOSIS MERCY SC, ALONG WITH S T LUKE'S REGIONAL MEDICAL CENTER, SIOUXLAND COMMUNITY HEALTH CENTER AND SIOUXLAND MENTAL HEALTH, HAVE DEVELOPED A MENTAL HEALTH CARE COORDINATOR POSITION TO WORK WITH INDIVIDUALS WITH A MENTAL HEALTH CONDITION UPON DISCHARGE FROM EITHER HOSPITAL'S ER CANCER SCREENING MERCY SC PROVIDED PERSONNEL, FINANCIAL, AND PROGRAM DEVELOPMENT SUPPORT TO THE SDHD, WHO O FFER TWO PROGRAMS THAT PROMOTE CANCER SCREENINGS THE CARE FOR YOURSELF PROGRAM OFFERS MAM MOGRAMS SDHD STAFF PROVIDE ENROLLMENT AND CASE MANAGEMENT SERVICES FOR WOMEN IN EIGHT SUR ROUNDING COUNTIES MERCY SC HAS A PHYSICIAN REFERRAL SYSTEM IN PLACE TO LINK PATIENTS TO T HIS PROGRAM TEEN BIRTHS WAS IDENTIFIED AS A NEED IN THE COLLABORATIVE CHNA PROCESS WITH S IOUXLAND DISTRICT HEALTH DEPARTMENT AND UNITY POINT-ST LUKES HOSPITAL AS UNITY POINT ACC OUNTS FOR THE MAJORITY OF THE BIRTHS IN THE SIOUXLAND AREA, THEY AGREED TO ADDRESS THE NEE D FOR THIS REASON, MERCY SC AND DUNES WILL NOT SPECIFICALLY ADDRESS TEEN BIRTHS</p>

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-DUBUQUE	<p>PART V, SECTION B, LINE 11 THE SIGNIFICANT NEED TO BE ADDRESSED IS OBESITY OBESITY IS CH ARACTERISTIC OF 29% OF DUBUQUE COUNTY ADULTS THE GOAL IS REDUCE OBESITY AMONG DUBUQUE COU NTY ADULTS TO 27% BY JUNE 30, 2018 MERCY DUB WAS INVOLVED IN THE FOLLOWING PROJECTS FOR TA X YEAR 2016, TO HELP REDUCE OBESITY IN OUR COMMUNITY MERCY DUB IS A MEMBER OF DUBUQUE COUN TY WELLNESS COALITION AND A PARTNER OF DUBUQUE EATS WELL WITH THIS, MERCY DUB IS CONNECTE D WITH THE IOWA STATE UNIVERSITY DESIGN LAB TO ADDRESS COMMUNITY NEED PROJECTS DOUBLE-UP BUCKS PROMOTION - DOUBLES THE VALUE OF THE FEDERAL SUPPLEMENTAL NUTRITION ASSISTANCE PROGR AM (SNAP) FOR EVERY "BUCK" SPENT, A MATCHED DOLLAR IS GIVEN TO BE EXCLUSIVELY SPENT ON FR UITS AND VEGETABLES AT THE FARMERS MARKET SINSINAWA COLLABORATIVE FARM - SERVES THE NEEDS OF BEGINNING FARMERS WITH ACCESS TO LAND, ESPECIALLY TO UNDER-SERVED POPULATIONS, TO GROW FRESH FOODS AND VEGETABLES FARM TO INSTITUTIONS NETWORK AND PROCUREMENT - LONG TERM STRAT EGIC PLAN FOR INCREASING THE SUPPLY AND DEMAND OF FRESH FRUITS AND VEGETABLES AT INSTITUTI ONS MERCY DUB PARTNERED WITH DUBUQUE WELLNESS COALITION AND DUBUQUE COMMUNITY SCHOOL DIST RICT TO SPONSOR AN EVENT, "DUBUQUE ON THE MOVE," TO CONNECT COMMUNITY MEMBERS WITH HEALTH AND WELLNESS PROFESSIONALS DURING A WALKING EVENT IN EFFORTS FOR WEIGHT REDUCTION, MERCY DUB OFFERS THE FOLLOWING COMMUNITY CLASSES "12 WEEK WEIGHT LOSS PROGRAM AND "JUST FOR YOU WEIGHT LOSS PROGRAM" GRANT MONEY IS AVAILABLE FOR COMMUNITY MEMBERS THROUGH MERCY DUB'S COMMUNITY BENEFIT MINISTRY PROGRAM FOR THOSE WHO CANNOT AFFORD THE PROGRAM MERCY DUB ACKNO WLEDGES THE WIDE RANGE OF PRIORITY HEALTH ISSUES THAT EMERGED FROM THE CHNA PROCESS AND DE TERMINED THAT IT COULD EFFECTIVELY FOCUS ON ONLY THOSE HEALTH NEEDS WHICH IT DEEMED MOST P RESSING, UNDER-ADDRESSED, AND WITHIN ITS ABILITY TO INFLUENCE MERCY DUB IS NOT PLANNING T O TAKE ACTION AT THIS TIME ON THE FOLLOWING HEALTH NEEDS REDUCING ALCOHOL AND SUBSTANCE AB USE - NOT INCLUDED FOR ACTION IN MERCY DUB'S IMPLEMENTATION STRATEGY BECAUSE OF OTHER ORGA NIZATIONS THAT ARE ALREADY HAVING SOME SUCCESS IN THIS AREA, ESPECIALLY THE SUBSTANCE ABUS E COALITION DIABETES SCREENING AND MANAGEMENT - NOT INCLUDED FOR ACTION IN MERCY DUB'S IMP LEMENTATION STRATEGY BECAUSE OF LIMITED RESOURCES, EXISTING PROGRAMS IN THE COMMUNITY, AND COMPETING PRIORITIES NONCOMPLIANCE WITH BLOOD PRESSURE MEDICATIONS - NOT INCLUDED FOR ACT ION IN MERCY DUB'S IMPLEMENTATION STRATEGY BECAUSE THIS WAS FELT TO BE AN EFFORT BEST HAND LED BY THE MEDICAL COMMUNITY (I E , INDIVIDUAL PHYSICIANS) PROSTATE CANCER SCREENING - NOT INCLUDED FOR ACTION IN MERCY DUB'S IMPLEMENTATION STRATEGY BECAUSE OF LIMITED RESOURCES A ND COMPETING PRIORITIES INSUFFICIENT ACCESS TO MENTAL HEALTH PROVIDERS - NOT INCLUDED FOR ACTION IN MERCY DUB'S IMPLEMENTATION STRATEGY BECAUSE OF INSUFFICIENT REIMBURSEMENT FROM I NSURANCE AND PUBLIC FUNDING PROGRAMS, AND PROVEN DIFFICULTY IN RECRUITING SUCH PROFESSIONA LS, AT LEAST PARTIALLY BECAUSE</p>

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-DUBUQUE	OF THAT LACK OF REIMBURSEMENT MORE BILINGUAL HEALTH CARE PROVIDERS - NOT INCLUDED FOR ACTION IN MERCY DUB'S IMPLEMENTATION STRATEGY BECAUSE OF THE LOW FEASIBILITY OF SUCCESS IN AT TRACTING SUCH PROVIDERS TO THIS COMMUNITY

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

Form and Line Reference	Explanation
DUNES SURGICAL HOSPITAL	<p>PART V, SECTION B, LINE 11 AFTER REVIEWING ALL INFORMATION AND DATA AVAILABLE FOR THE 2016 CHNA, THE FOLLOWING SEVEN NEEDS WERE IDENTIFIED FOR THE SIOUXLAND AREA TOBACCO/SUBSTANCE ABUSE, OBESITY, TEEN BIRTHS, ACCESS TO CARE, MENTAL ILLNESS, CANCER SCREENINGS, AND HOUSING BOTH MERCY SC AND DUNES TOGETHER HAVE ADDRESSED THESE NEEDS WITHIN THE PAST YEAR FOR YEARS, SEVERAL AGENCIES HAVE BEEN WORKING ON TOBACCO AND SUBSTANCE ABUSE SIOUXLAND CARES HAS FOCUSED ON YOUTH PREVENTION FOR NEARLY 25 YEARS, AND HAS POSITIVELY IMPACTED THE SUBSTANCE ABUSE NUMBERS LOCALLY IN COLLABORATION WITH SIOUXLAND CARES, WE HAVE PROVIDED SEVERAL MEDIA CAMPAIGNS ABOUT DRINKING AND DRIVING MERCY SC ALSO COLLABORATED WITH THE SIOUXLAND DISTRICT HEALTH DEPARTMENT (SDHD) AND WORKED TO PROMOTE QUITLINE IOWA, 2A'S AND R (ASK, ADVICE, REFER) TRAINING FOR CLINIC STAFF, AND TO PROMOTE SMOKE FREE MULTI-UNIT HOUSING COMPLEXES, EVENTS, WORKSITES, AND PARKS MERCY SC IS PARTNERING WITH THE SIOUXLAND TOBACCO COALITION, THROUGH THE PARTICIPATION OF THREE MERCY SC BOARD MEMBERS, AND IN PROGRAMS TO CURB TOBACCO USE INCLUDING LOCALLY PRODUCED TV PUBLIC SERVICE ANNOUNCEMENTS SDHD, MERCY SC, AND DUNES HAVE COLLABORATED TO OFFER THE FOLLOWING PROGRAMS IN FISCAL YEAR 2017 TOBACCO/SUBSTANCE ABUSE SIOUXLAND COMMUNITY HEALTH AND JACKSON RECOVERY PARTICIPATED IN A TRAINING PROVIDED BY MERCY SC, THROUGH THE SOCIETY OF PUBLIC HEALTH EDUCATORS, FOR SMOKING CESSATION &amp; REDUCTION IN PREGNANCY TREATMENT (SCRIPT) SCRIPT IS AN AWARD-WINNING, EVIDENCE-BASED PROGRAM SHOWN TO BE EFFECTIVE IN HELPING THOUSANDS OF PREGNANT WOMEN QUIT SMOKING IT'S DESIGNED TO BE A COMPONENT OF A PATIENT EDUCATION PROGRAM FOR PRENATAL CARE PROVIDERS, AND IS CITED BY THE AGENCY FOR HEALTH CARE RESEARCH &amp; QUALITY'S SMOKING CESSATION CLINICAL PRACTICE GUIDELINES HEALTH CARE IS A YOUTH E-CIGARETTE PREVENTION PROGRAM, WHOSE GOAL IS TO INCREASE STUDENTS' KNOWLEDGE OF E-CIGARETTES, NICOTINE AND ADDICTION DANGERS THE AIMS TO INFORM AND EDUCATE TEACHERS, PARENTS, AND HEALTH PROFESSIONALS IN THE SCHOOL/AFTER-SCHOOL SETTING TO EQUIP STUDENTS WITH ANSWERS ABOUT E-CIGARETTES TO MAKE INFORMED DECISIONS CURRICULUM LICENSES WERE PURCHASED AND PROVIDED TO 3 MIDDLE SCHOOLS AND 12 ELEMENTARY SCHOOLS IN SIOUX CITY THE PROGRAM TARGETED TO 11-14 YEAR OLDS DURING FISCAL YEAR 2017, THE CURRICULUM WAS AVAILABLE TO ALL MIDDLE AND ELEMENTARY SCHOOLS TWENTY LANDLORDS WERE TRAINED FOR SMOKE FREE HOUSING REGARDING CLEAN INDOOR AIR AND ADDED A LEASE ADDENDUM PROHIBITING SMOKING IN THE HOUSING THEY PROVIDE THESE LANDLORDS ATTENDED A FOUR HOUR SEMINAR ABOUT TOBACCO AND NICOTINE FREE HOUSING, LEASING, FINDING A GOOD TENANT, APPLICANTS/APPLICATION PROCESS, AND BACKGROUND CHECKS EACH LANDLORD THAT ATTENDED RECEIVED A COPY OF "AN APARTMENT MANAGER'S GUIDE", A SAMPLE LEASE ADDENDUM, QUITLINE IOWA PRODUCTS THAT PROMOTE THE PROGRAM, AND INFORMATION ABOUT CESSATION PROGRAMS IN SIOUX CITY ALL THE INFORMATION THAT WAS PROVIDED AT THE SEMINAR WAS GIV</p>

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

Form and Line Reference	Explanation
DUNES SURGICAL HOSPITAL	<p>EN TO THE SIOUXLAND RENTAL ASSOCIATION LEADERSHIP TO BE PROVIDED TO INTERESTED MEMBERS OB ESITY FROM 2012 THROUGH 2017, MUCH WORK HAS BEGUN IN THE AREA OF OBESITY PREVENTION SEVER AL WORKSITES HAVE IMPLEMENTED WELLNESS POLICIES AND A VARIETY OF PROGRAMMING FOR THEIR EMP LOYEEES BLUEZONES PROVIDED TECHNICAL ASSISTANCE IN AIDING SIOUX CITY TO BECOME A CERTIFIED BLUEZONE COMMUNITY WITH CHANGES TO RESTAURANTS, SCHOOLS, WORKPLACES AND THE COMMUNITY SD HD HAS PROVIDED TECHNICAL ASSISTANCE TO SEVERAL WORKSITES, CHILD-CARE CENTERS, SCHOOLS, CL INICS AND COMMUNITIES ON IMPLEMENTING POLICY, SYSTEM, AND ENVIRONMENTAL CHANGES TO IMPROVE THE HEALTH OF SIOUXLAND RESIDENTS SEVERAL OTHER ENTITIES IN THE COMMUNITY, INCLUDING BOT H HOSPITALS, HAVE ALSO IMPLEMENTED A VARIETY OF PROGRAMS, INCLUDING BUT NOT LIMITED TO COM MUNITY GARDENS, COMPLETE STREET RESOLUTIONS, WALKING SCHOOL BUSES, AND FARM TO SCHOOL PROG RAMS IN AN EFFORT TO CURB THE PREVALENCE OF OBESITY, MERCY SC EXECUTED KIDSHAPE, AN 8-WEE K PROGRAM, WHICH INVOLVED LIFESTYLE MODIFICATION FOR BOTH CHILDREN AND FAMILIES, WAS OFFER ED IN TWO MAJOR ELEMENTARY SCHOOLS, WITH ASSISTANCE IN DIET EDUCATION, EXERCISE AND RECIPE DEVELOPMENT WE HAVE ALSO BEEN COLLABORATING WITH THE SIOUXLAND Y FOR "HEALTHY WEIGHT &amp; Y OUR CHILD", A FAMILY FOCUSED PROGRAM THAT HELPS KIDS AGES 7-13 YEARS OLD REACH A HEALTHY W EIGHT AND LIVE A HEALTHIER LIFESTYLE ACCESS TO CARE THROUGHOUT THE YEAR, SIOUXLAND COMMUN ITY HEALTH CENTER STAFFED CERTIFIED APPLICATION COUNSELORS TO ASSIST PATIENTS AT THE HEALT H CENTER AS WELL AS LOCATIONS AROUND THE SIOUXLAND COMMUNITY TO ANSWER QUESTIONS REGARDING THE AFFORDABLE CARE ACT AND ALSO ASSIST CONSUMERS WITH THE ENROLLMENT PROCESS COMMUNITY CLINICS' RECRUITMENT OF ADVANCED PRACTICE PROVIDERS SUPPLEMENT NEEDS FOR PRIMARY CARE PHYS ICIANS AND SPECIALISTS IN THE SERVICE AREA MERCY SC IS LOCATED IN A MEDICALLY UNDERSERVED AREA WHICH ENABLES THE HOSPITAL TO RECRUIT PHYSICIANS WITH J1 WAIVERS COMMUNITY HOSPITAL S SUPPORT/SUBSIDIZE THE SIOUXLAND MEDICAL EDUCATION FOUNDATION RESIDENCY PROGRAM FOR FAMIL Y PRACTICE PHYSICIANS MANY OF THESE PHYSICIANS STAY IN THE LOCAL COMMUNITIES UPON GRADUAT ION COMMUNITY URGENT CARE CLINICS AND SIOUXLAND COMMUNITY HEALTH CENTER HAVE EXTENDED HOU RS TO ACCOMMODATE NEEDS OF THE PATIENTS' SCHEDULES IN ADDITION, MERCY SC HAS LED EFFORTS TO ENROLL PEOPLE IN THE INSURANCE EXCHANGE, AS WELL AS PARTNERING WITH SOCIAL SERVICES AGE NCIES AND OTHER NON-PROFIT ORGANIZATIONS TO PROVIDE COMMUNITY MEMBERS WITH EASY ACCESS TO VIABLE INSURANCE OPTIONS HOUSING MERCY SC AND DUNES COLLABORATED WITH THE SIOUXLAND STREE T PROJECT TO ADDRESS HOMELESSNESS IN THE SIOUXLAND AREA FROM THIS LARGE GROUP, SUB-COMMIT TEES WERE FORMED THAT SEEK TO CONCENTRATE IN A SPECIFIC AREA OF FOCUS TO ADDRESS THE FACET S THAT ARISE FROM CHRONIC HOMELESSNESS DETOXIFICATION/MENTAL ILLNESS, SHELTER, ORGANIZATI ON REPORTING AND RETOOLING, SCREENING AND INTAKE, RESEARCH, EDUCATION AND COMMUNITY AWAREN ESS THE CONSENSUS IS THAT THE</p>

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

Form and Line Reference	Explanation
DUNES SURGICAL HOSPITAL	<p>WARMING SHELTER, WHICH OPERATES NIGHTS ONLY, IS NOT SUFFICIENT DURING WINTER TO MEET THE GROWING DEMANDS OF THE HOMELESS A SHELTER THAT OPERATES 24/7, 365 DAYS A YEAR IS IN NEED THIS REQUIRES COLLABORATION AND FUNDING FROM ALL AGENCIES INVOLVED FROM THESE MEETINGS A ONE-MONTH TRIAL RUN WAS FUNDED BY MERCY SC FOR A DAY SHELTER THAT HAS PROVEN TO MEET A DI RE NEED THE WARMING SHELTER WILL BE OPERATIVE DAY AND NIGHT DURING THE WINTER MONTHS TRA NSPORTATION WILL BE PROVIDED BY A COMMUNITY PARTNER TO AND FROM THE WARMING SHELTER TO THE SOUP KITCHEN MERCY SC AND DUNES COORDINATED A PRESENTATION OF DR WITHERS FROM PITTSBURG H MERCY TO PRESENT STREET MEDICINE, WHICH RESULTED IN A GROUP OF COMMUNITY PARTNERS TO CHA MPION THE STREET MEDICINE PROJECT, LED BY SUNNYBROOK CHURCH MERCY SC HAS SUPPORTED THIS E FFORT IN BRINGING ACCESS TO CARE FOR THE HOMELESS AT FOUR LOCATIONS OVER 50 COMMUNITY PAR TNERS MEET TO CONTINUE THE WORK FOR THE PLANNING OF THE SIOUXLAND STREET PROJECT THE OVER ARCHING STRATEGIC FOCUS OF THE SESSIONS IS TO BRING A SUPER SHELTER THAT CAN ADDRESS ALL T HE NEEDS OF THE HOMELESS POPULATION IN ONE CENTRALIZED LOCATION MENTAL ILLNESS THROUGHOUT THE YEAR, COLLABORATION HAS OCCURRED TO IMPROVE THE MENTAL ILLNESS THAT IS PREVALENT IN T HE SIOUXLAND AREA SIOUXLAND MENTAL HEALTH HAS BEGUN BOTH THE PEDIATRIC AND ADULT INTEGRAT ED HOME HEALTH PROGRAM FOR INDIVIDUALS WITH MENTAL HEALTH DIAGNOSIS MERCY SC, ALONG WITH ST LUKE'S REGIONAL MEDICAL CENTER, SIOUXLAND COMMUNITY HEALTH CENTER AND SIOUXLAND MENTAL HEALTH, HAVE DEVELOPED A MENTAL HEALTH CARE COORDINATOR POSITION TO WORK WITH INDIVIDUALS WITH A MENTAL HEALTH CONDITION UPON DISCHARGE FROM EITHER HOSPITAL'S ER CANCER SCREENING MERCY SC PROVIDED PERSONNEL, FINANCIAL, AND PROGRAM DEVELOPMENT SUPPORT TO THE SDHD, WHO OFFER TWO PROGRAMS THAT PROMOTE CANCER SCREENINGS THE CARE FOR YOURSELF PROGRAM OFFERS MA MMOGRAMS SDHD STAFF PROVIDE ENROLLMENT AND CASE MANAGEMENT SERVICES FOR WOMEN IN EIGHT SU RROUNDING COUNTIES MERCY SC HAS A PHYSICIAN REFERRAL SYSTEM IN PLACE TO LINK PATIENTS TO THIS PROGRAM TEEN BIRTHS WAS IDENTIFIED AS A NEED IN THE COLLABORATIVE CHNA PROCESS WITH SIOUXLAND DISTRICT HEALTH DEPARTMENT AND UNITY POINT-ST LUKES HOSPITAL AS UNITY POINT AC COUNTS FOR THE MAJORITY OF THE BIRTHS IN THE SIOUXLAND AREA, THEY AGREED TO ADDRESS THE NE ED FOR THIS REASON, MERCY SC AND DUNES WILL NOT SPECIFICALLY ADDRESS TEEN BIRTHS</p>



