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Form 990

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

2018

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.

Go to www.irs.gov/Form990 for instructions and the latest information.

Department of the Treasury
Internal Revenue Service

Form 990

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

2018

Open to Public Inspection

A For the 2019 calendar year, or tax year beginning 07-01-2018 , and ending 06-30-2019

B Check if applicable:
☐ Address change
☐ Name change
☐ Initial return
☐ Final return/terminated
☐ Amended return
☐ Application pending

C Name of organization
MERCY MEDICAL CENTER

Doing business as

Number and street (or P.O. box if mail is not delivered to street address) Room/suite
701 10TH ST SE

City or town, state or province, country, and ZIP or foreign postal code
CEDAR RAPIDS, IA 52403

D Employer identification number
42-0698295

E Telephone number
(319) 398-6107

G Gross receipts \$ 455,384,678

F Name and address of principal officer:
NATHAN VAN GENDEREN
701 10TH ST SE
CEDAR RAPIDS, IA 52403

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 ▶ 0928

I Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) () ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW.MERCYCARE.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1900

M State of legal domicile: IA

Part I Summary

1 Briefly describe the organization's mission or most significant activities:
TO CARE FOR THE SICK AND ENHANCE THE HEALTH OF THE COMMUNITIES WE SERVE, GUIDED BY THE SPIRIT OF THE SISTERS OF MERCY.

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

3 Number of voting members of the governing body (Part VI, line 1a) 3 28

4 Number of independent voting members of the governing body (Part VI, line 1b) 4 25

5 Total number of individuals employed in calendar year 2018 (Part V, line 2a) 5 2,814

6 Total number of volunteers (estimate if necessary) 6 950

7a Total unrelated business revenue from Part VIII, column (C), line 12 7a 1,224,796

7b Net unrelated business taxable income from Form 990-T, line 34 7b 322,111

8 Contributions and grants (Part VIII, line 1h) 5,225,828 2,824,748

9 Program service revenue (Part VIII, line 2g) 328,772,367 337,080,026

10 Investment income (Part VIII, column (A), lines 3, 4, and 7d) 8,434,276 9,686,638

11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) -1,159,085 -1,592,343

12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12) 341,273,386 347,999,069

13 Grants and similar amounts paid (Part IX, column (A), lines 1–3) 14,829,040 5,888,315

14 Benefits paid to or for members (Part IX, column (A), line 4) 0 0

15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10) 155,104,967 165,025,921

16a Professional fundraising fees (Part IX, column (A), line 11e) 0 0

16b Total fundraising expenses (Part IX, column (D), line 25) ▶ 0

17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e) 164,565,783 170,666,779

18 Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25) 334,499,790 341,581,015

19 Revenue less expenses. Subtract line 18 from line 12 6,773,596 6,418,054

20 Total assets (Part X, line 16) 573,230,191 591,175,878

21 Total liabilities (Part X, line 26) 197,287,969 219,631,338

22 Net assets or fund balances. Subtract line 21 from line 20 375,942,222 371,544,540

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
NATHAN VAN GENDEREN EXECUTIVE VP/CFO
Type or print name and title

2020-06-09
Date

Paid Preparer Use Only

Print/Type preparer's name
Firm's name ▶ RSM US LLP
Firm's address ▶ 4650 E 53RD ST
DAVENPORT, IA 528073479

Preparer's signature
Date

Check ☐ if self-employed
Firm's EIN ▶ 42-0714325
Phone no. (563) 888-4000

PTIN P01306883

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 (2018)

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:

TO CARE FOR THE SICK AND ENHANCE THE HEALTH OF THE COMMUNITIES WE SERVE, GUIDED BY THE SPIRIT OF THE SISTERS OF MERCY.

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 \$ 268,559,646 including grants of \$ 5,888,315) (Revenue \$ 334,464,155) |
| See Additional Data | |

| | |
|-----------|--|
| 4b | (Code:) (Expenses \$ including grants of \$) (Revenue \$) |
|-----------|--|

| | |
|-----------|--|
| 4c | (Code:) (Expenses \$ including grants of \$) (Revenue \$) |
|-----------|--|

| | |
|-----------|---|
| 4d | Other program services (Describe in Schedule O.) |
| | (Expenses \$ including grants of \$) (Revenue \$) |

| | |
|-----------|---|
| 4e | Total program service expenses ▶ 268,559,646 |
|-----------|---|

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 Yes | |
| 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 | No |
| 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 Yes | |
| 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 Yes | |
| 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 |
| 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 | No |

Part IV Checklist of Required Schedules (continued)

| | | Yes | No |
|------------|--|----------------|----|
| 23 | Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i> | 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? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i> | 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? <i>If "Yes," complete Schedule L, Part I</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? <i>If "Yes," complete Schedule L, Part I</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? <i>If "Yes," complete Schedule L, Part II</i> | 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? <i>If "Yes," complete Schedule L, Part III</i> | 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? <i>If "Yes," complete Schedule L, Part IV</i> | 28a | No |
| b | A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> | 28b | No |
| 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? <i>If "Yes," complete Schedule L, Part IV</i> | 28c Yes | |
| 29 | Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i> | 29 | No |
| 30 | Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i> | 30 Yes | |
| 31 | Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i> | 31 | No |
| 32 | Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i> | 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? <i>If "Yes," complete Schedule R, Part I</i> | 33 Yes | |
| 34 | Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i> | 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)? <i>If "Yes," complete Schedule R, Part V, line 2</i> | 35b Yes | |
| 36 | Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i> | 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? <i>If "Yes," complete Schedule R, Part VI</i> | 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 | 1a 158 | |
| b | Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable | 1b 0 | |
| c | Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? | 1c Yes | |

Form **990** (2018)

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 | 1a 28 | | |
| 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 | 1b 25 | | |
| 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 | Yes | |
| 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 | Yes | |
| 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 | Yes | |
| 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 | No |
| 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 | |
| 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 | No |
| b Other officers or key employees of the organization | 15b | No |
| 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 | No |
| 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 | |

Section C. Disclosure

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

18 Section 6104 requires an organization to make its Form 1023 (or 1024-A 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:
 ► KAY CRIST 701 10TH STREET SE CEDAR RAPIDS, IA 52403 (319) 398-6107

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

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

7

● 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]

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

| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W-2/1099-MISC) | (E) Reportable compensation from related organizations (W-2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|--|--|---|-----------------------|---------|--------------|------------------------------|--------|--|---|---|
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| See Additional Data Table | | | | | | | | | | |
| | | | | | | | | | | |
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| | | | | | | | | | | |
| 1b Sub-Total | | | | | | | | | | |
| c Total from continuation sheets to Part VII, Section A | | | | | | | | | | |
| d Total (add lines 1b and 1c) | | | | | | | | 8,305,570 | 0 | 436,757 |

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 ▶ 132

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

Section B. Independent Contractors

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

| (A) Name and business address | (B) Description of services | (C) Compensation |
|--|----------------------------------|---------------------|
| UNIVERSITY OF IOWA HEALTH CARE 200 HAWKINS DRIVE IOWA CITY, IA 52242 | HEALTHCARE PROFESSIONAL SERVICES | 4,832,610 |
| ONCOLOGY ASSOCIATES OF CEDAR RAPIDS 701 10TH STREET CEDAR RAPIDS, IA 52403 | HEALTHCARE PROFESSIONAL SERVICES | 3,709,795 |
| SOUND PHYSICIANS PO BOX 942936 LOS ANGELES, CA 90074 | HEALTHCARE PROFESSIONAL SERVICES | 3,252,999 |
| FOCUSONE SOLUTIONS LLC 13609 CALIFORNIA STREET 500 OMAHA, NE 68154 | HEALTHCARE PROFESSIONAL SERVICES | 2,079,689 |
| WEATHERBY LOCUMS INC PO BOX 972633 DALLAS, TX 75397 | HEALTHCARE PROFESSIONAL SERVICES | 1,842,082 |

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 ▶ 51

Part VIII Statement of Revenue

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

Contributions, Gifts, Grants and Other Similar Amounts

| | | | (A) Total revenue | (B) Related or exempt function revenue | (C) Unrelated business revenue | (D) Revenue excluded from tax under sections 512 - 514 |
|----|--|----|----------------------|--|---|--|
| 1a | Federated campaigns . . . | 1a | | | | |
| b | Membership dues . . . | 1b | | | | |
| c | Fundraising events . . . | 1c | | | | |
| d | Related organizations | 1d | 2,527,822 | | | |
| e | Government grants (contributions) | 1e | | | | |
| f | All other contributions, gifts, grants, and similar amounts not included above | 1f | 296,926 | | | |
| g | Noncash contributions included in lines 1a - 1f:\$ 5,493 | | | | | |
| h | Total. Add lines 1a-1f | | 2,824,748 | | | |

Program Service Revenue

| | | Business Code | | | | |
|----|------------------------------------|---------------|-------------|-------------|---------|--|
| 2a | PATIENT REVENUES | 900099 | 231,042,672 | 231,042,672 | | |
| b | LABORATORY REVENUE | 621500 | 110,377,078 | 109,580,509 | 796,569 | |
| c | FAMILY COUNSELING REVENUE | 624100 | 280,409 | 280,409 | | |
| d | LESS: PROVISION FOR BAD DEBT | 900099 | -4,620,133 | -4,620,133 | | |
| e | | | | | | |
| f | All other program service revenue. | | | | | |
| g | Total. Add lines 2a-2f | | 337,080,026 | | | |

Other Revenue

| | | | | | | | |
|---|---|---------------|-------------|-------------|-----------|-----------|--------|
| 3 Investment income (including dividends, interest, and other similar amounts) ▶ | | | 6,918,255 | | | 6,918,255 | |
| 4 Income from investment of tax-exempt bond proceeds ▶ | | | | | | | |
| 5 Royalties ▶ | | | | | | | |
| 6a Gross rents | (i) Real | (ii) Personal | | | | | |
| | 2,528,436 | | | | | | |
| | b Less: rental expenses | 2,262,969 | | | | | |
| | c Rental income or (loss) | 265,467 | | | | | |
| d Net rental income or (loss) ▶ | | | 265,467 | | | 265,467 | |
| 7a Gross amount from sales of assets other than inventory | (i) Securities | (ii) Other | | | | | |
| | 104,762,244 | 55,305 | | | | | |
| | b Less: cost or other basis and sales expenses | 102,047,280 | | | | | 1,886 |
| | c Gain or (loss) | 2,714,964 | | | | | 53,419 |
| d Net gain or (loss) ▶ | | | 2,768,383 | | | 2,768,383 | |
| 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 ▶ | | | -466,735 | | | -466,735 | |
| Miscellaneous Revenue | | Business Code | 2,417,943 | 1,989,716 | 428,227 | | |
| 11a INVESTMENT PARTNERSHIP INCOME (LOS) | | 561000 | | | | | |
| b MISCELLANEOUS REVENUE | | 900099 | | | | | |
| c MRI JOINT VENTURE | | 621110 | | | | | |
| d All other revenue | | | | | | | |
| e Total. Add lines 11a–11d ▶ | | | -1,391,075 | | | | |
| 12 Total revenue. See Instructions. ▶ | | | 347,999,069 | 334,464,155 | 1,224,796 | 9,485,370 | |

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 ☐

| | (A) Total expenses | (B) Program service expenses | (C) Management and general expenses | (D) Fundraising expenses |
|--|-----------------------|---------------------------------|--|-----------------------------|
| Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII. | | | | |
| 1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 | 5,888,315 | 5,888,315 | | |
| 2 Grants and other assistance to domestic individuals. See Part IV, line 22 | | | | |
| 3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16. | | | | |
| 4 Benefits paid to or for members | | | | |
| 5 Compensation of current officers, directors, trustees, and key employees | 4,021,603 | 3,146,630 | 874,973 | |
| 6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) | | | | |
| 7 Other salaries and wages | 127,441,254 | 99,714,078 | 27,727,176 | |
| 8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions) | 3,971,154 | 3,107,157 | 863,997 | |
| 9 Other employee benefits | 20,568,341 | 16,093,322 | 4,475,019 | |
| 10 Payroll taxes | 9,023,569 | 7,060,327 | 1,963,242 | |
| 11 Fees for services (non-employees): | | | | |
| a Management | | | | |
| b Legal | 131,223 | 102,673 | 28,550 | |
| c Accounting | | | | |
| d Lobbying | 30,845 | 24,134 | 6,711 | |
| e Professional fundraising services. See Part IV, line 17 | | | | |
| f Investment management fees | 3,970 | 3,106 | 864 | |
| g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O) | 27,066,339 | 21,177,562 | 5,888,777 | |
| 12 Advertising and promotion | 1,600,029 | 1,251,913 | 348,116 | |
| 13 Office expenses | 86,923,021 | 68,011,328 | 18,911,693 | |
| 14 Information technology | 482,763 | 377,729 | 105,034 | |
| 15 Royalties | | | | |
| 16 Occupancy | 4,085,130 | 3,196,335 | 888,795 | |
| 17 Travel | 268,460 | 210,052 | 58,408 | |
| 18 Payments of travel or entertainment expenses for any federal, state, or local public officials | | | | |
| 19 Conferences, conventions, and meetings | 116,739 | 91,340 | 25,399 | |
| 20 Interest | 4,658,176 | 3,644,705 | 1,013,471 | |
| 21 Payments to affiliates | | | | |
| 22 Depreciation, depletion, and amortization | 23,687,050 | 18,533,499 | 5,153,551 | |
| 23 Insurance | 959,299 | 750,586 | 208,713 | |
| 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 UNRELATED BUSINESS INCO | 67,643 | 67,643 | | |
| b CONTRACTED SERVICES | 11,063,723 | 8,656,608 | 2,407,115 | |
| c REPAIRS | 2,102,858 | 1,645,343 | 457,515 | |
| d TAXES & LICENSES | 1,948,768 | 1,524,778 | 423,990 | |
| e All other expenses | 5,470,743 | 4,280,483 | 1,190,260 | |
| 25 Total functional expenses. Add lines 1 through 24e | 341,581,015 | 268,559,646 | 73,021,369 | 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 | | 3,797,559 | 1 | 13,103,421 | |
| | 2 | Savings and temporary cash investments | | 3,070,974 | 2 | 6,235,105 | |
| | 3 | Pledges and grants receivable, net | | | 3 | | |
| | 4 | Accounts receivable, net | | 43,496,407 | 4 | 39,891,124 | |
| | 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 | | 617,655 | 7 | 792,679 | |
| | 8 | Inventories for sale or use | | 7,837,655 | 8 | 7,682,746 | |
| | 9 | Prepaid expenses and deferred charges | | 3,844,737 | 9 | 8,336,801 | |
| | 10a | Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D | 10a | 498,485,519 | | | |
| | b | Less: accumulated depreciation | 10b | 312,333,935 | 184,088,189 | 10c | 186,151,584 |
| | 11 | Investments—publicly traded securities | | 251,859,574 | 11 | 254,005,511 | |
| | 12 | Investments—other securities. See Part IV, line 11 | | 82,033 | 12 | 0 | |
| | 13 | Investments—program-related. See Part IV, line 11 | | 74,535,408 | 13 | 74,976,907 | |
| | 14 | Intangible assets | | | 14 | | |
| | 15 | Other assets. See Part IV, line 11 | | | 15 | | |
| 16 | Total assets. Add lines 1 through 15 (must equal line 34) | | 573,230,191 | 16 | 591,175,878 | | |
| Liabilities | 17 | Accounts payable and accrued expenses | | 37,543,949 | 17 | 53,474,783 | |
| | 18 | Grants payable | | | 18 | | |
| | 19 | Deferred revenue | | | 19 | | |
| | 20 | Tax-exempt bond liabilities | | 105,469,496 | 20 | 104,511,718 | |
| | 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 | | 54,274,524 | 25 | 61,644,837 | |
| | 26 | Total liabilities. Add lines 17 through 25 | | 197,287,969 | 26 | 219,631,338 | |
| 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 | | 326,727,077 | 27 | 321,845,853 | |
| | 28 | Temporarily restricted net assets | | 21,768,488 | 28 | 22,052,009 | |
| | 29 | Permanently restricted net assets | | 27,446,657 | 29 | 27,646,678 | |
| | 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 | | 375,942,222 | 33 | 371,544,540 | | |
| 34 | Total liabilities and net assets/fund balances | | 573,230,191 | 34 | 591,175,878 | | |

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 | 347,999,069 |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 341,581,015 |
| 3 | Revenue less expenses. Subtract line 2 from line 1 | 3 | 6,418,054 |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | 375,942,222 |
| 5 | Net unrealized gains (losses) on investments | 5 | 3,015,767 |
| 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 | -13,831,503 |
| 10 | Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 371,544,540 |

