

Form **990**

**Return of Organization Exempt From Income Tax**  
Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

OMB No. 1545-0047

**2016**

Open to Public Inspection

Department of the Treasury  
Internal Revenue Service

▶ Do not enter social security numbers on this form as it may be made public.  
▶ Information about Form 990 and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

**A For the 2016 calendar year, or tax year beginning and ending**

|  |  |  |
|--|--|--|
| <b>B</b> Check if applicable:<br><br><input type="checkbox"/> Address change<br><input type="checkbox"/> Name change<br><input type="checkbox"/> Initial return<br><input type="checkbox"/> Final return/terminated<br><input type="checkbox"/> Amended return<br><input type="checkbox"/> Application pending | <b>C Name of organization</b><br>METHODIST MEDICAL CENTER OF ILLINOIS<br>Doing business as<br>Number and street (or P.O. box if mail is not delivered to street address) Room/suite<br>221 NE GLEN OAK AVE<br>City or town, state or province, country, and ZIP or foreign postal code<br>PEORIA, IL 61636-0002<br><b>F Name and address of principal officer:</b> DEBBIE SIMON<br>SAME AS C ABOVE | <b>D Employer identification number</b><br>37-0661223<br><b>E Telephone number</b><br>309-672-5914<br><b>G Gross receipts \$</b> 509,987,680.<br><b>H(a) Is this a group return for subordinates?</b> ..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>H(b) Are all subordinates included?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If "No," attach a list. (see instructions)<br><b>H(c) Group exemption number</b> ▶ |
| <b>I Tax-exempt status:</b> <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) ( ) ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527   |  |  |
| <b>J Website:</b> ▶ WWW. UNITYPOINT.ORG/PEORIA   |  |  |
| <b>K Form of organization:</b> <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶  |  |  |
| <b>L Year of formation:</b> 1898   |  | <b>M State of legal domicile:</b> IL   |

**Part I Summary**

|                                    |                |   |  |                    |
|------------------------------------|----------------|---|--|--------------------|
|                                    | <b>1</b>       | Briefly describe the organization's mission or most significant activities: <b>WE ARE COMMITTED TO DELIVERING OUTSTANDING HEALTHCARE. PERIOD.</b> |  |                    |
|                                    | <b>2</b>       | Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.           |  |                    |
| <b>Activities &amp; Governance</b> | <b>3</b>       | Number of voting members of the governing body (Part VI, line 1a) .....   | <b>3</b>   | 16                 |
|                                    | <b>4</b>       | Number of independent voting members of the governing body (Part VI, line 1b) .....   | <b>4</b>   | 11                 |
|                                    | <b>5</b>       | Total number of individuals employed in calendar year 2016 (Part V, line 2a) .....  | <b>5</b>   | 4257               |
|                                    | <b>6</b>       | Total number of volunteers (estimate if necessary) .....  | <b>6</b>   | 264                |
|                                    | <b>7a</b>      | Total unrelated business revenue from Part VIII, column (C), line 12 .....  | <b>7a</b>  | 3,197,564.         |
|                                    | <b>7b</b>      | Net unrelated business taxable income from Form 990-T, line 34 .....  | <b>7b</b>  | -46,488.           |
|                                    | <b>Revenue</b> | <b>8</b>  | Contributions and grants (Part VIII, line 1h) .....                    | <b>Prior Year</b>  |
| <b>9</b>                           |                | Program service revenue (Part VIII, line 2g) .....  | 2,511,058.   | 1,972,375.         |
| <b>10</b>                          |                | Investment income (Part VIII, column (A), lines 3, 4, and 7d) .....   | 381,167,876.   | 386,089,866.       |
| <b>11</b>                          |                | Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) .....  | 11,795,011.  | 4,293,229.         |
| <b>12</b>                          |                | Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12) .....  | 5,838,055.   | 6,252,050.         |
|                                    |                |   | 401,312,000.   | 398,607,520.       |
| <b>Expenses</b>                    |                | <b>13</b>   | Grants and similar amounts paid (Part IX, column (A), lines 1-3) ..... | 532,813.           |
|                                    | <b>14</b>      | Benefits paid to or for members (Part IX, column (A), line 4) .....   | 0.   | 0.                 |
|                                    | <b>15</b>      | Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10) .....   | 193,318,446.   | 223,846,052.       |
|                                    | <b>16a</b>     | Professional fundraising fees (Part IX, column (A), line 11e) .....   | 0.   | 0.                 |
|                                    | <b>b</b>       | Total fundraising expenses (Part IX, column (D), line 25) ▶ .....   | 0.   |                    |
|                                    | <b>17</b>      | Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e) .....  | 185,559,846.   | 165,674,705.       |
|                                    | <b>18</b>      | Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25) .....   | 379,411,105.   | 390,177,102.       |
|                                    | <b>19</b>      | Revenue less expenses. Subtract line 18 from line 12 .....  | 21,900,895.  | 8,430,418.         |
| <b>Net Assets or Fund Balances</b> | <b>20</b>      | Total assets (Part X, line 16) .....  | <b>Beginning of Current Year</b>                                       | <b>End of Year</b> |
|                                    | <b>21</b>      | Total liabilities (Part X, line 26) .....   | 535,720,116.   | 536,052,066.       |
|                                    | <b>22</b>      | Net assets or fund balances. Subtract line 21 from line 20 .....  | 323,901,261.   | 307,652,567.       |
|                                    |                |   | 211,818,855.   | 228,399,499.       |

**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.

|                               |  |                      |              |   |      |
|-------------------------------|--|----------------------|--------------|---|------|
| <b>Sign Here</b>              | Signature of officer<br>ROBERT A. QUIN, VP FINANCE/CFO<br>Type or print name and title | Date                 |              |   |      |
| <b>Paid Preparer Use Only</b> | Print/Type preparer's name   | Preparer's signature | Date         | Check if self-employed <input type="checkbox"/> | PTIN |
|                               | Firm's name ▶  | Firm's address ▶     | Firm's EIN ▶ | Phone no.                                       |      |

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

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission: WE ARE COMMITTED TO DELIVERING OUTSTANDING HEALTHCARE. PERIOD.

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 [X] No

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

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses.

4a (Code: ) (Expenses \$ 282,290,736. including grants of \$ 0. ) (Revenue \$ 390,335,061. )

HEALTH-CARE SERVICES
METHODIST MEDICAL CENTER OF ILLINOIS IS AN IMPORTANT ELEMENT OF THE HEALTH-CARE DELIVERY SYSTEM THAT THE CENTRAL ILLINOIS COMMUNITIES RELY ON EVERY DAY. IT IS COMMITTED TO PROVIDING QUALITY HEALTH CARE AND TO USING ITS RESOURCES TO THE GREATEST COMMUNITY BENEFIT.

METHODIST MEDICAL CENTER OF ILLINOIS PROVIDES INPATIENT AND OUTPATIENT MEDICAL SERVICES TO TREAT INDIVIDUALS WITH DISEASES, ILLNESS AND INJURIES WITH VARYING COMPLEXITIES. IT PROVIDES SERVICES TO IMPROVE THE HEALTH OF PATIENTS AND TO BETTER THEIR QUALITY OF LIFE. ALL SERVICES ARE PROVIDED REGARDLESS OF AN INDIVIDUAL'S RACE, CREED, SEX, NATIONALITY, HANDICAP, AGE OR ABILITY TO COMPENSATE FOR SERVICES

4b (Code: ) (Expenses \$ 21,748,299. including grants of \$ 661,558. ) (Revenue \$ 0. )

COMMUNITY BENEFIT, INCLUDING CHARITY CARE
CHARITY CARE AND MEANS-TESTED PROGRAMS: METHODIST MEDICAL CENTER OF ILLINOIS PROVIDES CHARITY CARE AND OTHER MEANS-TESTED PROGRAMS WITH THE GOAL TO IMPROVE THE COMMUNITY'S OVERALL HEALTH AND ACCESS TO CARE. THIS INCLUDES HEALTH-CARE SERVICES REGARDLESS OF THE PATIENT'S INSURANCE COVERAGE OR FINANCIAL STATUS. CHARITY CARE AND PARTIAL TO FULL FINANCIAL ASSISTANCE IS PROVIDED TO PATIENTS ON A CASE-BY-CASE BASIS. CHARITY CARE WAS MADE AVAILABLE AT A VALUE OF \$1,892,817 IN 2016. OFTENTIMES, METHODIST MEDICAL CENTER OF ILLINOIS RECEIVES PAYMENTS FROM PAYORS OR PATIENTS THAT ARE LESS THAN IT CHARGES FOR SERVICES. METHODIST MEDICAL CENTER OF ILLINOIS PARTICIPATES IN MEDICAID AND OTHER GOVERNMENT-SPONSORED HEALTH-CARE PROGRAMS.

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 304,039,035.

**Part IV Checklist of Required Schedules**

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

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

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

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

X

Table with columns for question number, description, and Yes/No checkboxes. Includes sections for backup withholding, employee reporting, foreign accounts, prohibited transactions, and charitable contributions.

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

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

**Section A. Governing Body and Management**

|           |  | Yes | No |
|-----------|--|-----|----|
| <b>1a</b> | Enter the number of voting members of the governing body at the end of the tax year<br>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>1a</b> 16   |     |    |
| <b>b</b>  | Enter the number of voting members included in line 1a, above, who are independent   |     |    |
|           | <b>1b</b> 11   |     |    |
| <b>2</b>  | Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?  | X   |    |
| <b>3</b>  | Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person?   |     | X  |
| <b>4</b>  | Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?   |     | X  |
| <b>5</b>  | Did the organization become aware during the year of a significant diversion of the organization's assets?   |     | X  |
| <b>6</b>  | Did the organization have members or stockholders?   | X   |    |
| <b>7a</b> | Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?   | X   |    |
| <b>b</b>  | Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?  | X   |    |
| <b>8</b>  | Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:  |     |    |
| <b>a</b>  | The governing body?  | X   |    |
| <b>b</b>  | Each committee with authority to act on behalf of the governing body?  | X   |    |
| <b>9</b>  | Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O   |     | X  |

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

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

**Section C. Disclosure**

- 17** List the states with which a copy of this Form 990 is required to be filed **CA, IL**
- 18** Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.  
 Own website     Another's website     Upon request     Other (explain in Schedule O)
- 19** Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
- 20** State the name, address, and telephone number of the person who possesses the organization's books and records: **▶**  
**TONY MOORE - 309-672-5914**  
**221 NORTHEAST GLEN OAK AVE, PEORIA, IL 61636**

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

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

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

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

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

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

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

| (A)<br>Name and Title                 | (B)<br>Average hours per week (list any hours for related organizations below line) | (C)<br>Position (do not check more than one box, unless person is both an officer and a director/trustee) |                       |         |              |                              |          | (D)<br>Reportable compensation from the organization (W-2/1099-MISC) | (E)<br>Reportable compensation from related organizations (W-2/1099-MISC) | (F)<br>Estimated amount of other compensation from the organization and related organizations |
|---------------------------------------|---|---|-----------------------|---------|--------------|------------------------------|----------|--|---|---|
|                                       |   | Individual trustee or director  | Institutional trustee | Officer | Key employee | Highest compensated employee | Former   |  |   |   |
| BRUCE ALKIRE, CHAIR (TO 5/16)         | 1.00  |   |                       |         |              |                              |          |  |   |   |
| BOARD MEMBER (FR 6/16)                | 1.00  | X   |                       | X       |              |                              | 0.       | 0.   | 0.  |   |
| KEVIN BARBIER                         | 1.00  |   |                       |         |              |                              |          |  |   |   |
| BOARD MEMBER (TO 5/16)                | 1.00  | X   |                       |         |              |                              | 0.       | 0.   | 0.  |   |
| BRIAN COHEN, MD                       | 40.00   |   |                       |         |              |                              |          |  |   |   |
| BOARD MEMBER                          | 1.00  | X   |                       |         |              |                              | 414,833. | 0.   | 68,898.   |   |
| FRANK CRESPO                          | 1.00  |   |                       |         |              |                              |          |  |   |   |
| BOARD VICE CHAIR (FR 6/16)            | 1.00  | X   |                       | X       |              |                              | 0.       | 0.   | 0.  |   |
| JILL DAUGHERTY                        | 1.00  |   |                       |         |              |                              |          |  |   |   |
| BOARD MEMBER                          | 1.00  | X   |                       |         |              |                              | 0.       | 0.   | 0.  |   |
| GREG GERSTNER                         | 1.00  |   |                       |         |              |                              |          |  |   |   |
| BOARD MEMBER                          | 1.00  | X   |                       |         |              |                              | 0.       | 0.   | 0.  |   |
| VAUGHN HANNA, MD                      | 40.00   |   |                       |         |              |                              |          |  |   |   |
| BOARD MEMBER (TO 5/16)                | 1.00  | X   |                       |         |              |                              | 262,673. | 0.   | 58,772.   |   |
| ALEXIS KHAZZAM                        | 1.00  |   |                       |         |              |                              |          |  |   |   |
| BOARD MEMBER                          | 1.00  | X   |                       |         |              |                              | 0.       | 0.   | 0.  |   |
| RICH KRIEGSMAN                        | 1.00  |   |                       |         |              |                              |          |  |   |   |
| BOARD MEMBER                          | 1.00  | X   |                       |         |              |                              | 0.       | 0.   | 0.  |   |
| STEPHANIE LINDSTROM, MD               | 40.00   |   |                       |         |              |                              |          |  |   |   |
| BOARD MEMBER                          | 1.00  | X   |                       |         |              |                              | 353,873. | 0.   | 44,901.   |   |
| MEGHAN LUNDEEN                        | 1.00  |   |                       |         |              |                              |          |  |   |   |
| BOARD MEMBER (TO 5/16)                | 1.00  | X   |                       |         |              |                              | 0.       | 0.   | 0.  |   |
| PATRICK O'LEARY, VICE CHAIR (TO 5/16) | 1.00  |   |                       |         |              |                              |          |  |   |   |
| BOARD MEMBER (FR 6/16)                | 1.00  | X   |                       | X       |              |                              | 0.       | 0.   | 0.  |   |
| SCOTT REID, DO                        | 1.00  |   |                       |         |              |                              |          |  |   |   |
| BOARD MEMBER (TO 5/16)                | 1.00  | X   |                       |         |              |                              | 0.       | 0.   | 0.  |   |
| DEBORAH SIMON                         | 40.00   |   |                       |         |              |                              |          |  |   |   |
| BOARD MEMBER/PRESIDENT & CEO          | 1.00  | X   |                       | X       |              |                              | 779,065. | 0.   | 87,986.   |   |
| JAMES VERGON                          | 1.00  |   |                       |         |              |                              |          |  |   |   |
| BOARD MEMBER                          | 1.00  | X   |                       |         |              |                              | 0.       | 0.   | 0.  |   |
| DAVID WALTY                           | 1.00  |   |                       |         |              |                              |          |  |   |   |
| BOARD MEMBER                          | 1.00  | X   |                       |         |              |                              | 0.       | 0.   | 0.  |   |
| ROBERT QUIN                           | 40.00   |   |                       |         |              |                              |          |  |   |   |
| SECRETARY/TREASURER/CFO               | 1.00  |   |                       | X       |              |                              | 416,220. | 0.   | 46,076.   |   |

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

| (A)<br>Name and title  | (B)<br>Average hours per week (list any hours for related organizations below line) | (C)<br>Position (do not check more than one box, unless person is both an officer and a director/trustee) |                       |         |              |                              |        | (D)<br>Reportable compensation from the organization (W-2/1099-MISC) | (E)<br>Reportable compensation from related organizations (W-2/1099-MISC) | (F)<br>Estimated amount of other compensation from the organization and related organizations |
|--|---|---|-----------------------|---------|--------------|------------------------------|--------|--|---|---|
|  |   | Individual trustee or director  | Institutional trustee | Officer | Key employee | Highest compensated employee | Former |  |   |   |
| TODD BAKER<br>VP STRATEGY & DEVELOPMENT                        | 40.00<br>0.00   |   |                       |         | X            |                              |        | 222,800.   | 0.  | 41,343.   |
| GARY KNEPP, MD<br>EVP MED AFFAIRS/MED STAFF AFFRS              | 40.00<br>0.00   |   |                       |         | X            |                              |        | 638,420.   | 0.  | 33,925.   |
| KEITH KNEPP, MD<br>EVP CLINICAL SERVICES/COO                   | 40.00<br>1.00   |   |                       |         | X            |                              |        | 568,451.   | 0.  | 64,597.   |
| JOY LEDBETTER<br>VP HUMAN RESOURCES & CUSTOMER SERVIC          | 40.00<br>0.00   |   |                       |         | X            |                              |        | 306,631.   | 0.  | 58,394.   |
| PAUL MACEK<br>VP REGIONAL DEVELOPMENT                          | 40.00<br>0.00   |   |                       |         | X            |                              |        | 352,311.   | 0.  | 6,917.  |
| JOHN MILLER<br>VP PHYS RELATIONS/MED AFFAIRS                   | 40.00<br>0.00   |   |                       |         | X            |                              |        | 288,378.   | 0.  | 48,882.   |
| JEANINE SPAIN<br>VP HOSPITAL NURSING SERVICES, CNO             | 40.00<br>0.00   |   |                       |         | X            |                              |        | 346,613.   | 0.  | 63,252.   |
| KISHORE KARAMCHANDANI, MD<br>PHYSICIAN                         | 40.00<br>0.00   |   |                       |         |              | X                            |        | 842,646.   | 0.  | 54,474.   |
| RAVINDRA KASHYAP, MD<br>PHYSICIAN                              | 40.00<br>0.00   |   |                       |         |              | X                            |        | 761,331.   | 0.  | 61,791.   |
| <b>1b Sub-total</b>  |   |   |                       |         |              |                              |        | 6,554,245.   | 0.  | 740,208.  |
| <b>c Total from continuation sheets to Part VII, Section A</b> |   |   |                       |         |              |                              |        | 2,211,700.   | 562,194.  | 112,341.  |
| <b>d Total (add lines 1b and 1c)</b>                           |   |   |                       |         |              |                              |        | 8,765,945.   | 562,194.  | 852,549.  |

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 **258**

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

**Section B. Independent Contractors**

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

| (A)<br>Name and business address   | (B)<br>Description of services | (C)<br>Compensation |
|--|--------------------------------|---------------------|
| RIVER CITY CONSTRUCTION LLC<br>101 HOFFER LANE, EAST PEORIA, IL 61611                | CONSTRUCTION                   | 13,898,458.         |
| PROFESSIONAL THERAPY SERVICES INC, 2810<br>FRANK SCOTT PRKWAY WEST, BELLEVILLE, IL   | PHYSICAL THERAPY               | 4,107,196.          |
| UNIVERSITY OF IL COLLEGE, COLLEGE OF<br>MEDICINE, ONE ILLINI DR, PEORIA, IL 61605    | TEACHING                       | 3,390,242.          |
| COMPREHENSIVE EMERGENCY SOLUTIONS, 401 SW<br>WATER STREET, STE 509, PEORIA, IL 61602 | ER SERVICES                    | 2,279,849.          |
| LASER ELECTRIC INC<br>3611 SW ADAMS ST, PEORIA, IL 61605                             | CONSTRUCTION                   | 1,557,023.          |

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 **113**

SEE PART VII, SECTION A CONTINUATION SHEETS





**Part VIII Statement of Revenue**

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

|   |   |  | (A)                  | (B)                                | (C)                        | (D)  |           |
|---|---|--|----------------------|------------------------------------|----------------------------|--|-----------|
|   |   |  | Total revenue        | Related or exempt function revenue | Unrelated business revenue | Revenue excluded from tax under sections 512 - 514 |           |
| <b>Contributions, Gifts, Grants and Other Similar Amounts</b> | <b>1 a</b> Federated campaigns  | <b>1a</b>                                      |                      |                                    |                            |  |           |
|   | <b>b</b> Membership dues  | <b>1b</b>                                      |                      |                                    |                            |  |           |
|   | <b>c</b> Fundraising events   | <b>1c</b>                                      |                      |                                    |                            |  |           |
|   | <b>d</b> Related organizations  | <b>1d</b>                                      | 1,192,995.           |                                    |                            |  |           |
|   | <b>e</b> Government grants (contributions)  | <b>1e</b>                                      | 372,684.             |                                    |                            |  |           |
|   | <b>f</b> All other contributions, gifts, grants, and similar amounts not included above   | <b>1f</b>                                      | 406,696.             |                                    |                            |  |           |
|   | <b>g</b> Noncash contributions included in lines 1a-1f: \$  |  |                      |                                    |                            |  |           |
|   | <b>h Total.</b> Add lines 1a-1f   |  |                      | 1,972,375.                         |                            |  |           |
|   |   |  |                      |                                    |                            |  |           |
| <b>Program Service Revenue</b>                                | <b>2 a</b> NET PATIENT REVENUE  | <b>Business Code</b>                           | 900099               | 366,118,328.                       | 366,118,328.               |  |           |
|   | <b>b</b> EDUCATION & RESEARCH   |  | 900099               | 11,386,081.                        | 11,386,081.                |  |           |
|   | <b>c</b> LABORATORY SERVICES  |  | 900099               | 3,940,678.                         | 1,664,754.                 | 2,275,924.   |           |
|   | <b>d</b> SUBS & JOINT VENTURES  |  | 900099               | 2,365,550.                         | 2,353,412.                 | 12,138.  |           |
|   | <b>e</b> MANAGEMENT, IT AND SUPPORT SERVIC  |  | 561000               | 1,550,190.                         | 1,550,190.                 |  |           |
|   | <b>f</b> All other program service revenue  |  | 900099               | 729,039.                           | 729,039.                   |  |           |
|   | <b>g Total.</b> Add lines 2a-2f   |  |                      | 386,089,866.                       |                            |  |           |
|   |   |  |                      |                                    |                            |  |           |
| <b>Other Revenue</b>  | <b>3</b> Investment income (including dividends, interest, and other similar amounts)   |  |                      | 4,796,953.                         | 90,046.                    | 4,706,907.   |           |
|   | <b>4</b> Income from investment of tax-exempt bond proceeds   |  |                      |                                    |                            |  |           |
|   | <b>5</b> Royalties  |  |                      |                                    |                            |  |           |
|   | <b>6 a</b> Gross rents  | (i) Real                                       | (ii) Personal        |                                    |                            |  |           |
|   |   | b Less: rental expenses                        |                      |                                    |                            |  |           |
|   |   | c Rental income or (loss)                      |                      |                                    |                            |  |           |
|   |   | d Net rental income or (loss)                  |                      |                                    |                            |  |           |
|   | <b>7 a</b> Gross amount from sales of assets other than inventory   | (i) Securities                                 | (ii) Other           |                                    |                            |  |           |
|   |   | b Less: cost or other basis and sales expenses |                      |                                    |                            |  |           |
|   |   | c Gain or (loss)                               |                      |                                    |                            |  |           |
|   |   | d Net gain or (loss)                           |                      |                                    | -503,724.                  |  | -503,724. |
|   | <b>8 a</b> 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 |                      |                                    |                            |  |           |
|   | <b>9 a</b> Gross income from gaming activities. See Part IV, line 19  | a  |                      |                                    |                            |  |           |
|   |   | b Less: direct expenses                        | b                    |                                    |                            |  |           |
|   |   | c Net income or (loss) from gaming activities  |                      |                                    |                            |  |           |
|   | <b>10 a</b> Gross sales of inventory, less returns and allowances   | a  | 96,118.              |                                    |                            |  |           |
| b Less: cost of goods sold                                    |   | b  | 114,585.             |                                    |                            |  |           |
| c Net income or (loss) from sales of inventory                |   |  |                      | -18,467.                           |                            | -18,467.   |           |
| <b>Miscellaneous Revenue</b>                                  |   |  | <b>Business Code</b> |                                    |                            |  |           |
| <b>11 a</b> MISCELLANEOUS REVENUE                             |   | 900099   | 3,548,228.           | 3,245,647.                         | 302,581.                   |  |           |
| <b>b</b> CAFETERIA  |   | 722210   | 1,396,527.           |                                    |                            | 1,396,527.   |           |
| <b>c</b> CHILDCARE AND ADULTCARE SERVICES                     |   | 624410   | 1,325,762.           |                                    | 606,921.                   | 718,841.   |           |
| <b>d</b> All other revenue                                    |   |  |                      |                                    |                            |  |           |
| <b>e Total.</b> Add lines 11a-11d                             |   |  | 6,270,517.           |                                    |                            |  |           |
| <b>12 Total revenue.</b> See instructions.                    |   |  | 398,607,520.         | 387,137,497.                       | 3,197,564.                 | 6,300,084.   |           |