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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-NEW HAMPTON	<p>PART V, SECTION B, LINE 11 MERCY NH RESOURCES AND OVERALL ALIGNMENT WITH THE HOSPITAL'S MISSION, GOALS AND STRATEGIC PRIORITIES WERE TAKEN INTO CONSIDERATION OF THE SIGNIFICANT HEALTH NEEDS IDENTIFIED THROUGH THE MOST RECENT CHNA PROCESS MERCY NH IS FOCUSING ON DEVELOPING AND/OR SUPPORTING INITIATIVES AND MEASURES THEIR EFFECTIVENESS, TO IMPROVE THE FOLLOWING HEALTH NEEDS PRIMARY CARE ACCESS PATIENTS HAVE HAD DIFFICULTY ACCESSING PRIMARY CARE IN THE SERVICE AREA PATIENTS SOMETIMES HAVE TO WAIT ONE WEEK TO SEE THEIR PRIMARY CARE PROVIDER DUE TO LACK OF OPEN APPOINTMENTS PATIENTS REPORT HAVING A DIFFICULT TIME GETTING TO THE CLINIC FOR APPOINTMENTS BETWEEN TRADITIONAL HOURS OF 8-5, AS A RESULT, CLINIC HOURS HAVE BEEN EXTENDED TO 7 00 P M TWO DAYS PER WEEK EIGHT SCHEDULE BLOCKS PER DAY FOR EACH PROVIDER ARE BEING RESERVED FOR SAME DAY APPOINTMENTS A HEALTH COACH IS CLOSELY MONITORING CHRONIC HEALTH PATIENTS TO ENSURE THEY ARE BEING SEEN BY THEIR PRIMARY CARE PHYSICIAN (PCP) A HEALTH NAVIGATOR IS MONITORING PATIENT VISITS AND WORKING WITH SCHEDULERS TO FIT IN ANNUAL EXAMS, RE-CHECKS AND PREVENTATIVE WELLNESS TESTING WITH THEIR PCP BEHAVIORAL HEALTH/CHEMICAL DEPENDENCY MERCY NH HAS BEEN BUILDING THE COMMUNITY'S CAPACITY TO ADDRESS MENTAL HEALTH ISSUES BY IMPROVING ACCESS TO AVAILABLE SERVICES AND HEALTH IMPROVEMENT OPTIONS/ OPPORTUNITIES BY USING NEW COMMUNICATION CHANNELS AND TECHNOLOGIES UNDER THE THEORY THAT MENTAL HEALTH ISSUES HAVE BEEN PUSHED TO THE COUNTY LEVEL WITH NO ADDED RESOURCES TO PROVIDE MUCH NEEDED SERVICES, MERCY NH IS IDENTIFYING KEY COUNTY STAKEHOLDERS TO FORM OR STRENGTHEN A COUNTY BEHAVIORAL COALITION MERCY NH WILL SUPPORT THIS COALITION IN DEVELOPING AND IMPLEMENTING PROGRAMS TO SUPPORT LOCAL MENTAL HEALTH ISSUES A RENOVATION PROJECT WAS RECENTLY STARTED FOR THE EMERGENCY DEPARTMENT, WHICH WILL INCLUDE A PSYCHIATRIC EXAM ROOM, TO KEEP OUR MENTAL HEALTH PATIENTS SAFE WHILE THEY ARE IN THE EMERGENCY DEPARTMENT MAINTAIN &amp; INCREASE SPECIALTY SERVICES THE COMMUNITY'S ACCESS TO SPECIALTY SERVICES DELIVERED LOCALLY HAS DECREASED OVER THE PAST COUPLE OF YEARS WITH AN INCREASE IN POPULATION OF THOSE OVER THE AGE OF 70 AND LIMITED RESOURCES FOR PUBLIC TRANSPORTATION OUTSIDE OF OUR COMMUNITY , IT IS IMPORTANT TO OFFER MORE SERVICES LOCALLY MERCY NH IS THE ONLY HOSPITAL IN OUR COUNTY, WHICH IS CLASSIFIED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION AS MEDICALLY UNDERSERVED MERCY NH'S GENERAL SURGEON IS VISITING WEEKLY NOW INSTEAD OF ONCE A MONTH A PAIN CLINIC HAS ALSO BEEN STARTED NEW EQUIPMENT HAS BEEN PURCHASED FOR THE SURGERY DEPARTMENT TO BE ABLE TO PERFORM MORE MINOR SAME-DAY SURGERY PROCEDURES LOCALLY AS WELL MERCY NH ACKNOWLEDGES THE WIDE RANGE OF PRIORITY HEALTH ISSUES THAT EMERGED FROM THE 2016 CHNA PROCESS, AND DETERMINED THAT IT COULD EFFECTIVELY FOCUS ON ONLY THOSE HEALTH NEEDS WHICH IT DEEMED MOST PRESSING, UNDER-ADDRESSED, AND WITHIN ITS ABILITY TO INFLUENCE MERCY NH WILL NOT TAKE ACTION ON THE FOLLOWING</p>

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-NEW HAMPTON	G HEALTH NEED AREA PHARMACY DEMAND EXCEEDS AVAILABILITY - MERCY NH HAS BEEN WORKING CLOSELY WITH THE NEW HAMPTON ECONOMIC DEVELOPMENT OFFICE ON RECRUITING ANOTHER PHARMACY TO THE AREA AND CONTINUES TO WORK CLOSELY WITH PHARMACIES IN NORTHEAST IOWA ABOUT THE OPPORTUNITIES AVAILABLE IN NEW HAMPTON. IN PARTICULAR, THE POTENTIAL OPPORTUNITY FOR TELE-PHARMACY AS IT IS BROUGHT TO IOWA IN 2017

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-DYERSVILLE	<p>PART V, SECTION B, LINE 11 THE SIGNIFICANT NEED TO BE ADDRESSED IS OBESITY OBESITY IS CH ARACTERISTIC OF 29% OF DUBUQUE COUNTY ADULTS THE GOAL IS REDUCE OBESITY AMONG DUBUQUE COU NTY ADULTS TO 27% BY JUNE 30, 2018 MERCY DYR WAS INVOLVED IN THE FOLLOWING PROJECTS FOR TA X YEAR 2016 TO HELP REDUCE OBESITY IN OUR COMMUNITY MERCY DYR IS A MEMBER OF DUBUQUE COUN TY WELLNESS COALITION AND A PARTNER OF DUBUQUE EATS WELL WITH THIS, MERCY DYR IS CONNECTE D WITH THE IOWA STATE UNIVERSITY DESIGN LAB TO ADDRESS COMMUNITY NEED PROJECTS DOUBLE-UP BUCKS PROMOTION - DOUBLES THE VALUE OF THE FEDERAL SUPPLEMENTAL NUTRITION ASSISTANCE PROGR AM (SNAP) FOR EVERY "BUCK" SPENT, A MATCHED DOLLAR IS GIVEN TO BE EXCLUSIVELY SPENT ON FR UITS AND VEGETABLES AT THE FARMERS MARKET SINSINAWA COLLABORATIVE FARM - SERVES THE NEEDS OF BEGINNING FARMERS WITH ACCESS TO LAND, ESPECIALLY TO UNDER-SERVED POPULATIONS, TO GROW FRESH FOODS AND VEGETABLES FARM TO INSTITUTIONS NETWORK AND PROCUREMENT - LONG TERM STRAT EGIC PLAN FOR INCREASING THE SUPPLY AND DEMAND OF FRESH FRUITS AND VEGETABLES AT INSTITUTI ONS MERCY DYR PARTNERED WITH DUBUQUE WELLNESS COALITION AND DUBUQUE COMMUNITY SCHOOL DIST RICT TO SPONSOR AN EVENT, "DUBUQUE ON THE MOVE," TO CONNECT COMMUNITY MEMBERS WITH HEALTH AND WELLNESS PROFESSIONALS DURING A WALKING EVENT IN EFFORTS FOR WEIGHT REDUCTION, MERCY DYR OFFERS THE FOLLOWING COMMUNITY CLASSES "12 WEEK WEIGHT LOSS PROGRAM AND "JUST FOR YOU WEIGHT LOSS PROGRAM" GRANT MONEY IS AVAILABLE FOR COMMUNITY MEMBERS THROUGH MERCY DYR'S COMMUNITY BENEFIT MINISTRY PROGRAM FOR THOSE WHO CANNOT AFFORD THE PROGRAM MERCY DYR ACKNO WLEDGES THE WIDE RANGE OF PRIORITY HEALTH ISSUES THAT EMERGED FROM THE CHNA PROCESS AND DE TERMINED THAT IT COULD EFFECTIVELY FOCUS ON ONLY THOSE HEALTH NEEDS WHICH IT DEEMED MOST P RESSING, UNDER-ADDRESSED, AND WITHIN ITS ABILITY TO INFLUENCE MERCY DYR IS NOT PLANNING T O TAKE ACTION AT THIS TIME ON THE FOLLOWING HEALTH NEEDS REDUCING ALCOHOL AND SUBSTANCE AB USE - NOT INCLUDED FOR ACTION IN MERCY DYR'S IMPLEMENTATION STRATEGY BECAUSE OF OTHER ORGA NIZATIONS THAT ARE ALREADY HAVING SOME SUCCESS IN THIS AREA, ESPECIALLY THE SUBSTANCE ABUS E COALITION DIABETES SCREENING AND MANAGEMENT - NOT INCLUDED FOR ACTION IN MERCY DYR'S IMP LEMENTATION STRATEGY BECAUSE OF LIMITED RESOURCES, EXISTING PROGRAMS IN THE COMMUNITY, AND COMPETING PRIORITIES NONCOMPLIANCE WITH BLOOD PRESSURE MEDICATIONS - NOT INCLUDED FOR ACT ION IN MERCY DYR'S IMPLEMENTATION STRATEGY BECAUSE THIS WAS FELT TO BE AN EFFORT BEST HAND LED BY THE MEDICAL COMMUNITY (I E , INDIVIDUAL PHYSICIANS) PROSTATE CANCER SCREENING - NOT INCLUDED FOR ACTION IN MERCY DYR'S IMPLEMENTATION STRATEGY BECAUSE OF LIMITED RESOURCES A ND COMPETING PRIORITIES INSUFFICIENT ACCESS TO MENTAL HEALTH PROVIDERS - NOT INCLUDED FOR ACTION IN MERCY DYR'S IMPLEMENTATION STRATEGY BECAUSE OF INSUFFICIENT REIMBURSEMENT FROM I NSURANCE AND PUBLIC FUNDING PROGRAMS, AND PROVEN DIFFICULTY IN RECRUITING SUCH PROFESSIONA LS, AT LEAST PARTIALLY BECAUSE</p>

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-DYERSVILLE	OF THAT LACK OF REIMBURSEMENT MORE BILINGUAL HEALTHCARE PROVIDERS - NOT INCLUDED FOR ACTI ON IN MERCY DYN'S IMPLEMENTATION STRATEGY BECAUSE OF THE LOW FEASIBILITY OF SUCCESS IN ATT RACTING SUCH PROVIDERS TO THIS COMMUNITY

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-NORTH IOWA	PART V, SECTION B, LINE 13H THE HOSPITAL RECOGNIZES THAT NOT ALL PATIENTS ARE ABLE TO PROVIDE COMPLETE FINANCIAL AND/OR SOCIAL INFORMATION THEREFORE, APPROVAL FOR FINANCIAL SUPPORT MAY BE DETERMINED BASED ON AVAILABLE INFORMATION EXAMPLES OF PRESUMPTIVE CASES INCLUDE DECEASED PATIENTS WITH NO KNOWN ESTATE, THE HOMELESS, UNEMPLOYED PATIENTS, NON-COVERED MEDICALLY NECESSARY SERVICES PROVIDED TO PATIENTS QUALIFYING FOR PUBLIC ASSISTANCE PROGRAMS, PATIENT BANKRUPTCIES, AND MEMBERS OF RELIGIOUS ORGANIZATIONS WHO HAVE TAKEN A VOW OF POVERTY AND HAVE NO RESOURCES INDIVIDUALLY OR THROUGH THE RELIGIOUS ORDER FOR THE PURPOSE OF HELPING FINANCIALLY NEEDY PATIENTS, A THIRD PARTY IS UTILIZED TO CONDUCT A REVIEW OF PATIENT INFORMATION TO ASSESS FINANCIAL NEED THIS REVIEW UTILIZES A HEALTH CARE INDUSTRY-RECOGNIZED, PREDICTIVE MODEL THAT IS BASED ON PUBLIC RECORD DATABASES THESE PUBLIC RECORDS ENABLE THE HOSPITAL TO ASSESS WHETHER THE PATIENT IS CHARACTERISTIC OF OTHER PATIENTS WHO HAVE HISTORICALLY QUALIFIED FOR FINANCIAL ASSISTANCE UNDER THE TRADITIONAL APPLICATION PROCESS IN CASES WHERE THERE IS AN ABSENCE OF INFORMATION PROVIDED DIRECTLY BY THE PATIENT, AND AFTER EFFORTS TO CONFIRM COVERAGE AVAILABILITY, THE PREDICTIVE MODEL PROVIDES A SYSTEMATIC METHOD TO GRANT PRESUMPTIVE ELIGIBILITY TO FINANCIALLY NEEDY 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 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-SIOUX CITY	PART V, SECTION B, LINE 13H THE HOSPITAL RECOGNIZES THAT NOT ALL PATIENTS ARE ABLE TO PROVIDE COMPLETE FINANCIAL AND/OR SOCIAL INFORMATION THEREFORE, APPROVAL FOR FINANCIAL SUPPORT MAY BE DETERMINED BASED ON AVAILABLE INFORMATION EXAMPLES OF PRESUMPTIVE CASES INCLUDE DECEASED PATIENTS WITH NO KNOWN ESTATE, THE HOMELESS, UNEMPLOYED PATIENTS, NON-COVERED MEDICALLY NECESSARY SERVICES PROVIDED TO PATIENTS QUALIFYING FOR PUBLIC ASSISTANCE PROGRAMS, PATIENT BANKRUPTCIES, AND MEMBERS OF RELIGIOUS ORGANIZATIONS WHO HAVE TAKEN A VOW OF POVERTY AND HAVE NO RESOURCES INDIVIDUALLY OR THROUGH THE RELIGIOUS ORDER FOR THE PURPOSE OF HELPING FINANCIALLY NEEDY PATIENTS, A THIRD PARTY IS UTILIZED TO CONDUCT A REVIEW OF PATIENT INFORMATION TO ASSESS FINANCIAL NEED THIS REVIEW UTILIZES A HEALTH CARE INDUSTRY-RECOGNIZED, PREDICTIVE MODEL THAT IS BASED ON PUBLIC RECORD DATABASES THESE PUBLIC RECORDS ENABLE THE HOSPITAL TO ASSESS WHETHER THE PATIENT IS CHARACTERISTIC OF OTHER PATIENTS WHO HAVE HISTORICALLY QUALIFIED FOR FINANCIAL ASSISTANCE UNDER THE TRADITIONAL APPLICATION PROCESS IN CASES WHERE THERE IS AN ABSENCE OF INFORMATION PROVIDED DIRECTLY BY THE PATIENT, AND AFTER EFFORTS TO CONFIRM COVERAGE AVAILABILITY, THE PREDICTIVE MODEL PROVIDES A SYSTEMATIC METHOD TO GRANT PRESUMPTIVE ELIGIBILITY TO FINANCIALLY NEEDY 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 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-DUBUQUE	PART V, SECTION B, LINE 13H THE HOSPITAL RECOGNIZES THAT NOT ALL PATIENTS ARE ABLE TO PROVIDE COMPLETE FINANCIAL AND/OR SOCIAL INFORMATION THEREFORE, APPROVAL FOR FINANCIAL SUPPORT MAY BE DETERMINED BASED ON AVAILABLE INFORMATION EXAMPLES OF PRESUMPTIVE CASES INCLUDE DECEASED PATIENTS WITH NO KNOWN ESTATE, THE HOMELESS, UNEMPLOYED PATIENTS, NON-COVERED MEDICALLY NECESSARY SERVICES PROVIDED TO PATIENTS QUALIFYING FOR PUBLIC ASSISTANCE PROGRAMS, PATIENT BANKRUPTCIES, AND MEMBERS OF RELIGIOUS ORGANIZATIONS WHO HAVE TAKEN A VOW OF POVERTY AND HAVE NO RESOURCES INDIVIDUALLY OR THROUGH THE RELIGIOUS ORDER FOR THE PURPOSE OF HELPING FINANCIALLY NEEDY PATIENTS, A THIRD PARTY IS UTILIZED TO CONDUCT A REVIEW OF PATIENT INFORMATION TO ASSESS FINANCIAL NEED THIS REVIEW UTILIZES A HEALTH CARE INDUSTRY-RECOGNIZED, PREDICTIVE MODEL THAT IS BASED ON PUBLIC RECORD DATABASES THESE PUBLIC RECORDS ENABLE THE HOSPITAL TO ASSESS WHETHER THE PATIENT IS CHARACTERISTIC OF OTHER PATIENTS WHO HAVE HISTORICALLY QUALIFIED FOR FINANCIAL ASSISTANCE UNDER THE TRADITIONAL APPLICATION PROCESS IN CASES WHERE THERE IS AN ABSENCE OF INFORMATION PROVIDED DIRECTLY BY THE PATIENT, AND AFTER EFFORTS TO CONFIRM COVERAGE AVAILABILITY, THE PREDICTIVE MODEL PROVIDES A SYSTEMATIC METHOD TO GRANT PRESUMPTIVE ELIGIBILITY TO FINANCIALLY NEEDY 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 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