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 type="checkbox"/> Consolidated basis <input checked="" 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: 42-0698295
Name: MERCY MEDICAL CENTER

Form 990 (2018)

Form 990, Part III, Line 4a:

THE HOSPITAL PROVIDES MEDICAL HEALTH CARE, INCLUDING 24 HOURS A DAY, SEVEN DAYS A WEEK TRAUMA CENTER SERVICE, TO ALL PATIENTS ACCESSING THE SYSTEM, REGARDLESS OF RACE, CREED, SEX, NATIONAL ORIGIN, HANDICAP, AGE OR ABILITY TO PAY. A PATIENT IS CLASSIFIED AS A CHARITY PATIENT BY REFERENCE TO CERTAIN ESTABLISHED POLICIES OF THE HOSPITAL. ESSENTIALLY, THESE POLICIES DEFINE CHARITY SERVICES AS THOSE SERVICES FOR WHICH NO OR NOMINAL PAYMENT IS ANTICIPATED. ADDITIONALLY, EACH HOSPITAL DEPARTMENT ACCEPTS ALL PATIENTS WHO ARE COVERED BY GOVERNMENTAL INDIGENT PROGRAMS. SUCH INDIGENT PROGRAMS TYPICALLY REMIT AMOUNTS SUBSTANTIALLY LESS THAN CHARGES. THE FOLLOWING SUMMARIZES THE HOSPITAL'S CARE OF THE UNINSURED AND UNDERINSURED. COSTS IN EXCESS OF MEDICARE REIMBURSEMENT (COSTS OF PROVIDING THE SERVICES LESS THE AMOUNTS RECEIVED FROM MEDICARE) - \$20,160,000; OTHER COMMUNITY BENEFITS (INCLUDES SUBSIDIZED HEALTH SERVICES, FINANCIAL CONTRIBUTIONS) - \$4,144,000; FREE SERVICE (TO PATIENTS WHO MEET MERCY'S FREE-SERVICE GUIDELINES - \$4,770,000; COSTS IN EXCESS OF MEDICAID REIMBURSEMENT (COSTS OF PROVIDING THE SERVICES LESS THE AMOUNTS RECEIVED FROM MEDICAID) - \$12,090,000, PHYSICIAN EDUCATION - \$978,000. IN ADDITION, CHARITY CARE AND COMMUNITY SERVICE ARE PROVIDED THROUGH MANY REDUCED PRICE SERVICES AND FREE PROGRAMS OFFERED THROUGHOUT THE YEAR. THESE PROGRAMS PROVIDE A BONA FIDE COMMUNITY HEALTH NEED, INCLUDING: A. PUBLIC AND PROFESSIONAL EDUCATIONAL SEMINAR ARE OFFERED ON A VARIETY OF TOPICS INCLUDING JOINT REPLACEMENT SURGERY, PRENATAL EDUCATION, DIABETES, MENTAL HEALTH DISORDERS, AND NUMEROUS OTHER MEDICAL CONDITIONS OF MEDICAL AND PSYCHOSOCIAL NATURE. SPECIALIZED CANCER SEMINARS ARE ALSO FREQUENTLY OFFERED. B. HOSPITAL MEETING FACILITIES WHICH ARE FREQUENTLY USED WITHOUT CHARGE BY SUCH GROUPS AS THE AMERICAN HEART ASSOCIATION, IOWA BREAST CANCER FOUNDATION, HEALTHY LINN NETWORK ADVISORY COMMITTEE, OVEREATERS ANONYMOUS, CATHOLIC LAYMEN, UNITED WAY, CATHERINE MCAULEY CENTER FOR WOMEN, THE AMERICAN CANCER SOCIETY. M.S. SUPPORT GROUP, EASTERN IOWA ONCOLOGY NURSES SOCIETY, THE IOWA CANCER CONSORTIUM, RADIATION THERAPIST AND DOSIMETRIST, THE PARENT EDUCATION CONSORTIUM, ARC OF EAST CENTRAL IOWA, AND SEVERAL CANCER SUPPORT GROUPS. C. CONTRIBUTIONS OF APPROXIMATELY 176,000 HOURS TOWARD THE COMMON PURPOSE OF SERVING THE HEALTH CARE OF THE COMMUNITY. THE VALUE OF THESE CONTRIBUTIONS WAS APPROXIMATELY \$2,348,000 AND WAS GIVEN BACK TO THE COMMUNITY THROUGH LOWER COSTS.

| 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 | | | |
| JOHN-PAUL BESONG MEMBER BOARD OF TRUSTEES | 1.00 | X | | | | | | 0 | 0 | 0 |
| LYDIA BROWN MEMBER BOARD OF TRUSTEES | 1.00 | X | | | | | | 0 | 0 | 0 |
| MICHELE BUSSE MEMBER BOARD OF TRUSTEES | 1.00 | X | | | | | | 0 | 0 | 0 |
| BOB CATALDO MEMBER BOARD OF TRUSTEES | 1.00 | X | | | | | | 0 | 0 | 0 |
| TIMOTHY L CHARLES PRESIDENT & CEO | 40.00 | X | | X | | | | 911,772 | 0 | 69,551 |
| JACK COSGROVE MEMBER BOARD OF TRUSTEES | 1.00 | X | | | | | | 0 | 0 | 0 |
| CHRIS DEWOLF MEMBER BOARD OF TRUSTEES | 1.00 | X | | | | | | 0 | 0 | 0 |
| BARRIE ERNST MEMBER BOARD OF TRUSTEES | 1.00 | X | | | | | | 0 | 0 | 0 |
| TONY GOLOBIC MEMBER BOARD OF TRUSTEES | 1.00 | X | | | | | | 0 | 0 | 0 |
| SISTER LUANN HANNASCH MEMBER BOARD OF TRUSTEES | 1.00 | X | | | | | | 0 | 0 | 0 |

| Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors | | | | | | | | | | |
|---|--|---|-----------------------|---------|--------------|------------------------------|--------|---|--|---|
| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W- 2/1099-MISC) | (E) Reportable compensation from related organizations (W- 2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| NICHOLAS HODGMAN MD MEMBER BOARD OF TRUSTEES | 40.00 | X | | | | | | 905,231 | 0 | 21,877 |
| NANCY KASPAREK MEMBER BOARD OF TRUSTEES | 1.00 | X | | | | | | 0 | 0 | 0 |
| JAN KAZIMOUR MEMBER BOARD OF TRUSTEES | 1.00 | X | | | | | | 0 | 0 | 0 |
| SISTER SHARON KERRIGAN MEMBER BOARD OF TRUSTEES | 1.00 | X | | | | | | 0 | 0 | 0 |
| BARB KNAPP MEMBER BOARD OF TRUSTEES | 1.00 | X | | | | | | 0 | 0 | 0 |
| SISTER TERRY MALTBY MEMBER BOARD OF TRUSTEES | 1.00 | X | | | | | | 0 | 0 | 0 |
| CHERYLE MITVALSKY CHAIRMAN | 1.00 | X | | X | | | | 0 | 0 | 0 |
| DARREL MORF VICE CHAIRMAN/TREASURER | 1.00 | X | | X | | | | 0 | 0 | 0 |
| RUE PATEL MEMBER BOARD OF TRUSTEES | 1.00 | X | | | | | | 0 | 0 | 0 |
| FRED PILCHER MD MEMBER BOARD OF TRUSTEES | 1.00 | X | | | | | | 0 | 0 | 0 |

| Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors | | | | | | | | | | |
|---|--|---|-----------------------|---------|--------------|------------------------------|--------|---|--|---|
| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W- 2/1099-MISC) | (E) Reportable compensation from related organizations (W- 2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| MARY QUASS MEMBER BOARD OF TRUSTEES | 1.00 | X | | | | | | 0 | 0 | 0 |
| JOHN RIFE MEMBER BOARD OF TRUSTEES | 1.00 | X | | | | | | 0 | 0 | 0 |
| CHARLES ROHDE MEMBER BOARD OF TRUSTEES | 1.00 | X | | | | | | 0 | 0 | 0 |
| AL RUFFALO MEMBER BOARD OF TRUSTEES | 1.00 | X | | | | | | 0 | 0 | 0 |
| KYLE SKOGMAN MEMBER BOARD OF TRUSTEES | 1.00 | X | | | | | | 0 | 0 | 0 |
| JOHN SMITH MEMBER BOARD OF TRUSTEES | 1.00 | X | | | | | | 0 | 0 | 0 |
| SISTER MAURITA SOUKUP SECRETARY | 1.00 | X | | X | | | | 0 | 0 | 0 |
| SISTER RITA VALADE FORMER MEMBER BOARD OF TRUSTEES | 1.00 | X | | | | | | 0 | 0 | 0 |
| SISTER MARGARET WEIGEL MEMBER BOARD OF TRUSTEES | 1.00 | X | | | | | | 0 | 0 | 0 |
| NATHAN VANGENDEREN EXECUTIVE VP/CFO | 40.00 | | | X | | | | 491,075 | 0 | 55,372 |

| 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 | | | |
| TIMOTHY QUINN MD CHIEF OF CLINICAL OPERATIONS | 40.00 | | | X | | | | 632,807 | 0 | 64,937 |
| MARY BROBST CHIEF NURSING OFFICER | 40.00 | | | | X | | | 327,562 | 0 | 47,140 |
| JEFFREY CASH CHIEF INFORMATION OFFICER | 40.00 | | | | X | | | 326,398 | 0 | 49,366 |
| NANCY HILL-DAVIS VP - HUMAN RESOURCES | 40.00 | | | | X | | | 266,947 | 0 | 23,739 |
| AMANDEEP DHALIWAL MD PHYSICIAN | 40.00 | | | | | X | | 870,477 | 0 | 8,389 |
| SHANE A GAILUSHAS MD PHYSICIAN | 40.00 | | | | | X | | 706,623 | 0 | 21,877 |
| RYAN D HOLLENBECK MD PHYSICIAN | 40.00 | | | | | X | | 831,665 | 0 | 30,925 |
| CHONG C LEE MD PHYSICIAN | 40.00 | | | | | X | | 1,335,634 | 0 | 27,408 |
| SHINY MATHEWKUTTY MD PHYSICIAN | 40.00 | | | | | X | | 699,379 | 0 | 16,176 |

SCHEDULE A
(Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

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.
▶ Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
MERCY MEDICAL CENTER

Employer identification number
42-0698295

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), 170(b)(1)(A)(vi), and 170(b)(1)(A)(ix)

(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) 2014 | (b) 2015 | (c) 2016 | (d) 2017 | (e) 2018 | (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)2014 | (b)2015 | (c)2016 | (d)2017 | (e)2018 | (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 2018 (line 6, column (f) divided by line 11, column (f)) | 14 | |
| 15 | Public support percentage for 2017 Schedule A, Part II, line 14 | 15 | |

16a

33 1/3% support test—2018. 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 ▶ ☐

b

33 1/3% support test—2017. 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 ▶ ☐

17a

10%-facts-and-circumstances test—2018. 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 ▶ ☐

b

10%-facts-and-circumstances test—2017. 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 ▶ ☐

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 ▶ ☐

Schedule A (Form 990 or 990-EZ) 2018

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) 2014 | (b) 2015 | (c) 2016 | (d) 2017 | (e) 2018 | (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) 2014 | (b) 2015 | (c) 2016 | (d) 2017 | (e) 2018 | (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. <input type="checkbox"/> | | | | | | |

Section C. Computation of Public Support Percentage

| | | |
|--|-----------|--|
| 15 Public support percentage for 2018 (line 8, column (f) divided by line 13, column (f)) | 15 | |
| 16 Public support percentage from 2017 Schedule A, Part III, line 15 | 16 | |

Section D. Computation of Investment Income Percentage

| | | |
|--|-----------|--|
| 17 Investment income percentage for 2018 (line 10c, column (f) divided by line 13, column (f)) | 17 | |
| 18 Investment income percentage from 2017 Schedule A, Part III, line 17 | 18 | |

19a 33 1/3% support tests—2018. 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—2017. 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? If "Yes" to a, b, or c, provide detail in Part VI. | | |

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

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? If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s). | | |
| 3 By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? If "Yes," describe in Part VI the role the organization's supported organizations played in this regard. | | |

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. | Yes | No |
| a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities. | | |
| b Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement. | | |
| 3 Parent of Supported Organizations. Answer (a) and (b) below. | | |
| a Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? Provide details in Part VI. | | |
| b Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? If "Yes," describe in Part VI the role played by the organization in this regard. | | |

| | | | |
|--|--|----------------|--------------------------------|
| Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations | | | |
| <div><div>1</div><div><input type="checkbox"/></div><div>Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970 (explain in Part VI). See instructions. All other Type III non-functionally integrated supporting organizations must complete Sections A through E.</div></div> | | | |
| 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 | <div><div>7</div><div><input type="checkbox"/></div><div>Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)</div></div> | | |

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 2018 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-2018 | (iii) Distributable Amount for 2018 |
|---|-----------------------------|--|---|
| 1 Distributable amount for 2018 from Section C, line 6 | | | |
| 2 Underdistributions, if any, for years prior to 2018 (reasonable cause required-- explain in Part VI). See instructions. | | | |
| 3 Excess distributions carryover, if any, to 2018: | | | |
| a From 2013. | | | |
| b From 2014. | | | |
| c From 2015. | | | |
| d From 2016. | | | |
| e From 2017. | | | |
| f Total of lines 3a through e | | | |
| g Applied to underdistributions of prior years | | | |
| h Applied to 2018 distributable amount | | | |
| i Carryover from 2013 not applied (see instructions) | | | |
| j Remainder. Subtract lines 3g, 3h, and 3i from 3f. | | | |
| 4 Distributions for 2018 from Section D, line 7: | | | |
| \$ | | | |
| a Applied to underdistributions of prior years | | | |
| b Applied to 2018 distributable amount | | | |
| c Remainder. Subtract lines 4a and 4b from 4. | | | |
| 5 Remaining underdistributions for years prior to 2018, if any. Subtract lines 3g and 4a from line 2. If the amount is greater than zero, explain in Part VI. See instructions. | | | |
| 6 Remaining underdistributions for 2018. Subtract lines 3h and 4b from line 1. If the amount is greater than zero, explain in Part VI. See instructions. | | | |
| 7 Excess distributions carryover to 2019. Add lines 3j and 4c. | | | |
| 8 Breakdown of line 7: | | | |
| a Excess from 2014. | | | |
| b Excess from 2015. | | | |
| c Excess from 2016. | | | |
| d Excess from 2017. | | | |
| e Excess from 2018. | | | |

Additional Data

Software ID:
Software Version:
EIN: 42-0698295
Name: MERCY MEDICAL CENTER

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.
▶Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2018

Open to Public Inspection

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

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

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

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

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

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

| | |
|--|--|
| Name of the organization MERCY MEDICAL CENTER | Employer identification number 42-0698295 |
|--|--|

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 (see instructions for definition of "political campaign activities") | |
| 2 | Political campaign activity expenditures (see instructions) | ▶ \$ |
| 3 | Volunteer hours for political campaign activities (see instructions) | |

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-. |
|---|----------|-------------|---------|---|--|
| 1 | | | | | |
| 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) 2015 | (b) 2016 | (c) 2017 | (d) 2018 | (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)? | | No | |
| c | Media advertisements? | | No | |
| d | Mailings to members, legislators, or the public? | | No | |
| e | Publications, or published or broadcast statements? | | No | |
| f | Grants to other organizations for lobbying purposes? | | No | |
| g | Direct contact with legislators, their staffs, government officials, or a legislative body? | | No | |
| h | Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means? | | No | |
| i | Other activities? | Yes | | 30,845 |
| j | Total. Add lines 1c through 1i | | | 30,845 |
| 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? | 1 | |
| 2 | Did the organization make only in-house lobbying expenditures of \$2,000 or less? | 2 | |
| 3 | Did the organization agree to carry over lobbying and political expenditures from the prior year? | 3 | |

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: | 18.1% OR \$28,180 OF MEMBERSHIP DUES TO THE IOWA HOSPITAL ASSOCIATION IS ATTRIBUTABLE TO LOBBYING ACTIVITIES, 3.52% OR \$1,971 OF MEMBERSHIP DUES TO THE CATHOLIC HEALTH ASSOCIATION IS ATTRIBUTABLE TO LOBBYING ACTIVITIES, AND 5.55% OR \$694 OF MEMBERSHIP DUES TO THE CEDAR RAPIDS METRO ALLIANCE IS ATTRIBUTABLE TO LOBBYING ACTIVITIES. |

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

► Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
► Attach to Form 990.
► Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
MERCY MEDICAL CENTER

Employer identification number
42-0698295

Part I

Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.

Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

| | (a) Donor advised funds | (b) Funds and other accounts |
|---|-------------------------|------------------------------|
| 1 Total number at end of year | | |
| 2 Aggregate value of contributions to (during year) | | |
| 3 Aggregate value of grants from (during year) | | |
| 4 Aggregate value at end of year | | |

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?

☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?

☐ Yes ☐ No

Part II

Conservation Easements.

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

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

☐ Preservation of land for public use (e.g., recreation or education)

☐ Preservation of an historically important land area

☐ Protection of natural habitat

☐ Preservation of a certified historic structure

☐ Preservation of open space

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

| | Held at the End of the Year |
|--|-----------------------------|
| a Total number of conservation easements | 2a |
| b Total acreage restricted by conservation easements | 2b |
| c Number of conservation easements on a certified historic structure included in (a) | 2c |
| d Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register | 2d |

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

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

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?

☐ Yes ☐ No

6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ►

7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ► \$

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?

☐ Yes ☐ No

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

Part III

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

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

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

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

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

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

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

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

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

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

Cat. No. 52283D

Schedule D (Form 990) 2018

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 | 38,709,974 | 37,681,476 | 36,037,066 | 35,173,368 | 34,987,320 |
| b | Contributions | 188,283 | 129,753 | 294,653 | 1,481,758 | 298,033 |
| c | Net investment earnings, gains, and losses | 1,202,709 | 1,402,741 | 1,771,320 | -43,393 | 285,414 |
| d | Grants or scholarships | | | | | |
| e | Other expenditures for facilities and programs | -86,118 | -77,440 | -171,611 | | |
| f | Administrative expenses | 1,113,376 | 581,436 | 593,174 | 574,667 | 397,399 |
| g | End of year balance | 39,073,708 | 38,709,974 | 37,681,476 | 36,037,066 | 35,173,368 |

2

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

a

Board designated or quasi-endowment ▶ 16.620 %

b

Permanent endowment ▶ 70.530 %

c

Temporarily restricted endowment ▶ 12.850 %

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

3a

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

(i)

unrelated organizations

(ii)

related organizations

b

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

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

4

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

Part VI

Land, Buildings, and Equipment.

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

| Description of property | (a) Cost or other basis (investment) | (b) Cost or other basis (other) | (c) Accumulated depreciation | (d) Book value |
|-------------------------|---|---------------------------------|------------------------------|----------------|
| 1a | Land | 20,543,864 | | 20,543,864 |
| b | Buildings | 301,752,922 | 188,250,638 | 113,502,284 |
| c | Leasehold improvements | | | |
| d | Equipment | 172,887,462 | 121,420,330 | 51,467,132 |
| e | Other | 3,301,271 | 2,662,967 | 638,304 |
| Total. | Add lines 1a through 1e.(Column (d) must equal Form 990, Part X, column (B), line 10(c).) . . . ▶ | | | 186,151,584 |

Part VII

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

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

Part VIII

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

| (a) Description of investment | (b) Book value | (c) Method of valuation: Cost or end-of-year market value |
|---|----------------|--|
| (1) INVESTMENT IN MERCY MEDICAL CENTER FOUNDATION | 71,409,899 | C |
| (2) INVESTMENT IN CEDAR RAPIDS PHO | 1,321,000 | C |
| (3) SLEEP LAB JOINT VENTURE | 1,145,000 | C |
| (4) INVESTMENT IN MR ASSOCIATES | 458,000 | C |
| (5) INVESTMENT IN MEDICAL MALL | 343,008 | C |
| (6) INVESTMENT IN UMCSC | 300,000 | C |
| (7) | | |
| (8) | | |
| (9) | | |
| Total. (Column (b) must equal Form 990, Part X, col.(B) line 13.) ▶ | 74,976,907 | |

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 | |
| INTEREST RATE SWAP AGREEMENTS | 8,920,420 |
| PENSION LIABILITY | 41,929,323 |
| SELF INSURANCE RESERVES | 8,757,413 |
| THIRD PARTY SETTLEMENTS | 2,037,681 |
| (5) | |
| (6) | |
| (7) | |
| (8) | |
| (9) | |
| Total. (Column (b) must equal Form 990, Part X, col.(B) line 25.) ▶ | 61,644,837 |

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 | 334,124,599 |
| 2 | Amounts included on line 1 but not on Form 990, Part VIII, line 12: | | |
| a | Net unrealized gains (losses) on investments | 2a | 3,015,767 |
| b | Donated services and use of facilities | 2b | |
| c | Recoveries of prior year grants | 2c | |
| d | Other (Describe in Part XIII.) | 2d | -18,616,865 |
| e | Add lines 2a through 2d | 2e | -15,601,098 |
| 3 | Subtract line 2e from line 1 | 3 | 349,725,697 |
| 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 | -1,726,628 |
| c | Add lines 4a and 4b | 4c | -1,726,628 |
| 5 | Total revenue. Add lines 3 and 4c . (This must equal Form 990, Part I, line 12.) | 5 | 347,999,069 |

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 | 338,522,281 |
| 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 | 2,203,328 |
| e | Add lines 2a through 2d | 2e | 2,203,328 |
| 3 | Subtract line 2e from line 1 | 3 | 336,318,953 |
| 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 | 5,262,062 |
| c | Add lines 4a and 4b | 4c | 5,262,062 |
| 5 | Total expenses. Add lines 3 and 4c . (This must equal Form 990, Part I, line 18.) | 5 | 341,581,015 |

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: 42-0698295
Name: MERCY MEDICAL CENTER

Supplemental Information

| Return Reference | Explanation |
|--------------------|--|
| PART III, LINE 1A: | THE ORGANIZATION HAS A SMALL COLLECTION OF ARTWORK. THE COLLECTION IS ON DISPLAY FOR PUBLIC VIEWING. THE MEDICAL CENTER HAS ELECTED NOT TO CAPITALIZE THEIR COLLECTION AS PERMITTED BY STATEMENT OF FINANCIAL ACCOUNTING STANDARDS (SFAS) NO. 116, ACCOUNTING FOR CONTRIBUTIONS RECEIVED AND CONTRIBUTIONS MADE. THE MEDICAL CENTER'S COLLECTIONS THAT HAVE BEEN DONATED ARE NOT RECOGNIZED AS ASSETS ON THE BALANCE SHEETS. NONE OF THE ARTWORK HAS BEEN SOLD TO RAISE FUNDS. |

Supplemental Information

| Return Reference | Explanation |
|------------------|---|
| PART V, LINE 4: | MERCY HOSPITAL, CEDAR RAPIDS, IA ENDOWMENT FOUNDATION, INC., A RELATED ORGANIZATION, HOLDS THE ENDOWMENT FUNDS. THE FOUNDATION'S ENDOWMENT FUNDS ARE USED FOR THE HALL-PERRINE CANCER CENTER AND CANCER CENTER PROGRAMS, HALL RADIATION CENTER, OLDORF HOSPICE HOUSE, HOSPICE OF MERCY PROGRAMS, HALLMAR, WATTS LIBRARY, MERCY MEDICAL CENTER OPERATING AND CAPITAL PROJECTS, AND GENERAL ENDOWMENT FUNDS TO BE USED AT THE BOARD OF DIRECTOR'S DISCRETION. |

Supplemental Information

| Return Reference | Explanation |
|------------------|---|
| PART X, LINE 2: | <p>THE HOSPITAL IS A NOT-FOR-PROFIT AS DESCRIBED IN SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE AND IS EXEMPT FROM FEDERAL INCOME TAXES ON RELATED INCOME PURSUANT TO SECTION 501(A) OF THE CODE. THE HOSPITAL FILES A FORM 990 (RETURN OF ORGANIZATION EXEMPT FROM INCOME TAX) ANNUALLY. WHEN THIS RETURN IS 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 TAX POSITION TAKEN OR THE AMOUNT OF THE POSITION THAT WOULD ULTIMATELY BE SUSTAINED. EXAMPLES OF TAX POSITIONS COMMON TO HOSPITALS INCLUDE SUCH MATTERS AS THE FOLLOWING: THE TAX EXEMPT STATUS OF THE ENTITY, THE CONTINUED TAX EXEMPT STATUS OF BONDS ISSUED BY THE OBLIGATED GROUP, THE NATURE, THE CHARACTERIZATION AND TAXABILITY OF JOINT VENTURE INCOME AND VARIOUS POSITIONS RELATIVE TO POTENTIAL SOURCES OF UNRELATED BUSINESS INCOME (UBI). UBI IS REPORTED ON FORM 990T, AS APPROPRIATE. THE BENEFIT OF A TAX POSITION IS RECOGNIZED IN THE 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 BALANCE SHEET ALONG WITH ANY ASSOCIATED INTEREST AND PENALTIES THAT WOULD BE PAYABLE TO THE TAXING AUTHORITIES UPON EXAMINATION. AS OF JUNE 30, 2019 AND 2018, THERE WERE NO UNCERTAIN TAX BENEFITS IDENTIFIED AND RECORDED AS A LIABILITY. FORMS 990 AND 990T FILED BY THE HOSPITAL ARE SUBJECT TO EXAMINATION BY THE INTERNAL REVENUE SERVICE (IRS) UP TO THREE YEARS FROM THE EXTENDED DUE DATE OF EACH RETURN.</p> |

Supplemental Information

| Return Reference | Explanation |
|---------------------------------------|--|
| PART XI, LINE 2D - OTHER ADJUSTMENTS: | CHANGE IN FAIR VALUE OF INTEREST RATE SWAP AGREEMENTS -2,275,414. CHANGE IN UNRECOGNIZED F UNDED STATUS OF RETIREMENT PLAN -11,995,943. CHANGE IN INTEREST IN NET ASSETS OF MERCY MED ICAL CENTER FOUNDATION 819,492. GRANT TO MERCYARE SERVICE CORPORATION INCLUDED WITH REVENU ES -5,165,000. |

Supplemental Information

| Return Reference | Explanation |
|---------------------------------------|---|
| PART XI, LINE 4B - OTHER ADJUSTMENTS: | CAFETERIA COST OF GOODS SOLD NETTED WITH REVENUES -2,203,328. LOSS ON SALE OF ASSETS 53,419. BOOK/TAX DIFFERENCE IN PARTNERSHIP INCOME(LOSS) 383,422. REVENUE INCLUDED WITH EXPENSES ON AUDIT REPORT 43,643. AUXILIARY AND GIFT SHOP REVENUE NOT INCLUDED IN AUDIT REPORT -28,352. CONTRIBUTION REVENUE NOT RECORDED ON BOOKS 24,568. |

| Supplemental Information | |
|--|--|
| Return Reference | Explanation |
| PART XII, LINE 2D - OTHER ADJUSTMENTS: | CAFETERIA COST OF GOODS SOLD NETTED WITH REVENUES 2,203,328. |

Supplemental Information

| Return Reference | Explanation |
|--|--|
| PART XII, LINE 4B - OTHER ADJUSTMENTS: | GRANT TO MERCYCARE SERVICE CORPORATION INCLUDED WITH REVENUES 5,165,000. REVENUES INCLUDED WITH EXPENSES ON AUDIT REPORT 43,643. LOSS ON SALE OF FIXED ASSETS 53,419. |

SCHEDULE F
(Form 990)

Department of the Treasury
Internal Revenue Service

Name of the organization
MERCY MEDICAL CENTER

Statement of Activities Outside the United States

► Complete if the organization answered "Yes" to Form 990, Part IV, line 14b, 15, or 16.
► Attach to Form 990.
► Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2018

Open to Public Inspection

Employer identification number
42-0698295

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 |
|--|-------------------------------------|--|---|--|--|
| CENTRAL AMERICA AND THE CARIBBEAN - ANTIGUA & BARBUDA, ARUBA, BAHAMAS, | 0 | 0 | INVESTMENTS | | 2,402,633 |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| 3a Sub-total | 0 | 0 | | | 2,402,633 |
| b Total from continuation sheets to Part I | | | | | 0 |
| c Totals (add lines 3a and 3b) | 0 | 0 | | | 2,402,633 |

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) |
|----------|---------------------------------|---|-------------------|-----------------------------|---------------------------------|--|--|---|--|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

- 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.

[illegible]

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; don't file with Form 990)* ☐ 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; don't file with Form 990).* ☐ Yes ☒ No

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).

| ReturnReference | Explanation |
|-----------------|-------------|
| | |
| | |
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| | |

SCHEDULE H
(Form 990)

Department of the Treasury

Internal Revenue Service

Hospitals

► Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
► Attach to Form 990.
► Go to www.irs.gov/Form990EZ for instructions and the latest information.

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
MERCY MEDICAL CENTER

Employer identification number
42-0698295

Part I

Financial Assistance and Certain Other Community Benefits at Cost

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

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) | | | 39,087,126 | 29,711,940 | 9,375,186 | 2.740 % |
| b Medicaid (from Worksheet 3, column a) | | | 43,579,254 | 30,495,051 | 13,084,203 | 3.830 % |
| c Costs of other means-tested government programs (from Worksheet 3, column b) | | | | | | |
| d Total Financial Assistance and Means-Tested Government Programs | | | 82,666,380 | 60,206,991 | 22,459,389 | 6.570 % |
| Other Benefits | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4). | | | 260,852 | | 260,852 | 0.080 % |
| f Health professions education (from Worksheet 5) | | | 1,997,305 | 982,217 | 1,015,088 | 0.300 % |
| g Subsidized health services (from Worksheet 6) | | | 4,808,217 | 7,671,689 | 0 | 0 % |
| h Research (from Worksheet 7) | | | | | | |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | | | 521,676 | | 521,676 | 0.150 % |
| j Total. Other Benefits | | | 7,588,050 | 8,653,906 | 1,797,616 | 0.530 % |
| k Total. Add lines 7d and 7j | | | 90,254,430 | 68,860,897 | 24,257,005 | 7.100 % |

Part III

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

| | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community building expense | (d) Direct offsetting revenue | (e) Net community building expense | (f) Percent of total expense |
|--|---|-------------------------------|--------------------------------------|-------------------------------|------------------------------------|------------------------------|
| 1 Physical improvements and housing | | | | | | |
| 2 Economic development | | | | | | |
| 3 Community support | | | | | | |
| 4 Environmental improvements | | | | | | |
| 5 Leadership development and training for community members | | | 7,319 | | 7,319 | 0 % |
| 6 Coalition building | | | 439,711 | | 439,711 | 0.130 % |
| 7 Community health improvement advocacy | | | | | | |
| 8 Workforce development | | | 118,442 | | 118,442 | 0.030 % |
| 9 Other | | | | | | |
| 10 Total | | | 565,472 | | 565,472 | 0.160 % |

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 4,620,133 | |
| 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) | 5 134,133,586 | |
| 6 | Enter Medicare allowable costs of care relating to payments on line 5 | 6 154,295,603 | |
| 7 | Subtract line 6 from line 5. This is the surplus (or shortfall) | 7 -20,162,017 | |
| 8 | Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other | | |
| Section C. Collection Practices | | | |
| 9a | Did the organization have a written debt collection policy during the tax year? | 9a Yes | |
| b | If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI | 9b Yes | |

Part IV

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

| (a) Name of entity | (b) Description of primary activity of entity | (c) Organization's profit % or stock ownership % | (d) Officers, directors, trustees, or key employees' profit % or stock ownership % | (e) Physicians' profit % or stock ownership % |
|--|---|--|--|---|
| 1 1 MR ASSOCIATES LLP | MRI SERVICES | 33.000 % | 0 % | 33.000 % |
| 2 2 EASTERN IOWA SLEEP CENTER LLC | SLEEP STUDIES | 33.000 % | 0 % | 33.000 % |
| 3 3 PARAMOUNT HEALTH OPTIONS | PAYOR CONTRACTING | 40.000 % | 0 % | 60.000 % |
| 4 4 PCI REGIONAL MED MALL LLC | MEDICAL SERVICES | 10.000 % | 0 % | 80.000 % |
| 5 5 PCI LENDER LLC | FINANCIAL SERVICES | 7.500 % | 0 % | 85.000 % |
| 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?
1

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

| | Other (describe) | ER-other | ER-24 hours | Research facility | Critical access hospital | Teaching hospital | Children's hospital | General medical & surgical | Licensed hospital | Facility reporting group |
|---------------------------|------------------|----------|-------------|-------------------|--------------------------|-------------------|---------------------|----------------------------|-------------------|--------------------------|
| See Additional Data Table | | | | | | | | | | |
| | | | | | | | | | | |
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Part V Facility Information (continued)**Section B. Facility Policies and Practices**(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)
MERCY MEDICAL CENTER**Name of hospital facility or letter of facility reporting group** _____**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** _____

1

Community Health Needs Assessment

| | Yes | No |
|---|------------|-----|
| 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: 20 <u>18</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>SEE PART V</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: 20 <u>18</u> | | |
| 10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url): <u>SEE PART V</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)

| | | | |
|---|--|----|-----|
| MERCY MEDICAL CENTER | | | |
| Name of hospital facility or letter of facility reporting group | | | |
| 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: <div><div>a</div><div><input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200.000000000000 % and FPG family income limit for eligibility for discounted care of 400.000000000000 %</div><div>b</div><div><input type="checkbox"/> Income level other than FPG (describe in Section C)</div><div>c</div><div><input type="checkbox"/> Asset level</div><div>d</div><div><input type="checkbox"/> Medical indigency</div><div>e</div><div><input type="checkbox"/> Insurance status</div><div>f</div><div><input type="checkbox"/> Underinsurance discount</div><div>g</div><div><input type="checkbox"/> Residency</div><div>h</div><div><input type="checkbox"/> Other (describe in Section C)</div></div> | 13 | Yes |
| 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): <div><div>a</div><div><input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application</div><div>b</div><div><input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application</div><div>c</div><div><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</div><div>d</div><div><input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications</div><div>e</div><div><input type="checkbox"/> Other (describe in Section C)</div></div> | 15 | Yes |
| 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): <div><div>a</div><div><input checked="" type="checkbox"/> The FAP was widely available on a website (list url): HTTPS://WWW.MERCYCARE.ORG/FINANCIAL-ASSISTANCE-POLICY</div><div>b</div><div><input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): HTTPS://WWW.MERCYCARE.ORG/APP/FILES/PUBLIC/5043/FINANCIAL-ASSISTANCE-APPLIC</div><div>c</div><div><input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): HTTPS://WWW.MERCYCARE.ORG/APP/FILES/PUBLIC/7416/PLAIN-LANGUAGE-FINANCIAL-AS</div><div>d</div><div><input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)</div><div>e</div><div><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)</div><div>f</div><div><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)</div><div>g</div><div><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</div><div>h</div><div><input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP</div><div>i</div><div><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</div><div>j</div><div><input type="checkbox"/> Other (describe in Section C)</div></div> | 16 | Yes |

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

MERCY MEDICAL CENTER

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 nonpayment? | 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)

MERCY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

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

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

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

If "Yes," explain in Section C.