**Part IX Statement of Functional Expenses**

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

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

| Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.  | (A)<br>Total expenses | (B)<br>Program service expenses | (C)<br>Management and general expenses | (D)<br>Fundraising expenses |
|---|-----------------------|---------------------------------|--|-----------------------------|
| 1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21  | 577,877.              | 577,877.                        |  |                             |
| 2 Grants and other assistance to domestic individuals. See Part IV, line 22   | 78,468.               | 78,468.                         |  |                             |
| 3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16  |                       |                                 |  |                             |
| 4 Benefits paid to or for members   |                       |                                 |  |                             |
| 5 Compensation of current officers, directors, trustees, and key employees  | 5,574,209.            |                                 | 5,574,209.                             |                             |
| 6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)   | 199,263.              |                                 | 199,263.                               |                             |
| 7 Other salaries and wages  | 183,679,063.          | 153,389,450.                    | 30,289,613.                            |                             |
| 8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)  | 6,210,629.            | 5,186,465.                      | 1,024,164.                             |                             |
| 9 Other employee benefits   | 17,629,948.           | 14,722,679.                     | 2,907,269.                             |                             |
| 10 Payroll taxes  | 10,552,940.           | 8,812,706.                      | 1,740,234.                             |                             |
| 11 Fees for services (non-employees):   |                       |                                 |  |                             |
| a Management  | 28,978,407.           | 691,056.                        | 28,287,351.                            |                             |
| b Legal   | 1,908,037.            |                                 | 1,908,037.                             |                             |
| c Accounting  |                       |                                 |  |                             |
| d Lobbying  | 58,542.               |                                 | 58,542.                                |                             |
| e Professional fundraising services. See Part IV, line 17   |                       |                                 |  |                             |
| f Investment management fees  | 1,045,827.            | 416,388.                        | 629,439.                               |                             |
| g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)   | 29,894,325.           | 22,172,915.                     | 7,721,410.                             |                             |
| 12 Advertising and promotion  | 1,240,193.            | 24,330.                         | 1,215,863.                             |                             |
| 13 Office expenses  | 6,001,563.            | 5,252,072.                      | 749,491.                               |                             |
| 14 Information technology   | -1,972,632.           | -1,972,632.                     |  |                             |
| 15 Royalties  |                       |                                 |  |                             |
| 16 Occupancy  | 13,117,703.           | 10,898,036.                     | 2,219,667.                             |                             |
| 17 Travel   | 930,281.              | 560,800.                        | 369,481.                               |                             |
| 18 Payments of travel or entertainment expenses for any federal, state, or local public officials   |                       |                                 |  |                             |
| 19 Conferences, conventions, and meetings   | 102,833.              | 34,497.                         | 68,336.                                |                             |
| 20 Interest   | 3,854,469.            | 3,854,469.                      |  |                             |
| 21 Payments to affiliates   |                       |                                 |  |                             |
| 22 Depreciation, depletion, and amortization  | 15,281,272.           | 14,781,276.                     | 499,996.                               |                             |
| 23 Insurance  | 4,115,582.            | 4,384,861.                      | -269,279.                              |                             |
| 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 <b>INCOME TAXES</b>   | 266,600.              |                                 | 266,600.                               |                             |
| b <b>MEDICAL SUPPLIES</b>   | 45,721,942.           | 45,804,734.                     | -82,792.                               |                             |
| c <b>MEDICAID PROVIDER ASSES</b>  | 13,787,818.           | 13,787,818.                     |  |                             |
| d <b>MISCELLANEOUS EXPENSE</b>  | 702,705.              | 4,305.                          | 698,400.                               |                             |
| e All other expenses  | 639,238.              | 576,465.                        | 62,773.                                |                             |
| 25 <b>Total functional expenses.</b> Add lines 1 through 24e  | 390,177,102.          | 304,039,035.                    | 86,138,067.                            | 0.                          |
| 26 <b>Joint costs.</b> Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation.                              |                       |                                 |  |                             |

Check here  if following SOP 98-2 (ASC 958-720)

**Part X Balance Sheet**

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

|  |  | (A)                     |              | (B)          |  |
|--|--|-------------------------|--------------|--------------|--|
|  |  | Beginning of year       |              | End of year  |  |
| <b>Assets</b>  | <b>1</b> Cash - non-interest-bearing .....   | 24,538,821.             | <b>1</b>     | 9,397,355.   |  |
|  | <b>2</b> Savings and temporary cash investments .....  | 3,275,161.              | <b>2</b>     | 237,588.     |  |
|  | <b>3</b> Pledges and grants receivable, net .....  | 6,140,503.              | <b>3</b>     | 6,039,062.   |  |
|  | <b>4</b> Accounts receivable, net .....  | 50,410,198.             | <b>4</b>     | 53,597,620.  |  |
|  | <b>5</b> Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L .....   |                         | <b>5</b>     |              |  |
|  | <b>6</b> Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instr). Complete Part II of Sch L ..... |                         | <b>6</b>     |              |  |
|  | <b>7</b> Notes and loans receivable, net .....   | 66,938,542.             | <b>7</b>     | 61,616,624.  |  |
|  | <b>8</b> Inventories for sale or use .....   | 4,915,015.              | <b>8</b>     | 5,450,265.   |  |
|  | <b>9</b> Prepaid expenses and deferred charges .....   | 3,052,200.              | <b>9</b>     | 3,316,466.   |  |
|  | <b>10a</b> Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D .....   | <b>10a</b> 241,203,512. |              |              |  |
|  | <b>b</b> Less: accumulated depreciation .....  | <b>10b</b> 82,204,508.  |              |              |  |
|  | <b>11</b> Investments - publicly traded securities .....   | 155,940,192.            | <b>10c</b>   | 158,999,004. |  |
|  | <b>12</b> Investments - other securities. See Part IV, line 11 .....   | 177,612,871.            | <b>11</b>    | 196,818,052. |  |
|  | <b>13</b> Investments - program-related. See Part IV, line 11 .....  | 42,035,150.             | <b>12</b>    |              |  |
|  | <b>14</b> Intangible assets .....  | 861,463.                | <b>13</b>    | 40,358,429.  |  |
|  | <b>15</b> Other assets. See Part IV, line 11 .....   |                         | <b>14</b>    | 221,601.     |  |
| <b>16</b> <b>Total assets.</b> Add lines 1 through 15 (must equal line 34) .....   | 535,720,116.   | <b>15</b>               |              |              |  |
| <b>17</b> Accounts payable and accrued expenses .....  | 37,622,420.  | <b>16</b>               | 536,052,066. |              |  |
| <b>18</b> Grants payable .....   |  | <b>17</b>               | 22,854,222.  |              |  |
| <b>19</b> Deferred revenue .....   | 3,205,129.   | <b>18</b>               |              |              |  |
| <b>20</b> Tax-exempt bond liabilities .....  | 88,175,000.  | <b>19</b>               | 2,043,742.   |              |  |
| <b>21</b> Escrow or custodial account liability. Complete Part IV of Schedule D .....  |  | <b>20</b>               | 31,045,600.  |              |  |
| <b>22</b> Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L ..... |  | <b>21</b>               |              |              |  |
| <b>23</b> Secured mortgages and notes payable to unrelated third parties .....   |  | <b>22</b>               |              |              |  |
| <b>24</b> Unsecured notes and loans payable to unrelated third parties .....   | 48,093,735.  | <b>23</b>               |              |              |  |
| <b>25</b> Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D .....                | 146,804,977.   | <b>24</b>               | 53,356,175.  |              |  |
| <b>26</b> <b>Total liabilities.</b> Add lines 17 through 25 .....  | 323,901,261.   | <b>25</b>               | 198,352,828. |              |  |
| <b>27</b> <b>Organizations that follow SFAS 117 (ASC 958), check here</b> <input checked="" type="checkbox"/> <b>and complete lines 27 through 29, and lines 33 and 34.</b>                          |  | <b>26</b>               | 307,652,567. |              |  |
| <b>28</b> Unrestricted net assets .....  | 189,062,974.   | <b>27</b>               | 205,179,838. |              |  |
| <b>29</b> Temporarily restricted net assets .....  | 17,737,841.  | <b>28</b>               | 17,824,065.  |              |  |
| <b>30</b> Permanently restricted net assets .....  | 5,018,040.   | <b>29</b>               | 5,395,596.   |              |  |
| <b>31</b> <b>Organizations that do not follow SFAS 117 (ASC 958), check here</b> <input type="checkbox"/> <b>and complete lines 30 through 34.</b>   |  |                         |              |              |  |
| <b>32</b> Capital stock or trust principal, or current funds .....   |  | <b>30</b>               |              |              |  |
| <b>33</b> Paid-in or capital surplus, or land, building, or equipment fund .....   |  | <b>31</b>               |              |              |  |
| <b>34</b> Retained earnings, endowment, accumulated income, or other funds .....   |  | <b>32</b>               |              |              |  |
| <b>35</b> Total net assets or fund balances .....  | 211,818,855.   | <b>33</b>               | 228,399,499. |              |  |
| <b>36</b> Total liabilities and net assets/fund balances .....   | 535,720,116.   | <b>34</b>               | 536,052,066. |              |  |

**Part XI Reconciliation of Net Assets**

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

|    |  |    |              |
|----|--|----|--------------|
| 1  | Total revenue (must equal Part VIII, column (A), line 12)  | 1  | 398,607,520. |
| 2  | Total expenses (must equal Part IX, column (A), line 25)   | 2  | 390,177,102. |
| 3  | Revenue less expenses. Subtract line 2 from line 1   | 3  | 8,430,418.   |
| 4  | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))                      | 4  | 211,818,855. |
| 5  | Net unrealized gains (losses) on investments   | 5  | 11,487,451.  |
| 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  | -3,337,225.  |
| 10 | Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 228,399,499. |

**Part XII Financial Statements and Reporting**

Check 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?  |     | X  |
| 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                 |  |     |    |
| b   | Were the organization's financial statements audited by an independent accountant?   | X   |    |
| If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both:              |  |     |    |
| <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis      |  |     |    |
| 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? | X   |    |
| If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.   |  |     |    |
| 3a  | As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?   |     | X  |
| 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     |     |    |

Form 990 (2016)



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

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

**Section A. Public Support**

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

**Section B. Total Support**

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

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

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

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

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

**Section A. Public Support**

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

**Section B. Total Support**

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

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

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

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

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

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

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

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

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



**Part IV Supporting Organizations**

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

**Section A. All Supporting Organizations**

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

**Part IV Supporting Organizations** (continued)

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

**Section B. Type I Supporting Organizations**

|  | Yes | No |
|--|-----|----|
| <b>1</b> Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? 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. |     |    |
| <b>2</b> Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? 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.   |     |    |
| <b>1</b>   |     |    |
| <b>2</b>   |     |    |

**Section C. Type II Supporting Organizations**

|   | Yes | No |
|---|-----|----|
| <b>1</b> Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? 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). |     |    |
| <b>1</b>  |     |    |

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

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

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

|  |  |     |    |
|--|--|-----|----|
| <b>1</b> Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions).   |  |     |    |
| <b>a</b> <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.   |  |     |    |
| <b>b</b> <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.  |  |     |    |
| <b>c</b> <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).  |  |     |    |
| <b>2</b> Activities Test. Answer (a) and (b) below.  |  | Yes | No |
| <b>a</b> Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? 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>b</b> Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? 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.  |  |     |    |
| <b>3</b> Parent of Supported Organizations. Answer (a) and (b) below.  |  |     |    |
| <b>a</b> Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? Provide details in Part VI.  |  |     |    |
| <b>b</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.   |  |     |    |
| <b>2a</b>  |  |     |    |
| <b>2b</b>  |  |     |    |
| <b>3a</b>  |  |     |    |
| <b>3b</b>  |  |     |    |

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

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

| <b>Section A - Adjusted Net Income</b> |  | (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                                      | <b>Adjusted Net Income</b> (subtract lines 5, 6, and 7 from line 4)  | 8              |                             |

| <b>Section B - Minimum Asset Amount</b> |   | (A) Prior Year | (B) Current Year (optional) |
|---|---|----------------|-----------------------------|
| 1                                       | Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year): |                |                             |
| a                                       | Average monthly value of securities   | 1a             |                             |
| b                                       | Average monthly cash balances   | 1b             |                             |
| c                                       | Fair market value of other non-exempt-use assets  | 1c             |                             |
| d                                       | <b>Total</b> (add lines 1a, 1b, and 1c)   | 1d             |                             |
| e                                       | <b>Discount</b> claimed for blockage or other factors (explain in detail in <b>Part VI</b> ):                                   |                |                             |
| 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                                       | <b>Minimum Asset Amount</b> (add line 7 to line 6)  | 8              |                             |

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

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

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

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



**Schedule B**

(Form 990, 990-EZ, or 990-PF)

Department of the Treasury  
Internal Revenue Service

**Schedule of Contributors**

▶ Attach to Form 990, Form 990-EZ, or Form 990-PF.  
▶ Information about Schedule B (Form 990, 990-EZ, or 990-PF) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No. 1545-0047

**2016**

Name of the organization

METHODIST MEDICAL CENTER OF ILLINOIS

Employer identification number

37-0661223

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

501(c)( 3 ) (enter number) organization

4947(a)(1) nonexempt charitable trust **not** treated as a private foundation

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

4947(a)(1) nonexempt charitable trust treated as a private foundation

501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule**.

**Note:** Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

**General Rule**

For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, contributions totaling \$5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.

**Special Rules**

For an organization described in section 501(c)(3) filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), that checked Schedule A (Form 990 or 990-EZ), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions of the greater of (1) \$5,000 or (2) 2% of the amount on (i) Form 990, Part VIII, line 1h, or (ii) Form 990-EZ, line 1. Complete Parts I and II.

For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than \$1,000 *exclusively* for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals. Complete Parts I, II, and III.

For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc., purposes, but no such contributions totaled more than \$1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Don't complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions totaling \$5,000 or more during the year ..... ▶ \$ \_\_\_\_\_

**Caution:** An organization that isn't covered by the General Rule and/or the Special Rules doesn't file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on its Form 990-PF, Part I, line 2, to certify that it doesn't meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990, 990-EZ, or 990-PF. Schedule B (Form 990, 990-EZ, or 990-PF) (2016)

|   |   |
|---|---|
| Name of organization<br><b>METHODIST MEDICAL CENTER OF ILLINOIS</b> | Employer identification number<br><b>37-0661223</b> |
|---|---|

**Part I Contributors** (See instructions). Use duplicate copies of Part I if additional space is needed.

| (a)<br>No. | (b)<br>Name, address, and ZIP + 4 | (c)<br>Total contributions | (d)<br>Type of contribution   |
|------------|-----------------------------------|----------------------------|---|
| 1          | <br><hr/><br><hr/><br><hr/>       | \$ <u>380,053.</u>         | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |
| 2          | <br><hr/><br><hr/><br><hr/>       | \$ <u>8,066.</u>           | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |
| 3          | <br><hr/><br><hr/><br><hr/>       | \$ <u>141,879.</u>         | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |
| 4          | <br><hr/><br><hr/><br><hr/>       | \$ <u>1,051,116.</u>       | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |
| 5          | <br><hr/><br><hr/><br><hr/>       | \$ <u>14,639.</u>          | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |
| 6          | <br><hr/><br><hr/><br><hr/>       | \$ <u>364,618.</u>         | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |

|   |   |
|---|---|
| Name of organization<br><b>METHODIST MEDICAL CENTER OF ILLINOIS</b> | Employer identification number<br><b>37-0661223</b> |
|---|---|

**Part I Contributors** (See instructions). Use duplicate copies of Part I if additional space is needed.

| (a)<br>No. | (b)<br>Name, address, and ZIP + 4 | (c)<br>Total contributions | (d)<br>Type of contribution   |
|------------|-----------------------------------|----------------------------|---|
| 7          | <hr/> <hr/> <hr/> <hr/>           | \$ 10,765.                 | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |
|            | <hr/> <hr/> <hr/> <hr/>           | \$ _____                   | Person <input type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.)            |
|            | <hr/> <hr/> <hr/> <hr/>           | \$ _____                   | Person <input type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.)            |
|            | <hr/> <hr/> <hr/> <hr/>           | \$ _____                   | Person <input type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.)            |
|            | <hr/> <hr/> <hr/> <hr/>           | \$ _____                   | Person <input type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.)            |
|            | <hr/> <hr/> <hr/> <hr/>           | \$ _____                   | Person <input type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.)            |
|            | <hr/> <hr/> <hr/> <hr/>           | \$ _____                   | Person <input type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.)            |



|   |   |
|---|---|
| Name of organization<br><br><b>METHODIST MEDICAL CENTER OF ILLINOIS</b> | Employer identification number<br><br><b>37-0661223</b> |
|---|---|

**Part II Noncash Property** (See instructions). Use duplicate copies of Part II if additional space is needed.

| (a)<br>No.<br>from<br>Part I | (b)<br>Description of noncash property given | (c)<br>FMV (or estimate)<br>(See instructions) | (d)<br>Date received |
|------------------------------|--|--|----------------------|
|                              |  | \$ _____                                       |                      |
|                              |  | \$ _____                                       |                      |
|                              |  | \$ _____                                       |                      |
|                              |  | \$ _____                                       |                      |
|                              |  | \$ _____                                       |                      |
|                              |  | \$ _____                                       |                      |
|                              |  | \$ _____                                       |                      |

|   |   |
|---|---|
| Name of organization<br><b>METHODIST MEDICAL CENTER OF ILLINOIS</b> | Employer identification number<br><b>37-0661223</b> |
|---|---|

**Part III** Exclusively religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than \$1,000 for the year from any one contributor. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of exclusively religious, charitable, etc., contributions of \$1,000 or less for the year. (Enter this info. once.) ▶ \$ \_\_\_\_\_  
Use duplicate copies of Part III if additional space is needed.

| (a) No. from Part I                     | (b) Purpose of gift | (c) Use of gift                          | (d) Description of how gift is held |
|---|---------------------|--|-------------------------------------|
|   |                     |  |                                     |
| <b>(e) Transfer of gift</b>             |                     |  |                                     |
| Transferee's name, address, and ZIP + 4 |                     | Relationship of transferor to transferee |                                     |
|   |                     |  |                                     |
|   |                     |  |                                     |
| <b>(e) Transfer of gift</b>             |                     |  |                                     |
| Transferee's name, address, and ZIP + 4 |                     | Relationship of transferor to transferee |                                     |
|   |                     |  |                                     |
|   |                     |  |                                     |
| <b>(e) Transfer of gift</b>             |                     |  |                                     |
| Transferee's name, address, and ZIP + 4 |                     | Relationship of transferor to transferee |                                     |
|   |                     |  |                                     |
|   |                     |  |                                     |
| <b>(e) Transfer of gift</b>             |                     |  |                                     |
| Transferee's name, address, and ZIP + 4 |                     | Relationship of transferor to transferee |                                     |
|   |                     |  |                                     |
|   |                     |  |                                     |
| <b>(e) Transfer of gift</b>             |                     |  |                                     |
| Transferee's name, address, and ZIP + 4 |                     | Relationship of transferor to transferee |                                     |
|   |                     |  |                                     |
|   |                     |  |                                     |

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

**Political Campaign and Lobbying Activities**

OMB No. 1545-0047

**2016**

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

For Organizations Exempt From Income Tax Under section 501(c) and section 527

- ▶ **Complete if the organization is described below. ▶ Attach to Form 990 or Form 990-EZ.**
- ▶ **Information about Schedule C (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).**

**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 organization<br><b>METHODIST MEDICAL CENTER OF ILLINOIS</b> | Employer identification number<br><b>37-0661223</b> |
|---|---|

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

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV.

- 2 Political campaign activity expenditures ..... ▶ \$ \_\_\_\_\_
- 3 Volunteer hours for political campaign activities ..... \_\_\_\_\_

**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? .....  Yes  No
- 4a Was a correction made? .....  Yes  No
- b If "Yes," describe in Part IV.

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

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

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

For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ. Schedule C (Form 990 or 990-EZ) 2016

**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.

| <b>Limits on Lobbying Expenditures</b><br>(The term "expenditures" means amounts paid or incurred.)  | (a) Filing organization's totals                   | (b) Affiliated group totals        |                    |                               |   |  |   |  |  |   |                   |              |  |  |
|--|--|------------------------------------|--------------------|-------------------------------|---|--|---|--|--|---|-------------------|--------------|--|--|
| <b>1a</b> Total lobbying expenditures to influence public opinion (grass roots lobbying) .....   |  |                                    |                    |                               |   |  |   |  |  |   |                   |              |  |  |
| <b>b</b> Total lobbying expenditures to influence a legislative body (direct lobbying) .....   |  |                                    |                    |                               |   |  |   |  |  |   |                   |              |  |  |
| <b>c</b> Total lobbying expenditures (add lines 1a and 1b) .....   |  |                                    |                    |                               |   |  |   |  |  |   |                   |              |  |  |
| <b>d</b> Other exempt purpose expenditures .....   |  |                                    |                    |                               |   |  |   |  |  |   |                   |              |  |  |
| <b>e</b> Total exempt purpose expenditures (add lines 1c and 1d) .....   |  |                                    |                    |                               |   |  |   |  |  |   |                   |              |  |  |
| <b>f</b> Lobbying nontaxable amount. Enter the amount from the following table in both columns.  |  |                                    |                    |                               |   |  |   |  |  |   |                   |              |  |  |
| <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:35%;">If the amount on line 1e, column (a) or (b) is:</th> <th style="width:65%;">The lobbying nontaxable amount is:</th> </tr> </thead> <tbody> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e.</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000.</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000.</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000.</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000.</td> </tr> </tbody> </table> | 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. |  |  |
| 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.                                       |                                    |                    |                               |   |  |   |  |  |   |                   |              |  |  |
| <b>g</b> Grassroots nontaxable amount (enter 25% of line 1f) .....   |  |                                    |                    |                               |   |  |   |  |  |   |                   |              |  |  |
| <b>h</b> Subtract line 1g from line 1a. If zero or less, enter -0- .....   |  |                                    |                    |                               |   |  |   |  |  |   |                   |              |  |  |
| <b>i</b> Subtract line 1f from line 1c. If zero or less, enter -0- .....   |  |                                    |                    |                               |   |  |   |  |  |   |                   |              |  |  |
| <b>j</b> 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? .....   | <input type="checkbox"/> Yes                       | <input type="checkbox"/> 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.)

| <b>Lobbying Expenditures During 4-Year Averaging Period</b>         |          |          |          |          |           |
|---|----------|----------|----------|----------|-----------|
| Calendar year<br>(or fiscal year beginning in)                      | (a) 2013 | (b) 2014 | (c) 2015 | (d) 2016 | (e) Total |
| <b>2a</b> Lobbying nontaxable amount                                |          |          |          |          |           |
| <b>b</b> Lobbying ceiling amount<br>(150% of line 2a, column(e))    |          |          |          |          |           |
| <b>c</b> Total lobbying expenditures                                |          |          |          |          |           |
| <b>d</b> Grassroots nontaxable amount                               |          |          |          |          |           |
| <b>e</b> Grassroots ceiling amount<br>(150% of line 2d, column (e)) |          |          |          |          |           |
| <b>f</b> Grassroots lobbying expenditures                           |          |          |          |          |           |

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

| For each "Yes," response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.   | (a) |    | (b)     |
|--|-----|----|---------|
|  | Yes | No | Amount  |
| <b>1</b> During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of: |     |    |         |
| <b>a</b> Volunteers? .....   |     | X  |         |
| <b>b</b> Paid staff or management (include compensation in expenses reported on lines 1c through 1i)? ..   |     | X  |         |
| <b>c</b> Media advertisements? .....   |     | X  |         |
| <b>d</b> Mailings to members, legislators, or the public? .....  |     | X  |         |
| <b>e</b> Publications, or published or broadcast statements? .....   |     | X  |         |
| <b>f</b> Grants to other organizations for lobbying purposes? .....  |     | X  |         |
| <b>g</b> Direct contact with legislators, their staffs, government officials, or a legislative body? .....   |     | X  |         |
| <b>h</b> Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means? .....   |     | X  |         |
| <b>i</b> Other activities? .....   | X   |    | 58,542. |
| <b>j</b> Total. Add lines 1c through 1i .....  |     |    | 58,542. |
| <b>2a</b> Did the activities in line 1 cause the organization to be not described in section 501(c)(3)? .....  |     | X  |         |
| <b>b</b> If "Yes," enter the amount of any tax incurred under section 4912 .....   |     |    |         |
| <b>c</b> If "Yes," enter the amount of any tax incurred by organization managers under section 4912 .....  |     |    |         |
| <b>d</b> If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year? .....  |     |    |         |

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

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

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

**PART II-B, LINE 1, LOBBYING ACTIVITIES:**

**FEES PAID FOR LOBBYING ON HOSPITAL-RELATED ISSUES INCLUDED IN MEMBERSHIP DUES.**

**SCHEDULE D**  
**(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Supplemental Financial Statements**

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.**  
▶ **Attach to Form 990.**

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

OMB No. 1545-0047

**2016**

**Open to Public Inspection**

**Name of the organization** METHODIST MEDICAL CENTER OF ILLINOIS **Employer identification number** 37-0661223

**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? .....  |                         | <input type="checkbox"/> Yes <input type="checkbox"/> 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? ..... |                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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

1 Purpose(s) of conservation easements held by the organization (check all that apply).  
 Preservation of land for public use (e.g., recreation or education)     Preservation of a historically important land area  
 Protection of natural habitat     Preservation of a certified historic structure  
 Preservation of open space

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

|  | Held at the End of the Tax Year |
|--|---------------------------------|
| a Total number of conservation easements .....   | 2a                              |
| b Total acreage restricted by conservation easements .....   | 2b                              |
| c Number of conservation easements on a certified historic structure included in (a) .....   | 2c                              |
| d Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register ..... | 2d                              |

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

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

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

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)? .....

