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Form 990

Return of Organization Exempt From Income Tax

OMB No 1545-0047

2016

Open to Public Inspection

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

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

Information about Form 990 and its instructions is at [www.irs.gov/form990](#)

Department of the Treasury
Internal Revenue Service

A For the 2016 calendar year, or tax year beginning 07-01-2016 , and ending 06-30-2017

B Check if applicable

☐ Address change

☐ Name change

☐ Initial return

☐ Final

☐ Return/terminated

☐ Amended return

☐ Application pending

C Name of organization

GENESIS HEALTH SYSTEM

Doing business as

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

1227 E RUSHOLME

City or town, state or province, country, and ZIP or foreign postal code

DAVENPORT, IA 528032498

F Name and address of principal officer

MARK G ROGERS

1227 E RUSHOLME

DAVENPORT, IA 528032498

H(a) Is this a group return for subordinates?

☐ Yes ☒ No

H(b) Are all subordinates included?

☐ Yes ☐ No

If "No," attach a list (see instructions)

H(c) Group exemption number ▶

D Employer identification number

42-1418847

E Telephone number

(563) 421-6508

G Gross receipts \$ 798,540,711

I Tax-exempt status

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

J Website: ▶ WWW.GENESISHEALTH.COM

K Form of organization

☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation 1994

M State of legal domicile IA

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities

GENESIS HEALTH SYSTEM (GHS IOWA) EXISTS TO PROVIDE COMPASSIONATE, QUALITY HEALTH SERVICES TO ALL THOSE IN NEED

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

3 Number of voting members of the governing body (Part VI, line 1a)

4 Number of independent voting members of the governing body (Part VI, line 1b)

5 Total number of individuals employed in calendar year 2016 (Part V, line 2a)

6 Total number of volunteers (estimate if necessary)

7a Total unrelated business revenue from Part VIII, column (C), line 12

7b Net unrelated business taxable income from Form 990-T, line 34

Revenue

8 Contributions and grants (Part VIII, line 1h)

9 Program service revenue (Part VIII, line 2g)

10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)

11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)

12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)

Expenses

13 Grants and similar amounts paid (Part IX, column (A), lines 1–3)

14 Benefits paid to or for members (Part IX, column (A), line 4)

15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)

16a Professional fundraising fees (Part IX, column (A), line 11e)

b Total fundraising expenses (Part IX, column (D), line 25) ▶0

17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)

18 Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)

19 Revenue less expenses Subtract line 18 from line 12

Net Assets or Fund Balances

20 Total assets (Part X, line 16)

21 Total liabilities (Part X, line 26)

22 Net assets or fund balances Subtract line 21 from line 20

Prior Year

Current Year

Beginning of Current Year

End of Year

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

2018-02-16

Date

MARK G ROGERS V P FINANCE/CFO GHS & ASST TREAS

Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name

JOHN J ROMANO

Preparer's signature

JOHN J ROMANO

Date

Check ☐ if self-employed

PTIN P00227323

Firm's name ▶ RSM US LLP

Firm's EIN ▶ 42-0714325

Firm's address ▶ 201 N HARRISON STREET SUITE 300

DAVENPORT, IA 528011999

Phone no (563) 888-4000

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

☒ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate instructions.

Cat No 11282Y

Form 990 (2016)

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

GENESIS HEALTH SYSTEM (GHS IOWA) EXISTS TO PROVIDE COMPASSIONATE, QUALITY HEALTH SERVICES TO ALL THOSE IN NEED

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 \$ 341,756,779	including grants of \$ 2,635,106	(Revenue \$ 376,478,555)
See Additional Data				

4b	(Code)	(Expenses \$ 106,474,321	including grants of \$)	(Revenue \$ 90,097,749)
See Additional Data				

4c	(Code)	(Expenses \$ 32,618,474	including grants of \$)	(Revenue \$ 33,239,782)
See Additional Data				

(Code)	(Expenses \$ 3,170,758	including grants of \$)	(Revenue \$ 2,725,000)
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GENESIS ACCOUNTABLE CARE ORGANIZATION (ACO) IS A SINGLE MEMBER IOWA LIMITED LIABILITY COMPANY FORMED IN DECEMBER 2011. ITS PURPOSE IS TO ENGAGE IN ANY LAWFUL BUSINESS RELATED TO THE CREATION AND ORGANIZATION OF A "PHYSICIAN-DRIVEN" NETWORK TO ACT AS, AND/OR PARTICIPATE IN, AN ACCOUNTABLE CARE ORGANIZATION WITHIN THE MEANING OF THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT. THE COMPANY IS ALSO ORGANIZED TO DEVELOP A CLINICALLY INTEGRATED NETWORK OF PROVIDERS INCLUDING PHYSICIANS, HEALTH PROFESSIONALS, HOSPITALS AND ANCILLARY PROVIDERS WORKING TOGETHER TO PROMOTE HIGH QUALITY, COORDINATED AND EFFICIENT CARE TO PATIENTS INCLUDING MEMBERS OF VARIOUS MANAGED CARE PAYERS AND THE COMMUNITY AT LARGE. GENESIS HEALTH SYSTEM (GHS IOWA) IS THE SOLE MEMBER OF GENESIS ACCOUNTABLE CARE ORGANIZATION, LLC. FOR INCOME TAX AND INFORMATIONAL RETURN PURPOSES, GENESIS ACCOUNTABLE CARE ORGANIZATION, LLC IS A DISREGARDED ENTITY AND IS INCLUDED WITHIN THE GHS IOWA'S INCOME TAX AND INFORMATIONAL RETURNS.

4d	Other program services (Describe in Schedule O)			
(Expenses \$ 3,170,758	including grants of \$)	(Revenue \$ 2,725,000)		

4e	Total program service expenses	484,020,332		
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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)? If "Yes," complete Schedule A	1 Yes	
2 Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?	2 Yes	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I	3	No
4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II	4 Yes	
5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? If "Yes," complete Schedule C, Part III	5	No
6 Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes," complete Schedule D, Part I	6	No
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II	7	No
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III	8	No
9 Did the organization report an amount in Part X, line 21 for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? If "Yes," complete Schedule D, Part IV	9	No
10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? If "Yes," complete Schedule D, Part V	10 Yes	
11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable		
a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI	11a Yes	
b Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII	11b Yes	
c Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII	11c	No
d Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part IX	11d	No
e Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	11e Yes	
f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part X	11f Yes	
12a Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII	12a	No
b Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional	12b Yes	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	13	No
14a Did the organization maintain an office, employees, or agents outside of the United States?	14a	No
b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV	14b Yes	
15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? If "Yes," complete Schedule F, Parts II and IV	15	No
16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? If "Yes," complete Schedule F, Parts III and IV	16	No
17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I (see instructions)	17	No
18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II	18	No
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III	19	No

Part IV Checklist of Required Schedules (continued)

	Yes	No	
20a Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H	20a	Yes	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	Yes	
21 Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? If "Yes," complete Schedule I, Parts I and II	21	Yes	
22 Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? If "Yes," complete Schedule I, Parts I and III	22	Yes	
23 Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? If "Yes," complete Schedule J	23	Yes	
24a Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a	24a	Yes	
b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		No
c Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		No
d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		No
25a Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? If "Yes," complete Schedule L, Part I	25a		No
b Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? If "Yes," complete Schedule L, Part I	25b		No
26 Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? If "Yes," complete Schedule L, Part II	26		No
27 Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? If "Yes," complete Schedule L, Part III	27		No
28 Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions) a A current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV 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	28a		No
28b A family member of a current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV	28b	Yes	
28c An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? If "Yes," complete Schedule L, Part IV	28c	Yes	
29 Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M	29	Yes	
30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? If "Yes," complete Schedule M	30		No
31 Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, Part I	31		No
32 Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? If "Yes," complete Schedule N, Part II	32		No
33 Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? If "Yes," complete Schedule R, Part I	33	Yes	
34 Was the organization related to any tax-exempt or taxable entity? If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1	34	Yes	
35a Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	Yes	
b If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? If "Yes," complete Schedule R, Part V, line 2	35b	Yes	
36 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? If "Yes," complete Schedule R, Part V, line 2	36		No
37 Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? If "Yes," complete Schedule R, Part VI	37		No
38 Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? Note. All Form 990 filers are required to complete Schedule O	38	Yes	

Part V Statements Regarding Other IRS Filings and Tax ComplianceCheck 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.	380	
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable.	0	
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	Yes	
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.	4,699	
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions).	Yes	
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?	Yes	
b	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O.	Yes	
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)?	Yes	
b	If "Yes," enter the name of the foreign country: CJ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).		
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?		
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?		No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		
7	Organizations that may receive deductible contributions under section 170(c).		
a	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?		No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		No
d	If "Yes," indicate the number of Forms 8282 filed during the year.		
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		
8	Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?		
9a	Did the sponsoring organization make any taxable distributions under section 4966?		
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?		
10	Section 501(c)(7) organizations. Enter		
a	Initiation fees and capital contributions included on Part VIII, line 12.		
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities.		
11	Section 501(c)(12) organizations. Enter		
a	Gross income from members or shareholders.		
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them).		
12a	Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year.		
13	Section 501(c)(29) qualified nonprofit health insurance issuers.		
a	Is the organization licensed to issue qualified health plans in more than one state? Note. See the instructions for additional information the organization must report on Schedule O.		
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.		
c	Enter the amount of reserves on hand.		
14a	Did the organization receive any payments for indoor tanning services during the tax year?		No
b	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O.		

Part VI Governance, Management, and Disclosure For each "Yes" response to lines 2 through 7b below, and for a "No" response to lines 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.

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

Section A. Governing Body and Management

		Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	19	
If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O			
b	Enter the number of voting members included in line 1a, above, who are independent	8	
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2	No
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?	3	No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4	No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5	No
6	Did the organization have members or stockholders?	6	No
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a	No
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b	No
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:		
a	The governing body?	8a	Yes
b	Each committee with authority to act on behalf of the governing body?	8b	Yes
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O	9	No

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

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

Section C. Disclosure

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

18 Section 6104 requires an organization to make its Form 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
☐ Own website ☐ Another's website ☒ Upon request ☐ Other (explain in Schedule O)

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

20 State the name, address, and telephone number of the person who possesses the organization's books and records.
 ▶ MARK G ROGERS 1227 E RUSHOLME DAVENPORT, IA 528032498 (563) 421-6508

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

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

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

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

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

[illegible]

[illegible]

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization ► 305

Section B. Independent Contractors

(A) Name and business address	(B) Description of services	(C) Compensation
FINDORFF ESTES LLC 300 S BEDFORD MADISON, WI 53703	CONSTRUCTION SERVICES	50,637,633
RENOVO SOLUTIONS LLC 1801 E PARKCOURT PLACE BLDG D STE SANTA ANA, CA 92701	ASSET MANAGEMENT SERVICES	2,419,767
EMERGENCY CARE AND HEALTH 15443 SUMMIT AVENUE SUITE 302 OAKBROOK TERRACE, IL 60181	ED PROFESSIONAL SERVICES	1,397,539
O'GRADY-PEYTON INTERNATIONAL (USA) INC 12400 HIGH BLUFF DRIVE SAN DIEGO, CA 92130	MEDICAL PROFESSIONAL SERVICES	1,134,684
WOUND MANAGEMENT CONSULTANTS PC 1351 W CENTRAL PARK SUITE 1225 DAVENPORT, IA 52804	MEDICAL PROFESSIONAL SERVICES	1,117,559

<p>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 ► 61</p>	
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Part VIII Statement of RevenueCheck if Schedule O contains a response or note to any line in this Part VIII ☐

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns . . .	1a				
	b Membership dues . . .	1b				
	c Fundraising events . . .	1c				
	d Related organizations	1d	1,441,202			
	e Government grants (contributions)	1e	696,462			
	f All other contributions, gifts, grants, and similar amounts not included above	1f	704,501			
	g Noncash contributions included in lines 1a-1f \$ _____		119,943			
	h Total. Add lines 1a-1f		2,842,165			
Program Service Revenue		Business Code				
	2a OUTPATIENT REVENUE	621400	570,580,741	570,580,741		
	b INPATIENT REVENUE	900099	545,092,405	545,092,405		
	c CLINIC/NURSING REVENUE	621400	221,572,389	221,572,389		
	d HOME HEALTH/PROFESSIONAL SERVICES	621400	18,583,326	17,145,300	1,438,026	
	e RESIDENT/LONG TERM CARE	624100	5,509,439	5,509,439		
	f All other program service revenue		-857,763,400	-857,763,400		
	g Total. Add lines 2a-2f		503,574,900			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)			9,648,856		9,648,856
	4 Income from investment of tax-exempt bond proceeds					
	5 Royalties					
	6a Gross rents	(i) Real	(ii) Personal			
	b Less rental expenses					
	c Rental income or (loss)					
	d Net rental income or (loss)					
	7a Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other			
	b Less cost or other basis and sales expenses		281,447,938			
	c Gain or (loss)		270,240,632			
	d Net gain or (loss)		11,207,306			
	8a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18	a				
	b Less direct expenses	b				
	c Net income or (loss) from fundraising events					
	9a Gross income from gaming activities See Part IV, line 19	a				
	b Less direct expenses	b				
	c Net income or (loss) from gaming activities					
	10a Gross sales of inventory, less returns and allowances	a				
	b Less cost of goods sold	b				
	c Net income or (loss) from sales of inventory					
Miscellaneous Revenue		Business Code				
11a VENDOR REBATES		900099	183,938	183,938		
b NUTRITIONAL SERVICES		900099	147,066	147,066		
c AMBULANCE		900099	51,633	51,633		
d All other revenue			21,575	21,575		
e Total. Add lines 11a-11d			404,212			
12 Total revenue. See Instructions			527,970,226	502,541,086	1,438,026	21,148,949

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.	2,557,341	2,557,341		
2 Grants and other assistance to domestic individuals. See Part IV, line 22.	77,765	77,765		
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.				
4 Benefits paid to or for members.				
5 Compensation of current officers, directors, trustees, and key employees.	5,119,960	1,458,370	3,661,590	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B).	182,397	182,397		
7 Other salaries and wages.	227,186,181	222,953,856	4,232,325	
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).				
9 Other employee benefits.	18,220,154	18,194,232	25,922	
10 Payroll taxes.	15,421,044	15,024,042	397,002	
11 Fees for services (non-employees):				
a Management.	4,931,306	3,057,506	1,873,800	
b Legal.	1,388,802	1,288,808	99,994	
c Accounting.	250,917	250,917		
d Lobbying.	137,247	40,000	97,247	
e Professional fundraising services. See Part IV, line 17.				
f Investment management fees.	661,648	44	661,604	
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	67,547,254	65,341,204	2,206,050	
12 Advertising and promotion.	1,998,202	1,384,484	613,718	
13 Office expenses.	8,012,992	6,888,106	1,124,886	
14 Information technology.	3,256,045	2,782,433	473,612	
15 Royalties.				
16 Occupancy.	19,140,213	17,407,034	1,733,179	
17 Travel.	2,282,023	1,601,438	680,585	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials.				
19 Conferences, conventions, and meetings.	777,988	738,117	39,871	
20 Interest.	2,135,961	2,135,961		
21 Payments to affiliates.				
22 Depreciation, depletion, and amortization.	26,105,633	26,105,633		
23 Insurance.	1,099,990	805,785	294,205	
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 FEDERAL AND STATE INCOME TAXES	174,546	174,546		
b MEDICAL AND PHARMACEUTICALS	42,949,683	42,948,393	1,290	
c PATIENT SUPPLY COST OF	42,432,967	42,432,967		
d FOOD, BEVERAGES, AND OTHER	6,938,587	6,127,045	811,542	
e All other expenses.	2,105,164	2,061,908	43,256	
25 Total functional expenses. Add lines 1 through 24e.	503,092,010	484,020,332	19,071,678	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 <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

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

				(A) Beginning of year		(B) End of year
Assets	1	Cash—non-interest-bearing		17,231,068	1	14,422,853
	2	Savings and temporary cash investments		83,734,562	2	31,919,101
	3	Pledges and grants receivable, net			3	
	4	Accounts receivable, net		79,517,999	4	96,542,919
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L.			5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L.			6	
	7	Notes and loans receivable, net		25,817,168	7	17,792,078
	8	Inventories for sale or use		11,121,056	8	11,664,936
	9	Prepaid expenses and deferred charges		62,848,115	9	9,751,609
	10a	Land, buildings, and equipment—cost or other basis. Complete Part VI of Schedule D.	10a 782,007,924			
	b	Less: accumulated depreciation	10b 472,905,470	239,182,045	10c	309,102,454
	11	Investments—publicly traded securities		214,111,204	11	229,843,441
	12	Investments—other securities. See Part IV, line 11		66,124,874	12	69,435,850
	13	Investments—program-related. See Part IV, line 11			13	
	14	Intangible assets		473,348	14	473,348
	15	Other assets. See Part IV, line 11		30,221,697	15	36,636,645
16	Total assets. Add lines 1 through 15 (must equal line 34)		830,383,136	16	827,585,234	
Liabilities	17	Accounts payable and accrued expenses		80,863,740	17	67,946,253
	18	Grants payable			18	
	19	Deferred revenue			19	
	20	Tax-exempt bond liabilities		179,157,606	20	170,260,572
	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			23	
	24	Unsecured notes and loans payable to unrelated third parties			24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D.		42,247,948	25	28,877,057
	26	Total liabilities. Add lines 17 through 25		302,269,294	26	267,083,882
Net Assets or Fund Balances	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		513,775,469	27	545,332,569
	28	Temporarily restricted net assets		14,338,373	28	15,168,783
	29	Permanently restricted net assets			29	
	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		528,113,842	33	560,501,352	
34	Total liabilities and net assets/fund balances		830,383,136	34	827,585,234	

Part XI Reconciliation of Net AssetsCheck 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	527,970,226
2	Total expenses (must equal Part IX, column (A), line 25)	2	503,092,010
3	Revenue less expenses Subtract line 2 from line 1	3	24,878,216
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	528,113,842
5	Net unrealized gains (losses) on investments	5	-477,247
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	7,986,541
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	560,501,352

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

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

Additional Data

Software ID:
Software Version:
EIN: 42-1418847
Name: GENESIS HEALTH SYSTEM

Form 990 (2016)

Form 990, Part III, Line 4a:

GENESIS HEALTH SYSTEM (GHS IOWA) IS A HEALTH SYSTEM LOCATED IN EASTERN IOWA CONSISTING OF THREE HOSPITAL FACILITIES, TWO IN DAVENPORT AND ONE IN DEWITT, IOWA GENESIS MEDICAL CENTER - DAVENPORT, CONTAINING 502 LICENSED ACUTE CARE BEDS STATISTICS INCLUDE 77,085 PATIENT DAYS, 21,015 PATIENT DISCHARGES, AND 209,333 OUTPATIENT VISITS, GENESIS MEDICAL CENTER - DEWITT, CONTAINING 13 LICENSED ACUTE CARE AND SWING BEDS AND 77 LONG-TERM CARE BEDS STATISTICS INCLUDE 1,911 PATIENT DAYS, 272 PATIENT DISCHARGES, AND 20,556 OUTPATIENT VISITS GHS IOWA ALSO INCLUDES A FAMILY MEDICINE RESIDENCY PROGRAM THAT CONTINUES TO EDUCATE RESIDENTS IN THE HOSPITAL SETTING

Form 990, Part III, Line 4b:

GENESIS HEALTH GROUP, A PHYSICIAN GROUP WITHIN GENESIS HEALTH SYSTEM (GHS IOWA), CONSISTS OF 52 CLINICS AND 160 PHYSICIANS ENCOMPASSING A WIDE VARIETY OF SPECIALTIES AND FAMILY PRACTICE GROUPS SERVING IOWA, ILLINOIS AND SURROUNDING COMMUNITIES IN EASTERN IOWA AND WESTERN ILLINOIS
STATISTICS INCLUDE TOTAL PRACTITIONER HOURS 298,938 AND RVU'S (RELATIVE VALUE UNITS) 976,225

Form 990, Part III, Line 4c:

GENESIS AT HOME VNA & HOSPICE, A VISITING NURSE AND HOSPICE CARE PROGRAM WITHIN GENESIS HEALTH SYSTEM (GHS IOWA) ENCOMPASSES HOME HEALTH SERVICES (INCLUDING PHYSICAL THERAPY, OCCUPATIONAL/SPEECH THERAPY, SKILLED NURSING, MEDICAL SOCIAL WORKER VISITS), COMMUNITY HOSPICE SERVICES, AND THE CLARISSA C COOK HOSPICE HOUSE LOCATED IN BETTENDORF, IOWA STATISTICS INCLUDE 147,222 HOME HEALTH SERVICE UNITS AND 59,872 HOSPICE/HOSPICE HOUSE DAYS

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

(A)(B)(C)(D)(E)(F)

