

Form 990

Department of the Treasury  
Internal Revenue ServiceEXTENDED TO MAY 15, 2018  
Return of Organization Exempt From Income Tax

OMB No 1545-0047

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

► Do not enter social security numbers on this form as it may be made public.

► Information about Form 990 and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).2016  
Open to Public  
Inspection

A For the 2016 calendar year, or tax year beginning JUL 1, 2016 and ending JUN 30, 2017

B Check if applicable	C Name of organization <b>MERCY HEALTH SYSTEM CORPORATION</b>		D Employer identification number <b>39-0816848</b>
<input type="checkbox"/> Address change	Doing business as		E Telephone number <b>608.756.6000</b>
<input type="checkbox"/> Name change	Number and street (or P.O. box if mail is not delivered to street address) <b>P.O. BOX 5003 - 1000 MINERAL POINT</b>		F City or town, state or province, country, and ZIP or foreign postal code <b>JANESVILLE, WI 53547-5003</b>
<input type="checkbox"/> Initial return	Room/suite		G Gross receipts \$ <b>575,814,818.</b>
<input type="checkbox"/> Final return/terminated			H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input type="checkbox"/> Amended return			H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Application pending			If "No," attach a list (see instructions)
I Tax-exempt status <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) ( ) (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527			
J Website. ► <a href="http://WWW.MERCYHEALTHSYSTEM.ORG">WWW.MERCYHEALTHSYSTEM.ORG</a>			
K Form of organization <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ►		L Year of formation <b>1972</b>	M State of legal domicile <b>WI</b>

## Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities <b>WITH A PASSION FOR MAKING LIVES BETTER.</b>	EXCEPTIONAL HEALTH CARE SERVICES	
	2 Check this box ► <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets	9	
	3 Number of voting members of the governing body (Part VI, line 1a)	3	9
	4 Number of independent voting members of the governing body (Part VI, line 1b)	4	7
	5 Total number of individuals employed in calendar year 2016 (Part V, line 2a)	5	4077
	6 Total number of volunteers (estimate if necessary)	6	0
	7 a Total unrelated business revenue from Part VIII, column (C), line 12	7a	11,075,039.
b Net unrelated business taxable income from Form 990-T, line 34	7b	-16,017.	
Revenue	8 Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
	9 Program service revenue (Part VIII, line 2g)	194,350.	160,970.
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	559,716,977.	570,077,522.
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	584,523.	241,615.
	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	-886,856.	3,027,050.
		559,608,994.	573,507,157.
		0.	0.
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0.	0.
	14 Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	318,127,034.	325,478,337.
	16a Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
	b Total fundraising expenses (Part IX, column (D), line 25)	221,777,264.	231,231,396.
	17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	539,904,298.	556,709,733.
	18 Total expenses Add lines 13-17 (must equal Part IX, column (A), line 25)	19,704,696.	16,797,424.
Net Assets or Fund Balances	19 Revenue less expenses Subtract line 18 from line 12	BEGINNING OF CURRENT YEAR	END OF YEAR
	20 Total assets (Part X, line 16)	490,009,322.	541,838,630.
	21 Total liabilities (Part X, line 26)	309,584,025.	330,277,187.
	22 Net assets or fund balances Subtract line 21 from line 20	180,425,297.	211,561,443.

## Part II Signature Block

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

Sign Here	► Signature of officer <i>Javon Bea</i>	Date <i>5/10/18</i>			
	► JAVON BEA, PRESIDENT/CEO	Type or print name and title			
Paid	Print/Type preparer's name <b>TROY E. MARINE, CPA</b>	Preparer's signature <i>Troy E. Marine, CPA</i>	Date <b>05/07/18</b>	Check <input type="checkbox"/> if self-employed	PTIN <b>P00187863</b>
Preparer	Firm's name ► <b>BAKER TILLY VIRCHOW KRAUSE, LLP</b>	Firm's EIN ► <b>39-0859910</b>			
Use Only	Firm's address ► <b>500 MIDLAND COURT, PO BOX 8130 JANESVILLE, WI 53547-8130</b>	Phone no <b>608.752.5835</b>			

May the IRS discuss this return with the preparer shown above? (see instructions)

632001 11-11-16 LHA For Paperwork Reduction Act Notice, see the separate instructions.

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Schedule H

G84

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

**THE MISSION OF MERCY HEALTH SYSTEM CORPORATION (MHSC) IS TO PROVIDE EXCEPTIONAL HEALTH CARE SERVICES WITH A PASSION FOR MAKING LIVES BETTER.**

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

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

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

If "Yes," describe these changes on Schedule O

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

4a (Code \_\_\_\_\_) (Expenses \$ **443,356,413.** including grants of \$ \_\_\_\_\_) (Revenue \$ **557,325,890.**)  
**HOSPITAL DISCHARGES 9,155, NURSING HOME ADMISSIONS 289, BIRTHS 1,001,**  
**OUTPATIENT VISITS 1,235,043.**

**MHSC CONTINUES ITS TRADITION OF GIVING BACK TO EACH OF THE COMMUNITIES WE SERVE IN A WIDE VARIETY OF FASHIONS. ONE OF THE LARGER AREAS OF CONTRIBUTION IS IN THE AREA OF PUBLIC HEALTH SERVICES. THIS INCLUDES EXTENSIVE DONATIONS OF TIME AND SUPPLIES TO HEALTHNET OF ROCK COUNTY, A LARGE FREE PRIMARY CARE CLINIC SERVING THE REGION. MORE THAN EIGHTY PERCENT OF THE PHYSICIAN SERVICES PROVIDED AT THE CLINIC ARE SUPPLIED THROUGH MHSC. WE HAVE A SIMILAR COMMITMENT TO OPEN ARMS FREE CLINIC THAT SERVICES LOW INCOME RESIDENTS IN WALWORTH COUNTY. ADDITIONALLY, WE PROVIDE HEALTH SCREENING AND RELATED SERVICES AT NUMEROUS EVENTS IN**

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

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

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\_\_\_\_\_

4d Other program services (Describe in Schedule O)

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

4e Total program service expenses ► **443,356,413.**

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ABPH5LRC

## Part IV Checklist of Required Schedules

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

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## Part IV Checklist of Required Schedules (continued)

		Yes	No
20a	Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	X	
21	Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? If "Yes," complete Schedule I, Parts I and II	X	
22	Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? If "Yes," complete Schedule I, Parts I and III	X	
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? If "Yes," complete Schedule J	X	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? If "Yes," answer lines 24b through 24d and complete Schedule K If "No", go to line 25a	X	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?		
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		
25a	<b>Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.</b> Did the organization engage in an excess benefit transaction with a disqualified person during the year? If "Yes," complete Schedule L, Part I	X	
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? If "Yes," complete Schedule L, Part I		
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? If "Yes," complete Schedule L, Part II	X	
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? If "Yes," complete Schedule L, Part III	X	
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions)		
a	A current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV	X	
b	A family member of a current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV		
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? If "Yes," complete Schedule L, Part IV	X	
29	Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M	X	
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? If "Yes," complete Schedule M	X	
31	Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, Part I	X	
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? If "Yes," complete Schedule N, Part II	X	
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301 7701-2 and 301 7701-3? If "Yes," complete Schedule R, Part I	X	
34	Was the organization related to any tax-exempt or taxable entity? If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1	X	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	X	
b	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? If "Yes," complete Schedule R, Part V, line 2		
36	<b>Section 501(c)(3) organizations.</b> Did the organization make any transfers to an exempt non-charitable related organization? If "Yes," complete Schedule R, Part V, line 2		
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? If "Yes," complete Schedule R, Part VI	X	
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19?	X	

**Note.** All Form 990 filers are required to complete Schedule O

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

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

		Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	342
1b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0
1c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c	X
2a	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	2a	4077
2b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? <i>Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)</i>	2b	X
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?	3a	X
3b	If "Yes," has it filed a Form 990-T for this year? If "No," to line 3b, provide an explanation in Schedule O	3b	X
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a	X
4b	If "Yes," enter the name of the foreign country ►  See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)	4b	
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a	X
5b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b	X
5c		5c	
6a	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	6a	X
6b		6b	
7a	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	7a	X
7b		7b	
7c	<b>7. Organizations that may receive deductible contributions under section 170(c).</b>	7c	X
7d	a Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?	7d	
7e	b If "Yes," did the organization notify the donor of the value of the goods or services provided?	7e	X
7f	c Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7f	X
7g	d If "Yes," indicate the number of Forms 8282 filed during the year	7g	
7h	e Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7h	
8	f Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	8	
9a	g If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	9a	
9b	h If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	9b	
10	<b>8. 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?	10	
11	<b>9. Sponsoring organizations maintaining donor advised funds.</b>	11	
10a	a Did the sponsoring organization make any taxable distributions under section 4966?	10a	
10b	b Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	10b	
11a	<b>10. Section 501(c)(7) organizations.</b> Enter	11a	
11b	a Initiation fees and capital contributions included on Part VIII, line 12	11b	
12a	b Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	12a	
12b	<b>11. Section 501(c)(12) organizations.</b> Enter	12b	
11a	a Gross income from members or shareholders	11a	
11b	b Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)	11b	
12a	<b>12. Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?	12a	
12b	b If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b	
13a	<b>13. Section 501(c)(29) qualified nonprofit health insurance issuers.</b>	13a	
13b	a Is the organization licensed to issue qualified health plans in more than one state? <i>Note. See the instructions for additional information the organization must report on Schedule O</i>	13b	
13c	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	13c	
14a	c Enter the amount of reserves on hand	14a	X
14b	<b>14. Did the organization receive any payments for indoor tanning services during the tax year?</b>	14b	
	<b>b If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O</b>		

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**Part VI Governance, Management, and Disclosure** For each "Yes" response to lines 2 through 7b below, and for a "No" response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes 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

1a 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.

1b Enter the number of voting members included in line 1a, above, who are independent

2 Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?

3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person?

4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?

5 Did the organization become aware during the year of a significant diversion of the organization's assets?

6 Did the organization have members or stockholders?

7a Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?

b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?

8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following

a The governing body?

b Each committee with authority to act on behalf of the governing body?

9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O

	Yes	No
1a		9
1b		7
2	X	
3		X
4		X
5		X
6	X	
7a	X	
7b	X	
8a	X	
8b	X	
9		X

### Section B. Policies

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

10a Did the organization have local chapters, branches, or affiliates?

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?

11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?

b Describe in Schedule O the process, if any, used by the organization to review this Form 990

12a Did the organization have a written conflict of interest policy? If "No," go to line 13

b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?

c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done

13 Did the organization have a written whistleblower policy?

14 Did the organization have a written document retention and destruction policy?

15 Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?

a The organization's CEO, Executive Director, or top management official

b Other officers or key employees of the organization

If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions)

16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?

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	No
10a		X
10b		
11a		X
12a	X	
12b	X	
12c	X	
13	X	
14	X	
15a	X	
15b	X	
16a		X
16b		

### Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed ► IL, WI

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

Own website  Another's website  Upon request  Other (explain in Schedule O)

19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year

20 State the name, address, and telephone number of the person who possesses the organization's books and records ► JOHN COOK - 608.756.6642

1000 MINERAL POINT AVE, JANESEVILLE, WI 53548

**Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors**
 Check if Schedule O contains a response or note to any line in this Part VII

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

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

• List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation Enter -0- in columns (D), (E), and (F) if no compensation was paid

• List all of the organization's **current** key employees, if any See instructions for definition of "key employee"

• List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations

• List all of the organization's **former** officers, key employees, and highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations

• List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box unless person is both an officer and a director/trustee)					(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee			
(1) ROWLAND J. MCCLELLAN CHAIRPERSON & DIRECTOR	1.00 4.00	X		X			0.	0.	0.
(2) THOMAS R. POOL VICE-CHAIR (PART YEAR) & DIRECTOR	1.00 4.00	X		X			21,000.	0.	0.
(3) CONNIE M. VITALI VICE-CHAIR & DIRECTOR (PART YEAR)	1.00 4.00	X		X			0.	0.	0.
(4) THOMAS D. BUDD SECRETARY/TREASURER & DIRECTOR	1.00 4.00	X		X			0.	0.	0.
(5) MARK L. GOELZER, M.D. DIRECTOR/PHYSICIAN	40.00 5.00	X					1,550,907.	0.	32,171.
(6) PAUL A. GREEN DIRECTOR	1.00 4.00	X					0.	0.	0.
(7) DAVE L. SYVERSON DIRECTOR	1.00 4.00	X					10,500.	0.	0.
(8) KATHERINE A. SCHACK DIRECTOR (PART YEAR)	1.00 4.00	X					0.	4,539.	0.
(9) WESLEY M. JOST DIRECTOR (PART YEAR)	1.00 4.00	X					0.	0.	0.
(10) JACK J. BECHERER DIRECTOR (PART YEAR)	1.00 4.00	X					0.	0.	0.
(11) JOANNA BEA BENNING VICE-PRESIDENT	55.00		X				322,248.	0.	30,687.
(12) BARBARA J. BORTNER VICE-PRESIDENT	55.00		X				304,709.	0.	40,852.
(14) E. PATRICK CRANLEY VICE-PRESIDENT	55.00		X				331,904.	0.	47,133.
(15) RICHARD H. GRUBER VICE-PRESIDENT	55.00		X				155,505.	0.	20,407.
(16) JENNIFER A. HALLETT VICE-PRESIDENT	55.00		X				300,733.	0.	41,615.
(17) KATHLEEN S. HARRIS VICE-PRESIDENT	55.00		X				220,768.	0.	30,966.
(18) THOMAS R. JENSEN VICE-PRESIDENT	55.00		X				149,796.	0.	21,747.

## 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 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			
(19) DANIEL A. PAROD VICE-PRESIDENT (PART YEAR)	55.00			X			0.	277,257.	35,872.
(20) DEBRA A. POTEMPA VICE-PRESIDENT	55.00			X			281,673.	0.	33,124.
(21) SUE A. RIPSCH VICE-PRESIDENT	55.00			X			489,184.	0.	34,839.
(22) RUTH M. YARBROUGH VICE-PRESIDENT	55.00			X			371,562.	0.	25,555.
(23) PAUL T. VAN DEN HEUVEL VICE-PRESIDENT	55.00			X			477,859.	0.	41,152.
(24) JOHN W. COOK VICE-PRESIDENT/CFO	50.00 5.00			X			826,626.	0.	39,932.
(25) JAVON R. BEA PRESIDENT & DIRECTOR	50.00 5.00	X		X			8,828,863.	0.	39,022.
(26) JOHN BUSSA, M.D. PHYSICIAN	40.00				X		2,008,118.	0.	34,288.
(27) MANISH GHARIA, M.D. PHYSICIAN	40.00				X		1,835,190.	0.	33,180.
1b Sub-total						►	18,487,145.	281,796.	582,542.
c Total from continuation sheets to Part VII, Section A						►	5,057,454.	0.	171,080.
d Total (add lines 1b and 1c)						►	23,544,599.	281,796.	753,622.

