

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

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

AS A VITAL PART OF MUNSON HEALTHCARE, MUNSON MEDICAL CENTER EXISTS TO DELIVER COMPREHENSIVE QUALITY CARE TO PATIENTS IN PARTNERSHIP WITH PHYSICIANS

**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 \$ 488,005,607	including grants of \$ 554,622 )	(Revenue \$ 597,325,022 )
	See Additional Data			

<b>4b</b>	(Code )	(Expenses \$	including grants of \$	(Revenue \$ )
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<b>4c</b>	(Code )	(Expenses \$	including grants of \$	(Revenue \$ )
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<b>4d</b>	Other program services (Describe in Schedule O )	(Expenses \$	including grants of \$	(Revenue \$ )
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<b>4e</b>	Total program service expenses ▶	488,005,607
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**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>	No
<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>	No
<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? <i>If "Yes," complete Schedule H</i> . . . . .	<b>20a</b> Yes	
<b>b</b> If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	<b>20b</b> 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? <i>If "Yes," complete Schedule I, Parts I and II</i> . . . . .	<b>21</b> 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? <i>If "Yes," complete Schedule I, Parts I and III</i> . . . . .	<b>22</b> 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? <i>If "Yes," complete Schedule J</i> . . . . .	<b>23</b> 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? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i> . . . . .	<b>24a</b> Yes	
<b>b</b> Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? . . . . .	<b>24b</b>	No
<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? . . . . .	<b>24c</b>	No
<b>d</b> Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? . . . . .	<b>24d</b>	No
<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? <i>If "Yes," complete Schedule L, Part I</i> . . . . .	<b>25a</b>	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? <i>If "Yes," complete Schedule L, Part I</i> . . . . .	<b>25b</b>	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? <i>If "Yes," complete Schedule L, Part II</i> . . . . .	<b>26</b>	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? <i>If "Yes," complete Schedule L, Part III</i> . . . . .	<b>27</b>	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? <i>If "Yes," complete Schedule L, Part IV</i> . . . . .	<b>28a</b>	No
<b>b</b> A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> . . . . .	<b>28b</b> Yes	
<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? <i>If "Yes," complete Schedule L, Part IV</i> . . . . .	<b>28c</b> Yes	
<b>29</b> Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i> . . . . .	<b>29</b>	No
<b>30</b> Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i> . . . . .	<b>30</b>	No
<b>31</b> Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i> . . . . .	<b>31</b>	No
<b>32</b> Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i> . . . . .	<b>32</b>	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? <i>If "Yes," complete Schedule R, Part I</i> . . . . .	<b>33</b>	No
<b>34</b> Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i> . . . . .	<b>34</b> Yes	
<b>35a</b> Did the organization have a controlled entity within the meaning of section 512(b)(13)?	<b>35a</b> Yes	
<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)? <i>If "Yes," complete Schedule R, Part V, line 2</i> . . . . .	<b>35b</b> Yes	
<b>36 Section 501(c)(3) organizations.</b> Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i> . . . . .	<b>36</b>	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? <i>If "Yes," complete Schedule R, Part VI</i>	<b>37</b>	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 . . . . .	<b>38</b> 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 . . . . .	416	
<b>b</b>	Enter the number of Forms W-2G included in line 1a Enter -0- if not applicable . . . . .	0	
<b>c</b>	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? . . . . .	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 . . . . .	4,667	
<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)	Yes	
<b>3a</b>	Did the organization have unrelated business gross income of \$1,000 or more during the year? . . . . .	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 . . . . .	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)? . . . . .		No
<b>b</b>	If "Yes," enter the name of the foreign country <span style="border-bottom: 1px solid black; display: inline-block; width: 200px;"></span> 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? . . . . .		No
<b>b</b>	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? . . . . .		No
<b>c</b>	If "Yes," to line 5a or 5b, did the organization file Form 8886-T? . . . . .		
<b>6a</b>	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . . . .		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>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? . . . . .		No
<b>b</b>	If "Yes," did the organization notify the donor of the value of the goods or services provided? . . . . .		
<b>c</b>	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? . . . . .		No
<b>d</b>	If "Yes," indicate the number of Forms 8282 filed during the year . . . . .		
<b>e</b>	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		No
<b>f</b>	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . . . . .		No
<b>g</b>	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? . . . . .		
<b>h</b>	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? . . . . .		
<b>8</b>	<b>Sponsoring organizations maintaining donor advised funds.</b> Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? . . . . .		
<b>9a</b>	Did the sponsoring organization make any taxable distributions under section 4966? . . . . .		
<b>b</b>	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . . . .		
<b>10</b>	<b>Section 501(c)(7) organizations.</b> Enter		
<b>a</b>	Initiation fees and capital contributions included on Part VIII, line 12 . . . . .		
<b>b</b>	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities		
<b>11</b>	<b>Section 501(c)(12) organizations.</b> Enter		
<b>a</b>	Gross income from members or shareholders . . . . .		
<b>b</b>	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them ) . . . . .		
<b>12a</b>	<b>Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?		
<b>b</b>	If "Yes," enter the amount of tax-exempt interest received or accrued during the year		
<b>13</b>	<b>Section 501(c)(29) qualified nonprofit health insurance issuers.</b>		
<b>a</b>	Is the organization licensed to issue qualified health plans in more than one state? <b>Note.</b> See the instructions for additional information the organization must report on Schedule O		
<b>b</b>	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans . . . . .		
<b>c</b>	Enter the amount of reserves on hand . . . . .		
<b>14a</b>	Did the organization receive any payments for indoor tanning services during the tax year? . . . . .		No
<b>b</b>	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O . . . . .		

**Part VI Governance, Management, and Disclosure** For each "Yes" response to lines 2 through 7b below, and for a "No" response to 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		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O		
<b>b</b>	Enter the number of voting members included in line 1a, above, who are independent		
<b>2</b>	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?		No
<b>3</b>	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?		No
<b>4</b>	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?		No
<b>5</b>	Did the organization become aware during the year of a significant diversion of the organization's assets?		No
<b>6</b>	Did the organization have members or stockholders?	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	Yes	
<b>b</b>	Other officers or key employees of the organization	Yes	
	If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).		
<b>16a</b>	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	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:  
 ► NICOLE SULAK MUNSON HEALTHCARE 4230 COPPER RIDGE DR TRAVERSE CITY, MI 49684 (231) 935-7777

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)

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
See Additional Data Table										
<b>1b Sub-Total</b>										
<b>c Total from continuation sheets to Part VII, Section A</b>										
<b>d Total (add lines 1b and 1c)</b>								4,804,347	1,432,874	722,326

**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 **▶ 160**

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

**Section B. Independent Contractors**

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

(A) Name and business address	(B) Description of services	(C) Compensation
INDIGO HOSPITAL MEDICINE TRAVERSE C, 10850 E TRAVERSE HWY TRAVERSE CITY, MI 496841320	MEDICAL SERVICE	9,378,477
AHSA LLC PO BOX 945 TRAVERSE CITY, MI 49685	TEMPORARY STAFF	6,761,187
CARDIOTHORACIC SURGEONS GT PC, 107 S CASS ST TRAVERSE CITY, MI 49684	MEDICAL SERVICE	3,835,428
SURGEONS NORTH PLLC, 1221 SIXTH ST SUITE 308 TRAVERSE CITY, MI 49684	MEDICAL SERVICE	3,041,427
MAYO COLLABORATIVE SERVICES INC, PO BOX 9146 MINNEAPOLIS, MN 554809146	LABORATORY SRV	2,702,556

**2** Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization **▶ 93**



<b>Part VIII</b>		<b>Statement of Revenue</b>						
Check if Schedule O contains a response or note to any line in this Part VIII <input type="checkbox"/>								
		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514			
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns . . .	1a						
	b Membership dues . . .	1b						
	c Fundraising events . . .	1c						
	d Related organizations	1d	3,404,481					
	e Government grants (contributions)	1e	3,000,553					
	f All other contributions, gifts, grants, and similar amounts not included above	1f	332,463					
	g Noncash contributions included in lines 1a-1f \$ _____							
	h Total. Add lines 1a-1f . . . . .		6,737,497					
Program Service Revenue			Business Code					
	2a MEDICARE AND MEDICAID PMTS		621990	303,785,489	303,785,489			
	b PATIENT SERVICE REVENUE		621990	283,999,210	283,999,210			
	c HEALTH SERVICE REVENUE		621990	4,626,511	4,626,511			
	d SERVICES TO OTHER ORGANIZATIO		621990	1,410,543	1,410,543			
	e RENT FROM RELATED ORGS		531120	475,452	475,452			
	f All other program service revenue			45,504		45,504		
	g Total. Add lines 2a-2f . . . . .		594,342,709					
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts) . . . . .		8,832,912		2,998,272		5,834,640	
	4 Income from investment of tax-exempt bond proceeds							
	5 Royalties . . . . .							
			(i) Real	(ii) Personal				
	6a Gross rents		174,114					
	b Less rental expenses							
	c Rental income or (loss)		174,114					
	d Net rental income or (loss) . . . . .		174,114				174,114	
			(i) Securities	(ii) Other				
	7a Gross amount from sales of assets other than inventory		249,508,761		64,013			
	b Less cost or other basis and sales expenses		245,443,909		34,468			
	c Gain or (loss)		4,064,852		29,545			
	d Net gain or (loss) . . . . .		4,094,397		29,545		4,064,852	
	8a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18 . . . . .		a					
	b Less direct expenses . . . . .		b					
	c Net income or (loss) from fundraising events . . . . .							
	9a Gross income from gaming activities See Part IV, line 19 . . . . .		a					
	b Less direct expenses . . . . .		b					
c Net income or (loss) from gaming activities . . . . .								
10a Gross sales of inventory, less returns and allowances . . .		a		34,495				
b Less cost of goods sold . . .		b		32,801				
c Net income or (loss) from sales of inventory . . . . .				1,694		1,694		
Miscellaneous Revenue		Business Code						
11a CAFETERIA SALES		722210		4,348,208		4,348,208		
b MISCELLANEOUS		621990		829,528		829,528		
c AUXILIARY GIFT SHOP		446199		431,414		431,414		
d All other revenue . . . . .								
e Total. Add lines 11a-11d . . . . .				5,609,150				
12 Total revenue. See Instructions . . . . .				619,792,473		597,325,022		
						47,198		
						15,682,756		

**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.	75,068	75,068		
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22.	479,554	479,554		
<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.	2,633,330	590,395	2,042,935	
<b>6</b> Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B).				
<b>7</b> Other salaries and wages.	180,076,139	167,412,268	12,663,871	
<b>8</b> Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).	18,255,381	16,956,383	1,298,998	
<b>9</b> Other employee benefits.	27,648,327	25,508,456	2,139,871	
<b>10</b> Payroll taxes.	12,831,110	11,812,668	1,018,442	
<b>11</b> Fees for services (non-employees):				
<b>a</b> Management.				
<b>b</b> Legal.	177,303		177,303	
<b>c</b> Accounting.				
<b>d</b> Lobbying.	19,556		19,556	
<b>e</b> Professional fundraising services. See Part IV, line 17.				
<b>f</b> Investment management fees.				
<b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	114,669,817	69,164,132	44,141,095	1,364,590
<b>12</b> Advertising and promotion.	143,242	143,242		
<b>13</b> Office expenses.	4,357,382	3,476,930	880,452	
<b>14</b> Information technology.	2,491,597	2,129,186	362,411	
<b>15</b> Royalties.				
<b>16</b> Occupancy.	8,128,537	7,789,333	339,204	
<b>17</b> Travel.	474,790	383,214	91,576	
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials.				
<b>19</b> Conferences, conventions, and meetings.	737,102	632,840	104,262	
<b>20</b> Interest.	6,680,351	5,837,705	842,646	
<b>21</b> Payments to affiliates.				
<b>22</b> Depreciation, depletion, and amortization.	22,630,308	19,778,572	2,851,736	
<b>23</b> Insurance.	3,356,237	2,599,099	757,138	
<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	139,961,981	139,961,981		
<b>b</b> BAD DEBT	11,314,594	11,314,594		
<b>c</b> REPAIRS AND MAINTENANCE	6,435,605	6,249,951	185,654	
<b>d</b> DIETARY	731,560	531,334	200,226	
<b>e</b> All other expenses	-5,865,140	-4,821,298	-1,043,842	
<b>25</b> Total functional expenses. Add lines 1 through 24e.	558,443,731	488,005,607	69,073,534	1,364,590
<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 . . . . .		26,812	<b>1</b>	89,215
	<b>2</b>	Savings and temporary cash investments . . . . .		189,838,925	<b>2</b>	197,811,581
	<b>3</b>	Pledges and grants receivable, net . . . . .		927,154	<b>3</b>	1,686,819
	<b>4</b>	Accounts receivable, net . . . . .		74,662,538	<b>4</b>	85,015,891
	<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 . . . . .		670,728	<b>7</b>	1,200,368
	<b>8</b>	Inventories for sale or use . . . . .		15,711,452	<b>8</b>	17,636,807
	<b>9</b>	Prepaid expenses and deferred charges . . . . .		7,680,766	<b>9</b>	4,962,476
	<b>10a</b>	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	<b>10a</b> 498,109,695			
	<b>b</b>	Less: accumulated depreciation	<b>10b</b> 244,853,722	268,841,459	<b>10c</b>	253,255,973
	<b>11</b>	Investments—publicly traded securities . . . . .		227,518,969	<b>11</b>	262,212,955
	<b>12</b>	Investments—other securities. See Part IV, line 11 . . . . .		19,784,072	<b>12</b>	24,510,737
	<b>13</b>	Investments—program-related. See Part IV, line 11 . . . . .			<b>13</b>	
	<b>14</b>	Intangible assets . . . . .		280,000	<b>14</b>	280,000
	<b>15</b>	Other assets. See Part IV, line 11 . . . . .		359,395	<b>15</b>	1,241,910
<b>16</b>	<b>Total assets.</b> Add lines 1 through 15 (must equal line 34) . . . . .		806,302,270	<b>16</b>	849,904,732	
<b>Liabilities</b>	<b>17</b>	Accounts payable and accrued expenses . . . . .		46,465,706	<b>17</b>	48,914,380
	<b>18</b>	Grants payable . . . . .			<b>18</b>	
	<b>19</b>	Deferred revenue . . . . .		818,388	<b>19</b>	743,554
	<b>20</b>	Tax-exempt bond liabilities . . . . .		150,916,387	<b>20</b>	148,503,047
	<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 . . . . .			<b>23</b>	
	<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		170,862,505	<b>25</b>	125,369,547
	<b>26</b>	<b>Total liabilities.</b> Add lines 17 through 25 . . . . .		369,062,986	<b>26</b>	323,530,528
<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		421,489,016	<b>27</b>	506,048,345
	<b>28</b>	Temporarily restricted net assets . . . . .		15,750,268	<b>28</b>	20,325,859
	<b>29</b>	Permanently restricted net assets			<b>29</b>	
	<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> . . . . .		437,239,284	<b>33</b>	526,374,204	
<b>34</b>	<b>Total liabilities and net assets/fund balances</b> . . . . .		806,302,270	<b>34</b>	849,904,732	

**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>	619,792,473
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	558,443,731
<b>3</b>	Revenue less expenses Subtract line 2 from line 1	<b>3</b>	61,348,742
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	437,239,284
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	10,699,995
<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>	17,086,183
<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>	526,374,204

**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:** 38-1362830  
**Name:** MUNSON MEDICAL CENTER

Form 990 (2016)

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

EXPENSES INCURRED WHILE PROVIDING HOSPITAL SERVICES TO THE RESIDENTS OF TRAVERSE CITY, MI AND THE SURROUNDING AREA WHILE FULFILLING THE HOSPITAL'S MISSION TO PROVIDE HEALTHCARE IN THE COMMUNITY MUNSON MEDICAL CENTER SERVES AS A RURAL REFERRAL CENTER FOR THE SURROUNDING 24-COUNTY AREA, WITH 22,056 INPATIENT ADMISSIONS IN FISCAL YEAR 2017 AND OVER 490,000 OUTPATIENT VISITS THE HOSPITAL SERVED MORE THAN 16,000 SURGICAL CASES, 1,825 OBSTETRICAL BIRTHS, AND OVER 54,000 EMERGENCY ROOM VISITS MUNSON MEDICAL CENTER ACCEPTS ALL PATIENTS, REGARDLESS OF ABILITY TO PAY THE HOSPITAL HAS 494 ACTIVE MEDICAL STAFF AND 352 VOLUNTEERS