Form and Line Reference	Explanation
DUNES SURGICAL HOSPITAL	PART V, SECTION B, LINE 13H THE HOSPITAL RECOGNIZES THAT NOT ALL PATIENTS ARE ABLE TO PROVIDE COMPLETE FINANCIAL AND/OR SOCIAL INFORMATION THEREFORE, APPROVAL FOR FINANCIAL SUPPORT MAY BE DETERMINED BASED ON AVAILABLE INFORMATION EXAMPLES OF PRESUMPTIVE CASES INCLUDE DECEASED PATIENTS WITH NO KNOWN ESTATE, THE HOMELESS, UNEMPLOYED PATIENTS, NON-COVERED MEDICALLY NECESSARY SERVICES PROVIDED TO PATIENTS QUALIFYING FOR PUBLIC ASSISTANCE PROGRAMS, PATIENT BANKRUPTCIES, AND MEMBERS OF RELIGIOUS ORGANIZATIONS WHO HAVE TAKEN A VOW OF POVERTY AND HAVE NO RESOURCES INDIVIDUALLY OR THROUGH THE RELIGIOUS ORDER FOR THE PURPOSE OF HELPING FINANCIALLY NEEDY PATIENTS, A THIRD PARTY IS UTILIZED TO CONDUCT A REVIEW OF PATIENT INFORMATION TO ASSESS FINANCIAL NEED THIS REVIEW UTILIZES A HEALTH CARE INDUSTRY-RECOGNIZED, PREDICTIVE MODEL THAT IS BASED ON PUBLIC RECORD DATABASES THESE PUBLIC RECORDS ENABLE THE HOSPITAL TO ASSESS WHETHER THE PATIENT IS CHARACTERISTIC OF OTHER PATIENTS WHO HAVE HISTORICALLY QUALIFIED FOR FINANCIAL ASSISTANCE UNDER THE TRADITIONAL APPLICATION PROCESS IN CASES WHERE THERE IS AN ABSENCE OF INFORMATION PROVIDED DIRECTLY BY THE PATIENT, AND AFTER EFFORTS TO CONFIRM COVERAGE AVAILABILITY, THE PREDICTIVE MODEL PROVIDES A SYSTEMATIC METHOD TO GRANT PRESUMPTIVE ELIGIBILITY TO FINANCIALLY NEEDY 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 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-NEW HAMPTON	PART V, SECTION B, LINE 13H THE HOSPITAL RECOGNIZES THAT NOT ALL PATIENTS ARE ABLE TO PROVIDE COMPLETE FINANCIAL AND/OR SOCIAL INFORMATION THEREFORE, APPROVAL FOR FINANCIAL SUPPORT MAY BE DETERMINED BASED ON AVAILABLE INFORMATION EXAMPLES OF PRESUMPTIVE CASES INCLUDE DECEASED PATIENTS WITH NO KNOWN ESTATE, THE HOMELESS, UNEMPLOYED PATIENTS, NON-COVERED MEDICALLY NECESSARY SERVICES PROVIDED TO PATIENTS QUALIFYING FOR PUBLIC ASSISTANCE PROGRAMS, PATIENT BANKRUPTCIES, AND MEMBERS OF RELIGIOUS ORGANIZATIONS WHO HAVE TAKEN A VOW OF POVERTY AND HAVE NO RESOURCES INDIVIDUALLY OR THROUGH THE RELIGIOUS ORDER FOR THE PURPOSE OF HELPING FINANCIALLY NEEDY PATIENTS, A THIRD PARTY IS UTILIZED TO CONDUCT A REVIEW OF PATIENT INFORMATION TO ASSESS FINANCIAL NEED THIS REVIEW UTILIZES A HEALTH CARE INDUSTRY-RECOGNIZED, PREDICTIVE MODEL THAT IS BASED ON PUBLIC RECORD DATABASES THESE PUBLIC RECORDS ENABLE THE HOSPITAL TO ASSESS WHETHER THE PATIENT IS CHARACTERISTIC OF OTHER PATIENTS WHO HAVE HISTORICALLY QUALIFIED FOR FINANCIAL ASSISTANCE UNDER THE TRADITIONAL APPLICATION PROCESS IN CASES WHERE THERE IS AN ABSENCE OF INFORMATION PROVIDED DIRECTLY BY THE PATIENT, AND AFTER EFFORTS TO CONFIRM COVERAGE AVAILABILITY, THE PREDICTIVE MODEL PROVIDES A SYSTEMATIC METHOD TO GRANT PRESUMPTIVE ELIGIBILITY TO FINANCIALLY NEEDY 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 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-DYERSVILLE	PART V, SECTION B, LINE 13H THE HOSPITAL RECOGNIZES THAT NOT ALL PATIENTS ARE ABLE TO PROVIDE COMPLETE FINANCIAL AND/OR SOCIAL INFORMATION THEREFORE, APPROVAL FOR FINANCIAL SUPPORT MAY BE DETERMINED BASED ON AVAILABLE INFORMATION EXAMPLES OF PRESUMPTIVE CASES INCLUDE DECEASED PATIENTS WITH NO KNOWN ESTATE, THE HOMELESS, UNEMPLOYED PATIENTS, NON-COVERED MEDICALLY NECESSARY SERVICES PROVIDED TO PATIENTS QUALIFYING FOR PUBLIC ASSISTANCE PROGRAMS, PATIENT BANKRUPTCIES, AND MEMBERS OF RELIGIOUS ORGANIZATIONS WHO HAVE TAKEN A VOW OF POVERTY AND HAVE NO RESOURCES INDIVIDUALLY OR THROUGH THE RELIGIOUS ORDER FOR THE PURPOSE OF HELPING FINANCIALLY NEEDY PATIENTS, A THIRD PARTY IS UTILIZED TO CONDUCT A REVIEW OF PATIENT INFORMATION TO ASSESS FINANCIAL NEED THIS REVIEW UTILIZES A HEALTH CARE INDUSTRY-RECOGNIZED, PREDICTIVE MODEL THAT IS BASED ON PUBLIC RECORD DATABASES THESE PUBLIC RECORDS ENABLE THE HOSPITAL TO ASSESS WHETHER THE PATIENT IS CHARACTERISTIC OF OTHER PATIENTS WHO HAVE HISTORICALLY QUALIFIED FOR FINANCIAL ASSISTANCE UNDER THE TRADITIONAL APPLICATION PROCESS IN CASES WHERE THERE IS AN ABSENCE OF INFORMATION PROVIDED DIRECTLY BY THE PATIENT, AND AFTER EFFORTS TO CONFIRM COVERAGE AVAILABILITY, THE PREDICTIVE MODEL PROVIDES A SYSTEMATIC METHOD TO GRANT PRESUMPTIVE ELIGIBILITY TO FINANCIALLY NEEDY PATIENTS

<b>Form 990 Part V Section C Supplemental Information for Part V, Section B.</b>	
<b>Section C. Supplemental Information for Part V, Section B.</b> Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.	
Form and Line Reference	Explanation
MERCY MEDICAL CENTER-SIOUX CITY	PART V, SECTION B, LINE 16J PLAIN LANGUAGE SUMMARIES OF THE FAP WERE SENT TO SIOUXLAND COMMUNITY HEALTH CENTER

<b>Form 990 Part V Section C Supplemental Information for Part V, Section B.</b>	
<b>Section C. Supplemental Information for Part V, Section B.</b> Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.	
Form and Line Reference	Explanation
MERCY MEDICAL CENTER-DUBUQUE	PART V, SECTION B, LINE 16J PLAIN LANGUAGE SUMMARIES OF THE FAP AND FINANCIAL ASSISTANCE BROCHURES WERE SENT TO CRESCENT COMMUNITY HEALTH CENTER

<b>Form 990 Part V Section C Supplemental Information for Part V, Section B.</b>	
<b>Section C. Supplemental Information for Part V, Section B.</b> Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.	
Form and Line Reference	Explanation
MERCY MEDICAL CENTER-DYERSVILLE	PART V, SECTION B, LINE 16J PLAIN LANGUAGE SUMMARIES OF THE FAP AND FINANCIAL ASSISTANCE BROCHURES WERE SENT TO CRESCENT COMMUNITY HEALTH 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 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-NORTH IOWA - PART V, SECTION B, LINE 7A	WWW MERCYNORTHIOWA COM/COMMUNITY-HEALTH-NEEDS-ASSESSMENT

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-NORTH IOWA - PART V, SECTION B, LINE 10A	WWW MERCYNORTHIOWA COM/COMMUNITY-HEALTH-NEEDS-ASSESSMENT

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-SIOUX CITY - PART V, SECTION B, LINE 7A	WWW MERCYSIOUXCITY COM/COMMUNITY-BENEFIT



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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-SIOUX CITY - PART V, SECTION B, LINE 10A	WWW MERCYSIOUXCITY COM/COMMUNITY-BENEFIT

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-DUBUQUE - PART V, SECTION B, LINE 7A	WWW MERCYDUBUQUE COM/COMMUNITY-BENEFIT

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-DUBUQUE - PART V, SECTION B, LINE 10A	WWW MERCYDUBUQUE COM/COMMUNITY-BENEFIT

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

Form and Line Reference	Explanation
DUNES SURGICAL HOSPITAL - PART V, SECTION B, LINE 7A	WWW DUNESSURGICALHOSPITAL COM/COMMUNITY-BENEFIT

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

Form and Line Reference	Explanation
DUNES SURGICAL HOSPITAL - PART V, SECTION B, LINE 10A	WWW DUNESSURGICALHOSPITAL COM/COMMUNITY-BENEFIT

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-NEW HAMPTON - PART V, SECTION B, LINE 7A	WWW MERCYNEWHAMPTON COM/COMMUNITY-HEALTH-NEEDS-ASSESSMENT

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-NEW HAMPTON - PART V, SECTION B, LINE 10A	WWW MERCYNEWHAMPTON COM/COMMUNITY-HEALTH-NEEDS-ASSESSMENT

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER- DYERSVILLE - PART V, SECTION B, LINE 7A	WWW MERCYDUBUQUE COM/DYERSVILLE-COMMUNITY-BENEFIT



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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-DYERSVILLE - PART V, SECTION B, LINE 10A	WWW MERCYDUBUQUE COM/DYERSVILLE-COMMUNITY-BENEFIT

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-NEW HAMPTON - PART V, SECTION B, LINE 9	AS PERMITTED IN THE FINAL SECTION 501(R) REGULATIONS, THE HOSPITAL'S IMPLEMENTATION STRATEGY WAS ADOPTED WITHIN 4 1/2 MONTHS AFTER THE FISCAL YEAR END THAT THE CHNA WAS COMPLETED AND MADE WIDELY AVAILABLE TO THE PUBLIC

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-NORTH IOWA - PART V, SECTION B, LINE 9	AS PERMITTED IN THE FINAL SECTION 501(R) REGULATIONS, THE HOSPITAL'S IMPLEMENTATION STRATEGY WAS ADOPTED WITHIN 4 1/2 MONTHS AFTER THE FISCAL YEAR END THAT THE CHNA WAS COMPLETED AND MADE WIDELY AVAILABLE TO THE PUBLIC

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

Form and Line Reference	Explanation
MERCY MEDICAL CENTER-SIOUX CITY - PART V, SECTION B, LINE 7B	WWW DUNESSURGICALHOSPITAL COM/COMMUNITY-BENEFITWWW SIOUXLANDDISTRICTHEALTH ORG/SERVICESCLINICS/HEALTH-PLANNING-/CHNAHIP HTMLWWW UNITYPOINT ORG/SIOUXCITY/ABOUT-COMMUNITY-BENEFIT ASPX

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

Form and Line Reference	Explanation
DUNES SURGICAL HOSPITAL - PART V, SECTION B, LINE 7B	WWW MERCYSIOUXCITY COM/COMMUNITY-BENEFITWWW SIOUXLANDDISTRICTHEALTH ORG/SERVICESCLINICS/HEALTH-PLANNING-/CHNAHIP HTMLWWW UNITYPOINT ORG/SIOUXCITY/ABOUT-COMMUNITY-BENEFIT ASPX

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)
1 - MEDICAL ASSOCIATES WEST CAMPUS 1500 ASSOCIATES DRIVE DUBUQUE, IA 52001	OCC HEALTH, PHYS THER, AMBULATORY SURGERY
2 - MEDICAL ASSOCIATES CLINIC 1240 BIG JACK ROAD PLATTEVILLE, WI 53818	X-RAY, LAB, EMPLOYED PHYSICIANS
3 - TRI-STATE OCCUPATIONAL HEALTH 1920 ELM STREET DUBUQUE, IA 52001	PHYS THERAPY,EMPLOYED PHYSICIANS
4 - MEDICAL ASSOCIATES CLINIC 10988 BARTELL BLVD GALENA, IL 61036	HOME CARE,LAB, EMPLOYED PHYSICIANS
5 - MERCY MEDICAL CENTER - DYERSVILLE 1121 THIRD STREET SW DYERSVILLE, IA 52040	CLINIC
6 - MEDICAL ASSOCIATES CLINIC 208 N 12TH STREET BELLEVUE, IA 52031	CLINIC
7 - MEDICAL ASSOCIATES CLINIC 911 NW CARTER ELKADER, IA 52043	CLINIC
8 - CASCADE FAMILY HEALTH CENTER 805 JOHNSON STREET SW CASCADE, IA 52033	EMPLOYED PHYSICIANS, LAB, X-RAY, PT
9 - MEDICAL ASSOCIATES CLINIC 117 SOUTH MADISON CUBA CITY, WI 53807	X-RAY, LAB, EMPLOYED PHYSICIANS
10 - MEDICAL ASSOCIATES CLINIC 560 PLEASANT ST ELIZABETH, IL 61028	CLINIC
11 - MEDICAL ASSOCIATES CLINIC 107 S PAGE MONONA, IA 52159	CLINIC
12 - MEDICAL ASSOCIATES EAST CAMPUS 1000 LANGWORTHY DUBUQUE, IA 52001	OCC HEALTH, PHYSICAL THERAPY
13 - DUNES MEDICAL LABORATORY 350 W ANCHOR DRIVE SUITE 20 DAKOTA DUNES, SD 57049	REFERENCE LABORATORY
14 - MASON CITY SURGERY CENTER 990 4TH STREET MASON CITY, IA 50401	AMBULATORY SURGERY
15 - MERCY FAMILY CLINIC - BUFFALO CENTER 115 NORTH MAIN BUFFALO CENTER, IA 50424	X-RAY, LAB, EMPLOYED PHYSICIANS

**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)
16 - TRI-STATE SURGERY CENTER 1500 ASSOCIATES DRIVE DUBUQUE, IA 52002	OUTPATIENT CLINIC, OPHTHALMOLOGY, ORTHOPEDICS

efile GRAPHIC print - DO NOT PROCESS

As Filed Data -

DLN: 93493135006218

Schedule I  
(Form 990)

OMB No 1545-0047

2016

Open to Public Inspection

Department of the Treasury  
Internal Revenue Service

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

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

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

Name of the organization  
MERCY HEALTH SERVICES - IOWA CORP

Employer identification number  
31-1373080

Part I

General Information on Grants and Assistance

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

☒ Yes ☐ No
- 2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States

Part II

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
See Additional Data Table							
(1)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table . . . . . 41

3 Enter total number of other organizations listed in the line 1 table . . . . . 5



**Part III** **Grants and Other Assistance to Domestic Individuals.** Complete if the organization answered "Yes" on Form 990, Part IV, line 22

Part III can be duplicated if additional space is needed

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
See Additional Data Table					
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					

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

Return Reference	Explanation
PART I, LINE 2	DONATIONS MADE BY MERCY HEALTH SERVICES - IOWA TO CHARITABLE ORGANIZATIONS ARE MADE IN FURTHERANCE OF THE RECIPIENT ORGANIZATION'S EXEMPT PURPOSE. DONATIONS ARE INCLUDED IN COMMUNITY BENEFITS IN SCHEDULE H IF THE CONTRIBUTION HAS BEEN FORMALLY RESTRICTED TO A COMMUNITY BENEFIT ACTIVITY THAT MEETS THE CRITERIA TO BE REPORTED ON SCHEDULE H.

Additional Data

Software ID:  
Software Version:  
EIN: 31-1373080  
Name: MERCY HEALTH SERVICES - IOWA CORP

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
WAHLERT CATHOLIC HIGH SCHOOL 2005 KANE ST DUBUQUE, IA 52001	42-0792429	RELIGIOUS SCHOOL	7,500				SUPPORT OF ATHLETIC TRAINER PROGRAM FOR THE HIGH SCHOOL
DUBUQUE COMMUNITY SCHOOLS 2500 CHANEY ROAD DUBUQUE, IA 52001	42-6001531	PUBLIC SCHOOL	15,000				SUPPORT OF ATHLETIC TRAINER PROGRAM FOR TWO HIGH SCHOOLS

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
ALMOST HOME GUEST HOUSE AT ST JOHN'S LUTHERAN CHURCH 1296 WHITE ST DUBUQUE, IA 52001	42-7421408	501(C)(3)	15,000				SUPPORT FOR ST JOHN'S LUTHERAN GUESTHOUSE FOR THE HOMELESS
CRESCENT COMMUNITY HEALTH CENTER 1789 ELM ST SUITE A DUBUQUE, IA 52001	48-1302204	501(C)(3)	12,377				SUPPORT FOR COMMUNITY GARDENING PROGRAM

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
PROJECT CONCERN 1789 ELM ST DUBUQUE, IA 52001	42-1298833	501(C)(3)	10,000				SUPPORT OF SHELTER PLUS CARE PROGRAM
ST STEPHEN'S FOODBANK 3145 CEDAR CREST RIDGE DUBUQUE, IA 52003	42-1222356	501(C)(3)	5,100				SUPPORT TO BRING IN FRESH FOOD FOR UNDERSERVED POPULATION

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
DUBUQUE MERCY HEALTH FOUNDATION 250 MERCY DRIVE DUBUQUE, IA 52001	26-2227941	501(C)(3)	429,901				FUNDING SUPPORT
DYERSVILLE HEALTH FOUNDATION INC 1111 3RD STREET SW DYERSVILLE, IA 52040	20-5383271	501(C)(3)	130,328				FUNDING SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CITY OF MASON CITY 10 1ST ST NW MASON CITY, IA 50401	42-6004948	501(C)(6)	25,000				COMMUNITY SUPPORT
NORTH IOWA AREA COMMUNITY COLLEGE FOUNDATION 500 COLLEGE DRIVE MASON CITY, IA 50401	23-7023677	501(C)(3)	6,500				COMMUNITY SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
NORTH IOWA COMMUNITY ACTION ORGANIZATION PO BOX 1627 MASON CITY, IA 50402	42-0921505	501(C)(3)	63,600				COMMUNITY SUPPORT
NORTH IOWA CORRIDOR ECONOMIC DEVELOPMENT 9 N FEDERAL MASON CITY, IA 50401	75-3190471	501(C)(6)	20,000				COMMUNITY SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
NORTHERN LIGHTS ALLIANCE FOR THE HOMELESS 307 N MONROE MASON CITY, IA 50401	42-1501295	501(C)(3)	61,141				COMMUNITY SUPPORT
SALVATION ARMY 747 VILLAGE GREEN DR MASON CITY, IA 50401	36-2167910	501(C)(3)	132,000				SUPPORT FOR ADULT DAY CARE TRANSPORTATION TO MEDICAL APPOINTMENTS



Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MENTAL HEALTH CENTER OF NORTH IOWA INC (DBA WELLSOURCE) 235 S EISENHOWER AVE MASON CITY, IA 50401	42-0763978	501(C)(3)	50,000				COMMUNITY SUPPORT
AMERICAN HEART ASSOCIATION PO BOX 4002902 DES MOINES, IA 50340	13-5613797	501(C)(3)	11,666				SPONSOR HW GALA GR2017

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
BRIAR CLIFF UNIVERSITY 3302 REBECCA ST SIOUX CITY, IA 51104	42-0707124	501(C)(3)	15,000				SUPPORT MERCY SIOUX CITY MINORITY NURSING SCHOLARSHIP
CATHOLIC CHARITIES OF THE DIOCESE OF SIOUX CITY 1601 MILITARY ROAD SIOUX CITY, IA 51103	42-0681062	501(C)(3)	22,000				FAMILY/CRISIS EMERGENCY FUNDING

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
HARD ROCK HOTEL & CASINO SIOUX CITY 111 3RD ST SIOUX CITY, IA 51101	46-1842686		8,500				2017 BATTERY PARK OUTDOOR CONCERTS CORPORATE SPONSORSHIP
HER HEALTH WOMENS CENTER 5732 SUNNYBROOK DR SIOUX CITY, IA 51106	42-1282535	501(C)(3)	7,500				UNDERWRITING DONATION FOR FUNDRAISING BANQUET

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
HOLY SPIRIT RETIREMENT HOME 1701 W 25TH ST SIOUX CITY, IA 51103	42-6102778	501(C)(3)	20,000				PLEDGE PAYMENT TO SUPPORT HOLY SPIRIT EXPANSION CAMPAIGN
IOWA CHAPTER OF CHILDREN'S ADVOCACY CENTER 505 FIFTH AVE SUITE 1001 DES MONIES, IA 50309	27-0473272	501(C)(3)	5,125				COMMUNITY SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
IWLC (IOWA WOMEN LEAD CHANGE) 200 FIRST STREET SE SUITE 2100 CEDAR RAPIDS, IA 52401	45-2932668	501(C)(3)	20,000				PRESENTING SPONSOR SIOUXLAND CONFERENCE
JACKSON RECOVERY CENTERS 800 5TH ST STE 200 SIOUX CITY, IA 51101	39-1900255	501(C)(3)	25,000				SUPPORT ADOLESCENT ADDICTION RECOVERY HOSPITAL

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
NEW HORIZON TUTORING 498 BISON TR DAKOTA DUNES, SD 57049	63-6744586		52,000				SUPPORT ACT PREP TUTORING
NORM WAITT SR YMCA 601 RIVERVIEW DR SIOUX CITY, NE 68776	42-0738980	501(C)(3)	5,300				COMMUNITY SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
NORTHEAST COMMUNITY COLLEGE FOUNDATION 801 EAST BENJAMIN AVE NORFLOK, NE 68702	51-0145185	501(C)(3)	27,500				MERCY SIOUX CITY & CONTINUING ED SCHOLARSHIP AND EMERGENCY FUND
UNITED STROKE ALLIANCE (RETREAT AND REFRESH STROKE) 2000 W PIONEER PKWY SUITE 16 PEORIA, IL 61615	64-0954851	501(C)(3)	26,650				SPONSOR STROKE CAMP

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
SIOUX CITY COMMUNITY SCHOOLS 627 4TH STREET SIOUX CITY, IA 51101	42-6003589	PUBLIC SCHOOL	10,000				GIVING HISTORY LIBERTY ELEM PTA SUPPORT, IRVING ELEM PTA SUPPORT
SIOUX CITY CONSERVATORY OF MUSIC 1309 PIERCE ST SIOUX CITY, IA 51105	45-1544074	501(C)(3)	10,000				HARMONY PROJECT EXPANSION



Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
SIOUX CITY SYMPHONY ORCHESTRA 518 PIERCE STREET SIOUX CITY, IA 51101	42-6006580	501(C)(3)	10,000				CONCERT SPONSORSHIP CHRISTMAS WITH THE SYMPHONY
SIOUXLAND COMMUNITY FOUNDATION 505 FIFTH STREET SUITE 412 SIOUX CITY, IA 51101	42-1323904	501(C)(3)	6,250				COMMUNITY SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
SIOUXLAND COMMUNITY HEALTH CENTER 1021 NEBRASKA STREET SIOUX CITY, IA 51102	42-1374894	501(C)(3)	15,000				SPONSORSHIP OF ANNUAL DINNER
SIOUXLAND HUMAN INVESTMENT PARTNERSHIP 1520 MORNINGSIDE AVE SIOUX CITY, IA 51106	42-1495836	501(C)(3)	16,500				BLUE ZONE PROJECT SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
THE SIOUXLAND INITIATIVE 101 PIERCE ST SIOUX CITY, IA 51101	42-1328697	501(C)(6)	25,000				COMMUNITY SUPPORT
SIOUXLAND MEDICAL EDUCATION FOUNDATION 2501 PIERCE ST SIOUX CITY, IA 51104	42-1036971	501(C)(3)	1,119,952				PHYSICIAN RESIDENTS EDUCATION & INTEGRATED BEHAVIORAL HEALTH SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
SIOUXLAND MENTAL HEALTH SERVICES INC PO BOX 1917 SIOUX CITY, IA 51102	42-6122297	501(C)(3)	38,939				COMMUNITY CARE COORDINATOR PROGRAM
THE SIOUXLAND Y 601 RIVERVIEW DRIVE SOUTH SIOUX CITY, NE 68776	42-0738980	501(C)(3)	5,300				CORPORATE SPONSORSHIPS

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
SIOUXLAND YOUTH FOR CHRIST PO BOX 1626 SIOUX CITY, IA 51102	42-1108779	501(C)(3)	10,000				CORPORATE SPONSORSHIPS
ST MICHAEL'S CATHOLIC CHURCH 715 CREIGHTON AVE HASTINGS, NE 68901	47-0403978	501(C)(3)	7,500				ST MICHAEL'S SCHOOL BUSINESS/EDUCATION SPONSORSHIP

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
UNITED WAY OF SIOUXLAND INC PO BOX 204 SIOUX CITY, IA 51102	42-0680395	501(C)(3)	5,500				COMMUNITY SUPPORT
THE WARMING SHELTER INC 601 PIERCE ST SIOUX CITY, IA 51101	47-1257560	501(C)(3)	10,000				COMMUNITY SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MERCY MEDICAL CENTER-SIOUX CITY FOUNDATION 801 5TH STREET SIOUX CITY, IA 51102	14-1880022	501(C)(3)	229,152				FUNDING SUPPORT
BAUM HARMON MERCY HOSPITAL 255 NORTH WELCH AVE PRIMGHAR, IA 51245	42-1500277	501(C)(3)	1,559,413				FUNDING SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
OAKLAND MERCY HOSPITAL 601 EAST 2ND STREET OAKLAND, NE 68045	20-8072234	501(C)(3)	709,572				FUNDING SUPPORT
NORTHEAST IOWA COMMUNITY ACTION CORP 305 MONTGOMERY ST DECORAH, IA 52101	42-6092713	501(C)(3)	6,000	0			SUPPORT CHICKASAW COUNTY RESIDENTS THAT ARE FACING HOMELESSNESS OR LOSS OF UTILITIES



Form 990, Schedule I, Part III, Grants and Other Assistance to Domestic Individuals.					
(a)Type of grant or assistance	(b)Number of recipients	(c)Amount of cash grant	(d)Amount of non-cash assistance	(e)Method of valuation (book, FMV, appraisal, other)	(f)Description of non-cash assistance
HOUSING, UTILITIES, AND OTHER SUPPORT	12	7,699			
TRANSPORTATION ASSISTANCE	397	20,932			
MEDICAL BILLS	140	28,906			
SCHOLARSHIPS	8	4,000			
LEGAL ASSISTANCE	4	2,474			

Form 990, Schedule I, Part III, Grants and Other Assistance to Domestic Individuals.					
(a)Type of grant or assistance	(b)Number of recipients	(c)Amount of cash grant	(d)Amount of non-cash assistance	(e)Method of valuation (book, FMV, appraisal, other)	(f)Description of non-cash assistance
OTHER MISCELLANEOUS ASSISTANCE	3	1,390			
FOOD ASSISTANCE	1	25			
SPONSORSHIP	2	200			
PRESCRIPTION ASSISTANCE	47	5,502			
MEDICAL EQUIPMENT FOR PATIENT	1	624			

Form 990, Schedule I, Part III, Grants and Other Assistance to Domestic Individuals.					
(a)Type of grant or assistance	(b)Number of recipients	(c)Amount of cash grant	(d)Amount of non-cash assistance	(e)Method of valuation (book, FMV, appraisal, other)	(f)Description of non-cash assistance
SPECIAL EDUCATIONAL NEEDS	17	1,563			

Schedule J  
(Form 990)

Department of the Treasury  
Internal Revenue Service

Compensation Information

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

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

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

OMB No 1545-0047

2015

Open to Public Inspection

Name of the organization MERCY HEALTH SERVICES - IOWA CORP	Employer identification number 31-1373080
---	--

Part I

Questions Regarding Compensation

	Yes	No
<b>1a</b> Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items. <div><div><input type="checkbox"/> First-class or charter travel</div><div><input type="checkbox"/> Travel for companions</div><div><input type="checkbox"/> Tax idemnification and gross-up payments</div><div><input type="checkbox"/> Discretionary spending account</div><div><input type="checkbox"/> Housing allowance or residence for personal use</div><div><input type="checkbox"/> Payments for business use of personal residence</div><div><input type="checkbox"/> Health or social club dues or initiation fees</div><div><input type="checkbox"/> Personal services (e g , maid, chauffeur, chef)</div></div>		
<b>b</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	<b>1b</b>	
<b>2</b> 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?	<b>2</b>	
<b>3</b> 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. <div><div><input type="checkbox"/> Compensation committee</div><div><input type="checkbox"/> Independent compensation consultant</div><div><input type="checkbox"/> Form 990 of other organizations</div><div><input type="checkbox"/> Written employment contract</div><div><input type="checkbox"/> Compensation survey or study</div><div><input type="checkbox"/> Approval by the board or compensation committee</div></div>		
<b>4</b> During the year, did any person listed on Form 990, Part VII, Section A, line 1a with respect to the filing organization or a related organization: <b>a</b> Receive a severance payment or change-of-control payment?	<b>4a</b>	Yes
<b>b</b> Participate in, or receive payment from, a supplemental nonqualified retirement plan?	<b>4b</b>	Yes
<b>c</b> 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.	<b>4c</b>	No
<b>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</b>		
<b>5</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of: <b>a</b> The organization?	<b>5a</b>	No
<b>b</b> Any related organization? If "Yes," on line 5a or 5b, describe in Part III.	<b>5b</b>	No
<b>6</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of: <b>a</b> The organization?	<b>6a</b>	No
<b>b</b> Any related organization? If "Yes," on line 6a or 6b, describe in Part III.	<b>6b</b>	No
<b>7</b> For persons listed on 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.	<b>7</b>	No
<b>8</b> Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III.	<b>8</b>	No
<b>9</b> If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	<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 on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that 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 on 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 3	MERCY HEALTH SERVICES - IOWA (MHS-IA) IS A SUBSIDIARY IN THE TRINITY HEALTH SYSTEM. MHS-IA HOSPITAL CEO'S ARE PAID DIRECTLY BY THE SYSTEM'S PARENT ENTITY, TRINITY HEALTH CORPORATION. TRINITY HEALTH CORPORATION USED THE FOLLOWING METHODS TO ESTABLISH THE COMPENSATION OF MHS-IA CEO'S: - COMPENSATION COMMITTEE - INDEPENDENT COMPENSATION CONSULTANT - FORM 990 OF OTHER ORGANIZATIONS - WRITTEN EMPLOYMENT CONTRACT - COMPENSATION SURVEY OR STUDY, AND - APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE.
PART I, LINES 4A-B	THE FOLLOWING INDIVIDUALS RECEIVED SEVERANCE PAYMENTS IN CALENDAR 2016. THESE AMOUNTS ARE INCLUDED IN COLUMN B(III) OF SCHEDULE J, PART II: JENNIFER BARNETT - \$390,824; LINDA KREI - \$118,487; JUDITH PERSICILLI - \$1,316,195. IN ADDITION, COLUMN C OF SCHEDULE J, PART II INCLUDES \$118,487 OF SEVERANCE FOR LINDA KREI WHICH WAS UNPAID AS OF 12/31/16. THE \$118,487 WAS PAID AND INCLUDED IN LINDA KREI'S TAXABLE INCOME IN 2017. COLUMN F OF SCHEDULE J, PART II INCLUDES THE PORTION OF THESE AMOUNTS THAT WERE REPORTED AS DEFERRED COMPENSATION IN PRIOR YEARS. THE FOLLOWING ARE PARTICIPANTS IN A TRINITY HEALTH SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN (SERP) IN 2016. THE PLAN PROVIDES RETIREMENT BENEFITS TO CERTAIN TRINITY HEALTH EXECUTIVES SUBJECT TO MEETING SPECIFIED VESTING AND EMPLOYMENT DATE REQUIREMENTS. BENEFITS FOR PARTICIPANTS VESTED IN A PLAN WERE PAID OUT IN 2016, AND BENEFITS FOR PARTICIPANTS NOT YET VESTED IN A PLAN WERE ACCRUED IN 2016. THE FOLLOWING PAYOUTS FOR 2016 FOR THE PLAN ARE INCLUDED IN COLUMN B(III) OF SCHEDULE J, PART II: BENJAMIN CARTER - \$206,373; JAMES FITZPATRICK - \$117,414; CLAYTON FITZHUGH - \$262,095; RICHARD GILFILLAN, MD - \$404,613; AGNES HAGERTY - \$99,731; RUSSELL KNIGHT - \$74,982; PAUL NEUMANN - \$161,674; RICHARD O'CONNELL - \$221,949; KAY TAKES - \$14,503; DANIEL VARNUM - \$102,608. THE FOLLOWING ARE PARTICIPANTS IN A TRINITY HEALTH RESTORATION OR RETENTION PLAN. THE RESTORATION PLAN PROVIDES RETIREMENT BENEFITS FOR CERTAIN TRINITY HEALTH SYSTEM OFFICE EXECUTIVES WITH EARNINGS ABOVE THE IRS PAY CAP FOR QUALIFIED PLANS (\$265,000 FOR 2016). THE FOLLOWING PAYOUTS FOR 2016 FOR THESE PLANS ARE INCLUDED IN COLUMN B(III) OF SCHEDULE J, PART II: RUSSELL KNIGHT - \$78,851; RICHARD O'CONNELL - \$121,018. COLUMN F OF SCHEDULE J, PART II INCLUDES THE PORTION OF THESE AMOUNTS THAT WERE REPORTED AS DEFERRED COMPENSATION IN PRIOR YEARS. THE FOLLOWING ARE PARTICIPANTS IN A MERCY HEALTH SERVICES - IOWA NON-QUALIFIED ELECTIVE DEFERRED COMPENSATION PLAN. THE FOLLOWING DEFERRALS FOR 2016 FOR THIS PLAN ARE INCLUDED IN COLUMN B (III) OF SCHEDULE J, PART II: MARK HAGANMAN - \$42,608; MICHAEL LAMPE - \$43,458; BRENT OWEN - \$34,542; ALIREZA YARAHMADI - \$50,209.

Additional Data

Software ID:

Software Version:

EIN: 31-1373080

Name: MERCY HEALTH SERVICES - IOWA CORP

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 on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1CLAYTON FITZHUGH DIR & TRINITY EVP CHRO THROUGH 7/16	(i)	0	0	0	0	0	0	0
	(ii)	511,710	216,184	277,220	15,900	-	-	0
					16,184		1,037,198	
1RODNEY SCHLADER TREASURER, REGIONAL CFO	(i)	0	0	0	0	0	0	0
	(ii)	305,424	56,637	1,382	19,875	-	-	0
					29,628		412,946	
2MARCIA SMITH SECRETARY, ASSOCIATE COUNSEL	(i)	0	0	0	0	0	0	0
	(ii)	252,029	28,408	1,081	12,294	-	-	0
					26,301		320,113	
3JAMES FITZPATRICK PRESIDENT & CEO SIOUX CITY	(i)	0	0	0	0	0	0	0
	(ii)	478,959	136,633	133,451	19,875	-	-	0
					14,671		783,589	
4DANIEL VARNUM CEO NORTH IOWA	(i)	0	0	0	0	0	0	0
	(ii)	419,335	129,217	118,946	15,900	-	-	0
					29,717		713,115	
5PAUL MANTERNACH SVP PHYS INTEGRATION/CMO NORTH IOWA	(i)	0	0	0	0	0	0	0
	(ii)	356,891	63,104	871	15,900	-	-	0
					24,085		460,851	
6KAY TAKES PRESIDENT DUBUQUE	(i)	0	0	0	0	0	0	0
	(ii)	255,520	74,029	22,327	20,475	-	-	0
					26,199		398,550	
7DIANE FISCHELS VP COO NORTH IOWA	(i)	0	0	0	0	0	0	0
	(ii)	289,127	50,804	1,261	19,875	-	-	0
					18,050		379,117	
8HUGH DEPAULIS VP FINANCE SIOUX CITY	(i)	0	0	0	0	0	0	0
	(ii)	219,301	36,615	909	16,272	-	-	0
					20,141		293,238	
9DANETTE ZOOK VP FINANCE NORTH IOWA	(i)	0	0	0	0	0	0	0
	(ii)	185,965	33,558	400	17,630	-	-	0
					19,741		257,294	
10KIM DUWE VP FINANCE DUBUQUE	(i)	0	0	0	0	0	0	0
	(ii)	163,057	33,570	332	9,441	-	-	0
					20,244		226,644	
11MARK HAGANMAN PHYSICIAN, FAMILY MEDICINE NORTH IA	(i)	493,817	184,926	44,102	19,875	28,612	771,332	0
	(ii)	0	0	0	0	-	-	0
					0	0	0	
12MICHAEL LAMPE PHYSICIAN, FAMILY MEDICINE NORTH IA	(i)	366,931	270,651	43,872	15,035	15,382	711,871	0
	(ii)	0	0	0	0	-	-	0
					0	0	0	
13YEN LIU PHYSICIAN, DERMATOLOGY NORTH IOWA	(i)	498,656	179,415	554	11,925	17,332	707,882	0
	(ii)	0	0	0	0	-	-	0
					0	0	0	
14BRENT OWEN PHYSICIAN, FAMILY MEDICINE NORTH IA	(i)	370,366	217,616	57,828	11,925	25,044	682,779	0
	(ii)	0	0	0	0	-	-	0
					0	0	0	
15ALIREZA YARAHMADI PHYSICIAN, NEUROLOGY NORTH IOWA	(i)	463,796	125,426	55,253	11,925	28,545	684,945	0
	(ii)	0	0	0	0	-	-	0
					0	0	0	
16JUDITH PERSICHILLI FORMER OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	0	0	2,115,151	0	-	-	0
					0		2,115,151	
17PAUL NEUMANN FORMER OFFICER, TRIN CHIEF LEGAL CNSL	(i)	0	0	0	0	0	0	0
	(ii)	650,319	191,115	229,021	11,925	-	-	0
					31,769		1,114,149	
18JENNIFER BARNETT FORMER OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	0	0	392,595	0	-	-	390,824
					17,120		409,715	
19AGNES HAGERTY FORMER OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	221,244	104,714	111,200	19,875	-	-	0
					13,867		470,900	

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 on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
<b>21</b> BENJAMIN CARTER FORMER OFFICER, TRINITY HEALTH CFO	(i)	0	0	0	0	0	0	0
	(ii)	834,329	239,942	232,036	11,925	-	-	0
						36,952	1,355,184	
<b>1</b> RICHARD GILFILLAN MD FORMER OFFICER, TRINITY HEALTH CEO	(i)	0	0	0	0	0	0	0
	(ii)	1,429,569	575,579	453,222	11,925	-	-	0
						34,588	2,504,883	
<b>2</b> RICHARD O'CONNELL FORMER KE, TRINITY EVP THR 11/16	(i)	0	0	0	0	0	0	0
	(ii)	878,773	258,051	408,585	11,925	-	-	112,018
						35,437	1,592,771	
<b>3</b> Jerome Pierson MD FORMER KE, MERCY SC PHYSICIAN	(i)	673,083	0	3,082	11,430	20,995	708,590	0
	(ii)	0	0	0	0	-	-	0
						0	0	
<b>4</b> RUSSELL KNIGHT FORMER KEY EMPLOYEE	(i)	0	0	0	0	0	0	0
	(ii)	0	49,020	153,833	1,471	-	-	72,805
						2,893	207,217	
<b>5</b> TERESA MOCK MD FORMER KE, SVP CCO AND CPHO N IOWA	(i)	0	0	0	0	0	0	0
	(ii)	305,051	53,857	2,078	15,900	-	-	0
						24,047	400,933	
<b>6</b> LINDA KREI FORMER KEY EMPLOYEE	(i)	0	0	0	0	0	0	0
	(ii)	117,723	38,576	119,452	130,266	-	-	0
						3,401	409,418	
<b>7</b> GARY GUETZKO FORMER KE, VP BUS DEVELOPMENT DUBUQUE	(i)	0	0	0	0	0	0	0
	(ii)	205,380	50,152	1,276	20,124	-	-	0
						18,004	294,936	
<b>8</b> BRIAN MONSMA FORMER KE, VP NTWK DVLPMNT SIOUX CITY	(i)	0	0	0	0	0	0	0
	(ii)	188,598	31,953	266	14,200	-	-	0
						23,577	258,594	
<b>9</b> TRACY LARSON FORMER KEY EMPLOYEE, CNO SIOUX CITY	(i)	0	0	0	0	0	0	0
	(ii)	190,411	32,110	268	9,760	-	-	0
						22,736	255,285	
<b>10</b> KIMBERLY CHAMBERLIN FORMER KEY EMPLOYEE, CNO NORTH IOWA	(i)	0	0	0	0	0	0	0
	(ii)	181,485	32,255	706	10,060	-	-	0
						14,480	238,986	
<b>11</b> SUE MEADE FORMER KE, VP PROF SVCS DUBUQUE	(i)	0	0	0	0	0	0	0
	(ii)	147,864	36,258	285	11,656	-	-	0
						13,011	209,074	
<b>12</b> LARRY SELLERS FORMER KE, CLINIC PHYS SIOUX CITY	(i)	97,939	0	2,096	8,013	24,015	132,063	0
	(ii)	0	0	0	0	-	-	0
						0	0	



Schedule L

(Form 990 or 990-EZ)

Department of the Treasury

Internal Revenue Service

Transactions with Interested Persons

▶ Complete if the organization answered "Yes" on Form 990, Part IV, lines 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, 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).

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization  
MERCY HEALTH SERVICES - IOWA CORP

Employer identification number  
31-1373080

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	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) NATHAN MOCK	FAMILY MEMBER OF TERESA MOCK, MD, FORMER KEY EMPLOYEE	11,597	EMPLOYMENT ARRANGEMENT		No
(2) AVERY OUTDOOR	MILTON AVERY, BOARD OFFICER, IS AN OWNER OF AVERY OUTDOOR	188,840	PAYMENTS MADE FOR SIGNS AND BILLBOARDS		No

**Part V Supplemental Information**

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

Return Reference	Explanation
------------------	-------------

SCHEDULE M  
(Form 990)

Department of the Treasury  
Internal Revenue Service

Noncash Contributions

►Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.  
► Attach to Form 990.  
►Information about Schedule M (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990)

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization  
MERCY HEALTH SERVICES - IOWA CORP

Employer identification number  
31-1373080

Part I

Types of Property

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art—Works of art . . . .	X	12	20,000	DONOR VALUED
2 Art—Historical treasures . .				
3 Art—Fractional interests . .				
4 Books and publications . .				
5 Clothing and household goods . . . . .				
6 Cars and other vehicles . .				
7 Boats and planes . . . .				
8 Intellectual property . . .				
9 Securities—Publicly traded .				
10 Securities—Closely held stock .				
11 Securities—Partnership, LLC, or trust interests . . . .				
12 Securities—Miscellaneous . .				
13 Qualified conservation contribution—Historic structures . . . . .				
14 Qualified conservation contribution—Other . . . .				
15 Real estate—Residential . .				
16 Real estate—Commercial . .				
17 Real estate—Other . . . .				
18 Collectibles . . . . .				
19 Food inventory . . . .				
20 Drugs and medical supplies .				
21 Taxidermy . . . . .				
22 Historical artifacts . . . .				
23 Scientific specimens . . .				
24 Archeological artifacts . . .				
25 Other ► ( )				
26 Other ► ( )				
27 Other ► ( )				
28 Other ► ( )				

29 Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement

29

30a During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 28, that it must hold for at least three years from the date of the initial contribution, and which is not required to be used for exempt purposes for the entire holding period? . . . . .

30a

Yes

No

b If "Yes," describe the arrangement in Part II

31 Does the organization have a gift acceptance policy that requires the review of any non-standard contributions?

31

Yes

No

32a Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions? . . . . .

32a

Yes

No

b If "Yes," describe in Part II

33 If the organization did not report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II

**Part II****Supplemental Information.**

Provide the information required by Part I, lines 30b, 32b, and 33, and whether the organization is reporting in Part I, column (b), the number of contributions, the number of items received, or a combination of both. Also complete this part for any additional information.