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 ► 456

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

## Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
EPIC SYSTEMS CORP 1979 MILKY WAY, VERONA, WI 53593	SOFTWARE/SYSTEM MAINTENANCE	3,218,178.
LAB CORP OF AMERICA HOLDINGS PO BOX 2240, BURLINGTON, NC 27216-2140	LAB SERVICES	1,998,081.
MAGILL CONSTRUCTION COMPANY 977 KOOPMAN LN, ELKHORN, WI 53121	CONSTRUCTION	1,793,333.
CAMELOT RADIOLOGY ASSOCIATES 3849 N PERRYVILLE RD, ROCKFORD, IL 61114	PHYSICIAN SERVICES - RADIOLOGISTS	1,196,096.
MORNINGSTAR MEDIA GROUP LTD 240 EDWARD ST, SYCAMORE, IL 60178	ADVERTISING	1,171,165.

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 ► 50

SEE PART VII, SECTION A CONTINUATION SHEETS

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## Part VI

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

Total to Part VII, Section A, line 1c

5,057,454.

171,080.

## Part VIII Statement of Revenue

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

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts	1 a Federated campaigns b Membership dues c Fundraising events d Related organizations e Government grants (contributions) f All other contributions, gifts, grants, and similar amounts not included above g Noncash contributions included in lines 1a-1f \$ h Total. Add lines 1a-1f ►	1a 1b 1c 1d 126,000. 1e 34,970. 1f			
		160,970.			
Program Service Revenue	2 a PATIENT SERVICE REVENUE b MERCYCARE EXPENSES c PHARMACY d CAFETERIA e RENT FROM AFFILIATED ORGANIZATION f All other program service revenue g Total. Add lines 2a-2f ►	Business Code 621110 561000 561000 722210 531190	557,325,890. 8,149,958. 2,925,081. 1,422,414. 254,179.	557,325,890. 8,149,958. 2,925,081. 1,422,414. 254,179.	
		570,077,522.			
	3 Investment income (including dividends, interest, and other similar amounts) ►		94,304.		94,304.
	4 Income from investment of tax-exempt bond proceeds ►				
	5 Royalties ►				
	6 a Gross rents b Less rental expenses c Rental income or (loss) d Net rental income or (loss) ►	(i) Real 31,547. 0. 31,547.		31,547.	31,547.
	7 a Gross amount from sales of assets other than inventory b Less cost or other basis and sales expenses c Gain or (loss) d Net gain or (loss) ►	(i) Securities 2,224,545. 2,214,489. 10,056.	(ii) Other 230,427. 93,172. 137,255.		147,311. 147,311.
	8 a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18 b Less direct expenses c Net income or (loss) from fundraising events ►	a b			
	9 a Gross income from gaming activities See Part IV, line 19 b Less direct expenses c Net income or (loss) from gaming activities ►	a b			
	10 a Gross sales of inventory, less returns and allowances b Less cost of goods sold c Net income or (loss) from sales of inventory ►	a b			
	Miscellaneous Revenue	Business Code			
	11 a MERCYCARE INS OPERATIONS b MISCELLANEOUS REVENUE c _____ d All other revenue e Total. Add lines 11a-11d ►	900099 900099 900099 573,507,157.	2,555,547. 439,956. 2,995,503.		2,555,547. 439,956. 2,995,503.
	12 Total revenue See instructions ►		557,325,890.	11,075,039.	4,945,258.

**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
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21				
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees				
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	487,850.	487,850.		
7 Other salaries and wages	252,365,186.	206,166,385.	46,198,801.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	5,106,777.	4,114,220.	992,557.	
9 Other employee benefits	37,055,006.	28,764,652.	8,290,354.	
10 Payroll taxes	15,340,479.	11,162,051.	4,178,428.	
11 Fees for services (non-employees)				
a Management	1,357,735.		1,357,735.	
b Legal	57,500.		57,500.	
c Accounting				
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees	46,598.		46,598.	
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O)	25,200,186.	14,599,825.	10,600,361.	
12 Advertising and promotion	2,706,035.	1,008.	2,705,027.	
13 Office expenses	7,925,657.	2,938,780.	4,986,877.	
14 Information technology	1,136,505.	907,886.	228,619.	
15 Royalties				
16 Occupancy	9,087,675.	7,259,598.	1,828,077.	
17 Travel	1,096,369.	472,408.	623,961.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	1,470,973.	1,002,039.	468,934.	
20 Interest	8,545,891.	6,826,800.	1,719,091.	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	27,123,890.	21,667,648.	5,456,242.	
23 Insurance	-946,057.	-1,395,470.	449,413.	
24 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.)				
a DRUGS & MEDICAL SUPPLIES	101,992,073.	101,797,227.	194,846.	
b BAD DEBTS	22,770,203.	22,770,203.	0.	
c MEDICAID ASSESSMENT TAX	8,033,849.	8,033,849.	0.	
d EQUIP REP & MAINT	7,826,806.	5,425,684.	2,401,122.	
e All other expenses	5,799,508.	353,770.	5,445,738.	
25 Total functional expenses. Add lines 1 through 24e	556,709,733.	443,356,413.	113,353,320.	0.
26 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 ►  if following SOP 98-2 (ASC 958-720)

## Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	27,009.	1	27,159.
	2 Savings and temporary cash investments	66,784,483.	2	79,472,994.
	3 Pledges and grants receivable, net		3	
	4 Accounts receivable, net	91,187,779.	4	105,414,893.
	5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L		5	
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instr) Complete Part II of Sch L		6	
	7 Notes and loans receivable, net		7	
	8 Inventories for sale or use	12,608,830.	8	12,959,739.
	9 Prepaid expenses and deferred charges	3,303,577.	9	4,964,914.
	10a Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	10a 581,472,307.		
	b Less accumulated depreciation	10b 321,831,138.	10c 270,180,411.	10c 259,641,169.
	11 Investments - publicly traded securities		11	
	12 Investments - other securities See Part IV, line 11	16,646,964.	12	50,265,818.
	13 Investments - program-related See Part IV, line 11	16,722,365.	13	19,277,912.
	14 Intangible assets		14	
	15 Other assets See Part IV, line 11	12,547,904.	15	9,814,032.
	16 Total assets. Add lines 1 through 15 (must equal line 34)	490,009,322.	16	541,838,630.
Liabilities	17 Accounts payable and accrued expenses	48,137,115.	17	60,102,708.
	18 Grants payable		18	
	19 Deferred revenue		19	
	20 Tax-exempt bond liabilities		20	
	21 Escrow or custodial account liability Complete Part IV of Schedule D		21	
	22 Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L		22	
	23 Secured mortgages and notes payable to unrelated third parties	3,940,779.	23	2,315,277.
	24 Unsecured notes and loans payable to unrelated third parties		24	
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24) Complete Part X of Schedule D	257,506,131.	25	267,859,202.
	26 Total liabilities. Add lines 17 through 25	309,584,025.	26	330,277,187.
	Organizations that follow SFAS 117 (ASC 958), check here ► <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.			
	27 Unrestricted net assets	180,425,297.	27	211,561,443.
	28 Temporarily restricted net assets		28	
	29 Permanently restricted net assets		29	
Net Assets or Fund Balances	Organizations that do not follow SFAS 117 (ASC 958), check here ► <input type="checkbox"/> and complete lines 30 through 34.			
	30 Capital stock or trust principal, or current funds		30	
	31 Paid-in or capital surplus, or land, building, or equipment fund		31	
	32 Retained earnings, endowment, accumulated income, or other funds		32	
	33 Total net assets or fund balances	180,425,297.	33	211,561,443.
	34 Total liabilities and net assets/fund balances	490,009,322.	34	541,838,630.

Form 990 (2016)

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

1 Total revenue (must equal Part VIII, column (A), line 12)	1	573,507,157.
2 Total expenses (must equal Part IX, column (A), line 25)	2	556,709,733.
3 Revenue less expenses Subtract line 2 from line 1	3	16,797,424.
4 Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	180,425,297.
5 Net unrealized gains (losses) on investments	5	-97,509.
6 Donated services and use of facilities	6	
7 Investment expenses	7	
8 Prior period adjustments	8	
9 Other changes in net assets or fund balances (explain in Schedule O)	9	14,436,231.
10 Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	211,561,443.

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

1 Accounting method used to prepare the Form 990  Cash  Accrual  Other \_\_\_\_\_  
If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O

2a Were the organization's financial statements compiled or reviewed by an independent accountant?  
If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both  
 Separate basis  Consolidated basis  Both consolidated and separate basis

2b Were the organization's financial statements audited by an independent accountant?  
If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both  
 Separate basis  Consolidated basis  Both consolidated and separate basis

2c If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?  
If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O

3a As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?  
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	No
2a		X
2b	X	
2c	X	
3a		X
3b		

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

## Public Charity Status and Public Support

OMB No 1545-0047

2016

**Open to Public  
Inspection**

Department of the Treasury  
Internal Revenue Service

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

**4947(a)(1) nonexempt charitable trust.**

► Attach to Form 990 or Form 990-EZ.

► **Information about Schedule A (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990)**

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**Name of the organization**

**Employer identification number**

MERCY HEALTH SYSTEM CORPORATION

39-0816848

Part II 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.)

03

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

- Enter the number of supported organizations
- Provide the following information about the supported organization(s)

g. Provide the following information about the supported organization(s)			iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-10 above (see instructions))	Yes	No		
Total						

Total

For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ. 632021 09-21-18 Schedule A (Form 990 or 990-EZ) 2018

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

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

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ►

	(a) 2012	(b) 2013	(c) 2014	(d) 2015	(e) 2016	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>4 Total.</b> Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
<b>6 Public support.</b> 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)						
<b>11 Total support.</b> Add lines 7 through 10						
<b>12 Gross receipts from related activities, etc (see instructions)</b>					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 **stop here** ► **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 from 2015 Schedule A, Part II, line 14	15	%
16a <b>33 1/3% support test - 2016.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization	►	<input type="checkbox"/>
b <b>33 1/3% support test - 2015.</b> If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization	►	<input type="checkbox"/>
17a <b>10% -facts-and-circumstances test - 2016.</b> If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization	►	<input type="checkbox"/>
b <b>10% -facts-and-circumstances test - 2015.</b> If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization	►	<input type="checkbox"/>
<b>18 Private foundation.</b> If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions	►	<input type="checkbox"/>

Schedule A (Form 990 or 990-EZ) 2016 MERCY HEALTH SYSTEM CORPORATION  
**Part III Support Schedule for Organizations Described in Section 509(a)(2)**

39-0816848 Page 3

(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) ►

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

	(a) 2012	(b) 2013	(c) 2014	(d) 2015	(e) 2016	(f) Total
1						
2						
3						
4						
5						
6						
7a						
b						
c						
8						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►

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

	(a) 2012	(b) 2013	(c) 2014	(d) 2015	(e) 2016	(f) Total
9						
10a						
b						
c						
11						
12						
13						

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**

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

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

17 Investment income percentage for 2016 (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from 2015 Schedule A, Part III, line 17	18	%
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 <b>stop here</b> . The organization qualifies as a publicly supported organization		► <input type="checkbox"/>
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 <b>stop here</b> . The organization qualifies as a publicly supported organization		► <input type="checkbox"/>
20 Private foundation. If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions		► <input type="checkbox"/>

632023 09-21-16

Schedule A (Form 990 or 990-EZ) 2016

**Part IV Supporting Organizations**

(Complete only if you checked a box in line 12 on 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**

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

	Yes	No
1		
2		
3a		
3b		
3c		
4a		
4b		
4c		
5a		
5b		
5c		
6		
7		
8		
9a		
9b		
9c		
10a		
10b		

**Part IV Supporting Organizations (continued)**

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

**Section B. Type I Supporting Organizations**

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

**Section C. Type II Supporting Organizations**

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

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

	Yes	No
1 Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (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?	1	
2 Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization(s) or (ii) serving on the governing body of a supported organization? If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s)	2	
3 By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.	3	

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

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

a  The organization satisfied the Activities Test Complete line 2 below

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

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

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

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

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

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

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

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

	Yes	No
2a		
2b		
3a		
3b		

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

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

Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1 Net short-term capital gain	1		
2 Recoveries of prior-year distributions	2		
3 Other gross income (see instructions)	3		
4 Add lines 1 through 3	4		
5 Depreciation and depletion	5		
6 Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6		
7 Other expenses (see instructions)	7		
<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)
1 Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year)			
a Average monthly value of securities	1a		
b Average monthly cash balances	1b		
c Fair market value of other non-exempt-use assets	1c		
<b>d Total</b> (add lines 1a, 1b, and 1c)	<b>1d</b>		
e Discount claimed for blockage or other factors (explain in detail in Part VI)			
2 Acquisition indebtedness applicable to non-exempt-use assets	2		
3 Subtract line 2 from line 1d	3		
4 Cash deemed held for exempt use Enter 1-1/2% of line 3 (for greater amount, see instructions)	4		
5 Net value of non-exempt-use assets (subtract line 4 from line 3)	5		
6 Multiply line 5 by 035	6		
7 Recoveries of prior-year distributions	7		
<b>8 Minimum Asset Amount</b> (add line 7 to line 6)	<b>8</b>		
Section C - Distributable Amount			Current Year
1 Adjusted net income for prior year (from Section A, line 8, Column A)	1		
2 Enter 85% of line 1	2		
3 Minimum asset amount for prior year (from Section B, line 8, Column A)	3		
4 Enter greater of line 2 or line 3	4		
5 Income tax imposed in prior year	5		
6 <b>Distributable Amount</b> . Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6		
7 <input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally integrated Type III supporting organization (see instructions)			

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

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

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- explain in Part VI) See instructions			
3 Excess distributions carryover, if any, to 2016			
a			
b			
c From 2013			
d From 2014			
e From 2015			
f <b>Total of lines 3a through e</b>			
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 For result greater than zero, explain in Part VI See instructions			
6 Remaining underdistributions for 2016 Subtract lines 3h and 4b from line 1 For result greater than zero, explain in Part VI See instructions			
7 <b>Excess distributions carryover to 2017.</b> 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.)