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 .....

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990. Schedule D (Form 990) 2016

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

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

- a  Public exhibition
- b  Scholarly research
- c  Preservation for future generations
- d  Loan or exchange programs
- e  Other \_\_\_\_\_

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

5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection?  Yes  No

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

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?  Yes  No

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

|                                 | Amount |
|---------------------------------|--------|
| c Beginning balance             | 1c     |
| d Additions during the year     | 1d     |
| e Distributions during the year | 1e     |
| f Ending balance                | 1f     |

2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability?  Yes  No

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

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

|  | (a) Current year | (b) Prior year | (c) Two years back | (d) Three years back | (e) Four years back |
|--|------------------|----------------|--------------------|----------------------|---------------------|
| 1a Beginning of year balance                     | 22,655,879.      | 23,339,324.    | 22,017,923.        | 14,117,151.          | 12,910,818.         |
| b Contributions                                  | 380,053.         | 369,421.       | 940,318.           | 6,655,071.           | 806,329.            |
| c Net investment earnings, gains, and losses     | 466,425.         | -674,107.      | 928,596.           | 1,696,222.           | 1,233,627.          |
| d Grants or scholarships                         | 382,698.         | 378,759.       | 547,513.           | 433,010.             | 811,152.            |
| e Other expenditures for facilities and programs |                  |                |                    | 17,511.              | 22,471.             |
| f Administrative expenses                        |                  |                |                    |                      |                     |
| g End of year balance                            | 23,119,659.      | 22,655,879.    | 23,339,324.        | 22,017,923.          | 14,117,151.         |

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

- a Board designated or quasi-endowment  .00 %
- b Permanent endowment  22.47 %
- c Temporarily restricted endowment  77.53 %

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

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

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

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

**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  |                                      | 1,458,352.                      |                              | 1,458,352.     |
| b Buildings  |                                      | 141,436,686.                    | 35,909,330.                  | 105,527,356.   |
| c Leasehold improvements   |                                      |                                 |                              |                |
| d Equipment  |                                      | 76,498,231.                     | 43,475,035.                  | 33,023,196.    |
| e Other  |                                      | 21,810,243.                     | 2,820,143.                   | 18,990,100.    |
| <b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.) |                                      |                                 |                              | 158,999,004.   |

**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)   |                |   |
| <b>Total.</b> (Col. (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) METHODIST MEDICAL CENTER  |                |   |
| (2) FOUNDATION  | 29,825,165.    | END-OF-YEAR MARKET VALUE                                  |
| (3) CENTRAL ILLINOIS WORK   |                |   |
| (4) INJURY RESOURCE   | 729,327.       | END-OF-YEAR MARKET VALUE                                  |
| (5) GREATER PEORIA SPECIALTY  |                |   |
| (6) HOSPITAL  | -423,313.      | END-OF-YEAR MARKET VALUE                                  |
| (7) CENTRAL ILLINOIS  |                |   |
| (8) ENDOSCOPY CENTER  | 6,279,839.     | END-OF-YEAR MARKET VALUE                                  |
| (9)   |                |   |
| <b>Total.</b> (Col. (b) must equal Form 990, Part X, col. (B) line 13.) ▶ | 40,358,429.    |   |

**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)   |                |
| <b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶ |                |

**Part X Other Liabilities.**

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

| 1. (a) Description of liability   | (b) Book value |
|---|----------------|
| (1) Federal income taxes  |                |
| (2) DUE TO AFFILIATES   | 84,880,722.    |
| (3) SELF-INSURANCE RESERVE  | 28,853,690.    |
| (4) LONG-TERM RETENTION INCENTIVES  | 7,173,342.     |
| (5) ASBESTOS REMOVAL LIABILITY  | 1,023,680.     |
| (6) DB RETIREMENT PLAN LIABILITY  | 74,333,453.    |
| (7) HEALTH AND WELFARE BENEFITS   |                |
| (8) RESERVE   | 1,760,952.     |
| (9) MISCELLANEOUS LIABILITY   | 326,989.       |
| <b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶ | 198,352,828.   |

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



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

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

|          |  |           |              |
|----------|--|-----------|--------------|
| <b>1</b> | Total revenue, gains, and other support per audited financial statements                       | <b>1</b>  | 409,000,000. |
| <b>2</b> | Amounts included on line 1 but not on Form 990, Part VIII, line 12:                            |           |              |
| <b>a</b> | Net unrealized gains (losses) on investments   | <b>2a</b> | 11,487,451.  |
| <b>b</b> | Donated services and use of facilities   | <b>2b</b> |              |
| <b>c</b> | Recoveries of prior year grants  | <b>2c</b> |              |
| <b>d</b> | Other (Describe in Part XIII.)   | <b>2d</b> | 473,902.     |
| <b>e</b> | Add lines <b>2a</b> through <b>2d</b>  | <b>2e</b> | 11,961,353.  |
| <b>3</b> | Subtract line <b>2e</b> from line <b>1</b>   | <b>3</b>  | 397,038,647. |
| <b>4</b> | Amounts included on Form 990, Part VIII, line 12, but not on line 1:                           |           |              |
| <b>a</b> | Investment expenses not included on Form 990, Part VIII, line 7b                               | <b>4a</b> | 532,181.     |
| <b>b</b> | Other (Describe in Part XIII.)   | <b>4b</b> | 1,036,692.   |
| <b>c</b> | Add lines <b>4a</b> and <b>4b</b>  | <b>4c</b> | 1,568,873.   |
| <b>5</b> | Total revenue. Add lines <b>3</b> and <b>4c</b> . (This must equal Form 990, Part I, line 12.) | <b>5</b>  | 398,607,520. |

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

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

|          |   |           |              |
|----------|---|-----------|--------------|
| <b>1</b> | Total expenses and losses per audited financial statements                                      | <b>1</b>  | 388,913,000. |
| <b>2</b> | Amounts included on line 1 but not on Form 990, Part IX, line 25:                               |           |              |
| <b>a</b> | Donated services and use of facilities  | <b>2a</b> |              |
| <b>b</b> | Prior year adjustments  | <b>2b</b> |              |
| <b>c</b> | Other losses  | <b>2c</b> |              |
| <b>d</b> | Other (Describe in Part XIII.)  | <b>2d</b> | 115,600.     |
| <b>e</b> | Add lines <b>2a</b> through <b>2d</b>   | <b>2e</b> | 115,600.     |
| <b>3</b> | Subtract line <b>2e</b> from line <b>1</b>  | <b>3</b>  | 388,797,400. |
| <b>4</b> | Amounts included on Form 990, Part IX, line 25, but not on line 1:                              |           |              |
| <b>a</b> | Investment expenses not included on Form 990, Part VIII, line 7b                                | <b>4a</b> | 532,181.     |
| <b>b</b> | Other (Describe in Part XIII.)  | <b>4b</b> | 847,521.     |
| <b>c</b> | Add lines <b>4a</b> and <b>4b</b>   | <b>4c</b> | 1,379,702.   |
| <b>5</b> | Total expenses. Add lines <b>3</b> and <b>4c</b> . (This must equal Form 990, Part I, line 18.) | <b>5</b>  | 390,177,102. |

**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.

**PART V, LINE 4:**

THE PERMANENT ENDOWMENTS ARE MAINTAINED TO PROVIDE A PERMANENT SOURCE OF INCOME, WITH THE STIPULATION THAT THE PRINCIPAL BALANCE MUST BE INVESTED AND KEPT INTACT IN PERPETUITY, WHILE ONLY THE INCOME GENERATED CAN BE USED BY THE ORGANIZATION.

THE TEMPORARY ENDOWMENTS ARE MAINTAINED TO PROVIDE A SOURCE OF INCOME FOR EITHER A SPECIFIC PERIOD OF TIME OR UNTIL A SPECIFIC EVENT OCCURS. THE MAJORITY OF METHODIST'S ENDOWMENTS HAVE DESIGNATIONS FOR USE FOR HOSPICE, MEDICAL EQUIPMENT AND PEDIATRIC CARE.

**PART X, LINE 2:**

**Part XIII** Supplemental Information (continued)

UNITYPOINT HEALTH AND MOST OF ITS SUBSIDIARIES ARE CLASSIFIED AS TAX-EXEMPT ORGANIZATIONS AS DESCRIBED IN SECTIONS 501(C)(3) AND 501(C)(2) OF THE INTERNAL REVENUE CODE (THE CODE). TAX-EXEMPT ORGANIZATIONS ARE NOT SUBJECT TO FEDERAL AND STATE INCOME TAXES ON RELATED INCOME, PURSUANT TO SECTION 501(A) OF THE CODE. THESE ORGANIZATIONS ARE SUBJECT TO FEDERAL AND STATE INCOME TAXES TO THE EXTENT THEY HAVE UNRELATED BUSINESS INCOME AS DESCRIBED UNDER PROVISIONS OF SECTION 511 OF THE CODE.

THE SYSTEM FILES FORM 990 FOR SUBSTANTIALLY ALL OF ITS OPERATING ENTITIES IN THE U.S. FEDERAL JURISDICTION AND IS NO LONGER SUBJECT TO EXAMINATION BY TAX AUTHORITIES FOR THE YEARS BEFORE 2013. THE SYSTEM HAS NO MATERIAL UNCERTAIN TAX POSITIONS.

CERTAIN SUBSIDIARIES ARE SUBJECT TO FEDERAL AND STATE INCOME TAXES. SOME OF THESE CORPORATIONS HAVE ACCUMULATED NET OPERATING LOSS CARRYFORWARDS THAT ARE AVAILABLE TO OFFSET FUTURE TAXABLE INCOME, IF ANY, DURING THE CARRYFORWARD PERIOD. DEFERRED TAX ASSETS AND LIABILITIES RELATED TO THESE SUBSIDIARIES WERE NOT MATERIAL.

## PART XI, LINE 2D - OTHER ADJUSTMENTS:

|   |          |
|---|----------|
| REVENUES IN TEMPORARILY RESTRICTED FUND BALANCE | 104,108. |
| SALES OF INVENTORY                              | 114,585. |
| SELF INSURED TRUST AGREEMENT INVESTMENT         | 253,999. |
| ROUNDING  | 1,210.   |
| TOTAL TO SCHEDULE D, PART XI, LINE 2D           | 473,902. |

## PART XI, LINE 4B - OTHER ADJUSTMENTS:

|                                       |          |
|---------------------------------------|----------|
| REVENUES IN UNRESTRICTED FUND BALANCE | 318,348. |
|---------------------------------------|----------|

**Part XIII** Supplemental Information (continued)

|  |            |
|--|------------|
| IOWA HEALTH SYSTEM CONTRACTING SERVICES PURCHASE REBATES | 141,879.   |
| LOSS ON BOND REFINANCE                                   | 576,465.   |
| TOTAL TO SCHEDULE D, PART XI, LINE 4B                    | 1,036,692. |

PART XII, LINE 2D - OTHER ADJUSTMENTS:

|  |          |
|--|----------|
| SALES OF INVENTORY                     | 114,585. |
| ROUNDING                               | 1,015.   |
| TOTAL TO SCHEDULE D, PART XII, LINE 2D | 115,600. |

PART XII, LINE 4B - OTHER ADJUSTMENTS:

|  |          |
|--|----------|
| EXPENSE IN UNRESTRICTED FUND BALANCE                     | 129,177. |
| IOWA HEALTH SYSTEM CONTRACTING SERVICES PURCHASE REBATES | 141,879. |
| LOSS ON BOND REFINANCE                                   | 576,465. |
| TOTAL TO SCHEDULE D, PART XII, LINE 4B                   | 847,521. |



**SCHEDULE H  
(Form 990)**

**Hospitals**

OMB No. 1545-0047

**2016**

Department of the Treasury  
Internal Revenue Service

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

**Open to Public  
Inspection**

**Name of the organization** **METHODIST MEDICAL CENTER OF ILLINOIS** **Employer identification number** **37-0661223**

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

|  | Yes                                 | No                                  |
|--|-------------------------------------|-------------------------------------|
| <b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a .....  | <input checked="" type="checkbox"/> |                                     |
| <b>b</b> If "Yes," was it a written policy? .....  | <input checked="" type="checkbox"/> |                                     |
| <b>2</b> 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.<br><input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities<br><input type="checkbox"/> Generally tailored to individual hospital facilities |                                     |                                     |
| <b>3</b> 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.  |                                     |                                     |
| <b>a</b> Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care?<br>If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: .....  | <input checked="" type="checkbox"/> |                                     |
| <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %  |                                     |                                     |
| <b>b</b> Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: .....  | <input checked="" type="checkbox"/> |                                     |
| <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other <u>600</u> %   |                                     |                                     |
| <b>c</b> 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.   |                                     |                                     |
| <b>4</b> 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"?  | <input checked="" type="checkbox"/> |                                     |
| <b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? .....  | <input checked="" type="checkbox"/> |                                     |
| <b>b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? .....  |                                     | <input checked="" type="checkbox"/> |
| <b>c</b> 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? .....  |                                     |                                     |
| <b>6a</b> Did the organization prepare a community benefit report during the tax year? .....   | <input checked="" type="checkbox"/> |                                     |
| <b>b</b> If "Yes," did the organization make it available to the public? .....   | <input checked="" type="checkbox"/> |                                     |

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

**7 Financial Assistance and Certain Other Community Benefits at Cost**

|  | (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 |
|--|---|-------------------------------|-------------------------------------|-------------------------------|-----------------------------------|------------------------------|
| <b>Financial Assistance and Means-Tested Government Programs</b>   |   |                               |                                     |                               |                                   |                              |
| <b>a</b> Financial Assistance at cost (from Worksheet 1) .....   |   |                               | 1,892,817.                          |                               | 1,892,817.                        | .49%                         |
| <b>b</b> Medicaid (from Worksheet 3, column a) .....   |   |                               | 78,443,462.                         | 68,908,374.                   | 9,535,088.                        | 2.44%                        |
| <b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b) .....              |   |                               |                                     |                               |                                   |                              |
| <b>d Total</b> Financial Assistance and Means-Tested Government Programs .....                           |   |                               | 80,336,279.                         | 68,908,374.                   | 11,427,905.                       | 2.93%                        |
| <b>Other Benefits</b>  |   |                               |                                     |                               |                                   |                              |
| <b>e</b> Community health improvement services and community benefit operations (from Worksheet 4) ..... |   |                               | 4,393,377.                          | 3,106,771.                    | 1,286,606.                        | .33%                         |
| <b>f</b> Health professions education (from Worksheet 5) .....   |   |                               | 10,752,887.                         | 4,447,828.                    | 6,305,059.                        | 1.62%                        |
| <b>g</b> Subsidized health services (from Worksheet 6) .....   |   |                               | 8,874,773.                          | 7,350,759.                    | 1,524,014.                        | .39%                         |
| <b>h</b> Research (from Worksheet 7) .....   |   |                               |                                     |                               |                                   |                              |
| <b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8) .....                   |   |                               | 1,204,715.                          |                               | 1,204,715.                        | .31%                         |
| <b>j Total.</b> Other Benefits .....   |   |                               | 25,225,752.                         | 14,905,358.                   | 10,320,394.                       | 2.65%                        |
| <b>k Total.</b> Add lines 7d and 7j .....  |   |                               | 105,562,031.                        | 83,813,732.                   | 21,748,299.                       | 5.58%                        |

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

|   | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community building expense | (d) Direct offsetting revenue | (e) Net community building expense | (f) Percent of total expense |
|---|---|-------------------------------|--------------------------------------|-------------------------------|------------------------------------|------------------------------|
| 1 Physical improvements and housing                         |   |                               |                                      |                               |                                    |                              |
| 2 Economic development                                      |   |                               |                                      |                               |                                    |                              |
| 3 Community support   |   |                               | 95,833.                              |                               | 95,833.                            | .02%                         |
| 4 Environmental improvements                                |   |                               |                                      |                               |                                    |                              |
| 5 Leadership development and training for community members |   |                               |                                      |                               |                                    |                              |
| 6 Coalition building  |   |                               | 18,086.                              |                               | 18,086.                            | .00%                         |
| 7 Community health improvement advocacy                     |   |                               |                                      |                               |                                    |                              |
| 8 Workforce development                                     |   |                               |                                      |                               |                                    |                              |
| 9 Other   |   |                               |                                      |                               |                                    |                              |
| 10 Total  |   |                               | 113,919.                             |                               | 113,919.                           | .02%                         |

**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? .....  | X   |    |
| 2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount .....   |     |    |
| 3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit ..... |     |    |
| 4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.  |     |    |

**Section B. Medicare**

|   |   |             |
|---|---|-------------|
| 5 Enter total revenue received from Medicare (including DSH and IME) .....  | 5 | 73,234,690. |
| 6 Enter Medicare allowable costs of care relating to payments on line 5 .....   | 6 | 78,538,435. |
| 7 Subtract line 6 from line 5. This is the surplus (or shortfall) .....   | 7 | -5,303,745. |
| 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:<br><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 | X |  |
| 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 | X |  |

**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 METHODIST MEDICAL CENTER OF IL ORTHOPEDIC CO-MANAGEMENT COMPANY, L.L.C. | ORTHOPEDIC SERVICE LINE MANAGEMENT            | 20.00%   | 8.00%  | 72.00%  |
| 2 METHODIST MEDICAL CENTER OF IL SURGERY CO-MANAGEMENT COMPANY, L.L.C.    | SURGICAL SERVICE LINE MANAGEMENT              | 20.00%   | 9.00%  | 71.00%  |
|   |   |  |  |   |
|   |   |  |  |   |



**Part V Facility Information** (continued)

**Section B. Facility Policies and Practices**

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

Name of hospital facility or letter of facility reporting group FACILITY REPORTING GROUP - A

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1, 2

|  | Yes | No |
|--|-----|----|
| <b>Community Health Needs Assessment</b>   |     |    |
| 1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? .....   |     | X  |
| 2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C .....  |     | X  |
| 3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 .....   | X   |    |
| If "Yes," indicate what the CHNA report describes (check all that apply):  |     |    |
| a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility  |     |    |
| b <input checked="" type="checkbox"/> Demographics of the community  |     |    |
| c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community  |     |    |
| d <input checked="" type="checkbox"/> How data was obtained  |     |    |
| e <input checked="" type="checkbox"/> The significant health needs of the community  |     |    |
| f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups  |     |    |
| g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs  |     |    |
| h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests   |     |    |
| i <input 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>16</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 ..... | X   |    |
| 6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C .....  | X   |    |
| b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C .....  | X   |    |
| 7 Did the hospital facility make its CHNA report widely available to the public? .....   | X   |    |
| If "Yes," indicate how the CHNA report was made widely available (check all that apply):   |     |    |
| a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>WWW.UNITYPOINT.ORG/PEORIA</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 .....  | X   |    |
| 9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>16</u>  |     |    |
| 10 Is the hospital facility's most recently adopted implementation strategy posted on a website? .....   | X   |    |
| a If "Yes," (list url): <u>WWW.UNITYPOINT.ORG/PEORIA</u>   |     |    |
| b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? .....   |     |    |
| 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)? .....  |     | X  |
| b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? .....   |     |    |
| c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$  |     |    |



**Part V Facility Information** (continued)

**Financial Assistance Policy (FAP)**

Name of hospital facility or letter of facility reporting group FACILITY REPORTING GROUP - A

|   |   | Yes | No |
|---|---|-----|----|
| Did the hospital facility have in place during the tax year a written financial assistance policy that:   |   |     |    |
| <b>13</b>   | Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? .....  | X   |    |
| If "Yes," indicate the eligibility criteria explained in the FAP:   |   |     |    |
| <b>a</b>  | <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>600</u> %  |     |    |
| <b>b</b>  | <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)   |     |    |
| <b>c</b>  | <input checked="" type="checkbox"/> Asset level   |     |    |
| <b>d</b>  | <input checked="" type="checkbox"/> Medical indigency   |     |    |
| <b>e</b>  | <input checked="" type="checkbox"/> Insurance status  |     |    |
| <b>f</b>  | <input checked="" type="checkbox"/> Underinsurance status   |     |    |
| <b>g</b>  | <input checked="" type="checkbox"/> Residency   |     |    |
| <b>h</b>  | <input checked="" type="checkbox"/> Other (describe in Section C)   |     |    |
| <b>14</b>   | Explained the basis for calculating amounts charged to patients? .....  | X   |    |
| <b>15</b>   | Explained the method for applying for financial assistance? .....   | X   |    |
| If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply): |   |     |    |
| <b>a</b>  | <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application  |     |    |
| <b>b</b>  | <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application  |     |    |
| <b>c</b>  | <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process  |     |    |
| <b>d</b>  | <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications  |     |    |
| <b>e</b>  | <input type="checkbox"/> Other (describe in Section C)  |     |    |
| <b>16</b>   | Was widely publicized within the community served by the hospital facility? .....   | X   |    |
| If "Yes," indicate how the hospital facility publicized the policy (check all that apply):  |   |     |    |
| <b>a</b>  | <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>WWW.UNITYPOINT.ORG/PEORIA/FINANCIAL-ASSISTANCE</u>   |     |    |
| <b>b</b>  | <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>  |     |    |
| <b>c</b>  | <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>   |     |    |
| <b>d</b>  | <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)  |     |    |
| <b>e</b>  | <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)   |     |    |
| <b>f</b>  | <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)  |     |    |
| <b>g</b>  | <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention |     |    |
| <b>h</b>  | <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP   |     |    |
| <b>i</b>  | <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations   |     |    |
| <b>j</b>  | <input type="checkbox"/> Other (describe in Section C)  |     |    |

**Part V Facility Information** (continued)

**Billing and Collections**

Name of hospital facility or letter of facility reporting group FACILITY REPORTING GROUP - A

|   | Yes | No |
|---|-----|----|
| <b>17</b> Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment? ..... | X   |    |
| <b>18</b> Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:                            |     |    |
| <b>a</b> <input type="checkbox"/> Reporting to credit agency(ies)   |     |    |
| <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party   |     |    |
| <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP  |     |    |
| <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process  |     |    |
| <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)   |     |    |
| <b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted  |     |    |
| <b>19</b> Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? .....   |     | X  |
| If "Yes," check all actions in which the hospital facility or a third party engaged:  |     |    |
| <b>a</b> <input type="checkbox"/> Reporting to credit agency(ies)   |     |    |
| <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party   |     |    |
| <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP  |     |    |
| <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process  |     |    |
| <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)   |     |    |
| <b>20</b> Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):   |     |    |
| <b>a</b> <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs  |     |    |
| <b>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process  |     |    |
| <b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications   |     |    |
| <b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations  |     |    |
| <b>e</b> <input type="checkbox"/> Other (describe in Section C)   |     |    |
| <b>f</b> <input type="checkbox"/> None of these efforts were made   |     |    |

**Policy Relating to Emergency Medical Care**

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

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

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

Name of hospital facility or letter of facility reporting group FACILITY REPORTING GROUP - A

|           |   | Yes       | No       |
|-----------|---|-----------|----------|
| <b>22</b> | 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.  |           |          |
| <b>a</b>  | <input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period   |           |          |
| <b>b</b>  | <input checked="" type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period   |           |          |
| <b>c</b>  | <input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period                              |           |          |
| <b>d</b>  | <input type="checkbox"/> The hospital facility used a prospective Medicare or Medicaid method   |           |          |
| <b>23</b> | 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? .....<br>If "Yes," explain in Section C. | <b>23</b> | <b>X</b> |
| <b>24</b> | 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? .....<br>If "Yes," explain in Section C.   | <b>24</b> | <b>X</b> |

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

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

FACILITY REPORTING GROUP - A

PART V, LINE 16B, FAP APPLICATION WEBSITE:

WWW.UNITYPOINT.ORG/PEORIA/FINANCIAL-ASSISTANCE

FACILITY REPORTING GROUP - A

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

WWW.UNITYPOINT.ORG/PEORIA/FINANCIAL-ASSISTANCE

SCHEDULE H, PART V, SECTION B. FACILITY REPORTING GROUP A

FACILITY REPORTING GROUP A CONSISTS OF:

- FACILITY 1: METHODIST MEDICAL CENTER OF ILLINOIS
- FACILITY 2: GREATER PEORIA SPECIALTY HOSPITAL

GROUP A-FACILITY 1 -- METHODIST MEDICAL CENTER OF ILLINOIS

PART V, SECTION B, LINE 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.