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			
EDWIN A NESS ..... DIRECTOR	1 00 ..... 40 00	X						0	940,867	171,580
ALFRED PILONG ..... CEO & PRESID	40 00 ..... 1 00	X		X				638,022	0	106,859
WALTER NOBLE MD ..... DIRECTOR	40 00 ..... 1 00	X						234,909	0	15,099
JILL E VOLLBRECHT MD ..... DIRECTOR	40 00 ..... 1 00	X						230,916	0	43,890
BRIAN KIESSLING ..... DIRECTOR	1 00 ..... 1 00	X						25,000	0	0
GEORGE BEARUP ..... PART-YEAR CH	2 00 ..... 1 00	X		X				24,500	0	0
DAVID FRIAR MD ..... DIRECTOR	1 00 ..... 1 00	X						12,500	0	0
SUSAN J UNGER ..... DIRECTOR	1 00 ..... 1 00	X						12,500	0	0
JOHN ERB ..... DIRECTOR	1 00 ..... 1 00	X						12,500	0	0
PATRICK E HEINTZ ..... PART-YEAR CH	2 00 ..... 1 00	X		X				12,500	0	0

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

(A)

(B)

(C)

(D)

(E)

(F)

Name and Title	Average hours per week (list any hours for related organizations below dotted line)	Position (do not check more than one box, unless person is both an officer and a director/trustee)						Reportable compensation from the organization (W- 2/1099-MISC)	Reportable compensation from related organizations (W- 2/1099-MISC)	Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JAMES W HOOK ..... PART-YEAR VI	2 00 ..... 0 00	X		X				12,500	0	0
DANIEL NAVIN MD ..... SECRETARY	2 00 .....	X		X				12,500	0	0
ROBERT P SCHAFER ..... TREASURER	2 00 .....	X		X				12,500	0	0
DOUGLAS LUCIANI ..... DIRECTOR	1 00 .....	X						12,500	0	0
CHARLES HAVILL ..... DIRECTOR	1 00 .....	X						12,500	0	0
CATHERINE COLLINS ..... DIRECTOR	1 00 .....	X						9,375	0	0
DANIEL C EDSON ..... DIRECTOR	1 00 ..... 0 00	X						0	0	0
TIMOTHY NELSON ..... DIRECTOR	1 00 .....	X						0	0	0
JOHN PELIZZARI ..... DIRECTOR	1 00 ..... 2 00	X						0	0	0
BARBARA MATTHEWS ..... DIRECTOR	1 00 .....	X						0	0	0

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			
DAVID WRIGHT ..... DIRECTOR	1 00 .....	X						0	0	0
MARK A HEPLER ..... CFO	2 00 ..... 40 00			X				0	492,007	81,915
DAVID MCGREAHAM MD ..... VP MEDICAL	40 00 .....				X			389,131	0	55,929
DERK PRONGER ..... CHIEF OPERAT	40 00 .....				X			337,590	0	59,870
JAMES FISCHER ..... VP PATIENT C	40 00 .....				X			283,672	0	19,046
THOMAS SCHERMERHORN MD ..... NEUROSURGEON	40 00 .....					X		955,712	0	36,022
ANDREW LUEA ..... PHYSICIAN	40 00 .....					X		425,832	0	30,574
AHMET SEVIMLI MD ..... NEPHROLOGIST	40 00 .....					X		405,609	0	47,241
JAMSHID AMANZADEH ..... PHYSICIAN	40 00 .....					X		373,625	0	21,298
YELENA KIER ..... PHYSICIAN	40 00 .....					X		357,954	0	33,003



<b>SCHEDULE A</b> (Form 990 or 990-EZ)	<b>Public Charity Status and Public Support</b> 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 <a href="http://www.irs.gov/form990">www.irs.gov/form990</a> .	OMB No 1545-0047 <b>2016</b> <b>Open to Public Inspection</b>
	Department of the Treasury Internal Revenue Service <b>Name of the organization</b> MUNSON MEDICAL CENTER	<b>Employer identification number</b> 38-1362830

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

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

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

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-10 above (see instructions))	(iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
<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 Total.</b> Add lines 1 through 5						
<b>7a</b> Amounts included on lines 1, 2, and 3 received from disqualified persons						
<b>b</b> Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
<b>c</b> Add lines 7a and 7b						
<b>8 Public support.</b> (Subtract line 7c from line 6.)						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►	(a)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 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>



<b>SCHEDULE C</b> (Form 990 or 990-EZ)	<b>Political Campaign and Lobbying Activities</b>  For Organizations Exempt From Income Tax Under section 501(c) and section 527 ▶ <b>Complete if the organization is described below.</b> ▶ <b>Attach to Form 990 or Form 990-EZ.</b> ▶ <b>Information about Schedule C (Form 990 or 990-EZ) and its instructions is at <a href="http://www.irs.gov/form990">www.irs.gov/form990</a>.</b>	OMB No 1545-0047  <b>2016</b>  <b>Open to Public Inspection</b>
Department of the Treasury Internal Revenue Service		

**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 MUNSON MEDICAL CENTER	<b>Employer identification number</b> 38-1362830
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**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 7202 for this year? ☐ Yes ☐ No

**4a** Was a correction made? ☐ Yes ☐ 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? ☐ Yes ☐ 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?	Yes		
<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		6,500
<b>g</b>	Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
<b>h</b>	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
<b>i</b>	Other activities?	Yes		13,056
<b>j</b>	Total Add lines 1c through 1i			19,556
<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
SCHEDULE C, PART II-B, LINE 1	GRASSROOTS LOBBYING EXPENSES GRANTED TO ORGANIZATIONS. OTHER ACTIVITIES INDICATE THE PORTION OF DUES ALLOCATED TO LOBBYING EXPENSES PAID TO REGIONAL OR NATIONAL ORGANIZATIONS

efile GRAPHIC print - DO NOT PROCESS		As Filed Data -		DLN: 93493212012608	
<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>
Name of the organization MUNSON MEDICAL CENTER				Employer identification number 38-1362830	
Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" on Form 990, Part IV, line 6.					
		(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>					
Part II Conservation Easements. Complete if the organization answered "Yes" on Form 990, Part IV, line 7.					
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					
Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets. Complete if the organization answered "Yes" on Form 990, Part IV, line 8.					
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	243,272,793	244,152,852	233,458,837	209,694,426	180,234,157
b Contributions	22,196,661	6,254,359	5,839,692	4,386,641	12,760,078
c Net investment earnings, gains, and losses	20,969,306	4,518,422	10,191,121	28,104,434	18,163,160
d Grants or scholarships	406,382	548,791	277,824	662,105	589,921
e Other expenditures for facilities and programs	2,213,218	10,014,072	3,960,064	6,934,457	80,507
f Administrative expenses	1,277,310	1,089,977	1,098,910	1,130,102	792,541
g End of year balance	282,541,850	243,272,793	244,152,852	233,458,837	209,694,426

2

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

a

Board designated or quasi-endowment

92 800 %

b

Permanent endowment

c

Temporarily restricted endowment

7 200 %

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

3a(i)

Yes

No

(ii) related organizations

3a(ii)

Yes

b

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

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		14,842,977		14,842,977
b Buildings		321,868,560	152,842,466	169,026,094
c Leasehold improvements		1,791,373	768,787	1,022,586
d Equipment		133,839,366	89,664,230	44,175,136
e Other		25,767,419	1,578,239	24,189,180
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c))				253,255,973

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)		
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Column (b) must equal Form 990, Part X, col (B) line 12 ) ▶		

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)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 15 ) . . . . . ▶	

Part X

Other Liabilities.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
MINIMUM PENSION LIABILITY	102,108,088
ESTIMATED THIRD PARTY SETTLEMENTS	10,368,952
RESERVE FOR THIRD PARTY SETTLEMENTS	9,187,606
SWAP MARKET VALUE BASIS	3,701,787
OTHER	3,114
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 25 ) ▶	125,369,547

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:** 38-1362830  
**Name:** MUNSON MEDICAL CENTER

**Supplemental Information**

Return Reference	Explanation
SCHEDULE D, PAGE 2, PART V, LINE 4	THE BOARD OF TRUSTEES DESIGNATES SUBSTANTIAL INVESTMENTS FOR THE REPLACEMENT, IMPROVEMENT, AND THE EXPANSION OF TANGIBLE FACILITIES OWNED BY MUNSON MEDICAL CENTER TO ENSURE FUNDS ARE AVAILABLE TO MAINTAIN THE HOSPITAL ASSETS TO CARRY OUT ITS MISSION A PORTION OF THE TERM ENDOWMENT ASSETS ARE THOSE HELD FOR SPECIFIC MEDICAL PURPOSES, AS DEFINED BY DONORS THOSE ASSETS ARE BEING HELD FOR A VARIETY OF DONOR INTERESTS INCLUDING ADAPTIVE SPORTS, PEDIATRIC THERAPY, OTHER PEDIATRIC MEDICAL NEEDS, RESEARCH, AND PATIENT ASSISTANCE

SCHEDULE H  
(Form 990)

Department of the Treasury

Internal Revenue Service

Hospitals

► 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).

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization

MUNSON MEDICAL CENTER

Employer identification number

38-1362830

Part I

Financial Assistance and Certain Other Community Benefits at Cost

	Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a Yes	
b If "Yes," was it a written policy?	1b Yes	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year		
<input checked="" type="checkbox"/> Applied uniformly to all hospital facilities		
<input type="checkbox"/> Applied uniformly to most hospital facilities		
<input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year		
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care	3a Yes	
<input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> 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	
<input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input checked="" type="checkbox"/> 400% <input type="checkbox"/> Other %		
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care		
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	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	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	No
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c	
6a Did the organization prepare a community benefit report during the tax year?	6a	No
b If "Yes," did the organization make it available to the public?	6b	
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)			1,401,352		1,401,352	0 250 %
b Medicaid (from Worksheet 3, column a)			64,411,041	40,311,511	24,099,530	4 330 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			65,812,393	40,311,511	25,500,882	4 580 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			2,306,808	421,833	1,884,975	0 340 %
f Health professions education (from Worksheet 5)			2,142,813	664,108	1,478,705	0 270 %
g Subsidized health services (from Worksheet 6)			102,796,947	89,890,545	12,906,402	2 320 %
h Research (from Worksheet 7)			940,651	404,055	536,596	0 100 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)			123,503		123,503	0 020 %
j Total. Other Benefits			108,310,722	91,380,541	16,930,181	3 050 %
k Total. Add lines 7d and 7j			174,123,115	131,692,052	42,431,063	7 630 %

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
<b>1</b> Physical improvements and housing			1,500		1,500	
<b>2</b> Economic development						
<b>3</b> Community support			10,040		10,040	
<b>4</b> Environmental improvements			28,803		28,803	
<b>5</b> Leadership development and training for community members						
<b>6</b> Coalition building						
<b>7</b> Community health improvement advocacy			5,119		5,119	
<b>8</b> Workforce development			30,549		30,549	0 010 %
<b>9</b> Other						
<b>10 Total</b>			76,011		76,011	0 010 %

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

**Section A. Bad Debt Expense**

		Yes	No
<b>1</b> Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	<b>1</b>	Yes	
<b>2</b> Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	<b>2</b>	11,563,928	
<b>3</b> Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	<b>3</b>	1,879,689	
<b>4</b> 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**

<b>5</b> Enter total revenue received from Medicare (including DSH and IME).	<b>5</b>	197,871,020
<b>6</b> Enter Medicare allowable costs of care relating to payments on line 5.	<b>6</b>	188,789,395
<b>7</b> Subtract line 6 from line 5. This is the surplus (or shortfall).	<b>7</b>	9,081,625
<b>8</b> Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used.		

☐ Cost accounting system ☒ Cost to charge ratio ☐ Other

**Section C. Collection Practices**

<b>9a</b> Did the organization have a written debt collection policy during the tax year?	<b>9a</b>	Yes	
<b>b</b> If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI.	<b>9b</b>	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 %
<b>1</b> NW MI SURGERY CENTER	AMBULATORY SURGERY CENTER	49 000 %		51 000 %
<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>				
<b>11</b>				
<b>12</b>				
<b>13</b>				

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

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

How many hospital facilities did the organization operate during the tax year?  
**1**

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

	Other (Describe)	ER-other	ER-24 hours	Research facility	Critical access hospital	Teaching hospital	Children's hospital	General medical & surgical	Licensed hospital	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)  
MUNSON MEDICAL CENTER**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** \_\_\_\_\_**1****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 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>HTTP //WWW MUNSONHEALTHCARE ORG/UPLOAD</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 15</u>		
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url) <u>HTTPS //WWW MUNSONHEALTHCARE ORG/UPLOA</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)**

MUNSON MEDICAL CENTER

**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 type="checkbox"/> Medical indigency			
<b>e</b> <input checked="" type="checkbox"/> Insurance status			
<b>f</b> <input 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) HTTP //WWW MUNSONHEALTHCARE ORG/UPLOAD			
<b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) HTTP //WWW MUNSONHEALTHCARE ORG/UPLOAD			
<b>c</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) HTTP //WWW MUNSONHEALTHCARE ORG/FINANC			
<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**

MUNSON MEDICAL CENTER

**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 checked="" 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)**

MUNSON MEDICAL CENTER

**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? 9

Name and address	Type of Facility (describe)
<b>1</b> MUNSON COMMUNITY HEALTH CENTER 550 MUNSON AVENUE TRAVERSE CITY, MI 49686	OUTPATIENT
<b>2</b> COWELL FAMILY CANCER CENTER 217 S MADISON ST TRAVERSE CITY, MI 49684	RADIATION THERAPY AND MRI
<b>3</b> SMITH FAMILY BREAST HEALTH CENTER 4100 PARK FOREST DR TRAVERSE CITY, MI 49684	MAMMOGRAPHY AND WOMEN'S HEALTH
<b>4</b> INFUSION CLINIC 217 S MADISON ST TRAVERSE CITY, MI 49684	IV THERAPY
<b>5</b> CHEMICAL DEPENDENCY CENTER 420 BROOK ST TRAVERSE CITY, MI 49684	REHABILITATION
<b>6</b> MUNSON MANOR 1220 MEDICAL CAMPUS DR TRAVERSE CITY, MI 49684	HOSPITALITY HOUSE
<b>7</b> ADVANCED WOUND CENTER 5085 ANNA DR TRAVERSE CITY, MI 49684	PATIENT WOUND CARE
<b>8</b> MUNSON HOSPICE HOUSE 450 BROOK ST TRAVERSE CITY, MI 49684	HOSPICE CARE HOUSE
<b>9</b> MUNSON RENAL DIALYSIS 4062 WEST ROYAL DRIVE TRAVERSE CITY, MI 49684	RENAL DIALYSIS UNIT
<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 - OTHER INCOME BASED CRITERIA FOR FREE OR DISCOUNTED CARE	INCOME UP TO 200% OF THE FPG = 100% DISCOUNT ON CHARGES INCOME BETWEEN 201% AND 300% FPG = 75% DISCOUNT ON CHARGES INCOME BETWEEN 301% AND 400% FPG = 65% DISCOUNT ON CHARGES FAMILY INCOME MAY INCLUDE ALL INCOME ATTRIBUTABLE TO ALL MEMBERS OF THE FAMILY IN THE RESIDENCE, OTHER THAN MINIMAL AMOUNTS EARNED BY MINORS FAMILY INCOME INCLUDES THE FOLLOWING WHEN COMPUTING FPG EARNINGS, UNEMPLOYMENT COMPENSATION, WORKER'S COMPENSATION, SOCIAL SECURITY, SUPPLEMENTAL SECURITY INCOME, PUBLIC ASSISTANCE, VETERANS' PAYMENTS, SURVIVOR BENEFITS, PENSION OR RETIREMENT INCOME, INTEREST, DIVIDENDS, RENTS, ROYALTIES, INCOME FROM ESTATES, EDUCATIONAL ASSISTANCE, ALIMONY, CHILD SUPPORT, ASSISTANCE FROM OUTSIDE THE HOUSEHOLD, AND OTHER MISCELLANEOUS SOURCES, CASH, CHECKING AND SAVINGS BALANCES, MONEY MARKET ACCOUNTS, CERTIFICATES OF DEPOSIT, IRAS TRUSTS, INHERITANCES, ANNUITIES, SAVINGS BONDS, STOCKS, MUTUAL FUNDS, AND/OR CASH VALUE OF LIFE INSURANCE