**SCHEDULE H**  
(Form 990)

Department of the Treasury  
Internal Revenue Service

**Hospitals**

OMB No 1545-0047

**2016**

Open to Public  
Inspection

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

Name of the organization

MERCY HEALTH SYSTEM CORPORATION

Employer identification number  
39-0816848

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

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

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

b If "Yes," was it a written policy?  
If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year

Applied uniformly to all hospital facilities  Applied uniformly to most hospital facilities  
 Generally tailored to individual hospital facilities

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

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

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

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

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

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

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

5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?  
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?  
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?

6a Did the organization prepare a community benefit report during the tax year?  
b If "Yes," did the organization make it available to the public?

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

**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)			3198804.		3198804.	.60%
b Medicaid (from Worksheet 3, column a)			74961493.	46990092.	27971401.	5.24%
c Costs of other means-tested government programs (from Worksheet 3, column b)			5124398.	2982792.	2141606.	.40%
d Total Financial Assistance and Means-Tested Government Programs			83284695.	49972884.	33311811.	6.24%
<b>Other Benefits</b>						
e Community health improvement services and community benefit operations (from Worksheet 4)			1671353.	94,800.	1576553.	.30%
f Health professions education (from Worksheet 5)			6510100.	1082265.	5427835.	1.02%
g Subsidized health services (from Worksheet 6)			18079424.	12457459.	5621965.	1.05%
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			516,648.		516,648.	.10%
j Total. Other Benefits			26777525.	13634524.	13143001.	2.47%
k Total. Add lines 7d and 7j			110062220	63607408.	46454812.	8.71%

**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

	<b>(a)</b> Number of activities or programs (optional)	<b>(b)</b> Persons served (optional)	<b>(c)</b> Total community building expense	<b>(d)</b> Direct offsetting revenue	<b>(e)</b> Net community building expense	<b>(f)</b> Percent of total expense
<b>1</b> Physical improvements and housing						
<b>2</b> Economic development						
<b>3</b> Community support						
<b>4</b> Environmental improvements						
<b>5</b> Leadership development and training for community members						
<b>6</b> Coalition building						
<b>7</b> Community health improvement advocacy			10,600.		10,600.	.00%
<b>8</b> Workforce development						
<b>9</b> Other						
<b>10</b> Total			10,600.		10,600.	.00%

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

## **Section A. Bad Debt Expense**

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

		Yes	No
ment Association			
2	<u>8,207,041.</u>	1	X
3	1,338,568.		

## Section B. Medicare

**5** Enter total revenue received from Medicare (including DSH and IME) 5 67 ,

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

**7** Subtract line 6 from line 5 This is the surplus (or shortfall) 7 -24 ,

**8** Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit  
Also describe in Part VI the costing methodology or source used to determine the amounts reported on line 6

Cost accounting system  Cost to charge ratio  Other

### **Section C. Collection Practices**

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

**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

**Part V Facility Information**

## Section A Hospital Facilities

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

How many hospital facilities did the organization operate during the tax year? 2

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

**Part V Facility Information (continued)**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3, 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

**MERCYHEALTH HOSPITAL AND TRAUMA CENTER-JANESVILLE:**

PART V, SECTION B, LINE 5: MERCY HEALTH SYSTEM CORPORATION (MHSC) SET OUT TO GATHER INFORMATION ON THE COMMUNITY OF ROCK COUNTY, WISCONSIN. MHSC COLLABORATED WITH THE HEALTH EQUITY ALLIANCE OF ROCK COUNTY (HEAR) WHICH INCLUDED HOSPITAL REPRESENTATION FROM: MHSC, SSM HEALTH, BELOIT HEALTH SYSTEM, AND EDGERTON HOSPITALS. OTHER PARTICIPANTS IN HEAR ARE ROCK COUNTY PUBLIC HEALTH DEPARTMENT, ROCK COUNTY HUMAN SERVICES, HEALTH NET, COMMUNITY HEALTH SYSTEMS, INC., COMMUNITY ACTION, UNIVERSITY OF WISCONSIN EXTENSION, HEAD START, SCHOOL DISTRICT OF BELOIT, AND VARIOUS OTHER ORGANIZATIONS. THE GROUP GATHERED INFORMATION THROUGH HOUSEHOLD SURVEYS, KEY INFORMANT INTERVIEWS, AND SECONDARY DATA SOURCES.

A THIRTY-FOUR QUESTION SURVEY WAS DISTRIBUTED TO 2,000 REGISTERED VOTERS WITHIN THE COMMUNITY AND COVERED VARIOUS TOPICS, INCLUDING HEALTH ISSUES IN THE COMMUNITY, UNHEALTHY BEHAVIORS IN THE COMMUNITY, WELL-BEING, ACCESSIBILITY TO HEALTHCARE, AND HEALTHY BEHAVIORS. ADDITIONALLY THE SURVEY WAS AVAILABLE ON-LINE VIA SURVEY MONKEY. A RESPONSE WAS RECEIVED FROM 1,468 HOUSEHOLDS THAT RECEIVED THE SURVEY.

COMMUNITY LEADERS AND STAKEHOLDERS PARTICIPATED IN KEY INFORMANT INTERVIEWS TO FURTHER ENHANCE THE VERSATILITY OF THE DATA UTILIZED IN THIS SURVEY.

A DETAILED ANALYSIS OF SECONDARY DATA WAS USED TO ASSESS THE COMMUNITY PROFILE, MORBIDITY RATES, AND CAUSES OF MORTALITY AND HEALTH STATUS OF THE COMMUNITY. SECONDARY DATA WAS DERIVED FROM A VARIETY OF PUBLICLY AVAILABLE

**Part V Facility Information (continued)**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3, 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

SOURCES, INCLUDING THE UNITED STATES CENSUS BUREAU, COMMUNITY COMMONS,

WISH AND THE CENTER FOR DISEASE CONTROL'S COUNTY HEALTH RANKINGS.

SECONDARY SOURCE DATA, WHEN COMBINED WITH THE INFORMATION GATHERED FROM

THE HOUSEHOLD SURVEYS, AND KEY INFORMANT SURVEYS HELPED TO IDENTIFY

CONCERNs RELATING TO THE HEALTH OF THE COMMUNITY, WHILE ASSESSING

AREA-BASED PROGRAMS AND ORGANIZATIONS AVAILABLE TO ADDRESS THE COMMUNITY'S

NEEDS. THESE NEEDS WERE PRIORITIZED BASED ON LEVEL OF IMPORTANCE TO THE

COMMUNITY AS WELL AS THE HOSPITAL'S ABILITY TO IMPACT THOSE NEEDS; IT

PROVIDED A PICTURE OF WHAT IS WORKING WELL IN ADDITION TO IDENTIFYING

OPPORTUNITIES FOR IMPROVEMENT FOR THE HEALTHCARE INFRASTRUCTURE OF ROCK

COUNTY AND THE COMMUNITY AS A WHOLE.

MERCYHEALTH HOSPITAL AND MEDICAL CENTER-WALWORTH:

PART V, SECTION B, LINE 5: THE SURVEY WAS CONDUCTED BY JKV RESEARCH LLC.

THE SURVEY WAS BASED ON A RANDOM LANDLINE SAMPLING (LISTED AND UNLISTED

NUMBERS) AND CELL PHONE SAMPLING OF WALWORTH COUNTRY RESIDENTS. DATA

COLLECTION WAS CONDUCTED BY MANAGEMENT DECISIONS INCORPORATED. A TOTAL OF

400 TELEPHONE INTERVIEWS WERE COMPLETED BETWEEN JULY 5 AND SEPTEMBER 10,

2016. ONCE THE SURVEY RESPONSES WERE TABULATED, THE SURVEY RESULTS WERE

EVALUATED AND ANALYZED FOR HEALTH AND DEMOGRAPHIC TRENDS.

QUESTIONS WERE ASKED ABOUT INDIVIDUAL AND CHILDREN'S HEALTH, THE HEALTH OF

THE COMMUNITY, ACCESS TO HEALTHCARE, INSURANCE COVERAGE, HEALTHY BEHAVIORS

AND BEHAVIORAL HEALTH RISKS. DATA GATHERED FROM HOUSEHOLD SURVEYS WAS

COMPARED WITH PRIOR YEARS AND COMPARED WITH THE MOST RECENT STATE AND

NATIONAL AVERAGES. RESPONSES BY DEMOGRAPHIC GROUP WERE COMPARED;

SIGNIFICANT CHANGES WERE NOTED.

**Part V Facility Information (continued)**

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 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

IN THE FALL OF 2016, THE CENTER FOR URBAN POPULATION HEALTH WAS ENLISTED TO CREATE REPORTS DETAILING THE HEALTH OF VARIOUS COUNTIES USING SECONDARY DATA. THESE HEALTH DATA REPORTS ARE ONE PIECE OF A VARIETY OF DATA SOURCES BEING USED BY LOCAL HEALTH SYSTEMS TO DESCRIBE THEIR COMMUNITIES AND THE HEALTH PRIORITIES OF THEIR SERVICE AREAS. THESE REPORTS WERE SPECIFICALLY DEVELOPED TO COMPLEMENT A TELEPHONE SURVEY BEING DONE IN EACH COUNTY. BECAUSE OF THEIR COMPLEMENTARY NATURE, THESE REPORTS ARE NOT ALL-INCLUSIVE. ALL OF THE DATA USED IN SECONDARY DATA SOURCE REPORT FOR THE WALWORTH ASSESSMENT COME FROM PUBLICLY AVAILABLE DATA SOURCES. DATA FOR EACH INDICATOR WERE PRESENTED BY RACE AND ETHNICITY AND GENDER WHEN THE DATA WERE AVAILABLE.

KEY INFORMANT INTERVIEWS WERE ALSO CONDUCTED FOR THE WALWORTH NEEDS ASSESSMENT AND A SEPARATE REPORT WAS COMPILED. THIS REPORT PRESENTED A SUMMARY OF PUBLIC HEALTH PRIORITIES FOR WALWORTH COUNTY, AS IDENTIFIED IN 2016 BY A RANGE OF PROVIDERS, POLICY-MAKERS, AND OTHER LOCAL EXPERTS AND COMMUNITY MEMBERS ("KEY INFORMANTS"). THESE FINDINGS ARE A CRITICAL SUPPLEMENT TO THE WALWORTH COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) SURVEY CONDUCTED THROUGH A PARTNERSHIP BETWEEN THE WALWORTH COUNTY DIVISION OF PUBLIC HEALTH, AURORA HEALTH CARE, CHILDREN'S HOSPITAL OF WISCONSIN, FORT HEALTHCARE, AND MERCY HEALTH SYSTEM. THE CHNA INCORPORATES INPUT FROM PERSONS REPRESENTING THE BROAD COMMUNITY SERVED BY THE HOSPITALS, FOCUSING ON A RANGE OF PUBLIC HEALTH ISSUES RELEVANT TO THE COMMUNITY AT LARGE. KEY INFORMANTS IN WALWORTH COUNTY WERE IDENTIFIED AND INTERVIEWED BY STAFF FROM THE WALWORTH COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES AND DIVISION OF PUBLIC HEALTH, AURORA HEALTH CARE, AND MHSC

**Part V Facility Information (continued)**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16, 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

DURING AUGUST, SEPTEMBER, AND OCTOBER 2016.

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MERCYHEALTH HOSPITAL AND TRAUMA CENTER-JANESVILLE:

PART V, SECTION B, LINE 6A: BELOIT HEALTH SYSTEM, EDGERTON HOSPITAL, SSM  
HEALTH

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MERCYHEALTH HOSPITAL AND MEDICAL CENTER-WALWORTH:

PART V, SECTION B, LINE 6A: AURORA HEALTH CARE AND CHILDREN'S HOSPITAL OF  
WISCONSIN

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MERCYHEALTH HOSPITAL AND TRAUMA CENTER-JANESVILLE:

PART V, SECTION B, LINE 6B: BUILDING A SAFER EVANSCVILLE, COMMUNITY  
ACTION, COMMUNITY ACTION - FIRST CHOICE, COMMUNITY CARE CONNECTIONS OF  
WISCONSIN, COMMUNITY HEALTH SYSTEMS, INC., EXCHANGE FAMILY RESOURCE  
CENTER, HEAD START, HEALTHNET, HEALTHY EDGERTON, JANESVILLE MOBILIZING 4  
CHANGE, ROCK COUNTY BOARD OF SUPERVISORS, ROCK COUNTY CRIMINAL JUSTICE  
ANALYST, ROCK COUNTY HUMAN SERVICES, ROCK COUNTY PUBLIC HEALTH DEPARTMENT,  
SCHOOL DISTRICT OF BELOIT, SOUTH CENTRAL AREA HEALTH EDUCATION CENTER,  
UNIVERSITY OF WISCONSIN EXTENSION, YOUTH-2-YOUTH

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MERCYHEALTH HOSPITAL AND MEDICAL CENTER-WALWORTH:

PART V, SECTION B, LINE 6B: CENTER FOR URBAN POPULATION HEALTH AND  
WALWORTH COUNTY PUBLIC HEALTH DEPARTMENT

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**Part V Facility Information (continued)**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16, 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.

MERCYHEALTH HOSPITAL AND TRAUMA CENTER-JANESVILLE:

PART V, SECTION B, LINE 11: CONSISTENT WITH THE ROCK AND WALWORTH COUNTY COMMUNITY NEEDS ASSESSMENT ACTION PLANS, MHSC CONTINUES TO ROLL OUT ITS IMPLEMENTATION PLANS.

MHSC'S PLAN IN ROCK COUNTY IS TO IMPROVE THE HEALTH OF PATIENTS WITH MENTAL HEALTH, SUBSTANCE ABUSE, AND ALCOHOL ABUSE ISSUES THROUGH INCREASED ACCESS TO EDUCATION AND CARE FOR THESE PATIENTS. TO THIS END, MHSC CONTINUES TO DEVELOP AND OFFER VARIOUS ACCESS SITES, MONITORS ITS CURRENT PROGRAMS, AND PARTNERS WITH LOCAL AGENCIES TO PROVIDE EDUCATION AND SUPPORT FOR PATIENTS AND THEIR FAMILIES. IT HAS IMPLEMENTED URGENT CLINIC APPOINTMENTS FOLLOWING DISCHARGE FROM ITS BEHAVIORAL HEALTH UNIT. MHSC'S PLAN IS TO IMPROVE THE PHYSICAL HEALTH OF PATIENTS THROUGH EDUCATION AND SUPPORT/SPONSORSHIP OF ATHLETIC EVENTS OR PROGRAMS THAT PROMOTE PHYSICAL ACTIVITY IN THE COMMUNITY. CHRONIC DISEASE PREVENTION IS ANOTHER FOCUS OF MHSC'S PLAN: EDUCATION, FREE SCREENINGS, SMOKING CESSATION CLASSES, AND PARTNERSHIP WITH NATIONAL ORGANIZATIONS.