THE COMMUNITY HEALTH NEEDS ASSESSMENT WAS A COLLABORATIVE UNDERTAKING BY ORGANIZATIONS THAT REPRESENT THE INTERESTS OF THE POPULATION SERVED BY THE HOSPITAL. IN ADDITION TO HOSPITAL MEMBERS, THE COLLABORATIVE INCLUDED THE PEORIA CITY/COUNTY HEALTH DEPARTMENT, TAZEWELL COUNTY HEALTH DEPARTMENT,

**Part V** Facility Information (continued)

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

WOODFORD COUNTY HEALTH DEPARTMENT, HEART OF ILLINOIS UNITED WAY AND HEARTLAND COMMUNITY HEALTH CLINIC (A FEDERALLY QUALIFIED HEALTH CARE CENTER). EACH OF THESE ORGANIZATIONS SERVE/REPRESENT BOTH THE GENERAL AND AT-RISK POPULATION OF THE PRIMARY SERVICE AREA.

IN ADDITION TO BROAD BASED REPRESENTATION ON THE COLLABORATIVE, THE CHNA INCLUDES A DETAILED ANALYSIS OF PRIMARY DATA COLLECTED FOR THE GENERAL POPULATION AND THE AT-RISK OR ECONOMICALLY DISADVANTAGED POPULATION. AREAS OF INVESTIGATION INCLUDED PERCEPTIONS OF THE COMMUNITY HEALTH ISSUES, UNHEALTHY BEHAVIORS, ISSUES WITH QUALITY OF LIFE, HEALTH BEHAVIORS AND ACCESS TO MEDICAL CARE, DENTAL CARE, PRESCRIPTION MEDICATIONS AND MENTAL HEALTH COUNSELING. ADDITIONALLY, DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS WERE UTILIZED TO PROVIDE INSIGHTS INTO WHY CERTAIN SEGMENTS OF THE POPULATION BEHAVED DIFFERENTLY.

GROUP A-FACILITY 1 -- METHODIST MEDICAL CENTER OF ILLINOIS  
PART V, SECTION B, LINE 6A: METHODIST MEDICAL CENTER OF ILLINOIS' CHNA WAS A COLLABORATIVE UNDERTAKING BY PROCTOR HOSPITAL, METHODIST MEDICAL CENTER OF ILLINOIS, KINDRED HOSPITAL, ADVOCATE EUREKA HOSPITAL, HOPEDALE MEDICAL CENTER, PEKIN HOSPITAL AND OSF SAINT FRANCIS MEDICAL CENTER TO HIGHLIGHT THE HEALTH NEEDS AND WELL-BEING OF RESIDENTS IN PEORIA, TAZEWELL, AND WOODFORD COUNTIES.

GROUP A-FACILITY 1 -- METHODIST MEDICAL CENTER OF ILLINOIS  
PART V, SECTION B, LINE 6B: PEORIA CITY/COUNTY HEALTH DEPARTMENT, TAZEWELL COUNTY HEALTH DEPARTMENT, WOODFORD COUNTY HEALTH DEPARTMENT, HEART OF ILLINOIS UNITED WAY, HEARTLAND COMMUNITY HEALTH CLINIC AND BRADLEY

**Part V** Facility Information (continued)

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

UNIVERSITY.

GROUP A-FACILITY 1 -- METHODIST MEDICAL CENTER OF ILLINOIS

PART V, SECTION B, LINE 11: PUBLIC LAW REQUIRES CHARITABLE HOSPITAL

ORGANIZATIONS TO CONDUCT A COMMUNITY HEALTH NEEDS ASSESSMENT AT LEAST ONCE

EVERY THREE YEARS AND TO ADOPT AN IMPLEMENTATION STRATEGY TO MEET THE

COMMUNITY HEALTH NEEDS IDENTIFIED THROUGH THE CHNA. UPH METHODIST AND UPH

PROCTOR ARE IN THE THIRD YEAR OF AN IMPLEMENTATION PLAN TO ADDRESS THE

COMMUNITY NEEDS IDENTIFIED IN THE LOCAL ASSESSMENT THAT WAS DONE IN 2013.

A COPY OF THE PLAN IS ATTACHED IN 10B. A STEERING COMMITTEE COMPRISED OF

MEMBERS FROM THE THREE LOCAL HOSPITALS, COUNTY HEALTH DEPARTMENT

REPRESENTATIVES FROM THE THREE COUNTIES IN THE PRIMARY SERVICE AREA, AND

REPRESENTATIVES FROM THE UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE AT

PEORIA, THE HEART OF ILLINOIS UNITED WAY, AND THE HEARTLAND COMMUNITY

HEALTH CLINIC IDENTIFIED EIGHT CRITICAL HEALTH RELATED ISSUES THAT NEEDED

ADDRESSED:

- ACCESS TO HEALTHCARE

- RISKY BEHAVIORS

- ASTHMA

- DIABETES

- HEALTHY BEHAVIORS

- LUNG CANCER

- MENTAL HEALTH

- OBESITY

UPH - METHODIST AND UPH - PROCTOR CHOSE TO DEPLOY RESOURCES TO ADDRESS ALL

EIGHT ISSUES. BY PROVIDING FINANCIAL AND MANPOWER SUPPORT AND THROUGH

**Part V Facility Information** (continued)

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

UNITYPOINT CLINICS, THE IN-SCHOOL HEALTH PROGRAM, THE WELLMOBILE, THE HULT EDUCATION CENTER AND OTHER RESOURCES, THE TWO HOSPITALS HAVE IMPROVED THE HEALTH AND LIVES OF AREA RESIDENTS. A SUMMARY OF THE EFFORTS BEING MADE IS PROVIDED BELOW:

**ACCESS:**

PRIMARY CARE, DENTAL CARE AND COUNSELING SERVICES WERE IDENTIFIED AS ACCESS ISSUES. THROUGH THE DEPLOYMENT OF THE RESOURCES LISTED, ACCESS WAS EXPANDED IN ALL THREE AREAS. FOR EXAMPLE, ED DENTAL VISITS DECLINED FROM 1,380 IN 2012 TO 1,281 IN 2014.

**RISKY BEHAVIORS:**

TO ADDRESS RISKY BEHAVIORS, UPH - METHODIST AND UPH - PROCTOR IDENTIFIED A GOAL OF DECREASING THE RATE OF ADULT SMOKING BY 1% AND EDUCATING YOUTH ON THE DANGERS OF ALCOHOL, TOBACCO, AND DRUG USE. A SMOKER REGISTRY WAS DEVELOPED IN THE UNITYPOINT CLINICS ALONG WITH CESSATION PROGRAMS AND HEALTH INSURANCE INCENTIVES FOR PLAN PARTICIPANTS THAT ARE NON-SMOKERS. THE KIDS KONNECTED PROGRAM OFFERS EDUCATION ON THE DANGERS OF TOBACCO AND DRUG USAGE AND PSYCHOSOCIAL COUNSELING IS OFFERED TO YOUTH THROUGH IN-SCHOOL HEALTH AT NO COST.

**ASTHMA:**

OUR IN-SCHOOL HEALTH COLLABORATED WITH THE LOCAL PEORIA SCHOOL DISTRICT TO PROVIDE ASTHMA EDUCATION TO STUDENTS AND FAMILIES TO HELP IMPROVE ADHERENCE TO TREATMENT PROTOCOLS AND HELP WITH EARLY IDENTIFICATION AND DIAGNOSIS OF ASTHMATIC CHILDREN.

**Part V Facility Information** (continued)

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

**DIABETES:**

MANAGEMENT OF ADULT AND CHILDHOOD DIABETES IS BEING ADDRESSED WITH THE DEVELOPMENT OF A DIABETIC REGISTRY IN THE UNITYPOINT CLINICS AND THROUGH EDUCATION PROGRAMS OFFERED THROUGH THE DIABETIC CENTER AND HULT. HGBA1C MEASURES ARE TRACKED FOR AT-RISK PATIENTS AND LIFESTYLE COACHING AND NUTRITION EDUCATION ARE PROVIDED.

**HEALTHY BEHAVIORS:**

EXERCISE AND DIET WERE IDENTIFIED AS HEALTHY BEHAVIORS THAT NEEDED IMPROVEMENT. COACHING IS PROVIDED FOR AT RISK PATIENTS THROUGH THE UNITYPOINT CLINICS AND THE IMPORTANCE OF EXERCISE AND GOOD NUTRITION IS EMPHASIZED THROUGH EDUCATIONAL PROGRAMS FOR YOUTH THROUGH IN-SCHOOL HEALTH AND THROUGH HULT.

**LUNG CANCER:**

BOTH LOW COST AND FREE SCREENINGS ARE OFFERED TO HELP EARLY DIAGNOSE LUNG CANCER AND DECREASE LUNG CANCER MORTALITY. OVER 80 STAGE I LUNG CANCER CASES HAVE BEEN DIAGNOSED SINCE THE PROGRAM BEGAN THAT MAY HAVE OTHERWISE GONE UNDETECTED.

**MENTAL HEALTH:**

ACCESS TO GOOD MENTAL HEALTH CARE IS AN ISSUE IN THE SERVICE AREA. 25% OF AREA RESIDENTS SURVEYED IDENTIFIED THAT THEY EXPERIENCED POOR MENTAL HEALTH BETWEEN 1 AND 7 DAYS EACH MONTH. UPH COLLABORATED WITH THE FAYETTE COMPANIES AND UICOMP TO REDUCE ACUTE CARE UTILIZATION FOR BEHAVIORAL DISORDERS THROUGH IMPROVED ACCESS TO COMMUNITY-BASED MENTAL HEALTH PROVIDERS AND THROUGH PRIMARY CARE SCREENING FOR DEPRESSION. THIRTY DAY



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

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

READMISSION RATES FOR BEHAVIORAL HEALTH DIAGNOSIS HAVE DECREASED FROM 13.6% IN 2012 TO 12.8% IN 2015.

## OBESITY:

OBESITY IN THE AREA POPULATION IS SLIGHTLY HIGHER THAN THE ILLINOIS AVERAGE. ILLINOIS, HOWEVER, HAS THE 6TH HIGHEST OBESITY RATE IN THE U.S. OBESITY IS LINKED TO MANY CHRONIC DISEASES INCLUDING DIABETES, HYPERTENSION, HIGH BLOOD PRESSURE AND ORTHOPEDIC PROBLEMS. UPH METHODIST AND UPH PROCTOR SET OUT TO REDUCE THE INCIDENCE OF OBESITY AMONG UNITYPOINT CLINIC PATIENTS AND UNITYPOINT HEALTH METHODIST | PROCTOR EMPLOYEES THROUGH CLINIC EDUCATION, HEALTH PLAN PREMIUM INCENTIVES AND FREE LIFESTYLE COACHING AND COUNSELING FOR AT RISK PATIENTS. THE GOAL WAS TO ASSURE THAT 95% OF ALL UPC PATIENTS HAD A CURRENT BMI RECORDED SO THAT PROGRESS TOWARD WEIGHT LOSS COULD BE MONITORED. 98.7% OF ALL UPC PATIENTS HAVE A BMI DOCUMENTED WITHIN THE LAST YEAR.

MORE DETAIL IS AVAILABLE IN THE CURRENT CHNA IMPLEMENTATION PLAN DOCUMENT ATTACHED IN 10B. A NEW COMMUNITY HEALTH NEEDS ASSESSMENT WILL BE CONDUCTED IN 2016.

## GROUP A-FACILITY 1 -- METHODIST MEDICAL CENTER OF ILLINOIS

PART V, SECTION B, LINE 13H: PATIENTS WHO QUALIFY AND ARE RECEIVING BENEFITS FROM THE FOLLOWING PROGRAMS MAY BE PRESUMED ELIGIBLE FOR 100% FINANCIAL ASSISTANCE: THE US. DEPARTMENT OF AGRICULTURE FOOD AND NUTRITION SERVICE FOOD STAMP PROGRAM; WOMEN, INFANTS & CHILDREN (WIC); AND VARIOUS COUNTY AND STATE RELIEF PROGRAMS. THIRD PARTY AGENCIES ARE USED TO ASSIST WITH COLLECTIONS AND, IF THOSE AGENCIES PROVIDE A STATEMENT

**Part V Facility Information** (continued)

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

REGARDING A PATIENT'S LIKELY INCOME LEVEL, THAT INFORMATION IS USED IN DETERMINING THE ELIGIBILITY STATUS AND THE LEVEL OF DISCOUNT AVAILABLE.

GROUP A-FACILITY 2 -- GREATER PEORIA SPECIALTY HOSPITAL

PART V, SECTION B, LINE 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.

THE COMMUNITY HEALTH NEEDS ASSESSMENT WAS A COLLABORATIVE UNDERTAKING BY ORGANIZATIONS THAT REPRESENT THE INTERESTS OF THE POPULATION SERVED BY THE HOSPITAL. IN ADDITION TO HOSPITAL MEMBERS, THE COLLABORATIVE INCLUDED THE PEORIA CITY/COUNTY HEALTH DEPARTMENT, TAZEWEEL COUNTY HEALTH DEPARTMENT, WOODFORD COUNTY HEALTH DEPARTMENT, HEART OF ILLINOIS UNITED WAY AND HEARTLAND COMMUNITY HEALTH CLINIC (A FEDERALLY QUALIFIED HEALTH CARE CENTER). EACH OF THESE ORGANIZATIONS SERVE/REPRESENT BOTH THE GENERAL AND AT-RISK POPULATION OF THE PRIMARY SERVICE AREA.

IN ADDITION TO BROAD BASED REPRESENTATION ON THE COLLABORATIVE, THE CHNA INCLUDES A DETAILED ANALYSIS OF PRIMARY DATA COLLECTED FOR THE GENERAL POPULATION AND THE AT-RISK OR ECONOMICALLY DISADVANTAGED POPULATION. AREAS OF INVESTIGATION INCLUDED PERCEPTIONS OF THE COMMUNITY HEALTH ISSUES, UNHEALTHY BEHAVIORS, ISSUES WITH QUALITY OF LIFE, HEALTH BEHAVIORS AND ACCESS TO MEDICAL CARE, DENTAL CARE, PRESCRIPTION MEDICATIONS AND

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

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

MENTAL HEALTH COUNSELING. ADDITIONALLY, DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS WERE UTILIZED TO PROVIDE INSIGHTS INTO WHY CERTAIN SEGMENTS OF THE POPULATION BEHAVED DIFFERENTLY.

GROUP A-FACILITY 2 -- GREATER PEORIA SPECIALTY HOSPITAL

PART V, SECTION B, LINE 6A: METHODIST MEDICAL CENTER OF ILLINOIS' CHNA WAS A COLLABORATIVE UNDERTAKING BY PROCTOR HOSPITAL, METHODIST MEDICAL CENTER OF ILLINOIS, KINDRED HOSPITAL, ADVOCATE EUREKA HOSPITAL, HOPEDALE MEDICAL CENTER, PEKIN HOSPITAL AND OSF SAINT FRANCIS MEDICAL CENTER TO HIGHLIGHT THE HEALTH NEEDS AND WELL-BEING OF RESIDENTS IN PEORIA, TAZEWELL, AND WOODFORD COUNTIES.

GROUP A-FACILITY 2 -- GREATER PEORIA SPECIALTY HOSPITAL

PART V, SECTION B, LINE 6B: PEORIA CITY/COUNTY HEALTH DEPARTMENT, TAZEWELL COUNTY HEALTH DEPARTMENT, WOODFORD COUNTY HEALTH DEPARTMENT, HEART OF ILLINOIS UNITED WAY, HEARTLAND COMMUNITY HEALTH CLINIC AND BRADLEY UNIVERSITY.

GROUP A-FACILITY 2 -- GREATER PEORIA SPECIALTY HOSPITAL

PART V, SECTION B, LINE 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.

THE CHNA IDENTIFIED 11 POTENTIAL HEALTH RELATED ISSUES. THE METHODIST GOVERNING BOARD REVIEWED THE IDENTIFIED HEALTH ISSUES AND SELECTED FIVE AREAS AS HAVING THE HIGHEST PRIORITY: HEALTHY BEHAVIORS (HEALTHY EATING

**Part V Facility Information** (continued)

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

AND ACTIVE LIVING), MENTAL HEALTH, ACCESS TO HEALTHCARE, SUBSTANCE ABUSE, AND CANCER. IN MAKING ITS SELECTION, THE GOVERNING BOARD EVALUATED EXISTING PROGRAMS AND RESOURCES WITHIN METHODIST IN ORDER TO OPTIMIZE THE IMPACT OF OUR EFFORTS AND ACHIEVE STRATEGIC ALIGNMENT. THE GOVERNING BOARD FURTHER EVALUATED THE DEPLOYMENT OF OTHER COMMUNITY RESOURCES IN ADDRESSING THE HEALTH NEEDS IDENTIFIED IN ORDER TO BALANCE THE COMMUNITY'S RESPONSE AND AVOID DUPLICATION OF EFFORT. THE HEALTH NEEDS THAT ARE NOT LISTED IN THE CHNA IMPLEMENTATION PLAN ARE STILL BEING ADDRESSED THROUGH EXISTING METHODIST PROGRAMS AND BY THE SERVICES OFFERED BY OTHER COMMUNITY ORGANIZATIONS.

THE FIVE AREAS OF FOCUS SELECTED BY THE GOVERNING BOARD ARE BEING ADDRESSED THROUGH AN IMPLEMENTATION PLAN. AN ACTION PLAN HAS BEEN DEVELOPED FOR EACH HEALTH ISSUE DETAILING THE IDENTIFIED NEED, OBJECTIVES, COLLABORATORS, EXISTING RESOURCES, ACTION STEPS TO ADDRESS THE NEED, RESOURCE COMMITMENT AND METRICS. EXECUTION OF THE IMPLEMENTATION PLAN IS MONITORED BY A CROSS-FUNCTIONAL COMMITTEE CONSISTING OF THE INDIVIDUALS RESPONSIBLE FOR ADDRESSING EACH PRIORITY HEALTH NEED.

GROUP A-FACILITY 2 -- GREATER PEORIA SPECIALTY HOSPITAL  
PART V, SECTION B, LINE 13H: PATIENTS WHO QUALIFY AND ARE RECEIVING BENEFITS FROM THE FOLLOWING PROGRAMS MAY BE PRESUMED ELIGIBLE FOR 100% FINANCIAL ASSISTANCE: THE US. DEPARTMENT OF AGRICULTURE FOOD AND NUTRITION SERVICE FOOD STAMP PROGRAM; WOMEN, INFANTS & CHILDREN (WIC); AND VARIOUS COUNTY AND STATE RELIEF PROGRAMS. THIRD PARTY AGENCIES ARE USED TO ASSIST WITH COLLECTIONS AND, IF THOSE AGENCIES PROVIDE A STATEMENT REGARDING A PATIENT'S LIKELY INCOME LEVEL, THAT INFORMATION IS USED IN

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

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

**DETERMINING THE ELIGIBILITY STATUS AND THE LEVEL OF DISCOUNT AVAILABLE.**

Multiple horizontal lines for data entry.

**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? 27

| Name and address  | Type of Facility (describe)                                    |
|---|--|
| 1 UPHM EAST CAMPUS<br>415 ST. MARKS COURT<br>PEORIA, IL 61603                 | METHODIST COLLEGE OF NURSING;<br>DAYCARE; ADMINISTRATION       |
| 2 UPHM HEART, LUNG, AND VASCULAR INST<br>112 CRESCENT AVE<br>PEORIA, IL 61603 | PHYSICIAN OFFICES; MEDICAL<br>IMAGING; CARDIOLOGY              |
| 3 UPHM ATRIUM<br>900 MAIN STREET<br>PEORIA, IL 61602                          | PHYSICIAN OFFICES;<br>REHABILITATION; SLEEP LAB,<br>WOUND CARE |
| 4 UPHM FAMILY MEDICAL CENTER<br>815 MAIN STREET<br>PEORIA, IL 61602           | PHYSICIAN OFFICES  |
| 5 UPHM AT FARMINGTON<br>158 E. FULTON AVENUE<br>FARMINGTON, IL 61531          | PHYSICIAN OFFICES  |
| 6 UPHM CENTER FOR WOMENS HEALTH<br>9101 N. ALLEN ROAD<br>PEORIA, IL 61615     | PHYSICIAN OFFICES  |
| 7 UPHM AT CHILLICOTHE<br>525 SWEETBRIAR<br>CHILLICOTHE, IL 61523              | PHYSICIAN OFFICES;<br>REHABILITATION                           |
| 8 UPHM AT METAMORA<br>901 W. WALNUT<br>METAMORA, IL 61548                     | PHYSICIAN OFFICES  |
| 9 UPHM AT PRINCEVILLE<br>223 EAST MAIN STREET<br>PRINCEVILLE, IL 61559        | PHYSICIAN OFFICES  |
| 10 UPHM NORTH<br>2338 WEST SUDS PKWY<br>PEORIA, IL 61615                      | PHYSICIAN OFFICES;<br>REHABILITATION; DIAGNOSTIC<br>TESTING    |

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

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

How many non-hospital health care facilities did the organization operate during the tax year? 27

| Name and address   | Type of Facility (describe)          |
|--|--------------------------------------|
| 11 UPHM AT CANTON<br>2076 N. MAIN STREET<br>CANTON, IL 61520               | PHYSICIAN OFFICES                    |
| 12 UPHM AT LACON<br>1112 E. FIFTH STREET<br>LACON, IL 61540                | PHYSICIAN OFFICES                    |
| 13 UPHM AT EAST PEORIA<br>200 RIVER ROAD<br>EAST PEORIA, IL 61611          | PHYSICIAN OFFICES                    |
| 14 UPHM AT KNOXVILLE<br>2709 N. KNOXVILLE AVE<br>PEORIA, IL 61604          | PHYSICIAN OFFICES                    |
| 15 UPHM GLEN OAK MEDICAL CENTER<br>120 NE GLEN OAK AVE<br>PEORIA, IL 61602 | ADMINISTRATION                       |
| 16 UPHM AT STERLING<br>3335 N. STERLING AVE<br>PEORIA, IL 61615            | PHYSICIAN OFFICES                    |
| 17 UPHM MEDPOINTE AT PEORIA<br>8914 N. KNOXVILLE AVE<br>PEORIA, IL 61615   | PHYSICIAN OFFICES                    |
| 18 UPHM AT MORTON<br>1909 N. MORTON AVE<br>MORTON, IL 61550                | PHYSICIAN OFFICES;<br>REHABILITATION |
| 19 UPHM AT PEKIN<br>1800 BROADWAY<br>PEKIN, IL 61554                       | PHYSICIAN OFFICES                    |
| 20 UPHM AT PEARTREE<br>6831 N. PEAR TREE LANE<br>PEORIA, IL 61615          | PHYSICIAN OFFICES                    |

Schedule H (Form 990) 2016

**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? 27

| Name and address   | Type of Facility (describe)          |
|--|--------------------------------------|
| 21 UPHM ON SOUTH JEFFERSON<br>2127 SE JEFFERSON<br>PEORIA, IL 61605                          | PHYSICIAN OFFICES                    |
| 22 UPHM CARDIOLOGY<br>765 KELLOGG STREET<br>GALESBURG, IL 61401                              | PHYSICIAN OFFICES                    |
| 23 CENTRAL ILLINOIS CANCER CARE CENTER<br>7309 N. KNOXVILLE AVE<br>PEORIA, IL 61614          | OUTPATIENT RADIATION THERAPY         |
| 24 CENTRAL ILLINOIS ENDOSCOPY CENTER<br>1001 MAIN ST, SUITE 500B<br>PEORIA, IL 61606         | ENDOSCOPY SERVICES                   |
| 25 ILLINOIS WORK INJURY RESOURCE CENTER<br>736 SW WASHINGTON ST, SUITE 2<br>PEORIA, IL 61602 | OCCUPATIONAL MEDICINE                |
| 26 UPHM AT WASHINGTON<br>205 CUMMINGS LANE<br>WASHINGTON, IL 61571                           | PHYSICIAN OFFICES;<br>REHABILITATION |
| 27 REHABILITATION THERAPY SERVICES<br>2988 COURT STREET<br>PEKIN, IL 61554                   | REHABILITATION                       |
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**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.