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

If "Yes," explain in Section C.

| | Yes | No |
|-----------|-----|----|
| 22 | | |
| 23 | | No |
| 24 | | No |

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? _____

| Name and address | Type of Facility (describe) |
|------------------|-----------------------------|
| 1 | |
| 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: | DISCOUNTED CARE IS AVAILABLE TO ALL MERCY MEDICAL CENTER PATIENTS WHO DO NOT HAVE ACTIVE MEDICAL INSURANCE COVERAGE, NOT JUST THOSE WITHIN A FEDERAL POVERTY GUIDELINE FAMILY INCOME LIMIT. IF PATIENTS STILL FIND THEMSELVES UNABLE TO PAY, THEY MAY APPLY FOR ADDITIONAL FINANCIAL ASSISTANCE. |

| 990 Schedule H, Supplemental Information | |
|--|----------------|
| Form and Line Reference | Explanation |
| PART I, LINE 6A: | NOT APPLICABLE |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|-------------------------|---|
| PART I, LINE 7: | MERCY MEDICAL CENTER UTILIZED WORKSHEET 2 TO CALCULATE ITS COST-TO-CHARGE RATIO, AND THIS RATIO WAS USED IN COMPUTING THE INFORMATION REPORTED IN PART I, LINE 7. |

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): | BAD DEBT EXPENSE WAS NOT INCLUDED IN THE DENOMINATOR BECAUSE IT WAS REPORTED ON LINE 2D OF PART VIII, STATEMENT OF REVENUE. THE ORGANIZATION'S TOTAL COMMUNITY BENEFIT EXPENSE AS A PERCENTAGE OF TOTAL EXPENSES IS 26.42%. THIS PERCENTAGE INCREASES TO 71.59% IF MEDICARE ALLOWABLE COSTS ARE INCLUDED IN THE TOTAL COMMUNITY BENEFIT EXPENSE. |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|---|--|
| PART II, COMMUNITY BUILDING ACTIVITIES: | <p>MERCY MEDICAL CENTER (MERCY) PARTICIPATED IN A NUMBER OF COMMUNITY BUILDING ACTIVITIES THAT PROMOTED THE HEALTH OF THE COMMUNITIES IT SERVES. SPECIFICALLY, MERCY PARTICIPATES IN ACTIVITIES TO ADDRESS SOCIAL DETERMINANTS OF HEALTH. ADDRESSING SOCIAL DETERMINANTS OF HEALTH IS IMPORTANT FOR IMPROVING HEALTH AND REDUCING HEALTH DISPARITIES. THIS INCLUDED MERCY STAFF REPRESENTATION ON A NUMBER OF COALITIONS, COMMITTEES AND BOARDS SUCH AS BIG BROTHERS BIG SISTERS, THE CATHERINE MCAULEY CENTER, AND THE UNITED WAY OF EAST CENTRAL IOWA. ANNUALLY, MERCY STAFF PARTICIPATE IN THE UNITED WAY DAY OF CARING WHICH IS A DAY OF COMMUNITY SERVICE PARTNERING LOCAL BUSINESSES WITH NONPROFITS. STAFF ALSO PARTICIPATED IN WORKFORCE DEVELOPMENT EXPERIENCES WITH LOCAL HIGH SCHOOL STUDENTS. MERCY MADE FINANCIAL CONTRIBUTIONS TO NON-PROFIT ORGANIZATIONS THAT SUPPORT COMMUNITY-BUILDING EFFORTS, THE MAJORITY TO THOSE ORGANIZATIONS THAT PROVIDE COMMUNITY SUPPORT THROUGH THEIR PROGRAMS.</p> |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|-------------------------|--|
| PART III, LINE 2: | THE HOSPITAL PROVIDES CARE TO PATIENTS WHO MEET CERTAIN CRITERIA UNDER ITS CHARITY CARE POLICY WITHOUT CHARGE OR AT AMOUNTS LESS THAN ITS ESTABLISHED RATES. BECAUSE THE HOSPITAL DOES NOT PURSUE COLLECTION OF THESE AMOUNTS, THEY ARE NOT REPORTED AS REVENUE IN THE AUDITED FINANCIAL STATEMENTS. THEREFORE, NO BAD DEBT EXPENSE IS RECOGNIZED FOR UNCOLLECTED AMOUNTS ON PATIENT ACCOUNTS ELIGIBLE UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY. |

| 990 Schedule H, Supplemental Information | |
|--|----------------|
| Form and Line Reference | Explanation |
| PART III, LINE 3: | NOT APPLICABLE |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|-------------------------|--|
| PART III, LINE 4: | SEE PAGE 8 OF THE ATTACHED AUDITED FINANCIAL STATEMENTS FOR A DESCRIPTION OF BAD DEBT EXPENSE. |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|-------------------------|--|
| PART III, LINE 8: | <p>THE COSTS SHOWN FOR THE MEDICARE SHORTFALL ARE BASED ON TOTAL CHARGES OF ALL MEDICARE AND MEDICARE REPLACEMENT (PART C) PATIENTS. THE SHORTFALL IS CALCULATED BY MULTIPLYING THE TOTAL CHARGES BY THE COST TO CHARGE RATIO CALCULATED ON WORKSHEET 2, LESS PAYMENTS WE RECEIVED FOR THESE SERVICES. THE MEDICARE COST REPORT IS NOT AN APPROPRIATE SOURCE TO DETERMINE THE COSTS FOR THESE PATIENTS. MANY ITEMS, INCLUDING ALL OUTPATIENT SERVICES FOR PATIENTS WHO ARE COVERED BY A MEDICARE REPLACEMENT PLAN (PART C) AND MANY SERVICES SUCH AS LABORATORY, PHYSICAL AND OCCUPATIONAL THERAPY, AND OTHERS PAID ON A FEE FOR SERVICE BASIS, ARE NOT INCLUDED ON THE MEDICARE COST REPORT. IN ADDITION, HOSPICE, HOME HEALTH, AND DIALYSIS SERVICES, ALTHOUGH INCLUDED IN MEDICARE COST REPORT, DO NOT SHOW THE COSTS AND PAYMENTS ASSOCIATED WITH THESE SERVICES FOR MEDICARE BENEFICIARIES. FOR MERCY MEDICAL CENTER, 48% OF OUR GROSS CHARGES ARE GENERATED BY PATIENTS WITH MEDICARE AND MEDICARE REPLACEMENT (PART C) COVERAGE. ANOTHER 14% OF OUR GROSS CHARGES ARE GENERATED BY PATIENTS WITH MEDICAID COVERAGE. NEITHER GOVERNMENT PROGRAM HAS HISTORICALLY REIMBURSED ENOUGH TO COVER THE COSTS OF THE SERVICES PROVIDED TO THESE PATIENTS. IF WE DID NOT SERVE THESE PATIENT POPULATIONS, ANOTHER FACILITY WOULD HAVE TO PROVIDE THE SERVICE.</p> |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|-------------------------|---|
| PART III, LINE 9B: | <p>MERCY MEDICAL CENTER UNDERSTANDS PATIENTS MAY NOT HAVE THE ABILITY TO PAY FOR SERVICES NOR RECOGNIZE THE OPPORTUNITY THEY MAY HAVE TO RECEIVE FINANCIAL ASSISTANCE. TO AID IN THIS PROCESS, MERCY MEDICAL CENTER HAS IMPLEMENTED A PRESUMPTIVE CHARITY ELIGIBILITY PROGRAM (PCEP). PATIENTS WHO QUALIFY FOR THIS PROGRAM DO NOT COMPLETE PAPERWORK. MERCY MEDICAL CENTER UTILIZES AN OUTSIDE VENDOR TO ASSIST IN DETERMINING A PATIENT'S FINANCIAL RISK. MERCY MEDICAL CENTER USES BILLING AND COLLECTION RECOMMENDATIONS FROM THE IOWA HOSPITAL ASSOCIATION. THESE RECOMMENDATIONS INCLUDE: - MERCY MEDICAL CENTER WILL PROVIDE THE SAME INFORMATION CONCERNING SERVICES AND CHARGES TO ALL PATIENTS. - MERCY MEDICAL CENTER WILL NOT KNOWINGLY SEND A PATIENT'S BILL TO A COLLECTION AGENCY BEFORE INITIAL FINANCIAL ELIGIBILITY ASSISTANCE DETERMINATION HAS BEEN MADE. - MERCY MEDICAL CENTER WILL REVIEW THE PATIENT'S RECORD TO DETERMINE IF REASONABLE EFFORTS WERE UNDERTAKEN TO ENSURE THAT FINANCIAL ASSISTANCE WAS OFFERED AND/OR IF FINANCIAL ASSISTANCE IS APPROPRIATE BEFORE ANY COLLECTION AGENCY ASSIGNMENT.</p> |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|-------------------------|---|
| PART VI, LINE 2: | <p>MERCY MEDICAL CENTER UNDERSTANDS THE NEED FOR ONGOING ASSESSMENT AND USES DATA AND INFORMATION OBTAINED FROM HOSPITAL FINANCIAL ASSISTANCE CASES, COMMUNITY FREE CLINICS, UNITED WAY OF EAST CENTRAL IOWA AND THE LOCAL PUBLIC HEALTH DEPARTMENT REPORTS TO MODIFY CURRENT ACTIVITIES AND CREATE NEW PROGRAMS TO ADDRESS HEALTH NEEDS. ADDITIONALLY, MERCY MEDICAL CENTER RECEIVES REQUESTS FROM LOCAL NON-PROFIT ORGANIZATIONS FOR FINANCIAL AND IN-KIND SUPPORT TO ADDRESS COMMUNITY NEEDS FOR WHICH THEY PROVIDE PROGRAMS AND SERVICES. MERCY MEDICAL CENTER UTILIZES ALL OF THIS INFORMATION, IN ADDITION TO THE CHNA TO COMPLETE A COMMUNITY BENEFIT PLAN FOR THE HOSPITAL.</p> |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|-------------------------|---|
| PART VI, LINE 4: | <p>MERCY MEDICAL CENTER (MERCY) SERVES A PRIMARY SERVICE AREA (PSA) OF LINN COUNTY AND A SECONDARY SERVICE AREA (SSA) OF EIGHT COUNTIES (BENTON, BUCHANAN, CEDAR, DELAWARE, IOWA, JOHNSON, JONES AND TAMA). THE MAJORITY OF MERCY'S PATIENTS FOR BOTH INPATIENT AND OUTPATIENT SERVICES LIVE IN LINN COUNTY. THE COMMUNITY ADDITIONALLY INCLUDES THOSE COUNTIES ADJACENT TO LINN COUNTY AND WITHIN A REASONABLE DRIVING TIME TO THE HOSPITAL. THE TOTAL POPULATION OF LINN COUNTY IN 2018 WAS 225,909. THE TOTAL POPULATION OF BOTH PRIMARY AND SECONDARY SERVICE AREAS WAS 513,495. THE PROJECTED 10 YEAR POPULATION GROWTH FOR THE PSA IS 2% AND THE SSA, 1%, ANNUALLY. DEMOGRAPHICS FOR THE COMBINED SERVICE AREA ARE AS FOLLOWS: 50.1% MALE, 49.9% FEMALE 93.4% CAUCASIAN 2.3% AFRICAN AMERICAN 1.2% NATIVE AMERICAN 1.4% ASIAN/PACIFIC 1.5% TWO OR MORE RACES 3.5% HISPANIC 18.0% OF PERSONS LIVING IN MERCY'S COMBINED SERVICE AREA ARE AGE 65 OR OLDER 93.0% ARE HIGH SCHOOL GRADUATES WHILE 24.4% HOLD A BACHELOR'S DEGREE OR HIGHER THE MEDIAN HOUSEHOLD INCOME IS \$60,194 THE PERCENTAGE OF PEOPLE LIVING BELOW POVERTY LEVEL IS 9.28% AS COMPARED TO 11.8% FOR ALL OF IOWA THE AVERAGE PERSONS PER HOUSEHOLD ARE 2.43 FEDERALLY-DESIGNATED MEDICALLY UNDERSERVED AREAS ARE PRESENT IN BENTON, BUCHANAN, DELAWARE, IOWA, JONES, LINN AND TAMA COUNTIES AS OF OCTOBER 2019, THE UNEMPLOYMENT RATE FOR LINN COUNTY IS 2.5%. THE EIGHT CONTIGUOUS UNEMPLOYMENT RATES RANGE FROM 1.5-2.2%. LINN COUNTY FEATURES A DIVERSE EMPLOYER BASE INCLUDING MANUFACTURING, TRADE, EDUCATION, SERVICE, FINANCE AND AGRICULTURE. UNITYPOINT HEALTH - ST. LUKE'S HOSPITAL IS LOCATED IN LINN COUNTY AND SERVES A SIMILAR GEOGRAPHIC SERVICE AREA AS MERCY MEDICAL CENTER. ADDITIONALLY, THE UNIVERSITY OF IOWA AND MERCY IOWA CITY ARE LOCATED IN JOHNSON COUNTY, REGIONAL MEDICAL CENTER IS LOCATED IN DELAWARE COUNTY, UNITYPOINT HEALTH - JONES REGIONAL MEDICAL CENTER IS LOCATED IN JONES COUNTY, AND VIRGINIA GAY HOSPITAL IS LOCATED IN BENTON COUNTY.</p> |