Name and Title	Average hours per week (list any hours for related organizations below dotted line)	Position (do not check more than one box, unless person is both an officer and a director/trustee)						Reportable compensation from the organization (W- 2/1099-MISC)	Reportable compensation from related organizations (W- 2/1099-MISC)	Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
STEVEN C BAHLS VICE CHAIR	8 00	X		X				0	0	0
MARK D BAWDEN DIRECTOR	4 00	X						0	0	0
PETER J BENSON DIRECTOR	4 00	X						0	0	0
GREGORY J BUSH TREASURER	4 00	X		X				0	0	0
CHRISTOPHER J COX DIRECTOR	4 00	X						0	0	0
EDMUND P COYNE JR MD DIRECTOR	4 00	X						0	0	0
DOUGLAS P CROPPER PRESIDENT/CEO GHS	60 00	X		X				1,070,452	0	29,667
PATRICIA S GROVES PHD RN DIRECTOR	4 00	X						0	0	0
ROGER J HILL SECRETARY	4 00	X		X				0	0	0
MARK C KILMER DIRECTOR	4 00	X						0	0	0

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JAMES W KOEHLER DIRECTOR	4 00	X						0	0	0
GEORGE J KONTOS JR MD DIRECTOR	40 00	X						662,836	0	22,538
DAVID C LARSON DIRECTOR	4 00	X						0	0	0
CHARLENE E MAASKE DIRECTOR	4 00	X						0	0	0
EDWIN V MOTTO MD DIRECTOR	10 00	X						0	0	0
EDWARD J ROGALSKI PHD DIRECTOR	10 00	X						0	0	0
G CHRISTOPHER WAHLIG CHAIR	10 00	X		X				0	0	0
C DANA WATERMAN III DIRECTOR	4 50	X						0	0	0
DALE D ZUDE DIRECTOR	4 00	X						0	0	0
PAUL BOLLINGER LEGAL AFFAIRS VICE PRESIDENT AND ASST SECRETARY	40 00			X				0	0	0

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(A) Name and Title	Average hours per week (list any hours for related organizations below dotted line)	(B) (C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
MARK G ROGERS V P FINANCE/CFO/ASST TREASURER	40 00			X				604,244	0	89,329
HAROLD L WAGHER FORMER CHIEF COMPLIANCE RISK OFFICER	40 00			X				255,668	0	18,579
KURT A ANDERSEN MD PRESIDENT GHG	40 00				X			578,071	0	19,912
DALE GIESS PHYSICIAN-CARDIOTHORACIC	40 00				X			860,939	0	12,279
NIDAL HARB CHIEF MEDICAL OFFICER	40 00				X			694,765	0	22,760
JORDAN VOIGT HOSPITAL PRESIDENT GMC DAVENPORT	40 00				X			524,384	0	17,771
JOSEPH BROOKS MD PHYSICIAN	40 00					X		547,475	0	25,680
MICHAEL BURCHETT PHYSICIAN	40 00					X		565,385	0	20,158
NATHAN MELOY MD PHYSICIAN	40 00					X		647,451	0	18,632
ERIC MOHR MD PHYSICIAN	40 00					X		554,866	0	22,683

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
TODD RIDENOUR MD PHYSICIAN	40 00					X		849,670	0	21,367
JACQUELINE K ANHALT FORMER V P PATIENT SERVICES	40 00						X	335,387	0	26,520
CHRISTOPHER CROME FORMER PHYSICIAN/DIVISION CHAIR	40 00						X	438,868	0	16,994
ROBERT W FRIEDEN FORMER V P INFORMATION SERVICES	40 00						X	417,017	0	26,691
RICHARD M KISHIUE MD FORMER PRESIDENT, GHG	40 00						X	253,009	0	11,661
GEORGE KOVACH FORMER V P MEDICAL STAFF AFFAIRS	40 00						X	156,856	0	1,098

SCHEDULE A (Form 990 or 990-EZ)	Public Charity Status and Public Support Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust. ▶ Attach to Form 990 or Form 990-EZ. ▶ Information about Schedule A (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990 .	OMB No 1545-0047 2016 Open to Public Inspection
Department of the Treasury Internal Revenue Service Name of the organization GENESIS HEALTH SYSTEM		Employer identification number 42-1418847

Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.
The organization is not a private foundation because it is (For lines 1 through 12, check only one box)

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

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

Part II

Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)
(Complete only if you checked the box on line 5, 7, 8, or 9 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support						
Calendar year (or fiscal year beginning in) ▶	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 Public support. Subtract line 5 from line 4						

Section B. Total Support						
Calendar year (or fiscal year beginning in) ▶	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here ▶ <input type="checkbox"/>						

Section C. Computation of Public Support Percentage						
14 Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f))					14	
15 Public support percentage for 2015 Schedule A, Part II, line 14					15	
16a 33 1/3% support test—2016. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here . The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>						
b 33 1/3% support test—2015. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here . The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>						
17a 10%-facts-and-circumstances test—2016. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here . Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>						
b 10%-facts-and-circumstances test—2015. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here . Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>						
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ <input type="checkbox"/>						

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 Public support. (Subtract line 7c from line 6.)						

Section B. Total Support

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

14 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a 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 **stop here**. The organization qualifies as a publicly supported organization ☐

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

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

	Yes	No
1 Are all of the organization's supported organizations listed by name in the organization's governing documents? <i>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.</i>	1	
2 Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? <i>If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).</i>	2	
3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? <i>If "Yes," answer (b) and (c) below.</i>	3a	
b Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? <i>If "Yes," describe in Part VI when and how the organization made the determination.</i>	3b	
c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? <i>If "Yes," explain in Part VI what controls the organization put in place to ensure such use.</i>	3c	
4a Was any supported organization not organized in the United States ("foreign supported organization")? <i>If "Yes" and if you checked 12a or 12b in Part I, answer (b) and (c) below.</i>	4a	
b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? <i>If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.</i>	4b	
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)? <i>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.</i>	4c	
5a Did the organization add, substitute, or remove any supported organizations during the tax year? <i>If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in 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).</i>	5a	
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?	5b	
c Substitutions only. Was the substitution the result of an event beyond the organization's control?	5c	
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? <i>If "Yes," provide detail in Part VI.</i>	6	
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? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>	7	
8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>	8	
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))? <i>If "Yes," provide detail in Part VI.</i>	9a	
b Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? <i>If "Yes," provide detail in Part VI.</i>	9b	
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? <i>If "Yes," provide detail in Part VI.</i>	9c	
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)? <i>If "Yes," answer line 10b below.</i>	10a	
b Did the organization have any excess business holdings in the tax year? <i>(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)</i>	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?		
b A family member of a person described in (a) above?		
c A 35% controlled entity of a person described in (a) or (b) above? <i>If "Yes" to a, b, or c, provide detail in Part VI</i>		
11a		
11b		
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? <i>If "No," describe in Part VI how the supported organization(s) effectively operated, supervised, or controlled the organization's activities. If the organization had more than one supported organization, describe how the powers to appoint and/or remove directors or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year.</i>		
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? <i>If "Yes," explain in Part VI how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised or controlled the supporting organization.</i>		
1		
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)? <i>If "No," describe in Part VI how control or management of the supporting organization was vested in the same persons that controlled or managed the supported organization(s).</i>		
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?		
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? <i>If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s).</i>		
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? <i>If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.</i>		
1		
2		
3		

Section E. Type III Functionally-Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions)		
a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.		
b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
c <input type="checkbox"/> 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? <i>If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.</i>		
b Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? <i>If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.</i>		
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? <i>Provide details in Part VI.</i>		
b Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i>		
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. **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	
8 Adjusted Net Income (subtract lines 5, 6 and 7 from line 4)	8	

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)	1	
a Average monthly value of securities	1a	
b Average monthly cash balances	1b	
c Fair market value of other non-exempt-use assets	1c	
d Total (add lines 1a, 1b, and 1c)	1d	
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	
8 Minimum Asset Amount (add line 7 to line 6)	8	

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 Distributable Amount. 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	
7 Total annual distributions. Add lines 1 through 6	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI) See instructions	
9 Distributable amount for 2016 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

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

Part VI **Supplemental Information.**

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

Facts And Circumstances Test

SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

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

OMB No 1545-0047

2016

Open to Public Inspection

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

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

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

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

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

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

Name of the organization GENESIS HEALTH SYSTEM	Employer identification number 42-1418847
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Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

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

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

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

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

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

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

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

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

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

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

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

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

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

d Other exempt purpose expenditures

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

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

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

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

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

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

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

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

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

Lobbying Expenditures During 4-Year Averaging Period

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

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

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

		(a)		(b)
		Yes	No	Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
a	Volunteers?		No	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?	Yes		
c	Media advertisements?		No	
d	Mailings to members, legislators, or the public?	Yes		
e	Publications, or published or broadcast statements?		No	
f	Grants to other organizations for lobbying purposes?	Yes		3,000
g	Direct contact with legislators, their staffs, government officials, or a legislative body?	Yes		78,159
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?	Yes		94,248
j	Total. Add lines 1c through 1i			175,407
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

Part IV Supplemental Information

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

Return Reference	Explanation
PART II-B, LINE 1	PART II-B, LINE 1B, PAID STAFF OR MANAGEMENT GENESIS HEALTH SYSTEM (GHS IOWA) HAD THREE STAFF MEMBERS INVOLVED IN LOBBYING ACTIVITIES ON A PART TIME BASIS THEIR LOBBYING ACTIVITIES WERE FOCUSED ON SENDING LETTERS OR PUBLICATIONS TO GOVERNMENT OFFICIALS OR LEGISLATORS AND MEETING WITH OR CALLING GOVERNMENT OFFICIALS OR LEGISLATORS ON HEALTHCARE RELATED MATTERS ALSO, ON FEBRUARY 22, 2017, 39 GHS IOWA STAFF MEMBERS TOOK TIME OUT OF THEIR REGULAR BUSINESS HOURS TO VISIT WITH SEVERAL GOVERNMENT OFFICIALS AND LEGISLATORS TO DISCUSS ISSUES RELATED TO CERTIFICATE OF NEED PART II-B, LINE 1D, MAILINGS TO MEMBERS, LEGISLATORS, OR THE PUBLIC EMPLOYEES OF GENESIS HEALTH SYSTEM (GHS IOWA) ARE ENCOURAGED TO PARTICIPATE IN THE IOWA HOSPITAL ASSOCIATION'S "IHA ACTION ALERTS " THE EMPLOYEES PARTICIPATE BY RESPONDING TO E-MAIL ALERTS WHICH ALLOWS THEM TO VOICE THEIR OPINIONS TO THEIR STATE REPRESENTATIVES ON HEALTHCARE RELATED MATTERS (NOT CANDIDATE-SPECIFIC) THERE IS NO DIRECT COST TO GHS IOWA REGARDING THIS ACTIVITY PART II-B, LINE 1F, GRANTS TO OTHER ORGANIZATIONS FOR LOBBYING PURPOSES GENESIS HEALTH SYSTEM (GHS IOWA) PRESENTED ONE GRANT TO ONE ORGANIZATION 1) QUAD CITIES CHAMBER - IOWA LEGISLATIVE LUNCHEON 2017, \$3,000 PART II-B, LINE 1G, DIRECT CONTACT WITH LEGISLATORS, THEIR STAFFS, GOVERNMENT OFFICIALS, OR A LEGISLATIVE BODY GENESIS HEALTH SYSTEM (GHS IOWA) HAD THREE STAFF MEMBERS INVOLVED IN LOBBYING ACTIVITIES ON A PART TIME BASIS THEIR LOBBYING ACTIVITIES WERE FOCUSED ON SENDING LETTERS OR PUBLICATIONS TO GOVERNMENT OFFICIALS OR LEGISLATORS AND MEETING WITH OR CALLING GOVERNMENT OFFICIALS OR LEGISLATORS ON HEALTHCARE RELATED MATTERS THE DIRECT COSTS RELATED TO THEIR LOBBYING ACTIVITIES INCLUDED SALARIES - \$59,617, AND MILEAGE/TRAVEL EXPENSES - \$1,553 ALSO, ON FEBRUARY 22, 2017, 39 GHS IOWA STAFF MEMBERS TOOK TIME OUT OF THEIR REGULAR BUSINESS HOURS TO VISIT WITH SEVERAL GOVERNMENT OFFICIALS AND LEGISLATORS TO DISCUSS ISSUES RELATED TO FAIR MEDICAID SYSTEM AND TELEHEALTH ADVANCEMENT THE DIRECT COSTS INCLUDED SALARIES - \$15,914 AND TRAVEL EXPENSES - \$1,075 PART II-B, LINE 1I, OTHER LOBBYING ACTIVITIES IN FISCAL YEAR 2015, GENESIS HEALTH SYSTEM (GHS IOWA) RECEIVED PROFESSIONAL LOBBYING AND GOVERNMENTAL RELATIONS CONSULTING SERVICES FROM EIDE & HEISINGER, LLC AT A COST OF \$25,000 LOBBYING EXPENDITURES RELATED TO MEMBERSHIP DUES INCLUDED 21% OF MEMBERSHIP DUES TO THE IOWA HOSPITAL ASSOCIATION, OR \$24,528, 21 78% OF MEMBERSHIP DUES TO THE AMERICAN HOSPITAL ASSOCIATION, OR \$12,203, 55% OF MEMBERSHIP DUES TO THE AMERICAN MEDICAL ASSOCIATION, OR \$8,089, AND VARIOUS OTHER ASSOCIATIONS - \$24,428

efile GRAPHIC print - DO NOT PROCESS		As Filed Data -		DLN: 93493059015518									
<div>SCHEDULE D (Form 990)</div> <div>Department of the Treasury Internal Revenue Service</div>		<div>Supplemental Financial Statements</div> <div>► Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b. ► Attach to Form 990.</div> <div>Information about Schedule D (Form 990) and its instructions is at www.irs.gov/form990.</div>			<div>OMB No 1545-0047</div> <div>2016</div> <div>Open to Public Inspection</div>								
Name of the organization GENESIS HEALTH SYSTEM				Employer identification number 42-1418847									
Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" on Form 990, Part IV, line 6.													
		(a) Donor advised funds		(b) Funds and other accounts									
1	Total number at end of year												
2	Aggregate value of contributions to (during year)												
3	Aggregate value of grants from (during year)												
4	Aggregate value at end of year												
5		Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?											
		<div><input type="checkbox"/> Yes</div> <div><input type="checkbox"/> No</div>											
6		Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?											
		<div><input type="checkbox"/> Yes</div> <div><input type="checkbox"/> No</div>											
Part II Conservation Easements. Complete if the organization answered "Yes" on Form 990, Part IV, line 7.													
1 Purpose(s) of conservation easements held by the organization (check all that apply)													
<div><input type="checkbox"/> Preservation of land for public use (e g , recreation or education)</div> <div><input type="checkbox"/> Preservation of an historically important land area</div> <div><input type="checkbox"/> Protection of natural habitat</div> <div><input type="checkbox"/> Preservation of a certified historic structure</div> <div><input type="checkbox"/> Preservation of open space</div>													
2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year													
		<div>Held at the End of the Year</div> <table><tr><td>2a</td><td></td></tr><tr><td>2b</td><td></td></tr><tr><td>2c</td><td></td></tr><tr><td>2d</td><td></td></tr></table>				2a		2b		2c		2d	
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?													
<div><input type="checkbox"/> Yes</div> <div><input type="checkbox"/> No</div>													
6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ►													
7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ► \$													
8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?													
<div><input type="checkbox"/> Yes</div> <div><input type="checkbox"/> No</div>													
9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements													
Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets. Complete if the organization answered "Yes" on Form 990, Part IV, line 8.													
1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items													
b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items													
(i) Revenue included on Form 990, Part VIII, line 1		► \$											
(ii) Assets included in Form 990, Part X		► \$											
2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items													
a Revenue included on Form 990, Part VIII, line 1		► \$											
b Assets included in Form 990, Part X		► \$											
For Paperwork Reduction Act Notice, see the Instructions for Form 990.													
		Cat No 52283D		Schedule D (Form 990) 2016									

Part III

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

3

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

a

☐ Public exhibition

b

☐ Scholarly research

c

☐ Preservation for future generations

d

☐ Loan or exchange programs

e

☐ Other

4

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

5

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

☐ Yes

☐ No

Part IV

Escrow and Custodial Arrangements.

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

1a

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

☐ Yes

☐ No

b

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

c

Beginning balance

d

Additions during the year

e

Distributions during the year

f

Ending balance

	Amount
1c	
1d	
1e	
1f	

2a

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

☐ Yes

☐ No

b

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

☐

Part V

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

	(a)Current year	(b)Prior year	(c)Two years back	(d)Three years back	(e)Four years back
1a Beginning of year balance	12,080,730	11,227,334	9,123,481	7,838,024	7,633,243
b Contributions	191,448	1,087,419	1,985,014	374,838	2,101
c Net investment earnings, gains, and losses	1,042,683	-178,681	118,839	910,619	561,816
d Grants or scholarships	5,000				359,136
e Other expenditures for facilities and programs					
f Administrative expenses	60,205	55,342			
g End of year balance	13,249,656	12,080,730	11,227,334	9,123,481	7,838,024

2

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

a

Board designated or quasi-endowment

41 550 %

b

Permanent endowment

58 450 %

c

Temporarily restricted endowment

0 %

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

3a

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

(i) unrelated organizations

3a(i)

Yes

No

(ii) related organizations

3a(ii)

Yes

b

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

3b

Yes

4

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

Part VI

Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		32,911,640		32,911,640
b Buildings		336,270,337	146,866,153	189,404,184
c Leasehold improvements		24,283,805	19,564,919	4,718,886
d Equipment		346,747,721	287,745,581	59,002,140
e Other		41,794,421	18,728,817	23,065,604
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c))				309,102,454

Schedule D (Form 990) 2016

Part VII

Investments—Other Securities.

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

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other		
See Additional Data Table (A)		
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Column (b) must equal Form 990, Part X, col (B) line 12)	69,435,850	

Part VIII

Investments—Program Related.

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

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

Part IX

Other Assets.

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

(a) Description	(b) Book value
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 15)	

Part X

Other Liabilities.

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

(a) Description of liability	(b) Book value
(1) Federal income taxes	
ACCRUED PENSION LIABILITY	12,812,364
ACCRUED INS TRUST LOSSES	1,792,357
NONQUALIFIED PENSION LIABILITY	14,060,061
LT DEFERRED EXPENSE CREDIT	212,275
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 25)	28,877,057

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		
a	Net unrealized gains (losses) on investments	2a	
b	Donated services and use of facilities	2b	
c	Recoveries of prior year grants	2c	
d	Other (Describe in Part XIII)	2d	
e	Add lines 2a through 2d	2e	
3	Subtract line 2e from line 1	3	
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	
b	Other (Describe in Part XIII)	4b	
c	Add lines 4a and 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		
a	Donated services and use of facilities	2a	
b	Prior year adjustments	2b	
c	Other losses	2c	
d	Other (Describe in Part XIII)	2d	
e	Add lines 2a through 2d	2e	
3	Subtract line 2e from line 1	3	
4	Amounts included on Form 990, Part IX, line 25, but not on line 1 :		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	
b	Other (Describe in Part XIII)	4b	
c	Add lines 4a and 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.