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**PART I, LINE 6A:**

METHODIST MEDICAL CENTER OF ILLINOIS' COMMUNITY BENEFIT REPORT IS CONTAINED WITHIN THE UNITYPOINT HEALTH COMMUNITY BENEFIT REPORT WHICH CAN BE LOCATED AT WWW.UNITYPOINT.ORG. THIS SYSTEM-WIDE REPORT IS COMPLETED IN ADDITION TO THE COMMUNITY BENEFIT REPORT FOR THE HOSPITAL AND ITS REGIONAL AFFILIATES.

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**PART I, LINE 7:**

A COST-TO-CHARGE RATIO (FROM WORKSHEET 2) IS USED TO CALCULATE THE AMOUNTS ON LINE 7A. THE AMOUNTS ON LINES 7B-7C (UNREIMBURSED MEDICAID AND OTHER MEANS-TESTED GOVERNMENT PROGRAMS) ARE OBTAINED FROM A COST ACCOUNTING SYSTEM OF APPLICABLE PATIENT SEGMENTS. SEGMENTS NOT PASSED TO COST ACCOUNTING SYSTEM USE COST-TO-CHARGE RATIO. THE AMOUNTS FOR LINES 7E, F, H, AND I WOULD COME FROM THE BOOKS AND RECORDS OF SPECIFIC SEGMENTS OF THE ORGANIZATION AND ARE BASED ON COST. THE AMOUNTS ON 7G ARE DERIVED FROM A COST ACCOUNTING SYSTEM OF APPLICABLE PATIENT SEGMENTS. SEGMENTS NOT PASSED TO A COST ACCOUNTING SYSTEM USE THE COST-TO-CHARGE RATIO.

**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.

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**PART I, LINE 7G:**

METHODIST SUBSIDIZES SEVERAL PEDIATRIC HEALTH SERVICES INCLUDING PEDIATRIC GASTROENTEROLOGY ALONG WITH CHILD AND ADOLESCENT PSYCHIATRY INPATIENT HEALTH SERVICES AND PERINATOLOGY AT THE MEDICAL CENTER. THE MEDICAL CENTER ALSO SUBSIDIZED HOSPICE, IN-SCHOOL HEALTH AND GERIATRIC SERVICES IN 2016.

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**PART I, LINE 7, COLUMN (F):**

THE BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25(A), BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGE IN THIS COLUMN IS \$ 62,223.

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**PART II, COMMUNITY BUILDING ACTIVITIES:**

COMMUNITY BUILDING ACTIVITIES ARE ESSENTIAL ROLES FOR HEALTH-CARE ORGANIZATIONS IN THAT THEY ADDRESS MANY OF THE UNDERLYING DETERMINANTS OF HEALTH. RESEARCH HAS CONTINUALLY SHOWN THAT WHEN THE FACTORS INFLUENCING HEALTH ARE EXPLORED, HEALTH CARE ACTUALLY PLAYS THE SMALLEST ROLE PROPORTIONATELY. A REPORT IN THE JOURNAL OF AMERICAN MEDICAL ASSOCIATION

**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.
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- 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.

AND THE CENTER FOR DISEASE CONTROL (MCGINNIS, 1996) SUGGESTS THAT THE FACTORS IMPACTING HEALTH ARE AS FOLLOWS: LIFESTYLE AND BEHAVIORS, 50%, ENVIRONMENT (HUMAN AND NATURAL), 20%, GENETICS AND HUMAN BIOLOGY, 20%, AND HEALTH CARE, 10%. COMMUNITY BUILDING ACTIVITIES HELP TO ADDRESS THE OTHER INDICATORS OUTSIDE OF THE ROLE TRADITIONALLY PLAYED BY HEALTH-CARE ORGANIZATIONS. THESE ACTIVITIES ARE ALMOST EXCLUSIVELY DONE IN SOME FORM OF PARTNERSHIP IN WHICH THE COMMUNITY OR OTHER ORGANIZATIONS ARE BETTER SUITED TO ADDRESS. HEALTH-CARE ORGANIZATIONS GENERALLY PROVIDE TIMELY AND SPECIFIC RESOURCES TO HELP THESE ISSUES. HEALTH-CARE ORGANIZATIONS CAN BE A RICH AND VALUABLE COMMUNITY RESOURCE IN WAYS NOT TYPICALLY CONSIDERED. OFTEN THE MOST EFFECTIVE WAY TO HELP IMPACT AND IMPROVE THE COMMUNITY HEALTH STATUS IS TO SUPPORT OTHER AGENCIES AND ORGANIZATIONS IN A VARIETY OF WAYS OUTSIDE OF HEALTH SERVICES. THIS IS OFTEN DONE THROUGH CASH OR IN-KIND SERVICES TO SUPPORT OTHER NON-PROFITS, DONATIONS OF DURABLE MEDICAL EQUIPMENT AND SUPPLIES TO CERTAIN AGENCIES, OR THROUGH LEADERSHIP AND EDUCATIONAL EXPERTISE. METHODIST CONTRIBUTES TO MANY AREA COMMUNITY BUILDING ACTIVITIES IN CENTRAL ILLINOIS. THESE ORGANIZATIONS HELP BUILD ACTIVITIES IN THE AREAS OF ECONOMIC AND HEALTHCARE IMPROVEMENT. THESE

**Part VI Supplemental Information**

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TYPES OF ACTIVITIES SPEAK TO THE BREADTH AND CAPACITY THAT THE HOSPITAL HAS IN IMPACTING THE HEALTH STATUS OF THE COMMUNITY IN A COMPREHENSIVE AND INTENTIONAL APPROACH.

PART III, LINE 4:

THE HEALTH SYSTEM PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS BASED UPON A REVIEW OF OUTSTANDING RECEIVABLES, HISTORICAL COLLECTION INFORMATION AND EXISTING ECONOMIC CONDITIONS. AS A SERVICE TO THE PATIENT, THE HEALTH SYSTEM BILLS THIRD-PARTY PAYERS DIRECTLY AND BILLS THE PATIENT WHEN THE PATIENT'S LIABILITY IS DETERMINED. PATIENT ACCOUNTS RECEIVABLE ARE DUE IN FULL WHEN BILLED. ACCOUNTS ARE CONSIDERED DELINQUENT AND SUBSEQUENTLY WRITTEN OFF AS BAD DEBTS BASED ON INDIVIDUAL CREDIT EVALUATION AND SPECIFIC CIRCUMSTANCES OF THE ACCOUNT.

THE AMOUNT REPORTED ON LINE 2 WAS CALCULATED USING IRS WORKSHEET 2 'RATIO OF PATIENT CARE COST TO CHARGES' TO CALCULATE THE COST TO CHARGE RATIO FOR THE FINLEY HOSPITAL. THIS RATIO WAS THEN APPLIED AGAINST THE BAD DEBT ATTRIBUTABLE TO PATIENT ACCOUNTS USING IRS WORKSHEET A TO ARRIVE AT THE

**Part VI Supplemental Information**

Provide the following information.

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- 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.

BAD DEBT EXPENSE AT COST REPORTED ON LINE 2.

PART III, LINE 8:

AMOUNTS ON LINE 6 WERE CALCULATED USING IRS WORKSHEET B 'TOTAL MEDICARE ALLOWABLE COSTS.' THE MEDICARE ALLOWABLE COSTS WERE OBTAINED FROM THE MEDICARE COST REPORTS AND THEN REDUCED BY ANY AMOUNTS ALREADY CAPTURED IN COMMUNITY BENEFIT EXPENSE IN PART I ABOVE.

THE METHODOLOGY DESCRIBED IN THE INSTRUCTIONS TO SCHEDULE H, PART III, SECTION B, LINE 6 DOES NOT TAKE INTO ACCOUNT ALL COSTS INCURRED BY THE HOSPITAL AND DOES NOT REPRESENT THE TOTAL COMMUNITY BENEFIT CONFERRED IN THIS AREA. THE MEDICARE SHORTFALL REFLECTED ON SCHEDULE H, PART III, SECTION B WAS DETERMINED USING INFORMATION FROM THE ORGANIZATION'S MEDICARE COST REPORT. HOWEVER THE MEDICARE COST REPORT DISALLOWS CERTAIN ITEMS THAT WE BELIEVE ARE LEGITIMATE EXPENSES INCURRED IN THE PROCESS OF CARING FOR OUR MEDICARE PATIENTS. EXAMPLES OF THESE ITEMS INCLUDE PROVIDER BASED PHYSICIAN EXPENSE, SELF INSURANCE EXPENSE, HOME OFFICE EXPENSE AND THE SHORTFALL FROM FEE SCHEDULE PAYMENTS.

**Part VI Supplemental Information**

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 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.

THE HOSPITAL BELIEVES THE ENTIRE AMOUNT OF THE MEDICARE SHORTFALL SHOULD BE TREATED AS COMMUNITY BENEFIT, MORE SPECIFICALLY, AS CHARITY CARE. THE ELDERLY CONSTITUTE A CLEARLY-RECOGNIZED CHARITABLE CLASS, AND MANY MEDICARE BENEFICIARIES, LIKE THEIR MEDICAID COUNTERPARTS, ARE POOR AND THUS WOULD HAVE QUALIFIED FOR THE HOSPITAL'S CHARITY CARE PROGRAM, MEDICAID OR OTHER NEEDS-BASED GOVERNMENT PROGRAMS ABSENT THE MEDICARE PROGRAM. BY ACCEPTING PAYMENT BELOW COST TO TREAT THESE INDIVIDUALS, THE BURDENS OF GOVERNMENT ARE RELIEVED WITH RESPECT TO THESE INDIVIDUALS. ADDITIONALLY, THERE IS A SIGNIFICANT POSSIBILITY THAT CONTINUED REDUCTION IN REIMBURSEMENT MAY ACTUALLY CREATE DIFFICULTIES IN ACCESS FOR THESE INDIVIDUALS. FINALLY, THE AMOUNT SPENT TO COVER THE MEDICARE SHORTFALL IS MONEY NOT AVAILABLE TO COVER CHARITY CARE AND OTHER COMMUNITY BENEFIT NEEDS.

PART III, LINE 9B:

AFTER THE PATIENT MEETS THE QUALIFICATIONS FOR FINANCIAL ASSISTANCE, THE ACCOUNT BALANCE IS PARTIALLY OR ENTIRELY WRITTEN OFF, AS APPROPRIATE. ANY

**Part VI Supplemental Information**

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- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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REMAINING BALANCE, IF ANY, WOULD BE COLLECTED UNDER THE NORMAL DEBT COLLECTION POLICY.

PART VI, LINE 2:

THE COMMUNITY BENEFITS PLAN ADOPTED BY METHODIST IS ABOUT IMPROVING HEALTH; THE HEALTH OF EACH INDIVIDUAL, AND THE HEALTH OF THE COMMUNITY. IN DEVELOPING THE PLAN, SEVERAL SOURCES OF INFORMATION WERE UTILIZED TO HELP IDENTIFY SPECIFIC HEALTHCARE NEEDS. FIRST, ONE OF THE MORE COMPREHENSIVE LOCAL ASSESSMENTS IS LED BY THE DEPARTMENT OF PUBLIC HEALTH. THE PEORIA COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT IDENTIFIED LOCAL HEALTH PRIORITIES AS CEREBROVASCULAR DISEASE (STROKE), HIP FRACTURES AND INFANT MORTALITY. THE LEADING CAUSES OF MORTALITY WERE IDENTIFIED AS HEART DISEASES. THE SECOND SOURCE WAS HEALTHY PEOPLE 2010. HEALTHY PEOPLE 2010 SET OUT NATIONAL OBJECTIVES FOR HEALTH IMPROVEMENT AND ARE BUILT AROUND THE CONCEPTS OF DISEASE PREVENTION AND HEALTH PROMOTION. OTHER SOURCES OF DATA WERE REVIEWED, HEARTLAND ALLIANCE MID-AMERICA INSTITUTE ON POVERTY, UNITED STATES CENSUS BUREAU DATA, ILLINOIS BEHAVIORAL RISK FACTOR SURVEILLANCE SURVEY DATA, METHODIST ACCESS DATA AND CENSUS BUREAU DATA.

**Part VI Supplemental Information**

Provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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COLLECTIVELY, THESE DATA SOURCES HAVE SUPPORTED OUR ASSESSMENT OF THE COMMUNITIES NEEDS.

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PART VI, LINE 3:

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PATIENTS WHO QUALIFY AND ARE RECEIVING BENEFITS FROM THE FOLLOWING PROGRAMS MAY BE PRESUMED ELIGIBLE FOR 100% FINANCIAL ASSISTANCE: THE US. DEPARTMENT OF AGRICULTURE FOOD AND NUTRITION SERVICE FOOD STAMP PROGRAM; WOMEN, INFANTS & CHILDREN (WIC); AND VARIOUS COUNTY AND STATE RELIEF PROGRAMS. THIRD PARTY AGENCIES ARE USED TO ASSIST WITH COLLECTIONS AND, IF THOSE AGENCIES PROVIDE A STATEMENT REGARDING A PATIENT'S LIKELY INCOME LEVEL, THAT INFORMATION IS USED IN DETERMINING THE ELIGIBILITY STATUS AND THE LEVEL OF DISCOUNT AVAILABLE.

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PART VI, LINE 4:

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METHODIST IS THE SECOND LARGEST HEALTHCARE PROVIDER IN CENTRAL ILLINOIS. THE HOSPITAL IS LICENSED FOR 329 BEDS. ALONG WITH METHODIST THERE ARE TWO OTHER HOSPITALS IN THE PEORIA AREA, ALONG WITH FOUR SMALLER HOSPITALS IN OUR SERVICE AREA. IN 2016, METHODIST SERVED 14,270 INPATIENTS, 210,029

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Provide the following information.

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OUTPATIENTS AND 49,830 EMERGENCY PATIENTS. METHODIST'S PRIMARY SERVICE AREA CONSISTS OF FULTON, PEORIA, TAZEWEEL AND WOODFORD COUNTIES. THIS GEOGRAPHIC REGION REPRESENTS 85% OF ALL HOSPITAL ADMISSIONS. THE SECONDARY SERVICE AREA INCLUDES 14 CENTRAL ILLINOIS COUNTIES, MOSTLY RURAL IN NATURE. COMBINED, METHODIST SERVES A POPULATION OF NEARLY ONE MILLION PEOPLE. METHODIST IS CLASSIFIED AS AN URBAN, TEACHING HOSPITAL.

AS COMPARED TO THE DEMOGRAPHIC CHARACTERISTICS OF THE PEKIN/PEORIA MSA (METROPOLITAN STATISTICAL AREA), METHODIST SERVES A LARGER MINORITY AND SENIOR POPULATION. THE DEMOGRAPHICS OF METHODIST'S PATIENT POPULATION ARE A FUNCTION OF SEVERAL VARIABLES SUCH AS THE INCIDENCE AND PREVALENCE OF DISEASE AMONG AGE COHORTS, AND RACES, GEOGRAPHIC PROXIMITY TO MINORITY POPULATIONS AND OUTREACH EFFORTS TO IMPROVE ACCESS TO MEDICAL SERVICES. METHODIST'S INPATIENTS ARE: WHITE 85.8%, BLACK 9.0%, ASIAN 1.8%, HISPANIC 2.0% AND OTHER 1.4%. THIS IS COMPARED TO THE PEKIN/PEORIA MSA OF: WHITE 85.5%, BLACK 9.1%, ASIAN 1.6%, HISPANIC 2.3% AND OTHER 1.5%. METHODIST HAS THE LEAST FAVORABLE PAYOR MIX IN OUR PRIMARY SERVICE AREA. METHODIST HAS THE LARGEST MEDICAID MARKET SHARE BECAUSE OF OUR BEHAVIORAL HEALTH AND

**Part VI Supplemental Information**

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EMERGENCY PROGRAMS. THE MEDIAN AGE IN OUR SERVICE AREA IS 38.9 AS COMPARED TO 37.3 YEARS STATEWIDE. THE MEDIAN AGE IS HIGHER DUE TO A GREATER PERCENTAGE OF THE POPULATION AT AGE 65 OR ABOVE.

PART VI, LINE 5:

THE HOSPITAL IS ORGANIZED AND OPERATED EXCLUSIVELY FOR CHARITABLE PURPOSES WITH THE GOAL OF PROMOTING THE HEALTH OF THE COMMUNITIES IT SERVES. THE HOSPITAL SUPPORTS THIS MISSION WITH A COMMUNITY BOARD, OPEN MEDICAL STAFF, AND AN EMERGENCY ROOM AVAILABLE TO PATIENTS REGARDLESS OF ABILITY TO PAY. THE BOARD OF DIRECTORS OF THE HOSPITAL IS COMPOSED OF CIVIC LEADERS WHO RESIDE IN THE SERVICE AREA OF THE HOSPITAL. THE BOARD ACTIVELY DEBATES AND SETS POLICY AND STRATEGIC DIRECTION FOR THE HOSPITAL BUT DOES NOT GET INVOLVED IN ISSUES RELATED TO THE DIRECT OPERATIONS OF THE HOSPITAL. THE BOARD TAKES A BALANCED APPROACH WHEN ADDRESSING COMMUNITY AND BUSINESS/FINANCIAL CONCERNS. THE BOARD IS ALSO THE PRIMARY GROUP FOR DETERMINING THE USE OF HOSPITAL SURPLUS FUNDS, WHICH ARE ALL USED TO FURTHER OUR CHARITABLE PURPOSE.

**Part VI** Supplemental Information

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PHYSICIAN OFFICES ARE SPREAD ACROSS THE REGION TO PROVIDE BETTER ACCESS TO  
A WIDE NUMBER OF PATIENTS.

PART VI, LINE 6:

THE HOSPITAL IS PART OF IOWA HEALTH SYSTEM (D/B/A UNITYPOINT HEALTH).  
THROUGH RELATIONSHIPS WITH 33 HOSPITALS IN METROPOLITAN AND RURAL  
COMMUNITIES AND MORE THAN 400 OUTPATIENT SITES, UNITYPOINT HEALTH PROVIDES  
CARE THROUGHOUT IOWA, WESTERN ILLINOIS, AND SOUTHERN WISCONSIN.

UNITYPOINT HEALTH ENTITIES EMPLOY THE STATE'S LARGEST NONPROFIT WORKFORCE,  
WITH MORE THAN 31,000 EMPLOYEES WORKING TOWARD INNOVATIVE ADVANCEMENTS TO  
DELIVER THE BEST OUTCOME FOR EVERY PATIENT EVERY TIME. EACH YEAR, THROUGH  
MORE THAN 5.9 MILLION PATIENT VISITS, UNITYPOINT HEALTH HOSPITALS AND  
CLINICS PROVIDE A FULL RANGE OF CARE TO PATIENTS AND FAMILIES. WITH ANNUAL  
REVENUES OF \$4.1 BILLION, UNITYPOINT HEALTH IS THE FOURTH LARGEST  
NONDENOMINATIONAL HEALTH SYSTEM IN AMERICA AND PROVIDES COMMUNITY BENEFIT  
PROGRAMS AND SERVICES TO IMPROVE THE HEALTH OF PEOPLE IN ITS COMMUNITIES.

**Part VI Supplemental Information**

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UNITYPOINT HEALTH AND ITS AFFILIATES ENGAGE IN COMMUNITY HEALTH PROGRAMS AND SERVICES THROUGHOUT IOWA, AND WORK WITH VOLUNTEER AND CIVIC ORGANIZATIONS, SCHOOLS, BUSINESSES, INSURERS AND INDIVIDUALS TO SUPPORT ACTIVITIES THAT BENEFIT PEOPLE THROUGHOUT THE STATE. IN 2016, UNITYPOINT HEALTH AND ITS AFFILIATES PROVIDED MORE THAN \$519 MILLION OF COMMUNITY BENEFIT. THE CONTRIBUTIONS TO THEIR COMMUNITIES BY UNITYPOINT HEALTH AND ITS AFFILIATES ARE REPORTED IN DETAIL IN STATEMENT OF PROGRAM SERVICE ACCOMPLISHMENTS (PART III) OF THE IRS FORM 990 OF THOSE AFFILIATES.

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

**SCHEDULE I  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

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

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

▶ Attach to Form 990.