Return Reference

Explanation

**SCHEDULE O**  
(Form 990 or 990-EZ)Department of the Treasury  
Internal Revenue ServiceName of the organization  
MERCY HEALTH SERVICES - IOWA CORP**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).

OMB No 1545-0047

**2016****Open to Public  
Inspection**

Employer identification number

31-1373080

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 2	RODNEY SCHLADER, OFFICER, DANIEL VARNUM, KEY EMPLOYEE, AND MARTI RODAMAKER, BOARD DIRECTOR, HAVE A BUSINESS RELATIONSHIP

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 6	THE SOLE MEMBER OF MERCY HEALTH SERVICES - IOWA (MHS-IA) IS TRINITY HEALTH CORPORATION SEE LINE 7 FOR ADDITIONAL INFORMATION

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7A	TRINITY HEALTH CORPORATION IS THE SOLE MEMBER OF MHS-IA TRINITY HEALTH CORPORATION HAS THE RIGHT TO APPOINT ALL PERSONS TO THE BOARD OF DIRECTORS OF MHS-IA

## 990 Schedule O, Supplemental Information

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



# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	PRIOR TO FILING, THE FORM 990 FOR MHS-IA IS REVIEWED BY SENIOR MANAGEMENT IN ADDITION, CERTAIN KEY SECTIONS OF THE FORM ARE REVIEWED BY THE BOARD OF DIRECTORS EACH MEMBER OF THE BOARD RECEIVES A COPY OF THE RETURN IN ITS FINAL FORM BEFORE IT IS FILED WITH THE INTERNAL REVENUE SERVICE

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	<p>MHS-IA HAS ADOPTED TRINITY HEALTH'S GOVERNANCE POLICY NO. 1, WHICH SETS FORTH THE ORGANIZATION'S CONFLICT OF INTEREST POLICY AND PROCESSES. IT APPLIES TO ALL "INTERESTED PERSONS" OF MHS-IA, WHICH INCLUDES DIRECTORS, PRINCIPAL OFFICERS, KEY EMPLOYEES, AND MEMBERS OF COMMITTEES WITH BOARD-DELEGATED POWERS. INTERESTED PERSONS ARE EXPECTED TO DISCHARGE THEIR DUTIES IN A MANNER THE PERSON REASONABLY BELIEVES TO BE IN THE BEST INTERESTS OF MHS-IA AND TO AVOID SITUATIONS INVOLVING A CONFLICT OF INTEREST. ON AN ANNUAL BASIS, INTERESTED PERSONS ARE REQUIRED TO COMPLETE A CONFLICT OF INTEREST DISCLOSURE STATEMENT AND TO AFFIRM THEIR RECEIPT OF THE CONFLICT OF INTEREST POLICY, COMPLIANCE WITH ITS REQUIREMENTS, AND AGREE TO NOTIFY THE ORGANIZATION OF CHANGES IMPACTING THEIR ANNUAL DISCLOSURE IN ACCORDANCE WITH THE POLICY. THE ANNUAL DISCLOSURES ARE PROVIDED TO INTERNAL LEGAL COUNSEL AND THE INTEGRITY AND COMPLIANCE OFFICER, FROM WHICH LEGAL COUNSEL PREPARES A REPORT FOR THE BOARD CHAIR AND CEO. A SUMMARY OF POTENTIAL CONFLICTS IS REVIEWED WITH THE BOARD OF DIRECTORS OF MHS-IA (OR A DELEGATED COMMITTEE OF THE BOARD) ON A YEARLY BASIS. INTERESTED PERSONS ARE REQUIRED TO MAKE FULL DISCLOSURE TO MHS-IA OF ANY FINANCIAL OR BUSINESS INTERESTS THAT MIGHT RESULT IN OR HAVE THE APPEARANCE OF A CONFLICT OF INTEREST. THE BOARD OF DIRECTORS OF MHS-IA (OR A DELEGATED COMMITTEE OF THE BOARD) IS RESPONSIBLE FOR THE REVIEW OF TRANSACTIONS TO DETERMINE WHETHER AN ACTUAL CONFLICT OF INTEREST EXISTS. IN THE EVENT OF AN ACTUAL CONFLICT, THE BOARD (OR A DELEGATED COMMITTEE OF THE BOARD) WILL EITHER AVOID THE CONFLICT OR APPROPRIATELY SCRUTINIZE THE TRANSACTION TO ENSURE IT IS IN THE BEST INTERESTS OF MHS-IA. INTERESTED PERSONS ARE REQUIRED TO RECUSE THEMSELVES FROM DISCUSSION AND VOTING ON MATTERS INVOLVING A CONFLICT OF INTEREST. THE POLICY FURTHER ADDRESSES THE PROPER DOCUMENTATION OF THE PROCEEDINGS AND POTENTIAL DISCIPLINARY AND CORRECTIVE ACTION FOR VIOLATIONS OF THE POLICY. THE POLICY IS AVAILABLE TO THE PUBLIC UPON REQUEST.</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15	QUESTIONS 15A AND 15B ARE ANSWERED "NO" BECAUSE THE COMPENSATION FOR CERTAIN OFFICERS AND KEY MANAGEMENT OFFICIALS OF MHS-IA IS ESTABLISHED BY TRINITY HEALTH, A RELATED ORGANIZATION IN ESTABLISHING CEO AND CFO COMPENSATION, TRINITY HEALTH FOLLOWS A PROCESS AND POLICY THAT IS INTENDED TO MIRROR THE IRC SECTION 4958 GUIDELINES FOR OBTAINING A "REBUTTABLE PRESUMPTION OF REASONABLENESS" WITH REGARD TO COMPENSATION AND BENEFITS AS PART OF THAT PROCESS, THE COMPENSATION AND BENEFITS OF THE HOSPITAL CEO'S AND CFO'S OF MHS-IA ARE REVIEWED AT LEAST ANNUALLY BY THE TRINITY HEALTH BOARD OR THE TRINITY HEALTH HUMAN RESOURCES AND COMPENSATION COMMITTEE (HRCC) OF THE BOARD, AUTHORIZED TO ACT ON BEHALF OF THE BOARD WITH RESPECT TO CERTAIN COMPENSATION MATTERS AS PART OF ITS REVIEW PROCESS, THE HRCC RETAINS AN INDEPENDENT FIRM EXPERIENCED IN COMPENSATION AND BENEFIT MATTERS FOR NOT-FOR-PROFIT HEALTH CARE ORGANIZATIONS TO ADVISE IT IN THE DETERMINATIONS IT MAKES ON THE REASONABLENESS OF PROPOSED COMPENSATION AND BENEFITS ARRANGEMENTS

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	MHS-IA IS A SUBSIDIARY ORGANIZATION IN THE TRINITY HEALTH SYSTEM. TRINITY HEALTH MAKES CERTAIN OF ITS KEY DOCUMENTS AVAILABLE TO THE PUBLIC ON ITS WEBSITE, WWW.TRINITY-HEALTH.ORG, IN THE "ABOUT US" SECTION. IN THIS SECTION, THE CONSOLIDATED AUDITED FINANCIAL STATEMENTS ARE PUBLICLY AVAILABLE. IN ADDITION, MHS-IA INCLUDES A COPY OF ITS MOST RECENTLY FILED SCHEDULE H ON TRINITY HEALTH'S WEBSITE. MHS-IA'S GOVERNING DOCUMENTS AND CONFLICT OF INTEREST POLICY ARE AVAILABLE UPON REQUEST.

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART IX, LINE 11G	<p>CONSULTING SERVICES PROGRAM SERVICE EXPENSES 0 MANAGEMENT AND GENERAL EXPENSES 306,683 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 306,683 LAUNDRY AND LINEN SERVICES PROGRAM SERVICE EXPENSES 548,544 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 548,544 BILLING SERVICES PROGRAM SERVICE EXPENSES 0 MANAGEMENT AND GENERAL EXPENSES 19,829 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 19,829 MEDICAL SPECIALIST FEES PROGRAM SERVICE EXPENSES 29,989,354 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 29,989,354 RECRUITING SERVICES PROGRAM SERVICE EXPENSES 0 MANAGEMENT AND GENERAL EXPENSES 2,713,429 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 2,713,429 MEDICAL SERVICES PROGRAM SERVICE EXPENSES 15,104,939 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 15,104,939 CONTRACT LABOR PROGRAM SERVICE EXPENSES 14,329,288 MANAGEMENT AND GENERAL EXPENSES 1,280,888 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 15,610,176 MISCELLANEOUS PURCHASED SERVICES PROGRAM SERVICE EXPENSES 10,414,835 MANAGEMENT AND GENERAL EXPENSES 930,977 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 11,345,812</p>

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9	NET EQUITY TRANSFERS TO/FROM AFFILIATES -16,153,432 OTHER TRANSACTIONS 3,101,329 EQUITY GAIN/LOSS IN UNCONSOLIDATED AFFILIATES 2,466,781

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XII, LINE 2	MHS-IA'S FINANCIAL STATEMENTS WERE INCLUDED IN THE FY17 CONSOLIDATED FINANCIAL STATEMENTS OF TRINITY HEALTH, WHICH WERE AUDITED BY AN INDEPENDENT PUBLIC ACCOUNTING FIRM

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PAGE 1, DOING BUSINESS AS NAMES	DUNES MEDICAL LABORATORIES, FOREST PARK PHARMACY, HEALTHWORKS, MARIAN HEALTH CENTER, MERCY FAMILY PHARMACY, MERCY HEALTH CENTER-DUBUQUE (ST JOSEPH'S), MERCY HEALTH CENTER-DYERSVILLE (ST MARY'S),MERCY HEART CENTER & VASCULAR INSTITUTE, MERCY HOME CARE-NORTH IOWA, MERCY HOME HEALTHCARE DUBUQUE, MERCY MEDICAL CENTER-DUBUQUE, MERCY MEDICAL CENTER-DYERSVILLE, MERCY MEDICAL CENTER-NEW HAMPTON, MERCY MEDICAL CENTER-NORTH IOWA, MERCY MEDICAL CENTER-SIOUX CITY, MERCY VASULAR MEDICINE CLINIC, MHC ANESTHESIA SERVICES, NORTH IOWA MERCY CLINICS, NORTH IOWA MERCY HEALTH CENTER, NORTH IOWA MERCY HOME HEALTHCARE, NORTH IOWA TEXTILE SERVICES, SHEFFIELD PHARMACY, SIOUXLAND PATHOLOGY GROUP-SMHC, SIOUXLAND RADIOLOGY-SMHC, ST JOSEPH COMMUNITY HOSPITAL



SCHEDULE R  
(Form 990)

Department of the Treasury  
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

▶ Attach to Form 990.▶ Information about Schedule R (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization  
MERCY HEALTH SERVICES - IOWA CORP

Employer identification number  
31-1373080

Part I Identification of Disregarded Entities

Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) MERCY CARE CONNECTIONS LLC 1000 4TH STREET SW MASON CITY, IA 50401 35-2473948	ACCOUNTABLE CARE ORGANIZATION	IA	0	0	MERCY HEALTH SERVICES-IOWA CORP

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.

See Additional Data Table

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

**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.

See Additional Data Table

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

**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.

See Additional Data Table

(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

**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

Yes

1d

No

1e

Yes

1f

No

1g

No

1h

No

1i

No

1j

No

1k

No

1l

Yes

1m

Yes

1n

No

1o

No

1p

Yes

1q

Yes

1r

Yes

1s

Yes

**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

See Additional Data Table

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved

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

[illegible]

**Part VII** **Supplemental Information**

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

Additional Data

Software ID:  
Software Version:  
EIN: 31-1373080  
Name: MERCY HEALTH SERVICES - IOWA CORP

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?	
						Yes	No
(1)  245 STATE ST SE GRAND RAPIDS, MI 49503 27-2491974	HEALTH CARE SERVICES	MI	501(C)(3)	LINE 10	TRINITY HEALTH- MICHIGAN	Yes	
(1)  33920 US HIGHWAY 19 NORTH SUITE 269 PALM HARBOR, FL 34684 58-1492325	GRANT MAKING	FL	501(C)(3)	LINE 12A, I	TRINITY HEALTH CORPORATION	Yes	
(2)  114 WOODLAND STREET HARTFORD, CT 06105 06-1450170	HEALTH CARE SERVICES	CT	501(C)(3)	LINE 3	TRINITY HEALTH OF NEW ENGLAND CORP INC	Yes	
(3)  255 NORTH WELCH AVENUE PRIMGHAR, IA 51245 42-1500277	HEALTH CARE AND HOSPITAL SERVICES	IA	501(C)(3)	LINE 3	MERCY HEALTH SERVICES-IOWA CORP	Yes	
(4)  255 NORTH WELCH AVENUE PRIMGHAR, IA 51245 26-2973307	FOUNDATION	IA	501(C)(3)	LINE 12A, I	BAUM HARMON MERCY HOSPITAL	Yes	
(5)  2212 BURDETT AVE TROY, NY 12180 14-1651563	TITLE HOLDING COMPANY	NY	501(C)(2)	N/A	LTC (EDDY) INC	Yes	
(6)  905 WATSON STREET PITTSBURGH, PA 15219 25-1436685	HOMELESS SHELTER	PA	501(C)(3)	LINE 7	PITTSBURGH MERCY HEALTH SYSTEM INC	Yes	
(7)  40 AUTUMN DRIVE SLINGERLANDS, NY 12159 14-1717028	SENIOR LIVING COMMUNITY	NY	501(C)(3)	LINE 10	LTC (EDDY) INC	Yes	
(8)  1221 MAIN STREET SUITE 213 HOLYOKE, MA 01040 04-2182395	HEALTH CARE SERVICES	MA	501(C)(3)	LINE 10	THE MERCY HOSPITAL INC	Yes	
(9)  421 WEST COLUMBIA ST COHOES, NY 12047 14-1701597	LONG TERM CARE	NY	501(C)(3)	LINE 10	LTC (EDDY) INC	Yes	
(10)  1200 EARHART RD ANN ARBOR, MI 48105 20-1681131	HOME HEALTH SERVICES	MI	501(C)(3)	LINE 10	GLACIER HILLS INC	Yes	
(11)  PO BOX 995 ANN ARBOR, MI 48106 38-2507173	HEALTH CARE SERVICES	MI	501(C)(3)	LINE 3	TRINITY HEALTH- MICHIGAN	Yes	
(12)  20555 VICTOR PARKWAY LIVONIA, MI 48152	GOVERNANCE AND MANAGEMENT OF TRINITY HEALTH SYSTEM	VT	501(C)(3)	LINE 1	N/A		No
(13)  111 CENTRAL AVENUE NEWARK, NJ 07102 26-2616342	INACTIVE ENTITY	NJ	501(C)(3)	LINE 10	SAINT MICHAEL'S MEDICAL CENTER	Yes	
(14)  1111 W LONG LAKE RD STE 102 TROY, MI 48098 38-3320699	HOSPICE SERVICES	MI	501(C)(3)	LINE 10	TRINITY HOME HEALTH SERVICES	Yes	
(15)  6150 EAST BROAD STREET COLUMBUS, OH 43213 34-2032340	HEALTH CARE AND HOSPITAL SERVICES	OH	501(C)(3)	LINE 3	MOUNT CARMEL HEALTH SYSTEM	Yes	
(16)  250 MERCY DRIVE DUBUQUE, IA 52001 26-2227941	FOUNDATION	IA	501(C)(3)	LINE 12A, I	MERCY HEALTH SERVICES-IOWA CORP	Yes	
(17)  1111 3RD STREET SW DYERSVILLE, IA 52040 20-5383271	FOUNDATION	IA	501(C)(3)	LINE 12A, I	MERCY HEALTH SERVICES-IOWA CORP	Yes	
(18)  ONE WEST ELM STREET SUITE 100 CONSHOHOCKEN, PA 19428 23-2515999	HEALTH CARE SERVICES	PA	501(C)(3)	LINE 3	MERCY PHYSICIAN NETWORK	Yes	
(19)  433 RIVER ST SUITE 3000 TROY, NY 12180 14-1818568	HOME HEALTH SERVICES	NY	501(C)(3)	LINE 3	LTC (EDDY) INC	Yes	

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?	
						Yes	No
(21)  333 BUTTERNUT DRIVE SUITE 100 DEWITT, NY 13214 46-1051881	PACE PROGRAM	NY	501(C)(3)	LINE 10	ST JOSEPH'S HEALTH INC	Yes	
(1)  10 BLACKSMITH DRIVE MALTA, NY 12020 14-1795732	HOME HEALTH SERVICES	NY	501(C)(3)	LINE 10	LTC (EDDY) INC	Yes	
(2)  1221 MAIN STREET SUITE 213 HOLYOKE, MA 01040 04-2501711	LONG TERM CARE	MA	501(C)(3)	LINE 3	THE MERCY HOSPITAL INC	Yes	
(3)  PO BOX 2500 WILMINGTON, DE 19805 22-3008680	LONG TERM CARE (INACTIVE)	DE	501(C)(3)	LINE 10	ST FRANCIS HOSPITAL	Yes	
(4)  1200 EARHART RD ANN ARBOR, MI 48105 20-8072723	FOUNDATION	MI	501(C)(3)	LINE 12A, I	GLACIER HILLS INC	Yes	
(5)  1200 EARHART RD ANN ARBOR, MI 48105 38-1891500	SENIOR LIVING COMMUNITY	MI	501(C)(3)	LINE 10	TRINITY CONTINUING CARE SERVICES	Yes	
(6)  1 GLEN EDDY DRIVE NISKAYUNA, NY 12309 14-1794150	SENIOR LIVING COMMUNITY	NY	501(C)(3)	LINE 10	LTC (EDDY) INC	Yes	
(7)  20555 VICTOR PARKWAY LIVONIA, MI 48152 42-1253527	HEALTH CARE SERVICES	MI	501(C)(3)	LINE 12A, I	TRINITY HEALTH CORPORATION	Yes	
(8)  5401 LAKE OCONEE PARKWAY GREENSBORO, GA 30642 26-1720984	HEALTH CARE AND HOSPITAL SERVICES	GA	501(C)(3)	LINE 3	ST MARY'S HEALTH CARE SYSTEM INC	Yes	
(9)  701 W NORTH AVE MELROSE PARK, IL 60160 36-3332852	COMMUNITY OUTREACH	IL	501(C)(3)	LINE 10	GOTTLIEB MEMORIAL HOSPITAL	Yes	
(10)  701 W NORTH AVE MELROSE PARK, IL 60160 74-3260011	FOUNDATION	IL	501(C)(3)	LINE 12C, III-FI	N/A		No
(11)  701 W NORTH AVE MELROSE PARK, IL 60160 36-2379649	HEALTH CARE AND HOSPITAL SERVICES	IL	501(C)(3)	LINE 3	LOYOLA UNIVERSITY HEALTH SYSTEM	Yes	
(12)  945 OTTAWA AVE NW GRAND RAPIDS, MI 49503 23-7270669	MEDICAL EDUCATION TRAINING PROGRAMS	MI	501(C)(3)	LINE 12A, I	TRINITY HEALTH-MICHIGAN	Yes	
(13)  125 E SOUTHERN AVENUE MUSKEGON, MI 49442 38-1386362	HEALTH CARE SERVICES	MI	501(C)(3)	LINE 10	MERCY HEALTH PARTNERS	Yes	
(14)  30 COMMUNITY WAY EAST GREENBUSH, NY 12061 80-0102840	SENIOR LIVING COMMUNITY	NY	501(C)(3)	LINE 10	LTC (EDDY) INC	Yes	
(15)  PO BOX 2153 WATERBURY, CT 06722 83-0416893	MANAGEMENT	CT	501(C)(3)	LINE 12A, I	N/A		No
(16)  2920 TIBBITS AVE TROY, NY 12180 14-1725101	LONG TERM CARE	NY	501(C)(3)	LINE 10	LTC (EDDY) INC	Yes	
(17)  PO BOX 9184 FARMINGTON HILLS, MI 48152 52-1945054	LONG TERM CARE	MD	501(C)(3)	LINE 10	TRINITY CONTINUING CARE SERVICES	Yes	
(18)  1500 FOREST GLEN RD SILVER SPRING, MD 20910 20-8428450	FOUNDATION	MD	501(C)(3)	LINE 7	HOLY CROSS HEALTH INC	Yes	
(19)  1500 FOREST GLEN RD SILVER SPRING, MD 20910 52-0738041	HEALTH CARE AND HOSPITAL SERVICES	MD	501(C)(3)	LINE 3	TRINITY HEALTH CORPORATION	Yes	