WALWORTH COUNTY'S PLAN IS TO IMPROVE THE GENERAL HEALTH OF INDIVIDUALS LIVING IN WALWORTH COUNTY. MHSC CONTINUES TO DEVELOP AND OFFER VARIOUS ACCESS SITES FOR PRIMARY AND SPECIALTY CARE SERVICES, PROACTIVELY MANAGES MEDICARE POPULATION THROUGH ACO INITIATIVES FOCUSED ON PREVENTIVE CARE, AND PROVIDES HEALTH EDUCATION AND AWARENESS (WITH EMPHASIS TOWARD SCREENING, IMMUNIZATIONS, AND VACCINATIONS). IT IS MHSC'S PLAN TO IMPROVE THE HEALTH STATUS OF INDIVIDUALS WITH CHRONIC ILLNESS, PROMOTE HEALTHY LIFESTYLES AND TO IMPROVE THE HEALTH OF PATIENTS WITH SPECIFIC NEEDS, SUCH AS GERIATRIC SERVICES AND ALCOHOL AND SUBSTANCE ABUSE. IT WILL MONITOR AND

**Part V Facility Information (continued)**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3, 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

INCREASE TESTING, PROVIDE SMOKING CESSATION MATERIALS AND PROGRAMS,  
PROVIDE FREE BLOOD PRESSURE CHECKS, AND PROMOTE SERVICES FOR SPECIAL NEEDS  
OF ELDERLY OR THOSE SUFFERING FROM ABUSE ISSUES.

PROMOTING HYPERTENSION AWARENESS, SUPPORTING OBESITY EDUCATION AND SMOKING  
CESSATION PROGRAMS ARE PRIORITIES IN ROCK AND WALWORTH COUNTIES.

MHSC PARTNERS WITH MULTIPLE COMMUNITY BASED ORGANIZATIONS IN ROCK AND  
WALWORTH COUNTY TO ACCOMPLISH SUCCESSFUL IMPLEMENTATION OF THESE  
STRATEGIES. DURING THE COURSE OF THIS TAX YEAR 2016 (FISCAL YEAR JULY 1,  
2016-JUNE 30, 2017) MHSC PARTICIPATED IN NUMEROUS COMMUNITY HEALTH FAIRS,  
PROVIDED FREE SCREENINGS AT OUR CLINICS AND IN CONJUNCTION WITH COMMUNITY  
BASED ORGANIZATIONS, OFFERED SCREENINGS TO FREE AND SLIDING FEE SCHEDULE  
PRIMARY CARE CLINICS, AND SCHOOL DISTRICTS IN BOTH COUNTIES. MHSC ALSO  
PROVIDES FINANCIAL INCENTIVES FOR THEIR EMPLOYEES TO PARTICIPATE IN  
SMOKING CESSATION PROGRAMS. ALL OF THESE EFFORTS ARE SUPPORTED THROUGH  
BROAD BASED MARKETING AND ADVERTISING PROGRAMS DIRECTED TO AUDIENCES IN  
BOTH COUNTIES PROMOTING THESE PROGRAMS.

IN THE AREA OF OBJECTIVES RELATED TO MENTAL HEALTH CARE, AUTISM SUPPORT  
AND DECREASING SUBSTANCE ABUSE, MHSC CONTINUES TO ATTEMPT TO BUILD  
ADDITIONAL CAPACITY FOR OUTPATIENT THERAPY AND EDUCATION. FINALLY IN THE  
AREA OF SCREENINGS, MHSC PARTNERS WITH COMMUNITY AGENCIES AND MHSC STAFF  
TO OFFER SCREENINGS AT HEALTH FAIRS, MHSC SPONSORED EVENTS, AND THROUGH  
FREE AND SLIDING FEE SCALE PRIMARY CLINICS IN ROCK AND WALWORTH COUNTIES.

MERCYHEALTH HOSPITAL AND TRAUMA CENTER-J

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**Part V Facility Information (continued)**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 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

**PART V, LINE 16B, FAP APPLICATION WEBSITE:**

**MERCYHEALTHSYSTEM.ORG/FINANCIAL-POLICIES**

**MERCYHEALTH HOSPITAL AND MEDICAL CENTER-**

**PART V, LINE 16B, FAP APPLICATION WEBSITE:**

**MERCYHEALTHSYSTEM.ORG/FINANCIAL-POLICIES**

**MERCYHEALTH HOSPITAL AND TRAUMA CENTER-J**

**PART V, LINE 16C, FAP PLAIN LANGUAGE SUMMARY WEBSITE:**

**MERCYHEALTHSYSTEM.ORG/FINANCIAL-POLICIES**

**MERCYHEALTH HOSPITAL AND MEDICAL CENTER-**

**PART V, LINE 16C, FAP PLAIN LANGUAGE SUMMARY WEBSITE:**

**MERCYHEALTHSYSTEM.ORG/FINANCIAL-POLICIES**

**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? 48

Name and address	Type of Facility (describe)
1 MERCYHEALTH TRANSITIONAL CENTER 1000 MINERAL POINT AVENUE JANESVILLE, WI 53548	SKILLED NURSING/SUB-ACUTE CARE FACILITY
2 MERCYHEALTH REGIONAL CANCER CENTER 1000 MINERAL POINT AVENUE JANESVILLE, WI 53548	RADIATION ONCOLOGY CLINIC/RADIATION THERAPY FACILITY
3 HOUSE OF MERCY HOMELESS CENTER 320 LINCOLN STREET JANESVILLE, WI 53548	HOMELESS CENTER
4 MERCYHEALTH ALGONQUIN 2401 HARNISH DRIVE, SUITE 101 ALGONQUIN, WI 60102	OUTPATIENT PHYSICIAN CLINIC
5 MERCYHEALTH BARRINGTON 500 WEST HIGHWAY 22 BARRINGTON, IL 60010	OUTPATIENT PHYSICIAN CLINIC
6 MERCYHEALTH BELOIT 2825 PRAIRIE AVENUE BELOIT, WI 53511	OUTPATIENT PHYSICIAN CLINIC/URGENT CARE FACILITY
7 MERCYHEALTH BROADHEAD 2310 FIRST CENTER AVENUE BROADHEAD, WI 53520	OUTPATIENT PHYSICIAN CLINIC
8 MERCYHEALTH MCHENRY EYE CENTER 406 N FRONT ST SUITE C MCHENRY, IL 60050	OUTPATIENT PHYSICIAN CLINIC
9 MERCYHEALTH EAST 3524 EAST MILWAUKEE STREET JANESVILLE, WI 53546	OUTPATIENT PHYSICIAN CLINIC/URGENT CARE FACILITY
10 MERCYHEALTH EAST PHARMACY 3524 EAST MILWAUKEE STREET JANESVILLE, WI 53546	RETAIL PHARMACY

**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? 48

Name and address	Type of Facility (describe)
11 MERCYHEALTH SOUTH 849 KELLOGG AVENUE JANESVILLE, WI 53546	RESIDENCY PROGRAM / OUTPATIENT PHYSICIAN CLINIC
12 MERCYHEALTH WEST 1000 MINERAL POINT AVENUE JANESVILLE, WI 53548	OUTPATIENT PHYSICIAN CLINIC & MEDICAL ONCOLOGY
13 MERCYHEALTH WEST PHARMACY 1000 MINERAL POINT AVENUE JANESVILLE, WI 53548	RETAIL PHARMACY
14 MERCYHEALTH CRYSTAL LAKE CHIROPRACTIC 330 W. TERRA COTTA ROAD (RTE 176) CRYSTAL LAKE, IL 60014	CHIROPRACTOR
15 MERCYHEALTH CRYSTAL LAKE EAST 390 CONGRESS PARKWAY CRYSTAL LAKE, IL 60014	OUTPATIENT PHYSICIAN CLINIC
16 MERCYHEALTH CRYSTAL LAKE OB/GYN 750 E. TERRA COTTA, STE. B CRYSTAL LAKE, IL 60014	OUTPATIENT PHYSICIAN CLINIC
17 MERCYHEALTH CRYSTAL LAKE SOUTH 415-A CONGRESS PARKWAY CRYSTAL LAKE, IL 60014	OUTPATIENT PHYSICIAN CLINIC
18 MERCYHEALTH DELAVAN 1038 E. GENEVA STREET DELAVAN, WI 53115	OUTPATIENT PHYSICIAN CLINIC
19 MERCYHEALTH EDGERTON 217 N. MAIN STREET EDGERTON, WI 53534	OUTPATIENT PHYSICIAN CLINIC
20 MERCYHEALTH EVANSVILLE 300 UNION STREET EVANSVILLE, WI 53536	OUTPATIENT PHYSICIAN CLINIC

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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? 48

Name and address	Type of Facility (describe)
21 MERCYHEALTH HARVARD SOUTH 348 S. DIVISION HARVARD, IL 60033	OUTPATIENT PHYSICIAN CLINIC
22 MERCYHEALTH MALL 1010 NORTH WASHINGTON JANESVILLE, WI 53548	OUTPATIENT PHYSICIAN CLINIC/URGENT CARE FACILITY
23 MERCYHEALTH MALL PHARMACY 1010 NORTH WASHINGTON JANESVILLE, WI 53548	RETAIL PHARMACY
24 MERCYHEALTH LAKE GENEVA 350 PELLER ROAD LAKE GENEVA, WI 53147	OUTPATIENT PHYSICIAN CLINIC
25 MERCYHEALTH LAKESIDE ORTHOPEDICS 352 PELLER ROAD LAKE GENEVA, WI 53147	OUTPATIENT PHYSICIAN CLINIC
26 MERCYHEALTH MCHENRY 3922 MERCY DRIVE MCHENRY, IL 60050	OUTPATIENT PHYSICIAN CLINIC
27 MERCYHEALTH MILTON 725 SOUTH JANESVILLE STREET MILTON, WI 53563	OUTPATIENT PHYSICIAN CLINIC
28 MERCYHEALTH MILTON PHARMACY 725 SOUTH JANESVILLE STREET MILTON, WI 53563	RETAIL PHARMACY
29 MERCYHEALTH NORTHWEST WOMEN'S GROUP 47 WEST ACORN LANE LAKE IN THE HILLS, IL 60156-4804	OUTPATIENT PHYSICIAN CLINIC
30 MERCYHEALTH BEHAVIORAL HEALTH CLINIC 903 MINERAL POINT AVENUE JANESVILLE, WI 53548	PHYSICIAN & THERAPIST SERVICES: MENTAL HEALTH & ADDICTION TREATMENT

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## 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? 48

Name and address	Type of Facility (describe)
31 MERCYHEALTH DIALYSIS CENTER 903 MINERAL POINT AVENUE JANESVILLE, WI 53548	DIALYSIS CENTER
32 MERCYHEALTH LUNG CENTER 903 MINERAL POINT AVENUE JANESVILLE, WI 53548	PHYSICIANS CLINIC & SLEEP DISORDER CENTER
33 MERCYHEALTH RICHMOND 9715 PRAIRIE RIDGE RICHMOND, IL 60071	OUTPATIENT PHYSICIAN CLINIC
35 MERCYHEALTH SPORTS MEDICINE AND REHAB 557 NORTH WASHINGTON JANESVILLE, WI 53548	OUTPATIENT PHYSICIAN CLINIC AND REHABILITATION FACILITY
36 MERCYHEALTH TERRACE 510 N. TERRACE STREET JANESVILLE, WI 53548	OUTPATIENT PHYSICIAN CLINIC
38 MERCYHEALTH WHITEWATER 507 WEST MAIN STREET WHITEWATER, WI 53190	OUTPATIENT PHYSICIAN CLINIC
39 MERCYHEALTH SPORTS MEDICINE & REHAB 519 WEST MAIN STREET WHITEWATER, WI 53190	OUTPATIENT PHYSICIAN CLINIC AND REHABILITATION FACILITY
40 MERCYHEALTH WOODSTOCK 2000 LAKE AVENUE WOODSTOCK, IL 60098	OUTPATIENT PHYSICIAN CLINIC/URGENT CARE FACILITY
41 MERCYHEALTH WOODSTOCK PHARMACY 2000 LAKE AVENUE WOODSTOCK, IL 60098	RETAIL PHARMACY
45 MERCYHEALTH ELKHORN 839 N. WISCONSIN STREET ELKHORN, WI 53121	OUTPATIENT PHYSICIAN CLINIC

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**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? 48

Name and address	Type of Facility (describe)
46 MERCYCARE BUILDING 580 N. WASHINGTON STREET JANESVILLE, WI 53548	AUTISM PROGRAM/EMS TRAINING
47 MERCYHEALTH SLEEP DISORDERS CENTER 903 MINERAL POINT AVENUE JANESVILLE, WI 53548	OUTPATIENT PHYSICIAN CLINIC/SLEEP STUDY CENTER
48 MERCYHEALTH PEDIATRICS - ALGONQUIN 2537 W. ALGONQUIN ROAD JANESVILLE, WI 60102	OUTPATIENT PHYSICIAN CLINIC
49 MERCYHEALTH PEDIATRICS - ELGIN 2050 LARKIN AVENUE, STE 101 ELGIN, IL 60123	OUTPATIENT PHYSICIAN CLINIC
50 MERCYHEALTH WALWORTH N2950 STATE ROAD 67 LAKE GENEVA, WI 53147	OUTPATIENT PHYSICIAN CLINIC
51 MERCYHEALTH WALWORTH PHARMACY N2950 STATE ROAD 67 LAKE GENEVA, WI 53147	RETAIL PHARMACY
52 MERCYHEALTH BEHAVIORAL HEALTH CLINIC N2846 STATE ROAD 67 WILLIAMS BAY, WI 53191	OUTPATIENT PHYSICIAN CLINIC
53 MERCYHEALTH NORTH 3400 DEERFIELD DR JANESVILLE, WI 53546	OUTPATIENT PHYSICIAN CLINIC

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

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

Name of hospital facility or letter of facility reporting group MERCYHEALTH HOSPITAL AND TRAUMA CENTER-JLine number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1

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

## Part V Facility Information (continued)

## Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group MERCYHEALTH HOSPITAL AND TRAUMA CENTER-J

	Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that		
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13 X	
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>300</u> %		
b <input type="checkbox"/> Income level other than FPG (describe in Section C)		
c <input checked="" type="checkbox"/> Asset level		
d <input checked="" type="checkbox"/> Medical indigency		
e <input checked="" type="checkbox"/> Insurance status		
f <input checked="" type="checkbox"/> Underinsurance status		
g <input checked="" type="checkbox"/> Residency		
h <input type="checkbox"/> Other (describe in Section C)		
14 Explained the basis for calculating amounts charged to patients?	14 X	
15 Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	15 X	
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e <input type="checkbox"/> Other (describe in Section C)		
16 Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	16 X	
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>MERCYHEALTHSYSTEM.ORG/FINANCIAL-POLICIES</u>		
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>SEE PART V, PAGE 8</u>		
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>SEE PART V, PAGE 8</u>		
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j <input type="checkbox"/> Other (describe in Section C)		