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART I, LINE 7G - SUBSIDIZED HEALTH SERVICES EXPLANATION	THE COSTS RELATED TO PHYSICIAN CLINICS IN SUBSIDIZED HEALTH SERVICES TOTAL 15,958,042 THESE COSTS ARE OFFSET BY RELATED REVENUES IN COMPUTING THE NET COMMUNITY BENEFIT

# 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7, COLUMN (F) - EXCLUSIONS FROM PERCENT OF TOTAL EXPENSE	TOTAL EXPENSES FROM FORM 990, PART IX, LINE 25, ARE 558,443,731 AND THE PROPORTIONATE SHARE OF TOTAL EXPENSES OF THE AMBULATORY SURGERY CENTER IS 9,384,444 THE BAD DEBT EXPENSE INCLUDED IN THIS AMOUNT WAS 11,563,928 THE NET EXPENSE OF 547,129,137 WAS USED FOR PURPOSES OF CALCULATING LINE 7, COLUMN (F)

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART I, LINE 7 - COSTING METHODOLOGY EXPLANATION	COST VALUES FOR LINE 7 ARE BASED ON THE COST TO CHARGE RATIO COMPUTATION OR ACTUAL CASH PAID

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART II - COMMUNITY BUILDING ACTIVITIES	MUNSON MEDICAL CENTER (MMC) PROVIDED 76,011 IN COMMUNITY-BUILDING ACTIVITIES DURING THE 2016 TAX YEAR. THE MOST SIGNIFICANT PORTION OF THIS INVESTMENT WAS IN ENVIRONMENTAL IMPROVEMENTS RELATING TO THE RECYCLING OF ELECTRONIC EQUIPMENT. ANOTHER SIGNIFICANT PORTION WAS DEDICATED TO RECRUITMENT OF PHYSICIANS IN NEEDED SPECIALTIES FOR UNDERSERVED AREAS. ADDITIONAL ACTIVITIES INCLUDED ADMINISTRATIVE SUPPORT BOARDS, WORKFORCE DEVELOPMENT, ADVISORY COMMITTEES, AND COLLABORATIVE EFFORTS.

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 2 - BAD DEBT EXPENSE METHODOLOGY	DIRECT WRITE-OFF FROM UNPAID ACCOUNTS WHICH ARE DEEMED NO LONGER COLLECTIBLE ARE RECORDED AGAINST THE ALLOWANCE FOR BAD DEBT AN ESTIMATE OF BAD DEBT EXPENSE IS RECORDED BASED ON 1) AN ANALYSIS OF THE DIRECT WRITE- OFFS AND 2) AN ESTIMATE OF THE AMOUNT OF BAD DEBT, NET OF DISCOUNTS, IN THE ACCOUNTS RECEIVABLE BALANCE, CONSIDERING THE PAST EXPERIENCE AND CURRENT TRENDS OF PAYMENTS ON PATIENT ACCOUNTS FOR EACH OF THE MAJOR PAYOR SOURCES OF REVENUE



**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART III, LINE 3 BAD DEBT EXPENSE, PATIENTS ELIGIBLE FOR ASSISTANCE	THE METHODOLOGY USED TO DETERMINE THE ESTIMATED AMOUNT OF CHARITY IN BAD DET IS AS FOLLOWS WE DETERMINED THE APPROVAL RATE OF FINANCIAL COUNSELING BY TAKNG THE VALUE OF THE ACCOUNTS THAT SUCCESSFULLY QUALIFIED FOR CHARITY (INCLUDING PRESUMPTIVE APPROVALS) AND DIVIDING THAT NUMBER BY THE ACCOUNTS THAT WERE APPORVED FOR CHARITY PLUS THE ACCOUNTS THAT WERE DENIED THEN WE APPLIED THAT PERCENTAGE TO THE VALUE OF ACCOUNTS THAT DID NOT COMPLETE FINANCIAL COUNSELING AND WERE ASSIGNED TO BAD DEBT, MULTIPLIED BY THE APPROVAL RATE FOR FINANCIAL COUNSELING

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
BAD DEBT EXPENSE FOOTNOTE TO FINANCIAL STATEMENTS	THE ACCOUNTS RECEIVABLE FOOTNOTE TO THE AUDITED CONSOLIDATED FINANCIAL STATEMENTS OF MUNSON HEALTHCARE AND SUBSIDIARIES STATES THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS IS BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS CONSIDERING BUSINESS AND GENERAL ECONOMIC CONDITIONS IN ITS SERVICE AREA, TRENDS IN HEALTH CARE COVERAGE, AND OTHER COLLECTION INDICATORS THROUGHOUT THE YEAR, MANAGEMENT ASSESSES THE ADEQUACY OF THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS BASED UPON ACCOUNTS RECEIVABLE PAYOR COMPOSITION AND AGING AND HISTORICAL WRITE- OFF EXPERIENCE BY PAYOR CATEGORY AND OTHER FACTORS THE RESULTS OF THESE REVIEWS ARE THEN USED TO MAKE ANY MODIFICATIONS TO THE PROVISION FOR UNCOLLECTIBLE ACCOUNTS TO ESTABLISH AN APPROPRIATE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS AFTER AMOUNTS DUE FROM THIRD-PARTY PAYORS ARE SATISFIED AND REASONABLE EFFORTS TO COLLECT FROM THE PATIENT HAVE BEEN EXHAUSTED, THE ORGANIZATION FOLLOWS ESTABLISHED GUIDELINES FOR PLACING CERTAIN PAST-DUE PATIENT BALANCES WITH COLLECTION AGENCIES

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART III, LINE 9B - COLLECTION PRACTICES EXPLANATION	<p>MUNSON HEALTHCARE'S (MHC) INTERNAL AND EXTERNAL COLLECTION PRACTICES REFERENCED IN THE CREDIT AND COLLECTION POLICY (INCLUDING ACTIONS THE HOSPITAL MAY TAKE IN THE EVENT OF NON-PAYMENT, INCLUDING COLLECTION ACTIONS AND REPORTING TO COLLECTION AGENCIES) SHALL TAKE INTO ACCOUNT THE EXTENT TO WHICH THE PATIENT QUALIFIES FOR FINANCIAL ASSISTANCE, A PATIENT'S GOOD FAITH EFFORT TO APPLY FOR A GOVERNMENTAL PROGRAM OR FOR CHARITY FROM MHC, AND A PATIENT'S GOOD FAITH EFFORT TO COMPLY WITH HIS/HER PAYMENT AGREEMENTS WITH MHC FOR PATIENTS WHO QUALIFY FOR CHARITY AND WHO ARE COOPERATING IN GOOD FAITH TO RESOLVE THEIR DISCOUNTED HOSPITAL BILLS, MHC MAY OFFER EXTENDED PAYMENT PLANS, WILL NOT SEND UNPAID BILLS TO OUTSIDE COLLECTION AGENCIES, AND WILL CEASE ALL COLLECTION EFFORTS ON ANY UNPAID BALANCES ON ACCOUNTS THAT WERE OPENED WITHIN ONE YEAR OF THE DATE THAT THE PATIENT QUALIFIED FOR CHARITY UNDER THIS POLICY MHC WILL NOT IMPOSE EXTRAORDINARY COLLECTIONS ACTIONS SUCH AS WAGE GARNISHMENTS, LIENS ON PRIMARY RESIDENCES, OR OTHER LEGAL ACTIONS FOR ANY PATIENT WITHOUT FIRST MAKING REASONABLE EFFORTS TO DETERMINE WHETHER THAT PATIENT IS ELIGIBLE FOR CHARITY CARE UNDER THIS FINANCIAL ASSISTANCE POLICY REASONABLE EFFORTS SHALL INCLUDE 1)VALIDATING THAT THE PATIENT OWES THE UNPAID BILLS AND THAT ALL SOURCES OF THIRD-PARTY PAYMENTS HAVE BEEN IDENTIFIED AND BILLED BY THE HOSPITAL, 2)DOCUMENTING THAT MHC HAS OR HAS ATTEMPTED TO OFFER THE PATIENT THE OPPORTUNITY TO APPLY FOR CHARITY CARE PURSUANT TO THIS POLICY AND THAT THE PATIENT HAS NOT COMPLIED WITH THE HOSPITAL'S APPLICATION REQUIREMENTS, 3)DOCUMENTATING THAT THE PATIENT HAS BEEN OFFERED THE OPPORTUNITY TO ENTER INTO A PAYMENT PLAN BUT HAS NOT DONE SO, OR HAS ENTERED INTO A PAYMENT PLAN BUT HAS NOT HONORED THE TERMS OF THAT PLAN PATIENTS WILL BE NOTIFIED OF THE AVAILABILITY OF FINANCIAL ASSISTANCE FOR A PERIOD OF AT LEAST 120 DAYS FROM THE DATE OF THE FIRST POST-DISCHARGE BILLING STATEMENT PATIENT BALANCES WILL BE ELIGIBLE FOR FINANCIAL ASSISTANCE CONSIDERATION FOR AT LEAST 240 DAYS FROM THE DATE OF THE FIRST POST-DISCHARGE BILLING STATEMENT MEMBERS OF THE PUBLIC MAY OBTAIN THE CURRENT CREDIT AND COLLECTION POLICY FOR ANY MUNSON HEALTHCARE HOSPITAL ON THE WEBSITE, IN WRITING, AND FREE OF CHARGE BY CONTACTING MUNSON HEALTHCARE PATIENT FINANCIAL SERVICES DEPARTMENT AT 4230 COPPER RIDGE DR , TRAVERSE CITY, MI 49684</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART VI, LINE 2 - NEEDS ASSESSMENT	<p>THE MUNSON MEDICAL CENTER BOARD OF DIRECTORS MAINTAINS A STANDING COMMUNITY HEALTH COMMITTEE (CHC) TO SERVE MUNSON MEDICAL CENTER. THE CHC CONSISTS OF MUNSON MEDICAL CENTER BOARD MEMBERS AND OTHER INTERESTED AREA PHYSICIANS AND COMMUNITY MEMBERS APPOINTED BY THE MUNSON MEDICAL CENTER BOARD CHAIRPERSON. THE CHC MEETS AT LEAST QUARTERLY TO REVIEW EXISTING PROGRAMS AND SERVICES RELATED TO CURRENT COMMUNITY HEALTH NEEDS, CONSIDER THE MMC RESPONSE TO ANY EMERGING HEALTH TRENDS AS IDENTIFIED BY COMMUNITY HEALTH NEEDS ASSESSMENT, AND REVIEW ANY NEW COMMUNITY HEALTH BASED COLLABORATION OR PROGRAM. THE CHC IS RESPONSIBLE FOR COMMUNICATING INTERNALLY AND EXTERNALLY THE SIGNIFICANCE OF MMC COMMUNITY BENEFIT PROGRAMS AND SERVICES. THIS COMMITTEE IS SUPPORTED BY A COMMUNITY HEALTH DEPARTMENT OF MUNSON MEDICAL CENTER. MUNSON MEDICAL CENTER (MMC) IS A SIGNIFICANT CONTRIBUTOR TO REGIONAL EFFORTS THAT ASSESS THE HEALTH STATUS OF THE TOTAL POPULATION WITHIN OUR EXTENSIVE GEOGRAPHICAL AREA. COMMUNITY HEALTH ASSESSMENT IS AN IMPORTANT COMPONENT OF A COMMUNITY HEALTH IMPROVEMENT STRATEGY AS IT PROVIDES GUIDANCE AS TO WHERE EFFORTS SHOULD BE CONCENTRATED, AS WELL AS WHERE PROGRESS HAS BEEN MADE. THE DATA DOCUMENTED THROUGH AN ASSESSMENT SERVES AS A USEFUL REFERENCE FOR PROGRAM AND RESOURCE DEVELOPMENT EFFORTS. COMMUNITY- WIDE. MUNSON PREPARED A COMMUNITY NEEDS ASSESSMENT AND IMPLEMENTATION STRATEGY TO MEET THE REQUIREMENTS OF IRC SEC 501(R) DURING FISCAL 2016 IN ACCORDANCE WITH THE PLANS OF THE COMMUNITY HEALTH COMMITTEE OF THE BOARD. ADDITIONALLY, MUNSON WORKS IN CONJUNCTION WITH COMMUNITY COLLABORATIVES IN FIVE COUNTIES ANTRIM, BENZIE, GRAND TRAVERSE, LEELANAU, AND KALKASKA, AREA HEALTH DEPARTMENTS, AND OTHER REGIONAL ASSOCIATIONS TO MAINTAIN CURRENT UNDERSTANDING OF COMMUNITY NEED.</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART VI, LINE 3 - PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE	IT IS THE GOAL OF MUNSON HEALTHCARE TO COMMUNICATE AND EDUCATE PATIENTS AND THE PUBLIC REGARDING THE AVAILABILITY OF FINANCIAL ASSISTANCE THIS IS ACHIEVED THROUGH ONE OR MORE OF THE FOLLOWING METHODS INFORMATION BROCHURES AVAILABLE AT THE REGISTRATION DESKS BROCHURES THAT DESCRIBE MUNSON HEALTHCARE'S FINANCIAL ASSISTANCE PROGRAM ARE AVAILABLE AT ALL REGISTRATION SITES THE BROCHURE HAS CLEAR INFORMATION ON HOW TO CONTACT A FINANCIAL COUNSELOR STATEMENT ON BILLS STATEMENTS INCLUDE VERBIAGE THAT INSTRUCTS THE PATIENT TO CALL PATIENT FINANCIAL ASSISTANCE IF THEY NEED HELP WITH THEIR BILL SIGNS IN THE ER REGISTRATION AREA ADVISES THE PATIENTS THAT THEIR CARE IS NOT WITHHELD IF THEY HAVE NO INSURANCE OR MEANS TO PAY THE MUNSON HEALTHCARE INTERNET HAS THE FINANCIAL ASSISTANCE POLICY, THE FINANCIAL ASSISTANCE APPLICATION, THE PLAIN LANGUAGE SUMMARY AND THE BILLING AND COLLECTIONS POLICY AVAILABLE TO REVIEW AND PRINT REFERRAL BY REGISTRATION STAFF AT THE TIME OF REGISTRATION, SELF-PAY PATIENTS OR ANY PATIENT THAT MAY HAVE CONCERNS REGARDING THEIR UPCOMING ADMISSION IS REFERRED TO THE FINANCIAL COUNSELING STAFF MUNSON HEALTHCARE FINANCIAL COUNSELORS ARE AVAILABLE TO TALK WITH PATIENTS ABOUT THEIR FINANCIAL CONCERNS THE COUNSELOR VISIT ALL INPATIENTS THAT ARE DEEMED SELF-PAY, TO SEE IF THEY HAVE CONCERNS AND TO DETERMINE IF THEY WOULD LIKE HELP IF THE PATIENT WOULD LIKE HELP, THE COUNSELORS GATHER INCOME INFORMATION AND SCREEN THE PATIENT FOR MEDICAID GENERALLY, THESE TWO ACTIONS WILL DETERMINE WHAT PROGRAM THE PATIENT MIGHT QUALIFY FOR THE COUNSELOR DETERMINES WHAT THE PATIENT MAY QUALIFY FOR, THE COUNSELOR EDUCATES THE PATIENT ON THE AVAILABLE PROGRAMS AND ASSISTS THEM WITH COMPLETING THE APPROPRIATE APPLICATIONS THE COUNSELORS ALSO IDENTIFY ALL SELF-PAY OUTPATIENTS AND GO THROUGH THE SAME PROCESS, ONLY BY PHONE THE GOAL IS TO TALK WITH PATIENTS PRIOR TO ADMISSION, BUT WHEN THAT IS NOT POSSIBLE, THE CALL IS MADE SOON AFTER DISCHARGE AVAILABLE PROGRAMS INCLUDE BUT ARE NOT LIMITED TO MEDICAID (AND ALL OF ITS SUBSETS), SOCIAL SECURITY DISABILITY, TRAVERSE HEALTH CLINIC, MUNSON HEALTHCARE FINANCIAL ASSISTANCE, AND MUNSON MEDICAL CENTER MEDS PROGRAM MUNSON HEALTHCARE MAKES A PHONE CALL TO ALL PRIVATE-PAY PATIENTS PRIOR TO TRANSFERRING THEIR ACCOUNT TO A COLLECTION AGENCY TO INFORM THEM OF OUR FINANCIAL ASSISTANCE POLICY