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?	
						Yes	No
(41)  4725 NORTH FEDERAL HIGHWAY FT LAUDERDALE, FL 33308 59-0791028	HEALTH CARE AND HOSPITAL SERVICES	FL	501(C)(3)	LINE 3	TRINITY HEALTH CORPORATION	Yes	
(1)  4725 NORTH FEDERAL HIGHWAY FT LAUDERDALE, FL 33308 65-0666283	BUILDING MANAGEMENT SERVICES	FL	501(C)(2)	N/A	HOLY CROSS HOSPITAL INC	Yes	
(2)  4725 NORTH FEDERAL HIGHWAY FT LAUDERDALE, FL 33308 46-5421068	HEALTH CARE SERVICES	FL	501(C)(3)	LINE 10	HOLY CROSS HOSPITAL INC	Yes	
(3)  4725 NORTH FEDERAL HIGHWAY FT LAUDERDALE, FL 33308 81-2531495	HEALTH CARE SERVICES	FL	501(C)(3)	LINE 10	HOLY CROSS HOSPITAL INC	Yes	
(4)  114 WOODLAND STREET HARTFORD, CT 06105 81-0723591	HOME HEALTH SERVICES	CT	501(C)(3)	LINE 10	TRINITY HEALTH OF NEW ENGLAND CORP INC	Yes	
(5)  433 RIVER ST SUITE 3000 TROY, NY 12180 14-1514867	HOME HEALTH SERVICES	NY	501(C)(3)	LINE 10	LTC (EDDY) INC	Yes	
(6)  232 SECOND STREET SE MASON CITY, IA 50401 42-1173708	HOSPICE SERVICES	IA	501(C)(3)	LINE 10	MERCY HEALTH SERVICES-IOWA CORP	Yes	
(7)  4300 HAMILTON BLVD SIOUX CITY, IA 51104 38-3320710	HOSPICE SERVICES	IA	501(C)(3)	LINE 12A, I	N/A		No
(8)  24 FRANK LLOYD WRIGHT DR LOBBY J ANN ARBOR, MI 48106 38-3316559	HEALTH CARE SERVICES	MI	501(C)(3)	LINE 10	TRINITY HEALTH-MICHIGAN	Yes	
(9)  114 WOODLAND STREET HARTFORD, CT 06105 81-0709903	HEALTH CARE SERVICES	CT	501(C)(3)	LINE 10	TRINITY HEALTH OF NEW ENGLAND CORP INC	Yes	
(10)  114 WOODLAND STREET HARTFORD, CT 06105 47-5676956	HEALTH CARE AND HOSPITAL SERVICES	CT	501(C)(3)	LINE 3	TRINITY HEALTH OF NEW ENGLAND CORP INC	Yes	
(11)  114 WOODLAND STREET HARTFORD, CT 06105 81-0696923	HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT	CT	501(C)(3)	LINE 12B, II	TRINITY HEALTH OF NEW ENGLAND CORP INC	Yes	
(12)  1201 LANGHORNE-NEWTOWN ROAD LANGHORNE, PA 19047 23-2519529	HEALTH CARE SERVICES (INACTIVE)	PA	501(C)(3)	LINE 10	ST MARY MEDICAL CENTER	Yes	
(13)  1201 LANGHORNE-NEWTOWN ROAD LANGHORNE, PA 19047 23-2571699	HEALTH CARE SERVICES	PA	501(C)(3)	LINE 10	ST MARY MEDICAL CENTER	Yes	
(14)  2475 MCCLELLAN AVENUE PENNSAUKEN, NJ 08109 26-1854750	PACE PROGRAM	NJ	501(C)(3)	LINE 3	OUR LADY OF LOURDES HEALTH CARE SERVICES	Yes	
(15)  7TH AND CLAYTON STREETS WILMINGTON, DE 19805 45-2569214	PACE PROGRAM	DE	501(C)(3)	LINE 10	ST FRANCIS HOSPITAL	Yes	
(16)  1435 LIBERTY STREET HAMILTON, NJ 08629 22-2797282	PACE PROGRAM	NJ	501(C)(3)	LINE 10	ST FRANCIS MEDICAL CENTER TRENTON NJ	Yes	
(17)  100 GOSSMAN DRIVE SOUTHERN PINES, NC 28387 27-2159847	PACE PROGRAM	NC	501(C)(3)	LINE 3	ST JOSEPH OF THE PINES INC	Yes	
(18)  1201 LANGHORNE-NEWTOWN ROAD LANGHORNE, PA 19047 26-2976184	PACE PROGRAM	PA	501(C)(3)	LINE 10	ST MARY MEDICAL CENTER	Yes	
(19)  1600 HADDON AVENUE CAMDEN, NJ 08103 22-2568525	VOLUNTEER SERVICE AUXILIARY	NJ	501(C)(3)	LINE 12B, II	OUR LADY OF LOURDES HEALTH CARE SERVICES	Yes	



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?	
						Yes	No
(61)  1600 HADDON AVENUE CAMDEN, NJ 08103 27-4357794	HEALTH CARE SERVICES	NJ	501(C)(3)	LINE 3	OUR LADY OF LOURDES HEALTH CARE SERVICES	Yes	
(1)  218 SUNSET ROAD WILLINGBORO, NJ 08046 22-3612265	HEALTH CARE AND HOSPITAL SERVICES	NJ	501(C)(3)	LINE 3	OUR LADY OF LOURDES HEALTH CARE SERVICES	Yes	
(2)  905 W NORTH AVE MELROSE PARK, IL 60160 47-4147171	TRANSPORATION SERVICES	IL	501(C)(3)	LINE 10	LOYOLA UNIVERSITY MEDICAL CENTER	Yes	
(3)  2160 SOUTH FIRST AVENUE MAYWOOD, IL 60153 36-3342448	HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT	IL	501(C)(3)	LINE 12B, II	TRINITY HEALTH CORPORATION	Yes	
(4)  2160 SOUTH FIRST AVENUE MAYWOOD, IL 60153 36-4015560	HEALTH CARE AND HOSPITAL SERVICES	IL	501(C)(3)	LINE 3	LOYOLA UNIVERSITY HEALTH SYSTEM	Yes	
(5)  2212 BURDETT AVE TROY, NY 12180 22-2564710	MANAGEMENT SERVICES FOR LONG TERM CARE	NY	501(C)(3)	LINE 12B, II	ST PETER'S HEALTH PARTNERS	Yes	
(6)  3805 WEST CHESTER PIKE STE 100 NEWTOWN SQUARE, PA 19073 24-0711230	HEALTH CARE SERVICES (INACTIVE)	PA	501(C)(3)	LINE 10	MAXIS HEALTH SYSTEM	Yes	
(7)  801 5TH STREET SIOUX CITY, IA 51101 38-3320705	HOME HEALTH SERVICES (INACTIVE)	IA	501(C)(3)	LINE 12A, I	MERCY HEALTH SERVICES-IOWA CORP	Yes	
(8)  3805 WEST CHESTER PIKE STE 100 NEWTOWN SQUARE, PA 19073 91-1940902	HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT (INACTIVE)	PA	501(C)(3)	LINE 12A, I	TRINITY HEALTH CORPORATION	Yes	
(9)  275 STEELE ROAD WEST HARTFORD, CT 06117 06-1058086	SENIOR LIVING COMMUNITY	CT	501(C)(3)	LINE 10	MERCY COMMUNITY HEALTH INC	Yes	
(10)  PO BOX 992 ANN ARBOR, MI 48106 38-2561013	HEALTH CARE SERVICES (INACTIVE)	MI	501(C)(3)	LINE 3	CATHERINE MCAULEY HEALTH SERVICES CORP	Yes	
(11)  3333 FIFTH AVENUE PITTSBURGH, PA 15213 94-3436142	GRANT MAKING	PA	501(C)(3)	LINE 12B, II	PITTSBURGH MERCY HEALTH SYSTEM INC	Yes	
(12)  600 NORTHERN BLVD ALBANY, NY 12204 14-1338457	HEALTH CARE AND HOSPITAL SERVICES	NY	501(C)(3)	LINE 3	ST PETER'S HEALTH PARTNERS	Yes	
(13)  1111 W LONG LAKE RD STE 102 TROY, MI 48098 38-3320698	HOME HEALTH SERVICES	MI	501(C)(3)	LINE 10	TRINITY HOME HEALTH SERVICES	Yes	
(14)  17410 COLLEGE PARKWAY STE 150 LIVONIA, MI 48152 38-3320701	HOME HEALTH SERVICES	MI	501(C)(3)	LINE 10	TRINITY HOME HEALTH SERVICES	Yes	
(15)  424 DECATUR STREET ATLANTA, GA 30312 58-1448522	FOUNDATION	GA	501(C)(3)	LINE 7	SAINT JOSEPH'S HEALTH SYSTEM INC	Yes	
(16)  ONE WEST ELM STREET SUITE 100 CONSHOHOCKEN, PA 19428 23-1352191	HEALTH CARE AND HOSPITAL SERVICES	PA	501(C)(3)	LINE 3	MERCY HEALTH SYSTEM OF SOUTHEASTERN PENNSYLVANIA	Yes	
(17)  2021 ALBANY AVENUE WEST HARTFORD, CT 06117 06-1492707	HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT	CT	501(C)(3)	LINE 12B, II	TRINITY CONTINUING CARE SERVICES	Yes	
(18)  1001 BALTIMORE PIKE SUITE 310 SPRINGFIELD, PA 19064 23-2325059	HOME HEALTH SERVICES	PA	501(C)(3)	LINE 10	MERCY HOME HEALTH SERVICES	Yes	
(19)  2525 SOUTH MICHIGAN AVENUE CHICAGO, IL 60616 36-3227350	FOUNDATION	IL	501(C)(3)	LINE 7	MERCY HEALTH SYSTEM OF CHICAGO	Yes	

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?	
						Yes	No
(81)  888 TERRACE STREET MUSKEGON, MI 49440 38-3321856	HOSPICE & HOME HEALTH SERVICES	MI	501(C)(3)	LINE 10	TRINITY HOME HEALTH SERVICES	Yes	
(1)  ONE WEST ELM STREET SUITE 100 CONSHOHOCKEN, PA 19428 23-2829864	FOUNDATION	PA	501(C)(3)	LINE 12B, II	MERCY HEALTH SYSTEM OF SOUTHEASTERN PENNSYLVANIA	Yes	
(2)  1111 6TH AVENUE DES MOINES, IA 50314 42-1478417	HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT	DE	501(C)(3)	LINE 12B, II	N/A		No
(3)  1500 E SHERMAN BLVD MUSKEGON, MI 49444 38-2589966	HEALTH CARE AND HOSPITAL SERVICES	MI	501(C)(3)	LINE 3	TRINITY HEALTH-MICHIGAN	Yes	
(4)  ONE WEST ELM STREET SUITE 100 CONSHOHOCKEN, PA 19428 22-2483605	MEDICAID MANAGED CARE PLAN	PA	501(C)(3)	LINE 12B, II	MERCY HEALTH SYSTEM OF SOUTHEASTERN PENNSYLVANIA	Yes	
(5)  1000 4TH STREET SW MASON CITY, IA 50401 31-1373080	HEALTH CARE AND HOSPITAL SERVICES	DE	501(C)(3)	LINE 3	TRINITY HEALTH CORPORATION		No
(6)  2525 SOUTH MICHIGAN AVENUE CHICAGO, IL 60616 36-3163327	HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT	IL	501(C)(3)	LINE 12B, II	TRINITY HEALTH CORPORATION	Yes	
(7)  ONE WEST ELM STREET SUITE 100 CONSHOHOCKEN, PA 19428 23-2212638	HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT	PA	501(C)(3)	LINE 12C, III-FI	TRINITY HEALTH CORPORATION	Yes	
(8)  114 WAWBEEK AVENUE TUPPER LAKE, NY 12986 15-0532211	HEALTH CARE AND HOSPITAL SERVICES (INACTIVE)	NY	501(C)(3)	LINE 3	MERCY UIHLEIN HEALTH CORPORATION	Yes	
(9)  1410 N 4TH ST CLINTON, IA 52732 42-1316126	FOUNDATION	IA	501(C)(3)	LINE 7	N/A		No
(10)  1001 BALTIMORE PIKE SUITE 310 SPRINGFIELD, PA 19064 23-1352099	HOME HEALTH SERVICES	PA	501(C)(3)	LINE 10	MERCY HOME HEALTH SERVICES	Yes	
(11)  1001 BALTIMORE PIKE SUITE 310 SPRINGFIELD, PA 19064 23-2325058	MANAGEMENT SERVICES FOR HOME HEALTH	PA	501(C)(3)	LINE 12B, II	MERCY HEALTH SYSTEM OF SOUTHEASTERN PENNSYLVANIA	Yes	
(12)  2525 SOUTH MICHIGAN AVENUE CHICAGO, IL 60616 36-2170152	HEALTH CARE AND HOSPITAL SERVICES	IL	501(C)(3)	LINE 3	MERCY HEALTH SYSTEM OF CHICAGO	Yes	
(13)  1820 44TH ST SE KENTWOOD, MI 49508 20-3357131	FOUNDATION	MI	501(C)(3)	LINE 12A, I	TRINITY HEALTH-MICHIGAN	Yes	
(14)  4725 NORTH FEDERAL HIGHWAY FT LAUDERDALE, FL 33308 59-0791034	HEALTH CARE SERVICES (INACTIVE)	FL	501(C)(3)	LINE 12B, II	TRINITY HEALTH CORPORATION	Yes	
(15)  1200 REEDSDALE STREET PITTSBURGH, PA 15233 25-1604115	COMMUNITY OUTREACH	PA	501(C)(3)	LINE 10	PITTSBURGH MERCY HEALTH SYSTEM INC	Yes	
(16)  PO BOX 7957 MOBILE, AL 36670 27-3163002	PACE PROGRAM	AL	501(C)(3)	LINE 3	TRINITY HEALTH PACE	Yes	
(17)  1221 MAIN STREET SUITE 213 HOLYOKE, MA 01040 45-3086711	PACE PROGRAM	MA	501(C)(3)	LINE 3	SISTERS OF PROVIDENCE CARE CENTERS INC	Yes	
(18)  ONE WEST ELM STREET SUITE 100 CONSHOHOCKEN, PA 19428 23-2627944	HEALTH CARE SERVICES	PA	501(C)(3)	LINE 3	MERCY PHYSICIAN NETWORK	Yes	
(19)  1410 NORTH 4TH ST CLINTON, IA 52732 42-1336618	HEALTH CARE AND HOSPITAL SERVICES	DE	501(C)(3)	LINE 3	MERCY HEALTH SERVICES-IOWA CORP	Yes	

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?	
						Yes	No
(101)  801 5TH STREET SIOUX CITY, IA 51102 14-1880022	FOUNDATION	IA	501(C)(3)	LINE 7	MERCY HEALTH SERVICES-IOWA CORP	Yes	
(1)  1000 4TH STREET SW MASON CITY, IA 50401 42-1229151	FOUNDATION	IA	501(C)(3)	LINE 7	MERCY HEALTH SERVICES-IOWA CORP	Yes	
(2)  PO BOX 7957 MOBILE, AL 36670 63-6002215	PACE PROGRAM	AL	501(C)(3)	LINE 10	TRINITY HEALTH CORPORATION	Yes	
(3)  1221 MAIN STREET SUITE 213 HOLYOKE, MA 01040 45-4884805	HEALTH CARE SERVICES	MA	501(C)(3)	LINE 3	THE MERCY HOSPITAL INC	Yes	
(4)  ONE WEST ELM STREET SUITE 100 CONSHOHOCKEN, PA 19428 46-1187365	MANAGEMENT SERVICES FOR PHYSICIAN SERVICE ORGANIZATIONS	PA	501(C)(3)	LINE 12B, II	MERCY HEALTH SYSTEM OF SOUTHEASTERN PENNSYLVANIA	Yes	
(5)  424 DECATUR STREET ATLANTA, GA 30312 58-1366508	COMMUNITY OUTREACH	GA	501(C)(3)	LINE 7	SAINT JOSEPH'S HEALTH SYSTEM INC	Yes	
(6)  424 DECATUR STREET ATLANTA, GA 30312 27-2046353	TITLE HOLDING COMPANY	GA	501(C)(3)	LINE 12B, II	SAINT JOSEPH'S HEALTH SYSTEM INC	Yes	
(7)  PO BOX 9184 FARMINGTON HILLS, MI 48333 38-2719605	LONG TERM CARE	MI	501(C)(3)	LINE 10	TRINITY CONTINUING CARE SERVICES	Yes	
(8)  1221 MAIN STREET SUITE 213 HOLYOKE, MA 01040 26-4033168	HEALTH CARE SERVICES	MA	501(C)(3)	LINE 3	THE MERCY HOSPITAL INC	Yes	
(9)  ONE WEST ELM STREET SUITE 100 CONSHOHOCKEN, PA 19428 23-1396763	HEALTH CARE AND HOSPITAL SERVICES	PA	501(C)(3)	LINE 3	MERCY HEALTH SYSTEM OF SOUTHEASTERN PENNSYLVANIA	Yes	
(10)  3805 WEST CHESTER PIKE SUITE 100 NEWTOWN SQUARE, NY 19073 16-1535133	HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT (INACTIVE)	NY	501(C)(3)	LINE 12B, II	TRINITY HEALTH CORPORATION	Yes	
(11)  37595 SEVEN MILE ROAD LIVONIA, MI 48152 38-3181557	BUILDING MANAGEMENT SERVICES	DE	501(C)(3)	LINE 12A, I	N/A		No
(12)  6150 EAST BROAD STREET COLUMBUS, OH 43213 31-1308555	COLLEGE OF NURSING	OH	501(C)(3)	LINE 2	MOUNT CARMEL HEALTH SYSTEM	Yes	
(13)  6150 EAST BROAD STREET COLUMBUS, OH 43213 25-1912781	HEALTH INSURANCE	OH	501(C)(4)	N/A	MOUNT CARMEL HEALTH SYSTEM	Yes	
(14)  6150 EAST BROAD STREET COLUMBUS, OH 43213 31-1471229	MEDICARE HMO	OH	501(C)(4)	N/A	MOUNT CARMEL HEALTH SYSTEM	Yes	
(15)  6150 EAST BROAD STREET COLUMBUS, OH 43213 31-1439334	HEALTH CARE AND HOSPITAL SERVICES	OH	501(C)(3)	LINE 3	TRINITY HEALTH CORPORATION	Yes	
(16)  6150 EAST BROAD STREET COLUMBUS, OH 43213 31-1113966	FOUNDATION	OH	501(C)(3)	LINE 12A, I	MOUNT CARMEL HEALTH SYSTEM	Yes	
(17)  501 WEST SCHROCK ROAD WESTERVILLE, OH 43081 26-2729300	HOME HEALTH SERVICES	OH	501(C)(3)	LINE 10	TRINITY HOME HEALTH SERVICES	Yes	
(18)  500 BLUE HILLS AVENUE HARTFORD, CT 06112 22-2584082	FOUNDATION	CT	501(C)(3)	LINE 12C, III-FI	N/A		No
(19)  114 WOODLAND STREET HARTFORD, CT 06105 06-1422973	HEALTH CARE AND HOSPITAL SERVICES	CT	501(C)(3)	LINE 3	TRINITY HEALTH OF NEW ENGLAND CORP INC	Yes	