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**Part V Facility Information (continued)****Billing and Collections**Name of hospital facility or letter of facility reporting group MERCYHEALTH HOSPITAL AND TRAUMA CENTER-J

	Yes	No
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17 X	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
a <input checked="" type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input checked="" 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		
d <input type="checkbox"/> Actions that require a legal or judicial process		
e <input type="checkbox"/> Other similar actions (describe in Section C)		
f <input type="checkbox"/> None of these actions or other similar actions were permitted		
19 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?	19 X	
If "Yes," check all actions in which the hospital facility or a third party engaged		
a <input checked="" type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input checked="" 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		
d <input type="checkbox"/> Actions that require a legal or judicial process		
e <input type="checkbox"/> Other similar actions (describe in Section C)		
20 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)		
a <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 <input type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process		
c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications		
d <input checked="" type="checkbox"/> Made presumptive eligibility determinations		
e <input type="checkbox"/> Other (describe in Section C)		
f <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

21 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?	21 X	
If "No," indicate why		
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b <input type="checkbox"/> The hospital facility's policy was not in writing		
c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)		
d <input type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information (continued)****Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**Name of hospital facility or letter of facility reporting group MERCYHEALTH HOSPITAL AND TRAUMA CENTER-J

	Yes	No
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 <input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b <input checked="" type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
c <input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
d <input type="checkbox"/> 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?	23	X
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?	24	X
If "Yes," explain in Section C		

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

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

Name of hospital facility or letter of facility reporting group MERCYHEALTH HOSPITAL AND MEDICAL CENTER-

Line number of hospital facility, or line numbers of hospital

facilities in a facility reporting group (from Part V, Section A): 2

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

**Part V Facility Information (continued)****Financial Assistance Policy (FAP)**Name of hospital facility or letter of facility reporting group MERCYHEALTH HOSPITAL AND MEDICAL CENTER

	Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	X
If "Yes," indicate the eligibility criteria explained in the FAP		
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>300</u> %		
b <input type="checkbox"/> Income level other than FPG (describe in Section C)		
c <input checked="" type="checkbox"/> Asset level		
d <input checked="" type="checkbox"/> Medical indigency		
e <input checked="" type="checkbox"/> Insurance status		
f <input checked="" type="checkbox"/> Underinsurance status		
g <input checked="" type="checkbox"/> Residency		
h <input type="checkbox"/> Other (describe in Section C)		
Explained the basis for calculating amounts charged to patients?	14	X
Explained the method for applying for financial assistance?	15	X
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)		
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e <input type="checkbox"/> Other (describe in Section C)		
Was widely publicized within the community served by the hospital facility?	16	X
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)		
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>MERCYHEALTHSYSTEM.ORG/FINANCIAL-POLICIES</u>		
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>SEE PART V, PAGE 8</u>		
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>SEE PART V, PAGE 8</u>		
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i <input checked="" type="checkbox"/> The FAP, FAP application form and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j <input type="checkbox"/> Other (describe in Section C)		

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**Part V Facility Information (continued)****Billing and Collections**Name of hospital facility or letter of facility reporting group **MERCYHEALTH HOSPITAL AND MEDICAL CENTER-**

	Yes	No
<b>17</b> Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17	X
<b>18</b> Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
a <input checked="" type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input checked="" 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		
d <input type="checkbox"/> Actions that require a legal or judicial process		
e <input type="checkbox"/> Other similar actions (describe in Section C)		
f <input 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?	19	X
If "Yes," check all actions in which the hospital facility or a third party engaged		
a <input checked="" type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input checked="" 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		
d <input type="checkbox"/> Actions that require a legal or judicial process		
e <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)		
a <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 <input type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process		
c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications		
d <input checked="" type="checkbox"/> Made presumptive eligibility determinations		
e <input type="checkbox"/> Other (describe in Section C)		
f <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

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

**Part V Facility Information (continued)****Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**Name of hospital facility or letter of facility reporting group MERCYHEALTH HOSPITAL AND MEDICAL CENTER

		Yes	No
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	<input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b	<input checked="" type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
c	<input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
d	<input type="checkbox"/> 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?	23	X
	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?	24	X
	If "Yes," explain in Section C		

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## 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 B (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

Name of the organization

# MERCY HEALTH SYSTEM CORPORATION

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 2(a)(13) controlled entity?
MERCY HEALTH SYSTEM ASSOCIATION OF VOLUNTEERS - 39-0912682, 1000 MINERAL POINT AVE, JANEVILLE, WI 53548	SUPPORT OF HEALTHCARE	WISCONSIN	501(c) (3)	LINE 12C, III-FI	MERCY HEALTH SYSTEM CORPORATION	X
MERCY ASSISTED CARE, INC. - 39-1035110 101 MINERAL POINT AVE JANEVILLE, WI 53548	HEALTHCARE	WISCONSIN	501(c) (3)	LINE 10	MERCY HEALTH CORPORATION	X
MERCY HARVARD HOSPITAL, INC. - 31-1551871 101 GRANT STREET HARVARD, IL 60033	HEALTHCARE	ILLINOIS	501(c) (3)	LINE 3	MERCY HEALTH CORPORATION	X
MERCY CRYSTAL LAKE HOSPITAL AND MEDICAL CENTER - 20-1673011, 1000 MINERAL POINT AVE, JANEVILLE, WI 53548	NONE	ILLINOIS	501(c) (3)	LINE 3	MERCY HEALTH CORPORATION	X

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

## Part II Continuation of 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 52(b)(13) controlled organization?
Yes	No					
MERCY HEALTH CORPORATION - 47-2158680 2400 N ROCKTON AVE ROCKFORD , IL 61103	SUPPORT OF HEALTHCARE HEALTHCARE	ILLINOIS ILLINOIS	501(C) (3) 501(C) (3)	LINE 12A, I LINE 3	N/A MERCY HEALTH CORPORATION	X
ROCKFORD MEMORIAL HOSPITAL - 36-2167847 2400 N ROCKTON AVE ROCKFORD , IL 61103	SUPPORT OF HEALTHCARE HEALTHCARE	ILLINOIS ILLINOIS	501(C) (3) 501(C) (3)	LINE 12A, I LINE 3	MERCY HEALTH CORPORATION	X
MERCYHEALTH DEVELOPMENT FOUNDATION - 36-31197918 , 2400 N ROCKTON AVE , ROCKFORD , IL 61103	SUPPORT OF HEALTHCARE HEALTHCARE	ILLINOIS ILLINOIS	501(C) (3) 501(C) (3)	LINE 12A, I LINE 10	MERCY HEALTH CORPORATION MERCY HEALTH CORPORATION	X
MERCYHEALTH VISITING NURSES ASSOCIATION - 36-2167945 , 4223 E STATE STREET , ROCKFORD , IL 61108	HEALTHCARE	ILLINOIS	501(C) (3)	LINE 10	MERCY HEALTH CORPORATION	X
ROCKFORD HEALTH PHYSICIANS - 36-3097436 2300 N ROCKTON AVE ROCKFORD , IL 61103	HEALTHCARE	ILLINOIS	501(C) (3)	LINE 3	MERCY HEALTH CORPORATION	X

**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

## Identification of Related Organizations Taxable as a Partnership

**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
JANESVILLE MEDICAL CENTER, INC. - 39-1520130 1000 MINERAL POINT AVE JANESVILLE, WI 53548	MANAGEMENT OF UNION EMPLOYEES	WI	MERCY HEALTH SYSTEM CORPORATION	C CORP	9,156,761.	200.	100%	X		
MERCYCARE INSURANCE COMPANY - 29-1768192 580 N WASHINGTON ST JANESVILLE, WI 53546	INSURANCE	WI	MERCY HEALTH SYSTEM CORPORATION	C CORP	83,565,959.	48,398,510.	100%	X		
MERCYCARE HMO, INC. - CONSOLIDATED WITH MERCYCARE INSURANCE CO - 20-1482553, 580 N WASHINGTON ST, JANESVILLE, WI 53546	INSURANCE	WI	MERCY HEALTH SYSTEM CORPORATION	C CORP			100%	X		
ROCKFORD HEALTH INSURANCE LTD WELLESLEY HOUSE 2ND FL PEMBROKE, HM, BERMUDA	INSURANCE	BERMUDA	N/A	C CORP	N/A	N/A	N/A	X		

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

	Yes	No	
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 X		
b Gift, grant, or capital contribution to related organization(s)	1b X		
c Gift, grant, or capital contribution from related organization(s)	1c X		
d Loans or loan guarantees to or for related organization(s)	1d X		
e Loans or loan guarantees by related organization(s)	1e X		
f Dividends from related organization(s)	1f X		
g Sale of assets to related organization(s)	1g X		
h Purchase of assets from related organization(s)	1h X		
i Exchange of assets with related organization(s)	1i X		
j Lease of facilities, equipment, or other assets to related organization(s)	1j X		
k Lease of facilities, equipment, or other assets from related organization(s)	1k X		
l Performance of services or membership or fundraising solicitations for related organization(s)	1l X		
m Performance of services or membership or fundraising solicitations by related organization(s)	1m X		
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n X		
o Sharing of paid employees with related organization(s)	1o X		
p Reimbursement paid to related organization(s) for expenses	1p X		
q Reimbursement paid by related organization(s) for expenses	1q X		
r Other transfer of cash or property to related organization(s)	1r X		
s Other transfer of cash or property from related organization(s)	1s X		
2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds			
(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) MERCYCARE INSURANCE COMPANY MERCY HEALTH SYSTEM ASSOCIATION OF [2] VOLUNTEERS	Q	8,149,958.	COST OF SERVICES PROVIDED
(3) MERCY ASSISTED CARE, INC.	C	126,000.	CASH TRANSFERRED
(4) MERCYCARE INSURANCE COMPANY	A	131,946.	COST OF PROPERTY PROVIDED
(5)			
(6)			

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

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue)

**Part VII** Supplemental Information.

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



**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
KRISTEN GOELZER	FAMILY MEMBER OF MA	367,841.	EMPLOYMENT	X	
MEGAN KRAUSE	FAMILY MEMBER OF SU	120,009.	EMPLOYMENT	X	
JOANNA BEA BENNING	FAMILY MEMBER OF JA	352,935.	EMPLOYMENT	X	
JAVON R. BEA	FAMILY MEMBER OF JO	8,867,885.	EMPLOYMENT	X	

**Part V Supplemental Information**

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

SCH L, PART IV, BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS:(A) NAME OF PERSON: KRISTEN GOELZER(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:FAMILY MEMBER OF MARK GOELZER, DIRECTOR(D) DESCRIPTION OF TRANSACTION: EMPLOYMENT - PHYSICIAN(A) NAME OF PERSON: MEGAN KRAUSE(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:FAMILY MEMBER OF SUE RIPSCH, OFFICER(D) DESCRIPTION OF TRANSACTION: EMPLOYMENT - DIRECTOR(A) NAME OF PERSON: JOANNA BEA BENNING(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:FAMILY MEMBER OF JAVON BEA, PRESIDENT & DIRECTOR(D) DESCRIPTION OF TRANSACTION: EMPLOYMENT - VICE PRESIDENT(A) NAME OF PERSON: JAVON R. BEA(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:FAMILY MEMBER OF JOANNA BEA BENNING, VICE-PRESIDENT(D) DESCRIPTION OF TRANSACTION: EMPLOYMENT - PRESIDENT & DIRECTOR

## 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).

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**2016**

Open to Public  
Inspection

Name of the organization

MERCY HEALTH SYSTEM CORPORATION

Employer identification number  
39-0816848

### FORM 990, PART III, LINE 4A, PROGRAM SERVICE ACCOMPLISHMENTS:

ROCK AND WALWORTH COUNTIES IN WISCONSIN AND MCHENRY COUNTY IN ILLINOIS.

IN THAT SAME PERIOD OF TIME, MHSC ALSO PROVIDED MORE THAN \$516,000 IN  
FINANCIAL AND IN KIND CONTRIBUTIONS TO OTHER PRIVATE NOT FOR PROFIT  
HEALTH RELATED AGENCIES AND ORGANIZATION IN OUR SERVICE AREA.

BENEFICIARIES INCLUDED BUT ARE NOT LIMITED TO THE AMERICAN HEART  
ASSOCIATION, AMERICAN CANCER SOCIETY, UNITED WAY ORGANIZATIONS IN ROCK,  
WALWORTH, AND MCHENRY COUNTIES, YWCA CARE HOUSE, YMCA, AMERICAN LUNG  
ASSOCIATION, WALWORTH COUNTY ALLIANCE FOR CHILDREN, TURNING POINT  
WOMEN'S CENTER IN MCHENRY, OPEN ARMS FREE CLINIC, AND THE RED CROSS, TO  
NAME JUST A FEW RECIPIENTS.

MHSC ALSO ENCOURAGES ITS PARTNERS (EMPLOYEES) TO DONATE THEIR TIME AND  
ENERGY TO SUPPORT A WHOLE HOST OF COMMUNITY BASED CAUSES. THOUSANDS OF  
HOURS EACH YEAR ARE DONATED TO NOT FOR PROFIT AND PUBLIC AGENCIES  
THROUGHOUT OUR SERVICE AREA. EXAMPLES OF VOLUNTEER ACTIVITIES BEING  
SUPPORTED INCLUDE NURSING SERVICES AT COMMUNITY AND FREE CLINICS  
THROUGHOUT THE REGION, MEALS ON WHEELS DELIVERY ACTIVITIES, ACTIVE  
INVOLVEMENT AS GOVERNING BOARD MEMBERS FOR SUCH ORGANIZATIONS AS UNITED  
WAY, CRIME STOPPERS, ROTARY BOTANICAL GARDENS, HEALTHNET, AND MANY  
OTHER ORGANIZATIONS.

ANOTHER EXAMPLE OF MHSC'S COMMITMENT TO COMMUNITY IS ITS SUPPORT OF THE  
OPERATIONS THROUGH OFFERING SAFE RESIDENCE TO HOMELESS WOMEN AND THEIR  
CHILDREN AT THE HOUSE OF MERCY HOMELESS CENTER. SINCE ITS OPENING IN

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.