| Form and Line Reference | Explanation |
|-------------------------|---|
| PART VI, LINE 5: | <p>MERCY MEDICAL CENTER'S BOARD OF TRUSTEES IS MADE UP OF VOLUNTEERS, THE MAJORITY OF WHOM ARE RESIDENTS WITHIN THE PRIMARY SERVICE AREA. THE BOARD CONSISTS OF 27 MEMBERS WHO ARE NEITHER EMPLOYEES NOR CONTRACTORS OF THE ORGANIZATION. THE CEO OF THE CORPORATION AND THE PRESIDENT OF THE MEDICAL STAFF ADDITIONALLY SERVE AS EX-OFFICIO, VOTING MEMBERS. THE GOVERNANCE STRUCTURE ENSURES THAT COMMUNITY INTERESTS ARE REPRESENTED IN DECISION-MAKING FOR THE ORGANIZATION. IN ADDITION, THREE SEATS ARE ALLOCATED TO WOMEN RELIGIOUS WHO ENSURE THE ORGANIZATION REMAINS TRUE TO ITS CHARITABLE MISSION. THERE ARE CURRENTLY FIVE WOMEN RELIGIOUS SERVING ON THE BOARD. MERCY MEDICAL CENTER MAINTAINS AN OPEN MEDICAL STAFF, AS PRIVILEGES ARE EXTENDED TO ALL QUALIFIED PHYSICIANS. MERCY MEDICAL CENTER UTILIZES OPERATING INCOME SURPLUSES TO FUND CAPITAL EXPENDITURES. THE PROPOSED CAPITAL ITEMS ARE REVIEWED BY STAFF, MEDICAL STAFF AND ADMINISTRATION TO ENSURE ITEMS WILL PROVIDE ONGOING HIGH QUALITY, LOW COST CARE TO PATIENTS AND ALIGN WITH THE STRATEGIC INITIATIVES FOR THE FACILITY. ANY EXCESS OPERATING FUNDS RETAINED BY THE ORGANIZATION ARE USED FOR FUTURE CAPITAL IMPROVEMENTS OR OPERATING FUNDS AS NEEDED. MERCY MEDICAL CENTER CONTRIBUTES TO THE HEALTH OF THE COMMUNITIES IT SERVES IN A NUMBER OF WAYS. MERCY PROVIDES REPRESENTATION ON SEVERAL COMMUNITY BOARDS, COALITIONS AND COMMITTEES ADDRESSING HEALTH NEEDS. EXAMPLES INCLUDE:-THE ARC OF EAST CENTRAL IOWA BOARD-COMMUNITY HEALTH FREE CLINIC BOARD-LINN COUNTY MENTAL HEALTH ACCESS CENTER PLANNING COMMITTEE-MY CARE COMMUNITY, WHICH CONSISTS OF SOCIAL SERVICE, PUBLIC HEALTH, AND HEALTHCARE PROVIDERS IN LINN COUNTY -GEMS OF HOPE BOARD-HAWKEYE AREA COMMUNITY ACTION PROGRAM-WAYPOINT SERVICES MERCY EMPLOYEES HAVE PARTICIPATED IN THE TRAINING OF HEALTH CARE PROFESSIONS STUDENTS, PROVIDING HEALTH EDUCATION TO THE COMMUNITY, OFFERING SUPPORT OF HEALTH PREVENTION AND PROMOTION ACTIVITIES, THROUGH SCREENINGS AND SUPPORT GROUPS, SUPPORTING STROKE CAMP FOR STROKE SURVIVORS AND THEIR CAREGIVERS AND PROVIDING STAFF, MEDICATION AND SUPPLIES FOR A DIABETES CAMP FOR CHILDREN WITH DIABETES, PROVIDING IN-KIND PRINTING TO MULTIPLE NONPROFITS, DONATING AUTOMATIC EXTERNAL DEFIBRILLATORS TO LOCAL CHURCHES, SCHOOLS, AND NONPROFITS, AND COORDINATING ACTIVITIES TO SUPPORT LOCAL NONPROFITS. MERCY LAUNCHED AN EARLY-RECOVERY-AFTER-SURGERY PROGRAM TO DECREASE THE USE OF PRESCRIPTION OPIOIDS LINKED TO LONGER HOSPITAL RECOVERY TIMES, AND COLLABORATES WITH A COMMUNITY TASKFORCE TO ADDRESS. MERCY CARE HEALTH PARTNERS CLINIC CREATES AFFORDABLE, ACCESSIBLE CARE FOR PEOPLE WITH COMPLEX MEDICAL ISSUES WHO FACE BARRIERS TO ACHIEVING THEIR HEALTH GOALS. TO INCREASE ACCESS TO MEDICAL CARE IN RURAL IOWA, MERCYCARE TAMA AND MERCYCARE MONTICELLO OFFER PRIMARY CARE SERVICE S. CANCER, HEART, SURGERY, AND UROLOGY SPECIALISTS ALSO TRAVEL TO CLINICS OUTSIDE CEDAR RAPIDS TO CREATE EASIER ACCESS FOR PATIENTS IN MANCHESTER, VINTON, ANAMOSA, AND TAMA. THE FAMILY CAREGIVERS CENTER OF MERCY OPENED ITS DOORS IN DECEMBER 2015 AS IOWA'S FIRST COMPREHENSIVE CENTER FOR FAMILY CAREGIVERS. THE OVERALL GOAL OF THE CENTER IS TO REDUCE THE STRESS OF THE FAMILY CAREGIVER AND KEEP THEM HEALTHIER BY PROVIDING EMOTIONAL SUPPORTING AND CONNECTING THEM TO RESOURCES. MERCY PROVIDES IN-KIND LAB AND RADIOLOGY SERVICES FOR THE CITY'S TWO FREE CLINICS. MERCY WORKS WITH THE CEDAR RAPIDS COMMUNITY SCHOOL DISTRICT TO OFFER ELECTRONIC HEALTH RECORDS AT METRO CARE CONNECTION SCHOOL-BASED HEALTH CENTERS. MERCY HONORED THE LIFETIME ACCOMPLISHMENTS OF SR. MARY LAWRENCE HALLAGAN WITH A NON-PROFIT COMMUNITY CENTER THAT OPENED SEPT. 6, 2011 TO PROVIDE SPACE AND DIRECT CLIENT SERVICES TO NONPROFIT ORGANIZATIONS AT 420 6TH STREET, CEDAR RAPIDS. TENANTS INCLUDE: GEMS OF HOPE; KIDS FIRST LAW CENTER; YOUNG PARENTS NETWORK AND BOYS & GIRLS CLUB; CATHOLIC CHARITIES; AND METRO CATHOLIC OUTREACH. THESE AGENCIES SHARE MERCY'S VISION TO ENHANCE THE HEALTH AND WELL-BEING OF OUR COMMUNITY. TOGETHER, WE MAKE A DIFFERENCE IN THE LIVES OF MANY. MERCY LEASES THE SPACE FOR \$1 PER YEAR, PLUS THE COST OF MONTHLY UTILITIES. MERCY SUPPORTS THE CEDAR RAPIDS MEDICAL SELF-SUPPORTED MUNICIPAL IMPROVEMENT DISTRICT THE MEDICAL QUARTER REGIONAL MEDICAL DISTRICT (MEDQUARTER) TO ENHANCE OUR COMMUNITY'S NATIONALLY RECOGNIZED REPUTATION FOR HIGH-QUALITY, LOW-COST CARE WITH A CONCENTRATED AREA OF MEDICAL SERVICES THAT ARE EASILY ACCESSIBLE. MERCY MEDICAL CENTER PARTNERS WITH UNITYPOINT HEALTH - ST. LUKE'S HOSPITAL TO SUPPORT A FAMILY PRACTICE RESIDENCY PROGRAM. A COMMUNITY-BASED PROGRAM UNDERSCORES A COMMITMENT TO THE CONCEPT OF THE PATIENT-CENTERED MEDICAL HOME. THE MEDICAL HOME IS A COMMUNITY HEALTH CENTER, A FEDERALLY QUALIFIED HEALTH CENTER, ONE WHICH ALLOWS RESIDENTS TO CARE FOR THE NEEDS OF BOTH RURAL AND URBAN UNDERSERVED POPULATIONS. MERCY MEDICAL CENTER HAS COMMITTED A FULL-TIME EQUIVALENT TO THE ROLE OF DIRECTOR OF COMMUNITY BENEFIT AND PATIENT RELATIONS. IN ADDITION, MERCY ADMINISTRATION BUDGETS 2 HOURS PER</p> |

| Form and Line Reference | Explanation |
|-------------------------|---|
| PART VI, LINE 5: | R FULL-TIME EQUIVALENT THAT IS USED TO SUPPORT COMMUNITY BENEFIT ACTIVITIES AND PRECEPTING HEALTH PROFESSIONS STUDENTS. THE DIRECTOR OF COMMUNITY BENEFIT AND PATIENT RELATIONS REPORTS TO THE VICE PRESIDENT OF MISSION INTEGRATION, WHO REPORTS TO THE PRESIDENT & CHIEF EXECUTIVE OFFICER (CEO). |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|---|-------------|
| PART VI, LINE 7, REPORTS FILED WITH STATES | IA |

Additional Data

Software ID:

Software Version:

EIN: 42-0698295

Name: MERCY MEDICAL CENTER

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

| Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? 1 | | 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 |
|--|--|-------------------|----------------------------|---------------------|-------------------|--------------------------|-------------------|-------------|----------|------------------|--------------------------|
| 1 | MERCY MEDICAL CENTER 701 10TH STREET SE CEDAR RAPIDS, IA 52403 WWW.MERCYCARE.ORG 570036H | X | X | | X | | | X | | | |

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

| Form and Line Reference | Explanation |
|-------------------------|--|
| MERCY MEDICAL CENTER | PART V, SECTION B, LINE 5: THE 2018 ITERATION OF THE COMMUNITY HEALTH NEEDS ASSESSMENT (CH A) AND COMMUNITY HEATH IMPROVEMENT PLAN (CHIP) WERE LED BY LINN COUNTY PUBLIC HEALTH AND C ONDUCTED IN PARTNERSHIP WITH A MULTITUDE OF COMMUNITY PARTNERS, INCLUDING BOTH LINN COUNTY HOSPITALS, MERCY MEDICAL CENTER AND UNITYPOINT-ST. LUKE'S HOSPITAL, AND EASTERN IOWA HEAL TH CENTER, LINN COUNTY'S FEDERALLY QUALIFIED HEALTH CENTER. THE ALIGNMENT OF THE CHA AND C HIP FOR ALL FOUR ENTITIES IN LINN COUNTY MINIMIZES DUPLICATION AND MAXIMIZES IMPACT, AS AL L AFOREMENTIONED ORGANIZATIONS ARE REQUIRED UNDER LAW OR BY FUNDERS TO ASSESS THE HEALTH O F THE COMMUNITY AND DEVELOP AN IMPLEMENTATION PLAN FOR MEETING IDENTIFIED NEEDS OF THE COM MUNITY. THE 2018 ITERATION OF THE CHA AND CHIP PROCESS ENGAGED 1,589 RESIDENTS AND 112 COM MUNITY PARTNERS FROM 53 ORGANIZATIONS. THE TOGETHER! HEALTHY LINN STEERING COMMITTEE CONSI STS OF THE FOLLOWING PARTNERS: ABBEHEALTH, ALLIANT ENERGY, AREA SUBSTANCE ABUSE COUNCIL, B ETHANY LUTHERAN CHURCH, CEDAR RAPIDS CITY COUNCIL, CEDAR RAPIDS COMMUNITY SCHOOL DISTRICT, CITY OF CEDAR RAPIDS, CITY OF MARION POLICE DEPARTMENT, EASTERN IOWA HEALTH CENTER, GREAT ER CEDAR RAPIDS COMMUNITY FOUNDATION, IOWA STATE UNIVERSITY EXTENSION & OUTREACH, KIRKWOOD COMMUNITY COLLEGE, LINN COUNTY BOARD OF SUPERVISORS, LINN COUNTY PUBLIC HEALTH, MERCY MED ICAL CENTER, MOUNT MERCY UNIVERSITY, STATE OF IOWA SENATOR, THE GAZETTE, UNITED WAY OF EAS T CENTRAL IOWA, AND UNITYPOINT HEALTH: ST. LUKE'S HOSPITAL AND JONES REGIONAL MEDICAL CENT ER. IN ADDITION, THE SECONDARY SERVICE AREA PUBLIC HEALTH DEPARTMENTS WERE CONTACTED BY ME RCY MEDICAL CENTER TO BETTER UNDERSTAND THEIR COUNTY NEEDS THROUGH UTILIZING THEIR MOST RE CENT COMMUNITY HEALTH ASSESSMENT. THE TOGETHER! HEALTHY LINN COLLABORATIVE USES THE MOBILI ZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP) FRAMEWORK TO GUIDE THE CHA AND CH IP PROCESS. THE MAPP FRAMEWORK IS A NATIONALLY RECOGNIZED FRAMEWORK FOR CONDUCTING COMMUNI TY-WIDE STRATEGIC PLANNING TO IMPROVE COMMUNITY HEALTH. THE MAPP FRAMEWORK CONSISTS OF SIX PHASES, AND ALLOWS FOR THE COMMUNITY TO CONSIDER SOCIAL DETERMINANTS OF HEALTH AND HEALTH EQUITY AS IMPORTANT FACTORS WHICH INFLUENCE THE OVERALL HEALTH OF THE COMMUNITY. IN MARCH OF 2018, THE TOGETHER! HEALTHY LINN STEERING COMMITTEE PARTICIPATED IN A VISIONING WORKSH OP AND EXPRESSED MUTUAL COMMITMENT TO A HEALTHY COMMUNITY WHERE, "THE LOCAL PUBLIC HEALTH SYSTEM IS COLLABORATIVE, ENGAGED IN THE COMMUNITY, RESPONSIVE TO COMMUNITY NEEDS, EASY TO NAVIGATE, FOCUSED ON PREVENTION, AND CREATES ACCESS FOR ALL. THE SYSTEM IS DESIGNED FOR A CULTURE OF HEALTH, AND PROMOTES AN ACTIVE, SAFE, EMPOWERED, RESILIENT, AND CONNECTED COMMU NITY THAT EMBRACES DIVERSITY AND EQUITY." THIS SHARED COMMUNITY VISION WAS CREATED TO GUID E THE DEVELOPMENT OF THE CHA AND CHIP. THE COMMUNITY HEALTH ASSESSMENT CONSISTED OF FOUR U NIQUE ASSESSMENTS, EACH MEASURING DIFFERENT ASPECTS OF THE HEALTH OF LINN COUNTY AND EXIST ING ASSETS AVAILABLE WITHIN TH |

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

| Form and Line Reference | Explanation |
|-------------------------|---|
| MERCY MEDICAL CENTER | <p>E COUNTY. THE FOUR ASSESSMENTS INCLUDE COMMUNITY THEMES AND STRENGTHS (CTSA), COMMUNITY HEALTH STATUS, FORCES OF CHANGE AND LOCAL PUBLIC HEALTH SYSTEM. EACH ASSESSMENT HAD A SPECIFIC TARGET POPULATION, OR STAKEHOLDER GROUP OF FOCUS AND WAS GUIDED BY DISTINCT METHODOLOGIES. TOGETHER, THESE ASSESSMENTS WILL BE UTILIZED TO INFORM THE IDENTIFICATION OF PRIORITY STRATEGIC ISSUES THE COMMUNITY WILL ADDRESS IN THE 2019-2021 CHIP. THE CTSA IS A QUALITATIVE ANALYSIS OF PERCEPTIONS, THOUGHTS AND OPINIONS COMMUNITY MEMBERS HAVE REGARDING HEALTH. OF PARTICULAR INTEREST WAS IDENTIFYING NEEDS OF THE COMMUNITY, PERCEIVED QUALITY OF LIFE AND ASSETS AVAILABLE THAT MAY BE USED TO IMPROVE COMMUNITY HEALTH. FOR THIS ASSESSMENT, THE TARGET AUDIENCE INCLUDED COMMUNITY MEMBERS WHO WORK, RESIDE, WORSHIP, GO TO SCHOOL, OR SEEK ENTERTAINMENT IN LINN COUNTY. TO OBTAIN HIGH QUALITY INFORMATION FROM THE COMMUNITY REGARDING THEIR NEEDS, BARRIERS AND HEALTH PERCEPTIONS, THE SUBCOMMITTEE UTILIZED MULTIPLE ASSESSMENT STRATEGIES. THE ASSESSMENT PROCESS WAS GUIDED BY A CTSA SUBCOMMITTEE WITH REPRESENTATION FROM MULTIPLE ENTITIES AND ORGANIZATIONS WITHIN THE LOCAL PUBLIC HEALTH SYSTEM (LPHS) AND WAS ASSOCIATED WITH THE LARGER TOGETHER! HEALTHY LINN STEERING COMMITTEE. TO BEGIN, THE SUBCOMMITTEE REVIEWED THE CURRENT DATA AVAILABLE AND IDENTIFIED GAPS IN DATA FROM SPECIFIC POPULATIONS AND INFORMATION STILL NEEDING TO BE OBTAINED. THE GAP ANALYSIS INFORMED THE NEED TO GAIN ADDITIONAL DATA FROM OLDER ADULTS, DISABLED/SPECIAL NEEDS, LGBTQ+, RURAL, YOUNG CHILDREN, PARENTS, LOW-INCOME, MIDDLE TO LOWER-MIDDLE INCOME, RECENT COLLEGE GRADUATES AND MINORITY POPULATIONS. ONCE IDENTIFIED, THE GROUP SELECTED METHODS AND STRATEGIES TO REACH THE AFOREMENTIONED POPULATIONS. METHODS SELECTED INCLUDED A STICKER BOARD WITH AN OPEN-ENDED QUESTION, COMMUNITY SURVEY, WINDSHIELD SURVEY AND FOCUS GROUPS. IN MID-JUNE 2018, MEMBERS OF THE MAPP CORE GROUP CONDUCTED TWO FOCUS GROUPS. THE POPULATIONS WERE SELECTED BASED ON THE GAPS IN INFORMATION FOR SPECIFIC POPULATIONS NOTED BY THE SUBCOMMITTEE AND DECISION TO OVERSAMPLE LOW-INCOME AND MINORITY POPULATIONS. POPULATIONS OF INTEREST INCLUDED RESIDENTS AT GENEVA TOWER LOCATED IN DOWNTOWN CEDAR RAPIDS AND THE LGBTQ+ COMMUNITY, WHICH WAS HELD AT LINN COUNTY PUBLIC HEALTH. IN ADDITION TO THE METHODS SELECTED BY THE SUBCOMMITTEE, LINN COUNTY PUBLIC HEALTH ALSO EXPLORED THE USE OF VOX POP AND A STREET STALL (ALSO KNOWN AS WALLING WALL). DATA OBTAINED THROUGH THIS COMPREHENSIVE COMMUNITY ASSESSMENT WERE SYNTHESIZED INTO A SINGLE REPORT AND BROKEN DOWN INTO LOGICAL CATEGORIES TO RELAY ASSESSMENT FINDINGS. THE COMMUNITY HEALTH STATUS ASSESSMENT (CHSA) IS A QUANTITATIVE ANALYSIS WHICH ANSWERS THE QUESTIONS, "HOW HEALTHY ARE OUR RESIDENTS? AND "WHAT DOES THE HEALTH STATUS OF OUR COMMUNITY LOOK LIKE?" RESULTS OF THE CHSA PROVIDE AN UNDERSTANDING OF THE COMMUNITY'S HEALTH STATUS AND ENSURE THAT THE COMMUNITY'S PRIORITIES CONSIDER SPECIFIC HEALTH STATUS ISSUES, SUCH AS RATES</p> |