Form and Line Reference	Explanation
PART VI, LINE 4 - COMMUNITY INFORMATION	<p>MUNSON MEDICAL CENTER DESCRIPTION MUNSON MEDICAL CENTER (MMC) IS THE LARGEST HOSPITAL IN N ORTHERN LOWER PENINSULA OF MICHIGAN, WITH 439 LICENSED ACUTE CARE BEDS AND FACILITIES ON T WO MAJOR CAMPUSES. ONE OF NINE HOSPITALS IN THE MUNSON HEALTHCARE SYSTEM, MMC SERVES AS A RURAL REFERRAL CENTER FOR THE SURROUNDING 24-COUNTY AREA, WITH 22,056 INPATIENT ADMISSIONS IN FISCAL YEAR 2017 AND AN ADDITIONAL 501,300 OUTPATIENT VISITS. THE HOSPITAL SERVED MORE THAN 16,141 SURGICAL CASES, 1,825 OBSTETRICAL BIRTHS, AND OVER 54,923 EMERGENCY ROOM VISIT S IN FISCAL YEAR 2017. THE HOSPITAL HAS AN ACTIVE MEDICAL STAFF OF 494 PROVIDERS AND 352 V OLUNTEERS. WITH APPROXIMATELY 3,880 EMPLOYEES, MMC IS THE LARGEST EMPLOYER IN NORTHERN MIC HIGAN. DUE TO ITS GEOGRAPHIC LOCATION AND COMPREHENSIVE ARRAY OF SERVICES OFFERED, MMC IS DESIGNATED A RURAL REFERRAL CENTER BY THE CENTERS FOR MEDICARE AND MEDICAID. MMC IS ALSO R ECOGNIZED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) AS A SOLE COMMUNITY HOSP ITAL. BECAUSE OF THIS STATUS, IT IS EQUIPPED TO PROVIDE CRITICAL CARE FOR PATIENTS ACROSS THE 24-COUNTY REGION. MMC PROVIDES SERVICES IN MORE THAN 76 DIFFERENT MEDICAL SPECIALTIES AND OFFERS A WIDE RANGE OF INPATIENT AND OUTPATIENT SERVICE. MMC HAS AN AWARD- WINNING OPE N-HEART SURGERY AND INTERVENTIONAL CARDIOLOGY PROGRAM, PLUS THE ONLY LEVEL II TRAUMA CENTE R IN MICHIGAN'S REGION 7, WHICH COVERS 17 COUNTIES, AND THE ONLY NEONATAL INTENSIVE CARE U NIT IN NORTHERN LOWER MICHIGAN. MMC IS ALSO DESIGNATED AS A PRIMARY STROKE CENTER BY THE J OINT COMMISSION AND ACCREDITED AS A COMPREHENSIVE COMMUNITY CANCER CENTER BY THE COMMISSIO N ON CANCER OF THE AMERICAN COLLEGE OF SURGEONS. SPECIALIZED INPATIENT UNITS AVAILABLE AT MMC INCLUDE MEDICAL/SURGICAL INTENSIVE CARE, CARDIAC INTENSIVE CARE, NEONATAL INTENSIVE CA RE, ONCOLOGY, ORTHOPEDICS, INPATIENT MENTAL HEALTH, AND PHYSICAL MEDICINE AND REHABILITATI ON. COMPLEX SURGERIES INCLUDING CARDIOTHORACIC, HAND, NEURO, AND VASCULAR SURGERIES ARE AV AILABLE, AS WELL AS LESS COMPLEX SAME-DAY SURGERY. A BROAD SPECTRUM OF DIAGNOSTIC AND THER APEUTIC SERVICES SUPPORT MMC'S PROGRAMS, INCLUDING COMPREHENSIVE RADIOLOGY SERVICES WITH CT, MRI (TRADITIONAL, OPEN BORE, AND BREAST), PET/CT, ULTRASOUND, NUCLEAR MEDICINE, DIGITA L MAMMOGRAPHY, AND X-RAY. COMPREHENSIVE CANCER TREATMENT INCLUDING RADIATION ONCOLOGY DELIV ERED VIA BRACHYTHERAPY, IGRT AND IMRT RADIATION THERAPY, AND THE LATEST IN STEREOTACTIC RA DIOSURGERY. COMPUTERIZED INPATIENT AND OUTPATIENT LABORATORY SERVICES INCLUDING THE REGIONS ONLY MALDI-TOF SYSTEM FOR RAPID IDENTIFICATION OF MICROORGANISMS. COMPREHENSIVE REHABILITA TION SERVICES, INCLUDING PHYSICAL, OCCUPATIONAL, SPEECH AND HEARING, AND WOUND THERAPY. PRO GRAMS A DEDICATED CARDIAC DIAGNOSTIC SUITE USING THE LATEST IN ECHOCARDIOGRAPHY, AN ADJACE NT LAB FOR DIAGNOSTIC CATHETERIZATION AND ELECTROPHYSIOLOGY STUDIES, AND A DEDICATED CARDI AC REHABILITATION AND PREVENTION PROGRAM. OBSTETRIC CLINIC FOR INDIGENT PATIENTS. MENTAL HEA LTH AND SUBSTANCE ABUSE SERVICES, HOME HEALTH, DME AND DIALYSIS SERVICES. POPULATION SERVED BY MUNSON MEDICAL CENTER MMC SERVES PATIENTS FROM 24 COUNTIES IN NORTHERN LOWER MICHIGAN AND THE EASTERN PORTION OF THE UPPER PENINSULA - A POPULATION BASE OF APPROXIMATELY 540,00 0. IN THE 12-COUNTY REGION IMMEDIATELY SURROUNDING MMC, 23% OF THE POPULATION ARE 65 YEARS OR OLDER. UNEMPLOYMENT RATE (AS OF DECEMBER 2017) IS ABOVE THE MICHIGAN RATE OF 4.4% IN 10 OF THE 12 COUNTIES SERVED, AVERAGING 6.8% WITH RATES RANGING FROM 4.3% TO 9.9% (SOURCE: M ICHIGAN BUREAU OF LABOR MARKET INFORMATION AND STRATEGIC INITIATIVES). ABOUT 68% OF MMC INP ATIENT DISCHARGES ORIGINATE FROM THE FIVE COUNTIES IN CLOSEST PROXIMITY TO MMC - ANTRIM, B ENZIE, GRAND TRAVERSE, LEELANAU AND KALKASKA. 44% OF BIRTHS ARE COVERED BY MEDICAID IN THE SIX COUNTIES IMMEDIATELY SURROUNDING MMC. 14.1 PERCENT OF ADULTS 18-64 YEARS OF AGE LACK HEALTH INSURANCE, COMPARED TO A STATE AVERAGE OF 12.4 PERCENT. (SOURCE: US CENSUS BUREAU, SMALL AREA HEALTH INSURANCE ESTIMATES (SAHIE), 2014). QUALITY MMC'S REPUTATION FOR THE HIGH EST QUALITY CARE IS REPRESENTED BY REPEATED NATIONAL RECOGNITION RECEIVED. MMCS REPUTATION FOR THE HIGHEST QUALITY CARE IS REPRESENTED BY REPEATED NATIONAL RECOGNITION RECEIVED. TH E AMERICAN NURSES CREDENTIALING CENTER HAS RE-DESIGNATED MMC AS A MAGNET HOSPITAL FOR THE THIRD CONSECUTIVE TIME. MMC WAS FIRST DESIGNATED IN 2006. MMC IS ONE OF JUST TWO PERCENT O F HOSPITALS IN THE WORLD AND ONE OF TWO HOSPITALS IN MICHIGAN THAT HAS BEEN RE- DESIGNATED FOR A THIRD TIME. MAGNET DESIGNATION RECOGNIZES EXCELLENCE IN PATIENT CARE STANDARDS, RESP ECT OF CULTURAL AND ETHNIC DIVERSITY, AND LEADERSHIP OF THE NURSE ADMINISTRATOR IN SUPPORT ING PROFESSIONAL NURSING PRACTICE, AND THE MANAGEMENT AND PHILOSOPHY OF NURSING SERVICES. MAGNET HOSPITALS ARE KNOWN TO HAVE THE HIGHEST QUALITY OF PATIENT CARE, HIGH LEVELS OF PAT IENT SATISFACTION, LOWER VACANCY AND TURNOVER RATES FOR REGISTERED NURSE POSITIONS, AND HI GHER RATES OF JOB SATISFACTION. MMC IS FULLY ACCRE</p>

Form and Line Reference	Explanation
PART VI, LINE 4 - COMMUNITY INFORMATION	<p> DITED BY THE JOINT COMMISSION AND HAS EARNED THE GOLD SEAL OF APPROVAL, AN INTERNATIONALLY -RECOGNIZED SYMBOL OF HEALTH CARE QUALITY THE ACCREDITATION PROCESS DRIVES QUALITY CARE AND PATIENT SAFETY IMPROVEMENTS THROUGH NATIONALLY RECOGNIZED EVIDENCE-BASED STANDARDS WHICH ADDRESS CRITICAL PATIENT SAFETY AND QUALITY ISSUES, NATIONAL PATIENT SAFETY GOALS, AND PERFORMANCE MEASURES WHICH PROVIDE A FOUNDATION FOR QUALITY THE JOINT COMMISSION, ALONG WITH THE AMERICAN HEART ASSOCIATION AND AMERICAN STROKE ASSOCIATION HAS ALSO CERTIFIED MMC AS A PRIMARY STROKE CENTER SINCE 2012 FOR MEETING ALL CRITICAL ELEMENTS OF PERFORMANCE TO ACHIEVE LONG-TERM SUCCESS IN IMPROVING OUTCOMES FOR STROKE PATIENTS CERTIFICATION RECOGNIZES HOSPITALS THAT HAVE A DEDICATED STROKE-FOCUSED PROGRAM, ARE STAFFED BY QUALIFIED MEDICAL PROFESSIONALS TRAINED IN STROKE CARE, INVOLVE THE PATIENT IN THEIR HOSPITAL CARE, AND WHO USE DATA TO ASSESS AND CONTINUALLY IMPROVE QUALITY OF CARE FOR STROKE PATIENTS MMC IS RATED FOUR STARS BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES THE RATING SUMMARIZES UP TO 64 QUALITY MEASURES ON THE HOSPITAL COMPARE WEB SITE REFLECTING COMMON CONDITIONS THAT HOSPITALS TREAT, SUCH AS HEART ATTACKS OR PNEUMONIA HOSPITALS MAY PERFORM MORE COMPLEX SERVICES OR PROCEDURES NOT REFLECTED IN THE MEASURES ON HOSPITAL COMPARE THE OVERALL RATING SHOWS HOW WELL EACH HOSPITAL PERFORMED, ON AVERAGE, COMPARED TO OTHER HOSPITALS IN THE U.S. MMC IS RECOGNIZED AS A BLUE DISTINCTION CENTER+ IN THREE AREAS - CARDIAC CARE, MATERNITY CARE AND KNEE AND HIP REPLACEMENT - BY BLUE CROSS BLUE SHIELD OF MICHIGAN FOR DEMONSTRATING ITS EXPERTISE IN DELIVERING SAFE AND EFFECTIVE CARE, MEETING OUTLINED QUALITY MEASURES AND DEMONSTRATING EXPERTISE IN THESE AREAS MMC'S STROKE PROGRAM IS REPEATEDLY RECOGNIZED BY THE AMERICAN HEART ASSOCIATION AND AMERICAN STROKE ASSOCIATION FOR HIGH QUALITY CARE IN 2016, THE HOSPITAL WAS ONE OF FOUR IN MICHIGAN TO RECEIVE BOTH GOLD PLUS ACHIEVEMENT AND ELITE HONOR ROLL RECOGNITION IN THE NATIONAL ASSOCIATIONS GET WITH THE GUIDELINES QUALITY IMPROVEMENT PROGRAM IN 2016, THE AMERICAN ASSOCIATION OF CRITICAL-CARE NURSES CONFERRED A SILVER-LEVEL BEACON AWARD FOR EXCELLENCE ON MMCS A2 CARDIOTHORACIC NURSING UNIT IN THE WEBBER HEART CENTER THE NURSING STAFF OF A4 WEBBER HEART CENTER WON THE SAME AWARD IN 2014 THE BEACON AWARD FOR EXCELLENCE RECOGNIZES UNIT CAREGIVERS WHO SUCCESSFULLY IMPROVE PATIENT OUTCOMES AND ALIGN PRACTICES WITH AACNS SIX STANDARDS FOR A HEALTHY WORK ENVIRONMENT UNITS THAT ACHIEVE THIS THREE-YEAR, THREE-LEVEL AWARD WITH GOLD, SILVER, AND BRONZE DESIGNATIONS MEET NATIONAL CRITERIA CONSISTENT WITH MAGNET RECOGNITION, THE MALCOLM BALDRIDGE NATIONAL QUALITY AWARD, AND THE NATIONAL QUALITY HEALTHCARE AWARD SEVEN MUNSON HEALTHCARE SYSTEM HOSPITALS WERE NAMED MOST WIRED FOR 2016 BY THE AMERICAN HOSPITAL ASSOCIATIONS JOURNAL HOSPITALS AND HEALTH NETWORKS MMC HAS BEEN NAMED A MOST WIRED HOSPITAL IN SIX OUT OF THE SEVEN YEARS THE LIST HAS BEEN PUBLISHED, INCLUDING, 2011 (SMALL &amp; RURAL), 2012 (MOST IMPROVED) AND 2013-2016 THE AMERICAN COLLEGE OF SURGEONS REVERIFIED MUNSON MEDICAL CENTER AS A LEVEL II TRAUMA CENTER IN 2015 IT IS THE ONLY LEVEL II FACILITY IN MICHIGAN'S NORTHERN LOWER PENINSULA AND WAS FIRST VERIFIED IN 2006 MMCS SMITH FAMILY BREAST HEALTH CENTER IS ACCREDITED BY THE NATIONAL ACCREDITATION PROGRAM FOR BREAST CENTERS (NAPBC) THE THREE-YEAR RECOGNITION IS A PROGRAM OF THE AMERICAN COLLEGE OF SURGEONS THE NAPBC IS A CONSORTIUM OF PROFESSIONAL ORGANIZATIONS DEDICATED TO THE IMPROVEMENT OF THE QUALITY OF CARE AND MONITORING OF OUTCOMES OF PATIENTS WITH DISEASE OF THE BREAST ACCREDITATION BY THE NAPBC IS ONLY GIVEN TO THOSE CENTERS THAT HAVE VOLUNTARILY COMMITTED TO PROVIDE THE HIGHEST QUALITY BREAST CARE AND THAT UNDERGO A RIGOROUS EVALUATION AND REVIEW OF THEIR PERFORMANCE THE CENTER HAS BEEN DESIGNATED AS A BREAST IMAGING CENTER OF EXCELLENCE BY THE AMERICAN COLLEGE OF RADIOLOGY SINCE 2010 MMCS CARDI </p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART VI, LINE 5 - PROMOTION OF COMMUNITY HEALTH	<p>THE MUNSON MEDICAL CENTER BOARD OF TRUSTEES IS MADE UP OF COMMUNITY MEMBERS ALL OF WHOM RESIDE IN THE HOSPITAL'S PRIMARY SERVICE AREA THESE VOLUNTEERS GIVE COUNTLESS HOURS OF SERVICE TO THE HOSPITAL IN THEIR OVERSIGHT ROLE ADDITIONALLY, 100% OF MUNSON MEDICAL CENTER TRUSTEES SUPPORT MUNSON FINANCIALLY MEDICAL STAFF PRIVILEGES ARE OFFERED TO ALL QUALIFIED PHYSICIANS IN THE COMMUNITY SUBJECT TO CREDENTIALING REVIEW AND REQUIREMENTS OF THE MEDICAL STAFF AND THE BOARD OF TRUSTEES MUNSON MEDICAL CENTER UTILIZES SURPLUS FUNDS TO MAINTAIN ACCESS TO PATIENT SERVICES AND IMPROVE CARE TO PATIENTS THROUGHOUT ITS SERVICE AREA EXAMPLES OF HOW MUNSON MEDICAL CENTER PROMOTES THE HEALTH OF THE COMMUNITY THROUGH PROGRAMS INCLUDE HEALTHY FUTURES- A PARTNERSHIP OF AREA HEALTH CARE PROVIDERS, HEALTH DEPARTMENTS AND MUNSON HEALTHCARE, CREATED TO IMPROVE THE HEALTH OF PREGNANT WOMEN AND CHILDREN UP TO AGE FIVE THE PROGRAM INCLUDES CENTRAL ACCESS/DATA MANAGEMENT, REGISTERED NURSE (RN) CARE COORDINATION, EDUCATIONAL MAILINGS, AND HEALTH CARE-RELATED FINANCIAL ASSISTANCE THE HEALTHY FUTURES MODEL OF RN CARE COORDINATION CONSISTS OF AN OUTCOMES-BASED APPROACH TO INTERVENTION IN THE AREAS OF BREASTFEEDING LONGEVITY, ACCESS TO HEALTH CARE AND IMMUNIZATIONS MEDS PROGRAM- A PROGRAM THAT PROVIDES TO PATIENTS WITHOUT RESOURCES BEING DISCHARGED FROM THE HOSPITAL NEEDED MEDICATIONS, AS WELL AS ENROLLING THOSE PATIENTS INTO PHARMACEUTICAL COMPANY SPONSORED ASSISTANCE PROGRAMS SO THEY MAY CONTINUE TO GET THE NEEDED PHARMACEUTICALS NORTHERN MICHIGAN DIABETES INITIATIVE (NMDI)- A GROUP OF STAKEHOLDERS AND STEERING COMMITTEE MEMBERS THAT REPRESENT THE 14 COUNTY SERVICE AREA, WITH A VISION TO IMPROVE THE CHRONIC CARE MANAGEMENT OF DIABETES NMDI IS COMMITTED TO PROVIDING LOCAL, REGIONAL, AND NATIONAL RESOURCES FOR THE PREVENTION AND MANAGEMENT OF DIABETES WHILE MOST DIABETES COLLABORATIVES FOCUS ON PROVIDING OPTIMAL EVIDENCE BASED CARE MANAGEMENT TO THE PERSON ALREADY DIAGNOSED WITH DIABETES, NMDI FOCUSES ON CONCURRENT UPSTREAM TARGETED EDUCATION OF THREE SPECIFIC POPULATIONS THE GENERAL COMMUNITY, THE SOCIOECONOMICALLY CHALLENGED HIGH RISK POPULATION, AND RURAL PRIMARY CARE PROVIDERS (PCP) CARING FOR DIABETIC PATIENTS NORTHERN MICHIGAN VACCINE PREVENTABLE DISEASE TASK FORCE - A GROUP COORDINATED AND LED BY MUNSON HEALTHCARE, IS WORKING TO INFORM, EDUCATE, AND SUPPORT POLICY CHANGE THAT REVERSES THE REGION'S ONGOING TREND OF VERY LOW VACCINATION RATES AND SUPPORTS HEALTHY COMMUNITIES MEDICAL EDUCATION-THE MUNSON FAMILY PRACTICE RESIDENCY PROGRAM INTEGRATES OSTEOPATHIC AND ALLOPATHIC MEDICINE TOGETHER, WITH THE RESOURCES OF MUNSON MEDICAL CENTER THIS DUALY ACCREDITED 5/5/5 PROGRAM ACCEPTS BOTH DO AND MD TRAINEES THE PROGRAM IS AFFILIATED WITH MICHIGAN STATE UNIVERSITY MMC ALSO PARTNERS WITH SEVERAL COLLEGES AND SCHOOLS OF NURSING TO PROVIDE INTERNSHIPS AND CLINICAL EXPERIENCES FOR REGISTERED NURSES, RESPIRATORY THERAPISTS, PHARMACISTS, AND OTHER HEALTH PROFESSIONALS SHAPE UP NORTH- A COLLABORATIVE EFFORT LED BY MUNSON MEDICAL CENTER WITH OVER TWENTY COMMITTED COMMUNITY PARTNERS FOUR FOCUS AREA STRATEGIES WERE SELECTED FOR GREATEST COMMUNITY IMPACT PROVIDERS, SCHOOLS, BUSINESSES AND COMMUNITY AWARENESS THIS COLLABORATION ALLOWS PARTNERS TO WORK TOGETHER TO ADOPT CONSISTENT, CLEAR, AND UNIFIED MESSAGES AND DEVELOP COMMON INTERVENTION STRATEGIES IN AN EFFORT TO CREATE COLLECTIVE IMPACT</p>