Schedule O (Form 990 or 990-EZ) (2016)

632211 08-25-16

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1996, THE CENTER HAS SERVED MORE THAN 6,000 PERSONS, MOST OF WHOM ARE UNDER THE AGE OF 18 AT THE CENTER. THE CENTER OFFERS A SAFE HARBOR FOR THESE INDIVIDUALS AS WELL AS CASE MANAGEMENT, ASSISTANCE WITH JOB SEARCHES, FINDING PERMANENT HOUSING AND EDUCATION.

FORM 990, PART VI, SECTION A, LINE 1:

THE VOTING MEMBERS OF THE EXECUTIVE COMMITTEE CONSISTS OF SEVEN INDIVIDUALS, EACH OF WHOM SHALL HAVE A VOTE, INCLUDING THE CEO, THE CHAIRMAN, VICE-CHAIRMAN, IMMEDIATE PAST CHAIRMAN, TREASURER, AND TWO ADDITIONAL DIRECTORS OF THE BOARD. AT LEAST ONE MEMBER OF THE EXECUTIVE COMMITTEE SHALL BE A PHYSICIAN. THE EXECUTIVE COMMITTEE SHALL IN ALL INSTANCES BE COMPRISED OF AT LEAST 51% COMMUNITY MEMBERS. IN THE EVENT THAT ONE OR MORE OF THE AFOREMENTIONED VOTING MEMBERS OF THE EXECUTIVE COMMITTEE IS UNABLE TO SERVE IN SUCH CAPACITY, THEN THE CHAIRMAN OF THE CORPORATION SHALL DESIGNATE A REPLACEMENT FROM AMONG THE BOARD MEMBERS. THE EXECUTIVE COMMITTEE SHALL MEET AS NEEDED. WHEN THE BOARD OF DIRECTORS IS NOT IN SESSION, THE EXECUTIVE COMMITTEE SHALL HAVE ALL THE POWERS, DUTIES, RESPONSIBILITIES AND AUTHORITY OF THE BOARD, EXCEPT AS PROHIBITED BY LAW.

FORM 990, PART VI, SECTION A, LINE 2:

FAMILY RELATIONSHIP: JAVON R. BEA (FATHER) & JOANNA BEA BENNING (DAUGHTER)

FORM 990, PART VI, SECTION A, LINE 6:

MERCY HEALTH CORPORATION (MHC) IS THE SOLE MEMBER OF MERCY HEALTH SYSTEM CORPORATION (MHSC).

THE SOLE MEMBER SHALL HAVE POWERS AND VOTING RIGHTS TO DO THE FOLLOWING:

(A) APPOINT ALL THE DIRECTORS OF THE CORPORATION

(B) NOMINATE TO THE CORPORATION'S BOARD OF DIRECTORS ALL CANDIDATES FOR

Name of the organization

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SELECTION AS THE CORPORATION PRESIDENT

(C) APPROVE EXPRESSLY ALL AMENDMENTS TO THE CORPORATION'S ARTICLES OF INCORPORATION AND BYLAWS

(D) APPROVE ANNUAL BUDGETS, AND STRATEGIC, LONG-RANGE AND HEALTH MANPOWER DEVELOPMENT PLANS OF THE CORPORATION

(E) REQUIRE THE CORPORATION'S BOARD OF DIRECTORS TO TAKE ANY ACTION (INCLUDING AUTHORIZING THE PLEDGE OR TRANSFER OF ASSETS TO MHC OR AS DIRECTED BY MHC, OR THE EXECUTION OF CONTRACTS) WHICH WOULD IMPROVE THE CREDIT WORTHINESS OR OTHERWISE RESULT IN FINANCIAL BENEFIT TO MHC AND ITS TAX-EXEMPT AFFILIATED CORPORATIONS (PROVIDED THAT UNDER NO CIRCUMSTANCES MAY MHC REQUIRE TRANSFER OF ASSETS IN VIOLATION OF LAW OR THE TERMS OF ANY CHARITABLE TRUST OR DONATION).

(F) APPROVE ALL CONTRACTS OF INDEBTEDNESS EFFECTIVE FOR LONGER THAN EIGHTEEN MONTHS

(G) APPROVE ALL PLANS OF MERGER OR CONSOLIDATION

(H) APPROVE THE SALE, LEASE, EXCHANGE, MORTGAGE, PLEDGE OR OTHER DISPOSITION OF ALL OR SUBSTANTIALLY ALL, THE PROPERTY AND ASSETS OF THE CORPORATION

(I) APPROVE A VOLUNTARY DISSOLUTION OF THE CORPORATION

(J) APPROVE MATERIAL AMENDMENTS TO THE CORPORATION'S STANDARD FORM OF PHYSICIAN EMPLOYMENT AGREEMENT, PROVIDED THE CORPORATION SHALL HAVE THE AUTHORITY TO NEGOTIATE THE TERMS AND CONDITIONS OF INDIVIDUAL PHYSICIAN EMPLOYMENT AGREEMENTS SO LONG AS THE NEGOTIATED TERMS AND CONDITIONS ARE CONSISTENT WITH THE REQUIREMENTS OF APPLICABLE LAW AND THE STRATEGIC, LONG-RANGE AND HEALTH MANPOWER DEVELOPMENT PLANS APPROVED BY MHC.

(K) APPROVE MATERIAL AMENDMENTS TO THE STANDARD COMPENSATION SYSTEM USED BY THE CORPORATION TO ESTABLISH INDIVIDUAL PHYSICIAN COMPENSATION

(L) REQUIRE THE CORPORATION'S BOARD OF DIRECTORS TO TAKE ANY ACTION

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(INCLUDING AMENDING THE ARTICLES OF INCORPORATION OR BYLAWS), OR TO MODIFY OR RESCIND AN ACTION ALREADY TAKEN, IF MHC DETERMINES THAT FAILURE TO TAKE THE ACTION, OR TO MODIFY OR RESCIND AN ACTION ALREADY TAKEN, MAY RESULT IN THE CORPORATIONS FAILURE TO OBTAIN OR MAINTAIN ITS EXEMPTION AS AN ORGANIZATION DESCRIBED IN SECTION 501(C)(3) OF THE CODE

FORM 990, PART VI, SECTION A, LINE 7A:

SEE NARRATIVE FOR PART VI, LINE 6

FORM 990, PART VI, SECTION A, LINE 7B:

SEE NARRATIVE FOR PART VI, LINE 6

FORM 990, PART VI, SECTION B, LINE 11B:

MANAGEMENT REVIEWS THE FORM 990 BEFORE FILING AND IT IS AVAILABLE TO THE BOARD OF DIRECTORS.

FORM 990, PART VI, SECTION B, LINE 12C:

BY WRITTEN POLICY, MHC SENDS OUT, ON AN ANNUAL BASIS, THE CORPORATE CONFLICT AND DUALITY OF INTEREST POLICY TO ALL BOARD MEMBERS, CORPORATE OFFICERS AND OTHER KEY INDIVIDUALS (THOSE HAVING RESPONSIBILITY AND AUTHORITY TO MAKE FINAL DECISIONS REGARDING THE ACQUISITION OF PRODUCTS OR SERVICES). EACH RECIPIENT IS REQUIRED TO COMPLETE A FINANCIAL INTEREST DISCLOSURE STATEMENT, WHICH IS SUBMITTED TO THE VICE PRESIDENT, LEGAL SERVICES/GENERAL COUNSEL FOR REVIEW. WITH RESPECT TO PHYSICIANS AND MANAGERS WHO ARE KEY INDIVIDUALS, ANY POTENTIAL CONFLICT OF INTEREST IS REVIEWED WITH THE APPROPRIATE EXECUTIVE STAFF MEMBER FOR FOLLOW UP WITH THE DISCLOSING PARTY IN ORDER TO REVIEW THE MATTER IN MORE DETAIL. THIS INCLUDES EMPHASIZING THAT THE DISCLOSING PARTY IS NOT PERMITTED TO

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PARTICIPATE IN ANY NEGOTIATIONS FOR THE PURCHASE OF ANY PRODUCTS OR SERVICES WHERE THE CONFLICT IS DEEMED MATERIAL, OR AUTHORIZE THE SUBSEQUENT PURCHASE OF RELATED GOODS AND SERVICES. THE DISCLOSING PARTY IS ALSO REQUIRED TO IDENTIFY EACH AND EVERY INSTANCE OF A POTENTIAL CONFLICT AS THEY MAY ARISE IN THE ORDINARY COURSE OF BUSINESS. A SIMILAR PROCESS IS FOLLOWED FOR THE BOARD OF DIRECTORS, EXCEPT THAT ANY POTENTIAL CONFLICT IS REVIEWED BY THE BOARD'S GOVERNANCE COMMITTEE. BOARD MEMBERS MAY COMMENT ON TRANSACTIONS WHERE THERE IS A POTENTIAL CONFLICT, BUT CANNOT VOTE ON THE RELATED MATTER AND MAY BE REQUIRED TO LEAVE ANY MEETING WHERE THE POTENTIAL CONFLICT IS REVIEWED BY THE BOARD OR WHERE THE BOARD TAKES ACTION TO EITHER APPROVE OR NOT APPROVE THE PROPOSED TRANSACTION. A BOARD MEMBER ALSO HAS A CONTINUING DUTY TO REPORT ANY CONFLICTS AS THEY MAY ARISE IN THE ORDINARY COURSE OF BUSINESS. IN THE EVENT THAT A POTENTIAL CONFLICT OF INTEREST IS REPORTED OR DISCOVERED OUTSIDE THE ESTABLISHED PROCESS, APPROPRIATE REVIEW AND ACTION WOULD BE TAKEN. THIS PROCESS WAS LAST COMPLETED IN 2017, WHEN THE QUESTIONNAIRES WERE SENT TO ADDRESS ANY 2016 CONFLICTS IDENTIFIED. MHC AND MHSC HAVE THE SAME BOARD, AND THEREFORE THE MHC QUESTIONNAIRE IS USED TO ALSO ADDRESS POTENTIAL AND ACTUAL CONFLICTS FOR THE FILING ORGANIZATION. THE MHC CONFLICT OF INTEREST POLICY IS AVAILABLE UPON REQUEST.

FORM 990, PART VI, SECTION B, LINE 15:

THE MHCS COMPENSATION COMMITTEE IS COMPRISED OF THE BOARD CHAIRPERSON, SECRETARY, AND THE TREASURER. THE COMPENSATION COMMITTEE IS ASSISTED BY INDEPENDENT LEGAL COUNSEL AND AN INDEPENDENT COMPENSATION CONSULTANT. THE COMPENSATION COMMITTEE, LEGAL COUNSEL, AND THE COMPENSATION CONSULTANT MEET THROUGHOUT THE YEAR AND REPORT DIRECTLY TO THE BOARD OF DIRECTORS ANNUALLY. THIS PROCESS WAS COMPLETED FOR 2016.

Name of the organization

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FORM 990, PART VI, SECTION C, LINE 19:

GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY & FINANCIAL STATEMENTS ARE  
AVAILABLE UPON REQUEST.

FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

<u>CHANGES IN PENSION OBLIGATION OTHER THAN PENSION EXPENSE</u>	<u>11,055,000.</u>
<u>TRANSFER FROM MERCY HARVARD HOSPITAL, INC.</u>	<u>3,381,231.</u>
<u>TOTAL TO FORM 990, PART XI, LINE 9</u>	<u>14,436,231.</u>

**SCHEDULE J**  
**(Form 990)**

**Compensation Information**

OMB No 1545-0047

**2016**

Open to Public  
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Department of the Treasury  
Internal Revenue Service

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).

Name of the organization

**MERCY HEALTH SYSTEM CORPORATION**

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**39-0816848**

**Part I Questions Regarding Compensation**

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

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

b If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain

2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked on line 1a?

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

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

4 During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization

a Receive a severance payment or change-of-control payment?  
b Participate in, or receive payment from, a supplemental nonqualified retirement plan?  
c Participate in, or receive payment from, an equity-based compensation arrangement?

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

**Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.**

5 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of

a The organization?

b Any related organization?

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

6 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of

a The organization?

b Any related organization?

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

7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described on lines 5 and 6? If "Yes," describe in Part III

8 Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III

9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?

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

Schedule J (Form 990) 2016

## Part II Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees.

Use duplicate copies if additional space is needed

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

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

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) MARK L. GOELZER, M.D. DIRECTOR/PHYSICIAN	(i) 336,702.	174,880.	1,039,325.	17,505.	14,666.	1,583,078.	0.
(2) JOANNA BEA BENNING VICE-PRESIDENT	(ii) 0.	0.	0.	0.	0.	0.	0.
(3) BARBARA J. BORTNER VICE-PRESIDENT	(i) 174,679.	123,805.	6,225.	17,505.	13,182.	352,935.	0.
(4) E. PATRICK CRANLEY VICE-PRESIDENT	(i) 224,909.	96,872.	10,123.	17,505.	29,628.	379,037.	0.
(5) RICHARD H. GRUBER VICE-PRESIDENT	(i) 141,682.	11,263.	2,560.	3,604.	16,803.	175,912.	0.
(6) JENNIFER A. HALLETT VICE-PRESIDENT	(i) 170,009.	126,638.	4,086.	17,505.	24,110.	342,348.	0.
(7) KATHLEEN S. HARRIS VICE-PRESIDENT	(i) 120,351.	94,955.	5,462.	14,323.	16,643.	251,734.	0.
(8) THOMAS R. JENSEN VICE-PRESIDENT	(i) 117,743.	31,500.	553.	9,024.	12,723.	171,543.	0.
(9) DANIEL A. PAROD VICE-PRESIDENT (PART YEAR)	(i) 0.	0.	0.	0.	0.	0.	0.
(10) DEBRA A. POTEMPA VICE-PRESIDENT	(i) 200,352.	76,500.	4,821.	17,505.	15,619.	314,797.	0.
(11) SUE A. RIPSCH VICE-PRESIDENT	(i) 278,102.	200,004.	11,078.	17,505.	17,334.	524,023.	0.
(12) RUTH M. YARBROUGH VICE-PRESIDENT	(i) 207,742.	157,035.	6,785.	17,505.	0.	0.	0.
(13) PAUL T. VAN DEN HEUVEL VICE-PRESIDENT	(i) 269,836.	197,968.	10,055.	17,505.	23,647.	519,011.	0.
(14) JOHN W. COOK VICE-PRESIDENT/CFO	(i) 532,512.	284,286.	9,828.	17,505.	22,427.	866,558.	0.
(15) JAVON R. BEA PRESIDENT & DIRECTOR	(i) 1,222,481.	862,623.	6,743,759.	17,505.	21,517.	8,867,885.	0.
(16) JOHN BUSSA, M.D. PHYSICIAN	(i) 461,939.	212,024.	1,334,155.	18,000.	16,288.	2,042,406.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
	(iii) 0.	0.	0.	0.	0.	0.	0.