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

| Form and Line Reference | Explanation |
|-------------------------|---|
| MERCY MEDICAL CENTER | <p>OF INCREASING CHRONIC DISEASE AND SEXUALLY TRANSMITTED INFECTIONS. IN 2015, DURING THE PREVIOUS ITERATION OF THE CHA, AN INITIAL CHSA SUBCOMMITTEE PLANNED THE ASSESSMENT AND IDENTIFIED A LIST OF SPECIFIC INDICATORS AND SOURCES THAT MAY BE USED TO ACCESS THE DATA POINTS ASSOCIATED WITH THE ELEVEN CORE INDICATORS:-DEMOGRAPHIC CHARACTERISTICS-SOCIOECONOMIC CHARACTERISTICS-HEALTH RESOURCE AVAILABILITY-QUALITY OF LIFE -BEHAVIORAL RISK FACTORS-ENVIRONMENTAL HEALTH INDICATORS-SOCIAL AND MENTAL HEALTH-MATERNAL AND CHILD HEALTH-DEATH, ILLNESS AND INJURY -COMMUNICABLE DISEASE -SENTINEL EVENTS DATA FROM THESE CATEGORIES WAS COMPILED AND PRESENTED AS A DASHBOARD, IDENTIFYING TRENDS, HEALTH INEQUITIES AND COMPARED LINN COUNTY RATES TO STATE AND NATIONAL RATES, WHEN APPLICABLE. IN THE 2018 CHSA, THE DASHBOARD CONCEPT WAS USED AGAIN, BUT A SUBCOMMITTEE DID NOT CONVENE TO INFORM THE DATA POINTS TO BE INCLUDED ON THE DASHBOARD, AS LINN COUNTY PUBLIC HEALTH HAD JUST COMPLETED THE 2017 HEALTH OF LINN COUNTY REPORT, A COMPREHENSIVE QUANTITATIVE ANALYSIS OF THE HEALTH OF LINN COUNTY. ON MAY 24, 2018 LINN COUNTY CONDUCTED THE FORCES OF CHANGE ASSESSMENT (FOCA) AT INDIAN CREEK NATURE CENTER IN CEDAR RAPIDS. MEMBERS FROM MULTIPLE SECTORS WITHIN LINN COUNTY'S LPHS WERE INVITED OR SELF-ELECTED TO PARTICIPATE IN THE ASSESSMENT. THE IDEAL PARTICIPANTS FOR THE FOCA ARE COMMUNITY LEADERS AND OFFICIALS WITH INSIGHT ON FACTORS, EVENTS AND TRENDS THAT MAY POTENTIALLY IMPACT THE HEALTH OF THE PUBLIC OR THE OPERATION OF THE LPHS. THIS ASSESSMENT FOCUSES ON ISSUES THAT ARE BROADER REACHING, SUCH AS FACTORS THAT IMPACT THE ENVIRONMENT IN WHICH THE LPHS OPERATES, STATE AND FEDERAL LEGISLATION, RAPID TECHNOLOGICAL ADVANCES, CHANGES IN THE ORGANIZATION OF HEALTH CARE SERVICES, OR FUNDING SHIFTS. METHODS SELECTED FOR THIS ASSESSMENT INCLUDED AN AFFINITY DIAGRAM, PRIORITIZATION ACTIVITY AND FORCE FIELD ANALYSIS. PARTICIPANTS WERE ASKED TO BRAINSTORM A LIST OF UNIQUE FORCES, TRENDS, OR EVENTS THAT MIGHT IMPACT THE HEALTH OF THE COMMUNITY. PARTICIPANTS THEN CREATED AN AFFINITY DIAGRAM WHICH RESULTED IN THIRTEEN SEPARATE IDEAS OR "CLUSTERS." EACH PARTICIPANT RECEIVED TEN STICKERS TO VOTE ON THE SPECIFIC FORCES THEY BELIEVED TO BE MOST CRITICAL TO THE HEALTH OF THE COMMUNITY AND WERE NOT ALLOWED TO VOTE FOR A FORCE MORE THAN ONCE. THE FACILITATORS TALLIED THE RESULTS AND TRANSFERRED THE FINAL CATEGORIES ONTO LARGE FLIP CHART PAPER IN PREPARATION FOR THE FORCE FIELD ANALYSIS, THE FINAL ACTIVITY OF THE FOCA. THE ANALYSIS AIMS TO IDENTIFY BOTH OPPORTUNITIES AND THREATS POSED BY EACH FORCE CATEGORY. THE TEN FORCES WERE WRITTEN ON FLIP CHART PAPER AND PLACED THROUGHOUT THE CONFERENCE ROOM WHERE EACH PARTICIPANT HAD FIVE MINUTES TO WRITE A LIST OF SPECIFIC OPPORTUNITIES OR THREATS ASSOCIATED WITH EACH FORCE CATEGORY.</p> |

| | |
|--|---|
| Form 990 Part V Section C Supplemental Information for Part V, Section B. | |
| Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc. | |
| Form and Line Reference | Explanation |
| MERCY MEDICAL CENTER | PART V, SECTION B, LINE 6A: LINN COUNTY PUBLIC HEALTH FACILITATED A COMMUNITY HEALTH NEEDS ASSESSMENT FOR UNITYPOINT HEALTH - ST. LUKE'S HOSPITAL AND MERCY MEDICAL CENTER. BOTH HOSPITALS ARE LOCATED IN CEDAR RAPIDS, IA. |

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

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

| Form and Line Reference | Explanation |
|-------------------------|---|
| MERCY MEDICAL CENTER | PART V, SECTION B, LINE 6B: THIS PROCESS ALSO ENGAGED 1,589 RESIDENTS AND 112 COMMUNITY PARTNERS FROM 53 ORGANIZATIONS. IN ADDITION TO LINN COUNTY PUBLIC HEALTH AND UNITYPOINT HEALTH - ST. LUKE'S HOSPITAL, THE TOGETHER! HEALTHY LINN STEERING COMMITTEE CONSISTS OF THE FOLLOWING PARTNERS: ABBEHEALTH, ALLIANT ENERGY, AREA SUBSTANCE ABUSE COUNCIL, BETHANY LUTHERAN CHURCH, CEDAR RAPIDS CITY COUNCIL, CEDAR RAPIDS COMMUNITY SCHOOL DISTRICT, CITY OF CEDAR RAPIDS, CITY OF MARION POLICE DEPARTMENT, EASTERN IOWA HEALTH CENTER, GREATER CEDAR RAPIDS COMMUNITY FOUNDATION, IOWA STATE UNIVERSITY EXTENSION & OUTREACH, KIRKWOOD COMMUNITY COLLEGE, LINN COUNTY BOARD OF SUPERVISORS, LINN COUNTY PUBLIC HEALTH, MERCY MEDICAL CENTER, MOUNT MERCY UNIVERSITY, STATE OF IOWA SENATOR, THE GAZETTE, UNITED WAY OF EAST CENTRAL IOWA, AND UNITYPOINT HEALTH: ST. LUKE'S HOSPITAL AND JONES REGIONAL MEDICAL CENTER. ADDITIONALLY, MERCY MEDICAL CENTER REQUESTED INPUT FROM THE PUBLIC HEALTH DEPARTMENTS OF BENTON, BUCHANAN, CEDAR, DELAWARE, IOWA, JOHNSON, JONES, AND TAMA COUNTIES IN REGARDS TO HEALTH PRIORITIES IN THEIR AREA. |

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

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

| Form and Line Reference | Explanation |
|-------------------------|---|
| MERCY MEDICAL CENTER | PART V, SECTION B, LINE 11: MERCY MEDICAL CENTER IS ADDRESSING THE THREE PRIORITY SIGNIFICANT NEEDS IDENTIFIED IN THE MOST RECENTLY CONDUCTED COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) IN A VARIETY OF WAYS. MERCY IS ADDRESSING THE SIGNIFICANT HEALTH NEED OF OBESITY BY PROVIDING NUTRITION EDUCATION AND COUNSELING THROUGH OUTPATIENT TREATMENT AND CLASSES, PROVIDING SPECIALIZED CARE FOR THE PREVENTION AND TREATMENT OF CHILDHOOD AND ADOLESCENT OBESITY THROUGH MERCY PEDIATRIC CLINIC, PROVIDING SURGICAL WEIGHT-LOSS OPTIONS TO HELP INDIVIDUALS ACHIEVE LIFELONG SUCCESS WITH WEIGHT CONTROL AND HEALTHY LIVING THROUGH MERCY'S BARIATRIC SURGERY CLINIC, PROVIDING NUTRITION INFORMATION TO MERCY'S PATIENTS, VISITORS, AND STAFF, AND CONTINUING THE PURCHASE OF LOCAL FOODS.MERCY MEDICAL CENTER IS ADDRESSING THE SIGNIFICANT HEALTH NEED OF MENTAL HEALTH BY EXPLORING OPTIONS FOR MORE PSYCHIATRIC CONSULTATIVE ROLES WITHIN MERCYCARE CLINICS, PROVIDING LINN-MAR AND PRAIRIE SCHOOL DISTRICTS WITH A MENTAL HEALTH URGENT CARE PROGRAM, PARTICIPATING IN THE DEVELOPMENT OF THE LINN COUNTY MENTAL HEALTH ACCESS CENTER, INCREASING EARLY INTERVENTION SERVICES FOR SUICIDE THROUGH NEWLY IMPLEMENTED SCREENING TOOL AND CREATION OF SAFETY PLAN/INTERVENTIONS AND PROVIDING WALK-IN ACCESS, SCREENING, ONGOING SUPPORT, AND TREATMENT AT SEDLACEK TREATMENT CENTER.MERCY MEDICAL CENTER IS ADDRESSING THE SIGNIFICANT HEALTH NEED OF SAFETY BY ENHANCING MERCY'S ANTI-HUMAN TRAFFICKING EFFORTS, SUPPORTING EFFORTS OF LOCAL SCHOOLS AND COMMUNITY PARTNERS TO ADDRESS BULLYING AND VIOLENCE, COMPLETING A WORKPLACE VIOLENCE PREVENTION GAP ANALYSIS AND DEVELOPING AND EXECUTING AN ACTION PLAN, IMPLEMENTING PHYSICAL ENVIRONMENT SAFETY IMPROVEMENTS HOSPITAL-WIDE, OFFERING TRAINING RELATED TO SAFETY BOTH INTERNALLY AND EXTERNALLY TO MERCY MEDICAL CENTER. MERCY MEDICAL CENTER DESCRIBES IN ITS MOST RECENTLY ADOPTED IMPLEMENTATION STRATEGY HOW IT IS ADDRESSING OTHER NEEDS IDENTIFIED IN THE CHNA. THESE INCLUDE: ACCESS TO HEALTH CARE, ACCESS TO HEALTHY FOOD, ACCESS TO MENTAL HEALTH SERVICES, AFFORDABLE HOUSING, BUILT ENVIRONMENT, CHRONIC DISEASE, NATURAL ENVIRONMENT, SEXUAL HEALTH, SUBSTANCE USE, AND TRANSPORTATION. |

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

| Form and Line Reference | Explanation |
|---|--|
| SCHEDULE H, PART V, SECTION B, LINE 5, CONTINUED: | <p>LINN COUNTY CONDUCTED THE LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT (LPHSA) BETWEEN THE MONTHS OF MAY AND JULY OF 2015. MEMBERS FROM MULTIPLE SECTORS WITHIN LINN COUNTY'S LPHS WERE INVITED TO PARTICIPATE IN THE ASSESSMENT. ENTITIES WITHIN THE LPHS INCLUDE ALL ORGANIZATIONS WHO MAY IMPACT THE HEALTH OF THE COMMUNITY SUCH AS COMMUNITY CENTERS, EMPLOYERS, ELECTED OFFICIALS, TRANSIT, PUBLIC HEALTH AGENCY, HOME HEALTH, LABORATORIES, FAITH-BASED ORGANIZATIONS, NON-PROFITS, COMMUNITY HEALTH CLINICS, HOSPITALS, DOCTORS, NURSING HOMES, DRUG TREATMENT, MENTAL HEALTH, SCHOOLS, NEIGHBORHOOD ORGANIZATIONS, CORRECTIONS, LAW ENFORCEMENT, FIRE AND EMS. THE INTENT OF THE LPHSA IS TO ASSESS HOW ORGANIZATIONS WITHIN THE SYSTEM ARE DOING IN ADDRESSING THE TEN ESSENTIAL PUBLIC HEALTH SERVICES AND IS COMPLETED USING THE LOCAL INSTRUMENT OF THE NATIONAL PUBLIC HEALTH PERFORMANCE STANDARDS (NPHPS; CDC, 2015). THIS INSTRUMENT HELPS COMMUNITIES MEASURE NOT ONLY HOW THEY ARE DOING IN ADDRESSING THE OVERARCHING ESSENTIAL PUBLIC HEALTH SERVICES, BUT ALSO THE COMPETENCIES AND SUB-COMPETENCIES THAT FALL UNDER EACH SERVICE. THE LPHSA SUBCOMMITTEE DECIDED TO TAKE A TARGETED APPROACH IN GAINING FEEDBACK ON EACH OF THE ESSENTIAL PUBLIC HEALTH SERVICES BY SPLITTING PARTNERS WITHIN THE LPHS INTO FIVE WORKGROUPS EACH FOCUSING ON TWO OF THE ESSENTIAL PUBLIC HEALTH SERVICES. AN INITIAL SURVEY COVERING THE TARGETED PUBLIC HEALTH SERVICES WAS SENT TO THE MEMBERS OF THE WORKGROUPS IN JUNE OF 2015. THE WORKGROUPS WERE THEN CONVENED IN JULY OF 2015 TO ENGAGE IN FACILITATED DISCUSSIONS THAT COVERED THE COMPONENTS FALLING UNDER EACH OF THE TARGETED ESSENTIAL PUBLIC HEALTH SERVICES. FOLLOWING DISCUSSION, MEMBERS THEN RATED HOW WELL THE LPHS IS DOING IN ADDRESSING THE ESSENTIAL PUBLIC HEALTH SERVICES. ALL COMPONENTS WITH A "MINIMAL ACTIVITY OR "MODERATE ACTIVITY" RATING WERE HIGHLIGHTED IN A REPORT AS A NEEDED AREA OF IMPROVEMENT FOR THE LPHS TO ADDRESS MOVING FORWARD. IN AUGUST 2018, THE TOGETHER! HEALTHY LINN STEERING COMMITTEE REVIEWED DATA FROM 13 POTENTIAL STRATEGIC ISSUE CATEGORIES AND PRIORITIZED THREE ISSUES WHICH MUST BE ADDRESSED IN ORDER TO ACHIEVE THE TOGETHER! HEALTHY LINN VISION. FROM OCTOBER 2018 THROUGH DECEMBER 2018, COMMUNITY PARTNERS REVIEWED ASSESSMENT DATA RELATED TO THE THREE PRIORITY ISSUES AND IDENTIFIED A GOAL AND STRATEGIES THROUGH SMALL AND LARGE GROUP DISCUSSION WITH MULTI-VOTING. MERCY MEDICAL CENTER DID NOT RECEIVE ANY WRITTEN COMMENTS ON THE HOSPITAL FACILITY'S MOST RECENTLY CONDUCTED CHNA OR IMPLEMENTATION STRATEGY. HOWEVER, ON THE CHNA AND IMPLEMENTATION STRATEGY WEBPAGE OF THE MERCY WEBSITE, THERE IS A "CONTACT US" FORM THAT CAN BE FILLED OUT BY ANY INDIVIDUAL. THE SUBMITTED ONLINE FORM GOES TO MERCY'S MARKETING DEPARTMENT AND WOULD BE FORWARDED TO MERCY'S COMMUNITY BENEFIT OFFICE. ANY MAILED WRITTEN COMMENTS WOULD BE FORWARDED TO THE COMMUNITY BENEFIT OFFICE.</p> |

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

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

| Form and Line Reference | Explanation |
|--|---|
| SCHEDULE H, PART V, SECTION B, LINE 7A: | HTTPS://WWW.MERCYCARE.ORG/APP/FILES/PUBLIC/9502/CHNA-2018.PDF |

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

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

| Form and Line Reference | Explanation |
|---|---|
| SCHEDULE H, PART V, SECTION B, LINE 10A: | HTTPS://WWW.MERCYCARE.ORG/APP/FILES/PUBLIC/9866/2018-CHNA-IMPLEMENTATION-STRATEGY.PDF |

Note: To capture the full content of this document, please select landscape mode (11" x 8.5") when printing.