Return Reference	Explanation
See Additional Data Table	

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

Additional Data

Software ID:
Software Version:
EIN: 42-1418847
Name: GENESIS HEALTH SYSTEM

Form 990, Schedule D, Part VII - Investments Other Securities

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(3) Other (A) INVESTMENT IN GENVENTURES, INC	26,282,460	C
(3) Other (A) INVESTMENT IN MISERICORDIA ASSURANCE COMPANY, LTD	120,000	C
(B) INVESTMENT IN HEI COOP	4,765,062	C
(C) INVESTMENT IN SPRING PARK SURGERY CENTER, LLC	3,409,242	C
(D) INVESTMENT IN GENGASTRO, LLC	23,609,015	C
(E) INVESTMENT IN GENORTH0, LLC	1,833,011	C
(F) INVESTMENT IN GENRAD IMAGING, LLC	3,194,134	C
(G) OTHER INVESTMENTS - GMC	28,655	F
(H) INVESTMENT IN UNIVERSITY OF IOWA HEALTH ALLIANCE, LLC	2,702,293	C
(I) INVESTMENT IN DAVITA DIALYSIS, LLC	2,741,978	C

Form 990, Schedule D, Part VII - Investments Other Securities		
(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(K) INVESTMENT IN WELLMARK	750,000	C

Supplemental Information

Return Reference	Explanation
PART V, LINE 4	GENESIS HEALTH SERVICES FOUNDATION, A RELATED ORGANIZATION, HOLDS THE ENDOWMENT FUNDS THE INTENDED USE OF THE FOUNDATION'S ENDOWMENT FUNDS ARE AS FOLLOWS SCHOLARSHIPS FOR EDUCATION IN THE MEDICAL FIELD, CHARITY CARE FOR THE INDIGENT, EMPLOYEE EMERGENCY ASSISTANCE, VISITING NURSE, HOSPICE HOUSE, DIABETIC CARE, PEDIATRIC HOSPICE, DIALYSIS CARE, AND BREAST HEALTH SERVICES

Supplemental Information

Return Reference	Explanation
PART X, LINE 2	<p>GENESIS HEALTH SYSTEM (GHS IOWA), GENESIS HEALTH SYSTEM (GHS ILLINOIS), GENESIS SENIOR LIVING, ALEDO (GSL, ALEDO), GENESIS MEDICAL CENTER, ALEDO (GMC, ALEDO), GENESIS HEALTH SERVICES FOUNDATION (GENESIS FOUNDATION), GENESIS PHILANTHROPY (PHILANTHROPY) AND GENESIS HEALTH SYSTEM WORKERS' COMPENSATION PLAN AND TRUST (WORKERS' COMPENSATION TRUST) ALL FILE A FORM 990 (RETURN OF ORGANIZATION EXEMPT FROM INCOME TAX) ANNUALLY WHEN THESE RETURNS ARE FILED, IT IS HIGHLY CERTAIN THAT SOME POSITIONS TAKEN WOULD BE SUSTAINED UPON EXAMINATION BY THE TAXING AUTHORITIES, WHILE OTHERS ARE SUBJECT TO UNCERTAINTY ABOUT THE MERITS OF THE POSITION TAKEN OR THE AMOUNT OF THE POSITION THAT WOULD ULTIMATELY BE SUSTAINED. EXAMPLES OF TAX POSITIONS COMMON TO HEALTH SYSTEMS INCLUDE SUCH MATTERS AS THE FOLLOWING: THE TAX EXEMPT STATUS OF EACH ENTITY, THE NATURE, CHARACTERIZATION AND TAXABILITY OF JOINT VENTURE INCOME AND VARIOUS POSITIONS RELATIVE TO POTENTIAL SOURCES OF UNRELATED BUSINESS TAXABLE INCOME. UNRELATED BUSINESS TAXABLE INCOME IS REPORTED ON FORM 990T, AS APPROPRIATE. THE BENEFIT OF A TAX POSITION IS RECOGNIZED IN THE CONSOLIDATED FINANCIAL STATEMENTS IN THE PERIOD DURING WHICH, BASED ON ALL AVAILABLE EVIDENCE, MANAGEMENT BELIEVES THAT IT IS MORE LIKELY THAN NOT THAT THE POSITION WILL BE SUSTAINED UPON EXAMINATION, INCLUDING THE RESOLUTION OF APPEALS OR LITIGATION PROCESSES, IF ANY. TAX POSITIONS ARE NOT OFFSET OR AGGREGATED WITH OTHER POSITIONS. TAX POSITIONS THAT MEET THE "MORE LIKELY THAN NOT" RECOGNITION THRESHOLD ARE MEASURED AS THE LARGEST AMOUNT OF TAX BENEFIT THAT IS MORE THAN 50% LIKELY TO BE REALIZED ON SETTLEMENT WITH THE APPLICABLE TAXING AUTHORITY. THE PORTION OF THE BENEFITS ASSOCIATED WITH TAX POSITIONS TAKEN THAT EXCEEDS THE AMOUNT MEASURED AS DESCRIBED ABOVE IS REFLECTED AS A LIABILITY FOR UNCERTAIN TAX BENEFITS IN THE ACCOMPANYING CONSOLIDATED BALANCE SHEETS ALONG WITH ANY ASSOCIATED INTEREST AND PENALTIES THAT WOULD BE PAYABLE TO THE TAXING AUTHORITIES UPON EXAMINATION. FORMS 990 AND 990T FILED BY GHS IOWA, GHS ILLINOIS, GENESIS FOUNDATION, PHILANTHROPY AND WORKERS' COMPENSATION TRUST ARE SUBJECT TO EXAMINATION BY THE INTERNAL REVENUE SERVICE (IRS) UP TO THREE YEARS FROM THE EXTENDED DUE DATE OF EACH RETURN. FORMS 990 AND 990T FILED BY GHS IOWA, GHS ILLINOIS, GENESIS FOUNDATION AND WORKERS' COMPENSATION TRUST ARE NO LONGER SUBJECT TO EXAMINATION FOR THE FISCAL YEARS ENDED JUNE 30, 2013 AND PRIOR. GENVENTURES, INC. (GENVENTURES) IS A TAXABLE ORGANIZATION AND CURRENTLY FILES INCOME TAX RETURNS IN THE U.S. FEDERAL JURISDICTION AND VARIOUS STATE JURISDICTIONS. GENVENTURES IS NO LONGER SUBJECT TO INCOME TAX EXAMINATIONS FOR YEARS JUNE 30, 2013 AND PRIOR. THERE WERE NO UNCERTAIN TAX POSITIONS AS OF JUNE 30, 2017 AND 2016.</p>

SCHEDULE F (Form 990)	<h2 style="margin: 0;">Statement of Activities Outside the United States</h2> <p style="margin: 5px 0;">▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 14b, 15, or 16.</p> <p style="margin: 5px 0;">▶ Attach to Form 990. ▶ See separate instructions.</p> <p style="margin: 5px 0;">▶ Information about Schedule F (Form 990) and its instructions is at www.irs.gov/form990.</p>	OMB No 1545-0047 <div style="text-align: center; font-size: 2em; font-weight: bold;">2016</div> <div style="text-align: center; background-color: black; color: white; padding: 5px; font-weight: bold;">Open to Public Inspection</div>
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Department of the Treasury
Internal Revenue Service

Name of the organization GENESIS HEALTH SYSTEM	Employer identification number 42-1418847
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Part I **General Information on Activities Outside the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 14b.

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

☐ **Yes**
☐ **No**

2 For grantmakers. Describe in Part V the organization's procedures for monitoring the use of its grants and other assistance outside the United States

3 Activities per Region (The following Part I, line 3 table can be duplicated if additional space is needed)

(a) Region	(b) Number of offices in the region	(c) Number of employees, agents, and independent contractors in region	(d) Activities conducted in region (by type) (e g , fundraising, program services, investments, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for and investments in region
(1) CENTRAL AMERICAN AND THE CARIBBEAN	0	0	INVESTMENTS		
(2)					
(3)					
(4)					
(5)					
3a Sub-total	0	0			0
b Total from continuation sheets to Part I	0	0			0
c Totals (add lines 3a and 3b)	0	0			0

Part II Grants and Other Assistance to Organizations or Entities Outside the United States. Complete if the organization answered "Yes" to Form 990, Part IV, line 15, for any recipient who received more than \$5,000. Part II can be duplicated if additional space is needed.

1	(a) Name of organization	(b) IRS code section and EIN (if applicable)	(c) Region	(d) Purpose of grant	(e) Amount of cash grant	(f) Manner of cash disbursement	(g) Amount of non-cash assistance	(h) Description of non-cash assistance	(i) Method of valuation (book, FMV, appraisal, other)
(1)									
(2)									
(3)									
(4)									

- 2 Enter total number of recipient organizations listed above that are recognized as charities by the foreign country, recognized as tax-exempt by the IRS, or for which the grantee or counsel has provided a section 501(c)(3) equivalency letter ► _____
- 3 Enter total number of other organizations or entities ► _____

Part III **Grants and Other Assistance to Individuals Outside the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 16.

Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Region	(c) Number of recipients	(d) Amount of cash grant	(e) Manner of cash disbursement	(f) Amount of non-cash assistance	(g) Description of non-cash assistance	(h) Method of valuation (book, FMV, appraisal, other)
(1)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							
(13)							
(14)							
(15)							
(16)							
(17)							
(18)							

Part IV Foreign Forms

- 1 Was the organization a U S transferor of property to a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 926, Return by a U S Transferor of Property to a Foreign Corporation (see Instructions for Form 926)* ☒ Yes ☐ No
- 2 Did the organization have an interest in a foreign trust during the tax year? *If "Yes," the organization may be required to separately file Form 3520, Annual Return to Report Transactions with Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U S Owner (see Instructions for Forms 3520 and 3520-A)* ☐ Yes ☒ No
- 3 Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U S Persons with Respect to Certain Foreign Corporations (see Instructions for Form 5471)* ☒ Yes ☐ No
- 4 Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? *If "Yes," the organization may be required to file Form 8621, Information Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund (see Instructions for Form 8621)* ☐ Yes ☒ No
- 5 Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U S Persons with Respect to Certain Foreign Partnerships (see Instructions for Form 8865)* ☐ Yes ☒ No
- 6 Did the organization have any operations in or related to any boycotting countries during the tax year? *If "Yes," the organization may be required to separately file Form 5713, International Boycott Report (see Instructions for Form 5713)* ☐ Yes ☒ No

Additional Data

Software ID:

Software Version:

EIN: 42-1418847

Name: GENESIS HEALTH SYSTEM

Part V Supplemental Information

Provide the information required by Part I, line 2 (monitoring of funds); Part I, line 3, column (f) (accounting method; amounts of investments vs. expenditures per region); Part II, line 1 (accounting method); Part III (accounting method); and Part III, column (c) (estimated number of recipients), as applicable. Also complete this part to provide any additional information (see instructions).

SCHEDULE H (Form 990) Department of the Treasury Internal Revenue Service	<h2 style="margin:0;">Hospitals</h2> <p>► 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.</p>	OMB No 1545-0047 <div style="font-size: 2em; font-weight: bold; text-align: center;">2016</div> Open to Public Inspection
Name of the organization GENESIS HEALTH SYSTEM		Employer identification number 42-1418847

Part I Financial Assistance and Certain Other Community Benefits at Cost

		Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	Yes	
b If "Yes," was it a written policy?	1b	Yes	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year			
<input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities			
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year			
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for <i>free</i> care <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %	3a	Yes	
b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care <input checked="" type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %	3b	Yes	
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care			
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	Yes	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	Yes	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		No
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		
6a Did the organization prepare a community benefit report during the tax year?	6a	Yes	
b If "Yes," did the organization make it available to the public?	6b	Yes	
Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.			

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			4,278,081		4,278,081	0 850 %
b Medicaid (from Worksheet 3, column a)			88,419,989	63,479,113	24,940,876	4 960 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			92,698,070	63,479,113	29,218,957	5 810 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			766,548		766,548	0 150 %
f Health professions education (from Worksheet 5)			3,263,043	1,691,503	1,571,540	0 310 %
g Subsidized health services (from Worksheet 6)			3,621,979	1,931,519	1,690,460	0 340 %
h Research (from Worksheet 7)			275,445		275,445	0 050 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)			446,492		446,492	0 090 %
j Total. Other Benefits			8,373,507	3,623,022	4,750,485	0 940 %
k Total. Add lines 7d and 7j			101,071,577	67,102,135	33,969,442	6 750 %

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development			51,050		51,050	0.010 %
3 Community support			72,219		72,219	0.010 %
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy			20,122		20,122	0 %
8 Workforce development			8,616		8,616	0 %
9 Other						
10 Total			152,007		152,007	0.020 %

Part III Bad Debt, Medicare, & Collection Practices**Section A. Bad Debt Expense**

		Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	Yes	
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	2	13,570,967	
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3		
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME).	5	127,094,555
6 Enter Medicare allowable costs of care relating to payments on line 5.	6	128,288,481
7 Subtract line 6 from line 5. This is the surplus (or shortfall).	7	-1,193,926
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input type="checkbox"/> Cost to charge ratio <input checked="" type="checkbox"/> Other		

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures

(owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1 1 GENGASTRO LLC	AMBULATORY SURGERY CENTER	75.000 %	0 %	25.000 %
2 2 GENORTHO LLC	ORTHOPAEDIC SURGERY CENTER	50.000 %	0 %	50.000 %
3 3 SPRING PARK SURGERY CENTER LLC	OUTPATIENT SURGICAL CENTER	45.000 %	0 %	55.000 %
4 4 GENRAD IMAGING LLC	DIAGNOSTIC IMAGING CENTER	50.000 %	0 %	50.000 %
5 6 DAVITA DIALYSIS LLC	OUTPATIENT DIALYSIS CENTER	20.000 %	16.000 %	64.000 %
6				
7				
8				
9				
10				
11				
12				
13				

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

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

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

2

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

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

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

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

Name of hospital facility or letter of facility reporting group _____

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

1

Community Health Needs Assessment

	Yes	No
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3	Yes
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input type="checkbox"/> 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 <u>20 15</u>		
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	Yes
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	Yes
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>WWW.GENESISHEALTH.COM/COMMUNITY</u>		
b <input type="checkbox"/> Other website (list url) _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 15</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) <u>WWW.GENESISHEALTH.COM/COMMUNITY</u>	10	Yes
a		
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	No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

GENESIS MEDICAL CENTER - DAVENPORT

Name of hospital facility or letter of facility reporting group

	Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that		
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13 Yes	
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 000000000000 % and FPG family income limit for eligibility for discounted care of 200 000000000000 %		
b <input type="checkbox"/> Income level other than FPG (describe in Section C)		
c <input checked="" type="checkbox"/> Asset level		
d <input checked="" type="checkbox"/> Medical indigency		
e <input checked="" type="checkbox"/> Insurance status		
f <input checked="" type="checkbox"/> Underinsurance discount		
g <input type="checkbox"/> Residency		
h <input type="checkbox"/> Other (describe in Section C)		
14 Explained the basis for calculating amounts charged to patients?	14 Yes	
15 Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	15 Yes	
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e <input type="checkbox"/> Other (describe in Section C)		
16 Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	16 Yes	
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) WWW GENESISHEALTH COM		
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) WWW GENESISHEALTH COM		
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) WWW GENESISHEALTH COM		
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 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)		

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

GENESIS MEDICAL CENTER - DAVENPORT

Name of hospital facility or letter of facility reporting group

		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 non-payment?	17	Yes	
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 type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP 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 checked="" 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		No
If "Yes," check all actions in which the hospital facility or a third party engaged			
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> 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 checked="" 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	Yes	
If "No," indicate why			
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions b <input type="checkbox"/> The hospital facility's policy was not in writing c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) d <input type="checkbox"/> Other (describe in Section C)			

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

GENESIS MEDICAL CENTER - DAVENPORT

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

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
22		
23		No
24		No

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

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

Name of hospital facility or letter of facility reporting group _____

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

2

Community Health Needs Assessment

	Yes	No
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3 Yes	
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" 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 <u>20 14</u>		
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 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 Yes	
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a Yes	
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	No
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7 Yes	
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>WWW.GENESISHEALTH.COM/COMMUNITY</u>		
b <input type="checkbox"/> Other website (list url) _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> Other (describe in Section C) _____		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8 Yes	
9 Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 14</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) <u>WWW.GENESISHEALTH.COM/COMMUNITY</u>	10 Yes	
a _____		
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	No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

GENESIS MEDICAL CENTER - DEWITT

Name of hospital facility or letter of facility reporting group

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13	Yes	
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 000000000000 % and FPG family income limit for eligibility for discounted care of 200 000000000000 %			
b <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input checked="" type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input checked="" type="checkbox"/> Underinsurance discount			
g <input type="checkbox"/> Residency			
h <input type="checkbox"/> Other (describe in Section C)			
14 Explained the basis for calculating amounts charged to patients?	14	Yes	
15 Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	15	Yes	
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e <input type="checkbox"/> Other (describe in Section C)			
16 Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	16	Yes	
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) WWW.GENESISHEALTH.COM			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) WWW.GENESISHEALTH.COM			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) WWW.GENESISHEALTH.COM			
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)			

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

GENESIS MEDICAL CENTER - DEWITT

Name of hospital facility or letter of facility reporting group

		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 non-payment?	17	Yes	
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 type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP 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 checked="" 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		No
If "Yes," check all actions in which the hospital facility or a third party engaged			
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> 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 checked="" 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	Yes	
If "No," indicate why			
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions b <input type="checkbox"/> The hospital facility's policy was not in writing c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) d <input type="checkbox"/> Other (describe in Section C)			

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

GENESIS MEDICAL CENTER - DEWITT

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

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
22		
23		No
24		No

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

[illegible]

Part V **Facility Information** *(continued)***Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

How many non-hospital health care facilities did the organization operate during the tax year? **72**

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

Part VI Supplemental Information

Provide the following information

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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 3C	NOT APPLICABLE

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 6A	GENESIS HEALTH SYSTEM (GHS ILLINOIS) AND GENESIS MEDICAL CENTER, ALEDO (GMC, ALEDO)

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7	GENESIS HEALTH SYSTEM (GHS IOWA) UTILIZED WORKSHEET 2 TO CALCULATE ITS COST-TO-CHARGE RATIO THE CALCULATED COST-TO-CHARGE RATIO WAS USED TO CALCULATE THE COST OF CHARITY CARE AND UNREIMBURSED MEDICAID COSTS OF THE "OTHER BENEFITS" REPORTED IN 7E -7I WERE COMPILED THROUGHOUT THE YEAR IN THE COMMUNITY BENEFIT DATABASE (I E , CBISA) THAT GHS IOWA UTILIZES

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7G	NO COSTS ASSOCIATED WITH A PHYSICIAN CLINIC WERE REPORTED IN SUBSIDIZED HEALTH SERVICES

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LN 7 COL(F)	NO BAD DEBT EXPENSE WAS INCLUDED IN THE DENOMINATOR BECAUSE BAD DEBT WAS REPORTED IN LINE 2F OF PART VIII, STATEMENT OF REVENUE THE ORGANIZATION'S TOTAL COMMUNITY BENEFIT EXPENSE AS A PERCENTAGE OF TOTAL EXPENSES IS 20 09%, AND THE PERCENTAGE INCREASES TO 45 59% IF MEDICARE COST REPORT ALLOWABLE COSTS ARE INCLUDED IN TOTAL COMMUNITY BENEFIT EXPENSE

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART II, COMMUNITY BUILDING ACTIVITIES	<p>ECONOMIC DEVELOPMENT (F2) COUNCIL AND CHAMBER - GENESIS HEALTH SYSTEM (GHS IOWA) SUPPORTS EMPLOYEE INVOLVEMENT ON LOCAL COUNCIL AND CHAMBER COMMITTEES GRANTS TO COMMUNITY BUSINESSES - GHS IOWA SUPPORTS ITS COMMUNITY BY GIVING GRANTS TO LOCAL BUSINESSES TO IMPROVE ECONOMIC DEVELOPMENT AND RELIEVE OR REDUCE THE BURDEN OF GOVERNMENT OR OTHER TAX-EXEMPT ORGANIZATIONS COMMUNITY SUPPORT (F3) DISASTER READINESS - GHS IOWA PARTICIPATES IN COMMUNITY WIDE DISASTER READINESS DRILLS THROUGHOUT THE YEAR TO ENSURE ITS PREPAREDNESS FOR AN ARRAY OF DISASTERS JUNIOR ACHIEVEMENT - GHS IOWA PARTICIPATES IN A VOLUNTEER PARTNERSHIP WITH JUNIOR ACHIEVEMENT ADVOCACY FOR COMMUNITY HEALTH IMPROVEMENT/SAFETY (F7) HEALTH CARE ADVOCACY - GENESIS HEALTH SYSTEM (GHS IOWA) MAINTAINS AN ACTIVE EFFORT TO ADVOCATE FOR ACCESS TO HEALTH CARE WITH THE IOWA AND ILLINOIS STATE GOVERNMENTS AND IN WASHINGTON D C GENESIS EMPLOYEES PARTICIPATE IN A VOTER VOICE INITIATIVE TO ALSO ADVOCATE ON IMPORTANT HEALTH ISSUESWORKFORCE DEVELOPMENT (F8) PROGRAMS ON HEALTH CAREERS - GHS IOWA PARTNERS WITH THE LOCAL COMMUNITY COLLEGES AND UNIVERSITIES TO ADDRESS THE HEALTH CARE WORK FORCE SHORTAGE GHS IOWA WORKS WITH THE LOCAL COMMUNITY COLLEGES AND UNIVERSITIES TO ADDRESS COMMUNITY-WIDE WORKFORCE ISSUES BY SUPPORTING JOB CREATION AND TRAINING PROGRAMS</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 2	IN ACCORDANCE WITH HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION STATEMENT NO 15, BAD DEBT IS REPORTED AT THE FULL-ESTABLISHED CHARGE FROM THE MOST RECENT AUDITED FINANCIAL REPORT PAYMENTS RECEIVED AFTER AN ACCOUNT HAD BEEN WRITTEN OFF TO BAD DEBT WERE CREDITED TO A BAD DEBT RECOVERY ACCOUNT DISCOUNTS ONPATIENT ACCOUNTS PROVIDED BY THIRD-PARTY PAYERS WERE WRITTEN OFF TO A CONTRACTUAL ALLOWANCE ACCOUNT