**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART VI, LINE 6 - AFFILIATED HEALTH CARE SYSTEM	<p>MUNSON MEDICAL CENTER'S SOLE CORPORATE MEMBER IS MUNSON HEALTHCARE, A 501 (C)(3) CORPORATION. THE MUNSON HEALTHCARE SYSTEM CONSISTS OF A MAJOR TERTIARY REFERRAL HOSPITAL, SEVERAL RURAL-BASED MEDICAL CENTERS, EXTENSIVE OUTPATIENT TREATMENT AND REHABILITATION FACILITIES, AND ANCILLARY EMERGENCY, TRANSPORTATION AND HOME-BASED MEDICAL SERVICES THAT COVER 24 COUNTIES IN MICHIGAN'S NORTHERN LOWER PENINSULA AND THE EASTERN PORTION OF THE UPPER PENINSULA. THE MOST SIGNIFICANT OF THE MUNSON HEALTHCARE SUBSIDIARIES IS MUNSON MEDICAL CENTER (MMC). MMC IS ONE OF NINE NOT-FOR-PROFIT HOSPITALS WHICH ARE AFFILIATED WITH EACH OTHER AND SERVE AS THE ONLY HOSPITALS IN THEIR COMMUNITIES. EACH OF THE AFFILIATED HOSPITALS HAS INDIVIDUAL COMMUNITY HEALTH INITIATIVES AND/OR PROMOTION ACTIVITIES, AS WELL AS SHARED INITIATIVES. THE OWNED HOSPITALS IN THE MUNSON HEALTHCARE SYSTEM WHICH INCLUDE MUNSON MEDICAL CENTER, PAUL OLIVER MEMORIAL HOSPITAL, MUNSON HEALTHCARE CADILLAC, MUNSON HEALTHCARE GRAYLING, MUNSON HEALTHCARE CHARLEVOIX HOSPITAL AND MUNSON HEALTHCARE MANISTEE HOSPITAL PROVIDED 70.6 MILLION OF COMMUNITY BENEFIT IN THE 2016 TAX YEAR. ADDITIONALLY, MMC WORKS IN COOPERATION WITH OTHER ENTITIES IN THE MUNSON HEALTHCARE SYSTEM TO PROVIDE A FULL RANGE OF HEALTH SERVICES TO THE COMMUNITIES IN ITS SERVICE AREA. THE HOME HEALTH DIVISION OF MUNSON HEALTHCARE PROVIDES HOME NURSE AND AIDE SERVICES IN ADDITION TO DURABLE MEDICAL EQUIPMENT AND A PALLIATIVE CARE AND HOSPICE PROGRAM ON THE MUNSON CAMPUS. COMMUNITY BENEFIT, IN THE FORM OF CHARITY CARE AND UNREIMBURSED MEDICAID ARE PROVIDED THROUGH THIS DIVISION EACH YEAR. NORTH FLIGHT, INC. IS THE CHARITABLE TRANSPORTATION ENTITY IN THE SYSTEM. WITH ITS FIXED WING AND HELICOPTER AIR SERVICES, IN COMBINATION WITH GROUND TRANSPORT, PATIENTS IN THE SYSTEM ARE ABLE TO ACCESS APPROPRIATE CARE. NORTH FLIGHT, INC. PROVIDED APPROXIMATELY 631,000 IN CHARITY CARE AND UNREIMBURSED MEDICAID IN THE PAST FISCAL YEAR. MUNSON MEDICAL GROUP, THE EMPLOYED PHYSICIAN ORGANIZATION IN THE SYSTEM, PROVIDED APPROXIMATELY 910,000 IN CHARITY CARE AND COMMUNITY BENEFIT IN TAX YEAR 2016. MMC PERFORMS THE NEEDS ASSESSMENTS FOR MUNSON HEALTHCARE. UTILIZING THIS NEEDS ASSESSMENT, MUNSON HEALTHCARE COORDINATES COMMUNITY BENEFIT PROGRAMS THROUGH PLANNING, DEVELOPING, IMPLEMENTING, EVALUATING AND FUNDING PROGRAMS THAT ADDRESS COMMUNITY NEEDS. IN TOTAL, THE MUNSON HEALTHCARE SYSTEM PROVIDED 81.8 MILLION IN CHARITY CARE AND COMMUNITY BENEFITS, INCLUDING NUMEROUS UNCOMPENSATED COMMUNITY HEALTH IMPROVEMENT SERVICES AND PROGRAMS, OUTREACH PROGRAMS, BAD DEBT, AND UNREIMBURSED MEDICARE AND MEDICAID SERVICES TO NORTHERN MICHIGAN.</p>

# Additional Data

**Software ID:**

**Software Version:**

**EIN:** 38-1362830

**Name:** MUNSON MEDICAL CENTER

## 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? <b>1</b>											
Name, address, primary website address, and state license number											
1	MUNSON MEDICAL CENTER 1105 SIXTH ST TRAVERSE CITY, MI 49684 HTTP //WWW.MUNSONHEALTHCARE.ORG 1060000048	X	X		X		X	X			

**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
FACILITY 1, MUNSON MEDICAL CENTER - PART V, LINE 5	A COLLABORATIVE 21-MEMBER STEERING COMMITTEE GUIDED THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) PROCESS THIS STEERING COMMITTEE WAS COMPRISED OF HOSPITAL LEADERS AND PUBLIC HEALTH OFFICIALS AS THE CHNA PROCESS PROGRESSED, 5 COMMUNITY CONVERSATIONS WERE HELD WITH REPRESENTATION RANGING FROM 12 TO 30 AREA GROUPS AND ORGANIZATIONS AT EACH, TO ENSURE INPUT FROM THOSE WHO HAVE A BROAD KNOWLEDGE OF THE COMMUNITY THESE COMMUNITY CONVERSATION SESSIONS WERE CONDUCTED AT THE FIVE AREA COUNTY COLLABORATIVES, WITH ORGANIZATIONS REPRESENTING, OR MEMBERS OF, MEDICALLY UNDERSERVED, LOW-INCOME, AND MINORITY GROUPS INDIVIDUALS POSSESSING BROAD KNOWLEDGE OF ALL SEGMENTS OF THE FIVE-COUNTY AREA PARTICIPATED AS TO HELP ASSESS HEALTH CARE NEEDS THESE GROUPS INCLUDED INDIVIDUALS WITH KNOWLEDGE OF PEOPLE AND AREAS MOST IMPACTED BY HEALTH DISPARITIES FURTHER, A "WHAT MATTERS TO YOU?" SURVEY WAS DISTRIBUTED TO THE MUNSON MEDICAL CENTER (MMC) MAIN SERVICE AREA TO GATHER INPUT FROM THE BROAD COMMUNITY A HEALTH CARE PROVIDER SURVEY ALSO WAS DISTRIBUTED TO GAIN TARGETED PHYSICIAN INPUT AS WELL IN ADDITION TO SECONDARY DATA FROM OUR COMMUNITY DASHBOARD, THE PRIMARY DATA DISCUSSED ABOVE WAS USED TO COMPILE A COMPREHENSIVE LIST OF HEALTH NEEDS, THEN PRIORITIZED ITS TOP SEVEN HEALTH NEEDS
FACILITY 1, MUNSON MEDICAL CENTER - PART V, LINE 6A	PAUL OLIVER MEMORIAL HOSPITAL (POMH) AND KALKASKA MEMORIAL HEALTH CENTER (KMHC) ALSO PARTICIPATED, HOWEVER KMHC IS NOT REQUIRED TO REPORT ON 501(R) COMPLIANCE DUE TO THEIR EXEMPTION AS A GOVERNMENTAL ENTITY

**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
FACILITY 1, MUNSON MEDICAL CENTER - PART V, LINE 6B	A COLLABORATIVE 21-MEMBER STEERING COMMITTEE GUIDED THE CHNA PROCESS THIS STEERING COMMITTEE WAS COMPRISED OF HOSPITAL LEADERS AND PUBLIC HEALTH OFFICIALS, AS LISTED IN APPENDIX A OF THE CHNA AS THE CHNA PROCESS PROGRESSED, 5 COMMUNITY CONVERSATIONS WERE HELD WITH REPRESENTATION RANGING FROM 12 TO 30 AREA GROUPS AND ORGANIZATIONS AT EACH, TO ENSURE INPUT FROM THOSE WHO HAVE A BROAD KNOWLEDGE OF THE COMMUNITY SEE APPENDIX B OF THE CHNA FOR A LIST OF GROUPS AND AGENCIES THAT PARTICIPATED IN COMMUNITY CONVERSATIONS FACILITY 1, MUNSON MEDICAL CENTER - PART V, SECTION B, LINE 7 7A FULL URL TO THE CHNA <a href="http://www.munsonhealthcare.org/upload/docs/chna/2016%20MMC%20CHNA.pdf">HTTP //WWW MUNSONHEALTHCARE ORG/UPLOAD/DOCS/CHNA/2016%20MMC%20CHNA PDF</a> FACILITY 1, MUNSON MEDICAL CENTER - PART V, SECTION B, LINE 10 10A FULL URL TO THE IMPLEMENTATION STRATEGY <a href="https://www.munsonhealthcare.org/upload/docs/chna/2016%20MMC%20CHNA%20IMPLEMENTATION%20STRATEGY%20-%20MMC%20(11.03.16).pdf">HTTPS //WWW MUNSONHEALTHCARE ORG/UPLOAD/DOCS/CHNA/2016%20MMC%20CHNA %20IMPLEMENTATION%20STRATEGY%20-%20MMC%20(11.03.16) PDF</a>
FACILITY 1, MUNSON MEDICAL CENTER - PART V, LINE 11	WITH THE SUPPORT OF THE MUNSON MEDICAL CENTER BOARD'S COMMUNITY HEALTH COMMITTEE, MUNSON MEDICAL CENTER THOUGHTFULLY PARTICIPATES IN THE CONTINUAL EVALUATION OF THE HEALTH PROGRAMS DESIGNED TO MEET THE NEEDS OF THE COMMUNITIES IN MUNSON'S SERVICE AREA AS OUTLINED IN THE COMMUNITY HEALTH IMPLEMENTATION STRATEGY, THE CONTINUATION OF SUCCESSFUL PROGRAMS, COMBINED WITH OPPORTUNITIES TO INITIATE NEW PROGRAMS AT THE HOSPITAL OR AS A PARTNER IN MORE BROAD-BASED EFFORTS, FORM THE STRATEGIC BASIS TO IMPROVE ISSUES SURROUNDING HEALTH AND HEALTHCARE DELIVERY SEVEN TOP SIGNIFICANT HEALTH NEEDS WERE IDENTIFIED DUE TO THE CLEAR INTERCONNECTIVITY AMONG THE ISSUES, ALL WERE CONSIDERED IN THE BUILDING THE IMPLEMENTATION STRATEGY TECHNIQUES THAT CROSS OVER BETWEEN HEALTH ISSUES WERE USED AS TO ENHANCE COLLECTIVE IMPACT ON IMPROVING COMMUNITY HEALTH MMC'S ROLE IN ADDRESSING EACH VARIES AS FOR SOME MMC IS THE CONVENER WHILE FOR OTHER STRATEGIES OUR ROLE IS BEST SUITED TO BE A PARTICIPANT IN ACTIVELY ADDRESSING THE NEED