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

PART I, LINE 1A:

RESIDENCE FOR PERSONAL USE - THE CEO IS PROVIDED WITH A RESIDENCE. THE COST OF RENTING THE RESIDENCE IS TREATED AS TAXABLE COMPENSATION.

PAYMENTS FOR BUSINESS USE OF PERSONAL RESIDENCE - THE CEO IS REIMBURSED FOR INTERNET ACCESS AND COMMUNICATION COSTS USED FOR BUSINESS PURPOSES AT HIS PERSONAL RESIDENCE. THE REIMBURSEMENT IS TREATED AS TAXABLE COMPENSATION.

HEALTH CLUB DUES - THE CEO IS REIMBURSED FOR HEALTH CLUB DUES. THIS IS TREATED AS TAXABLE COMPENSATION.

PERSONAL SERVICES - THE CEO IS REIMBURSED FOR INCOME TAX PREPARATION SERVICES. THIS IS TREATED AS TAXABLE COMPENSATION.

PART I, LINE 3:

THE MHCS COMPENSATION COMMITTEE IS COMPRISED OF THE BOARD CHAIRPERSON, SECRETARY, AND THE TREASURER. THE COMPENSATION COMMITTEE IS ASSISTED BY INDEPENDENT LEGAL COUNSEL AND AN INDEPENDENT COMPENSATION CONSULTANT. THE COMPENSATION COMMITTEE, LEGAL COUNSEL, AND THE COMPENSATION CONSULTANT MEET

**Part III** Supplemental Information

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

**THROUGHOUT THE YEAR AND REPORT DIRECTLY TO THE BOARD OF DIRECTORS ANNUALLY.**  
**THIS PROCESS WAS COMPLETED FOR 2016.**

**PART I, LINE 4B:****457 (F) PLAN DISTRIBUTIONS:**MARK L. GOELZER, M.D. - \$1,036,620JOHN BUSSA, M.D. - \$1,334,155MANISH GHARIA, M.D. - \$1,277,038DAVID LUELLWITZ, M.D. - \$1,224,948CHRISTOPHER STURM, M.D. - \$300,143KENNETH WOLNAK, M.D. - \$921,653**INCENTIVE PLAN DISTRIBUTION:**JAVON R. BEA - \$5,837,389**PART II, LINE 16:**JAVON R. BEA - DEFERRED COMPENSATION PAYMENT

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

MR. BEA HAS BEEN EMPLOYED BY MHSC AS PRESIDENT AND CEO OVER THE PAST 29

YEARS. DURING THIS TIME, MR. BEA HAS LED AN INCREDIBLE TRANSFORMATION

TAKING A SMALL, SINGLE, STAND-ALONE COMMUNITY HOSPITAL AND CREATING A

VERTICALLY INTEGRATED HEALTH SYSTEM WITH 80 FACILITIES IN 39

COMMUNITIES THROUGHOUT SOUTHERN WISCONSIN AND NORTHERN ILLINOIS,

INCREASING GROSS REVENUE FROM \$33 MILLION TO OVER \$2.6 BILLION. THIS

HAS ALLOWED THE HEALTH SYSTEM TO GO FROM SERVING 89,000 PATIENTS IN

1989 TO OVER 2.2 MILLION PATIENTS TODAY WORKING TOGETHER WITH OVER

8,000 PARTNERS IN HEALTH CARE. TODAY, MHSC HAS BECOME THE LARGEST

EMPLOYER IN SOUTHERN WISCONSIN AND NORTHERN ILLINOIS.

THIS GROWTH CAN BE ATTRIBUTED TO MR. BEA'S VISIONARY LEADERSHIP.

LEADERSHIP THAT HAS LED TO MHSC RECEIVING NUMEROUS NATIONAL RECOGNIZED

AWARDS INCLUDING BEING NAMED THE FIRST FULLY INTEGRATED HEALTH SYSTEM

TO RECEIVE THE MALCOLM BALDRIGE NATIONAL QUALITY AWARD, THE MAGNET

RECOGNITION AWARD, BEING RANKED #1 AND #2 ON AARP'S TOP 100 BEST PLACES

TO WORK FOR WORKERS OVER 50, AND BEING RANKED IN THE TOP 25 ON THE TOP

100 INTEGRATED HEALTHCARE NETWORKS LIST BY MODERN HEALTHCARE FOR OVER

10 STRAIGHT YEARS.

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

THE TURNAROUND OF THE MHSC IMPLEMENTED BY MR. BEA IS UNPARALLELED. BY

PIONEERING A "PARTNERSHIP MODEL" OF COMPENSATION AND DESIGNING A CUSTOM

CULTURE OF EXCELLENCE, MR. BEA IS VITAL TO THE DECADES-LONG AND

CONTINUING GROWTH AT MHSC. THIS SUCCESS HAS MADE MR. BEA A HIGHLY

SOUGHT AFTER SPEAKER AND CONSULTANT AS HE IS NOW WELL-REOWNED FOR HIS

INNOVATIONS IN THE AREAS OF INTEGRATED HEALTHCARE AND PHYSICIAN

PARTNERSHIP MODELS.

THE TREMENDOUS SUCCESS OF MHSC UNDER THE LEADERSHIP OF MR. BEA HAS

ALLOWED HIM TO RECEIVE PAYOUTS FROM A DEFERRED COMPENSATION PACKAGE

WHICH MHSC HAS BEEN PAYING INTO OVER MANY YEARS. THESE PAYMENTS ONLY

BECAME PAYABLE IF MHSC ATTAINED CERTAIN DEFINED FINANCIAL AND STRATEGIC

GOALS AND THE AMOUNTS ARE AT RISK EVERY SINGLE YEAR. AS INDICATED

ABOVE, MANY OF THESE GOALS WERE ACHIEVED WITHIN THE PAST TWO YEARS

RESULTING IN A RELEASE OF THESE DEFERRED PAYMENTS WHICH IMPACTED MR.

BEA'S COMPENSATION REPORTING.

THE SETTING OF THESE GOALS WERE LAID OUT BY THE BOARD OF DIRECTORS IN

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.

COOPERATION WITH NATIONALLY RECOGNIZED COMPENSATION ATTORNEYS AND

CONSULTANTS TO MAKE SURE ALL FACTORS WERE TAKEN INTO CONSIDERATION. MR.

BEA'S COMPENSATION HAS ALSO BEEN SCRUTINIZED BY NUMEROUS OUTSIDE  
ORGANIZATIONS AND MOST IMPORTANTLY, THE INTERNAL REVENUE SERVICE; AND  
HAS PASSED INSPECTION IN EACH CASE. TOTAL COMPENSATION IS APPROVED  
ANNUALLY BY THE BOARD OF DIRECTORS OF MHSC.

PART II, LINES 17 THROUGH 21:

BASED ON A CHANGE IN POLICY ASSOCIATED WITH THE ORGANIZATION'S 457 (F)  
DEFERRED COMPENSATION PLAN, LONG-TERM PHYSICIANS RECEIVED DISBURSEMENTS  
OF MULTI-YEAR DEFERRALS DURING THIS YEAR.

**Part VI Supplemental Information**

Provide the following information

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

**PART I, LINE 3C:**

MERCY HEALTH SYSTEM CORPORATION (MHSC) OFFER A 20% SELF-PAY DISCOUNT TO ALL UNINSURED PATIENTS ON ALL MEDICALLY NECESSARY SERVICES. ELIGIBILITY FOR FINANCIAL ASSISTANCE IS BASED ON THE FOLLOWING: INDIVIDUAL OR HOUSEHOLD INCOME, INDIVIDUAL OR HOUSEHOLD ASSETS, HOUSEHOLD SIZE, AND OTHER SOURCES OF PAYMENT FOR SERVICES. THE AMOUNT OF ASSISTANCE IS BASED ON THE PATIENT'S ABILITY TO PAY AND THE SIZE OF THEIR OUTSTANDING BALANCE.  
IF PATIENT INCOME AND HOUSEHOLD ASSETS ARE LESS THAN 200% OF THE FEDERAL POVERTY GUIDELINES, THEN MHSC WILL COVER 100% OF THEIR OUTSTANDING BALANCE. IF THE PATIENT'S INCOME AND HOUSEHOLD ASSETS FALL BETWEEN 200% AND 300% OF THE FEDERAL POVERTY GUIDELINES, THEN A PATIENT'S REMAINING BALANCE CAN BE REDUCED AS MUCH AS 90% AND PAYMENT ARRANGEMENTS CAN BE EXTENDED FOR AS LONG AS TWENTY-FOUR (24) MONTHS OR LONGER IF THERE ARE EXTENUATING CIRCUMSTANCES. THIS FORMULA ALLOWS FOR PATIENTS WITH A MODERATE INCOME, BUT DIAGNOSED WITH CATASTROPHIC ILLNESSES, TO QUALIFY FOR ASSISTANCE.

**PART I, LINE 6A:**

632100 11-02-16

Schedule H (Form 990) 2016

**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
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MHSC SUBMITS AN ANNUAL COMMUNITY BENEFIT STATEMENT TO THE WISCONSIN HOSPITAL ASSOCIATION. PERIODICALLY, IT PUBLISHES A PAMPHLET EXPLAINING THE COMMUNITY BENEFITS THAT MHSC, AND THE RELATED ORGANIZATIONS PROVIDE TO THE COMMUNITIES THEY SERVE. MHSC HAS SUPPLIED SUPPLEMENTAL COMMUNITY BENEFIT STATEMENT INFORMATION WITH ITS TAX RETURN SINCE FISCAL YEAR 2006 (TAX FORM 2005).

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PART I, LINE 7:

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

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**Part VI Supplemental Information**

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**PART I, LINE 7G:**

THE SUBSIDIZED HEALTH CARE LINE INCLUDES \$2,747,309 OF EXPENSES (COLUMN C)  
AND \$1,719,402 OF NET EXPENSES (COLUMN E) ATTRIBUTABLE TO THE COSTS OF  
TRAUMA SURGEONS. THESE SURGEONS STAFF THE LEVEL II TRAUMA PROGRAM OF MHSC  
24/7. MERCYHEALTH SOUTH - FAMILY PRACTICE CLINIC WAS ALSO INCLUDED IN THIS  
LINE: EXPENSES IN COLUMN C TOTLED \$4,577,727 AND COLUMN E HAD \$276,816 OF  
NET EXPENSES.

**PART I, LN 7 COL(F):**

BAD DEBT EXPENSE OF \$22,770,203 INCLUDED ON FORM 990, PART IX, LINE 25,  
WAS EXCLUDED FROM EXPENSES WHEN CALCULATING THE PERCENTAGE IN THIS COLUMN.

**PART III, LINE 2:**

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

**PART III, LINE 3:**

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Schedule H (Form 990) 2016

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THE ESTIMATE OF BAD DEBT DOLLARS THAT MAY HAVE BEEN COVERED THROUGH MHSC FINANCIAL ASSISTANCE/CHARITY CARE POLICY (HAD THE PROPER PAPER WORK BEEN COMPLETED BY THE INDIVIDUAL NEEDING ASSISTANCE) IS ESTIMATED AT 16.31%.

THIS FIGURE WAS BASED ON THE PERCENT OF BAD DEBT ACCOUNT DOLLARS THAT ARE RECLASSIFIED FOR CHARITY AND/OR BANKRUPTCY PURPOSES.

PART III, LINE 4:

BAD DEBT EXPENSE IS ACCOUNTED FOR IN THE FOLLOWING MANNER (AS DETAILED IN NOTE 1 OF THE AUDITED FINANCIAL STATEMENTS OF MERCY HEALTH CORPORATION).

PATIENT ACCOUNTS RECEIVABLE ARE RECORDED NET OF CONTRACTUAL ADJUSTMENTS AND DISCOUNTS AND AN ALLOWANCE FOR DOUBTFUL ACCOUNTS WHICH REFLECTS MANAGEMENT'S BEST ESTIMATE OF THE AMOUNTS THAT WILL NOT BE COLLECTED. IN EVALUATING THE COLLECTABILITY OF PATIENT ACCOUNTS RECEIVABLE, THE CORPORATION ANALYZES HISTORICAL LOSS EXPERIENCE ON REVENUE FOR ALL PAYORS. USING THE LOSS EXPERIENCE RATE, THE CORPORATION ESTIMATES THE APPROPRIATE ALLOWANCE FOR DOUBTFUL ACCOUNTS AND PROVISION FOR BAD DEBTS. THE DIFFERENCE BETWEEN THE STANDARD RATES (OR THE DISCOUNTED RATES IF

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Schedule H (Form 990) 2016

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NEGOTIATED) AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE  
COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS CHARGED AGAINST THE ALLOWANCE  
FOR DOUBTFUL ACCOUNTS.

---

PART III, LINE 8:

DATA FOR LINES 5 & 6 OF PART III AND THE MEDICARE SHORTFALL IS BASED ON  
MHSC'S TWO HOSPITALS' MEDICARE COST REPORTS. (MERCYHEALTH HOSPITAL AND  
TRAUMA CENTER - JANESVILLE, AND MERCYHEALTH HOSPITAL AND MEDICAL CENTER -  
WALWORTH).

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PART III, LINE 9B:

PATIENTS WHO ARE SELF-PAY, REGARDLESS OF WHETHER THEY QUALIFY FOR MHSC'S  
COMMUNITY CARE PROGRAM, WILL RECEIVE A 20% DISCOUNT FROM MHSC'S STANDARD  
FEESCHEDULE. ALL SELF-PAY PATIENTS MEET WITH PATIENT FINANCIAL COUNSELORS  
AND DISCUSS PAYMENT OPTIONS INCLUDING MHSC'S COMMUNITY CARE PROGRAM.

PATIENTS MUST APPLY FOR COMMUNITY CARE AND SUPPLY MHSC WITH THE NECESSARY  
FINANCIAL AND OTHER INFORMATION REQUIRED. PATIENTS WHO QUALIFY FOR  
COMMUNITY CARE BENEFITS WILL RECEIVE A REDUCTION IN THE BALANCE OWED,

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EXTENDED PAYMENT TERMS, OR BOTH. THE AMOUNT OF THE COMMUNITY CARE BENEFIT WILL BE BASED ON THE PATIENT'S ABILITY TO PAY AND THE SIZE OF THE OUTSTANDING BALANCE.