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 3	GENESIS HEALTH SYSTEM (GHS IOWA) USES AVADYNE HEALTH TO PROCESS AGING PATIENT ACCOUNTS AVADYNE HEALTH'S COLLECTION PROCESS UTILIZES PUBLICLY AVAILABLE INFORMATION TO ENSURE ALL AGING PATIENT ACCOUNTS RECEIVE FINANCIAL ASSISTANCE IN ACCORDANCE TO GHS IOWA POLICY BEFORE BEING DEEMED BAD DEBT GHS IOWA REPORTED ZERO DOLLARS FOR THE ESTIMATED AMOUNT OF THE ORGANIZATION'S BAD DEBT ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 4	<p>PATIENT RECEIVABLES DUE DIRECTLY FROM THE PATIENTS ARE CARRIED AT THE ORIGINAL CHARGE FOR THE SERVICE PROVIDED LESS AMOUNTS COVERED BY THIRD-PARTY PAYORS AND LESS AN ESTIMATED ALLOWANCE FOR DOUBTFUL RECEIVABLES BASED ON A REVIEW OF ALL OUTSTANDING AMOUNTS ON A MONTHLY BASIS RECEIVABLES DUE FROM MEDICAL OFFICE BUILDING TENANTS AND FROM COMMERCIAL LAUNDRY CUSTOMERS ARE CARRIED AT THE ORIGINAL INVOICE AMOUNT LESS AN ESTIMATE MADE FOR DOUBTFUL ACCOUNTS MANAGEMENT DETERMINES THE ALLOWANCE FOR DOUBTFUL ACCOUNTS BY IDENTIFYING TROUBLED ACCOUNTS, BY HISTORICAL EXPERIENCE APPLIED TO AN AGING OF ACCOUNTS, AND BY CONSIDERING THE PATIENT'S FINANCIAL HISTORY, CREDIT HISTORY AND CURRENT ECONOMIC CONDITIONS GENESIS HEALTH SYSTEM (GHS IOWA) DOES NOT CHARGE INTEREST ON PATIENT RECEIVABLES RECEIVABLES ARE WRITTEN OFF AS BAD DEBTS WHEN DEEMED UNCOLLECTIBLE RECOVERIES OF RECEIVABLES PREVIOUSLY WRITTEN OFF ARE RECORDED AS A REDUCTION OF BAD DEBT EXPENSE WHEN RECEIVED</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 8	<p>THE MEDICARE COST REPORT WAS USED TO DETERMINE THE AMOUNT REPORTED IN PART III, LINES 5, 6, AND 7 FOR THE HOSPITALS NO MEDICARE SHORTFALLS WERE INCLUDED IN COMMUNITY BENEFIT THE MEDICARE COST REPORT SHORTFALL REPRESENTS THE DIFFERENCE BETWEEN THE TOTAL REVENUE RECEIVED FROM MEDICARE BASED ON MEDICARE COST REPORT REIMBURSEMENT RATES AND THE COSTS INCURRED BY GHS IOWA IN PROVIDING HEALTHCARE SERVICES TO THE ELDERLY THE TOTAL MEDICARE SHORTFALL, WHICH INCLUDES FEE SCREEN SERVICES, WAS \$1,193,927 IN 2010, THE PERCENT OF PERSONS 65 YEARS AND OVER IN ROCK ISLAND AND SCOTT COUNTIES WAS 18 6% IN ACCORDANCE WITH GHS IOWA'S MISSION STATEMENT, "TO PROVIDE COMPASSIONATE, QUALITY HEALTH SERVICES TO ALL THOSE IN NEED," THE ELDERLY WERE SERVED DESPITE THE TOTAL MEDICARE LOSS OF \$1,193,927 GHS IOWA HAS A CLEAR MISSION TO SERVE ALL THOSE IN NEED AND TO IMPROVE THE HEALTH OF THE COMMUNITY INCLUDING THE ELDERLY FURTHERMORE, THERE ARE NO FOR-PROFIT HOSPITALS IN THE COMMUNITY, AND THEREFORE GHS IOWA IS ONE OF TWO TAX-EXEMPT HEALTHCARE ORGANIZATIONS IN THE COMMUNITY WHO PROVIDE ACCESS TO HEALTHCARE FOR MEDICARE PATIENTS ACCORDINGLY, IT IS GHS IOWA'S POSITION FOR THE REASONS STATED ABOVE THAT THE TOTAL MEDICARE SHORTFALL OF \$1,193,927 REPRESENTS A COMMUNITY BENEFIT PURSUANT TO THE INSTRUCTIONS TO THE FORM 990, SCHEDULE H, THE MEDICARE SHORTFALL IS NOT INCLUDED IN PART I, LINE 7 IF THE TOTAL MEDICARE SHORTFALL WAS INCLUDED IN PART I, LINE 7, THEN PART I, LINE 7K, COLUMN F WOULD BE 6 99%</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 9B	EVERY EFFORT IS MADE TO DETERMINE A PATIENT'S ELIGIBILITY FOR FINANCIAL ASSISTANCE IF ELIGIBLE, PAYMENT PLANS ARE MADE AVAILABLE BASED ON THEIR RESOURCES AND INCOME ALL BALANCES OWING AFTER FINANCIAL ASSISTANCE ALLOWANCES HAVE BEEN TAKEN ARE PAYABLE IN MONTHLY PAYMENTS IN ACCORDANCE WITH THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 2	GENESIS HEALTH SYSTEM (GHS IOWA) UTILIZES THE COMMUNITY HEALTH NEEDS ASSEMSSMENT (CHNA) CONDUCTED BY PROFESSIONAL RESEARCH CONSULTANTS, INC (PRC) IN 2015 THE CHNA WAS FUNDED BY GHS IOWA AND UNITY POINT HEALTH- TRINITY AND SPONSORED BY COMMUNITY HEALTH CARE, GHS IOWA, QUAD CITY HEALTH INITIATIVE (QCHI), ROCK ISLAND COUNTY HEALTH DEPARTMENT, SCOTT COUNTY HEALTH DEPARTMENT, AND UNITY POINT HEALTH- TRINITY QCHI WAS FORMED BY GHS IOWA AND GENESIS HEALTH SYSTEM (GHS ILLINOIS) WHICH HAS HEADQUARTERS IN BOTH SCOTT COUNTY, IOWA, AND ROCK ISLAND COUNTY, ILLINOIS, AND UNITY POINT HEALTH-TRINITY, WHICH IS HEADQUARTERED IN ROCK ISLAND COUNTY, ILLINOIS QCHI IS NOW A COMMUNITY PARTNERSHIP OF OVER 300 COMMUNITY MEMBERS AND LEADERS PURSUING INITIATIVES TO CREATE A HEALTHIER COMMUNITY, SERVING AS A CATALYST FOR IMPROVING THE HEALTH AND OVERALL QUALITY OF LIFE WITHIN THE QUAD CITIES

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 3	INFORMATION ON THE AVAILABILITY OF FINANCIAL ASSISTANCE IS POSTED IN VISIBLE LOCATIONS IN THE ADMISSION DEPARTMENTS OF THE HOSPITALS IN ADDITION, THE HOSPITAL REGISTRATION STAFF MAKE AVAILABLE INFORMATIVE BROCHURES FOR PATIENTS IN THE EMERGENCY ROOM REGISTRATION AREA EXPLAINING THEIR ELIGIBILITY FOR ASSISTANCE GENESIS HEALTH SYSTEM (GHS IOWA) PROVIDES PATIENT FINANCIAL COUNSELORS ON EACH HOSPITAL CAMPUS TO DISCUSS OPTIONS WITH THE PATIENTS PATIENT FINANCIAL SERVICES PREPARES AND PROVIDES A LETTER TO EACH PATIENT, EXPLAINING THEIR CURRENT BALANCE AND ADVISING THEM OF THEIR OPTIONS A PHONE NUMBER IS PROVIDED WITH THE LETTER ENCOURAGING THE PATIENT TO CALL IF NEEDED

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 4	OUR PRIMARY SERVICE AREA (PSA), ALSO CALLED THE BI-STATE REGION, IS DEFINED AS SCOTT COUNTY, IA, AND ROCK ISLAND COUNTY, IL WITH A 2017 POPULATION OF 320,345 AND A PROJECTED GROWTH RATE OF 1.5% FROM 2017 TO 2022. OUR SECONDARY SERVICE AREA (SSA), ALSO CALLED THE 9-COUNTY REGION, CONSISTS OF THE BI-STATE REGION PLUS CLINTON, DES MOINES, HENRY IL, JACKSON, MUSCATINE, MERCER AND WHITESIDE COUNTIES (POPULATION 592,234). OUR TERTIARY SERVICE AREA (TSA), ALSO CALLED THE 17-COUNTY REGION, INCLUDES OUR SSA PLUS CEDAR, HENRY, LEE, AND LOUISA COUNTIES IN IA, AND CARROLL, HENDERSON, KNOX, AND WARREN COUNTIES IN IL. THE TSA HAS A TOTAL POPULATION OF 764,458 AND A PROJECTED GROWTH RATE OF 0.2% FROM 2017 TO 2022. WHILE OUR SERVICE AREA POPULATION IS NOT PROJECTED TO GROW SIGNIFICANTLY OVER TIME, THE PERCENTAGE OF PERSONS 65 AND OLDER IS PROJECTED TO GROW 12% FROM 2017 TO 2022.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 5	GENESIS MEDICAL CENTER (GHS IOWA) AND THE ENTIRE GENESIS HEALTH SYSTEM ARE COMMITTED TO PROVIDING QUALITY, COMPASSIONATE HEALTH CARE TO ALL THOSE IN NEED ONE WAY THIS COMMITMENT IS TANGIBLY EXPRESSED IS THROUGH THE PROMOTION OF COMMUNITY HEALTH THROUGH PROGRAMS SUCH AS FLU FREE QC, LIVE LIFE LEAD FREE (OUR NEWEST HEALTH PROGRAM, STARTED IN 2018, DESIGNED TO REDUCE THE INCIDENCE OF LEAD POISONING IN CHILDREN), FUNDS ALLOCATED TO AREA PROGRAMS THAT ADDRESS COMMUNITY HEALTH NEEDS LIKE CHILDHOOD OBESITY, MENTAL HEALTH PROGRAMS, PROVISION OF EMERGENCY AND TRAUMA CARE SERVICES AND MANY OTHER HEALTH CARE SERVICES IN ADDITION, GENESIS IS GOVERNED BY A 19-MEMBER COMMUNITY BOARD OF DIRECTORS REPRESENTATIVE OF THE BROADER COMMUNITY

Form and Line Reference	Explanation
PART VI, LINE 6	<p>GENESIS HEALTH SYSTEM (GHS IOWA), AN IOWA NONPROFIT CORPORATION, AND GENESIS HEALTH SYSTEM (GHS ILLINOIS), AN ILLINOIS NOT-FOR-PROFIT CORPORATION, HAVE IDENTICAL GOVERNING BOARDS, MANAGEMENT AND BYLAWS AND CAN ACT JOINTLY. GHS IOWA IS ALSO THE SOLE MEMBER OF GENESIS HEALTH SERVICES FOUNDATION, GENESIS PHILANTHROPY, GENESIS ACCOUNTABLE CARE ORGANIZATION, LLC AND GENESIS HEALTH SYSTEM WORKER'S COMPENSATION PLAN AND TRUST, THE SOLE STOCKHOLDER OF GENVENTURES, INC., A MEMBER OF MISERICORDIA ASSURANCE COMPANY, LTD. AND A PARTNER IN GENGASTRO, LLC. GHS ILLINOIS IS THE SOLE MEMBER OF GENESIS MEDICAL CENTER, ALEDO (GMC, ALEDO) AND GENESIS SENIOR LIVING, ALEDO (GSL, ALEDO) AND IS A PARTNER IN THE LARSON CENTER PARTNERSHIP. GHS IOWA, GHS ILLINOIS, GMC, ALEDO, AND GSL, ALEDO COLLECTIVELY REPRESENT THE OBLIGATED GROUP ON CERTAIN COMPONENTS OF THE SYSTEM'S LONG-TERM DEBT. GHS IOWA AND GHS ILLINOIS OPERATE THE FOLLOWING BUSINESS UNITS. GENESIS HEALTH SYSTEM PROVIDES ADMINISTRATIVE, MANAGEMENT, INFORMATION TECHNOLOGY AND OTHER SUPPORT SERVICES TO ITS AFFILIATES. GENESIS CLINICAL SERVICES OPERATES PHYSICIAN MEDICAL PRACTICES, CONVENIENT CARE PRACTICES AND AN OCCUPATIONAL MEDICINE CLINIC AND PROVIDES BEHAVIORAL HEALTH SERVICES TO THE RESIDENTS OF EASTERN IOWA AND WESTERN ILLINOIS. GENESIS MEDICAL CENTER - DAVENPORT (GMC - DAVENPORT) IS LICENSED AS A 502-BED ACUTE CARE HOSPITAL WHICH PROVIDES SERVICES FROM TWO HOSPITAL FACILITIES LOCATED IN DAVENPORT, IOWA. GENESIS FAMILY MEDICAL CENTER (GFMC) IS A FAMILY PRACTICE RESIDENCY TRAINING PROGRAM THAT OPERATES CLINICS IN DAVENPORT AND BLUE GRASS, IOWA TO PROVIDE A CLINICAL SETTING FOR THE RESIDENTS TO TREAT PATIENTS. GENESIS MEDICAL CENTER - DEWITT (GMC - DEWITT) IS CERTIFIED AS A CRITICAL ACCESS HOSPITAL, WHICH HAS 13-ACUTE CARE AND SWING BEDS, AND HAS A 77-BED LONG-TERM CARE FACILITY, WHICH PROVIDES SERVICES FROM ITS FACILITY IN DEWITT, IOWA. GENESIS VISITING NURSE ASSOCIATION AND HOSPICE (VNA) PROVIDES HOME HEALTH CARE, COMMUNITY NURSING SERVICES AND HOSPICE SERVICES TO PATIENTS IN EASTERN IOWA AND WESTERN ILLINOIS. GENESIS MEDICAL CENTER - SILVIS (GMC - SILVIS) IS LICENSED AS A 145-BED ACUTE CARE HOSPITAL WHICH PROVIDES SERVICES FROM ITS FACILITY IN SILVIS, ILLINOIS. ILLINI HOSPITAL NURSING HOME (INH) OPERATES ILLINI RESTORATIVE CARE CENTER AND CROSSTOWN SQUARE. ILLINI RESTORATIVE CARE CENTER IS A 120-BED LICENSED NURSING FACILITY, CONSISTING OF 92 SKILLED CARE BEDS AND 28 SHELTERED CARE BEDS. ALL 92 BEDS ARE DUALY LICENSED FOR MEDICARE/MEDICAID SERVICES. THE SHELTERED CARE UNIT PROVIDES PERSONAL CARE SIMILAR TO AN ASSISTED LIVING FACILITY. CROSSTOWN SQUARE IS AN INDEPENDENT LIVING FACILITY CONTAINING 64 RENTABLE APARTMENTS AND 3 GUEST ROOMS THAT OFFERS SERVICES DESIGNED TO MEET THE NEEDS OF SENIOR ADULTS. GHS IOWA AND GHS ILLINOIS HAVE A CONTROLLING OWNERSHIP INTEREST OR MEMBERSHIP IN THE FOLLOWING ORGANIZATIONS. GENESIS MEDICAL CENTER - ALEDO (GMC - ALEDO) IS CERTIFIED AS A CRITICAL ACCESS HOSPITAL, WHICH HAS 22-ACUTE CARE AND SWING BEDS, AS WELL AS A PHYSICIAN CLINIC, WHICH PROVIDES SERVICES FROM ITS FACILITY IN ALEDO, ILLINOIS. GENESIS SENIOR LIVING - ALEDO (GSL - ALEDO) IS CERTIFIED AS A NURSING FACILITY, WHICH HAS A 92-BED LONG-TERM CARE FACILITY, WHICH PROVIDES SERVICES FROM ITS FACILITY IN ALEDO, ILLINOIS. GENESIS HEALTH SERVICES FOUNDATION (GENESIS FOUNDATION) IS AN ORGANIZATION WHOSE MISSION IS TO DEVELOP, MANAGE, AND GRANT CHARITABLE SUPPORT TO MEET THE HEALTH-RELATED NEEDS OF THE COMMUNITIES SERVED BY GENESIS HEALTH SYSTEM. THE GENESIS FOUNDATION IS REFERRED TO AS THE FOUNDATION GENGASTRO, LLC (D/B/A THE CENTER FOR DIGESTIVE HEALTH) IS A LIMITED LIABILITY COMPANY, WHICH OPERATES A SINGLE-SPECIALTY GASTROENTEROLOGY AMBULATORY SURGERY CENTER LOCATED IN BETTENDORF, IOWA. GENESIS HEALTH SYSTEM (GHS IOWA) MAINTAINS A 75% OWNERSHIP INTEREST. THE LARSON CENTER PARTNERSHIP (LCP) IS A FOR-PROFIT REAL ESTATE PARTNERSHIP, WHICH OWNS A MEDICAL OFFICE BUILDING A DJACENT TO GMC SILVIS AND LEASES SPACE FOR CLINICS, LABORATORY, PHARMACY AND OFFICES TO GMC SILVIS AND OTHER THIRD-PARTY ORGANIZATIONS. GHS ILLINOIS IS A GENERAL PARTNER AND OWNS APPROXIMATELY 79.8% OF LCP GENVENTURES, INC. (GENVENTURES) IS A WHOLLY-OWNED FOR-PROFIT CORPORATION WHICH OPERATES THE FOLLOWING DIVISIONS, PRIMARILY IN THE QUAD CITIES. GENESIS AT HOME, CONTINUING CARE SELLS AND LEASES HOME MEDICAL EQUIPMENT, PROVIDES INTRAVENOUS THERAPY SERVICES, INCLUDING SALES OF RELATED SOLUTIONS AND SUPPLIES TO PATIENTS, AND PROVIDES RETAIL PHARMACEUTICAL AND OVER-THE-COUNTER PRODUCTS TO PATIENTS AND EMPLOYEES OF THE SYSTEM. GENPROPERTIES OWNS, LEASES AND/OR MANAGES OFFICE SPACE IN 15 MEDICAL OFFICE BUILDINGS LOCATED IN BETTENDORF, CLINTON, DAVENPORT, ELDRIDGE, LECLAIRE AND MUSCATINE, IOWA. CRESCENT LAUNDRY PROVIDES COMMERCIAL LAUNDRY SERVICES TO HEALTH CARE FACILITIES IN EASTERN IOWA AND IN NORTH-CENTRAL ILLINOIS. GENESIS ACCOUNTABLE CARE ORGANIZATION, LLC (GENESIS ACO) IS AN IOWA LIMITED LIABILITY COMPANY FORMED IN DECEMBER</p>

Form and Line Reference	Explanation
PART VI, LINE 6	<p>2011 ITS PURPOSE IS TO ENGAGE IN ANY LAWFUL BUSINESS AND ANY BUSINESS RELATED TO CREATION AND ORGANIZATION OF A "PHYSICIAN-DRIVEN" NETWORK TO ACT AS, AND/OR PARTICIPATE IN, AN ACCOUNTABLE CARE ORGANIZATION WITHIN THE MEANING OF THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT THE COMPANY IS ALSO ORGANIZED TO DEVELOP A CLINICALLY INTEGRATED NETWORK OF PROVIDERS INCLUDING PHYSICIANS, HEALTH PROFESSIONALS, HOSPITALS AND ANCILLARY PROVIDERS WORKING TOGETHER TO PROMOTE HIGH QUALITY, COORDINATED AND EFFICIENT CARE TO PATIENTS INCLUDING MEMBERS OF VARIOUS MANAGED CARE PAYORS AND THE COMMUNITY AT LARGE GENESIS PHILANTHROPY IS A WHOLLY-OWNED TAX-EXEMPT ENTITY FORMED IN 2013, WHICH PARTNERS WITH OTHER HOSPITAL FOUNDATIONS TO FORM A REGIONAL NETWORK TO ATTRACT DONORS TO HELP FUND SPECIFIC HEALTH-RELATED CAUSES AND PROMOTE WELLNESS IN THE REGION GENESIS HEALTH SYSTEM WORKERS' COMPENSATION PLAN AND TRUST (WORKERS' COMPENSATION TRUST) PROVIDES A FUND WHICH CAN BE USED TO PAY WORKERS' COMPENSATION CLAIMS AND COSTS FOR THE BENEFIT OF GENESIS HEALTH SYSTEM MISERICORDIA ASSURANCE COMPANY, LTD (MISERICORDIA) IS A WHOLLY-OWNED CAYMAN BASED CAPTIVE INSURANCE COMPANY WHICH UNDERWRITES THE GENERAL AND PROFESSIONAL LIABILITY RISKS OF GHS IOWA AND AFFILIATES</p>

990 Schedule H, Supplemental Information	
Form and Line Reference	Explanation
PART VI, LINE 7, REPORTS FILED WITH STATES	IL,IA