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?	
						Yes	No
(121)  7 HIGHTOWER STREET WATERVILLE, ME 04901 01-0274998	LONG TERM CARE	ME	501(C)(3)	LINE 3	MERCY COMMUNITY HEALTH INC	Yes	
(1)  1820 44TH STREET KENTWOOD, MI 49508 38-3073745	HEALTH CARE SERVICES (INACTIVE)	MI	501(C)(3)	LINE 10	TRINITY HEALTH-MICHIGAN	Yes	
(2)  565 W WESTERN AVENUE MUSKEGON, MI 49440 91-1932918	COMMUNITY OUTREACH	MI	501(C)(3)	LINE 7	MERCY HEALTH PARTNERS	Yes	
(3)  2701 HOLME AVENUE PHILADELPHIA, PA 19152 23-2300951	FOUNDATION	PA	501(C)(3)	LINE 12A, I	NAZARETH HOSPITAL	Yes	
(4)  2601 HOLME AVENUE PHILADELPHIA, PA 19152 23-2794121	HEALTH CARE AND HOSPITAL SERVICES	PA	501(C)(3)	LINE 3	MERCY HEALTH SYSTEM OF SOUTHEASTERN PENNSYLVANIA	Yes	
(5)  ONE WEST ELM STREET SUITE 100 CONSHOHOCKEN, PA 19428 20-3261266	HEALTH CARE SERVICES	PA	501(C)(3)	LINE 3	MERCY PHYSICIAN NETWORK	Yes	
(6)  ONE WEST ELM STREET SUITE 100 CONSHOHOCKEN, PA 19428 23-2497355	HEALTH CARE SERVICES (INACTIVE)	PA	501(C)(3)	LINE 3	MERCY PHYSICIAN NETWORK	Yes	
(7)  601 EAST 2ND STREET OAKLAND, NE 68045 20-8072234	HEALTH CARE AND HOSPITAL SERVICES	NE	501(C)(3)	LINE 3	MERCY HEALTH SERVICES-IOWA CORP	Yes	
(8)  601 E 2ND STREET OAKLAND, NE 68045 31-1678345	FOUNDATION	NE	501(C)(3)	LINE 12A, I	OAKLAND MERCY HOSPITAL	Yes	
(9)  114 WOODLAND STREET HARTFORD, CT 06105 06-0922325	BUILDING MANAGEMENT SERVICES	CT	501(C)(2)	N/A	SAINT FRANCIS HOSPITAL AND MEDICAL CENTER	Yes	
(10)  6150 EAST BROAD STREET COLUMBUS, OH 43213 31-1654603	COOPERATIVE HEALTH CARE DELIVERY SYSTEM	OH	501(C)(3)	LINE 12A, I	N/A		No
(11)  1600 HADDON AVENUE CAMDEN, NJ 08103 22-2568528	HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT	NJ	501(C)(3)	LINE 12B, II	MAXIS HEALTH SYSTEM	Yes	
(12)  1600 HADDON AVENUE CAMDEN, NJ 08103 22-2351960	FOUNDATION	NJ	501(C)(3)	LINE 7	OUR LADY OF LOURDES HEALTH CARE SERVICES	Yes	
(13)  1600 HADDON AVENUE CAMDEN, NJ 08103 21-0635001	HEALTH CARE AND HOSPITAL SERVICES	NJ	501(C)(3)	LINE 3	OUR LADY OF LOURDES HEALTH CARE SERVICES	Yes	
(14)  2 MERCYCARE LANE GUILDERLAND, NY 12084 14-1743506	LONG TERM CARE	NY	501(C)(3)	LINE 3	ST PETER'S HOSPITAL	Yes	
(15)  1221 MAIN STREET SUITE 213 HOLYOKE, MA 01040 45-4208896	HEALTH CARE SERVICES	MA	501(C)(3)	LINE 3	THE MERCY HOSPITAL INC	Yes	
(16)  3333 5TH AVENUE PITTSBURGH, PA 15213 25-1464211	HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT	PA	501(C)(3)	LINE 12B, II	TRINITY HEALTH CORPORATION	Yes	
(17)  2058 S STATE STREET ANN ARBOR, MI 48104 20-2020239	HEALTH CARE SERVICES	MI	501(C)(3)	LINE 10	TRINITY HEALTH-MICHIGAN	Yes	
(18)  965 FORK STREET MUSKEGON, MI 49442 38-2638284	HEALTH CARE SERVICES	MI	501(C)(3)	LINE 10	MERCY HEALTH PARTNERS	Yes	
(19)  271 CAREW ST SPRINGFIELD, MA 01104 81-1807730	HEALTH CARE SERVICES	MA	501(C)(3)	LINE 3	THE MERCY HOSPITAL INC	Yes	

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?	
						Yes	No
(141)  301 PROSPECT AVENUE SYRACUSE, NY 13203 27-1763712	HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT	NY	501(C)(3)	LINE 12A, I	ST JOSEPH'S HOSPITAL HEALTH CENTER	Yes	
(1)  1303 EAST HERNDON AVE FRESNO, CA 93720 94-1437713	HEALTH CARE AND HOSPITAL SERVICES	CA	501(C)(3)	LINE 3	TRINITY HEALTH CORPORATION	Yes	
(2)  1303 EAST HERNDON AVE FRESNO, CA 93720 94-2839324	HEALTH CARE SERVICES	CA	501(C)(3)	LINE 12A, I	SAINT AGNES MEDICAL CENTER	Yes	
(3)  1055 NORTH CURTIS RD BOISE, ID 83706 82-0401011	BUILDING MANAGEMENT SERVICES	ID	501(C)(3)	LINE 10	SAINT ALPHONSUS REGIONAL MEDICAL CENTER INC	Yes	
(4)  1055 NORTH CURTIS RD BOISE, ID 83706 94-3028978	HEALTH CARE SYSTEM SUPPORT	ID	501(C)(3)	LINE 12A, I	SAINT ALPHONSUS REGIONAL MEDICAL CENTER INC	Yes	
(5)  3325 POCAHONTAS ROAD BAKER CITY, OR 97814 94-3164869	FOUNDATION	OR	501(C)(3)	LINE 7	SAINT ALPHONSUS MEDICAL CENTER - BAKER CITY	Yes	
(6)  351 SW 9TH STREET ONTARIO, OR 97914 20-2683560	FOUNDATION	OR	501(C)(3)	LINE 7	SAINT ALPHONSUS MEDICAL CENTER-ONTARIO	Yes	
(7)  1055 N CURTIS ROAD BOISE, ID 83706 27-1929502	HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT	ID	501(C)(3)	LINE 12B, II	TRINITY HEALTH CORPORATION	Yes	
(8)  351 SW 9TH STREET ONTARIO, OR 97914 94-3059469	VOLUNTEER SERVICE AUXILIARY	OR	501(C)(3)	LINE 10	SAINT ALPHONSUS MEDICAL CENTER-ONTARIO	Yes	
(9)  3325 POCAHONTAS ROAD BAKER CITY, OR 97814 27-1790052	HEALTH CARE AND HOSPITAL SERVICES	OR	501(C)(3)	LINE 3	SAINT ALPHONSUS HEALTH SYSTEM INC	Yes	
(10)  1512 12TH AVENUE ROAD NAMPA, ID 83686 26-1737256	FOUNDATION	ID	501(C)(3)	LINE 7	SAINT ALPHONSUS MEDICAL CENTER-NAMPA	Yes	
(11)  1512 12TH AVENUE ROAD NAMPA, ID 83686 82-0200896	HEALTH CARE AND HOSPITAL SERVICES	ID	501(C)(3)	LINE 3	SAINT ALPHONSUS HEALTH SYSTEM INC	Yes	
(12)  351 SW 9TH STREET ONTARIO, OR 97914 27-1789847	HEALTH CARE AND HOSPITAL SERVICES	OR	501(C)(3)	LINE 3	SAINT ALPHONSUS HEALTH SYSTEM INC	Yes	
(13)  1055 NORTH CURTIS RD BOISE, ID 83706 82-0200895	HEALTH CARE AND HOSPITAL SERVICES	ID	501(C)(3)	LINE 3	SAINT ALPHONSUS HEALTH SYSTEM INC	Yes	
(14)  114 WOODLAND STREET HARTFORD, CT 06105 45-1994612	HEALTH CARE SERVICES	CT	501(C)(3)	LINE 12B, II	TRINITY HEALTH OF NEW ENGLAND PNO INC	Yes	
(15)  114 WOODLAND STREET HARTFORD, CT 06105 06-0646813	HEALTH CARE AND HOSPITAL SERVICES	CT	501(C)(3)	LINE 3	TRINITY HEALTH OF NEW ENGLAND CORP INC	Yes	
(16)  114 WOODLAND STREET HARTFORD, CT 06105 06-1008255	FOUNDATION	CT	501(C)(3)	LINE 12B, II	SAINT FRANCIS HOSPITAL AND MEDICAL CENTER	Yes	
(17)  111 CENTRAL AVENUE NEWARK, NJ 07102 26-2616230	INACTIVE ENTITY	NJ	501(C)(3)	LINE 10	SAINT MICHAEL'S MEDICAL CENTER	Yes	
(18)  20555 VICTOR PARKWAY LIVONIA, MI 48152 47-3129127	PACE PROGRAM	IN	501(C)(3)	LINE 7	TRINITY HEALTH PACE	Yes	
(19)  PO BOX 670 PLYMOUTH, IN 46563 35-1142669	HEALTH CARE AND HOSPITAL SERVICES	IN	501(C)(3)	LINE 3	SAINT JOSEPH REGIONAL MEDICAL CENTER INC	Yes	

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?	
						Yes	No
(161)  5215 HOLY CROSS PARKWAY MISHAWAKA, IN 46545 35-0868157	HEALTH CARE AND HOSPITAL SERVICES	IN	501(C)(3)	LINE 3	SAINT JOSEPH REGIONAL MEDICAL CENTER INC	Yes	
(1)  1915 LAKE AVENUE PLYMOUTH, IN 46563 35-6043563	VOLUNTEER SERVICE AUXILIARY	IN	501(C)(3)	LINE 12B, II	SAINT JOSEPH REGIONAL MEDICAL CENTER - PLYMOUTH CAMPUS INC	Yes	
(2)  5215 HOLY CROSS PARKWAY MISHAWAKA, IN 46545 35-1568821	HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT	IN	501(C)(3)	LINE 12B, II	TRINITY HEALTH CORPORATION	Yes	
(3)  424 DECATUR STREET ATLANTA, GA 30312 58-1744848	HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT	GA	501(C)(3)	LINE 12C, III-FI	TRINITY HEALTH CORPORATION	Yes	
(4)  424 DECATUR STREET ATLANTA, GA 30312 58-1752700	HEALTH CARE SERVICES	GA	501(C)(3)	LINE 7	SAINT JOSEPH'S HEALTH SYSTEM INC	Yes	
(5)  PO BOX 9184 FARMINGTON HILLS, MI 48333 31-1040468	SENIOR LIVING COMMUNITY	IN	501(C)(3)	LINE 10	TRINITY CONTINUING CARE SERVICES - INDIANA INC	Yes	
(6)  1430 MONROE NW STE 120 GRAND RAPIDS, MI 49505 38-3320700	HOME HEALTH SERVICES	MI	501(C)(3)	LINE 10	TRINITY HOME HEALTH SERVICES	Yes	
(7)  200 JEFFERSON ST SE GRAND RAPIDS, MI 49503 38-1779602	FOUNDATION	MI	501(C)(3)	LINE 7	TRINITY HEALTH-MICHIGAN	Yes	
(8)  56 FRANKLIN STREET WATERBURY, CT 06706 22-2528400	FOUNDATION	CT	501(C)(3)	LINE 7	SAINT MARY'S HOSPITAL INC	Yes	
(9)  56 FRANKLIN STREET WATERBURY, CT 06706 06-0646844	HEALTH CARE AND HOSPITAL SERVICES	CT	501(C)(3)	LINE 3	TRINITY HEALTH OF NEW ENGLAND CORP INC	Yes	
(10)  111 CENTRAL AVENUE NEWARK, NJ 07102 22-3311976	FOUNDATION	NJ	501(C)(3)	LINE 12A, I	SAINT MICHAEL'S MEDICAL CENTER	Yes	
(11)  111 CENTRAL AVENUE NEWARK, NJ 07102 26-2616046	HEALTH CARE AND HOSPITAL SERVICES	NJ	501(C)(3)	LINE 3	MAXIS HEALTH SYSTEM	Yes	
(12)  2215 BURDETT AVE TROY, NY 12180 14-1710225	CHILD CARE SERVICES	NY	501(C)(3)	LINE 10	ST PETER'S HEALTH PARTNERS	Yes	
(13)  2215 BURDETT AVE TROY, NY 12180 14-1338544	HEALTH CARE AND HOSPITAL SERVICES	NY	501(C)(3)	LINE 3	ST PETER'S HEALTH PARTNERS	Yes	
(14)  504 STATE ST SCHENECTADY, NY 12305 14-1708754	PACE PROGRAM	NY	501(C)(3)	LINE 10	LTC (EDDY) INC	Yes	
(15)  1300 MASSACHUSETTS AVENUE TROY, NY 12180 14-1505031	VOLUNTEER SERVICE AUXILIARY	NY	501(C)(3)	LINE 10	SETON HEALTH SYSTEM INC	Yes	
(16)  ONE ABELE BLVD CLIFTON PARK, NY 12065 14-1756230	LONG TERM CARE	NY	501(C)(3)	LINE 10	SETON HEALTH SYSTEM INC	Yes	
(17)  1300 MASSACHUSETTS AVENUE TROY, NY 12180 22-2345416	FOUNDATION	NY	501(C)(3)	LINE 12A, I	SETON HEALTH SYSTEM INC	Yes	
(18)  1300 MASSACHUSETTS AVENUE TROY, NY 12180 14-1776186	HEALTH CARE AND HOSPITAL SERVICES	NY	501(C)(3)	LINE 3	ST PETER'S HEALTH PARTNERS	Yes	
(19)  1221 MAIN STREET SUITE 213 HOLYOKE, MA 01040 22-2541103	LONG TERM CARE	MA	501(C)(3)	LINE 3	THE MERCY HOSPITAL INC	Yes	

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?	
						Yes	No
(181)  1221 MAIN STREET SUITE 213 HOLYOKE, MA 01040 04-3398374	HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT	MA	501(C)(3)	LINE 12B, II	TRINITY HEALTH CORPORATION	Yes	
(1)  424 DECATUR STREET ATLANTA, GA 30312 47-2299757	HEALTH CARE SYSTEM SUPPORT	GA	501(C)(3)	LINE 12B, II	SAINT JOSEPH'S HEALTH SYSTEM INC	Yes	
(2)  ONE WEST ELM STREET SUITE 100 CONSHOHOCKEN, PA 19428 23-2840137	PACE PROGRAM	PA	501(C)(3)	LINE 3	MERCY HEALTH SYSTEM OF SOUTHEASTERN PENNSYLVANIA	Yes	
(3)  ONE WEST ELM STREET SUITE 100 CONSHOHOCKEN, PA 19428 23-2415137	FOUNDATION	PA	501(C)(3)	LINE 12A, I	ST AGNES CONTINUING CARE CENTER	Yes	
(4)  PO BOX 2500 WILMINGTON, DE 19805 51-0374158	FOUNDATION	DE	501(C)(3)	LINE 12A, I	ST FRANCIS HOSPITAL	Yes	
(5)  PO BOX 2500 WILMINGTON, DE 19805 51-0064326	HEALTH CARE AND HOSPITAL SERVICES	DE	501(C)(3)	LINE 3	TRINITY HEALTH CORPORATION	Yes	
(6)  601 HAMILTON AVENUE TRENTON, NJ 08629 52-1025476	FOUNDATION	NJ	501(C)(3)	LINE 7	ST FRANCIS MEDICAL CENTER TRENTON NJ	Yes	
(7)  601 HAMILTON AVENUE TRENTON, NJ 08629 22-3431049	HEALTH CARE AND HOSPITAL SERVICES	NJ	501(C)(3)	LINE 3	MAXIS HEALTH SYSTEM	Yes	
(8)  411 CANISTEO STREET HORNELL, NY 14843 22-3127184	HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT (INACTIVE)	NY	501(C)(3)	LINE 12A, I	TRINITY HEALTH CORPORATION	Yes	
(9)  44405 WOODWARD AVE PONTIAC, MI 48341 35-2356789	FOUNDATION	MI	501(C)(3)	LINE 12A, I	TRINITY HEALTH-MICHIGAN	Yes	
(10)  100 GOSSMAN DRIVE SOUTHERN PINES, NC 28387 56-0694200	LONG TERM CARE	NC	501(C)(3)	LINE 3	TRINITY CONTINUING CARE SERVICES	Yes	
(11)  206 PROSPECT AVENUE SYRACUSE, NY 13203 20-2497520	COLLEGE OF NURSING	NY	501(C)(3)	LINE 2	ST JOSEPH'S HOSPITAL HEALTH CENTER	Yes	
(12)  301 PROSPECT AVENUE SYRACUSE, NY 13203 23-7219294	BUILDING MANAGEMENT SERVICES	NY	501(C)(3)	LINE 12B, II	ST JOSEPH'S HEALTH INC	Yes	
(13)  301 PROSPECT AVENUE SYRACUSE, NY 13203 47-4754987	HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT	NY	501(C)(3)	LINE 12B, II	TRINITY HEALTH CORPORATION	Yes	
(14)  301 PROSPECT AVENUE SYRACUSE, NY 13203 15-0532254	HEALTH CARE AND HOSPITAL SERVICES	NY	501(C)(3)	LINE 3	ST JOSEPH'S HEALTH INC	Yes	
(15)  301 PROSPECT AVENUE SYRACUSE, NY 13203 22-2149775	FOUNDATION	NY	501(C)(3)	LINE 12A, I	ST JOSEPH'S HEALTH INC	Yes	
(16)  301 PROSPECT AVENUE SYRACUSE, NY 13203 27-3899821	HEALTH CARE SERVICES	NY	501(C)(3)	LINE 12A, I	ST JOSEPH'S HOSPITAL HEALTH CENTER	Yes	
(17)  301 PROSPECT AVENUE SYRACUSE, NY 13203 16-1516863	HEALTH CARE SERVICES	NY	501(C)(3)	LINE 12A, I	ST JOSEPH'S HOSPITAL HEALTH CENTER	Yes	
(18)  1201 LANGHORNE-NEWTOWN ROAD LANGHORNE, PA 19047 46-1827502	TITLE HOLDING COMPANY	PA	501(C)(2)	N/A	ST MARY MEDICAL CENTER	Yes	
(19)  1201 LANGHORNE-NEWTOWN ROAD LANGHORNE, PA 19047 46-5354512	HEALTH CARE SERVICES	PA	501(C)(3)	LINE 10	ST MARY MEDICAL CENTER	Yes	

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?	
						Yes	No
(201)  2021 ALBANY AVENUE WEST HARTFORD, CT 06117 06-0646843	LONG TERM CARE	CT	501(C)(3)	LINE 3	MERCY COMMUNITY HEALTH INC	Yes	
(1)  1201 LANGHORNE-NEWTOWN ROAD LANGHORNE, PA 19047 23-1913910	HEALTH CARE AND HOSPITAL SERVICES	PA	501(C)(3)	LINE 3	TRINITY HEALTH CORPORATION	Yes	
(2)  1201 LANGHORNE-NEWTOWN ROAD LANGHORNE, PA 19047 23-2567468	FOUNDATION	PA	501(C)(3)	LINE 7	ST MARY MEDICAL CENTER	Yes	
(3)  1230 BAXTER STREET ATHENS, GA 30606 58-2544232	FOUNDATION	GA	501(C)(3)	LINE 12A, I	ST MARY'S HEALTH CARE SYSTEM INC	Yes	
(4)  1230 BAXTER STREET ATHENS, GA 30606 81-1660088	FOUNDATION	GA	501(C)(3)	LINE 12A, I	ST MARY'S HEALTH CARE SYSTEM INC	Yes	
(5)  1230 BAXTER STREET ATHENS, GA 30606 58-0566223	HEALTH CARE AND HOSPITAL SERVICES	GA	501(C)(3)	LINE 3	TRINITY HEALTH CORPORATION	Yes	
(6)  1230 BAXTER STREET ATHENS, GA 30606 02-0576648	SENIOR LIVING COMMUNITY	GA	501(C)(3)	LINE 3	ST MARY'S HEALTH CARE SYSTEM INC	Yes	
(7)  1230 BAXTER STREET ATHENS, GA 30606 26-1858563	HEALTH CARE SERVICES	GA	501(C)(3)	LINE 3	ST MARY'S HEALTH CARE SYSTEM INC	Yes	
(8)  367 CLEAR CREEK PARKWAY LAVONIA, GA 30553 47-3752176	HEALTH CARE AND HOSPITAL SERVICES	GA	501(C)(3)	LINE 3	ST MARY'S HEALTH CARE SYSTEM INC	Yes	
(9)  315 SOUTH MANNING BLVD ALBANY, NY 12208 45-3570715	HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT	NY	501(C)(3)	LINE 12B, II	TRINITY HEALTH CORPORATION	Yes	
(10)  315 SOUTH MANNING BLVD ALBANY, NY 12208 46-1177336	HEALTH CARE SERVICES	NY	501(C)(3)	LINE 3	ST PETER'S HEALTH PARTNERS	Yes	
(11)  315 SOUTH MANNING BLVD ALBANY, NY 12208 14-1348692	HEALTH CARE AND HOSPITAL SERVICES	NY	501(C)(3)	LINE 3	ST PETER'S HEALTH PARTNERS	Yes	
(12)  310 SOUTH MANNING BLVD ALBANY, NY 12208 22-2262982	FOUNDATION	NY	501(C)(3)	LINE 7	ST PETER'S HEALTH PARTNERS	Yes	
(13)  1270 BELMONT AVE SCHENECTADY, NY 12308 14-1338386	HEALTH CARE AND HOSPITAL SERVICES	NY	501(C)(3)	LINE 3	ST PETER'S HEALTH PARTNERS	Yes	
(14)  1270 BELMONT AVE SCHENECTADY, NY 12308 22-2505127	FOUNDATION	NY	501(C)(3)	LINE 12A, I	SUNNYVIEW HOSPITAL AND REHABILITATION CENTER	Yes	
(15)  445 NEW KARNER RD ALBANY, NY 12205 22-2692940	FOUNDATION	NY	501(C)(3)	LINE 7	THE COMMUNITY HOSPICE INC	Yes	
(16)  445 NEW KARNER RD ALBANY, NY 12205 14-1608921	HOSPICE SERVICES	NY	501(C)(3)	LINE 3	ST PETER'S HEALTH PARTNERS	Yes	
(17)  707 EAST CEDAR STREET SOUTH BEND, IN 46617 35-1654543	FOUNDATION	IN	501(C)(3)	LINE 7	SAINT JOSEPH REGIONAL MEDICAL CENTER INC	Yes	
(18)  2256 BURDETT AVE TROY, NY 12180 22-2570478	LONG TERM CARE	NY	501(C)(3)	LINE 10	LTC (EDDY) INC	Yes	
(19)  421 WEST COLUMBIA ST COHOES, NY 12047 14-1793885	LONG TERM CARE	NY	501(C)(3)	LINE 10	LTC (EDDY) INC	Yes	