**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
FACILITY 1, MUNSON MEDICAL CENTER - PART V, LINE 13H	PATIENTS WHOSE FAMILY INCOME EXCEEDS 400% OF THE FPG MAY BE ELIGIBLE TO RECEIVE DISCOUNTED RATES ON A CASE-BY-CASE BASIS BASED ON THEIR SPECIFIC CIRCUMSTANCES, AT THE SOLE DISCRETION OF MUNSON HEALTHCARE FACILITY 1, MUNSON MEDICAL CENTER - QUESTION V, SECTION B, LINE 16 16A FULL URL TO FINANCIAL ASSISTANCE POLICY <a href="http://www.munsonhealthcare.org/upload/docs/patients%20and%20visitors/financial%20assistance/financial-assistance-policy-10-16-17.pdf">HTTP //WWW MUNSONHEALTHCARE ORG/UPLOAD/DOCS/PATIENTS%20AND %20VISITORS/FINANCIAL%20ASSISTANCE/FINANCIAL-ASSISTANCE-POLICY-10 16-17 PDF</a> 16B FULL URL TO FINANCIAL ASSISTANCE POLICY APPLICATION <a href="http://www.munsonhealthcare.org/upload/docs/munson%20healthcare/financial%20assistance/munson%20medical%20218.pdf">HTTP //WWW MUNSONHEALTHCARE ORG/UPLOAD/DOCS/MUNSON%20HEALTHCARE/FINANCIAL %20ASSISTANCE/MUNSON%20MEDICAL%20218 PDF</a> 16C FULL URL TO PLAIN LANGUAGE SUMMARY <a href="http://www.munsonhealthcare.org/financialhelp">HTTP //WWW MUNSONHEALTHCARE ORG/FINANCIALHELP</a>
FACILITY 1, MUNSON MEDICAL CENTER - PART V, LINE 16J	IT IS THE GOAL OF MUNSON HEALTHCARE TO COMMUNICATE TO THE PATIENTS AND TO THE PUBLIC THE AVAILABILITY OF FINANCIAL ASSISTANCE TO THOSE WHO QUALIFY THIS WILL BE ACHIEVED THROUGH ONE OR MORE OF THE FOLLOWING METHODS INFORMATION BROCHURES AVAILABLE AT THE REGISTRATION DESKS, BROCHURES DISTRIBUTED TO ALL SELF-PAY PATIENTS, INFORMATION POSTED ON THE WEBSITE, STATEMENT ON BILLS, SIGNS IN THE REGISTRATION AREAS, AND CALLS MADE TO ALL SELF-PAY PATIENTS AFTER SERVICE

**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
FACILITY 1, MUNSON MEDICAL CENTER - PART V, LINE 20E	MUNSON MEDICAL CENTER (MUNSON) REVIEWS LARGE DOLLAR ACCOUNTS TO ENSURE ASSISTANCE HAS BEEN OFFERED TO PATIENTS BEFORE THE ACCOUNTS ARE TRANSFERRED TO A CREDIT AGENCY. ONCE AN ACCOUNT HAS BEEN TRANSFERRED TO A CREDIT AGENCY, THE AGENCY REVIEWS THE ACCOUNT TO SEE IF THE PATIENT WOULD BE A POSSIBLE CANDIDATE FOR FINANCIAL ASSISTANCE BEFORE FILING ANY LAWSUITS OR LIENS. MUNSON WILL NOT IMPOSE EXTRAORDINARY COLLECTIONS ACTIONS SUCH AS WAGE GARNISHMENTS, LIENS ON PRIMARY RESIDENCES, OR OTHER LEGAL ACTIONS FOR ANY PATIENT WITHOUT FIRST MAKING REASONABLE EFFORTS TO DETERMINE WHETHER THAT PATIENT IS ELIGIBLE FOR CHARITY CARE UNDER THIS FINANCIAL ASSISTANCE POLICY. REASONABLE EFFORTS SHALL INCLUDE: 1. VALIDATING THAT THE PATIENT OWES THE UNPAID BILLS AND THAT ALL SOURCES OF THIRD-PARTY PAYMENTS HAVE BEEN IDENTIFIED AND BILLED BY THE HOSPITAL; 2. DOCUMENTING THAT MUNSON HAS OR HAS ATTEMPTED TO OFFER THE PATIENT THE OPPORTUNITY TO APPLY FOR CHARITY CARE PURSUANT TO THIS POLICY AND THAT THE PATIENT HAS NOT COMPLIED WITH THE HOSPITAL'S APPLICATION REQUIREMENTS; 3. DOCUMENTING THAT THE PATIENT HAS BEEN OFFERED THE OPPORTUNITY TO ENTER INTO A PAYMENT PLAN BUT HAS NOT DONE SO, OR HAS ENTERED INTO A PAYMENT PLAN BUT HAS NOT HONORED THE TERMS OF THAT PLAN. THE METHOD IN WHICH MHC DOES THIS IS AS FOLLOWS: ALL STATEMENTS INCLUDE A STATEMENT REGARDING THE AVAILABILITY OF PAYMENT PLANS, FINANCIAL ASSISTANCE AND CHARITY CARE. MUNSON WORKS WITH THE COLLECTION AGENCIES TO IDENTIFY INDIVIDUALS THAT MAY QUALIFY FOR CHARITY. IF THEY FIND AN INDIVIDUAL, THEY MAY REFER THE PATIENT TO PATIENT ACCOUNTS FOR EVALUATION. ALL ACCOUNTS THAT ARE PATIENT-PAY RECEIVE A PHONE CALL TO MAKE THE PATIENT AWARE OF OUR FINANCIAL ASSISTANCE POLICY PRIOR TO THEM GOING TO COLLECTIONS.

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Schedule I  
(Form 990)

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).

OMB No 1545-0047

2016

Open to Public  
Inspection

Department of the  
Treasury  
Internal Revenue Service

Name of the organization  
MUNSON MEDICAL CENTER

Employer identification number  
38-1362830

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
(1) TRAVERSE HEALTH CLINIC & COALITION 1719 S GARFIELD AVENUE TRAVERSE CITY, MI 49686	30-0224028	501C3		55,068	FMV	MEDICATION	MEDICALLY UNDERSERVE
(2) UNITED WAY OF NORTHWEST MICHIGAN 521 SOUTH UNION STREET TRAVERSE CITY, MI 49684	38-1679060	501C3	20,000				COMMUNITY SUPPORT

2

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

2

3

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

**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
(1) MEDICAL INSURANCE PAYMENT	45	23,507			
(2) TRANSPORT, HOUSING, WIGS	754	185,625			
(3) TRANSPORT, HOUSING, FOOD	2305	134,506			
(4) MAMMOGRAPHY ASSISTANCE	439	56,534			
(5) MEALS FOR PATIENT FAMILY	1291		27,320	FMV	MEALS
(6) MEDICAL, TRANSPORT & DRUG	129	52,062			
(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
SCHEDULE I, PAGE 1, PART I, LINE 2	MUNSON MEDICAL CENTER AWARDS MOST GRANTS BASED ON AN APPLICATION PROCESS FOR PRE-APPROVED SERVICES AND PURCHASES IN ACCORDANCE WITH PROTOCOLS ESTABLISHED WITH CASE MANAGERS WORKING FOR THE DEPARTMENTS WHICH APPLY FOR ASSISTANCE THE ASSISTANCE CAN EITHER BE REQUESTED FOR THE DEPARTMENT OR ON BEHALF OF PATIENTS WHO INDICATE AN UNMET NEED THAT POSES A BARRIER TO THE RECEIPT OF HEALTH CARE SERVICES CASE MANAGERS MONITOR THE USE OF THE FUNDS IN LINE WITH THE PROTOCOLS MUNSON MEDICAL CENTER MAINTAINS RECORDS OF SUPPORT FOR EXPENSES USED FOR FUNDED REQUESTS MUNSON MEDICAL CENTER MAY AWARD A GRANT OR CONTRIBUTION TO ANOTHER TAX- EXEMPT ORGANIZATION BASED ON A REQUEST FOR REIMBURSEMENT FOR PRE-APPROVED SERVICES OR PURCHASES THE AWARD IS BASED ON AN EVALUATION OF THE USE OF THE FUNDS FOR THE PROMOTION OF HEALTH IN THE COMMUNITY THE ONGOING RELATIONSHIP OF MUNSON MEDICAL CENTER WITH ITS PARTNERS IN THE COMMUNITY FOR THE PROMOTION OF HEALTH ALLOWS FOR THE MONITORING OF THE GRANT AWARD



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  
MUNSON MEDICAL CENTER

Employer identification number  
38-1362830

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><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>				
<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.			1b	
<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?			2	
<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><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>				
<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?			4a	Yes
<b>b</b> Participate in, or receive payment from, a supplemental nonqualified retirement plan?			4b	Yes
<b>c</b> Participate in, or receive payment from, an equity-based compensation arrangement?			4c	No
If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.				
<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?			5a	No
<b>b</b> Any related organization?			5b	No
If "Yes," on line 5a or 5b, describe in Part III.				
<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?			6a	No
<b>b</b> Any related organization?			6b	No
If "Yes," on line 6a or 6b, describe in Part III.				
<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.			7	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.			8	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)?			9	

**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
SCHEDULE J, PAGE 1, PART I, LINE 4	EDWIN A. NESS 0 134,260 0 ALFRED PILONG 0 73,538 0 MARK A. HEPLER 0 36,529 0 DAVID MCGREAHAM, MD 0 19,455 0 DERK PRONGER 0 27,009 0 JAMES FISCHER 96,044 0 0
SCHEDULE J, PART III	PART I, LINE 4A EXECUTIVE SEVERANCE PLAN. SUBJECT TO REVIEW AND APPROVAL BY THE BOARD COMPENSATION AND EXECUTIVE LEADERSHIP COMMITTEE, IN ORDER TO RECRUIT AND MAINTAIN QUALIFIED EXECUTIVES, A COMPETITIVE BENEFIT PACKAGE IS OFFERED TO THE PRESIDENT AND VICE-PRESIDENTS, WHICH INCLUDES A SEVERANCE PLAN. MUNSON HAS A SEVERANCE PLAN FOR THE PRESIDENT AND VICE-PRESIDENT/EXECUTIVE LEVEL POSITIONS, WHICH PROVIDES FOR THE PRESIDENT UP TO TWO YEARS OF PAY IN THE EVENT EMPLOYMENT ENDS UNDER CERTAIN CONDITIONS AND FOR VICE-PRESIDENTS, UP TO ONE-YEAR OF PAY IN THE EVENT EMPLOYMENT ENDS UNDER CERTAIN CONDITIONS. THE PLAN PROVIDES FOR A 50% OFFSET FOR SUBSEQUENT EMPLOYMENT DURING THE SEVERANCE PERIOD. MEDICAL BENEFITS ARE PROVIDED DURING THE SEVERANCE PERIOD. PART I, LINE 4B EXECUTIVE SUPPLEMENTAL EXECUTIVE RETIREMENT PLANS. SUBJECT TO REVIEW AND APPROVAL BY THE BOARD COMPENSATION AND EXECUTIVE LEADERSHIP COMMITTEE, IN ORDER TO RECRUIT AND MAINTAIN QUALIFIED EXECUTIVES, INCLUDING THE PRESIDENT AND VICE-PRESIDENTS, A COMPETITIVE BENEFIT PACKAGE IS OFFERED WHICH INCLUDES PARTICIPATION IN A NON-QUALIFIED SUPPLEMENTAL RETIREMENT PLAN. FOR THE PRESIDENT, THE PLAN PROVIDES A TARGETED BENEFIT AT AGE 62. ANNUAL CONTRIBUTIONS, AT MUNSON'S DISCRETION, ARE MADE TO THE PLAN IN ORDER TO ACHIEVE THE TARGETED RETIREMENT BENEFIT LEVEL. VICE-PRESIDENTS ARE ELIGIBLE TO PARTICIPATE IN AN AMOUNT NOT TO EXCEED 6% OF BASE COMPENSATION, FUNDED ANNUALLY, AT THE SOLE DISCRETION OF MUNSON. THESE FUNDS ARE AVAILABLE TO VESTED PARTICIPANTS UPON SEPARATION OF EMPLOYMENT FROM MUNSON.

Additional Data

Software ID:

Software Version:

EIN: 38-1362830

Name: MUNSON MEDICAL CENTER

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				
1EDWIN A NESSDIRECTOR	(i)						
	(ii)	675,627	261,450	3,790	146,937	24,643	1,112,447
1ALFRED PILONG CEO & PRESIDENT	(i)	467,145	151,661	19,216	86,215	20,644	744,881
	(ii)					-	-
2WALTER NOBLE MD DIRECTOR	(i)	217,189	16,697	1,023	5,968	9,131	250,008
	(ii)					-	-
3JILL E VOLLBRECHT MD DIRECTOR	(i)	214,186		16,730	19,807	24,083	274,806
	(ii)					-	-
4MARK A HEPLERCFO	(i)						10,889
	(ii)	336,845	96,246	58,916	56,740	25,175	573,922
5DAVID MCGREAHAM MD VP MEDICAL AFFAIRS	(i)	299,888	66,474	22,769	37,448	18,481	445,060
	(ii)					-	-
6DERK PRONGER CHIEF OPERATING OFFI	(i)	243,762	74,532	19,296	39,648	20,222	397,460
	(ii)					-	-
7JAMES FISCHER VP PATIENT CARE	(i)	105,920	38,624	139,128	6,355	12,691	302,718
	(ii)					-	-
8THOMAS SCHERMERHORN MD NEUROSURGEON	(i)	937,157		18,555	12,677	23,345	991,734
	(ii)					-	-
9ANDREW LUEAPHYSICIAN	(i)	352,757	54,829	18,246	12,677	17,897	456,406
	(ii)					-	-
10AHMET SEVIMLI MD NEPHROLOGIST	(i)	385,907		19,702	23,154	24,087	452,850
	(ii)					-	-
11JAMSHID AMANZADEH PHYSICIAN	(i)	347,463	25,000	1,162	12,182	9,116	394,923
	(ii)					-	-
12YELENA KIERPHYSICIAN	(i)	357,387		567	12,677	20,326	390,957
	(ii)					-	-

Schedule K  
(Form 990)

Department of the Treasury  
Internal Revenue Service

Name of the organization  
MUNSON MEDICAL CENTER

Supplemental Information on Tax Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.  
▶ Attach to Form 990.  
▶ Information about Schedule K (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

Employer identification number  
38-1362830

Part I Bond Issues											
(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pool financing	
						Yes	No	Yes	No	Yes	No
A CNTY GRD TRAVSE HOSP FIN AUTH 2011	38-6004832	386523EE0	08-10-2011	128,728,067	REFUND PRIOR BONDS		X		X		X
B CNTY GRAD TRAV HOSP FIN AUTH 2014 A	38-6004832	386523EH3	12-17-2014	30,370,807	CANCER CENTER CONSTUCTION		X		X		X

Part II		Proceeds							
		A		B		C		D	
1	Amount of bonds retired . . . . .								
2	Amount of bonds legally defeased . . . . .								
3	Total proceeds of issue . . . . .	128,728,067		30,374,573					
4	Gross proceeds in reserve funds . . . . .								
5	Capitalized interest from proceeds . . . . .								
6	Proceeds in refunding escrows . . . . .								
7	Issuance costs from proceeds . . . . .	1,756,787		370,807					
8	Credit enhancement from proceeds . . . . .								
9	Working capital expenditures from proceeds . . . . .								
10	Capital expenditures from proceeds . . . . .			30,003,766					
11	Other spent proceeds . . . . .	126,971,281							
12	Other unspent proceeds . . . . .								
13	Year of substantial completion . . . . .			2016					
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue? . . . . .	X			X				
15	Were the bonds issued as part of an advance refunding issue? . . . . .		X		X				
16	Has the final allocation of proceeds been made? . . . . .	X			X				
17	Does the organization maintain adequate books and records to support the final allocation of proceeds? . . . . .	X		X					

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

**Part III Private Business Use** (Continued)

	<b>A</b>		<b>B</b>		<b>C</b>		<b>D</b>	
	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
<b>3a</b> Are there any management or service contracts that may result in private business use of bond-financed property? . . . . .	X			X				
<b>b</b> If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?		X						
<b>c</b> Are there any research agreements that may result in private business use of bond-financed property? . . . . .	X			X				
<b>d</b> If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?		X						
<b>4</b> Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government . . . . . ▶								
<b>5</b> Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government . . . . . ▶	0 090 %							
<b>6</b> Total of lines 4 and 5 . . . . .	0 090 %							
<b>7</b> Does the bond issue meet the private security or payment test? . . .		X		X				
<b>8a</b> Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued? . . . . .		X		X				
<b>b</b> If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of . .								
<b>c</b> If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1 141-12 and 1 145-2? . . . . .								
<b>9</b> Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1 141-12 and 1 145-2? . . . . .	X		X					

**Part IV Arbitrage**

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

**Part IV Arbitrage** (Continued)

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

**Part V Procedures To Undertake Corrective Action**

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

**Part VI Supplemental Information.** Provide additional information for responses to questions on Schedule K (see instructions).