Additional Data

Software ID:
Software Version:
EIN: 42-1418847
Name: GENESIS HEALTH SYSTEM

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

Section A. Hospital Facilities		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER—24 hours	ER—other	Other (Describe)	Facility reporting group
(list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? 2											
1	GENESIS MEDICAL CENTER - DAVENPORT 1227 E RUSHOLME STREET DAVENPORT, IA 52803 WWW.GENESISHEALTH.COM 820011H	X	X					X			
2	GENESIS MEDICAL CENTER - DEWITT 1118 11TH STREET DEWITT, IA 52742 WWW.GENESISHEALTH.COM 230149H	X	X			X		X			

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

Form and Line Reference	Explanation
GENESIS MEDICAL CENTER - DAVENPORT	<p>PART V, SECTION B, LINE 5 GENESIS HEALTH SYSTEM (GHS IOWA) AND GENESIS HEALTH SYSTEM (GHS ILLINOIS) CONTINUE TO WORK WITH THE QUAD CITY HEALTH INITIATIVE (QCHI), COMMUNITY HEALTH CARE, THE ROCK ISLAND COUNTY HEALTH DEPARTMENT, THE SCOTT COUNTY HEALTH DEPARTMENT, UNITY POINT TRINITY BETTENDORF AND OTHER HEALTH AND SOCIAL SERVICE AGENCIES TO IMPROVE THE HEALTH STATUS AND QUALITY OF LIFE IN THE QUAD CITY REGION THROUGH THE QCHI ORGANIZATION. THE CO-ORDINATED ASSESSMENT APPROACH INCLUDES PRIMARY DATA COLLECTION, SECONDARY DATA ANALYSIS, AND QUALITATIVE INPUT FROM COMMUNITY LEADERS. EACH HEALTH DEPARTMENT CONVENED A COMMUNITY HEALTH TASK FORCE TO REVIEW AND PRIORITIZE SECONDARY DATA AND COLLECT QUALITATIVE INPUT FROM THE COMMUNITY LEADERS IN SCOTT AND ROCK ISLAND COUNTIES. IN ADDITION, THROUGH QCHI, BOTH GENESIS AND UNITY POINT HEALTH SYSTEMS FUNDED A SURVEY AND DATA COLLECTION FOR THE BI-STATE AREA AND HIRED PROFESSIONAL RESEARCH CONSULTANTS, INC. (PRC) TO PERFORM THIS WORK. THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) INCORPORATES DATA FROM THE PRIMARY RESEARCH (THE PRC COMMUNITY HEALTH SURVEY) AND SECONDARY RESEARCH (EG VITAL STATISTICS AND OTHER HEALTH-RELATED DATA), THESE COMPONENTS ALLOWED FOR TRENDING AND COMPARISON TO STATE AND NATIONAL DATA. THE SURVEY INSTRUMENT USED FOR THIS STUDY IS BASED PRIMARILY ON THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (BRFSS) PLUS OTHER PUBLIC HEALTH SURVEYS AND CUSTOMIZED QUESTIONS ADDRESSING GAPS IN INDICATOR DATA RELATIVE TO HEALTH PROMOTION AND DISEASE PREVENTION OBJECTIVES AND OTHER HEALTH ISSUES. THE FINAL SURVEY INSTRUMENT WAS DEVELOPED BY THE SPONSORING ORGANIZATIONS AND PRC, AND IS SIMILAR TO THE PREVIOUS SURVEYS USED IN THE REGION. THIS ENABLED US TO ANALYZE TRENDS IN THE DATA. RESEARCHERS USED A TELEPHONE INTERVIEW METHODOLOGY THAT INCORPORATED BOTH LANDLINE AND CELL PHONE INTERVIEWS TO ENSURE THE BEST REPRESENTATION OF THE POPULATION SURVEYED. THE PRIMARY ADVANTAGES OF USING THE TELEPHONE FOR SURVEY INTERVIEWS ARE TIMELINESS, EFFICIENCY AND THE ABILITY TO RANDOMLY SELECT RESPONDENTS. THE SAMPLE DESIGN USED FOR THIS PROJECT INCLUDE A STRATIFIED RANDOM SAMPLE OF 801 INDIVIDUALS AGE 18 AND OLDER RESIDING IN THE QUAD CITY AREA (402 RESPONDENTS IN ROCK ISLAND COUNTY AND 399 IN SCOTT COUNTY). IN ADDITION, AN OVERSAMPLE OF 122 ADDITIONAL INTERVIEW WAS IMPLEMENTED AMONG AFRICAN-AMERICAN AND HISPANIC ADULTS TO ENSURE THAT THESE POPULATIONS WERE ADEQUATELY REPRESENTED IN THE SAMPLE AND COULD BE ANALYZED INDEPENDENTLY. THIS EFFORT GARNERED 87 INTERVIEWS WITH AFRICAN-AMERICAN ADULTS AND 101 INTERVIEWS WITH HISPANIC INDIVIDUALS (INCLUDING RESPONDENTS REACHED THROUGH BOTH THE RANDOM SAMPLE AND OVERSAMPLE INTERVIEWS). ONCE THE SURVEY WORK WAS COMPLETED, THE 923 TOTAL INTERVIEWS WERE WEIGHTED IN PROPORTION NOT THE ACTUAL POPULATION DISTRIBUTION SO AS TO APPROPRIATELY REPRESENT THE QUAD CITIES AREA AS A WHOLE. ALL ADMINISTRATION OF THE SURVEY, DATA COLLECTION AND DATA</p>

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

Form and Line Reference	Explanation
GENESIS MEDICAL CENTER - DAVENPORT	ANALYSIS WAS PERFORMED BY PRC FOR STATISTICAL PURPOSES, THE MAXIMUM RATE OF ERROR ASSOCIATED WITH A SAMPLE SIZE OF 932 RESPONDENTS IS +/- 3.3% AT THE 95TH PERCENT LEVEL OF CONFIDENCE. IT IS A COMMON AND PREFERRED PRACTICE TO "WEIGHT" THE RAW DATA TO IMPROVE THE REPRESENTATION OF CERTAIN GROUPS. EVEN MORE, THIS IS DONE BY ADJUSTING THE RESULTS OF THE RANDOM SAMPLE TO MATCH THE GEOGRAPHIC DISTRIBUTION AND DEMOGRAPHIC MAKEUP OF THE POPULATION SURVEYED (POST STRATIFICATION), TO ELIMINATE ANY NATURALLY OCCURRING BIAS. SPECIFICALLY, ONCE THE RAW DATA ARE GATHERED, RESPONDENTS ARE EXAMINED BY KEY DEMOGRAPHIC CHARACTERISTICS (I.E. GENDER, AGE, RACE, ETHNICITY, AND POVERTY STATUS) AND A STATISTICAL APPLICATION ALLOWS WEIGHTING VARIABLES THAT PRODUCE A SAMPLE, WHICH MORE CLOSELY MATCHES THE POPULATION FOR THESE CHARACTERISTICS. THEREFORE, WHILE THE INTEGRITY OF EACH INDIVIDUAL'S RESPONSES IS PRESERVED, ONE RESPONDENT'S RESPONSES MAY CONTRIBUTE TO THE WHOLE THE WEIGHT AS, FOR EXAMPLE, 11 RESPONDENTS. ANOTHER RESPONDENT, WHOSE DEMOGRAPHIC CHARACTERISTICS MAY HAVE BEEN SLIGHTLY OVERSAMPLED, MAY CONTRIBUTE THE SAME WEIGHT AS 0.9 RESPONDENTS. A VARIETY OF EXISTING (SECONDARY) DATA SOURCES WAS CONSULTED TO COMPLEMENT THE RESEARCH. QUALITY OF THIS COMMUNITY HEALTH ASSESSMENT DATA FOR ROCK ISLAND AND SCOTT COUNTIES WERE GATHERED FROM THE FOLLOWING SOURCES -CENTER FOR APPLIED RESEARCH AND ENVIRONMENTS SYSTEMS (CARES)-CENTER FOR DISEASE CONTROL AND PREVENTION-COMMUNITY COMMONS-ESRI ARCGIS MAP GALLERY-NATIONAL CENTER INSTITUTE, STATE CANCER PROFILES-OPENSTATEMAP (OSM)-US DEPARTMENT OF AGRICULTURE, ECONOMIC RESEARCH SERVICE-IOWA DEPARTMENT OF PUBLIC SAFETY/ILLINOIS STATE POLICE-US CENSUS BUREAU- US DEPARTMENT OF HEALTH AND HUMAN SERVICES-US DEPARTMENT OF JUSTICE, FEDERAL BUREAU OF INVESTIGATIONS-US DEPARTMENT OF LABOR, BUREAU OF STATISTICS-NOTE SECONDARY DATA ARE COUNTY LEVEL DATA

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

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

Form and Line Reference	Explanation
GENESIS MEDICAL CENTER - DEWITT	PART V, SECTION B, LINE 5 TO COMPLETE THE COMMUNITY HEALTH NEEDS ASSESSMENT, EXISTING HEALTH-RELATED DATA WERE COLLECTED VIA THE ONLINE COMMUNITY COMMONS COMMUNITY HEALTH NEEDS ASSESSMENT REPORT TOOL AT HTTP //WWW COMMUNITYCOMMONS ORG/MAPS-DATA THIS SITE ALLOWS FOR IDENTIFICATION OF 87 DISTINCT HEALTH AND SOCIAL INDICATORS AT THE COUNTY LEVEL, ALONG WITH COMPARISONS TO STATE AND NATIONAL DATA, AND HEALTH PEOPLE 2020 TARGETS, WHERE AVAILABLE ONCE AN INDICATORS REPORT WAS GENERATED, RELEVANT INDICATORS WERE REVIEWED TO DETERMINE HOW CLINTON AND JACKSON COUNTIES COMPARED TO AVAILABLE STATE/NATIONAL DATA (SEE THE "DETAILED HEALTH INDICATORS" SECTION OF THIS DOCUMENT INFORMATION GAPS BECAUSE THIS CHNA RELIES ON EXISTING DATASETS, IT IS LIMITED IN SCOPE TO THOSE INDICATORS CURRENTLY AVAILABLE THROUGH DATABASE COLLECTION IT DOES NOT INCLUDE A PRIMARY RESEARCH COMPONENT AND MANY IMPORTANT ISSUES ARE UNADDRESSED (E G ACCESS TO HEALTHCARE) ANOTHER LIMITATION IS THAT MOST MEASURES INCLUDED IN THIS ASSESSMENT REPRESENT DATA THAT ARE SEVERAL YEARS OLD COMMUNITY STAKEHOLDER INPUT GENESIS MEDICAL CENTER DEWITT AND JACKSON COUNTY REGIONAL HEALTH CENTER (JCRHC) GOT INPUT FROM PUBLIC HEALTH OFFICIALS AND OTHER COMMUNITY STAKEHOLDERS THROUGH A SERIES OF MEETINGS THE ORGANIZATIONS INVOLVED INCLUDE -WESTWING SENIOR LIVING-CLINTON COUNTY PUBLIC HEALTH DEPARTMENT-GMC DEWITT-COMMUNITY PARTNERSHIP FOR PROTECTING CHILDREN-PATIENT HEALTH SERVICES JACK COUNTY BOARD OF HEALTH-GMC DEWITT SOCIAL SERVICES-EARLY CHILDHOOD IOWA/DECAT COORDINATOR-ST AMBROSE UNIVERSITY SCHOOL OF HEALTH SCIENCES-I-SMILE, VISITING NURSE SERVICES-GMC DEWITT COMMUNITY HEALTH LIAISON-JACKSON COUNTY MENTAL HEALTH-JCRHC ADMINISTRATION-JACKSON COUNTY BOARD OF HEALTH-JACKSON COUNTY BOARD OF SUPERVISORSAN IMPORTANT COMPONENT OF THE THESE MEETINGS WAS THE DISCUSSION OF THE PRIMARY AND CHRONIC DISEASE NEEDS AND OTHER HEALTH ISSUES OF THOSE WITHOUT HEALTH INSURANCE, LOW INCOME AND MINORITY PERSONS (DESCRIBED LATER IN THIS SECTION)

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

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

Form and Line Reference	Explanation
GENESIS MEDICAL CENTER - DAVENPORT	PART V, SECTION B, LINE 6A UNITY POINT HEALTH-TRINITY

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

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

Form and Line Reference	Explanation
GENESIS MEDICAL CENTER - DEWITT	PART V, SECTION B, LINE 6A JACKSON COUNTY REGIONAL HEALTH CENTER

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.	
Form and Line Reference	Explanation
GENESIS MEDICAL CENTER - DAVENPORT	PART V, SECTION B, LINE 6B COMMUNITY HEALTH CARE, QUAD CITY HEALTH INITIATIVE, ROCK ISLAND COUNTY HEALTH DEPARTMENT, AND THE SCOTT COUNTY HEALTH DEPARTMENT

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

Form and Line Reference	Explanation
GENESIS MEDICAL CENTER - DAVENPORT	PART V, SECTION B, LINE 11 GENESIS HEALTH SYSTEM (GHS IOWA), IN COLLABORATION WITH COMMUN ITY ORGANIZATIONS SUCH AS THE QUAD CITY HEALTH INITIATIVE (QCHI), THE HEALTH DEPARTMENTS A ND OTHER AGENCIES, CONTINUES TO ADDRESS THE SIGNIFICANT NEEDS IDENTIFIED IN THE MOST RECE N T COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) THROUGH OUR ONGOING PROGRAMS AND RESOURCES THE SE PROGRAMS INCLUDE NEED ACCESS TO HEALTH CARE-THE IMPLEMENTATION OF THE TEAM-BASED CARE MODEL AT GENESIS HEALTH GROUP THIS MODEL ENABLES PHYSICIANS TO INCREASE THE NUMBER OF PRI MARY CARE PATIENTS SEEN BY USING STAFF MORE EFFICIENTLY -EXPANSION OF TELEHEALTH SERVICES TO THE PUBLIC-PROVISION OF OUR GENESIS CONVENIENT CARE CLINIC NOW LOCATED IN HYVEE GROCERY STORE THIS CLINIC PROVIDES VERY BASIC, URGENT CARE SERVICES A SECOND CLINIC WILL BE ADD ED AT THE END OF 2018 -OPENING OF THE WEST DAVENPORT HEALTHPLEX - THIS WILL PROVIDE PRIMAR Y CARE, URGENT CARE SERVICES, PHYSICAL THERAPY, DIAGNOSTIC IMAGING AND LAB THIS CONFIGURA TION OF SERVICES WILL CARE IN A MORE CONVENIENT SETTING NEED CANCER CARE-CONTINUED SUPPOR T OF THE GENESIS CANCER CARE INSTITUTE - TREATING CANCER WITH THE NEXT GENERATION OF CANCE R FIGHTING TECHNOLOGY -CENTER FOR BREAST HEALTH-CANCER CLINICAL TRIALS-SUPPORT OF THE GRAN T AND VOUCHER PROGRAMS FOR LOW-INCOME WOMEN - PART OF OUR WORK AS A FOUNDING SPONSOR OF TH E SUSAN G KOMEN RACE FOR THE CURE NEED HEART DISEASE AND STROKE-CONTINUED DEVELOPMENT OF OUR HEART FAILURE PROGRAM-CONTINUED SUPPORT OF THE "MEDICAL HOME" MODEL-PROVISION OF HEAL TH CARE NAVIGATORS, COACHES AND CASE MANAGERS AT OUR GENESIS HEALTH GROUP OFFICES - THESE INDIVIDUALS MONITOR THE HEALTH STATUS OF CHRONICALLY ILL PATIENTS AND INTERVENE AS NEEDED TO KEEP PATIENT FUNCTIONING IN THEIR HOMES -GENESIS HEALTH BEAT EXERCISE PROGRAMS/EXERCISE STATIONS LOCATED AT AREA PARKS AND WALKING/BIKING TRAILS -ESTABLISHMENT OF A GENESIS HEAL TH GROUP NEUROLOGY PRACTICE - THIS PRACTICE IS NEEDED TO ADDRESS THE DEMAND FOR NEUROLOGIC AL CARE IN THE REGION NEED NUTRITION, PHYSICAL ACTIVITY AND WEIGHT MANAGEMENT-CONTINUED S UPPORT OF THE "MEDICAL HOME" MODEL-PROVISION OF HEALTH CARE NAVIGATORS, COACHES AND CASE M ANAGERS AT OUR GENESIS HEALTH GROUP OFFICES - THESE INDIVIDUALS MONITOR THE HEALTH STATUS OF CHRONICALLY ILL PATIENTS AND INTERVENE AS NEEDED TO KEEP PATIENT FUNCTIONING IN THEIR H OMES -GENESIS HEALTH BEAT EXERCISE PROGRAMS/EXERCISE STATIONS LOCATED AT AREA PARKS AND WA LKING/BIKING TRAILS -METABOLIC HEALTH SCREENING ("NATURALLY SLIM" PROGRAM) OFFERED TO ALL GENESIS EMPLOYEES AND MEMBERS OF THE PUBLIC LOW-INCOME INDIVIDUALS CAN PARTICIPATE VIA GR ANTS FROM GENESIS PHILANTHROPY -GENESIS IMMUNIZATION CRM PROGRAM-COMMUNITY HEALTH EDUCATIO N RE HAND WASHING-GENESIS WELLNESS PROGRAM OFFERINGS-PARTNERSHIPS WITH AREA YMCAS TO OFFE R PROGRAMS AND DISCOUNTS TO GENESIS EMPLOYEES-GENESIS CENTER FOR WEIGHT MANAGEMENT-HEALTHY LIFESTYLE SPONSORSHIPS SUCH AS THE GENESIS FIRECRACKER RUN, BIX 7, AND OTHER EVENTS -ALCO HOL FREE FAMILY SECTION AT MOD

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

Form and Line Reference	Explanation
GENESIS MEDICAL CENTER - DAVENPORT	ERN WOODMAN PARKNEED MENTAL HEALTH-CONTINUED SUPPORT OF THE "MEDICAL HOME" MODEL-PROVISIO N OF HEALTH CARE NAVIGATORS, COACHES AND CASE MANAGERS AT OUR GENESIS HEALTH GROUP OFFICES - THESE INDIVIDUALS MONITOR THE HEALTH STATUS OF PATIENTS TO IDENTIFY DEPRESSION AND OTHE R MENTAL ILLNESS AND PROVIDE REFERRALS TO CARE AS NEEDED -GENESIS PSYCHOLOGY ASSOCIATES-EX PANSION OF THE GENESIS INPATIENT UNITS FOR CHILDREN AND ADOLESCENTS AND A UNIT FOR ADULTS PLANS ARE BEING DEVELOPED FOR A GERI-PSYCH PROGRAM-FOUNDER OF THE SCOTT COUNTY MENTAL HEA LTH COURT DESIGNED TO KEEP THOSE WITH MENTAL ILLNESSES OUT OF JAIL -ADVOCACY IN SUPPORT OF MENTAL HEALTH REFORM-SPONSORSHIP - NAMI

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

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

Form and Line Reference	Explanation
GENESIS MEDICAL CENTER - DEWITT	PART V, SECTION B, LINE 11 GENESIS HEALTH SYSTEM (GHS IOWA), IN COLLABORATION WITH COMMUNITY ORGANIZATIONS SUCH AS THE QUAD CITY HEALTH INITIATIVE (QCHI), THE HEALTH DEPARTMENTS AND OTHER AGENCIES, CONTINUES TO ADDRESS THE SIGNIFICANT NEEDS IDENTIFIED IN THE MOST RECENT COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) THROUGH OUR ONGOING PROGRAMS AND RESOURCES THESE PROGRAMS INCLUDE NEED NUTRITION, PHYSICAL ACTIVITY AND WEIGHT MANAGEMENT-CONTINUED SUPPORT OF THE "MEDICAL HOME" MODEL-GENESIS HEALTH BEAT EXERCISE PROGRAMS/EXERCISE STATIONS LOCATED AT AREA PARKS AND WALKING/BIKING TRAILS-METABOLIC HEALTH SCREENING ("NATURALLY SLIM" PROGRAM) OFFERED TO ALL GENESIS EMPLOYEES AND MEMBERS OF THE PUBLIC LOW-INCOME INDIVIDUALS CAN PARTICIPATE VIA GRANTS FROM GENESIS PHILANTHROPY -GENESIS IMMUNIZATION CRM PROGRAM-COMMUNITY HEALTH EDUCATION RE HAND WASHING-GENESIS WELLNESS PROGRAM OFFERINGS-PARTNERSHIPS WITH AREA YMCAS TO OFFER PROGRAMS AND DISCOUNTS TO GENESIS EMPLOYEES-GENESIS CENTER FOR WEIGHT MANAGEMENT-HEALTHY LIFESTYLE SPONSORSHIPS SUCH AS THE GENESIS FIRECRACKER RUN, BIX 7, AND OTHER EVENTS -ALCOHOL FREE FAMILY SECTION AT MODERN WOODMAN PARKNEED SUBSTANCE ABUSE - TOBACCO AND ALCOHOL-ALCOHOL FREE FAMILY SECTION AT MODERN WOODMAN PARK-SMOKE FREE CAMPUSES THROUGHOUT THE HEALTH SYSTEM AT OUR SITES LOCATED THROUGHOUT THE COMMUNITY-GENESIS WELLNESS PROGRAM OFFERINGS-COMMUNITY HEALTH EDUCATION RE SECOND HAND SMOKE IMPACT ON CHILDRENNEED IMMUNIZATIONS AND INFECTIOUS DISEASES-FLU FREE QC-GENESIS IMMUNIZATION CRM PROGRAM-COMMUNITY HEALTH EDUCATION RE HAND WASHING-RYAN WHITE HIV PROGRAM