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?	
						Yes	No
(221)  1221 MAIN STREET SUITE 213 HOLYOKE, MA 01040 04-3398280	HEALTH CARE AND HOSPITAL SERVICES	MA	501(C)(3)	LINE 3	TRINITY HEALTH OF NEW ENGLAND CORP INC	Yes	
(1)  310 SOUTH MANNING BLVD ALBANY, NY 12208 22-2743478	FOUNDATION	NY	501(C)(3)	LINE 7	ST PETER'S HEALTH PARTNERS	Yes	
(2)  114 WOODLAND STREET HARTFORD, CT 06105 06-0660403	VOLUNTEER SERVICE AUXILIARY	CT	501(C)(3)	LINE 12B, II	N/A		No
(3)  309 GRAND RIVER PORT HURON, MI 48060 38-2485700	HEALTH CARE SERVICES	MI	501(C)(3)	LINE 12A, I	N/A		No
(4)  PO BOX 9184 FARMINGTON HILLS, MI 48333 38-2559656	LONG TERM CARE	MI	501(C)(3)	LINE 10	TRINITY HEALTH CORPORATION	Yes	
(5)  PO BOX 9184 FARMINGTON HILLS, MI 48333 93-0907047	LONG TERM CARE	IN	501(C)(3)	LINE 10	TRINITY CONTINUING CARE SERVICES	Yes	
(6)  20555 VICTOR PARKWAY LIVONIA, MI 48152 38-2113393	HEALTH CARE AND HOSPITAL SERVICES	MI	501(C)(3)	LINE 3	TRINITY HEALTH CORPORATION	Yes	
(7)  20555 VICTOR PARKWAY LIVONIA, MI 48152 35-1443425	HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT	IN	501(C)(3)	LINE 12B, II	CATHOLIC HEALTH MINISTRIES	Yes	
(8)  20555 VICTOR PARKWAY LIVONIA, MI 48152 47-5244984	PACE PROGRAM	PA	501(C)(3)	LINE 10	TRINITY HEALTH PACE	Yes	
(9)  114 WOODLAND STREET HARTFORD, CT 06105 06-1491191	HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT	CT	501(C)(3)	LINE 12C, III-FI	TRINITY HEALTH CORPORATION	Yes	
(10)  114 WOODLAND STREET HARTFORD, CT 06105 06-1450168	HEALTH CARE SERVICES	CT	501(C)(3)	LINE 3	TRINITY HEALTH OF NEW ENGLAND CORP INC	Yes	
(11)  20555 VICTOR PARKWAY LIVONIA, MI 48152 47-3073124	PACE PROGRAM	MI	501(C)(3)	LINE 12B, II	TRINITY HEALTH CORPORATION	Yes	
(12)  20555 VICTOR PARKWAY LIVONIA, MI 48152 20-8151733	RETIREE MEDICAL AND RETIREE LIFE INSURANCE	MI	501(C)(9)	N/A	TRINITY HEALTH CORPORATION	Yes	
(13)  17410 COLLEGE PARKWAY STE 150 LIVONIA, MI 48152 38-2621935	MANAGEMENT SERVICES FOR HOME HEALTH SYSTEM	MI	501(C)(3)	LINE 10	TRINITY HEALTH CORPORATION	Yes	
(14)  3805 WEST CHESTER PIKE SUITE 100 NEWTOWN SQUARE, PA 19073 15-0532190	HEALTH CARE SERVICES (INACTIVE)	NY	501(C)(3)	LINE 3	MERCY UIHLEIN HEALTH CORPORATION	Yes	
(15)  111 CENTRAL AVENUE NEWARK, NJ 07102 22-3100162	TITLE HOLDING COMPANY	NJ	501(C)(2)	N/A	SAINT MICHAEL'S MEDICAL CENTER	Yes	
(16)  301 HACKETT BLVD ALBANY, NY 12208 14-1438749	LONG TERM CARE	NY	501(C)(3)	LINE 3	ST PETER'S HOSPITAL	Yes	
(17)  1820 44TH STREET KENTWOOD, MI 49508 38-3280200	HEALTH NETWORK	MI	501(C)(4)	N/A	MERCY HEALTH PARTNERS	Yes	

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

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

[illegible]

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

[illegible]

Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust									
(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of- year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity?	
								Yes	No
(1) AFFILIATED MANAGEMENT SERVICES CORPORATION INC 1300 MASSACHUSETTS AVENUE TROY, NY 12180 14-1668024	REAL ESTATE	NY	N/A	C				Yes	
(1) CARBONDALE PHYSICIANS' SERVICES INC 100 LINCOLN AVE CARBONDALE, PA 18407 23-2365077	PHARMACY	PA	N/A	C				Yes	
(2) CATHERINE HORAN BUILDING CORP 1233 MAIN STREET HOLYOKE, MA 01040 04-2938160	BUILDING MANAGEMENT	MA	N/A	C				Yes	
(3) CHESTNUT RISK SERVICES LTD 11 VICTORIA STREET HAMILTON BD	INSURANCE	BD	N/A	C				Yes	
(4) DIVERSIFIED COMMUNITY SERVICES INC 1233 MAIN STREET HOLYOKE, MA 01040 04-3128890	MEDICAL SERVICES	MA	N/A	C				Yes	
(5) FHS SERVICES INC 333 BUTTERNUT DRIVE SUITE 100 DEWITT, NY 13214 27-2995699	MEDICAL SERVICES	NY	N/A	C				Yes	
(6) FRANCISCAN ASSOCIATES INC 333 BUTTERNUT DRIVE SUITE 100 DEWITT, NY 13214 20-2991688	MEDICAL SERVICES	NY	N/A	C				Yes	
(7) FRANCISCAN HEALTH SUPPORT INC 333 BUTTERNUT DRIVE SUITE 100 DEWITT, NY 13214 16-1236354	MEDICAL SERVICES	NY	N/A	C				Yes	
(8) FRANCISCAN MANAGEMENT SERVICES INC 333 BUTTERNUT DRIVE SUITE 100 DEWITT, NY 13214 16-1351193	MANAGEMENT SERVICES	NY	N/A	C				Yes	
(9) FRANKLIN MEDICAL GROUP PC 56 FRANKLIN ST WATERBURY, CT 06706 06-1470493	PHYSICIAN OFFICE	CT	N/A	C				Yes	
(10) GOTTLIEB MANAGEMENT SERVICES INC 701 W NORTH AVE MELROSE PARK, IL 60160 36-3330529	MANAGEMENT SERVICES	IL	N/A	C				Yes	
(11) HEF INC 1820 44TH STREET SE KENTWOOD, MI 49508 38-3086401	OFFICE STAFFING	MI	N/A	C				Yes	
(12) HACKLEY HEALTH MANAGEMENT INC 1820 44TH STREET SE KENTWOOD, MI 49508 38-2961814	WEIGHT MANAGEMENT	MI	N/A	C				Yes	
(13) HACKLEY HEALTH VENTURES INC 1820 44TH STREET SE KENTWOOD, MI 49508 38-2589959	OTHER MEDICAL SERVICES	MI	N/A	C				Yes	
(14) HACKLEY HEALTHCARE EQUIPMENT CORP 1820 44TH STREET SE KENTWOOD, MI 49508 38-2578569	HOME MEDICAL EQUIPMENT	MI	N/A	C				Yes	

Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust									
(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of- year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity?	
								Yes	No
(16) HACKLEY PROFESSIONAL PHARMACY INC 1820 44TH STREET SE KENTWOOD, MI 49508 38-2447870	PHARMACY	MI	N/A	C				Yes	
(1) HEALTH CARE MANAGEMENT ADMINISTRATORS INC 333 BUTTERNUT DRIVE SUITE 100 DEWITT, NY 13214 16-1450960	HEALTH CARE MANAGEMENT	NY	N/A	C				Yes	
(2) HEALTH MANAGEMENT SERVICES ORG INC 500 GROVE STREET SUITE 100 HADDON HEIGHTS, NJ 08035 22-3366580	MEDICAL ADMINISTRATION	NJ	N/A	C				Yes	
(3) HOLY CROSS PRIVATE HOME SERVICES CORP 1500 FOREST GLEN RD SILVER SPRING, MD 20910 52-1986562	HOME CARE SERVICES	MD	N/A	C				Yes	
(4) HURON ARBOR CORPORATION 5301 EAST HURON RIVER DR ANN ARBOR, MI 48106 38-2475644	PROVIDES OFFICE RENTAL SPACE	MI	N/A	C				Yes	
(5) IHA AFFILIATION CORPORATION 24 FRANK LLOYD WRIGHT DR LOBBY J ANN ARBOR, MI 48106 38-3188895	MEDICAL MANAGEMENT	MI	N/A	C				Yes	
(6) LANGHORNE SERVICES II INC 1201 LANGHORNE-NEWTOWN ROAD LANGHORNE, PA 19047 25-3795549	GENERAL PARTNER OF LMOB PARTNERS, II	PA	N/A	C				Yes	
(7) LANGHORNE SERVICES INC 1201 LANGHORNE-NEWTOWN ROAD LANGHORNE, PA 19047 23-2625981	GENERAL PARTNER OF LMOB PARTNERS	PA	N/A	C				Yes	
(8) LIFECARE PHYSICIANS PC 601 HAMILTON AVENUE TRENTON, NJ 08629 26-1649038	HEALTH CARE SERVICES	NJ	N/A	C				Yes	
(9) LOURDES MEDICAL ASSOCIATES PA 500 GROVE STREET SUITE 100 HADDON HEIGHTS, NJ 08035 22-3361862	MEDICAL SERVICES	NJ	N/A	C				Yes	
(10) LOURDES URGENT CARE SERVICES PC 1600 HADDON AVENUE CAMDEN, NJ 08103 46-4188202	URGENT CARE CENTER	NJ	N/A	C				Yes	
(11) MARYLAND CARE GROUP INC 1500 FOREST GLEN RD SILVER SPRING, MD 20910 52-1815313	HEALTH CARE HOLDING	MD	N/A	C				Yes	
(12) MCMC EASTWICK INC C/O MHS ONE WEST ELM STREET STE 100 CONSHOHOCKEN, PA 19428 23-2184261	MEDICAL OFFICE BUILDINGS	PA	N/A	C				Yes	
(13) MEDNOW INC 1512 12TH AVENUE ROAD NAMPA, ID 83686 82-0389927	MEDICAL SERVICES	ID	N/A	C				Yes	
(14) MERCY HOME CARE INC 1233 MAIN STREET HOLYOKE, MA 01040 04-3317426	HEALTH CARE SERVICES	MA	N/A	C				Yes	

Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust									
(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity?	
								Yes	No
(31) MERCY INPATIENT MEDICAL ASSOCIATES INC 1233 MAIN STREET HOLYOKE, MA 01040 04-3029929	MEDICAL SERVICES	MA	N/A	C				Yes	
(1) MERCY MEDICAL SERVICES 801 5TH STREET SIOUX CITY, IA 51101 42-1283849	PRIMARY CARE PHYSICIANS	IA	MERCY HEALTH SERVICES-IOWA CORP	C	-3,396,096	14,437,160	100 000 %	Yes	
(2) MERCY SERVICES CORPORATION 2525 SOUTH MICHIGAN AVENUE CHICAGO, IL 60616 36-3227348	DORMANT	IL	N/A	C				Yes	
(3) MOUNT CARMEL HEALTH PROVIDERS INC 6150 EAST BROAD STREET COLUMBUS, OH 43213 31-1382442	MEDICAL SERVICES	OH	N/A	C				Yes	
(4) NURSING NETWORK INC 4725 NORTH FEDERAL HIGHWAY FORT LAUDERDALE, FL 33308 59-1145192	MEDICAL SERVICES	FL	N/A	C				Yes	
(5) SAINT ALPHONSUS HEALTH ALLIANCE INC 1055 NORTH CURTIS ROAD BOISE, ID 83706 82-0524649	ACCOUNTABLE CARE ORGANIZATION	ID	N/A	C				Yes	
(6) SAINT ALPHONSUS PHYSICIANS PA 1055 NORTH CURTIS ROAD BOISE, ID 83706 33-1078261	HEALTH CARE SERVICES (INACTIVE)	ID	N/A	C				Yes	
(7) SAINT FRANCIS BEHAVIORAL HEALTH GROUP PC 114 WOODLAND STREET STE 4312 HARTFORD, CT 06105 06-1384686	MEDICAL SERVICES	CT	N/A	C				Yes	
(8) SAINT FRANCIS CARE MEDICAL GROUP PC 114 WOODLAND STREET HARTFORD, CT 06105 06-1432373	MEDICAL SERVICES	CT	N/A	C				Yes	
(9) SAMARITAN MEDICAL OFFICE BUILDING INC 2212 BURDETT AVENUE TROY, NY 12180 14-1607244	REAL ESTATE	NY	N/A	C				Yes	
(10) SJM PROPERTIES INC 411 CANISTEO STREET HORNELL, NY 14843 16-1294991	PROPERTY HOLDINGS	NY	N/A	C				Yes	
(11) SJPE PRACTICE MANAGEMENT SERVICES INC 301 PROSPECT AVE SYRACUSE, NY 13203 45-4164964	MANAGEMENT SERVICES	NY	N/A	C				Yes	
(12) SJRMC HOLDINGS INC 5215 HOLY CROSS PARKWAY MISHAWAKA, IN 46545 47-4763735	PROPERTY HOLDINGS	IN	N/A	C				Yes	
(13) ST ELIZABETH HEALTH SUPPORT SERVICES INC 2209 GENESEE STREET UTICA, NY 13501 16-1540486	MEDICAL SERVICES	NY	N/A	C				Yes	
(14) ST MARY'S HIGHLAND HILLS VILLAGE INC 1230 BAXTER STREET ATHENS, GA 30606 58-2276801	ASSISTED LIVING	GA	N/A	C				Yes	



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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of- year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity?	
								Yes	No
(46) SYSTEM COORDINATED SERVICES INC 1233 MAIN STREET HOLYOKE, MA 01040 04-2938161	LAB SERVICES	MA	N/A	C				Yes	
(1) THRE SERVICES LLC 20555 VICTOR PARKWAY LIVONIA, MI 48152 45-2603654	REAL ESTATE BROKERAGE SERVICES	MI	N/A	C				Yes	
(2) TRI-HOSPITAL MRI CENTER 4190 24TH AVENUE FORT GRATIOT, MI 48054 38-2884297	HEALTH CARE SERVICES	MI	N/A	C				Yes	
(3) TRINITY ASSURANCE LTD PO BOX 1051 GRAND CAYMAN GRAND CAYMAN CJ 98-0453602	PROVISION OF INSURANCE COVERAGE	CJ	N/A	C				Yes	
(4) TRINITY HEALTH ACO INC 20555 VICTOR PARKWAY LIVONIA, MI 48152 47-3794666	ACCOUNTABLE CARE ORGANIZATION	DE	N/A	C				Yes	
(5) TRINITY HEALTH EMPLOYEE BENEFIT TRUST 20555 VICTOR PARKWAY LIVONIA, MI 48152 38-3410377	GRANTOR TRUST	MI	N/A	T				Yes	
(6) TRINITY SENIOR SERVICES MANAGEMENT INC PO BOX 9184 FARMINGTON HILLS, MI 48333 37-1572595	SENIOR SERVICES	PA	N/A	C				Yes	
(7) WEST SHORE PROFESSIONAL BUILDING CONDOMINIUM 1820 44TH STREET SE KENTWOOD, MI 49508 38-2700166	CONDOMINIUM ASSOCIATION	MI	N/A	C				Yes	
(8) WORKPLACE HEALTH OF GRAND HAVEN INC 1820 44TH STREET SE KENTWOOD, MI 49508 38-3112035	OCCUPATIONAL HEALTH	MI	N/A	C				Yes	

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

<b>(a)</b> Name of related organization		<b>(b)</b> Transaction type(a-s)	<b>(c)</b> Amount Involved	<b>(d)</b> Method of determining amount involved
<b>(1)</b>	DUBUQUE MERCY HEALTH FOUNDATION	C	980,877	PER BOOKS
<b>(1)</b>	DUBUQUE MERCY HEALTH FOUNDATION	B	429,901	PER BOOKS
<b>(2)</b>	DYERSVILLE HEALTH FOUNDATION INC	B	130,328	PER BOOKS
<b>(3)</b>	TRINITY HOME HEALTH SERVICES	P	63,848	PER BOOKS
<b>(4)</b>	TRINITY HEALTH CORPORATION	A	3,274	PER BOOKS
<b>(5)</b>	TRINITY HEALTH CORPORATION	B	26,756,412	PER BOOKS
<b>(6)</b>	TRINITY HEALTH CORPORATION	M	72,518,131	PER BOOKS
<b>(7)</b>	TRINITY HEALTH CORPORATION	P	18,516,990	PER BOOKS
<b>(8)</b>	TRINITY HEALTH CORPORATION	Q	3,096,308	PER BOOKS
<b>(9)</b>	TRINITY HEALTH CORPORATION	R	7,393,905	PER BOOKS
<b>(10)</b>	TRINITY HEALTH CORPORATION	E	17,400,000	PER BOOKS
<b>(11)</b>	MERCY HEART CTR OP SERVICES LLC	C	217,180	PER BOOKS
<b>(12)</b>	MERCY HEART CTR OP SERVICES LLC	L	110,332	PER BOOKS
<b>(13)</b>	MASON CITY AMBULATORY SURGERY CENTER LLC	C	3,331,060	PER BOOKS
<b>(14)</b>	MASON CITY AMBULATORY SURGERY CENTER LLC	L	327,945	PER BOOKS
<b>(15)</b>	FOREST PARK IMAGING LLC	C	1,604,813	PER BOOKS
<b>(16)</b>	FOREST PARK IMAGING LLC	L	661,551	PER BOOKS
<b>(17)</b>	HOSPICE OF NORTH IOWA	L	58,080	PER BOOKS
<b>(18)</b>	HOSPICE OF NORTH IOWA	M	154,614	PER BOOKS
<b>(19)</b>	HOSPICE OF NORTH IOWA	Q	599,123	PER BOOKS
<b>(20)</b>	MERCY MEDICAL CENTER FOUNDATION-NORTH IOWA	C	210,030	PER BOOKS
<b>(21)</b>	TRINITY CONTINUING CARE SERVICES	M	387,689	PER BOOKS
<b>(22)</b>	BAUM HARMON MERCY HOSPITAL	B	1,559,413	PER BOOKS
<b>(23)</b>	BAUM HARMON MERCY HOSPITAL	L	545,552	PER BOOKS
<b>(24)</b>	BAUM HARMON MERCY HOSPITAL	M	73,265	PER BOOKS

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

(a)	Name of related organization	(b)	Transaction type(a-s)	(c)	Amount Involved	(d)	Method of determining amount involved
(26)	BAUM HARMON MERCY HOSPITAL	P		251,696		PER BOOKS	
(1)	BAUM HARMON MERCY HOSPITAL	Q		371,615		PER BOOKS	
(2)	OAKLAND MERCY HOSPITAL	B		709,572		PER BOOKS	
(3)	OAKLAND MERCY HOSPITAL	L		499,473		PER BOOKS	
(4)	OAKLAND MERCY HOSPITAL	M		64,654		PER BOOKS	
(5)	OAKLAND MERCY HOSPITAL	P		226,865		PER BOOKS	
(6)	OAKLAND MERCY HOSPITAL	Q		319,054		PER BOOKS	
(7)	MERCY MEDICAL SERVICES	B		5,730,450		PER BOOKS	
(8)	MERCY MEDICAL SERVICES	L		779,973		PER BOOKS	
(9)	MERCY MEDICAL SERVICES	M		170,761		PER BOOKS	
(10)	MERCY MEDICAL SERVICES	P		1,543,799		PER BOOKS	
(11)	MERCY MEDICAL SERVICES	Q		1,940,780		PER BOOKS	
(12)	MERCY MEDICAL CENTER-SIOUX CITY FOUNDATION	B		229,152		PER BOOKS	
(13)	MERCY MEDICAL CENTER-SIOUX CITY FOUNDATION	C		2,326,510		PER BOOKS	
(14)	MERCYUSP HEALTH VENTURES LLC	C		10,795,879		PER BOOKS	
(15)	DYERSVILLE HEALTH FOUNDATION INC	C		118,505		PER BOOKS	
(16)	MAGNETIC RESONANCE SERVICES PARTNERSHIP	C		952,504		PER TAX RETURN	