PART VI, LINE 2:

MHSC, ALONG WITH ITS SISTER ORGANIZATION, MERCY HARVARD HOSPITAL INC (MHH), WORK IN CONJUNCTION WITH THE PUBLIC HEALTH DEPARTMENTS OF ROCK (WI), WALWORTH (WI) AND MCHENRY (IL) COUNTIES TO COMPLETE. MHSC HAS DEDICATED STAFF THAT WORKS WITH VARIOUS AGENCIES/PROGRAMS TO ASSESS HEALTH NEEDS IN THE COMMUNITIES THAT MHSC AND MHH SERVE. COLLABORATIVE EXAMPLES OF MHSC AND MHH'S RELATED ENTITIES INCLUDE:

I) THE COMMUNITY HEALTH CENTER AT MERCYHEALTH SOUTH: PARTNERSHIP WITH THE COMMUNITY HEALTH CENTER, INC. OF BELOIT, WI IN 2006. MHSC PARTNERED WITH COMMUNITY HEALTH CENTER, INC. TO OPEN THIS CLINIC IN JANESVILLE. IT PROVIDES FREE AND LOW-COST CARE TO LOW-INCOME, UNINSURED AND UNDERINSURED PATIENTS. THIS FIRST-OF-ITS-KIND PARTNERSHIP IS THE RESULT OF YEARS OF WORK WITH LOCAL PARTNERS AND THE FEDERAL GOVERNMENT TO DESIGN AND DEBUT A

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Schedule H (Form 990) 2016

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NEW MODEL OF CARE FOR THE UNDERSERVED. THE CLINIC SEES OVER 200 NEW PATIENTS EACH MONTH, HAS SIGNIFICANTLY IMPROVED PATIENT OUTCOMES, AND HAS SAVED MILLIONS IN UNNECESSARY EMERGENCY DEPARTMENT COSTS.

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II) HEALTHNET FREE CLINIC IN JANESVILLE: MHSC PHYSICIANS VOLUNTEER THEIR SERVICES. MHSC ALSO DONATES LAB, RADIOLOGY AND OTHER ANCILLARY SERVICES TO PATIENTS.

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III) FAMILY HEALTH PARTNERSHIP CLINIC AND WELL CHILD CLINIC IN WOODSTOCK, IL AND HARVARD FREE CLINIC IN MCHENRY COUNTY, IL: MHSC PHYSICIANS VOLUNTEER THEIR SERVICES.

---

IV) FAMILY HEALTH PARTNERSHIP CLINIC: MCHENRY COUNTY DEPARTMENT OF HEALTH COLLABORATION TO PROVIDE MAMMOGRAMS AT MHSC FACILITIES FOR WOMEN WHO CANNOT OTHERWISE AFFORD THE SERVICE.

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V) ROCK COUNTY HEALTH DEPARTMENT: BIOTERRORISM READINESS PROJECT.

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**VI) RED CROSS: BLOOD DRIVE AND COOPERATIVE VOLUNTEER EFFORTS.**

**VII) UNITED WAY: FUND RAISING CAMPAIGN AND ROCK COUNTY NEEDS ASSESSMENT**

**SURVEY CONTRIBUTOR.**

**VIII) AREA POLICE AND FIRE DEPARTMENTS: PROVIDE PORTABLE DEFIBRILLATORS**

**FOR POLICE VEHICLES AND FREE OR REDUCED-COST PARAMEDIC/EMT EDUCATIONAL**

**OPPORTUNITIES.**

**IX) COMMUNITY ACTION, INC.: MHSC LEADERSHIP SERVES ON STRATEGIC PLANNING**

**COMMITTEE AND COMMUNITY ACTION DEVELOPMENT BOARD.**

**PART VI, LINE 3:**

**ALL UNINSURED PATIENTS ARE NOTIFIED OF MHSC'S FINANCIAL AID POLICY UPON**

**REGISTRATION. INFORMATION IS ALSO AVAILABLE AT THE HEALTH SYSTEM'S**

**WEBSITE, IN OUR EMERGENCY ROOMS, MEDICAL LABS, ADMITTING DEPARTMENTS,**

**OUTPATIENT RADIOLOGY, REGISTRATION DESKS, FINANCIAL SERVICES OFFICES, AND**

**WITH THE PATIENT FINANCIAL COUNSELORS. APPROPRIATE PERSONNEL HAVE BEEN**

**TRAINED ON HOW TO INTERACT WITH PATIENTS ABOUT FINANCIAL AID AVAILABILITY,**

632100 11-02-16

Schedule H (Form 990) 2016

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AND HOW TO DIRECT PATIENTS TO APPROPRIATE FINANCIAL AID STAFF. THE HOSPITALS HAVE TRANSLATION SERVICES AVAILABLE AS NEEDED.

PART VI, LINE 4:

MERCYHEALTH HOSPITAL AND TRAUMA CENTER IS LOCATED IN JANESVILLE, WI: ROCK COUNTY. IT IS ONE OF TWO ACUTE CARE HOSPITALS IN JANESVILLE, WI. IT IS LICENSED FOR 240 ACUTE BEDS. IT HAS 24/7 EMERGENCY SERVICES, WITH A TRAUMA II DESIGNATION. IT IS A TEACHING HOSPITAL WITH A RESIDENCY PROGRAM.

UNEMPLOYMENT IN ROCK COUNTY (2015) WAS AT 8.5% WHILE THE STATE (WI) AND THE NATION WERE AT 6.3% AND 8.3%, RESPECTIVELY. MEDIAN HOUSEHOLD INCOME (2015) WAS \$50,324 IN ROCK COUNTY, WHICH IS LOWER THAN BOTH THE STATE'S \$53,357 AND NATIONAL MEDIAN OF \$53,889. IN 2015, 15% OF ROCK COUNTY RESIDENTS LIVED BELOW THE POVERTY LEVEL; THIS IS LARGER THAN THE STATE'S AVERAGE OF 13%, BUT LESS THAN THE NATIONAL AVERAGE OF 15.5%.

MERCYHEALTH HOSPITAL AND MEDICAL CENTER - WALWORTH IS LOCATED IN LAKE GENEVA, WI: WALWORTH COUNTY. IT IS A CRITICAL ACCESS HOSPITAL LICENSED FOR

632100 11-02-16

Schedule H (Form 990) 2016

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25 ACUTE BEDS THAT PROVIDES 24/7 EMERGENCY SERVICES.

---

UNEMPLOYMENT IN WALWORTH COUNTY (2014) WAS AT 8.0%; WHEREAS THE STATE'S (WI) RATE WAS BETTER AT 7.2%. THE PERCENTAGE OF ALL AGES IN POVERTY FOR THE COUNTRY (2014) WAS HIGHER THAN THE STATE'S (WI) AVERAGE, 13.7% VS 13.2%, RESPECTIVELY.

---

MHSC'S PAYOR DEMOGRAPHICS FOR ITS HOSPITALS INCLUDE 43.41% MEDICARE, AND 15.84% MEDICAID FOR THE FISCAL YEAR OF JULY 1, 2016 - JUNE 30, 2017 (AS DETERMINED BY CHARGES BILLED).

---

PART VI, LINE 5:

MHSC HAS AN OPEN MEDICAL STAFF WITH PRIVILEGES AVAILABLE TO ALL QUALIFIED PHYSICIANS IN THE AREA. MHSC HAS A GOVERNING BODY COMPRISED OF A MAJORITY OF INDEPENDENT PERSONS REPRESENTATIVE OF THE COMMUNITY.

---

PART VI, LINE 6:

MHSC HAS TWO HOSPITALS THAT PROVIDE ACUTE CARE SERVICES IN ROCK AND

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Schedule H (Form 990) 2016

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WALWORTH COUNTIES OF WISCONSIN. MHSC ALSO OPERATES COMMUNITY CLINICS

LOCATED THROUGHOUT SIX COUNTIES OF WISCONSIN AND ILLINOIS. IT IS PART OF A

LARGER INTEGRATED HEALTHCARE SYSTEM AND IS AFFILIATED WITH OTHER

SEPARATELY REPORTED ORGANIZATIONS.

MERCY HEALTH CORPORATION (MHC) IS THE PARENT COMPANY OF MHSC, MERCY ASSISTED CARE, INC., MERCY HARVARD HOSPITAL, INC., ROCKFORD MEMORIAL HOSPITAL, ROCKFORD HEALTH PHYSICIANS, AND MERCYHEALTH VISITING NURSES ASSOCIATION. MERCY HARVARD HOSPITAL, INC. PROVIDES ACUTE CARE SERVICES IN MCHENRY COUNTY ILLINOIS. MERCY ASSISTED CARE, INC. PROVIDES HOME HEALTH SERVICES AND DME (DURABLE MEDICAL EQUIPMENT) SERVICES; THUS PROVIDING CONTINUATION OF CARE TO MHC PATIENTS. ROCKFORD MEMORIAL HOSPITAL PROVIDES INPATIENT, OUTPATIENT, AND EMERGENCY CARE SERVICES TO RESIDENTS OF ROCKFORD, ILLINOIS AND THE SURROUNDING COMMUNITIES. THE ROCKFORD HEALTH PHYSICIANS PROVIDE PHYSICIAN AND AMBULATORY CARE SERVICES AT SEVERAL ILLINOIS SITES.

MHSC WORKS WITH THE MERCYHEALTH DEVELOPMENT FOUNDATION TO OPERATE A

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Schedule H (Form 990) 2016

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HOMELESS SHELTER IN JANESVILLE, WI: THE HOUSE OF MERCY HOMELESS CENTER  
PROVIDES SHELTER, SUPPORT, AND TRAINING TO WOMEN, CHILDREN, AND FAMILIES  
TO HELP FIGHT HOMELESSNESS. IT OPENED IN 1996, AND NOW SHELTERS AN AVERAGE  
OF 253 INDIVIDUALS PER YEAR, BASED ON THE PRIOR THREE YEARS.

---

MERCY HOSPITAL ASSOCIATION OF VOLUNTEERS, INC. IS THE ORGANIZATION/TAX  
ENTITY OF MHSC'S VOLUNTEERS. VOLUNTEERS NUMBERED 745 IN CALENDAR YEAR  
2016. THIS ORGANIZATION NOT ONLY SUPPORTS MHSC'S SERVICES, BUT PROVIDES  
BENEFITS TO THE COMMUNITY AS A WHOLE. IN CONJUNCTION WITH MHSC'S MEAL  
PREPARATION, THE VOLUNTEERS PARTICIPATE IN AND OVERSEE A MEALS ON WHEELS  
PROGRAM: PARTICIPANT/NUTRITION SPECIFIC MEALS ARE PREPARED AND DELIVERED  
TO THE ELDERLY NEEDING ASSISTANCE IN JANESVILLE. THE VOLUNTEER ASSOCIATION  
RUNS A HOSPITALITY HOUSE IN WHICH FAMILY MEMBERS OF PATIENTS ARE OFFERED  
FREE HOUSING DURING THEIR LOVED ONES EXTENDED HOSPITAL STAY AND  
REHABILITATION.

---

PART VI, LINE 7, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:

WI, IL

632100 11-02-16

Schedule H (Form 990) 2016

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**LINE 6**

MHSC FILES A COMMUNITY BENEFIT REPORT WITHIN WISCONSIN WITH THE  
WISCONSIN HOSPITAL ASSOCIATION.

**SCHEDULE D**  
(Form 990)

Department of the Treasury  
Internal Revenue Service

**Supplemental Financial Statements**

► 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.

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

OMB No. 1545-0047

**2016**  
Open to Public  
Inspection

Name of the organization

MERCY HEALTH SYSTEM CORPORATION

Employer identification number

3 9 - 0 8 1 6 8 4 8

**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?  Yes  No

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

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

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

Preservation of land for public use (e.g., recreation or education)  Preservation of a historically important land area  
 Protection of natural habitat  Preservation of a certified historic structure  
 Preservation of open space

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

	Held at the End of the Tax Year
2a	
2b	
2c	
2d	

a Total number of conservation easements  
b Total acreage restricted by conservation easements  
c Number of conservation easements on a certified historic structure included in (a)  
d Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ► \_\_\_\_\_

4 Number of states where property subject to conservation easement is located ► \_\_\_\_\_

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?  Yes  No

6 Staff and volunteer hours devoted to monitoring, inspecting, 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)?  Yes  No

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

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

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

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 ► \$ \_\_\_\_\_

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632051 08-29-16

**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 211a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?  Yes  No

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

	Amount
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 on 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					
b Contributions					
c Net investment earnings, gains, and losses					
d Grants or scholarships					
e Other expenditures for facilities and programs					
f Administrative expenses					
g End of year balance					

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

a Board designated or quasi-endowment ► \_\_\_\_\_ %

b Permanent endowment ► \_\_\_\_\_ %

c Temporarily restricted endowment ► \_\_\_\_\_ %

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

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

(i) unrelated organizations

(ii) related organizations

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

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

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

**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		27,052,591.		27,052,591.
b Buildings		313,820,740.	141,297,032.	172,523,708.
c Leasehold improvements		4,960,713.	4,056,314.	904,399.
d Equipment		225,142,811.	170,794,431.	54,348,380.
e Other		10,495,452.	5,683,361.	4,812,091.

Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10c.) ► 259,641,169.

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**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	1,315,393.	COST
(3) Other		
(A) ASSETS UNDER BOND		
(B) INDENTURE AGREEMENT	4,336,615.	END-OF-YEAR MARKET VALUE
(C) DEFERRED COMPENSATION	41,025,020.	END-OF-YEAR MARKET VALUE
(D) INVESTMENTS - ZURICH	3,588,790.	END-OF-YEAR MARKET VALUE
(E)		
(F)		
(G)		
(H)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 12.) ►	50,265,818.	

**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. (Col. (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

(a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) DEFERRED COMPENSATION	41,025,020.
(3) PENSION LIABILITY	15,015,917.
(4) CAPITAL LEASES PAYABLE	77,472.
(5) DUE TO MERCY HEALTH CORPORATION	191,501,911.
(6) DUE TO THIRD PARTIES	4,262,698.
(7) ACCRUED LIABILITY UNDER	
(8) SELF-INSURANCE PROGRAM	15,976,184.
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ►	267,859,202.

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

1 Total revenue, gains, and other support per audited financial statements

1

2 Amounts included on line 1 but not on Form 990, Part VIII, line 12

2a
2b
2c
2d

2e

3 Subtract line 2e from line 1

3

4 Amounts included on Form 990, Part VIII, line 12, but not on line 1

4a
4b

4c

5 Total revenue Add lines 3 and 4c. (This must equal Form 990, Part I, line 12.)

5

**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

1 Total expenses and losses per audited financial statements

1

2 Amounts included on line 1 but not on Form 990, Part IX, line 25

2a
2b
2c
2d

2e

3 Subtract line 2e from line 1

3

4 Amounts included on Form 990, Part IX, line 25, but not on line 1

4a
4b

4c

5 Total expenses Add lines 3 and 4c. (This must equal Form 990, Part I, line 18.)

5

**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