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

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

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

Name and address	Type of Facility (describe)
1 - GENESIS HEART INSTITUTE 1236 E RUSHOLME STREET DAVENPORT, IA 52803	O/P CARDIAC DIAGNOSTIC & REHAB CARE
2 - GENESIS IMAGING CENTER 53RD STREET 1970 E 53RD STREET DAVENPORT, IA 52507	OUTPATIENT RADIOLOGY SERVICES
3 - CENTRAL PARK MEDICAL PAVILIONS 1 & 2 1351 W CENTRAL PARK AVENUE DAVENPORT, IA 52804	O/P CANCER, REHAB, WOUND, NEUROLSURGICAL, & PHYS CLINIC
4 - GENESIS MEDICAL PLAZA 2535 MAPLECREST ROAD BETTENDORF, IA 52722	O/P REHAB, PAIN, PHYS THERAPY, SPINE CTR & PHSY CLINIC
5 - VISITING NURSE ASSOC & HOSPICE HOUSE 2535 MAPLECREST ROAD BETTENDORF, IA 52272	HOME HEALTH & HOSPICE
6 - ILLINI LARSON CENTER 855 ILLINI DRIVE SILVIS, IL 61282	OUTPATIENT LAB & PHYSICIAN CLINIC
7 - BETTENDORF HEALTH PLEX 2140 53RD AVENUE BETTENDORF, IA 52722	OUTPATIENT PHYSICIAN CLINIC
8 - BETTENDORF IMAGING CENTER 2140 53RD AVENUE SUITE 40 BETTENDORF, IA 52722	OUTPATIENT RADIOLOGY SERVICES
9 - VISITING NURSE ASSOC & HOSPICE HOUSE 2546 TECH DRIVE BETTENDORF, IA 52722	HOME HEALTH & HOSPICE
10 - MEDICAL OFFICE BUILDING #1 1228 E RUSHOLME STREET DAVENPORT, IA 52803	O/P MAMMOGRAPHY & DIALYSIS SERVICES
11 - GENESIS HEALTH GROUP 865 LINCOLN ROAD BETTENDORF, IA 52722	OUTPATIENT PHYSICIAN CLINIC
12 - MOLINE HEALTHPLEX 3900 28TH AVENUE MOLINE, IL 61265	OUTPATIENT PHYSICIAN CLINIC
13 - ELDRIDGE FAMILY PRACTICE 301 N 4TH AVENUE ELDRIDGE, IA 52748	OUTPATIENT PHYSICIAN CLINIC
14 - VISITING NURSE ASSOC 4711 44TH STREET STE 2 ROCK ISLAND, IL 61201	HOME HEALTH & HOSPICE
15 - DEWITT WEST WING PLACE 1118 11TH STREET DEWITT, IA 52742	OUTPATIENT PHYSICIAN CLINIC

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

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

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

Name and address	Type of Facility (describe)
16 - SCOTT COUNTY YMCA 3800 TANGLEFOOT LANE BETTENDORF, IA 52722	OUTPATIENT REHABILITATION CLINIC
17 - NORTH FAMILY PRACTICE 210 W 53RD STREET DAVENPORT, IA 52806	OUTPATIENT PHYSICIAN CLINIC
18 - LOMBARD PHYSICAL THERAPY 1414 W LOMBARD STREET DAVENPORT, IA 52804	OUTPATIENT PHYSICAL THERAPY CLINIC
19 - GENESIS PHYSICAL REHAB - CROW VALLEY 2300 53RD AVENUE STE LL02 BETTENDORF, IA 52722	O/P PHYSICAL THERAPY CLINIC
20 - GENESIS PHYSICAL REHAB - VALLEY FAIR 2300 53RD STREET BETTENDORF, IA 52722	O/P PHYSICAL THERAPY CLINIC
21 - CONVENIENT CARE - DAVENPORT 1520 W 53RD STREET DAVENPORT, IA 52806	OUTPATIENT URGENT CARE CLINIC
22 - GENRAD IMAGING LLC 1970 E 53RD STREET DAVENPORT, IA 52807	DIAGNOSTIC IMAGING CENTER
23 - GHG PULMONARY 1801 E 54TH STREET DAVENPORT, IA 52807	OUTPATIENT PHYSICIAN CLINIC
24 - GENGASTRO LLC 2222 53RD AVENUE BETTENDORF, IA 52722	AMBULATORY SURGERY CENTER
25 - GENESIS HEALTH GROUP - SPECIALTY CLINIC 1007 NW 3RD STREET ALED0, IL 61231	OUTPATIENT REHABILITATION CLINIC
26 - DIVISION STREET CLINIC 3618 N DIVISION STREET DAVENPORT, IA 52804	OUTPATIENT PHYSICIAN CLINIC
27 - FAMILY PRACTICE AT WEST CAMPUS 1345 W CENTRAL PARK AVENUE DAVENPORT, IA 52804	OUTPATIENT PHYSICIAN CLINIC
28 - GENORTHO LLC 2300 53RD STREET BETTENDORF, IA 52722	ORTHOPEDIC SURGERY CENTER
29 - GENESIS CONVENIENT CARE - ILLINOIS 2350 41ST STREET MOLINE, IL 61265	OUTPATIENT URGENT CARE CLINIC
30 - CONVENIENT CARE - BETTENDORF 4017 DEVILS GLEN ROAD BETTENDORF, IA 52722	OUTPATIENT URGENT CARE CLINIC

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

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

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

Name and address	Type of Facility (describe)
31 - ILLINI BUILDING #1 903-05 ILLINI DRIVE SILVIS, IL 61282	HOME HEALTH & O/P PHYSICIAN CLINIC
32 - SPRING PARK SURGERY CENTER LLC 3319 SPRING STREET STE 202A DAVENPORT, IA 52807	OUTPATIENT SURGICAL CENTER
33 - ILLINI BUILDING #2 1504 10TH STREET SILVIS, IL 61282	OUTPATIENT PHYSICIAN CLINIC
34 - SILVIS ANESTHESIOLOGY 801 ILLINI DRIVE SILVIS, IL 61282	OUTPATIENT PHYSICIAN CLINIC
35 - GENESIS PSYCHOLOGY ASSOCIATES 4455 E 56TH STREET DAVENPORT, IA 52804	OUTPATIENT COUNSELING CLINIC
36 - NORTHWEST FAMILY PRACTICE 1520 S 53RD STREET DAVENPORT, IA 52806	OUTPATIENT PHYSICIAN CLINIC
37 - DAVENPORT OBGYN (EDGERTON) 1510 E RUSHOLME STREET DAVENPORT, IA 52803	OUTPATIENT PHYSICIAN CLINIC
38 - DEWITT PAVILION 1 1118 11TH STREET DEWITT, IA 52742	LONG-TERM NURSING CARE FACILITY
39 - ELDRIDGE PHYSICAL THERAPY 170 S 4TH AVENUE ELDRIDGE, IA 52748	OUTPATIENT PHYSICAL THERAPY CLINIC
40 - GHS OCCUPATIONAL HEALTH - DAVENPORT 3319 SPRING STREET DAVENPORT, IA 52807	OUTPATIENT OCCUPATIONAL HEALTH
41 - DEWITT FAMILY PRACTICE 1008 11TH STREET DEWITT, IA 52742	OUTPATIENT PHYSICIAN CLINIC
42 - MUSCATINE FAMILY PRACTICE 2104 CEDARWOOD STREET STE 200 MUSCATINE, IA 52761	OUTPATIENT PHYSICIAN CLINIC
43 - GENESIS CENTER FOR BARIATRIC SURGERY 1230 E RUSHOLME STREET DAVENPORT, IA 52803	O/P COMPREHENSIVE BARIATRIC PROGRAM
44 - GHG - MERCY MEDICAL GROUP 221 MAIN AVENUE CLINTON, IA 52732	OUTPATIENT PHYSICIAN CLINIC
45 - SENIOR SERVICES 1345 W CENTRAL PARK AVENUE DAVENPORT, IA 52804	OUTPATIENT PHYSICIAN CLINIC

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

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

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

Name and address	Type of Facility (describe)
46 - IA CITY PEDIATRIC PT CLINIC 2451 CORAL CT CORALVILLE, IA 52241	OUTPATIENT PHYSICAL THERAPY CLINIC
47 - LECLAIRE FAMILY PRACTICE - RIVERVIEW 200 S CODY ROAD LECLAIRE, IA 52751	OUTPATIENT PHYSICIAN CLINIC
48 - DEWITT AMBULANCE 1220 11TH STREET DEWITT, IA 52742	AMBULANCE SERVICES
49 - ROCK ISLAND INTERNAL MEDICINE 2560 24TH STREET STE 202 ROCK ISLAND, IL 61201	OUTPATIENT PHYSICIAN CLINIC
50 - DURANT FAMILY PRACTICE 619 5TH STREET DURANT, IA 52747	OUTPATIENT PHYSICIAN CLINIC
51 - VISITING NURSE ASSOC & HOSPICE HOUSE 611 N 2ND AVENUE CLINTON, IA 52732	HOME HEALTH & HOSPICE
52 - GENESIS PHYSICAL THERAPY AT LECLAIRE 1003 CANAL SHORE DRIVE LECLAIRE, IA 52751	OUTPATIENT PHYSICAL THERAPY CLINIC
53 - GENESIS OCCUPATIONAL HEALTH 2350 41ST STREET MOLINE, IL 61265	OUTPATIENT OCCUPATIONAL HEALTH
54 - DAVENPORT CLINIC 1820 W 3RD ST DAVENPORT, IA 52803	OUTPATIENT PHYSICIAN CLINIC
55 - BLUE GRASS FAMILY MEDICAL 413 S MISSISSIPPI BLUE GRASS, IA 52726	OUTPATIENT PHYSICIAN CLINIC
56 - ERIE FAMILY PRACTICE 530 12TH STREET ERIE, IL 61205	OUTPATIENT PHYSICIAN CLINIC
57 - GHS - AUGUSTANA PT CLINIC 639 38TH STREET ROCK ISLAND, IL 61201	OUTPATIENT PHYSICAL THERAPY CLINIC
58 - GHS - U OF IA PEDIATRIC GASTRO 2222 53RD AVENUE BETTENDORF, IA 52722	OUTPATIENT PHYSICIAN CLINIC
59 - EAP - DAVENPORT 1910 E KIMBERLY DAVENPORT, IA 52806	COUNSELING SERVICES
60 - GENESIS PLASTIC SURGERY ASSOC 5335 EASTERN AVENUE STE C DAVENPORT, IA 52804	OUTPATIENT PHYSICIAN CLINIC

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

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

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

Name and address	Type of Facility (describe)
61 - GHG - LOWDEN FAMILY PRACTICE 305 MCKINLEY AVENUE LOWDEN, IA 52255	OUTPATIENT PHYSICIAN CLINIC
62 - GENESIS MEDICAL PARK 4017 DEVILS GLEN ROAD STE 100 BETTENDORF, IA 52722	OUTPATIENT PHYSICIAN CLINIC
63 - ROCK ISLAND ARSENAL FAMILY PRACTICE 1634 WHITTEMORE STE 101 ROCK ISLAND, IL 61299	OUTPATIENT PHYSICIAN CLINIC
64 - PHYSICAL THERAPY & SPORTS MEDICINE 1702 E 53RD STREET DAVENPORT, IA 52807	O/P PHYSICAL THERAPY & SPORTS PERF CLINIC
65 - DAV OBGYN 3319 SPRING STREET DAVENPORT, IA 52807	OUTPATIENT PHYSICIAN CLINIC
66 - MEDICAL OFFICE BUILDING #2 1230 E RUSHOLME STREET DAVENPORT, IA 52803	OUTPATIENT PHYSICIAN CLINIC
67 - ALPHA FAMILY PRACTICE - CAJIGAL A 202 PICARD STREET ALPHA, IL 61413	OUTPATIENT PHYSICIAN CLINIC
68 - SILVIS SURGICAL ASSOCIATES 1801 E 54TH STREET DAVENPORT, IA 52807	OUTPATIENT PHYSICIAN CLINIC
69 - VISITING NURSE ASSOCIATION KID'S NEST 606 W 2ND STREET DAVENPORT, IA 52803	HOME HEALTH (MOM/ BABE PROGRAM)
70 - EAP - MUSCATINE 1605 PLAZA PLACE MUSCATINE, IA 52761	COUNSELING SERVICES
71 - EAP - ROCK ISLAND 2100 18TH AVENUE ROCK ISLAND, IL 61201	COUNSELING SERVICES
72 - EAP - CLINTON 1127 N 2ND STREET CLINTON, IA 52732	COUNSELING SERVICES

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As Filed Data -

DLN: 93493059015518

Schedule I
(Form 990)

Grants and Other Assistance to Organizations,
Governments and Individuals in the United States
Complete if the organization answered "Yes," on Form 990, Part IV, line 21 or 22.
▶ Attach to Form 990.
▶ Information about Schedule I (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047
2016
Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
GENESIS HEALTH SYSTEM

Employer identification number
42-1418847

Part I

General Information on Grants and Assistance

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

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

Part II

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

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

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table 16

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

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

Part III can be duplicated if additional space is needed

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
(1) GRANTS FOR RESEARCH STUDIES	65	16,042			
(2) MEDICAL SUPPLIES TO INDIVIDUALS/MEDICAL MISSION	7329		61,722	FAIR MARKET VALUE	MEDICAL SUPPLIES AND PHARMACEUTICAL SUPPLIES
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					

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

Return Reference	Explanation
PART I, LINE 2	THE GENESIS HEALTH SYSTEM (GHS IOWA) STAFF REQUIRES RECEIPTS AND OTHER DOCUMENTATION PRIOR TO RELEASING FUNDS FOR PROJECTS AND SERVICES WITHIN THE SCOPE OF THE ORGANIZATION'S MISSION PROPER AUTHORIZATION OF GRANT REQUESTS IS ALSO REQUIRED STAFF FOLLOWS THE ORGANIZATION'S FUNDING ADMINISTRATIVE POLICY TO ENSURE THAT GRANTS ARE BEING APPROVED AND UTILIZED CORRECTLY

Additional Data

Software ID:
Software Version:
EIN: 42-1418847
Name: GENESIS HEALTH SYSTEM

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
AMERICAN CANCER SOCIETY 2010 E 38TH STREET SUITE 203 DAVENPORT, IA 52801	13-1788491	501(C)(3)	5,000				SPONSORSHIP
AMERICAN HEART ASSOCIATION 460 N LINDBERGH BLVD ST LOUIS, MO 63141	13-5613797	501(C)(3)	10,000				HEARTWALK SPONSORSHIP, GALA S17 SPONSOR

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CENTER FOR ACTIVE SENIORS INC 1035 WEST KIMBERLY ROAD DAVENPORT, IA 52806	42-1011267	501(C)(3)	5,000				SPONSORSHIP FOR ANNUAL CONFERENCE AND ST PATRICK'S WELLNESS RACE
CITY OF DAVENPORT REVENUE DIVISION PO BOX 8003 DAVENPORT, IA 52801	42-6004463	CITY OF DAVENPORT	5,000				SPONSORSHIP FOR 2016 AND 2017 SUMMER CONCERTS IN THE PARK

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
EASTERN IOWA COMMUNITY FOUNDATION 306 WEST RIVER DRIVE DAVENPORT, IA 52801	47-3173513	501(C)(3)	50,000				URBAN CAMPUS EXPANSION IN DOWNTOWN DAVENPORT
FRIENDS OF THE DAVENPORT PUBLIC LIBRARY 321 MAIN STREET DAVENPORT, IA 52801	42-1204594	501(C)(3)	10,000				SPONSORSHIP FOR 50TH ANNIVERSARY RENOVATION

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
GENESIS HEALTH SERVICES FOUNDATION 1227 E RUSHOLME STREET DAVENPORT, IA 52803	42-1421670	501(C)(3)	5,995				HEALTHCARE RELATED CONTRIBUTIONS
GENESIS HEALTH SYSTEM WORKERS' COMPENSATION PLAN & TRUST 1227 E RUSHOLME STREET DAVENPORT, IA 52803	39-1905171	501(C)(3)	1,349,719				CLAIM PAYMENTS

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
GENESIS PHILANTHROPY 1227 E RUSHOLME STREET DAVENPORT, IA 52803	46-2452851	501(C)(3)	750,000				HEALTHCARE RELATED CONTRIBUTIONS
GILDA'S CLUB QUAD CITIES 1234 E RIVER DRIVE DAVENPORT, IA 52803	42-1446989	501(C)(3)	20,000				ANNUAL INTIMATE CONVERSATIONS SERIES SPONSORSHIP

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MARCH OF DIMES FOUNDATION 2117 STATE STREET BETTENDORF, IA 52722	13-1846366	501(C)(3)	5,000				SPONSORSHIP FOR FY17 EVENT
PUTNAM MUSEUM AND SCIENCE CENTER 1717 W 12TH STREET DAVENPORT, IA 52804	42-0680474	501(C)(3)	15,000				SPONSORSHIP FOR HUNGRY PLANET TRAVELING EXHIBIT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
QUAD CITY ARTS INC 1715 2ND AVE ROCK ISLAND, IL 61201	36-3122824	501(C)(3)	5,000				SPONSORSHIP FOR VISITING ARTIST SERIES
QUAD CITIES CHAMBER OF COMMERCE 130 WEST SECOND STREET DAVENPORT, IA 52801	42-1500610	501(C)(6)	30,000				SPONSORSHIP ICESTRAVAGANZA, IA LEGISLATIVE LUNCHEON, RED WHITE AND BOOM SPONSOR

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
QUAD CITY SYMPHONY 327 BRADY STREET DAVENPORT, IA 52801	46-6017663	501(C)(3)	10,000				SPONSORSHIP HOLIDAY POPS CONCERT
SUSAN G KOMEN BREAST CANCER 5005 LBJ FREEWAY DALLAS, TX 75244	75-1835298	501(C)(3)	18,197				SPONSORSHIP FOR RACE FOR THE CURE

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
VERA FRENCH FOUNDATION 1441 W CENTRAL PARK AVE DAVENPORT, IA 52804	42-1256448	501(C)(3)	10,000				SPONSORSHIP THROUGH MY EYES MENTAL AWARENESS EVENT

Schedule J
(Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

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

▶ Information about Schedule J (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2015

Open to Public Inspection

Name of the organization GENESIS HEALTH SYSTEM	Employer identification number 42-1418847
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Part I

Questions Regarding Compensation

	Yes	No
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 <div><div><input type="checkbox"/> First-class or charter travel</div><div><input type="checkbox"/> Travel for companions</div><div><input type="checkbox"/> Tax idemnification and gross-up payments</div><div><input type="checkbox"/> Discretionary spending account</div><div><input type="checkbox"/> Housing allowance or residence for personal use</div><div><input type="checkbox"/> Payments for business use of personal residence</div><div><input type="checkbox"/> Health or social club dues or initiation fees</div><div><input type="checkbox"/> Personal services (e g , maid, chauffeur, chef)</div></div>		
b If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	1b	No
2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?	2	No
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 <div><div><input type="checkbox"/> Compensation committee</div><div><input type="checkbox"/> Independent compensation consultant</div><div><input type="checkbox"/> Form 990 of other organizations</div><div><input type="checkbox"/> Written employment contract</div><div><input type="checkbox"/> Compensation survey or study</div><div><input type="checkbox"/> Approval by the board or compensation committee</div></div>		
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?	4a	Yes
b Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b	Yes
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	4c	No
Only 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?	5a	No
b Any related organization? If "Yes," on line 5a or 5b, describe in Part III	5b	No
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?	6a	No
b Any related organization? If "Yes," on line 6a or 6b, describe in Part III	6b	No
7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III	7	No
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	8	No
9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9	