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

OMB No. 1545-0047

**2016**

Open to Public  
Inspection

Name of the organization **METHODIST MEDICAL CENTER OF ILLINOIS** Employer identification number **37-0661223**

**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.

| 1 (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 |
|--|------------|---------------------------------|--------------------------|-----------------------------------|---|---------------------------------------|------------------------------------|
| AMERICAN HEART ASSOCIATION<br>221 S. MISSOURI AVE<br>MORTON, IL 61550  | 13-5613797 | 501(C)(3)                       | 20,000.                  | 0.                                |   |                                       | EVENT SPONSOR                      |
| BOY SCOUTS OF AMERICA<br>614 NE MADISON AVE<br>PEORIA, IL 61603  | 37-0661188 | 501(C)(3)                       | 10,000.                  | 0.                                |   |                                       | PROGRAM SUPPORT                    |
| DOWNTOWN DEVELOPMNT CORP PEORIA<br>820 SW ADAMS ST<br>PEORIA, IL 61602   | 46-4486780 | 501(C)(3)                       | 36,000.                  | 0.                                |   |                                       | EVENT SPONSOR                      |
| DREAM CENTER PEORIA<br>714 HAMILTON BLVD.<br>PEORIA, IL 61603  | 52-2376242 | 501(C)(3)                       | 5,000.                   | 0.                                |   |                                       | EVENT SPONSOR                      |
| EASTER SEALS CENTRAL ILLINOIS<br>233 SOUTH WACKER DRIVE, SUITE 2400<br>CHICAGO, IL 60606-6410                  | 36-2171726 | 501(C)(3)                       | 13,100.                  | 0.                                |   |                                       | PROGRAM SUPPORT                    |
| EP!C, AKA PEORIA ASSOCIATION FOR<br>RETARDED CITIZENS INC. - 1913 W<br>TOWNLINER RD - PEORIA, IL<br>61615-1621 | 37-0794792 | 501(C)(3)                       | 9,833.                   | 0.                                |   |                                       | PROGRAM SUPPORT                    |

- 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 **2.**

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

Schedule I (Form 990) (2016)

**Part II** Continuation of Grants and Other Assistance to Governments and Organizations in the United States (Schedule I (Form 990), Part II.)

| (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 |
|---|------------|-------------------------------|--------------------------|-----------------------------------|---|--|------------------------------------|
| HEART OF ILLINOIS UNITED WAY<br>509 W. HIGH STREET<br>PEORIA, IL 61605                  | 37-0661504 | 501(C)(3)                     | 118,245.                 | 0.                                |   |  | PROGRAM SUPPORT                    |
| HEARTLAND COMMUNITY HEALTH CLINIC<br>2214 N. UNIVERSITY ST.<br>PEORIA, IL 61604-3221    | 37-1270794 | 501(C)(3)                     | 10,000.                  | 0.                                |   |  | PROGRAM SUPPORT                    |
| HULT CENTER FOR HEALTHY LIVING<br>5215 N. KNOXVILLE AVE<br>PEORIA, IL 61614             | 36-3510390 | 501(C)(3)                     | 122,165.                 | 0.                                |   |  | PROGRAM SUPPORT                    |
| ICC EDUCATIONAL FOUNDATION<br>ONE COLLEGE DRIVE<br>EAST PEORIA, IL 61635                | 37-1207827 | GOVERNMENT                    | 5,000.                   | 0.                                |   |  | PROGRAM SUPPORT                    |
| RONALD & CAMILLA RABJOHN, IWEC,<br>INC. - 2116 N PROSPECT RD -<br>PEORIA, IL 61603-2124 | 46-1323458 | 501(C)(3)                     | 5,000.                   | 0.                                |   |  | PROGRAM SUPPORT                    |
| THE LINCOLN ACADEMY OF ILLINOIS<br>500 E MADISON ST<br>SPRINGFIELD, IL 62701-1010       | 36-6127397 | 501(C)(3)                     | 6,750.                   | 0.                                |   |  | PROGRAM SUPPORT                    |
| PEKIN MEMORIAL HOSPITAL<br>600 S. 13TH ST<br>PEKIN, IL 61554-4936                       | 37-0692351 | 501(C)(3)                     | 6,000.                   | 0.                                |   |  | PROGRAM SUPPORT                    |
| PEORIA CHIEFS BOOSTER CLUB, INC.<br>730 SW JEFFERSON AVE<br>PEORIA, IL 61605-3901       | 37-1233146 | 501(C)(4)                     | 35,000.                  | 0.                                |   |  | PROGRAM SUPPORT                    |
| PEORIA PROMISE FOUNDATION<br>331 FULTON ST<br>PEORIA, IL 61602                          | 13-4353454 | 501(C)(3)                     | 10,000.                  | 0.                                |   |  | PROGRAM SUPPORT                    |

Schedule I (Form 990)

| <b>Part II</b> Continuation of Grants and Other Assistance to Governments and Organizations in the United States (Schedule I (Form 990), Part II.) |            |                               |                          |                                   |   |  |                                    |
|--|------------|-------------------------------|--------------------------|-----------------------------------|---|--|------------------------------------|
| (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 |
| PEORIA RIVERFRONT MUSEUM<br>222 SW WASHINGTON ST<br>PEORIA, IL 61602   | 27-2920016 | 501(C)(3)                     | 10,000.                  | 0.                                |   |  | PROGRAM SUPPORT                    |
| PEORIA SYMPHONY ORCHESTRA<br>203 HARRISON STREET<br>PEORIA, IL 61602   | 37-0901338 | 501(C)(3)                     | 10,000.                  | 0.                                |   |  | PROGRAM SUPPORT                    |
| QUEST CHARTER ACADEMY<br>2503 N. UNIVERSITY AVE.<br>PEORIA, IL 61604   | 27-0681058 | 501(C)(3)                     | 7,500.                   | 0.                                |   |  | PROGRAM SUPPORT                    |
| SUSAN G. KOMEN BREAST CANCER<br>505 LBJ FREEWAY, STE. 250<br>DALLAS, TX 75244-6125   | 75-2462834 | 501(C)(3)                     | 15,000.                  | 0.                                |   |  | PROGRAM SUPPORT                    |
|  |            |                               |                          |                                   |   |  |                                    |
|  |            |                               |                          |                                   |   |  |                                    |
|  |            |                               |                          |                                   |   |  |                                    |
|  |            |                               |                          |                                   |   |  |                                    |
|  |            |                               |                          |                                   |   |  |                                    |
|  |            |                               |                          |                                   |   |  |                                    |
|  |            |                               |                          |                                   |   |  |                                    |

**Part III** **Grants and Other Assistance to Domestic Individuals.** Complete if the organization answered "Yes" on Form 990, Part IV, line 22.  
Part III can be duplicated if additional space is needed.

| (a) Type of grant or assistance | (b) Number of recipients | (c) Amount of cash grant | (d) Amount of non-cash assistance | (e) Method of valuation (book, FMV, appraisal, other) | (f) Description of noncash assistance |
|---------------------------------|--------------------------|--------------------------|-----------------------------------|---|---------------------------------------|
| MAMMOGRAM EXPENSES              | 244                      | 78,468.                  | 0.                                |   |                                       |
|                                 |                          |                          |                                   |   |                                       |
|                                 |                          |                          |                                   |   |                                       |
|                                 |                          |                          |                                   |   |                                       |
|                                 |                          |                          |                                   |   |                                       |
|                                 |                          |                          |                                   |   |                                       |

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

PART I, LINE 2:

RECIPIENTS WERE GIVEN GRANTS BASED ON THE NEEDS OF THE MEDICAL COMMUNITY  
AND THE LOCAL COMMUNITY AT LARGE. COMMUNITY BENEFITS COMMITTEE AND CEO  
REVIEW ASSISTANCE REQUESTS AND APPROVE BASED ON NEED.



**SCHEDULE J  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Compensation Information**

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

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

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

OMB No. 1545-0047

**2016**

Open to Public Inspection

Name of the organization

**METHODIST MEDICAL CENTER OF ILLINOIS**

Employer identification number

**37-0661223**

**Part I Questions Regarding Compensation**

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

- |   |   |
|---|---|
| <input type="checkbox"/> First-class or charter travel                        | <input 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 checked="" type="checkbox"/> Tax indemnification 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 (such as, maid, chauffeur, chef) |

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

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

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

- |   |   |
|---|---|
| <input checked="" type="checkbox"/> Compensation committee              | <input checked="" 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? .....
- b** Participate in, or receive payment from, a supplemental nonqualified retirement plan? .....
- c** Participate in, or receive payment from, an equity-based compensation arrangement? .....
- If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.

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

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

- a** The organization? .....
- b** Any related organization? .....
- If "Yes" on line 5a or 5b, describe in Part III.

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

- a** The organization? .....
- b** Any related organization? .....
- If "Yes" on line 6a or 6b, describe in Part III.

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

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

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

|           | Yes | No |
|-----------|-----|----|
| <b>1b</b> | X   |    |
| <b>2</b>  | X   |    |
| <b>4a</b> | X   |    |
| <b>4b</b> | X   |    |
| <b>4c</b> |     | X  |
| <b>5a</b> |     | X  |
| <b>5b</b> |     | X  |
| <b>6a</b> |     | X  |
| <b>6b</b> |     | X  |
| <b>7</b>  |     | X  |
| <b>8</b>  |     | X  |
| <b>9</b>  |     |    |

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

Schedule J (Form 990) 2016

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

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

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

| (A) Name and Title                    |      | (B) Breakdown of W-2 and/or 1099-MISC compensation |                                     |                                     | (C) Retirement and other deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation in column (B) reported as deferred on prior Form 990 |
|---------------------------------------|------|--|-------------------------------------|-------------------------------------|--|-------------------------|---------------------------------|---|
|                                       |      | (i) Base compensation                              | (ii) Bonus & incentive compensation | (iii) Other reportable compensation |  |                         |                                 |   |
| BRIAN COHEN, MD                       | (i)  | 405,574.   | 5,584.                              | 3,675.                              | 40,560.  | 28,338.                 | 483,731.                        | 0.  |
| BOARD MEMBER                          | (ii) | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
| VAUGHN HANNA, MD                      | (i)  | 261,806.   | 0.                                  | 867.                                | 36,140.  | 22,632.                 | 321,445.                        | 0.  |
| BOARD MEMBER (TO 5/16)                | (ii) | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
| STEPHANIE LINDSTROM, MD               | (i)  | 340,993.   | 5,895.                              | 6,985.                              | 29,538.  | 15,363.                 | 398,774.                        | 0.  |
| BOARD MEMBER                          | (ii) | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
| DEBORAH SIMON                         | (i)  | 517,854.   | 114,338.                            | 146,873.                            | 72,033.  | 15,953.                 | 867,051.                        | 0.  |
| BOARD MEMBER/PRESIDENT & CEO          | (ii) | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
| ROBERT QUIN                           | (i)  | 302,873.   | 60,100.                             | 53,247.                             | 31,800.  | 14,276.                 | 462,296.                        | 50,364.   |
| SECRETARY/TREASURER/CFO               | (ii) | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
| TODD BAKER                            | (i)  | 195,951.   | 23,375.                             | 3,474.                              | 27,240.  | 14,103.                 | 264,143.                        | 0.  |
| VP STRATEGY & DEVELOPMENT             | (ii) | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
| GARY KNEPP, MD                        | (i)  | 369,301.   | 73,037.                             | 196,082.                            | 19,472.  | 14,453.                 | 672,345.                        | 119,788.  |
| EVP MED AFFAIRS/MED STAFF AFFRS       | (ii) | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
| KEITH KNEPP, MD                       | (i)  | 394,531.   | 77,397.                             | 96,523.                             | 39,730.  | 24,867.                 | 633,048.                        | 64,458.   |
| EVP CLINICAL SERVICES/COO             | (ii) | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
| JOY LEDBETTER                         | (i)  | 222,192.   | 44,100.                             | 40,339.                             | 34,699.  | 23,695.                 | 365,025.                        | 0.  |
| VP HUMAN RESOURCES & CUSTOMER SERVICE | (ii) | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
| PAUL MACEK                            | (i)  | 5,831.   | 34,375.                             | 312,105.                            | 6,917.   | 0.                      | 359,228.                        | 311,676.  |
| VP REGIONAL DEVELOPMENT               | (ii) | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
| JOHN MILLER                           | (i)  | 264,247.   | 20,776.                             | 3,355.                              | 31,800.  | 17,082.                 | 337,260.                        | 0.  |
| VP PHYS RELATIONS/MED AFFAIRS         | (ii) | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
| JEANINE SPAIN                         | (i)  | 247,776.   | 49,059.                             | 49,778.                             | 39,753.  | 23,499.                 | 409,865.                        | 0.  |
| VP HOSPITAL NURSING SERVICES, CNO     | (ii) | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
| KISHORE KARAMCHANDANI, MD             | (i)  | 831,232.   | 0.                                  | 11,414.                             | 33,125.  | 21,349.                 | 897,120.                        | 0.  |
| PHYSICIAN                             | (ii) | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
| RAVINDRA KASHYAP, MD                  | (i)  | 759,888.   | 65.                                 | 1,378.                              | 33,453.  | 28,338.                 | 823,122.                        | 0.  |
| PHYSICIAN                             | (ii) | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
| LU YE, MD                             | (i)  | 739,066.   | 0.                                  | 3,675.                              | 23,850.  | 13,765.                 | 780,356.                        | 0.  |
| PHYSICIAN                             | (ii) | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
| STEVEN AMBROSE, MD                    | (i)  | 711,420.   | 50,000.                             | 1,925.                              | 13,250.  | 2,574.                  | 779,169.                        | 0.  |
| PHYSICIAN                             | (ii) | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |

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

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

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

| (A) Name and Title                     |      | (B) Breakdown of W-2 and/or 1099-MISC compensation |                                     |                                     | (C) Retirement and other deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation in column (B) reported as deferred on prior Form 990 |
|--|------|--|-------------------------------------|-------------------------------------|--|-------------------------|---------------------------------|---|
|  |      | (i) Base compensation                              | (ii) Bonus & incentive compensation | (iii) Other reportable compensation |  |                         |                                 |   |
| SHAHID WAZIR, MD<br>PHYSICIAN          | (i)  | 704,491.   | 0.                                  | 1,123.                              | 16,382.  | 20,751.                 | 742,747.                        | 0.  |
|  | (ii) | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
| ERICK LAINE<br>FORMER SENIOR VP (2012) | (i)  | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
|  | (ii) | 7,251.   | 68,863.                             | 486,080.                            | 1,752.   | 20,017.                 | 583,963.                        | 106,110.  |
|  | (i)  |  |                                     |                                     |  |                         |                                 |   |
|  | (ii) |  |                                     |                                     |  |                         |                                 |   |
|  | (i)  |  |                                     |                                     |  |                         |                                 |   |
|  | (ii) |  |                                     |                                     |  |                         |                                 |   |
|  | (i)  |  |                                     |                                     |  |                         |                                 |   |
|  | (ii) |  |                                     |                                     |  |                         |                                 |   |
|  | (i)  |  |                                     |                                     |  |                         |                                 |   |
|  | (ii) |  |                                     |                                     |  |                         |                                 |   |
|  | (i)  |  |                                     |                                     |  |                         |                                 |   |
|  | (ii) |  |                                     |                                     |  |                         |                                 |   |
|  | (i)  |  |                                     |                                     |  |                         |                                 |   |
|  | (ii) |  |                                     |                                     |  |                         |                                 |   |
|  | (i)  |  |                                     |                                     |  |                         |                                 |   |
|  | (ii) |  |                                     |                                     |  |                         |                                 |   |
|  | (i)  |  |                                     |                                     |  |                         |                                 |   |
|  | (ii) |  |                                     |                                     |  |                         |                                 |   |
|  | (i)  |  |                                     |                                     |  |                         |                                 |   |
|  | (ii) |  |                                     |                                     |  |                         |                                 |   |
|  | (i)  |  |                                     |                                     |  |                         |                                 |   |
|  | (ii) |  |                                     |                                     |  |                         |                                 |   |

**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.

**PART I, LINE 1A:**

**TAX INDEMNIFICATION AND GROSS-UP PAYMENTS:**

IF AN INDIVIDUAL IS PROVIDED SOMETHING FROM THE EMPLOYER OF VALUE, SUCH AS A PAID BENEFIT, GIFT CARD OR GIFT, WHICH IS CONSIDERED TAXABLE INCOME, THEN THE EMPLOYER WILL ADD IMPUTED AMOUNTS TO PAYCHECK IN ORDER TO TAX APPROPRIATELY.

**PART I, LINE 1B:**

**TAX INDEMNIFICATION AND GROSS-UP PAYMENTS:**

IF AN INDIVIDUAL IS PROVIDED SOMETHING FROM THE EMPLOYER OF VALUE, SUCH AS A PAID BENEFIT, GIFT CARD OR GIFT, WHICH IS CONSIDERED TAXABLE INCOME, THEN THE EMPLOYER WILL ADD IMPUTED AMOUNTS TO PAYCHECK IN ORDER TO TAX APPROPRIATELY.

**PART I, LINES 4A-B:**

**SEVERANCE PAYMENTS:**

THE FOLLOWING INDIVIDUAL(S) RECEIVED SEVERANCE PAYMENTS DURING THE YEAR THAT WERE INCLUDED IN THEIR TAXABLE INCOME: ERICK LAINE \$378,351.

**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.

**NONQUALIFIED RETIREMENT PLAN EARNINGS:**

THE FOLLOWING INDIVIDUAL(S) PARTICIPATED IN A SUPPLEMENTAL NON-QUALIFIED RETIREMENT PLAN WITH THE FOLLOWING CHANGES TO THEIR ACCOUNTS: GARY KNEPP \$64,183; KEITH KNEPP \$68,419; JOY LEDBETTER \$38,985; ROBERT QUIN \$52,106; DEBORAH SIMON \$93,806; JEANINE SPAIN \$44,191.

**NONQUALIFIED RETIREMENT PLAN DISTRIBUTIONS:**

THE FOLLOWING INDIVIDUAL(S) PARTICIPATED IN AND RECEIVED PAYMENTS FROM A SUPPLEMENTAL NON-QUALIFIED PLAN: GARY KNEPP \$183,971; KEITH KNEPP \$64,458; ERICK LAINE \$106,110; JOY LEDBETTER \$38,273; PAUL MACEK \$311,676; ROBERT QUIN \$50,364; DEBORAH SIMON \$93,806; JEANINE SPAIN \$44,191. PAYOUTS ARE MADE WITH VESTED FUNDS, AS ESTABLISHED BY PLAN DOCUMENTS.

**Supplemental Information on Tax-Exempt Bonds**

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.**

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

Name of the organization **METHODIST MEDICAL CENTER OF ILLINOIS** Employer identification number **37-0661223**

| <b>Part I Bond Issues</b>               |                   |                  |                 |                     |                            |              |    |                         |          |                      |          |
|---|-------------------|------------------|-----------------|---------------------|----------------------------|--------------|----|-------------------------|----------|----------------------|----------|
| (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) Pooled financing |          |
|   |                   |                  |                 |                     |                            | Yes          | No | Yes                     | No       | Yes                  | No       |
| <b>ILLINOIS FINANCE<br/>A AUTHORITY</b> | <b>86-1091967</b> | <b>45203HAE2</b> | <b>05/12/11</b> | <b>115,000,000.</b> | <b>SEE PART VI</b>         | <b>X</b>     |    |                         | <b>X</b> |                      | <b>X</b> |
| <b>B</b>                                |                   |                  |                 |                     |                            |              |    |                         |          |                      |          |
| <b>C</b>                                |                   |                  |                 |                     |                            |              |    |                         |          |                      |          |
| <b>D</b>                                |                   |                  |                 |                     |                            |              |    |                         |          |                      |          |

| <b>Part II Proceeds</b>  |                     |          |     |    |     |    |     |    |  |  |
|--|---------------------|----------|-----|----|-----|----|-----|----|--|--|
|  | A                   |          | B   |    | C   |    | D   |    |  |  |
|  | Yes                 | No       | Yes | No | Yes | No | Yes | No |  |  |
| <b>1</b> Amount of bonds retired .....   | <b>32,500,000.</b>  |          |     |    |     |    |     |    |  |  |
| <b>2</b> Amount of bonds legally defeased .....  | <b>51,220,000.</b>  |          |     |    |     |    |     |    |  |  |
| <b>3</b> Total proceeds of issue .....   | <b>115,000,000.</b> |          |     |    |     |    |     |    |  |  |
| <b>4</b> Gross proceeds in reserve funds .....   |                     |          |     |    |     |    |     |    |  |  |
| <b>5</b> Capitalized interest from proceeds .....  |                     |          |     |    |     |    |     |    |  |  |
| <b>6</b> Proceeds in refunding escrows .....   | <b>54,135,000.</b>  |          |     |    |     |    |     |    |  |  |
| <b>7</b> Issuance costs from proceeds .....  | <b>1,133,300.</b>   |          |     |    |     |    |     |    |  |  |
| <b>8</b> Credit enhancement from proceeds .....  | <b>46,985.</b>      |          |     |    |     |    |     |    |  |  |
| <b>9</b> Working capital expenditures from proceeds .....  |                     |          |     |    |     |    |     |    |  |  |
| <b>10</b> Capital expenditures from proceeds .....   | <b>43,144,715.</b>  |          |     |    |     |    |     |    |  |  |
| <b>11</b> Other spent proceeds .....   | <b>16,540,000.</b>  |          |     |    |     |    |     |    |  |  |
| <b>12</b> Other unspent proceeds .....   |                     |          |     |    |     |    |     |    |  |  |
| <b>13</b> Year of substantial completion .....   | <b>2011</b>         |          |     |    |     |    |     |    |  |  |
|  | Yes                 | No       | Yes | No | Yes | No | Yes | No |  |  |
| <b>14</b> Were the bonds issued as part of a current refunding issue? .....  | <b>X</b>            |          |     |    |     |    |     |    |  |  |
| <b>15</b> Were the bonds issued as part of an advance refunding issue? .....   |                     | <b>X</b> |     |    |     |    |     |    |  |  |
| <b>16</b> Has the final allocation of proceeds been made? .....  | <b>X</b>            |          |     |    |     |    |     |    |  |  |
| <b>17</b> Does the organization maintain adequate books and records to support the final allocation of proceeds? ..... | <b>X</b>            |          |     |    |     |    |     |    |  |  |

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

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

|   | A    |    | B   |    | C   |    | D   |    |
|---|------|----|-----|----|-----|----|-----|----|
|   | Yes  | No | Yes | No | Yes | No | Yes | No |
| <b>3a</b> Are there any management or service contracts that may result in private business use of bond-financed property? .....  | X    |    |     |    |     |    |     |    |
| <b>b</b> If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property? .....   | X    |    |     |    |     |    |     |    |
| <b>c</b> Are there any research agreements that may result in private business use of bond-financed property? .....   |      | X  |     |    |     |    |     |    |
| <b>d</b> If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property? .....   |      |    |     |    |     |    |     |    |
| <b>4</b> Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government .....  | 1.81 | %  |     | %  |     | %  |     | %  |
| <b>5</b> Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ..... | .00  | %  |     | %  |     | %  |     | %  |
| <b>6</b> Total of lines 4 and 5 .....   | 1.81 | %  |     | %  |     | %  |     | %  |
| <b>7</b> Does the bond issue meet the private security or payment test? .....   |      | X  |     |    |     |    |     |    |
| <b>8a</b> Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued? .....   |      | X  |     |    |     |    |     |    |
| <b>b</b> If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of .....  |      | %  |     | %  |     | %  |     | %  |
| <b>c</b> If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2? .....  |      |    |     |    |     |    |     |    |
| <b>9</b> Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2? .....                           | X    |    |     |    |     |    |     |    |

**Part IV Arbitrage**

|  | A                    |    | B   |    | C   |    | D   |    |
|--|----------------------|----|-----|----|-----|----|-----|----|
|  | Yes                  | No | Yes | No | Yes | No | Yes | No |
| <b>1</b> Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate? .....    |                      | X  |     |    |     |    |     |    |
| <b>2</b> If "No" to line 1, did the following apply? .....   |                      |    |     |    |     |    |     |    |
| <b>a</b> Rebate not due yet? .....   |                      | X  |     |    |     |    |     |    |
| <b>b</b> Exception to rebate? .....  | X                    |    |     |    |     |    |     |    |
| <b>c</b> No rebate due? .....  |                      | X  |     |    |     |    |     |    |
| If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed .....                                    |                      |    |     |    |     |    |     |    |
| <b>3</b> Is the bond issue a variable rate issue? .....  | X                    |    |     |    |     |    |     |    |
| <b>4a</b> Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue? ..... | X                    |    |     |    |     |    |     |    |
| <b>b</b> Name of provider .....  | MORGAN STANLEY CAPIT |    |     |    |     |    |     |    |
| <b>c</b> Term of hedge .....   | 33.5000000           |    |     |    |     |    |     |    |
| <b>d</b> Was the hedge superintegrated? .....  |                      | X  |     |    |     |    |     |    |
| <b>e</b> Was the hedge terminated? .....   | 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  |     |    |     |    |     |    |
| 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  |     |    |     |    |     |    |
| 7 Has the organization established written procedures to monitor the requirements of section 148? ..... | 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 isn't available under applicable regulations? ..... | X   |    |     |    |     |    |     |    |

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

**PART I, COLUMN (F)**

LINE A - REFUND THE ILLINOIS FINANCE AUTHORITY'S HOSPITAL FACILITIES REVENUE BONDS, (METHODIST MEDICAL CENTER) SERIES 1998; REFINANCE BANK LINE OF CREDIT





**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 |
| CENTRAL ILLINOIS ENDOSCOPY    | COMMON BOARD MEMBER   | 6,337,000.                | INVESTMENT,                    |   | X  |
| GREATER PEORIA SPECIALTY H    | COMMON BOARD MEMBER   | 423,000.                  | INVESTMENT                     |   | X  |
| JENNIFER REID                 | FAMILY MEMBER OF BO   | 24,213.                   | EMPLOYMENT                     |   | X  |
| KERI BOSWELL                  | FAMILY MEMBER OF KE   | 21,627.                   | EMPLOYMENT                     |   | X  |
| PAIGE LEDBETTER               | FAMILY MEMBER OF KE   | 37,813.                   | EMPLOYMENT                     |   | X  |
| REHABILITATION THERAPY SER    | COMMON BOARD MEMBER   | 2,208,000.                | INVESTMENT,                    |   | X  |
|                               |   |                           |                                |   |    |
|                               |   |                           |                                |   |    |
|                               |   |                           |                                |   |    |

**Part V Supplemental Information**

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

**SCH L, PART IV, BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS:**

(A) NAME OF PERSON: CENTRAL ILLINOIS ENDOSCOPY CENTER, L.L.C.

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

COMMON BOARD MEMBER/OFFICER

(C) AMOUNT OF TRANSACTION \$ 6,337,000.

(D) DESCRIPTION OF TRANSACTION: INVESTMENT, MANAGEMENT FEES, SUPPLIES

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: GREATER PEORIA SPECIALTY HOSPITAL, L.L.C.

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

COMMON BOARD MEMBER/OFFICER

(C) AMOUNT OF TRANSACTION \$ 423,000.

(D) DESCRIPTION OF TRANSACTION: INVESTMENT

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: JENNIFER REID

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

FAMILY MEMBER OF BOARD MEMBER SCOTT REID

(C) AMOUNT OF TRANSACTION \$ 24,213.