Return Reference	Explanation
SCHEDULE K - DIFFERENCES IN ISSUE PRICE EXPLANATION	CNTY GRAD TRAV HOSP FIN AUTH 2014 A INVESTMENT INCOME EARNED

Return Reference	Explanation
SCHEDULE K - PURPOSE OF ISSUE DESCRIPTION	CNTY GRD TRAVSE HOSP FIN AUTH 2011 THE SERIES 2011A, 2011B AND 2011C BONDS WERE ISSUED TO PURCHASE AND CANCEL TENDERED BONDS, TENDERED DURING A TENDER PROGRAM INITIATED BY MUNSON HEALTHCARE THE TENDERED BONDS INCLUDED COUNTY OF GRAND TRAVERSE HOSPITAL AUTHORITY (MUNSON HEALTHCARE OBLIGATED GROUP) HOSPITAL REVENUE AND REFUNDING BONDS SERIES 1998A, ISSUED 9/1/98, REVENUE BONDS SERIES 2001A, ISSUED 1/9/01, REVENUE REFUNDING BONDS SERIES 2002A, ISSUED 9/17/02, REVENUE REFUNDING BONDS SERIES 2005A, ISSUED 11/3/05 AND REVENUE BONDS SERIES 2005B, ISSUED 11/3/05



Return Reference	Explanation
SCHEDULE K - DATE REBATE COMPUTATION PERFORMED	CNTY GRD TRAVSE HOSP FIN AUTH 2011 02/05/14

Return Reference	Explanation
SCHEDULE K - ADDITIONAL INFORMATION	<p>CNTY GRAD TRAV HOSP FIN AUTH 2014 A OBLIGATED GROUP ISSUE RECORDED ON RELATED ORGANIZATIONS ON DECEMBER 17, 2014, THE MUNSON HEALTHCARE OBLIGATED GROUP ISSUED COUNTY OF GRAND TRAVERSE HOSPITAL FINANCE AUTHORITY REVENUE BONDS (MUNSON HEALTHCARE OBLIGATED GROUP) SERIES 2014A, 2014B AND 2014C, AT A PREMIUM THE 2014 SERIES A BONDS ARE RECORDED ON MUNSON MEDICAL CENTER'S BOOKS AND RECORDS AT A PAR VALUE OF 27,620,000 THE 2014 SERIES B BONDS ARE RECORDED ON MUNSON HEALTHCARE GRAYLING'S BOOKS AND RECORDS AT A PAR VALUE OF 13,805,000 THE 2014 SERIES C BONDS ARE RECORDED ON MUNSON HEALTHCARE CADILLAC'S BOOKS AND RECORDS AT A PAR VALUE OF 15,870,000 THE RELATED BOND PREMIUM WAS RECORDED ON THE RESPECTIVE ENTITIES' BOOKS AND RECORDS PART III, QUESTION 3B AND D MUNSON MEDICAL CENTER MAINTAINS POLICIES AND PROCEDURES TO REVIEW AND MONITOR ALL CONTRACTS, INCLUDING LEASES, MANAGEMENT, SERVICE AND RESEARCH CONTRACTS THE MONITORING PROCESS INCLUDES A REVIEW BY THE INTERNAL LEGAL DEPARTMENT OUTSIDE COUNSEL MAY BE CONSULTED, AS NECESSARY OUTSIDE COUNSEL IS RETAINED FOR ALL NEW EXEMPT BOND OFFERINGS, DURING WHICH A THOROUGH DUE DILIGENCE PROCESS REVIEWS APPLICABLE CONTRACTS SINCE NEW BONDS WERE ISSUED IN 2014, OUTSIDE COUNSEL WAS ENGAGED DURING THAT TAX YEAR</p>

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  
MUNSON MEDICAL CENTER

Employer identification number  
38-1362830

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) JEFF BERRY	FAMILY OF TRUST	125,767	RELATED FAMILY COMP		No
(2) KRISTINE NAVIN	FAMILY OF TRUST	16,791	RELATED FAMILY COMP		No

**Part V Supplemental Information**

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

Return Reference	Explanation
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**SCHEDULE O**  
(Form 990 or 990-EZ)

Department of the Treasury  
Internal Revenue Service  
Name of the organization  
MUNSON MEDICAL CENTER

**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**

38-1362830

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PAGE 1, ITEM B	THERE WAS A CHANGE TO THE COST TO CHARGE RATIO COMPUTATION TO CORRECT AN ERROR ON WORKSHEET 2 OF SCHEDULE H THE CHANGE IMPACTED THE FOLLOWING LINE ITEMS AND DISCLOSURES ON THE FORM 990 -SCHEDULE H, PART I, LINES 7A, 7B, 7D, 7G, 7J AND 7K -SCHEDULE H, PART VI, LINE 6, AFFILIATED HEALTH CARE SYSTEM

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 6	MUNSON MEDICAL CENTER IS ORGANIZED ON A NONSTOCK MEMBERSHIP BASIS THE SOLE MEMBER IS MUNSON HEALTHCARE, AN IRS SECTION 501(C)(3) TAX-EXEMPT ORGANIZATION IN THE EVENT OF DISSOLUTION, MUNSON MEDICAL CENTER'S NET ASSETS WOULD BE DISTRIBUTED TO MUNSON HEALTHCARE

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 7A	MUNSON HEALTHCARE, AS THE SOLE MEMBER, ELECTS THE TRUSTEES FOR ALL SUBSIDIARY ENTITIES, INCLUDING MUNSON MEDICAL CENTER. NOMINATIONS TO MUNSON HEALTHCARE FOR SUBSIDIARY TRUSTEES ARE CONSIDERED AND RECOMMENDED BY THE MUNSON HEALTHCARE GOVERNANCE COMMITTEE. FOUR TRUSTEES OF MUNSON MEDICAL CENTER ALSO ARE DIRECTORS OF MUNSON HEALTHCARE.

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 7B	CERTAIN DECISIONS OF THE MUNSON MEDICAL CENTER (MMC) TRUSTEES ARE APPROVED BY THE MUNSON HEALTHCARE BOARD OF DIRECTORS INCLUDING ADOPTION, AMENDMENT, RESTATEMENT OR REPEAL OF THE ARTICLES OF INCORPORATION OR BYLAWS OF MMC, ADOPTION, EXECUTION, REVOCATION OR ABANDONMENT OF A PLAN OF DISSOLUTION, MERGER, CONSOLIDATION, OR REORGANIZATION INVOLVING MMC, SALE, LEASE, EXCHANGE OR OTHER DISPOSITION OF ALL OR SUBSTANTIALLY ALL OF THE PROPERTY AND ASSETS OF MMC, ACQUISITION OF OR THE ESTABLISHMENT OF ANY SUBSIDIARY OR AFFILIATE OF MMC, ADOPTION OF ALL OPERATING BUDGETS AND CAPITAL EXPENDITURE BUDGETS FOR MMC, INCURRENCE OF OPERATING OR CAPITAL EXPENDITURES BY MMC WHICH CAUSE THE AGGREGATE OPERATING OR CAPITAL EXPENDITURES TO EXCEED BUDGETED AGGREGATES BY MORE THAN FIVE PERCENT (5%) IN ANY FISCAL YEAR, INCURRENCE OF SECURED BORROWINGS OF MMC, WITH THE EXCEPTION OF EQUIPMENT LEASES AND PURCHASE MONEY SECURITY INTERESTS APPROVED AS PART OF MMC'S BUDGET, ADOPTION OR CHANGE IN THE MISSION STATEMENT, PURPOSES OR THE STRATEGIC GOALS OF MMC, CHANGING SUBSTANTIALLY THE SCOPE OF MMC'S CLINICAL SERVICES AND PROGRAMS OFFERED BY MMC, AND APPOINTMENT OR REMOVAL THE PRESIDENT OF MMC



**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 11B	THE MUNSON MEDICAL CENTER BOARD IS COMMITTED TO THE ACCURACY AND THOROUGHNESS OF THE FORM 990 REPORTING. MUNSON MEDICAL CENTER BELONGS TO THE MUNSON HEALTHCARE SYSTEM. MUNSON HEALTHCARE IS THE PARENT COMPANY IN THE MUNSON HEALTHCARE SYSTEM, WHICH UNDERGOES AN AUDIT BY AN EXTERNAL AUDIT FIRM. AT THE CORPORATE LEVEL, THE RESPONSIBLE INDIVIDUALS FROM THE FINANCE, ADMINISTRATION, PATIENT FINANCIAL SERVICES, LEGAL, HUMAN RESOURCES, PUBLIC RELATIONS, AND FUND DEVELOPMENT DEPARTMENTS PREPARE AND REVIEW PORTIONS OF THE FORM 990. THE COMPENSATION AND LEADERSHIP DEVELOPMENT COMMITTEE REVIEWS THE COMPENSATION INFORMATION CONTAINED IN THE CORE FORM AS WELL AS THE SCHEDULE J INFORMATION. THE CONFLICT, VALUATION AND COMPLIANCE COMMITTEE OVERSEES THE CONFLICT OF INTEREST DISCLOSURE PROCESS FOR BOARD MEMBERS AND KEY EMPLOYEES TO ENSURE COMPLIANCE WITH THE CONFLICT OF INTEREST POLICY. THE AUDIT COMMITTEE OVERSEES THE FORM 990 PREPARATION PROCESS BY ENSURING PROPER CONTROLS, POLICIES, PEOPLE AND RESOURCES ARE IN PLACE TO PRODUCE AN ACCURATE RETURN.

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 12C	<p>THE MUNSON HEALTHCARE BOARD OF DIRECTORS (THE SYSTEM PARENT ORGANIZATION) HAS A STANDING CONFLICT, VALUATION AND COMPLIANCE ("CVC") COMMITTEE. THE CVC COMMITTEE IS COMPOSED OF INDEPENDENT BOARD AND COMMUNITY MEMBERS. THE CVC COMMITTEE IS DELEGATED AUTHORITY BY THE BOARD TO REVIEW AND APPROVE THE REASONABLENESS/FAIR MARKET VALUE OF FINANCIAL TRANSACTIONS/ARRANGEMENTS WITH DISQUALIFIED PERSONS. ANNUALLY, EACH BOARD MEMBER OF MUNSON HEALTHCARE AND ALL OF ITS SUBSIDIARY/CONTROLLED ENTITIES AND ALL MUNSON EXECUTIVES ARE REQUIRED TO COMPLETE A CONFLICT OF INTEREST DISCLOSURE/QUESTIONNAIRE. THE RESPONSES TO THE DISCLOSURE/QUESTIONNAIRE ARE REVIEWED BY THE MUNSON LEGAL DEPARTMENT. ANY FINANCIAL ARRANGEMENTS/POTENTIAL CONFLICTS IDENTIFIED THROUGH THE DISCLOSURE/QUESTIONNAIRES ARE PRESENTED TO THE CVC COMMITTEE FOR ITS REVIEW AND DETERMINATION AS TO THE REASONABLENESS/FAIR MARKET VALUE. WHEN AN ACTION ITEM IS CONSIDERED BY A BOARD WHICH INVOLVES A POTENTIAL CONFLICT BY A BOARD MEMBER, THE CONFLICT IS DISCLOSED AND A BOARD MEMBER WILL ABSTAIN FROM A VOTE ON THE ACTION ITEM, AND, IN ADDITION, THE BOARD CHAIR HAS THE DISCRETION/AUTHORITY TO REQUEST THAT THE CONFLICTED BOARD MEMBER BE EXCUSED FROM THE MEETING FOR AN OPPORTUNITY FOR THE BOARD TO DISCUSS THE MATTER WITHOUT THE PRESENCE OF THE CONFLICTED BOARD MEMBER.</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 15A	<p>THE PROCESS FOR DETERMINING APPROPRIATE LEVELS OF PAY FOR EXECUTIVE POSITIONS WITHIN MUNSON HEALTHCARE IS CAREFULLY AND THOUGHTFULLY DIRECTED BY THE BOARD OF DIRECTORS, THROUGH THE COMPENSATION AND EXECUTIVE LEADERSHIP DEVELOPMENT COMMITTEE. THE COMMITTEE UTILIZES "BEST PRACTICES" METHODS OF DETERMINING COMPENSATION AND, AS SUCH, IS COMPOSED OF SEVEN MEMBERS WHOSE VOTING MEMBERS ARE INDEPENDENT. THE COMMITTEE IS CHARGED WITH ENSURING THAT EXECUTIVE COMPENSATION IS DESIGNED TO ATTRACT AND RETAIN HIGH QUALITY, PROFESSIONAL LEADERSHIP WHILE MAINTAINING STRONG STEWARDSHIP FOR THE ORGANIZATION. ANNUALLY, THE COMMITTEE RETAINS A NATIONAL INDEPENDENT CONSULTANT TO ENSURE THAT MUNSON HEALTHCARE'S COMPENSATION PRACTICES AND LEVELS ARE INDEPENDENTLY REVIEWED WHILE BEING COMPETITIVE AND REASONABLE. THE MUNSON HEALTHCARE CONFLICT, VALUATION AND COMPLIANCE ("CVC") COMMITTEE ALSO REVIEWS THE SURVEY INFORMATION TO EVALUATE THE REASONABLENESS OF EXECUTIVE COMPENSATION. THAT ANALYSIS OCCURS EACH NOVEMBER. COMPENSATION LEVELS REFLECT THE SCOPE OF EACH EXECUTIVE'S RESPONSIBILITIES, EDUCATIONAL BACKGROUND, EXPERIENCE, AND INDUSTRY STANDING AS WELL AS INDIVIDUAL AND ORGANIZATIONAL PERFORMANCE. ANNUAL COMPENSATION FOR MUNSON EXECUTIVES IS DETERMINED IN PART BY MEASURABLE PROGRESS TOWARD THE ORGANIZATION'S GOALS INCLUDING CONTINUED IMPROVEMENT IN CLINICAL QUALITY, COMMUNITY HEALTH, AND OPERATIONAL EFFICIENCIES. MUNSON HEALTHCARE'S INTENT FOR EXECUTIVE BASE COMPENSATION IS TO BE AT THE MEDIAN WHEN COMPARED TO LIKE-SIZE NON-PROFIT HOSPITALS AND HEALTHCARE SYSTEMS.</p>