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

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

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

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

Part III Supplemental Information

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

Return Reference	Explanation
PART I, LINE 1A	GENESIS HEALTH SYSTEM (GHS IA) PROVIDES THE FOLLOWING TO INDIVIDUALS REPORTS IN PART VII, SECTION A, LINE 1A TRAVEL FOR COMPANIONS. IN TAX YEAR 2016, THE FOLLOWING TYPES OF LISTED INDIVIDUALS REPORTED IN PART VII RECEIVED THE TRAVEL FOR COMPANIONS BENEFIT: 6 DIRECTORS AND 4 OFFICERS. ALL INDIVIDUALS REIMBURSED GHS IOWA IN FULL AND NONE OF THE BENEFIT WAS LISTED AS TAXABLE COMPENSATION.
PART I, LINES 4A-B	THE FOLLOWING INDIVIDUAL RECEIVED SEVERANCE PAY FROM GENESIS HEALTH SYSTEM (GHS IOWA) DURING THE CALENDAR YEAR 2016: GEORGE KOVACH - \$83,653. THIS INFORMATION IS INCLUDED IN REPORTABLE COMPENSATION ON FORM 990, PART VII AND SCHEDULE J, PART II, IF APPLICABLE. THE FOLLOWING INDIVIDUALS PARTICIPATED IN A SUPPLEMENTAL ROTH INDEXED UNIVERSAL LIFE (IUL) PLAN IN 2016 SPONSORED BY GENESIS HEALTH SYSTEM (GHS IOWA): KURT ANDERSEN - \$71,380, JACQUELINE ANHALT - \$42,137, ROBERT W. FRIEDEN - \$61,593, NIDAL HARB - \$82,110, AND JORDAN VOIGT - \$69,054. THE DOLLAR AMOUNT REPRESENTS THE CURRENT YEAR CONTRIBUTION MADE BY GHS IOWA ON BEHALF OF THE INDIVIDUALS TO THE PLAN IN 2016. THIS INFORMATION IS INCLUDED IN REPORTABLE COMPENSATION ON THE FORM 990, PART VII AND SCHEDULE J, PART II. THE FOLLOWING INDIVIDUAL PARTICIPATED IN A SUPPLEMENTAL EXECUTIVE RETIREMENT SAVINGS BENEFIT PLAN IN 2016 SPONSORED BY GHS IOWA: MARK G. ROGERS - \$63,005. THE DOLLAR AMOUNT REPRESENTS THE CURRENT YEAR CONTRIBUTION MADE BY GHS IOWA ON BEHALF OF THE INDIVIDUAL TO THE PLAN IN 2016. THIS INFORMATION IS INCLUDED IN REPORTABLE COMPENSATION ON THE FORM 990, PART VII AND SCHEDULE J, PART II. THE FOLLOWING INDIVIDUAL PARTICIPATED IN A SUPPLEMENTAL EXECUTIVE RETIREMENT SAVINGS BENEFIT PLAN IN 2016 SPONSORED BY GHS IOWA: MARK G. ROGERS - \$63,005. THE DOLLAR AMOUNT REPRESENTS THE CURRENT YEAR CONTRIBUTION MADE BY GHS IOWA ON BEHALF OF THE INDIVIDUAL TO THE PLAN IN 2016. THIS INFORMATION IS INCLUDED IN DEFERRED COMPENSATION ON THE FORM 990, PART VII AND SCHEDULE J, PART II. THE FOLLOWING INDIVIDUAL PARTICIPATED IN A SPLIT-DOLLAR LIFE INSURANCE BENEFIT PLAN IN 2016 SPONSORED BY GENESIS HEALTH SYSTEM (GHS IOWA), A RELATED ORGANIZATION: DOUGLAS P. CROPPER - \$8,529,736. GHS IOWA DEPOSITED FUNDS INTO LIFE INSURANCE POLICIES ON THE PARTICIPANT'S LIFE DURING LIFE, AND SUBJECT TO THE POLICIES GENERATING SUFFICIENT VALUES, THE PARTICIPANT CAN BORROW FROM ONE OF THE POLICIES, WHERE THE BORROWING IS MONITORED AND LIMITED SO THE POLICIES DO NOT LAPSE. AT THE PARTICIPANT'S DEATH, GHS IOWA RECOVERS PREMIUMS PLUS INTEREST PLUS ADDITIONAL KEY-PERSON INSURANCE PROCEEDS.

Additional Data

Software ID:
Software Version:
EIN: 42-1418847
Name: GENESIS HEALTH SYSTEM

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1DOUGLAS P CROPPER PRESIDENT/CEO GHS	(i)	741,435	307,117	21,900	5,750	23,917	1,100,119	0
	(ii)	0	0	0	0	- 0	- 0	0
1GEORGE J KONTOS JR MD DIRECTOR	(i)	462,260	0	200,576	6,000	16,538	685,374	0
	(ii)	0	0	0	0	- 0	- 0	0
2MARK G ROGERS V P FINANCE/CFO/ASST TREASURER	(i)	390,543	128,636	85,065	70,197	19,132	693,573	0
	(ii)	0	0	0	0	- 0	- 0	0
3HAROLD L WAGHER FORMER CHIEF COMPLIANCE RISK OFFICER	(i)	220,956	34,016	696	4,500	14,079	274,247	0
	(ii)	0	0	0	0	- 0	- 0	0
4KURT A ANDERSEN MD PRESIDENT GHG	(i)	366,855	90,287	120,929	4,500	15,412	597,983	0
	(ii)	0	0	0	0	- 0	- 0	0
5DALE GIESS PHYSICIAN- CARDIOTHORACIC	(i)	849,548	0	11,391	6,000	6,279	873,218	0
	(ii)	0	0	0	0	- 0	- 0	0
6NIDAL HARB CHIEF MEDICAL OFFICER	(i)	445,182	109,089	140,494	6,000	16,760	717,525	0
	(ii)	0	0	0	0	- 0	- 0	0
7JORDAN VOIGT HOSPITAL PRESIDENT GMC DAVENPORT	(i)	327,787	97,621	98,976	4,500	13,271	542,155	0
	(ii)	0	0	0	0	- 0	- 0	0
8JOSEPH BROOKS MD PHYSICIAN	(i)	406,822	2,083	138,570	4,498	21,182	573,155	0
	(ii)	0	0	0	0	- 0	- 0	0
9MICHAEL BURCHETT PHYSICIAN	(i)	437,449	0	127,936	4,500	15,658	585,543	0
	(ii)	0	0	0	0	- 0	- 0	0
10NATHAN MELOY MD PHYSICIAN	(i)	629,786	0	17,665	4,500	14,132	666,083	0
	(ii)	0	0	0	0	- 0	- 0	0
11ERIC MOHR MD PHYSICIAN	(i)	451,230	78,287	25,349	4,375	18,308	577,549	0
	(ii)	0	0	0	0	- 0	- 0	0
12TODD RIDENOUR MD PHYSICIAN	(i)	814,588	0	35,082	6,000	15,367	871,037	0
	(ii)	0	0	0	0	- 0	- 0	0
13JACQUELINE K ANHALT FORMER V P PATIENT SERVICES	(i)	233,556	40,933	60,898	9,602	16,918	361,907	0
	(ii)	0	0	0	0	- 0	- 0	0
14CHRISTOPHER CROME FORMER PHYSICIAN/DIVISION CHAIR	(i)	373,186	21,653	44,029	5,276	11,718	455,862	0
	(ii)	0	0	0	0	- 0	- 0	0
15ROBERT W FRIEDEN FORMER V P INFORMATION SERVICES	(i)	272,069	55,993	88,955	9,578	17,113	443,708	0
	(ii)	0	0	0	0	- 0	- 0	0
16RICHARD M KISHIUE MD FORMER PRESIDENT, GHG	(i)	230,712	0	22,297	6,000	5,661	264,670	0
	(ii)	0	0	0	0	- 0	- 0	0
17GEORGE KOVACH FORMER V P MEDICAL STAFF AFFAIRS	(i)	72,403	0	84,453	695	403	157,954	0
	(ii)	0	0	0	0	- 0	- 0	0

Schedule K
(Form 990)

Department of the Treasury
Internal Revenue Service
Name of the organization
GENESIS HEALTH SYSTEM

Supplemental Information on Tax Exempt Bonds

► Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
► Attach to Form 990.
► Information about Schedule K (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2016

Open to Public Inspection

Employer identification number
42-1418847

Part I Bond Issues											
(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pool financing	
						Yes	No	Yes	No	Yes	No
A IOWA FINANCE AUTHORITY	52-1699886	46246PLP4	06-24-2010	90,995,000	REFUND 12-23-97 AND 08-02-00 BOND ISSUE, RENOVATE AND EQUIP FACILITY		X		X		X
B IOWA FINANCE AUTHORITY	52-1699886	46246PMG3	11-26-2013	121,000,000	CONSTRUCT AND EQUIP EAST CAMPUS TOWER		X		X		X

Part II		Proceeds							
		A		B		C		D	
1	Amount of bonds retired	37,725,000							
2	Amount of bonds legally defeased								
3	Total proceeds of issue	95,545,195		125,205,892					
4	Gross proceeds in reserve funds			862,622					
5	Capitalized interest from proceeds								
6	Proceeds in refunding escrows								
7	Issuance costs from proceeds	1,478,186		1,267,563					
8	Credit enhancement from proceeds								
9	Working capital expenditures from proceeds								
10	Capital expenditures from proceeds	23,700,000		123,844,399					
11	Other spent proceeds	70,367,009							
12	Other unspent proceeds								
13	Year of substantial completion	2010		2017					
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue?	X			X				
15	Were the bonds issued as part of an advance refunding issue?		X		X				
16	Has the final allocation of proceeds been made?	X			X				
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X					

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

Part III

Private Business Use (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?	X		X					
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?	X		X					
c Are there any research agreements that may result in private business use of bond-financed property?	X		X					
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?	X		X					
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶	0 910 %		0 910 %					
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶	0 %		0 %					
6 Total of lines 4 and 5	0 910 %		0 910 %					
7 Does the bond issue meet the private security or payment test? . . .		X		X				
8a Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?		X		X				
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of . .								
c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1 141-12 and 1 145-2?								
9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1 141-12 and 1 145-2?	X		X					

Part IV

Arbitrage

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

Part IV Arbitrage (Continued)

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

Part V Procedures To Undertake Corrective Action

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

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

Return Reference	Explanation
SCHEDULE K, PART I, LINE A, COLUMN E & PART II, LINE 3, COLUMN A	A PREMIUM OF \$4,550,195 WAS PAID TO THE ISSUER BY THE BONDHOLDERS AT THE DATE OF SALE

Return Reference	Explanation
SCHEDULE K, PART I, LINE A, COLUMN E & PART II, LINE 3, COLUMN B	A PREMIUM OF \$3,950,091 WAS PAID TO THE ISSUER BY THE BONDHOLDERS AT THE DATE OF SALE FURTHERMORE, \$953,406 WAS EARNED BY INVESTING THE RESERVE FUNDS

Schedule L
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions with Interested Persons

▶ Complete if the organization answered
"Yes" on Form 990, Part IV, lines 25a, 25b, 26, 27, 28a, 28b, or 28c,
or Form 990-EZ, Part V, line 38a or 40b.
▶ Attach to Form 990 or Form 990-EZ.
▶ Information about Schedule L (Form 990 or 990-EZ) and its instructions is at
www.irs.gov/form990.

OMB No 1545-0047

2016

Open to Public
Inspection

Name of the organization
GENESIS HEALTH SYSTEM

Employer identification number
42-1418847

Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 501(c)(29) organizations only)
Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b

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

2 Enter the amount of tax incurred by organization managers or disqualified persons during the year under section 4958 ▶ \$

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

Part II Loans to and/or From Interested Persons.
Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a, or Form 990, Part IV, line 26, or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22

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

Part III Grants or Assistance Benefiting Interested Persons.
Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance

Part IV Business Transactions Involving Interested Persons.

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

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

Part V Supplemental Information

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

Return Reference	Explanation
FORM 990, SCHEDULE L, PART IV, COLUMN B	DESCRIPTION OF RELATIONSHIP - GENVENTURES, INC MARK G ROGERS AND ROGER J HILL ARE OFFICERS, AND JAMES W KOEHLER IS A DIRECTOR OF GENESIS HEALTH SYSTEM (GHS IOWA) AND ARE REPORTED ON THE FORM 990, PART VII DURING THE TAX YEAR, MARK G ROGERS, ROGER J HILL, AND JAMES W KOEHLER WERE OFFICERS OF GENVENTURES, INC
FORM 990, SCHEDULE L, PART IV, COLUMN B	DESCRIPTION OF RELATIONSHIP - DAVITA RENAL CAREEDWIN V MOTTO, M D IS A DIRECTOR ON THE BOARD OF GENESIS HEALTH SYSTEM (GHS IOWA) AND IS ALSO ON THE BOARD OF DAVITA RENAL CARE AND HAS A PERCENTAGE OF OWNERSHIP IN DAVITA RENAL CARE
FORM 990, SCHEDULE L, PART IV, COLUMN B	DESCRIPTION OF RELATIONSHIP - LANE & WATERMAN LLPC DANA WATERMAN III IS A DIRECTOR OF GENESIS HEALTH SYSTEM (GHS IOWA) AND A MANAGING PARTNER OF LANE & WATERMAN LLP
FORM 990, SCHEDULE L, PART IV, COLUMN B	DESCRIPTION OF RELATIONSHIP - CARDIOVASCULAR MEDICINE, PCEDMUND P COYNE, JR, M D IS A DIRECTOR OF GENESIS HEALTH SYSTEM (GHS IOWA) AND IS ALSO A DIRECTOR OF CARDIOVASCULAR MEDICINE, PC
FORM 990, SCHEDULE L, PART IV, COLUMN B	DESCRIPTION OF RELATIONSHIP - QUAD CITY BANK & TRUST COMPANYPETER J BENSON AND MARK C KILMER ARE DIRECTORS OF GENESIS HEALTH SYSTEM (GHS IA) PETER J BENSON IS AN OFFICER OF QUAD CITY BANK & TRUST COMPANY, AND MARK C KILMER IS THE CHAIRMAN OF THE BOARD OF QUAD CITY BANK & TRUST COMPANY
FORM 990, SCHEDULE L, PART IV, COLUMN B	DESCRIPTION OF RELATIONSHIP - HEALTH ENTERPRISESDOUGLAS P CROPPER IS THE BOARD PRESIDENT/CEO OF GENESIS HEALTH SYSTEM (GHS IOWA) AND A DIRECTOR ON THE BOARD OF HEALTH ENTERPRISES
FORM 990, SCHEDULE L, PART IV, COLUMN B	DESCRIPTION OF RELATIONSHIP - LISA ROGALSKILISA ROGALSKI IS THE DAUGHTER-IN-LAW OF EDWARD J ROGALSKI, PH D, DIRECTOR OF GENESIS HEALTH SYSTEM (GHS IOWA)
FORM 990, SCHEDULE L, PART IV, COLUMN B	DESCRIPTION OF RELATIONSHIP - CLAIRE MOTTOCLAIRE MOTTO IS THE DAUGHTER OF EDWIN V MOTTO, DIRECTOR OF GENESIS HEALTH SYSTEM (GHS IOWA)
FORM 990, SCHEDULE L, PART IV, COLUMN B	DESCRIPTION OF RELATIONSHIP - KRISTI SOUTHERLANDKRISTI SOUTHERLAND IS THE SISTER OF KURT A ANDERSEN, M D, PRESIDENT OF GHG, KEY EMPLOYEE OF GENESIS HEALTH SYSTEM (GHS IOWA)
FORM 990, SCHEDULE L, PART IV, COLUMN B	DESCRIPTION OF RELATIONSHIP - DOUGLAS P CROPPERDOUGLAS P CROPPER IS THE BOARD PRESIDENT/CEO OF GENESIS HEALTH SYSTEM (GHS IOWA)

Additional Data

Software ID:
Software Version:
EIN: 42-1418847
Name: GENESIS HEALTH SYSTEM

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) GENVENTURES INC	SEE BELOW IN PART V	24,822,992	GENVENTURES, INC PAID GENESIS HEALTH SYSTEM (GHS IOWA) AS A COMMON PAYMASTER AND REIMBURSEMENT OF INTEREST		No
(1) GENVENTURES INC	SEE BELOW IN PART V	16,725,842	GENESIS HEALTH SYSTEM (GHS IOWA) PAID GENVENTURES, INC FOR FACILITY LEASE PAYMENTS, MEDICAL SUPPLIES, LAUNDRY SERVICES, AND A LOAN ADVANCE		No

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(3) DAVITA RENAL CARE	SEE BELOW IN PART V	86,031	INVESTMENT IN DAVITA		No
(1) LANE & WATERMAN LLP	SEE BELOW IN PART V	687,207	LEGAL SERVICES		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons					
(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(5) CARDIOVASCULAR MEDICINE PC	SEE BELOW IN PART V	753,585	HEALTHCARE PROFESSIONAL SERVICES		No
(1) QUAD CITY BANK & TRUST COMPANY	SEE BELOW IN PART V	215,387	INTEREST EXPENSE, DEPOSIT ACCOUNT, CREDIT CARD SERVICE, LOCK BOX FEES, AND INTEREST INCOME		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons					
(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(7) HEALTH ENTERPRISES	SEE BELOW IN PART V	98,324	HEALTHCARE SUPPORT SERVICES		No
(1) LISA ROGALSKI	SEE BELOW IN PART V	115,153	REPORTABLE COMPENSATION AS AN EMPLOYEE		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons					
(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(9) CLAIRE MOTTO	SEE BELOW IN PART V	42,182	REPORTABLE COMPENSATION AS AN EMPLOYEE		No
(1) KRISTI SOUTHERLAND	SEE BELOW IN PART V	25,061	REPORTABLE COMPENSATION AS AN EMPLOYEE		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons					
(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(11) DOUGLAS P CROPPER	SEE BELOW IN PART V	8,529,736	JOINT INVESTMENT IN A CASH VALUE LIFE INSURANCE POLICY TO SUPPLEMENT RETIREMENT INCOME AND RETURN INVESTMENT AND INTEREST TO GHS IOWA		No

SCHEDULE M
(Form 990)

Department of the Treasury
Internal Revenue Service

Noncash Contributions

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

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
GENESIS HEALTH SYSTEM

Employer identification number
42-1418847

Part I

Types of Property

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art—Works of art				
2 Art—Historical treasures . .				
3 Art—Fractional interests . .				
4 Books and publications . .				
5 Clothing and household goods				
6 Cars and other vehicles . . .				
7 Boats and planes				
8 Intellectual property				
9 Securities—Publicly traded .				
10 Securities—Closely held stock .				
11 Securities—Partnership, LLC, or trust interests				
12 Securities—Miscellaneous . .				
13 Qualified conservation contribution—Historic structures				
14 Qualified conservation contribution—Other				
15 Real estate—Residential . .				
16 Real estate—Commercial . .				
17 Real estate—Other				
18 Collectibles				
19 Food inventory				
20 Drugs and medical supplies .				
21 Taxidermy				
22 Historical artifacts				
23 Scientific specimens				
24 Archeological artifacts . . .				
25 Other ► (MISCELLANEOUS)	X	112	119,943	FAIR MARKET VALUE
26 Other ► ()				
27 Other ► ()				
28 Other ► ()				
29 Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement			29	

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

30a

No

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

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

31

Yes

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

32a

No

b If "Yes," describe in Part II

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

Part II **Supplemental Information.**

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

Return Reference	Explanation
PART I, COLUMN (B)	PART I, COLUMN B IS REPORTED USING A COMBINATION OF NUMBER OF CONTRIBUTIONS AND ITEMS CONTRIBUTED

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service
Name of the organization
GENESIS HEALTH SYSTEM

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.