(D) DESCRIPTION OF TRANSACTION: EMPLOYMENT

**Part V Supplemental Information**

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: KERI BOSWELL

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

FAMILY MEMBER OF KEY EMPLOYEE JOY LEDBETTER

(C) AMOUNT OF TRANSACTION \$ 21,627.

(D) DESCRIPTION OF TRANSACTION: EMPLOYMENT

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: PAIGE LEDBETTER

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

FAMILY MEMBER OF KEY EMPLOYEE JOY LEDBETTER

(C) AMOUNT OF TRANSACTION \$ 37,813.

(D) DESCRIPTION OF TRANSACTION: EMPLOYMENT

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: REHABILITATION THERAPY SERVICES, L.L.C.

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

COMMON BOARD MEMBER/OFFICER

(C) AMOUNT OF TRANSACTION \$ 2,208,000.

(D) DESCRIPTION OF TRANSACTION: INVESTMENT, PATIENT SERVICES, MANAGEMENT FEES, FINANCIAL SERVICES, ETC.

(E) SHARING OF ORGANIZATION REVENUES? = NO

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

Department of the Treasury  
Internal Revenue Service

**Supplemental Information to Form 990 or 990-EZ**

Complete to provide information for responses to specific questions on  
Form 990 or 990-EZ or to provide any additional information.

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

**2016**

Open to Public  
Inspection

Name of the organization

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

RENDERED. THESE INCLUDE, BUT ARE NOT LIMITED TO, GENERAL ACUTE CARE, SURGERIES, HOME HEALTH, INTENSIVE CARE AND CRITICAL CARE, MENTAL HEALTH CARE, CARDIOLOGY, ONCOLOGY, REHABILITATION, SKILLED NURSING, BEHAVIORAL DISORDER PROGRAMS, MATERNAL/CHILD CARE, LABORATORY, PALLIATIVE CARE, PHARMACEUTICAL DRUGS, EMERGENCY SERVICES, OUTPATIENT CLINICS, CHECK-UPS AND RADIOLOGY. SOME OF THE SERVICES PROVIDED DO NOT GENERATE ENOUGH INCOME TO OFFSET THEIR COST. IN THE FISCAL PERIOD ENDED DECEMBER 31, 2016, METHODIST MEDICAL CENTER OF ILLINOIS ADMITTED 13,844 PATIENTS RESULTING IN A TOTAL OF 66,242 PATIENT DAYS. OUTPATIENT VISITS TOTALED 209,670 AND TOTAL OUTPATIENT SURGERY REGISTRATIONS FOR THE SAME PERIOD WERE 7,014. THERE WERE ALSO 50,809 EMERGENCY ROOM VISITS AND 1,876 BABIES DELIVERED.

FORM 990, PART III, LINE 4B, PROGRAM SERVICE ACCOMPLISHMENTS:

METHODIST MEDICAL CENTER OF ILLINOIS' NET COST OF PROVIDING CARE FOR WHICH IT RECEIVES PAYMENT BELOW ITS COST IS \$9,535,088 FOR 2016. TOTAL CHARITY CARE AND MEANS-TESTED PROGRAMS REPORTED VALUE: \$11,427,905.

OTHER BENEFITS: METHODIST MEDICAL CENTER OF ILLINOIS PROVIDES SEVERAL OTHER BENEFITS THAT ASSIST THE COMMUNITY. PROGRAMS MAY INCLUDE, BUT ARE NOT LIMITED TO, COMMUNITY HEALTH IMPROVEMENT SERVICES AND COMMUNITY BENEFIT OPERATIONS SUCH AS PREVENTION AND HEALTH SCREENINGS; CONTINUING EDUCATION FOR HEALTH PROFESSIONALS; SUBSIDIZED HEALTH SERVICES; RESEARCH; AND CASH AND IN-KIND CONTRIBUTIONS TO COMMUNITY GROUPS.

METHODIST MEDICAL CENTER OF ILLINOIS COLLABORATES WITH OTHER HOSPITALS,

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

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

632211 08-25-16

|  |  |
|--|--|
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|--|--|

CHURCHES, SCHOOLS, CHAMBERS OF COMMERCE AND DAYCARE CENTERS TO IMPROVE COMMUNITY HEALTH AND EXPAND ACCESS TO HEALTH CARE. METHODIST MEDICAL CENTER OF ILLINOIS HAS DEDICATED STAFF TO ASSIST COMMUNITY BENEFIT EFFORTS. TOTAL OTHER BENEFITS REPORTED VALUE: \$10,320,394.

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

GARY KNEPP; KEITH KNEPP; FAMILY RELATIONSHIP

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

METHODIST HEALTH SERVICES CORPORATION, A TAX-EXEMPT ILLINOIS NOT-FOR-PROFIT CORPORATION, IS THE SOLE MEMBER.

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

METHODIST HEALTH SERVICES CORPORATION, AS THE SOLE MEMBER, MAY APPOINT AND REMOVE ALL BOARD MEMBERS.

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

METHODIST HEALTH SERVICES CORPORATION, AS SOLE MEMBER, DIRECTS, APPROVES AND RECOMMENDS MERGERS, CONSOLIDATIONS, ACQUISITIONS, DISSOLUTION, LIQUIDATION OR DISPOSITION, INITIATES AND APPROVES BUDGETS AND LONG-RANGE STRATEGIC PLANS, INITIATES AND APPROVES THE FORMATION OF ANY PERSON CONTROLLED BY A SUBSIDIARY, APPROVES CONFLICT OF INTEREST POLICY, AND AMENDMENTS TO ARTICLES AND BYLAWS.

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

THE FORM 990 IS PREPARED INTERNALLY BY THE IOWA HEALTH SYSTEM TAX DEPARTMENT USING INFORMATION GATHERED FROM VARIOUS FUNCTIONAL AREAS OF THE ORGANIZATION. EACH SECTION OF THE RETURN IS REVIEWED BY THE RESPONSIBLE

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FUNCTIONAL AREA ALONG WITH THE TAX DEPARTMENT. A DRAFT COPY OF THE RETURN IS PROVIDED TO THE CFO FOR REVIEW. A FULL COPY OF THE FORM 990 IS PROVIDED TO THE BOARD OF DIRECTORS PRIOR TO FILING WITH THE IRS.

FORM 990, PART V, LINES 1A & 1B

CASH DISBURSEMENTS ARE CENTRALIZED THROUGH THE PARENT ORGANIZATION, IOWA HEALTH SYSTEM (D/B/A UNITYPOINT HEALTH). THE PARENT MAKES THE PAYMENTS AND FILES THE RELATED FORMS 1099 AND 1096 ON BEHALF OF ALL UNITYPOINT HEALTH SYSTEM RELATED ORGANIZATIONS.

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

THE ORGANIZATION HAS A CONFLICT OF INTEREST POLICY. ANNUALLY ALL OFFICERS, DIRECTORS, KEY EMPLOYEES AND REPORTING PHYSICIANS ARE REQUESTED TO COMPLETE A QUESTIONNAIRE TO REPORT POTENTIAL CONFLICTS OF INTEREST. PERSONS WHO HAVE NOT RETURNED QUESTIONNAIRES ARE CONTACTED ADDITIONAL TIMES IN AN EFFORT TO RECEIVE COMPLETE AND ACCURATE RESPONSES FROM ALL PERSONS.

THE ANNUAL QUESTIONNAIRES INCLUDE AN ACKNOWLEDGEMENT THAT THE OFFICER, DIRECTOR, KEY EMPLOYEE OR REPORTING PHYSICIAN: 1) HAS ACCESS TO A COPY OF THE CONFLICT OF INTEREST POLICY; 2) HAS READ AND UNDERSTANDS THE POLICY; 3) AGREES TO COMPLY WITH THE POLICY; 4) UNDERSTANDS THAT THE POLICY APPLIES TO ALL COMMITTEES AND SUBCOMMITTEES HAVING BOARD-DELEGATED POWERS; AND 5) UNDERSTANDS THAT THE ORGANIZATION IS A CHARITABLE ORGANIZATION AND THAT IN ORDER TO MAINTAIN ITS TAX-EXEMPT STATUS, IT MUST CONTINUOUSLY ENGAGE PRIMARILY IN ACTIVITIES WHICH ACCOMPLISH ONE OR MORE OF ITS TAX-EXEMPT PURPOSES.

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SENIOR ADMINISTRATIVE STAFF AT ALL RELATED ORGANIZATIONS PROVIDE INFORMATION TO A CENTRAL COORDINATOR RELATED TO THE IDENTIFICATION OF WHICH INDIVIDUALS SHOULD RECEIVE THE QUESTIONNAIRE FOR COMPLETION. THE RESULTS ARE COMPILED CENTRALLY AND REVIEWED BY THE IOWA HEALTH SYSTEM COMPLIANCE OFFICER AND DIRECTOR OF INTERNAL AUDIT. THE DETAIL RESULTS ARE REPORTED TO A COMMITTEE OF THE SYSTEM BOARD. THE RESULTS RELATED TO SPECIFIC REGIONAL PARENT COMPANIES, THEIR HOSPITALS AND RELATED ORGANIZATIONS, ARE DISTRIBUTED IN DETAIL TO THE CHAIRPERSON OF THE REGIONAL PARENT ORGANIZATION, THE CHIEF EXECUTIVE OFFICER, CHIEF FINANCIAL OFFICER AND COMPLIANCE MANAGER. THESE INDIVIDUALS ARE ALSO REMINDED OF THE APPROPRIATE PROCESS TO BE FOLLOWED DURING THE YEAR TO ADDRESS POTENTIAL CONFLICTS OF INTEREST THAT RELATE TO MATTERS THAT ARE BROUGHT TO THE BOARD OF DIRECTORS FOR ACTION.

THE INFORMATION DISCLOSED IS USED TO IDENTIFY POTENTIAL CONFLICTS OF INTEREST AND TO ASSIST IN COMPLETING IRS AND MEDICAID QUESTIONNAIRES. ANY DUALITY OF INTEREST OR POSSIBLE CONFLICT OF INTEREST ON THE PART OF ANY ORGANIZATIONAL OFFICER, DIRECTOR, KEY EMPLOYEE OR REPORTING PHYSICIAN TOGETHER WITH ALL MATERIAL FACTS, SHOULD BE DISCLOSED TO THE BOARD OF DIRECTORS AND MADE A MATTER OF RECORD, EITHER THROUGH AN ANNUAL PROCEDURE OR WHEN THE INTEREST OCCURS OR BECOMES A MATTER OF BOARD ACTION. ANY ORGANIZATIONAL OFFICER, DIRECTOR, KEY EMPLOYEE OR REPORTING PHYSICIAN HAVING A CONFLICT OF INTEREST IN ANY MATTER SHOULD NOT BE PRESENT DURING GENERAL DISCUSSION NOR VOTE OR USE HIS OR HER PERSONAL INFLUENCE ON THE MATTER, AND HE OR SHE SHOULD NOT BE COUNTED IN DETERMINING THE EXISTENCE OF A QUORUM FOR PURPOSES OF THE MATTER OR ITEM AS TO WHICH A CONFLICT EXISTS. THE BOARD SHOULD EXCLUDE THE INDIVIDUAL FROM ANY DISCUSSION OR VOTE IN WHICH THE BOARD DECIDES WHETHER OR NOT A CONFLICT OF INTEREST EXISTS.

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IN CASES IN WHICH AN OFFICER, DIRECTOR, KEY EMPLOYEE, REPORTING PHYSICIAN OR THE INDIVIDUAL'S HOUSEHOLD MEMBER HAS A CONFLICT OF INTEREST IN AN ARRANGEMENT OR TRANSACTION, THE FOLLOWING ADDITIONAL STEPS MAY BE TAKEN AT THE DIRECTION OF THE BOARD OF DIRECTORS: 1) AFTER DISCLOSURE OF THE FINANCIAL INTEREST AND ALL MATERIAL FACTS, AND AFTER ANY DISCUSSION WITH THE INTERESTED PERSON, HE OR SHE SHALL LEAVE THE BOARD OR COMMITTEE MEETING WHILE THE DETERMINATION OF A CONFLICT OF INTEREST IS DISCUSSED AND VOTED UPON. THE REMAINING BOARD OR COMMITTEE MEMBERS SHALL 1) DECIDE IF A CONFLICT OF INTEREST EXISTS, 2) A DISINTERESTED PERSON OR COMMITTEE MAY BE APPOINTED TO INVESTIGATE ALTERNATIVES TO THE PROPOSED ARRANGEMENT OR TRANSACTION; 3) IN ORDER TO APPROVE THE ARRANGEMENT OR TRANSACTION, THE BOARD MUST FIRST FIND, BY MAJORITY VOTE OF DISINTERESTED MEMBERS, THAT THE ARRANGEMENT OR TRANSACTION IS IN THE ORGANIZATION'S BEST INTEREST, IS FAIR AND REASONABLE TO THE ORGANIZATION, AND, AFTER REASONABLE INVESTIGATION, THE DISINTERESTED MEMBERS HAVE DETERMINED THAT A MORE ADVANTAGEOUS TRANSACTION OR ARRANGEMENT CANNOT BE OBTAINED WITH REASONABLE EFFORTS UNDER THE CIRCUMSTANCES;

THE MINUTES OF THE BOARD AND ALL COMMITTEES WITH BOARD-DELEGATED POWERS SHALL CONTAIN: 1) THE NAMES OF THE PERSONS WHO DISCLOSED OR OTHERWISE WERE FOUND TO HAVE A FINANCIAL INTEREST IN CONNECTION WITH AN ACTUAL OR POSSIBLE CONFLICT OF INTEREST, THE NATURE OF THE FINANCIAL INTEREST, ANY ACTION TAKEN TO DETERMINE WHETHER A CONFLICT OF INTEREST WAS PRESENT, AND THE BOARD'S OR COMMITTEE'S DECISION AS TO WHETHER A CONFLICT OF INTEREST IN FACT EXISTED; 2) THE NAMES OF THE PERSONS WHO WERE PRESENT FOR DISCUSSIONS AND VOTES RELATING TO THE TRANSACTION OR ARRANGEMENT, THE CONTENT OF THE DISCUSSION, INCLUDING ANY ALTERNATIVES TO THE PROPOSED TRANSACTION OR



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ARRANGEMENT, AND A RECORD OF ANY VOTES TAKEN IN CONNECTION THEREWITH;

IN ORDER TO PROTECT THE ORGANIZATION'S BEST INTERESTS, APPROPRIATE DISCIPLINARY ACTION MAY BE TAKEN WITH RESPECT TO AN OFFICER, DIRECTOR, KEY EMPLOYEE OR REPORTING PHYSICIAN WHO VIOLATES THE CONFLICT OF INTEREST POLICY.

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

THE EXECUTIVE COMMITTEE OF THE IOWA HEALTH SYSTEM BOARD OF DIRECTORS ("COMMITTEE") CONDUCTS A COMPREHENSIVE REVIEW OF ALL COMPENSATION AND BENEFITS PROVIDED TO THE ORGANIZATION'S OFFICERS AND KEY EMPLOYEES, INCLUDING THE IHS CHIEF EXECUTIVE OFFICER (THE "CEO"). THIS REVIEW COMPARES THE TOTAL COMPENSATION AND VALUE OF BENEFITS PROVIDED TO EACH EXECUTIVE, ON A POSITION BY POSITION BASIS, TO THAT PROVIDED TO FUNCTIONALLY SIMILAR POSITIONS IN SIMILARLY SITUATED ORGANIZATIONS. THIS REVIEW IS CONDUCTED BY THE COMMITTEE WITH THE ASSISTANCE OF A NATIONAL, INDEPENDENT COMPENSATION CONSULTANT REPORTING DIRECTLY TO THE COMMITTEE. THE COMMITTEE HAS BEEN DELEGATED THE RESPONSIBILITY FOR OVERSIGHT OF EXECUTIVE COMPENSATION AND IS MADE UP ENTIRELY OF INDEPENDENT DIRECTORS WITHIN THE MEANING OF THE "REBUTTABLE PRESUMPTION OF REASONABLENESS" UNDER THE FEDERAL INCOME TAX INTERMEDIATE SANCTIONS RULES. THE COMPENSATION CONSULTANT HOLDS ITSELF OUT TO THE PUBLIC AS A COMPENSATION CONSULTANT, PERFORMS THESE VALUATIONS ON A REGULAR BASIS, IS QUALIFIED TO MAKE THE VALUATIONS OF THE SERVICES INVOLVED, AND HAS SO INDICATED IN A WRITTEN CERTIFICATION TO THE COMMITTEE.

BASED UPON THE ADVICE OF THE COMPENSATION CONSULTANT, AND APPLYING THE BOARD'S COMPENSATION PHILOSOPHY, THE COMMITTEE ESTABLISHES THE OVERALL

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ADJUSTMENT IN COMPENSATION AND BENEFITS FOR THE TOP EXECUTIVES IN THE ENTIRE HEALTH SYSTEM AND DELEGATES TO THE CEO THE AUTHORITY TO MAKE ADJUSTMENTS, CONSISTENT WITH THE COMMITTEE'S DIRECTION, FOR THE OTHER EXECUTIVES. THE COMMITTEE DETERMINES ALL ASPECTS OF THE COMPENSATION AND BENEFITS OF THE CEO. THE COMMITTEE INTENTIONALLY TAKES ALL THE STEPS NECESSARY TO QUALIFY FOR THE REBUTTABLE PRESUMPTION OF REASONABLENESS UNDER THE FEDERAL INCOME TAX LAW INTERMEDIATE SANCTIONS RULES, INCLUDING CONTEMPORANEOUS SUBSTANTIATION OF ALL COMMITTEE MEETINGS AND ACTIONS. THE ORGANIZATION BELIEVES IT IS IN FULL COMPLIANCE WITH SECTION 4958 OF THE IRC, PROVIDES NO MORE THAN REASONABLE AND FAIR MARKET VALUE COMPENSATION AND BENEFITS FOR ITS EMPLOYEES AND DOES NOT PROVIDE ANY EXCESS COMPENSATION OR BENEFITS AS PROHIBITED BY SECTION 4958.

THE REVIEW OF COMPENSATION AND BENEFITS WAS LAST PERFORMED IN DECEMBER 2016 FOR THE FOLLOWING INDIVIDUALS: DEBORAH SIMON.

THE COMPENSATION AND BENEFITS OF THE OTHER PERSONS LISTED ON FORM 990, PART VII WAS ESTABLISHED BY AN INDEPENDENT PERSON/COMMITTEE USING AN INDEPENDENT COMPENSATION CONSULTANT AND/OR COMPENSATION SURVEY OR STUDY FOR SIMILARLY QUALIFIED PERSONS IN FUNCTIONALLY COMPARABLE POSITIONS AT SIMILARLY SITUATED ORGANIZATIONS. COMPENSATION AND BENEFITS ARE BASED ON THE FAIR MARKET VALUE OF THE SERVICES PROVIDED TO THE ORGANIZATION.

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

THE ORGANIZATION'S GOVERNING DOCUMENTS ARE AVAILABLE UPON REQUEST THROUGH THE IOWA HEALTH SYSTEM, OUR PARENT ORGANIZATION, LEGAL DEPARTMENT. THE ORGANIZATION'S CONFLICT OF INTEREST POLICY AND FINANCIAL STATEMENTS ARE PUBLICLY AVAILABLE ON THE IOWA HEALTH SYSTEM WEBSITE, [WWW.UNITYPOINT.ORG](http://WWW.UNITYPOINT.ORG).

|   |   |
|---|---|
| Name of the organization<br><b>METHODIST MEDICAL CENTER OF ILLINOIS</b> | Employer identification number<br><b>37-0661223</b> |
|---|---|

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

|   |             |
|---|-------------|
| CHANGE IN BENEFICIAL INTEREST IN METHODIST MEDICAL CENTER |             |
| FOUNDATION  | 1,327,871.  |
| CHANGES IN PENSION LIABILITY                              | -4,919,095. |
| SELF INSURED TRUST AGREEMENT INVESTMENT                   | 253,999.    |
| TOTAL TO FORM 990, PART XI, LINE 9                        | -3,337,225. |

**SCHEDULE R  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Related Organizations and Unrelated Partnerships**

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

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

OMB No. 1545-0047

**2016**

**Open to Public  
Inspection**

Name of the organization **METHODIST MEDICAL CENTER OF ILLINOIS** Employer identification number **37-0661223**

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

| (a)<br>Name, address, and EIN (if applicable)<br>of disregarded entity | (b)<br>Primary activity | (c)<br>Legal domicile (state or<br>foreign country) | (d)<br>Total income | (e)<br>End-of-year assets | (f)<br>Direct controlling<br>entity |
|--|-------------------------|---|---------------------|---------------------------|-------------------------------------|
|  |                         |   |                     |                           |                                     |
|  |                         |   |                     |                           |                                     |
|  |                         |   |                     |                           |                                     |
|  |                         |   |                     |                           |                                     |
|  |                         |   |                     |                           |                                     |
|  |                         |   |                     |                           |                                     |
|  |                         |   |                     |                           |                                     |
|  |                         |   |                     |                           |                                     |
|  |                         |   |                     |                           |                                     |
|  |                         |   |                     |                           |                                     |
|  |                         |   |                     |                           |                                     |

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

| (a)<br>Name, address, and EIN<br>of related organization                                      | (b)<br>Primary activity                                  | (c)<br>Legal domicile (state or<br>foreign country) | (d)<br>Exempt Code<br>section | (e)<br>Public charity<br>status (if section<br>501(c)(3)) | (f)<br>Direct controlling<br>entity            | (g)<br>Section 512(b)(13)<br>controlled<br>entity? |    |
|---|--|---|-------------------------------|---|--|--|----|
|   |  |   |                               |   |  | Yes  | No |
| ALLEN COLLEGE - 42-1351526<br>1825 LOGAN AVENUE<br>WATERLOO, IA 50703                         | EDUCATE AND DEVELOP<br>HEALTHCARE PROFESSIONALS          | IOWA  | 501(C)(3)                     | 170(B)(1)<br>(A)(II)                                      | ALLEN HEALTH<br>SYSTEMS, INC.                  |  | X  |
| ALLEN HEALTH SYSTEMS, INC. - 42-1201924<br>1825 LOGAN AVENUE<br>WATERLOO, IA 50703            | SUPPORT AFFILIATES'<br>MISSION TO IMPROVE HEALTH<br>CARE | IOWA  | 501(C)(3)                     | 509(A)(3),<br>TYPE II                                     | IOWA HEALTH<br>SYSTEM                          |  | X  |
| ALLEN MEMORIAL HOSPITAL CORPORATION -<br>42-0698265, 1825 LOGAN AVENUE, WATERLOO, IA<br>50703 | HOSPITAL   | IOWA  | 501(C)(3)                     | 170(B)(1)<br>(A)(III)                                     | ALLEN HEALTH<br>SYSTEMS, INC.                  |  | X  |
| ANAMOSA AREA AMBULANCE SERVICE - 42-1466284<br>101 GRANT WOOD DRIVE<br>ANAMOSA, IA 52205      | PROVIDE AMBULANCE SERVICES                               | IOWA  | 501(C)(3)                     | 509(A)(2)   | ST. LUKE'S/JONES<br>REGIONAL MEDICAL<br>CENTER |  | X  |