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 15B	COMPENSATION OF OTHER KEY EMPLOYEES IS CONSISTENT WITH THAT OF THE TOP EXECUTIVES FOR MUNSON MEDICAL CENTER

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 19	THE MUNSON MEDICAL CENTER ARTICLES OF INCORPORATION ARE AVAILABLE TO THE PUBLIC ON THE MICHIGAN DEPARTMENT OF TREASURY WEBSITE. MUNSON MEDICAL CENTER DOES NOT MAKE THE BYLAWS OR CONFLICT OF INTEREST POLICY AVAILABLE TO THE PUBLIC. ANNUALLY, MUNSON HEALTHCARE, PARENT CORPORATION, SUBMITS ITS ANNUAL CONSOLIDATED FINANCIAL STATEMENTS TO THE MSRB IN COMPLIANCE WITH BOND DISCLOSURE REQUIREMENTS. ADDITIONALLY, MUNSON MEDICAL CENTER PREPARES AND DISTRIBUTES AN ANNUAL REPORT TO THE COMMUNITY, WHICH CONTAINS FINANCIAL AS WELL AS PROGRAM DATA.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART IX, LINE 11G	PURCHASED SERVICES 35,249,035 43,943,179 1,364,590 PROFESSIONAL FEES 33,915,097 197,916 0 TOTAL 69,164,132 44,141,095 1,364,590

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9	INVEST IN MUNSON HEALTHCARE FOUNDATION CONTRIBUTIO 7,193,442 PENSION AND POST RETIREMENT C HANGES 45,678,257 SWAP MARKET VALUE CHANGE 1,723,339 TEMPORARILY RESTRICTED ACTIVITY -2,61 7,851 TRANSFERS TO AFFILIATES -34,891,004 TOTAL 17,086,183

efile GRAPHIC print - DO NOT PROCESS		As Filed Data -		DLN: 93493212012608	
SCHEDULE R (Form 990)	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 <a href="http://www.irs.gov/form990">www.irs.gov/form990</a> .				OMB No 1545-0047
					2016
	Department of the Treasury Internal Revenue Service	Name of the organization MUNSON MEDICAL CENTER			Employer identification number 38-1362830

Part I Identification of Disregarded Entities Complete if the organization answered "Yes" on Form 990, Part IV, line 33.					
(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity

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

(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	
<b>(1)</b> MUNSON MEDICAL BUILDING PARTNERS PO BOX 1188 TRAVERSE CITY, MI 496851188 38-2830005	REAL ESTAT	MI	MUNSON MED MUNSON MEDICAL CENTER	RELATED	484,345	3,983,664		No		Yes		84.000 %
<b>(2)</b> NORTHERN MICHIGAN SUPPLY ALLIANCE 2651 AERO PARK DR TRAVERSE CITY, MI 49686 38-3453378	PURCHASING	MI	N/A					No			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.

(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
<b>(1)</b> MEDICAL OFFICE CONDOMINIUM ASSOCIATION PO BOX 1188 TRAVERSE CITY, MI 496851188 20-1902620	REAL ESTAT	MI	N/A					Yes	
<b>(2)</b> SIXTH STREET DRUGS PO BOX 1188 TRAVERSE CITY, MI 496851188 38-2298290	PHARMACY	MI	N/A					Yes	
<b>(3)</b> MUNSON SUPPORT SERVICES PO BOX 1188 TRAVERSE CITY, MI 496851188 38-2872821	LAUNDRY	MI	N/A					Yes	
<b>(4)</b> MUNSON SERVICES INC PO BOX 1188 TRAVERSE CITY, MI 496851188 38-3144382	PHARMACY	MI	N/A					Yes	
<b>(5)</b> MEDICAL OFFICE BUILDING CONDOMINIUM ASSOCIATION PO BOX 1188 TRAVERSE CITY, MI 496851188 38-3567278	REAL ESTAT	MI	N/A					Yes	
<b>(6)</b> MUNSON MOBILE IMAGING PO BOX 1188 TRAVERSE CITY, MI 496851188 38-2704069	IMAGING	MI	N/A					Yes	

**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 . . . . .

1a

No

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

1b

Yes

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

1c

Yes

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

1d

No

e Loans or loan guarantees by related organization(s) . . . . .

1e

No

f Dividends from related organization(s) . . . . .

1f

No

g Sale of assets to related organization(s) . . . . .

1g

No

h Purchase of assets from related organization(s) . . . . .

1h

No

i Exchange of assets with related organization(s) . . . . .

1i

No

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

1j

Yes

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

1k

Yes

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

1l

Yes

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

1m

Yes

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

1n

No

o Sharing of paid employees with related organization(s) . . . . .

1o

Yes

p Reimbursement paid to related organization(s) for expenses . . . . .

1p

Yes

q Reimbursement paid by related organization(s) for expenses . . . . .

1q

Yes

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

1r

Yes

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

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

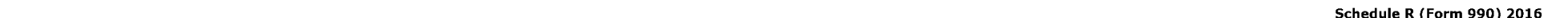
Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization. See instructions regarding exclusion for certain investment partnerships.

[illegible]

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

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

Return Reference	Explanation
SCHEDULE R	MUNSON MEDICAL CENTER USED THE ACCRUAL METHOD OF ACCOUNTING TO VALUE THE TRANSACTIONS WITH RELATED ENTITIES. ALL INTERCOMPANY TRANSACTIONS WITH RELATED ENTITIES WERE REVIEWED, SUMMARIZED, AND RECONCILED TO DETERMINE THE DISCLOSURE AMOUNTS.



Additional Data

Software ID:  
Software Version:  
EIN: 38-1362830  
Name: MUNSON MEDICAL CENTER

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)  1105 SIXTH ST TRAVERSE CITY, MI 49684 38-3097861	DIALYSIS	MI	C3	3	MUNSON HC MUNSON HEALTHCARE	Yes	
(1)  1105 SIXTH ST TRAVERSE CITY, MI 49684 38-2640544	HEALTHCARE	MI	C3	12B	N/A		No
(2)  1105 SIXTH ST TRAVERSE CITY, MI 49684 38-2642724	RAISE FUND	MI	C3	7	MUNSON HC MUNSON HEALTHCARE	Yes	
(3)  1105 SIXTH ST TRAVERSE CITY, MI 49684 38-2191390	HOME HEALT	MI	C3	10	MUN HOME H MUNSON HOME HEALTH	Yes	
(4)  1105 SIXTH ST TRAVERSE CITY, MI 49684 38-3335362	HOME HEALT	MI	C3	12B	MUNSON HC MUNSON HEALTHCARE	Yes	
(5)  1105 SIXTH ST TRAVERSE CITY, MI 49684 38-2543463	HOME HEALT	MI	C3	10	MUN HOME H MUNSON HOME HEALTH	Yes	
(6)  1105 SIXTH ST TRAVERSE CITY, MI 49684 38-2657917	MED TRANSP	MI	C3	12B	MUNSON HC MUNSON HEALTHCARE	Yes	
(7)  1105 SIXTH ST TRAVERSE CITY, MI 49684 38-1415623	HEALTHCARE	MI	C3	3	MUNSON HC MUNSON HEALTHCARE	Yes	
(8)  1105 SIXTH ST TRAVERSE CITY, MI 49684 27-3600575	PHYSICIAN	MI	C3	10	MUNSON MED MUNSON MEDICAL CENTER	Yes	
(9)  1105 SIXTH ST TRAVERSE CITY, MI 49684 47-1156297	HOSPITAL	MI	C3	3	MUNSON HC MUNSON HEALTHCARE	Yes	
(10)  1105 SIXTH ST TRAVERSE CITY, MI 49684 47-1161992	HOSPITAL	MI	C3	3	MUNSON HC MUNSON HEALTHCARE	Yes	
(11) FOUNDATION 1105 SIXTH ST TRAVERSE CITY, MI 49684 47-2857600	RAISE FUND	MI	C3	7	MHC CADILL MUNSON HEALTHCARE CADILLAC	Yes	
(12)  14700 LAKE SHORE DRIVE CHARLEVOIX, MI 49720 38-1459366	HOSPITAL	MI	C3	3	MUNSON HC	Yes	
(13) HOSPITAL FOUNDATION 14700 LAKE SHORE DRIVE CHARLEVOIX, MI 49720 75-3078034	RAISE FUND	MI	C3	12A	MHC CHARLE HOSPITAL	Yes	
(14)  1465 E PARKDALE AVE MANISTEE, MI 496609709 38-0350304	HOSPITAL	MI	C3	3	MUNSON HC	Yes	
(15) HOSPITAL FOUNDATION 1465 E PARKDALE AVE MANISTEE, MI 496609709 38-3565083	RAISE FUND	MI	C3	12A	MHC MANIST HOSPITAL	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>	MUNSON DIALYSIS CENTER	O	87,327	ACTUAL AMOUNT PAID
<b>(1)</b>	MUNSON DIALYSIS CENTER	Q	3,722,853	ACTUAL AMOUNT PAID
<b>(2)</b>	MUNSON HEALTHCARE	B	34,881,820	ACTUAL AMOUNT PAID
<b>(3)</b>	MUNSON HEALTHCARE	L	596,255	ACTUAL AMOUNT PAID
<b>(4)</b>	MUNSON HEALTHCARE	M	44,588,146	ACTUAL AMOUNT PAID
<b>(5)</b>	MUNSON HEALTHCARE	O	354,458	ACTUAL AMOUNT PAID
<b>(6)</b>	MUNSON HEALTHCARE	P	151,865,562	ACTUAL AMOUNT PAID
<b>(7)</b>	MUNSON HEALTHCARE	Q	153,591,729	ACTUAL AMOUNT PAID
<b>(8)</b>	MUNSON DIALYSIS CENTER	P	1,374,120	ACTUAL AMOUNT PAID
<b>(9)</b>	MUNSON HEALTHCARE	S	272,653	ACTUAL AMOUNT PAID
<b>(10)</b>	MUNSON HEALTHCARE	R	425,821	ACTUAL AMOUNT PAID
<b>(11)</b>	MUNSON HEALTHCARE CADILLAC	M	123,150	ACTUAL AMOUNT PAID
<b>(12)</b>	MUNSON HEALTHCARE CADILLAC	O	110,739	ACTUAL AMOUNT PAID
<b>(13)</b>	MUNSON HEALTHCARE CADILLAC	P	941,922	ACTUAL AMOUNT PAID
<b>(14)</b>	MUNSON HEALTHCARE CADILLAC	L	900,225	ACTUAL AMOUNT PAID
<b>(15)</b>	MUNSON HEALTHCARE CADILLAC	Q	27,940,060	ACTUAL AMOUNT PAID
<b>(16)</b>	MUNSON HEALTHCARE CADILLAC	R	182,693	ACTUAL AMOUNT PAID
<b>(17)</b>	MUNSON HEALTHCARE GRAYLING	M	83,704	ACTUAL AMOUNT PAID
<b>(18)</b>	MUNSON HEALTHCARE GRAYLING	P	417,128	ACTUAL AMOUNT PAID
<b>(19)</b>	MUNSON HEALTHCARE GRAYLING	L	821,349	ACTUAL AMOUNT PAID
<b>(20)</b>	MUNSON HEALTHCARE GRAYLING	O	77,901	ACTUAL AMOUNT PAID
<b>(21)</b>	MUNSON HEALTHCARE GRAYLING	Q	27,363,020	ACTUAL AMOUNT PAID
<b>(22)</b>	MUNSON HEALTHCARE GRAYLING	R	136,000	ACTUAL AMOUNT PAID
<b>(23)</b>	MUNSON HEALTHCARE FOUNDATIONS	Q	669,321	ACTUAL AMOUNT PAID
<b>(24)</b>	MUNSON HEALTHCARE FOUNDATIONS	C	3,404,481	ACTUAL AMOUNT PAID

**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)	MUNSON HEALTHCARE FOUNDATIONS	P	169,663	ACTUAL AMOUNT PAID
(1)	MUNSON HOME CARE	J	169,320	LEASE CONTRACT AMOUNT
(2)	MUNSON HOME CARE	Q	13,581,741	ACTUAL AMOUNT PAID
(3)	MUNSON HOME CARE	P	57,839	ACTUAL AMOUNT PAID
(4)	MUNSON HOME SERVICES	Q	3,040,360	ACTUAL AMOUNT PAID
(5)	MUNSON MEDICAL BUILDING PARTNERS	Q	92,325	ACTUAL AMOUNT PAID
(6)	MUNSON MEDICAL GROUP	M	1,913,309	ACTUAL AMOUNT PAID
(7)	MUNSON MEDICAL GROUP	O	5,674,197	ACTUAL AMOUNT PAID
(8)	MUNSON MEDICAL GROUP	Q	17,062,112	ACTUAL AMOUNT PAID
(9)	MUNSON MEDICAL GROUP	P	169,313	ACTUAL AMOUNT PAID
(10)	MUNSON SERVICES INC	J	72,048	LEASE CONTRACT AMOUNT
(11)	MUNSON SERVICES INC	Q	10,728,122	ACTUAL AMOUNT PAID
(12)	MUNSON SERVICES INC	P	1,198,203	ACTUAL AMOUNT PAID
(13)	MUNSON SERVICES INC	L	105,652	ACTUAL AMOUNT PAID
(14)	MUNSON SUPPORT SERVICES	Q	1,565,002	ACTUAL AMOUNT PAID
(15)	MUNSON SUPPORT SERVICES	M	1,809,937	ACTUAL AMOUNT PAID
(16)	MUNSON SUPPORT SERVICES	R	178,379	ACTUAL AMOUNT PAID
(17)	NORTH FLIGHT INC	P	107,943	ACTUAL AMOUNT PAID
(18)	NORTH FLIGHT INC	Q	5,176,900	ACTUAL AMOUNT PAID
(19)	NORTHERN MICHIGAN SUPPLY ALLIANCE	J	227,400	LEASE CONTRACT AMOUNT
(20)	NORTHERN MICHIGAN SUPPLY ALLIANCE	L	496,719	ACTUAL AMOUNT PAID
(21)	NORTHERN MICHIGAN SUPPLY ALLIANCE	O	479,544	ACTUAL AMOUNT PAID
(22)	NORTHERN MICHIGAN SUPPLY ALLIANCE	M	7,750,676	ACTUAL AMOUNT PAID
(23)	NORTHERN MICHIGAN SUPPLY ALLIANCE	Q	5,733,273	ACTUAL AMOUNT PAID
(24)	NORTHERN MICHIGAN SUPPLY ALLIANCE	S	30,936,861	ACTUAL AMOUNT PAID



**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>(51)</b>	PAUL OLIVER MEMORIAL HOSPITAL	P	421,178	ACTUAL AMOUNT PAID
<b>(1)</b>	PAUL OLIVER MEMORIAL HOSPITAL	L	164,379	ACTUAL AMOUNT PAID
<b>(2)</b>	PAUL OLIVER MEMORIAL HOSPITAL	O	73,693	ACTUAL AMOUNT PAID
<b>(3)</b>	PAUL OLIVER MEMORIAL HOSPITAL	Q	6,888,669	ACTUAL AMOUNT PAID
<b>(4)</b>	SIXTH STREET DRUGS	Q	606,392	ACTUAL AMOUNT PAID
<b>(5)</b>	SIXTH STREET DRUGS	P	242,189	ACTUAL AMOUNT PAID
<b>(6)</b>	MUNSON HEALTHCARE CHARLEVOIX HOSPIT	L	167,484	ACTUAL AMOUNT PAID
<b>(7)</b>	MUNSON HEALTHCARE CHARLEVOIX HOSPIT	Q	237,776	ACTUAL AMOUNT PAID
<b>(8)</b>	MUNSON HEALTHCARE MANISTEE HOSPITAL	P	67,415	ACTUAL AMOUNT PAID