OMB No 1545-0047

2016

**Open to Public
Inspection**

Employer identification number

42-1418847

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	INTERNAL MANAGEMENT REVIEW IS COMPLETED OF THE COMPILED INFORMATION PRIOR TO PREPARATION AND REVIEW BY RSM US LLP FOLLOWING RSM US LLP'S PREPARATION AND REVIEW OF THE FORM 990, IT IS REVIEWED WITH THE ORGANIZATION'S VICE PRESIDENT, FINANCE/CFO, VICE PRESIDENT, LEGAL AFFAIRS, VICE PRESIDENT, HUMAN RESOURCES, AND CHIEF COMPLIANCE RISK OFFICER THE FORM 990 IS THEN REVIEWED AT THE ORGANIZATION'S FINANCE COMMITTEE MEETING PRIOR TO SUBMITTING THE FORM 990 TO THE IRS, IT IS E-MAILED TO THE ORGANIZATION'S BOARD OF DIRECTORS ONE WEEK IN ADVANCE OF A SCHEDULED MEETING AT THE BOARD OF DIRECTORS MEETING, INTERNAL MANAGEMENT REVIEWS THE FORM 990 WITH THE BOARD OF DIRECTORS SUGGESTED CHANGES FROM ALL OF THESE REVIEWS ARE CONSIDERED FOR INCLUSION IN THE FINAL FORM 990 SUBMITTED TO THE IRS

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	<p>ANY COVERED PERSON, DEFINED AS ANY DIRECTOR, OFFICER, OR MEMBER OF A BOARD OR BOARD COMMITTEE OF GENESIS HEALTH SYSTEM (GHS IOWA) OR AN AFFILIATE, SHOULD DISCLOSE AN INTEREST OR POTENTIAL INTEREST AS SOON AS THEY BECOME AWARE OF A POTENTIAL TRANSACTION THAT WILL BE CONSIDERED BY MANAGEMENT, THE BOARD, OR A COMMITTEE OF THE BOARD COVERED PERSONS ARE REQUIRED ANNUALLY TO DISCLOSE ANY POSSIBLE PERSONAL, FAMILY, OR BUSINESS RELATIONSHIPS THAT REASONABLY COULD GIVE RISE TO AN INTEREST OR CONFLICT INVOLVING GHS IOWA, OR AN AFFILIATE, OR WITH RESPECT TO DESIGNATED FACILITIES AND ACTIVITIES, AND ACKNOWLEDGE BY HIS OR HER SIGNATURE THAT HE OR SHE IS FAMILIAR WITH AND IS IN COMPLIANCE WITH THE LETTER AND SPIRIT OF THIS POLICY ANY COVERED PERSON FOUND TO HAVE A CONFLICT OF INTEREST MAY MAKE A PRESENTATION AT THE BOARD OR COMMITTEE MEETING TO PRESENT INFORMATION AND ADDRESS ANY QUESTIONS RAISED BY OTHER DIRECTORS OR COMMITTEE MEMBERS SAID PERSON SHALL NOT BE ALLOWED TO ACTIVELY AND AGGRESSIVELY ADVOCATE IN HIS OR HER OWN BEHALF NOR SHALL SUCH PERSON ADVOCATE HIS OR HER POSITION INFORMALLY THROUGH PRIVATE CONTACT, COMMUNICATION AND DISCUSSION WITH ANOTHER DIRECTOR AFTER SUCH PRESENTATION, THE PERSON SHALL LEAVE THE MEETING DURING THE DISCUSSION OF, AND THE VOTE ON, THE APPLICABLE TRANSACTION OR ARRANGEMENT</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15	<p>EACH EXECUTIVE POSITION IS EVALUATED USING A FORMAL EVALUATION PLAN THAT IS ESTABLISHED BY AN OUTSIDE CONSULTANT AT THE PRESENT TIME, THE CONSULTANT USES A POINT SYSTEM FOR JOB EVALUATION THE POINT VALUES ARE BASED ON "KNOW HOW", "PROBLEM SOLVING", "ACCOUNTABILITY", AND OTHER JOB ATTRIBUTES SPECIFIC TO THE POSITION ONCE THE POINT VALUE IS SET FOR A POSITION, MARKET COMPARISONS FOR JOBS WITH THE SAME ORGANIZATIONAL IMPACT CAN BE COMPARED FOR SALARY PURPOSES AND ESTABLISH PAY RANGES THE DESIGN OF THE PAY RANGES FOR EXECUTIVES IS BASED ON MARKET DATA THE MIDPOINT OF EACH PAY RANGE IS ESTABLISHED AT THE 50TH PERCENTILE OF THE MARKET COMPARISONS A MINIMUM AND MAXIMUM ARE ESTABLISHED OFF OF THE MIDPOINT SPECIFIC PAY RATES FOR EXECUTIVES ARE SUBJECT TO CEO AND COMPENSATION COMMITTEE AND THE GENESIS HEALTH SYSTEM (GHS IOWA) BOARD OF DIRECTORS APPROVAL PAY RANGES ARE REVIEWED EACH YEAR TO DETERMINE THE NEED FOR REVISION WHEN MARKET CONDITIONS SUGGEST AN ADJUSTMENT TO PAY RANGES, DATA WILL BE PRESENTED TO THE COMPENSATION COMMITTEE FOR ITS REVIEW THE SPECIFIC PAY RANGES ARE SUBJECT TO CEO, COMPENSATION COMMITTEE, AND GHS IOWA BOARD OF DIRECTOR APPROVAL THE PRESIDENT AND CEO HAS THE AUTHORITY AND RESPONSIBILITY TO ESTABLISH AND ADJUST, WITHIN THE RANGE APPROVED BY THE COMPENSATION COMMITTEE AND THE GHS IOWA BOARD OF DIRECTORS, THE BASE COMPENSATION OF EACH EXECUTIVE EMPLOYED BY GHS IOWA, AT APPROPRIATE TIMES THE GHS IOWA BOARD OF DIRECTORS SHALL ESTABLISH AND ADJUST, WITHIN THE RANGE APPROVED BY THE COMPENSATION COMMITTEE, THE BASE COMPENSATION FOR THE CEO OF GHS IOWA, AT APPROPRIATE TIMES THE LAST TIME THIS PROCESS WAS FORMALLY UNDERTAKEN WAS NOVEMBER 2016</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	THE ORGANIZATION'S GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS ARE NOT MADE AVAILABLE TO THE PUBLIC

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VII, LINE 1A	GENESIS HEALTH SYSTEM (GHS ILLINOIS), GENESIS MEDICAL CENTER, ALEDO, GENESIS SENIOR LIVING, ALEDO, GENESIS HEALTH SERVICES FOUNDATION, GENESIS PHILANTHROPY AND GENESIS HEALTH SYSTEM WORKERS' COMPENSATION PLAN AND TRUST ARE RELATED ORGANIZATIONS OF GENESIS HEALTH SYSTEM (GHS IOWA) THE AMOUNTS REPORTED AS REPORTABLE COMPENSATION FOR THE OFFICERS, KEY EMPLOYEES, AND HIGHLY COMPENSATED EMPLOYEES, UNLESS OTHERWISE NOTED ELSEWHERE IN PART VII, ARE FOR SERVICES RENDERED ON BEHALF OF ALL ORGANIZATIONS IT WOULD BE ADMINISTRATIVELY IMPRACTICABLE FOR MEMBERS OF THE GOVERNING BOARD AND THE EXECUTIVE TEAM TO BREAKOUT THEIR HOURS DEVOTED AS WELL AS THEIR REPORTABLE COMPENSATION AMONG EACH ORGANIZATION ALL REPORTABLE COMPENSATION, UNLESS OTHERWISE NOTED IN PART VII, IS PAID BY GHS IOWA

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART IX, LINE 11G	<p>ANESTHESIA SERVICES PROGRAM SERVICE EXPENSES 1,341,848 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 1,341,848 BLOOD BANK SERVICES PROGRAM SERVICE E XPENSES 1,911,061 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 1,911,061 COLLECTION SERVICES PROGRAM SERVICE EXPENSES 3,760,301 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 3,760,301 COMMUNICATIONS SERVICES PROGRAM SERVICE EXPENSES 355,290 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 355,290 DIALYSIS SERVICES PROGRAM SERVICE EXPENSES 716,143 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 716,143 ENVIRONMENTAL SERVICES PROGRAM SERVICE EXPENSES 3,335,789 MANAGEMENT AND GENERAL EXPENSES 3,100 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 3,338,889 HEALTH CARE PROFESSIONAL SERVICES PROGRAM SERVICE EXPENSES 8,719,384 MANAGEMENT AND GENERAL EXPENSES 152,754 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 8,872,138 HEALTH-RELATED IMAGING SERVICES PROGRAM SERVICE EXPENSES 13,546,436 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 13,546,436 HEALTHCARE DATA SYSTEM/STRATEGIC PLANNING PROGRAM SERVICE EXPENSES 2,723,612 MANAGEMENT AND GENERAL EXPENSES 1,934,652 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 4,658,264 IT OUTREACH SERVICES PROGRAM SERVICE EXPENSES 9,799,403 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 9,799,403 LAB SERVICES PROGRAM SERVICE EXPENSES 2,775,838 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 2,775,838 LAUNDRY SERVICES PROGRAM SERVICE EXPENSES 10,486 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 10,486 MAINTENANCE SERVICES PROGRAM SERVICE EXPENSES 9,588,004 MANAGEMENT AND GENERAL EXPENSES 110,344 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 9,698,348 NUTRITIONAL SERVICES PROGRAM SERVICE EXPENSES 1,087,470 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 1,087,470 OUTSIDE HEALTHCARE-RELATED SERVICES PROGRAM SERVICE EXPENSES 1,520,811 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 1,520,811 PATIENT TRANSPORT SERVICES PROGRAM SERVICE EXPENSES 345,082 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 345,082 PHYSICAL THERAPY SERVICES PROGRAM SERVICE EXPENSES 119,391 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 119,391 ROOM AND BOARD SERVICES PROGRAM SERVICE EXPENSES 1,789,929 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 1,789,929 SIGNAGE SERVICES PROGRAM SERVICE EXPENSES 670 MANAGEMENT AND GENERAL EXPENSES 5,200 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 5,870 TRANSCRIPTIONS SERVICES PROGRAM SERVICE EXPENSES 58,949 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 58,949 VISITING NURSE OUTSIDE SERVICES PROGRAM SERVICE EXPENSES 127,913 MANAGEMENT AND GENERAL</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART IX, LINE 11G	L EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 127,913 TRANSLATIONS SERVICES PROGR AM SERVICE EXPENSES 352,973 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TO TAL EXPENSES 352,973 EMERGENCY ROOM SERVICES PROGRAM SERVICE EXPENSES 1,354,421 MANAGEM ENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 1,354,421

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9	CHANGE IN FUNDED STATUS OF RETIREMENT 7,117,940 CHANGE IN NET ASSETS OF GENESIS HEALTH SERVICES FOUNDATION 988,544 NON-CASH CONTRIBUTIONS NOT REPORTED ON BOOKS -119,943

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XII, LINE 2C	THE OVERSIGHT AND SELECTION PROCESS HAS NOT CHANGED FROM THE PRIOR TAX YEAR

Name of the organization GENESIS HEALTH SYSTEM	Employer identification number 42-1418847
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Part I

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) GENESIS ACCOUNTABLE CARE ORGANIZATION LLC 1227 E RUSHOLME STREET DAVENPORT, IA 52803 45-4168932	ACCOUNTABLE CARE SERVICES	IA	-445,758	3,706,441	GENESIS HEALTH SYSTEM (GHS IOWA)
(2) SPIN ECHO LLC 1227 E RUSHOLME STREET DAVENPORT, IA 52803 42-1491373	PROPERTY MANAGEMENT	IA	-90,551	1,943,981	GENVENTURES INC

Part II

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
(1)GENESIS HEALTH SYSTEM (GHS ILLINOIS) 801 ILLINI DRIVE SILVIS, IL 61282 36-3616314	HEALTHCARE	IL	501(C)(3)	LINE 3	GENESIS HEALTH SYSTEM (GHS IOWA)	Yes	
(2)GENESIS HEALTH SERVICES FOUNDATION 1227 E RUSHOLME STREET DAVENPORT, IA 52803 42-1421670	CHARITY	IA	501(C)(3)	LINE 7	GENESIS HEALTH SYSTEM (GHS IOWA)	Yes	
(3)GENESIS HEALTH SYSTEM WORKERS' COMPENSATION PLAN & TRUST 1227 E RUSHOLME STREET DAVENPORT, IA 52803 39-1905171	EMPLOYEE/BENEFIT/TRUST	IA	501(C)(3)	LINE 12A, I	GENESIS HEALTH SYSTEM (GHS IOWA)	Yes	
(4)DAVENPORT HOSPITAL AMBULANCE CORPORATION 1204 E HIGH STREET DAVENPORT, IA 52803 42-1186903	AMBULANCE TRANSFERS	IA	501(C)(3)	LINE 12A, I	GENESIS HEALTH SYSTEM (GHS IOWA)	Yes	
(5)GENESIS SENIOR LIVING ALEDO 309 NW NINTH AVENUE ALEDO, IL 61231 45-4475803	SENIOR LIVING SERVICES	IL	501(C)(3)	LINE 3	GENESIS HEALTH SYSTEM (GHS ILLINOIS)	Yes	
(6)GENESIS MEDICAL CENTER ALEDO 409 NW NINTH AVENUE ALEDO, IL 61231 45-4475683	HEALTHCARE	IL	501(C)(3)	LINE 3	GENESIS HEALTH SYSTEM (GHS ILLINOIS)	Yes	
(7)GENESIS PHILANTHROPY 1227 E RUSHOLME STREET DAVENPORT, IA 52803 46-2452851	CHARITY	IA	501(C)(3)	LINE 10	GENESIS HEALTH SYSTEM (GHS IOWA)	Yes	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512- 514)	(f) Share of total income	(g) Share of end- of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) GENGASTRO LLC 2222 53RD AVENUE BETTENDORF, IA 52722 56-2315623	AMBULATORY SURGERY CENTER	IA	GENESIS HEALTH SYSTEM (GHS IOWA)	RELATED	3,680,552	461,330		No			No	75 000 %
(2) SPRING PARK SURGERY CENTER LLC 3319 SPRING STREET STE 202A DAVENPORT, IA 52807 42-1483989	OUTPATIENT SURGICAL CENTER	IA	GENESIS HEALTH SYSTEM (GHS IOWA)	RELATED	1,055,245	1,829,698		No			No	45 000 %
(3) LARSON CENTER PARTNERSHIP 801 ILLINI DRIVE SILVIS, IL 61282 36-3738454	PROPERTY MANAGEMENT	IL	N/A									
(4) GENORTHO LLC 2300 53RD AVENUE BETTENDORF, IA 52722 20-3406994	ORTHOPAEDIC SURGERY CENTER	IA	GENESIS HEALTH SYSTEM (GHS IOWA)	RELATED	1,740,728	1,615,323		No			No	50 000 %
(5) GENRAD IMAGING LLC 1970 E 53RD ST DAVENPORT, IA 52807 45-3571628	DIAGNOSTIC IMAGING CENTER	IA	GENESIS HEALTH SYSTEM (GHS IOWA)	RELATED	2,606,453	12,170,293		No			No	50 000 %
(6) GENRAD IMAGING ILLINOIS LLC 1970 E 53RD ST DAVENPORT, IA 52807 47-3785124	DIAGNOSTIC IMAGING CENTER	IL	N/A									

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of- year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity?	
								Yes	No
(1) GENVENTURES INC 1227 E RUSHOLME STREET DAVENPORT, IA 52803 42-1269171	SUPPORT SERVICES/PROPERTY MANAGEMENT	IA	GENESIS HEALTH SYSTEM (IOWA)	C	-492,764	44,120,501	100 000 %	Yes	
(2) GENESIS HEART INSTITUTE 1236 E RUSHOLME STREET DAVENPORT, IA 52803 42-1504979	HEALTHCARE MANAGEMENT	IA	GENESIS HEALTH SYSTEM (IOWA)	C			100 000 %	Yes	
(3) MISERICORDIA ASSURANCE COMPANY LTD PO BOX 1051 GRAND CAYMAN CJ 98-0457943	OTHER FINANCIAL VEHICLE	CJ	GENESIS HEALTH SYSTEM (IOWA)	C		25,718,872	100 000 %	Yes	
(4) MOB 1 OWNERS' ASSOCIATION 1227 E RUSHOLME STREET DAVENPORT, IA 52803 27-0865075	PROPERTY MANAGEMENT	IA	N/A	C				Yes	

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

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

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

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

1a Yes

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

1b Yes

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

1c Yes

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

1d

No

e Loans or loan guarantees by related organization(s)

1e

No

f Dividends from related organization(s)

1f Yes

g Sale of assets to related organization(s)

1g

No

h Purchase of assets from related organization(s)

1h Yes

i Exchange of assets with related organization(s)

1i

No

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

1j Yes

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

1k Yes

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

1l Yes

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

1m Yes

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

1n

No

o Sharing of paid employees with related organization(s)

1o

No

p Reimbursement paid to related organization(s) for expenses

1p Yes

q Reimbursement paid by related organization(s) for expenses

1q Yes

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

1r Yes

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

1s Yes

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

See Additional Data Table

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

Schedule R (Form 990) 2016

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

[illegible]

Part VII **Supplemental Information**

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

Return Reference	Explanation
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Additional Data

Software ID:
Software Version:
EIN: 42-1418847
Name: GENESIS HEALTH SYSTEM

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c) (3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
(1) 801 ILLINI DRIVE SILVIS, IL 61282 36-3616314	HEALTHCARE	IL	501(C)(3)	LINE 3	GENESIS HEALTH SYSTEM (GHS IOWA)	Yes	
(1) 1227 E RUSHOLME STREET DAVENPORT, IA 52803 42-1421670	CHARITY	IA	501(C)(3)	LINE 7	GENESIS HEALTH SYSTEM (GHS IOWA)	Yes	
(2) 1227 E RUSHOLME STREET DAVENPORT, IA 52803 39-1905171	EMPLOYEE/BENEFIT/TRUST	IA	501(C)(3)	LINE 12A, I	GENESIS HEALTH SYSTEM (GHS IOWA)	Yes	
(3) 1204 E HIGH STREET DAVENPORT, IA 52803 42-1186903	AMBULANCE TRANSFERS	IA	501(C)(3)	LINE 12A, I	GENESIS HEALTH SYSTEM (GHS IOWA)	Yes	
(4) 309 NW NINTH AVENUE ALED0, IL 61231 45-4475803	SENIOR LIVING SERVICES	IL	501(C)(3)	LINE 3	GENESIS HEALTH SYSTEM (GHS ILLINOIS)	Yes	
(5) 409 NW NINTH AVENUE ALED0, IL 61231 45-4475683	HEALTHCARE	IL	501(C)(3)	LINE 3	GENESIS HEALTH SYSTEM (GHS ILLINOIS)	Yes	
(6) 1227 E RUSHOLME STREET DAVENPORT, IA 52803 46-2452851	CHARITY	IA	501(C)(3)	LINE 10	GENESIS HEALTH SYSTEM (GHS IOWA)	Yes	

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

(a) Name of related organization		(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
(1)	GENVENTURES INC	A	615,119	FAIR MARKET VALUE
(1)	DAVENPORT HOSPITAL AMBULANCE	A	32,616	FAIR MARKET VALUE
(2)	GENESIS HEALTH SYSTEM WORKERS' COMPENSATION PLAN & TRUST	B	1,349,719	FAIR MARKET VALUE
(3)	GENESIS PHILANTHROPY	B	750,000	FAIR MARKET VALUE
(4)	GENESIS PHILANTHROPY	C	687,134	FAIR MARKET VALUE
(5)	GENESIS HEALTH SERVICES FOUNDATION	C	582,851	FAIR MARKET VALUE
(6)	MISERICORDIA ASSURANCE COMPANY LTD	F	565,000	FAIR MARKET VALUE
(7)	GENGASTRO LLC	H	3,691,350	FAIR MARKET VALUE
(8)	GENORTHO LLC	H	2,177,000	FAIR MARKET VALUE
(9)	SPRING PARK SURGERY CENTER LLC	H	995,805	FAIR MARKET VALUE
(10)	LARSON CENTER PARTNERSHIP	J	567,188	FAIR MARKET VALUE
(11)	GENVENTURES INC	K	6,853,806	FAIR MARKET VALUE
(12)	LARSON CENTER PARTNERSHIP	K	638,772	FAIR MARKET VALUE
(13)	GENESIS HEALTH SYSTEM (GHS ILLINOIS)	K	190,468	FAIR MARKET VALUE
(14)	GENESIS HEALTH SYSTEM WORKERS' COMPENSATION PLAN & TRUST	L	249,763	FAIR MARKET VALUE
(15)	DAVENPORT HOSPITAL AMBULANCE	M	594,817	FAIR MARKET VALUE
(16)	MISERICORDIA ASSURANCE COMPANY LTD	M	507,691	FAIR MARKET VALUE
(17)	GENESIS HEALTH SYSTEM (GHS ILLINOIS)	P	39,693,130	FAIR MARKET VALUE
(18)	GENESIS MEDICAL CENTER ALEDO	P	3,682,072	FAIR MARKET VALUE
(19)	GENVENTURES INC	P	2,130,469	FAIR MARKET VALUE
(20)	GENESIS SENIOR LIVING ALEDO	P	279,053	FAIR MARKET VALUE
(21)	DAVENPORT HOSPITAL AMBULANCE	P	68,038	FAIR MARKET VALUE
(22)	GENESIS HEALTH SYSTEM (GHS ILLINOIS)	Q	101,751,229	FAIR MARKET VALUE
(23)	GENVENTURES INC	Q	24,207,873	FAIR MARKET VALUE
(24)	GENESIS MEDICAL CENTER ALEDO	Q	16,048,779	FAIR MARKET VALUE

Form 990, Schedule R, Part V - Transactions With Related Organizations			
(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
(26) GENESIS SENIOR LIVING ALEDO	Q	2,965,308	FAIR MARKET VALUE
(1) GENESIS HEALTH SERVICES FOUNDATION	Q	2,799,636	FAIR MARKET VALUE
(2) GENESIS PHILANTHROPY	Q	567,980	FAIR MARKET VALUE
(3) GENVENTURES INC	R	7,741,567	FAIR MARKET VALUE
(4) GENESIS HEALTH SERVICES FOUNDATION	R	911,888	FAIR MARKET VALUE
(5) GENESIS HEALTH SYSTEM (GHS ILLINOIS)	S	188,872	FAIR MARKET VALUE