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.

▶ Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2018

Open to Public
Inspection

Department of the
Treasury
Internal Revenue Service

Name of the organization
MERCY MEDICAL CENTER

Employer identification number

42-0698295

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 noncash assistance | (h) Purpose of grant or assistance |
|--|---------|---------------------------------|--------------------------|-----------------------------------|---|---------------------------------------|------------------------------------|
| (1) See Additional Data | | | | | | | |
| (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 17
- 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 noncash assistance | (e) Method of valuation (book, FMV, appraisal, other) | (f) Description of noncash assistance |
|---------------------------------|--------------------------|--------------------------|----------------------------------|---|---------------------------------------|
| (1) | | | | | |
| (2) | | | | | |
| (3) | | | | | |
| (4) | | | | | |
| (5) | | | | | |
| (6) | | | | | |
| (7) | | | | | |

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

| Return Reference | Explanation |
|------------------|--|
| PART I, LINE 2: | ALL CHECKS ARE ISSUED DIRECTLY TO THE ORGANIZATION TO BE USED AT THEIR DISCRETION. |

Additional Data

Software ID:
Software Version:
EIN: 42-0698295
Name: MERCY MEDICAL CENTER

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 |
|---|------------|-------------------------------|--------------------------|-----------------------------------|---|--|---|
| MERCYCARE SERVICE CORPORATION 701 10TH STREET SE CEDAR RAPIDS, IA 52403 | 42-1199429 | 501(C)(3) | 5,165,000 | | | | FOR USE IN CONTINUING OPERATIONS |
| MERCY HOSPITAL CEDAR RAPIDS IA ENDOWMENT FOUNDATION 701 10TH STREET SE CEDAR RAPIDS, IA 52403 | 51-0233180 | 501(C)(3) | 255,108 | | | | FOR USE IN CONTINUING OPERATIONS AND CONTRIBUTION FOR ESPECIALLY FOR YOU RACE AGAINST BREAST CANCER |

| 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 |
| FOUR OAKS FAMILY AND CHILDREN SERVICES 5400 KIRKWOOD BLVD SW CEDAR RAPIDS, IA 52404 | 42-0998726 | 501(C)(3) | 35,000 | | | | GENERAL SUPPORT |
| ESPECIALLY FOR YOU RACE AGAINST BREAST CANCER 701 10TH STREET SE CEDAR RAPIDS, IA 52403 | 42-1199429 | 501(C)(3) | 40,000 | | | | GENERAL SUPPORT |

| Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments. | | | | | | | |
|--|------------|-------------------------------|--------------------------|-----------------------------------|---|--|------------------------------------|
| (a) Name and address of organization or government | (b) EIN | (c) IRC section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
| AMERICAN HEART ASSOCIATION INC 1035 N CENTER POINT RD SUITE B HIAWATHA, IA 52233 | 13-5613797 | 501(C)(3) | 36,000 | | | | GENERAL SUPPORT |
| UNITED WAY OF EAST CENTRAL IOWA 317 7TH AVENUE SE STE 401 CEDAR RAPIDS, IA 52401 | 42-0861239 | 501(C)(3) | 13,975 | 1,454 | FAIR MARKET VALUE | IN KIND DONATIONS | GENERAL SUPPORT |

| Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments. | | | | | | | |
|--|------------|-------------------------------|--------------------------|-----------------------------------|---|--|------------------------------------|
| (a) Name and address of organization or government | (b) EIN | (c) IRC section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
| JUVENILE DIABETES FOUNDATION (JDRF) 1026 A AVENUE NE SUITE 113 PO BOX 3026 CEDAR RAPIDS, IA 52402 | 23-1907729 | 501(C)(3) | 10,000 | | | | GENERAL SUPPORT |
| ORCHESTRA IOWA INC 119 THIRD AVENUE SE CEDAR RAPIDS, IA 52401 | 42-0772544 | 501(C)(3) | 10,000 | | | | GENERAL SUPPORT |

| Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments. | | | | | | | |
|--|------------|-------------------------------|--------------------------|-----------------------------------|---|--|------------------------------------|
| (a) Name and address of organization or government | (b) EIN | (c) IRC section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
| GEMS OF HOPE INC 420 6TH STREET SE CEDAR RAPIDS, IA 52401 | 20-3155610 | 501(C)(3) | 7,500 | | | | GENERAL SUPPORT |
| ALZHEIMER'S DISEASE & RELATED DISORDERS ASSOCIATION 317 7TH AVENUE SE STE 402 CEDAR RAPIDS, IA 52401 | 13-3039601 | 501(C)(3) | 7,500 | | | | GENERAL SUPPORT |

| Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments. | | | | | | | |
|--|------------|-------------------------------|--------------------------|-----------------------------------|---|--|------------------------------------|
| (a) Name and address of organization or government | (b) EIN | (c) IRC section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
| ZACH JOHNSON FOUNDATION PO BOX 2336 CEDAR RAPIDS, IA 52406 | 27-2683100 | 501(C)(3) | 6,500 | | | | GENERAL SUPPORT |
| WAYPOINT 318 5TH STREET SE CEDAR RAPIDS, IA 52401 | 42-0680307 | 501(C)(3) | 5,000 | | | | GENERAL SUPPORT |

| Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments. | | | | | | | |
|--|------------|-------------------------------|--------------------------|-----------------------------------|---|--|------------------------------------|
| (a) Name and address of organization or government | (b) EIN | (c) IRC section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
| CHAINS INTERRUPTED PO BOX 583 CEDAR RAPIDS, IA 52406 | 81-4426353 | 501(C)(3) | 6,000 | | | | GENERAL SUPPORT |
| LINN COUNTY MEDICAL SOCIETY 813 1ST AVE SE CEDAR RAPIDS, IA 52402 | 23-7410746 | 501(C)(6) | 5,000 | | | | GENERAL SUPPORT |

| Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments. | | | | | | | |
|--|------------|-------------------------------|--------------------------|-----------------------------------|---|--|------------------------------------|
| (a) Name and address of organization or government | (b) EIN | (c) IRC section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
| UNIVERSITY OF IOWA 105 JESSUP HALL IOWA CITY, IA 52242 | 42-6004813 | STATE OF IOWA | 5,200 | | | | GREAT IOWA NURSES PROGRAM |
| HAWKEYE AREA COMMUNITY ACTION PROGRAM INC 1515 HAWKEYE DRIVE HIAWATHA, IA 52233 | 42-0898405 | 501(C)(3) | 5,000 | | | | GENERAL SUPPORT |

| Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments. | | | | | | | |
|--|------------|-------------------------------|--------------------------|-----------------------------------|---|--|------------------------------------|
| (a) Name and address of organization or government | (b) EIN | (c) IRC section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
| NFC CEDAR RAPIDS LLC 1110 OLD MARION RD SUITE A CEDAR RAPIDS, IA 52402 | 82-4992170 | 501(C)(3) | 10,000 | | | | GENERAL SUPPORT |
| LINN COUNTY PUBLIC HEALTH 510 13TH ST NW CEDAR RAPIDS, IA 52405 | 42-6004338 | 501(C)(3) | 32,820 | | | | GENERAL SUPPORT |

| | | |
|--|---|--|
| Schedule J (Form 990) | Compensation Information | OMB No. 1545-0047 |
| | | 2018 |
| | | |
| Department of the Treasury Internal Revenue Service | For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees ▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23. ▶ Attach to Form 990. ▶ Go to www.irs.gov/Form990 for instructions and the latest information. | |
| Name of the organization MERCY MEDICAL CENTER | | Employer identification number 42-0698295 |

| 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. | | | |
| <input type="checkbox"/> First-class or charter travel | <input type="checkbox"/> Housing allowance or residence for personal use | | |
| <input type="checkbox"/> Travel for companions | <input type="checkbox"/> Payments for business use of personal residence | | |
| <input type="checkbox"/> Tax idemnification and gross-up payments | <input type="checkbox"/> Health or social club dues or initiation fees | | |
| <input type="checkbox"/> Discretionary spending account | <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef) | | |
| b If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain | | 1b | |
| 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 | Yes |
| 3 Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III. | | | |
| <input checked="" type="checkbox"/> Compensation committee | <input type="checkbox"/> Written employment contract | | |
| <input checked="" type="checkbox"/> Independent compensation consultant | <input checked="" type="checkbox"/> Compensation survey or study | | |
| <input type="checkbox"/> Form 990 of other organizations | <input checked="" type="checkbox"/> Approval by the board or compensation committee | | |
| 4 During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization: | | | |
| a Receive a severance payment or change-of-control payment? | | 4a | No |
| 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? | | 4c | No |
| If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III. | | | |
| Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9. | | | |
| 5 For persons listed 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? | | 5b | No |
| If "Yes," on line 5a or 5b, describe in Part III. | | | |
| 6 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of: | | | |
| a The organization? | | 6a | No |
| b Any related organization? | | 6b | No |
| If "Yes," on line 6a or 6b, describe in Part III. | | | |
| 7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III. | | 7 | Yes |
| 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 | |

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.

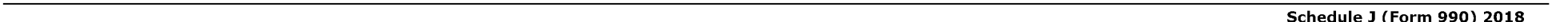
[illegible]

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 4B | THE FOLLOWING INDIVIDUALS PARTICIPATED IN A SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN IN 2018: MARY BROBST - \$18,369, JEFFERY CASH - \$17,662, TIMOTHY L CHARLES - \$47,404, TIMOTHY QUINN M.D. - \$34,470, AND NATHAN VAN GENDEREN - \$26,394. THE DOLLAR AMOUNT REPRESENTS THE CURRENT YEAR CONTRIBUTION MADE BY THE ORGANIZATION ON BEHALF OF THE INDIVIDUALS TO THE PLAN IN 2018. |

| Return Reference | Explanation |
|------------------|--|
| PART I, LINE 7 | BONUS PAYMENTS ARE MADE ANNUALLY BASED ON NUMEROUS CRITERIA SUCH AS THE ORGANIZATION'S CASH FLOW BUDGET, OPERATING MARGIN, QUALITY RESULTS, AS WELL AS PERSONAL METRICS AND GOALS. |



Additional Data

Software ID:
Software Version:
EIN: 42-0698295
Name: MERCY MEDICAL CENTER

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

| (A) Name and Title | | (B) Breakdown of W-2 and/or 1099-MISC compensation | | | (C) Retirement and other deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation in column (B) reported as deferred on prior Form 990 |
|--|------|--|-------------------------------------|-------------------------------------|--|-------------------------|---------------------------------|---|
| | | (i) Base Compensation | (ii) Bonus & incentive compensation | (iii) Other reportable compensation | | | | |
| TIMOTHY L CHARLES PRESIDENT & CEO | (i) | 673,822 | 221,192 | 16,758 | 54,279 | 15,272 | 981,323 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| NICHOLAS HODGMAN MD MEMBER BOARD OF TRUSTEES | (i) | 622,792 | 281,359 | 1,080 | 0 | 21,877 | 927,108 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| NATHAN VANGENDEREN EXECUTIVE VP/CFO | (i) | 372,724 | 110,576 | 7,775 | 33,269 | 22,103 | 546,447 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TIMOTHY QUINN MD CHIEF OF CLINICAL OPERATIONS | (i) | 486,603 | 137,337 | 8,867 | 41,345 | 23,592 | 697,744 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| MARY BROBST CHIEF NURSING OFFICER | (i) | 257,777 | 59,748 | 10,037 | 25,244 | 21,896 | 374,702 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| JEFFREY CASH CHIEF INFORMATION OFFICER | (i) | 250,946 | 65,545 | 9,907 | 24,537 | 24,829 | 375,764 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| NANCY HILL-DAVIS VP - HUMAN RESOURCES | (i) | 220,843 | 39,332 | 6,772 | 6,642 | 17,097 | 290,686 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| AMANDEEP DHALIWAL MD PHYSICIAN | (i) | 590,492 | 279,499 | 486 | 0 | 8,389 | 878,866 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SHANE A GAILUSHAS MD PHYSICIAN | (i) | 495,661 | 196,507 | 14,455 | 0 | 21,877 | 728,500 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| RYAN D HOLLENBECK MD PHYSICIAN | (i) | 573,593 | 257,586 | 486 | 0 | 30,925 | 862,590 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| CHONG C LEE MD PHYSICIAN | (i) | 1,319,108 | 0 | 16,526 | 0 | 27,408 | 1,363,042 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SHINY MATHEWKUTTY MD PHYSICIAN | (i) | 538,420 | 140,065 | 20,894 | 0 | 16,176 | 715,555 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

Note: To capture the full content of this document, please select landscape mode (11" x 8.5") when printing.

Schedule K
(Form 990)

Department of the Treasury
Internal Revenue Service

Name of the organization
MERCY MEDICAL CENTER

Supplemental Information on Tax-Exempt Bonds

► Complete if the organization answered "Yes" to Form 990, Part VI, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
► Attach to Form 990.
► Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2018

Open to Public Inspection

Employer identification number
42-0698295

| 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 CITY OF CEDAR RAPIDS IOWA | 42-6004336 | 150543AA4 | 04-10-2003 | 30,000,000 | REIMBURSE HOSPITAL FOR COSTS OF ACQUIRING AND CONSTRUCTING FACILITIES | | X | | X | | X |
| B CITY OF CEDAR RAPIDS IOWA | 42-6004336 | 150543AB2 | 11-17-2005 | 58,405,000 | ADVANCE REFUND OF 1999 BONDS | | X | | X | | X |
| C IOWA FINANCE AUTHORITY | 52-1699886 | 4624466EQ | 12-13-2012 | 45,604,359 | REIMBURSE HOSPITAL FOR CAPITAL | | X | | X | | X |

| Part II | | Proceeds | | | | | | | | | |
|---------|--|------------|----|------------|----|------------|----|-----|----|--|--|
| | | A | | B | | C | | D | | | |
| 1 | Amount of bonds retired | 5,550,000 | | 20,430,000 | | 6,115,000 | | | | | |
| 2 | Amount of bonds legally defeased | | | | | | | | | | |
| 3 | Total proceeds of issue | 30,000,000 | | 58,405,000 | | 45,604,359 | | | | | |
| 4 | Gross proceeds in reserve funds | | | | | | | | | | |
| 5 | Capitalized interest from proceeds | | | | | | | | | | |
| 6 | Proceeds in refunding escrows | | | | | | | | | | |
| 7 | Issuance costs from proceeds | 1,288,620 | | 1,552,500 | | 604,359 | | | | | |
| 8 | Credit enhancement from proceeds | | | | | | | | | | |
| 9 | Working capital expenditures from proceeds | | | | | | | | | | |
| 10 | Capital expenditures from proceeds | 28,711,380 | | | | 45,000,000 | | | | | |
| 11 | Other spent proceeds | | | 56,852,500 | | | | | | | |
| 12 | Other unspent proceeds | | | | | | | | | | |
| 13 | Year of substantial completion | 2003 | | 2005 | | 2013 | | | | | |
| | | Yes | No | Yes | No | Yes | No | Yes | No | | |
| 14 | Were the bonds issued as part of a current refunding issue? | | X | | X | | X | | X | | |
| 15 | Were the bonds issued as part of an advance refunding issue? | | X | X | | | X | | X | | |
| 16 | Has the final allocation of proceeds been made? | X | | X | | X | | X | | | |
| 17 | Does the organization maintain adequate books and records to support the final allocation of proceeds? | X | | X | | 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 | | X | | |
| 2 | Are there any lease arrangements that may result in private business use of bond-financed property? | | X | | 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 | | 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? | | | | | | | | |
| c | Are there any research agreements that may result in private business use of bond-financed property? | | X | | 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? | | | | | | | | |
| 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 % | | 0 % | | 0 % | | | |
| 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 % | | 0 % | | | |
| 6 | Total of lines 4 and 5 | 0 % | | 0 % | | 0 % | | | |
| 7 | Does the bond issue meet the private security or payment test? . . . | | X | | 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 | | 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 | | 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 | | X | | |
| 2 | If "No" to line 1, did the following apply? | | | | | | | | |
| a | Rebate not due yet? | | X | | X | X | | | |
| b | Exception to rebate? | | X | | X | | X | | |
| c | No rebate due? | X | | 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 | | | X | | |
| 4a | Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue? | X | | X | | | X | | |
| b | Name of provider | UBS AG | | UBS AG | | | | | |
| c | Term of hedge | 2900.0000000000 % | | 2400.0000000000 % | | | | | |
| d | Was the hedge superintegrated? | | X | | X | | | | |
| e | Was the hedge terminated? | | X | | X | | | | |

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 | | 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 | | X | | |
| 7 Has the organization established written procedures to monitor the requirements of section 148? | X | | 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 | | X | | | |

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

| Return Reference | Explanation |
|-----------------------------------|---|
| DATE REBATE COMPUTATION PERFORMED | ISSUER NAME: CITY OF CEDAR RAPIDS, IOWA DATE THE REBATE COMPUTATION WAS PERFORMED: 10/01/2008 ISSUER NAME: CITY OF CEDAR RAPIDS, IOWA DATE THE REBATE COMPUTATION WAS PERFORMED: 04/01/2009 |

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.
▶Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
MERCY MEDICAL CENTER

Employer identification number
42-0698295

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

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

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

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

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

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

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

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

Part IV Business Transactions Involving Interested Persons.

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

| (a) Name of interested person | (b) Relationship between interested person and the organization | (c) Amount of transaction | (d) Description of transaction | (e) Sharing of organization's revenues? | |
|-------------------------------|---|---------------------------|---|---|----|
| | | | | Yes | No |
| (1) MERCY CARE MANAGEMENT INC | SEE BELOW IN PART V | 1,723,730 | MERCY CARE MANAGEMENT, INC. PAID MERCY MEDICAL CENTER RENT. | | No |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

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 | TIMOTHY L. CHARLES IS AN OFFICER, AND KYLE SKOGMAN IS A MEMBER OF THE BOARD OF TRUSTEES OF MERCY MEDICAL CENTER AND ARE REPORTED ON THE FORM 990, PART VII. DURING THE TAX YEAR, ALL THE AFOREMENTIONED INDIVIDUALS WERE OFFICERS OR MEMBERS OF THE BOARD OF DIRECTORS OF MERCY CARE MANAGEMENT, INC. |

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.
►Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
MERCY MEDICAL CENTER

Employer identification number
42-0698295

Part I

Types of Property

| | (a) Check if applicable | (b) Number of contributions or items contributed | (c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g | (d) Method of determining noncash contribution amounts |
|--|-------------------------------|--|---|--|
| 1 Art—Works of art | X | 1 | 5,493 | FAIR MARKET VALUE |
| 2 Art—Historical treasures . . | | | | |
| 3 Art—Fractional interests . . | | | | |
| 4 Books and publications . . | | | | |
| 5 Clothing and household goods | | | | |
| 6 Cars and other vehicles . . . | | | | |
| 7 Boats and planes | | | | |
| 8 Intellectual property | | | | |
| 9 Securities—Publicly traded . | | | | |
| 10 Securities—Closely held stock . | | | | |
| 11 Securities—Partnership, LLC, or trust interests | | | | |
| 12 Securities—Miscellaneous . . | | | | |
| 13 Qualified conservation contribution—Historic structures | | | | |
| 14 Qualified conservation contribution—Other | | | | |
| 15 Real estate—Residential . . | | | | |
| 16 Real estate—Commercial . . | | | | |
| 17 Real estate—Other | | | | |
| 18 Collectibles | | | | |
| 19 Food inventory | | | | |
| 20 Drugs and medical supplies . | | | | |
| 21 Taxidermy | | | | |
| 22 Historical artifacts | | | | |
| 23 Scientific specimens | | | | |
| 24 Archeological artifacts | | | | |
| 25 Other ► () | | | | |
| 26 Other ► () | | | | |
| 27 Other ► () | | | | |
| 28 Other ► () | | | | |

29

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

29

30a

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

30a

Yes

No

b

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

31

Does the organization have a gift acceptance policy that requires the review of any nonstandard contributions?

31

Yes

No

32a

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

32a

Yes

No

b

If "Yes," describe in Part II.

33

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

Part II **Supplemental Information.**

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

| Return Reference | Explanation |
|---------------------|--|
| PART I, COLUMN (B): | MERCY MEDICAL CENTER IS REPORTING THE NUMBER OF CONTRIBUTIONS. |

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury

Internal Revenue Service
Name of the organization
MERCY MEDICAL CENTER**Supplemental Information to Form 990 or 990-EZ**Complete to provide information for responses to specific questions on
Form 990 or 990-EZ or to provide any additional information.

▶ Attach to Form 990 or 990-EZ.

▶ Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2018**Open to Public
Inspection****Employer identification number**

42-0698295

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PART VI, SECTION A, LINE 6 | THE SOLE MEMBER OF MERCY MEDICAL CENTER IS MERCYCARE SERVICE CORPORATION, AN IOWA NONPROFIT CORPORATION. THE SOLE MEMBER HAS THE EXCLUSIVE POWER TO APPOINT, AFTER CONSIDERATION OF ANY RECOMMENDATIONS FROM THE CORPORATION'S BOARD OF TRUSTEES, ANY TRUSTEE TO THE CORPORATION'S BOARD AND TO REMOVE ANY TRUSTEE FROM THE CORPORATION'S BOARD AT ANY TIME FOR ANY REASON. |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|--|
| FORM 990, PART VI, SECTION A, LINE 7A | AS THE SOLE MEMBER OF MERCY MEDICAL CENTER, MERCYCARE SERVICE CORPORATION HAS THE EXCLUSIV E POWER TO APPOINT, AFTER CONSIDERATION OF ANY RECOMMENDATIONS FROM THE CORPORATION'S BOAR D OF TRUSTEES, ANY TRUSTEE TO THE CORPORATION'S BOARD AND TO REMOVE ANY TRUSTEE FROM THE C ORPORATION'S BOARD AT ANY TIME FOR ANY REASON. |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|---|
| FORM 990, PART VI, SECTION A, LINE 7B | AS THE SOLE MEMBER OF MERCY MEDICAL CENTER, MERCYCARE SERVICE CORPORATION HAS THE POWER TO APPROVE THE FOLLOWING ACTIONS: 1. AMEND, REPEAL, OR RESTATE THE ARTICLES OF INCORPORATION ; 2. ANY MATTER DIRECTLY RELATED TO THE RELIGIOUS PRINCIPLES AND MORAL PHILOSOPHY OF THE SISTERS OF MERCY; 3. ADOPT OR CHANGE THE PHILOSOPHY AND MISSION OF THE CORPORATION; 4. SALE OF ALL OR SUBSTANTIALLY ALL OF THE ASSETS OF THE CORPORATION, AND MERGER OR CONSOLIDATION OF THE CORPORATION WITH ANOTHER ENTITY; 5. DISSOLUTION OF THE CORPORATION; 6. ADOPTION OR AMENDMENT TO LONG-TERM STRATEGIC PLANS; 7. ADOPTION OR AMENDMENT TO ANNUAL CAPITAL OR OPERATING BUDGETS; AND 8. APPOINTMENT OR REMOVAL OF THE CHIEF EXECUTIVE OFFICER OF THE CORPORATION. |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|--|
| FORM 990, PART VI, SECTION B, LINE 11B | THE 990 IS REVIEWED WITH THE EXECUTIVE COMMITTEE (SUBCOMMITTEE OF THE BOARD OF TRUSTEES) PRIOR TO FILING THE FORM. THE COMMITTEE IS PROVIDED WITH GENERAL BACKGROUND INFORMATION REGARDING THE FORM 990, AND THE FORM ITSELF (INCLUDING ATTACHMENTS) IS REVIEWED. UPON REQUEST, THE TAX RETURN WILL BE AVAILABLE FOR REVIEW BY THE BOARD OF TRUSTEES. MEMBERS OF THE EXECUTIVE COMMITTEE AND MANAGEMENT ARE AVAILABLE TO ANSWER QUESTIONS FROM THE TRUSTEES ON THE RETURN. |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PART VI, SECTION B, LINE 12C | <p>THE ORGANIZATION REQUIRES ALL DIRECTORS, OFFICERS, AND KEY EMPLOYEES, AS WELL AS EACH EMPLOYEE TO DISCLOSE ANY INTEREST IN, OBLIGATION OR DUTY TO, OR ACTIVITY FOR ANY CONCERN IN WHICH A DIRECTOR, OFFICER, KEY EMPLOYEE, OR EMPLOYEE OR THEIR FAMILY MEMBER MAY BE INVOLVED THAT: MIGHT CREATE AN ACTUAL OR POTENTIAL CONFLICT OF INTEREST OR MIGHT HAVE THE APPEARANCE OF ADVERSELY AFFECTING THE DIRECTOR'S, OFFICER'S, KEY EMPLOYEE'S, OR EMPLOYEE'S JUDGMENT OR ACTIONS IN PERFORMING HIS/HER DUTIES TOWARDS MERCY. ALL DIRECTORS, OFFICERS, KEY EMPLOYEES, AND EMPLOYEES SHALL FILE AN INITIAL CONFLICT OF INTEREST REPORT UPON HIRE AND SHALL BE REQUIRED TO FILE AN UPDATED REPORT IMMEDIATELY IF ANY CHANGES OCCUR WHICH RESULT IN A CONFLICT OF INTEREST OR FINANCIAL INTEREST. ALL DIRECTORS, OFFICERS, KEY EMPLOYEES, AND EMPLOYEES (SUPERVISOR AND ABOVE), PHYSICIANS, AND ANY EMPLOYEE IN A POSITION TO INFLUENCE A PURCHASE DECISION SHALL RE-SUBMIT A CONFLICT OF INTEREST DISCLOSURE STATEMENT, WITH ANY NECESSARY CHANGES, EACH YEAR AND IMMEDIATELY IF ANY ADDITIONAL CONFLICTING OR FINANCIAL INTEREST ARISE. ALL BOARD MEMBERS SHALL SUBMIT IN WRITING A CONFLICT OF INTEREST DISCLOSURE STATEMENT LISTING ALL FINANCIAL AND CONFLICTING INTERESTS. THE STATEMENT SHALL BE RESUBMITTED WITH ANY NECESSARY CHANGES EACH YEAR AND AS ANY ADDITIONAL CONFLICTING OR FINANCIAL INTEREST ARISE.</p> |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|---|
| FORM 990, PART VI, SECTION B, LINE 15 | COMPENSATION OF THE ORGANIZATION'S TOP MANAGEMENT IS SET BY THE MERCYCARE SERVICE CORPORAT ION'S COMPENSATION COMMITTEE. THE COMMITTEE USES MERCER (US) INC. FOR THE REVIEW OF SALARI ES AND COMPARES THEM TO COMPARABLE ENTITIES IN THE REGION. THIS PROCESS WAS LAST COMPLETED AND DOCUMENTED ON MARCH 29, 2018. |

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 XI, LINE 9: | BOOK/TAX DIFFERENCE IN PARTNERSHIP INCOME(LOSS) -383,422. CHANGE IN ADDITIONAL MINIMUM LIABILITY FOR RETIREMENT BENEFITS -11,995,943. CHANGE IN FAIR VALUE OF INTEREST RATE SWAP AGREEMENTS -2,275,414. CHANGE IN INTEREST IN NET ASSETS OF AUXILIARY AND GIFT SHOP 28,352. CHANGE IN INTEREST IN NET ASSETS OF FOUNDATION 819,492. CONTRIBUTION REVENUE NOT RECORDED FOR BOOKS -24,568. |

990 Schedule O, Supplemental Information

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

SCHEDULE R
(Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
▶ Attach to Form 990.
▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
MERCY MEDICAL CENTER

Employer identification number
42-0698295

| 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) MERCYCARE ACCOUNTABLE CARE ORGANIZATION LLC 701 10TH STREET SE CEDAR RAPIDS, IA 52403 83-3158753 | ACCOUNTABLE CARE ORGANIZATION | IA | -542 | 111,271 | MERCY MEDICAL CENTER |
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| 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)MERCY HOSPITAL CEDAR RAPIDS IA ENDOWMENT FOUNDATION INC 701 10TH STREET SE CEDAR RAPIDS, IA 52403 51-0233180 | FUNDRAISING FOR MERCY MEDICAL CENTER | IA | 501(C)(3) | LINE 12B, TYPE II | MERCY MEDICAL CENTER | Yes | |
| (2)MERCYCARE SERVICE CORPORATION 701 10TH STREET SE CEDAR RAPIDS, IA 52403 42-1199429 | HEALTHCARE OVERSIGHT | IA | 501(C)(3) | LINE 12B, TYPE II N/A | | | No |
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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) MR ASSOCIATES LLP 1455 SHERMAN ROAD HIAWATHA, IA 52233 42-1260463 | MEDICAL IMAGING | IA | MERCY MEDICAL CENTER | RELATED | 1,469,085 | 2,368,390 | | No | | Yes | | 33.330 % |
| (2) UNIVERSITY OF IOWA AFFILIATED HEALTH PROVIDERS LC 200 HAWKINS DRIVE IOWA CITY, IA 52242 42-1432272 | ACCOUNTABLE CARE ORGANIZATION | IA | N/A | | | | | | | | | |
| (3) EASTERN IOWA SLEEP CENTER 600 7TH STREET CEDAR RAPIDS, IA 52401 26-0310416 | SLEEP STUDIES | IA | | RELATED | 243,207 | 1,242,329 | | No | | Yes | | 33.330 % |
| | | | | | | | | | | | | |
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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) MERCY CARE MANAGEMENT INC PO BOX 786 CEDAR RAPIDS, IA 52406 42-1198970 | MEDICAL CLINICS | IA | N/A | C | | | | | No |
| (2) MERCY PHYSICIANS ASSOCIATES (SUB OF MERCY CARE MANAGEMENTINC) PO BOX 786 CEDAR RAPIDS, IA 52406 42-1442443 | MEDICAL SERVICES | IA | N/A | C | | | | | No |
| (3) MERCY PHYSICIAN SERVICES (SUB OF MERCY CARE MANAGEMENTINC) PO BOX 786 CEDAR RAPIDS, IA 52406 42-1442442 | SUPPORT SERVICES | IA | N/A | C | | | | | No |
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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

No

g

Sale of assets to related organization(s)

1g

No

h

Purchase of assets from related organization(s)

1h

No

i

Exchange of assets with related organization(s)

1i

No

j

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

1j

No

k

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

1k

No

l

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

1l

No

m

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

1m

No

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

No

q

Reimbursement paid by related organization(s) for expenses

1q

Yes

r

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

1r

No

s

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

1s

No

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

See Additional Data Table

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

Additional Data

Software ID:
Software Version:
EIN: 42-0698295
Name: MERCY MEDICAL CENTER

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) | MERCY CARE MANAGEMENT INC | A | 1,723,730 | FAIR MARKET VALUE |
| (1) | MERCY HOSPITAL CEDAR RAPIDS IA ENDOWMENT FOUNDATION | A | 1 | FAIR MARKET VALUE |
| (2) | MERCYCARE SERVICE CORPORATION | B | 5,165,000 | FAIR MARKET VALUE |
| (3) | MERCY HOSPITAL CEDAR RAPIDS IA ENDOWMENT FOUNDATION | B | 255,108 | FAIR MARKET VALUE |
| (4) | MERCY HOSPITAL CEDAR RAPIDS IA ENDOWMENT FOUNDATION | C | 2,187,146 | FAIR MARKET VALUE |
| (5) | MERCYCARE SERVICE CORPORATION | C | 365,244 | FAIR MARKET VALUE |
| (6) | MERCY HOSPITAL CEDAR RAPIDS IA ENDOWMENT FOUNDATION | Q | 722,686 | FAIR MARKET VALUE |