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

Schedule R (Form 990) 2016

**Part II** Continuation of Identification of Related Tax-Exempt Organizations

| (a)<br>Name, address, and EIN<br>of related organization   | (b)<br>Primary activity                                  | (c)<br>Legal domicile (state or<br>foreign country) | (d)<br>Exempt Code<br>section | (e)<br>Public charity<br>status (if section<br>501(c)(3)) | (f)<br>Direct controlling<br>entity | (g)<br>Section 512(b)(13)<br>controlled<br>organization? |    |
|--|--|---|-------------------------------|---|-------------------------------------|--|----|
|  |  |   |                               |   |                                     | Yes  | No |
| BLACK HAWK-GRUNDY MENTAL HEALTH CENTER, INC.<br>- 42-0733463, 3251 WEST NINTH STREET,<br>WATERLOO, IA 50702                | MENTAL HEALTH CARE                                       | IOWA  | 501(C)(3)                     | 170(B)(1)<br>(A)(VI)                                      | ALLEN HEALTH<br>SYSTEMS, INC.       |  | X  |
| CENTRAL IOWA HEALTH PROPERTIES CORPORATION -<br>42-1233759, 1200 PLEASANT STREET, DES<br>MOINES, IA 50309                  | PROPERTY HOLDING COMPANY                                 | IOWA  | 501(C)(2)                     |   | CENTRAL IOWA<br>HEALTH SYSTEM       |  | X  |
| CENTRAL IOWA HEALTH SYSTEM - 42-1189791<br>1200 PLEASANT STREET<br>DES MOINES, IA 50309                                    | SUPPORT AFFILIATES'<br>MISSION TO IMPROVE HEALTH<br>CARE | IOWA  | 501(C)(3)                     | 509(A)(3),<br>TYPE II                                     | IOWA HEALTH<br>SYSTEM               |  | X  |
| CENTRAL IOWA HOSPITAL CORPORATION -<br>42-0680452, 1200 PLEASANT STREET, DES<br>MOINES, IA 50309                           | HOSPITAL   | IOWA  | 501(C)(3)                     | 170(B)(1)<br>(A)(III)                                     | CENTRAL IOWA<br>HEALTH SYSTEM       |  | X  |
| DES MOINES AREA MEDICAL EDUCATION<br>CONSORTIUM, INC. - 42-1412497, 1415 WOODLAND<br>AVE., SUITE 130, DES MOINES, IA 50309 | COORDINATION OF MEDICAL<br>EDUCATION PROGRAMS            | IOWA  | 501(C)(3)                     | 509(A)(3),<br>TYPE III                                    |                                     |  | X  |
| FINLEY TRI-STATES HEALTH GROUP, INC. -<br>42-1307495, 350 NORTH GRANDVIEW AVENUE,<br>DUBUQUE, IA 52001                     | SUPPORT AFFILIATES'<br>MISSION TO IMPROVE HEALTH<br>CARE | IOWA  | 501(C)(3)                     | 509(A)(3),<br>TYPE II                                     | IOWA HEALTH<br>SYSTEM               |  | X  |
| FRIENDS OF THE BLACK HAWK-GRUNDY MENTAL<br>HEALTH CENTER - 42-1372380, 3820 HILLSIDE<br>DRIVE, CEDAR FALLS, IA 50613       | CHARITABLE FUNDRAISING                                   | IOWA  | 501(C)(3)                     | 170(B)(1)<br>(A)(VI)                                      | ALLEN HEALTH<br>SYSTEMS, INC.       |  | X  |
| HULT CENTER FOR HEALTHY LIVING, INC. -<br>36-3510390, 5409 N KNOXVILLE AVE, PEORIA, IL<br>61614                            | HEALTH EDUCATION TO THE<br>COMMUNITY                     | ILLINOIS  | 501(C)(3)                     | 170(B)(1)<br>(A)(VI)                                      | PROCTOR HOSPITAL                    |  | X  |
| IOWA HEALTH FOUNDATION - 42-1467682<br>1415 WOODLAND AVE., SUITE E-200<br>DES MOINES, IA 50309                             | CHARITABLE FUNDRAISING                                   | IOWA  | 501(C)(3)                     | 170(B)(1)<br>(A)(VI)                                      | CENTRAL IOWA<br>HEALTH SYSTEM       |  | X  |
| IOWA HEALTH SYSTEM - 42-1435199<br>1776 WEST LAKES PKWY, #400<br>WEST DES MOINES, IA 50266                                 | SUPPORT AFFILIATES'<br>MISSION TO IMPROVE HEALTH<br>CARE | IOWA  | 501(C)(3)                     | 509(A)(3),<br>TYPE III                                    |                                     |  | X  |
| IOWA PHYSICIANS CLINIC MEDICAL FOUNDATION -<br>42-1411630, 8101 BIRCHWOOD COURT, JOHNSTON,<br>IA 50131                     | PRIMARY HEALTH CARE<br>SERVICES                          | IOWA  | 501(C)(3)                     | 170(B)(1)<br>(A)(III)                                     | IOWA HEALTH<br>SYSTEM               |  | X  |
| MEMORIAL FOUNDATION OF ALLEN HOSPITAL -<br>42-1201138, 1825 LOGAN AVENUE, WATERLOO, IA<br>50703                            | CHARITABLE FUNDRAISING                                   | IOWA  | 501(C)(3)                     | 170(B)(1)<br>(A)(VI)                                      | ALLEN HEALTH<br>SYSTEMS, INC.       |  | X  |

**Part II** Continuation of Identification of Related Tax-Exempt Organizations

| (a)<br>Name, address, and EIN<br>of related organization   | (b)<br>Primary activity                                     | (c)<br>Legal domicile (state or<br>foreign country) | (d)<br>Exempt Code<br>section | (e)<br>Public charity<br>status (if section<br>501(c)(3)) | (f)<br>Direct controlling<br>entity         | (g)<br>Section 512(b)(13)<br>controlled<br>organization? |    |
|--|---|---|-------------------------------|---|---|--|----|
|  |   |   |                               |   |   | Yes  | No |
| MERITER FOUNDATION, INC. - 23-7098688<br>202 SOUTH PARK STREET<br>MADISON, WI 53715                              | CHARITABLE FUNDRAISING                                      | WISCONSIN   | 501(C)(3)                     | 170(B)(1)<br>(A)(VI)                                      | MERITER HEALTH<br>SERVICES, INC.            |  | X  |
| MERITER HEALTH SERVICES, INC. - 39-1412318<br>202 SOUTH PARK STREET<br>MADISON, WI 53715                         | SUPPORT AFFILIATES'<br>MISSION TO IMPROVE HEALTH<br>CARE    | WISCONSIN   | 501(C)(3)                     | 509(A)(3),<br>TYPE II                                     | IOWA HEALTH<br>SYSTEM                       |  | X  |
| MERITER HOSPITAL, INC. - 39-0806367<br>202 SOUTH PARK STREET<br>MADISON, WI 53715                                | HOSPITAL  | WISCONSIN   | 501(C)(3)                     | 170(B)(1)<br>(A)(III)                                     | MERITER HEALTH<br>SERVICES, INC.            |  | X  |
| MERITER MEDICAL GROUP, INC. - 05-0545222<br>202 SOUTH PARK STREET<br>MADISON, WI 53715                           | SUPPORT SERVICES FOR<br>MEDICAL CARE AND HEALTH<br>SERVICES | WISCONSIN   | 501(C)(3)                     | 509(A)(3),<br>TYPE II                                     | MERITER HOSPITAL,<br>INC.                   |  | X  |
| METHODIST HEALTH SERVICES CORPORATION -<br>37-1111135, 221 NORTHEAST GLEN OAK AVENUE,<br>PEORIA, IL 61636        | SUPPORT AFFILIATES'<br>MISSION TO IMPROVE HEALTH<br>CARE    | ILLINOIS  | 501(C)(3)                     | 509(A)(3),<br>TYPE III                                    | IOWA HEALTH<br>SYSTEM                       |  | X  |
| METHODIST MEDICAL CENTER FOUNDATION -<br>51-0186460, 221 NORTHEAST GLEN OAK AVENUE,<br>PEORIA, IL 61636          | CHARITABLE FUNDRAISING                                      | ILLINOIS  | 501(C)(3)                     | 170(B)(1)<br>(A)(VI)                                      | METHODIST HEALTH<br>SERVICES<br>CORPORATION |  | X  |
| METHODIST MEDICAL CENTER OF ILLINOIS -<br>37-0661223, 221 NORTHEAST GLEN OAK AVENUE,<br>PEORIA, IL 61636         | HOSPITAL  | ILLINOIS  | 501(C)(3)                     | 170(B)(1)<br>(A)(III)                                     | METHODIST HEALTH<br>SERVICES<br>CORPORATION |  | X  |
| METHODIST SERVICES, INC. - 37-1111134<br>221 NORTHEAST GLEN OAK AVENUE<br>PEORIA, IL 61636                       | OFFICE RENTAL   | ILLINOIS  | 501(C)(3)                     | 509(A)(2)   | METHODIST HEALTH<br>SERVICES<br>CORPORATION |  | X  |
| NELLIE R. SHERWOOD TRUST - 42-6061621<br>1026 A AVENUE NE<br>CEDAR RAPIDS, IA 52402                              | PAY MEDICAL BILLS OF<br>RETIRED TEACHERS UNABLE TO<br>PAY   | IOWA  | 501(C)(3)                     | 509(A)(3),<br>TYPE I                                      | ST. LUKE'S<br>METHODIST<br>HOSPITAL         |  | X  |
| NORTH CENTRAL IOWA MENTAL HEALTH CENTER,<br>INCORPORATED - 42-0937390, 720 KENYON DRIVE,<br>FORT DODGE, IA 50501 | MENTAL HEALTH CARE  | IOWA  | 501(C)(3)                     | 170(B)(1)<br>(A)(III)                                     | TRINITY HEALTH<br>SYSTEMS, INC.             |  | X  |
| NORTHWEST IOWA HOSPITAL CORPORATION -<br>42-1019872, 2720 STONE PARK BLVD., SIOUX<br>CITY, IA 51104              | HOSPITAL  | IOWA  | 501(C)(3)                     | 170(B)(1)<br>(A)(III)                                     | ST. LUKE'S HEALTH<br>SYSTEM, INC.           |  | X  |
| PROCTOR HEALTH CARE INCORPORATED -<br>37-1133412, 5409 N KNOXVILLE AVE, PEORIA, IL<br>61614                      | SUPPORT AFFILIATES'<br>MISSION TO IMPROVE HEALTH<br>CARE    | ILLINOIS  | 501(C)(3)                     | 170(B)(1)<br>(A)(III)                                     | METHODIST HEALTH<br>SERVICES<br>CORPORATION |  | X  |

**Part II** Continuation of Identification of Related Tax-Exempt Organizations

| (a)<br>Name, address, and EIN<br>of related organization  | (b)<br>Primary activity                                  | (c)<br>Legal domicile (state or<br>foreign country) | (d)<br>Exempt Code<br>section | (e)<br>Public charity<br>status (if section<br>501(c)(3)) | (f)<br>Direct controlling<br>entity        | (g)<br>Section 512(b)(13)<br>controlled<br>organization? |    |
|---|--|---|-------------------------------|---|--|--|----|
|   |  |   |                               |   |  | Yes  | No |
| PROCTOR HEALTH SYSTEMS - 36-4147437<br>5409 N KNOXVILLE AVE<br>PEORIA, IL 61614   | PRIMARY HEALTH CARE<br>SERVICES                          | ILLINOIS  | 501(C)(3)                     | 170(B)(1)<br>(A)(III)                                     | PROCTOR HEALTH<br>CARE INCORPORATED        |  | X  |
| PROCTOR HOSPITAL - 37-0681540<br>5409 N KNOXVILLE AVE<br>PEORIA, IL 61614   | HOSPITAL   | ILLINOIS  | 501(C)(3)                     | 170(B)(1)<br>(A)(III)                                     | PROCTOR HEALTH<br>CARE INCORPORATED        |  | X  |
| SELF INSURANCE TRUST AGREEMENT EST. BY<br>METHODIST MEDICAL CENTER OF ILLINOIS , 221<br>NORTHEAST GLEN OAK AVENUE, PEORIA, IL 61636 | FUND SELF-INSURANCE PLAN                                 | ILLINOIS  | 501(C)(3)                     | 509(A)(3),<br>TYPE I                                      | METHODIST MEDICAL<br>CENER OF ILLINOIS     | X  |    |
| SHARED MAGNETIC RESONANCE IMAGING FACILITY,<br>INC. - 39-1534744, 1104 JOHN NOLEN DRIVE,<br>MADISON, WI 53713                       | MEDICAL TECHNOLOGY                                       | WISCONSIN   | 501(C)(3)                     | 509(A)(3),<br>TYPE I                                      |  |  | X  |
| SIOUXLAND PACE, INC. - 26-1120134<br>313 COOK STREET<br>SIOUX CITY, IA 51103  | ALL-INCLUSIVE CARE FOR THE<br>ELDERLY                    | IOWA  | 501(C)(3)                     | 170(B)(1)<br>(A)(III)                                     | ST. LUKE'S HEALTH<br>SYSTEM, INC.          |  | X  |
| ST. LUKE'S HEALTH RESOURCES - 42-1059182<br>2720 STONE PARK BLVD.<br>SIOUX CITY, IA 51104   | OUTPATIENT CLINICS AND<br>HEALTHCARE SERVICES            | IOWA  | 501(C)(3)                     | 509(A)(2)   | ST. LUKE'S HEALTH<br>SYSTEM, INC.          |  | X  |
| ST. LUKE'S HEALTH SYSTEM, INC. - 42-1294091<br>2720 STONE PARK BLVD.<br>SIOUX CITY, IA 51104  | SUPPORT AFFILIATES'<br>MISSION TO IMPROVE HEALTH<br>CARE | IOWA  | 501(C)(3)                     | 509(A)(3),<br>TYPE III                                    | IOWA HEALTH<br>SYSTEM                      |  | X  |
| ST. LUKE'S HEALTHCARE - 42-1487968<br>1026 A AVENUE NE<br>CEDAR RAPIDS, IA 52402  | SUPPORT AFFILIATES'<br>MISSION TO IMPROVE HEALTH<br>CARE | IOWA  | 501(C)(3)                     | 509(A)(3),<br>TYPE II                                     | IOWA HEALTH<br>SYSTEM                      |  | X  |
| ST. LUKE'S METHODIST HOSPITAL - 42-0504780<br>1026 A AVENUE NE<br>CEDAR RAPIDS, IA 52402  | HOSPITAL   | IOWA  | 501(C)(3)                     | 170(B)(1)<br>(A)(III)                                     | ST. LUKE'S<br>HEALTHCARE                   |  | X  |
| ST. LUKE'S/JONES REGIONAL MEDICAL CENTER -<br>42-1487967, 1795 HIGHWAY 64 EAST, ANAMOSA,<br>IA 52205                                | HOSPITAL   | IOWA  | 501(C)(3)                     | 170(B)(1)<br>(A)(III)                                     | ST. LUKE'S<br>HEALTHCARE                   |  | X  |
| STL CARE COMPANY - 42-1276632<br>1026 A AVENUE NE<br>CEDAR RAPIDS, IA 52402   | IMPROVE PUBLIC HEALTH<br>SERVICES                        | IOWA  | 501(C)(3)                     | 509(A)(2)   | ST. LUKE'S<br>HEALTHCARE                   |  | X  |
| THE DUBUQUE VISITING NURSE ASSOCIATION -<br>42-0680410, 350 NORTH GRANDVIEW AVENUE,<br>DUBUQUE, IA 52001                            | PUBLIC HEALTH<br>SERVICES/HOME CARE                      | IOWA  | 501(C)(3)                     | 509(A)(2)   | FINLEY TRI-STATES<br>HEALTH GROUP,<br>INC. |  | X  |

**Part II** Continuation of Identification of Related Tax-Exempt Organizations

| (a)<br>Name, address, and EIN<br>of related organization  | (b)<br>Primary activity                                     | (c)<br>Legal domicile (state or<br>foreign country) | (d)<br>Exempt Code<br>section | (e)<br>Public charity<br>status (if section<br>501(c)(3)) | (f)<br>Direct controlling<br>entity        | (g)<br>Section 512(b)(13)<br>controlled<br>organization? |    |
|---|---|---|-------------------------------|---|--|--|----|
|   |   |   |                               |   |  | Yes  | No |
| THE FINLEY HOSPITAL -- 42-0680354<br>350 NORTH GRANDVIEW AVENUE<br>DUBUQUE, IA 52001                            | HOSPITAL  | IOWA  | 501(C)(3)                     | 170(B)(1)<br>(A)(III)                                     | FINLEY TRI-STATES<br>HEALTH GROUP,<br>INC. |  | X  |
| THE ROBERT YOUNG CENTER FOR COMMUNITY MENTAL<br>HEALTH - 36-3678909, 2701 17TH STREET, ROCK<br>ISLAND, IL 61201 | MENTAL HEALTH CARE  | ILLINOIS  | 501(C)(3)                     | 170(B)(1)<br>(A)(VI)                                      | TRINITY REGIONAL<br>HEALTH SYSTEM          |  | X  |
| TRIMARK PHYSICIANS GROUP -- 45-3791448<br>802 KENYON ROAD<br>FORT DODGE, IA 50501                               | SUPPORT SERVICES FOR<br>MEDICAL CARE AND HEALTH<br>SERVICES | IOWA  | 501(C)(3)                     | 170(B)(1)<br>(A)(III)                                     | TRINITY HEALTH<br>SYSTEMS, INC.            |  | X  |
| TRINITY BUILDING CORPORATION -- 42-1376187<br>802 KENYON ROAD<br>FORT DODGE, IA 50501                           | PROPERTY HOLDING COMPANY                                    | IOWA  | 501(C)(2)                     |   | TRINITY HEALTH<br>SYSTEMS, INC.            |  | X  |
| TRINITY COLLEGE OF NURSING & HEALTH SCIENCES<br>-- 81-0994377, 2122 25TH AVE, ROCK ISLAND, IL<br>61201          | EDUCATE AND DEVELOP<br>HEALTHCARE PROFESSIONALS             | ILLINOIS  | 501(C)(3)                     | 170(B)(1)<br>(A)(II)                                      | TRINITY MEDICAL<br>CENTER                  |  | X  |
| TRINITY HEALTH FOUNDATION -- 42-1222381<br>802 KENYON ROAD<br>FORT DODGE, IA 50501                              | CHARITABLE FUNDRAISING                                      | IOWA  | 501(C)(3)                     | 170(B)(1)<br>(A)(VI)                                      | TRINITY HEALTH<br>SYSTEMS, INC.            |  | X  |
| TRINITY HEALTH FOUNDATION -- 36-3321751<br>2701 17TH STREET<br>ROCK ISLAND, IL 61201                            | CHARITABLE FUNDRAISING                                      | ILLINOIS  | 501(C)(3)                     | 170(B)(1)<br>(A)(VI)                                      | TRINITY REGIONAL<br>HEALTH SYSTEM          |  | X  |
| TRINITY HEALTH SYSTEMS, INC. -- 42-1222877<br>802 KENYON ROAD<br>FORT DODGE, IA 50501                           | SUPPORT AFFILIATES'<br>MISSION TO IMPROVE HEALTH<br>CARE    | IOWA  | 501(C)(3)                     | 509(A)(3),<br>TYPE II                                     | IOWA HEALTH<br>SYSTEM                      |  | X  |
| TRINITY MEDICAL CENTER -- 36-2739299<br>2701 17TH STREET<br>ROCK ISLAND, IL 61201                               | HOSPITAL  | ILLINOIS  | 501(C)(3)                     | 170(B)(1)<br>(A)(III)                                     | TRINITY REGIONAL<br>HEALTH SYSTEM          |  | X  |
| TRINITY REGIONAL HEALTH SYSTEM -- 36-3351952<br>2701 17TH STREET<br>ROCK ISLAND, IL 61201                       | SUPPORT AFFILIATES'<br>MISSION TO IMPROVE HEALTH<br>CARE    | ILLINOIS  | 501(C)(3)                     | 509(A)(3),<br>TYPE II                                     | IOWA HEALTH<br>SYSTEM                      |  | X  |
| TRINITY REGIONAL HOSPITAL AUXILIARY --<br>42-6081474, 802 KENYON ROAD, FORT DODGE, IA<br>50501                  | CHARITABLE FUNDRAISING AND<br>VOLUNTEER SERVICES            | IOWA  | 501(C)(3)                     | 509(A)(2)   | TRINITY REGIONAL<br>MEDICAL CENTER         |  | X  |
| TRINITY REGIONAL MEDICAL CENTER -- 42-1009175<br>802 KENYON ROAD<br>FORT DODGE, IA 50501                        | HOSPITAL  | IOWA  | 501(C)(3)                     | 170(B)(1)<br>(A)(III)                                     | TRINITY HEALTH<br>SYSTEMS, INC.            |  | X  |





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

| (a)<br>Name, address, and EIN<br>of related organization  | (b)<br>Primary activity                                      | (c)<br>Legal domicile<br>(state or<br>foreign<br>country) | (d)<br>Direct controlling<br>entity | (e)<br>Predominant income<br>(related, unrelated,<br>excluded from tax under<br>sections 512-514) | (f)<br>Share of total<br>income | (g)<br>Share of<br>end-of-year<br>assets | (h)<br>Disproportionate<br>allocations? |    | (i)<br>Code V-UBI<br>amount in box<br>20 of Schedule<br>K-1 (Form 1065) | (j)<br>General or<br>managing<br>partner? |    | (k)<br>Percentage<br>ownership |
|---|--|---|-------------------------------------|---|---------------------------------|--|---|----|---|---|----|--------------------------------|
|   |  |   |                                     |   |                                 |  | Yes                                     | No |   | Yes                                       | No |                                |
| ADVANCED IMAGING CENTER, LLC<br>- 36-4356301, 615 VALLEY VIEW<br>DRIVE, MOLINE, IL 61265                            | DIAGNOSTIC<br>RADIOLOGY<br>CENTER                            | IA  | N/A                                 | N/A   | N/A                             | N/A                                      | N/A                                     |    | N/A   | N/A                                       |    | N/A                            |
| ALLEN MEMORIAL HOSPITAL<br>ORTHOPEDIC CO-MANAGEMENT CO.,<br>LLC - 45-3237125, 1825 LOGAN<br>AVE, WATERLOO, IA 50703 | ORTHOPEDIC<br>MANAGEMENT &<br>ADMINISTRATIVE<br>SERVICES     | IA  | N/A                                 | N/A   | N/A                             | N/A                                      | N/A                                     |    | N/A   | N/A                                       |    | N/A                            |
| CENTRAL IOWA CARDIOVASCULAR<br>CO-MANAGEMENT CO., L.L.C. -<br>27-3625869, 1200 PLEASANT ST,<br>DES MOINES, IA 50309 | CARDIOVASCULAR<br>MANAGEMENT &<br>ADMINISTRATIVE<br>SERVICES | IA  | N/A                                 | N/A   | N/A                             | N/A                                      | N/A                                     |    | N/A   | N/A                                       |    | N/A                            |
| CENTRAL IOWA ONCOLOGY<br>CO-MANAGEMENT COMPANY -<br>45-3017991, 1200 PLEASANT<br>STREET, DES MOINES, IA 50309       | ONCOLOGY<br>MANAGEMENT &<br>ADMINISTRATIVE<br>SERVICES       | IA  | N/A                                 | N/A   | N/A                             | N/A                                      | N/A                                     |    | N/A   | N/A                                       |    | N/A                            |

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

| (a)<br>Name, address, and EIN<br>of related organization                                | (b)<br>Primary activity         | (c)<br>Legal domicile<br>(state or<br>foreign<br>country) | (d)<br>Direct controlling<br>entity | (e)<br>Type of entity<br>(C corp, S corp,<br>or trust) | (f)<br>Share of total<br>income | (g)<br>Share of<br>end-of-year<br>assets | (h)<br>Percentage<br>ownership | (i)<br>Section<br>512(b)(13)<br>controlled<br>entity? |    |
|---|---------------------------------|---|-------------------------------------|--|---------------------------------|--|--------------------------------|---|----|
|   |                                 |   |                                     |  |                                 |  |                                | Yes   | No |
| BELCREST SERVICES LTD - 37-1196307<br>5409 N KNOXVILLE AVE<br>PEORIA, IL 61614          | MEDICAL SERVICES                | IL  | N/A                                 | C CORP   | N/A                             | N/A                                      | N/A                            |   | X  |
| BROADBAND, INC. - 27-3819741<br>1776 WEST LAKES PKWY. #400<br>WEST DES MOINES, IA 50266 | INFORMATION<br>TECHNOLOGY MGMT. | IA  | N/A                                 | C CORP   | N/A                             | N/A                                      | N/A                            |   | X  |
| DELHI POINT CONDO ASSOCIATION - 42-1467002<br>350 N. GRANDVIEW<br>DUBUQUE, IA 52001     | REAL ESTATE<br>MANAGEMENT       | IA  | N/A                                 | C CORP   | N/A                             | N/A                                      | N/A                            |   | X  |
| HCP CORPORATION - 39-1177562<br>202 SOUTH PARK STREET<br>MADISON, WI 53715              | REAL ESTATE RENTAL              | WI  | N/A                                 | C CORP   | N/A                             | N/A                                      | N/A                            |   | X  |
| HEALTH PLUS INC - 37-1295532<br>5409 N KNOXVILLE AVE<br>PEORIA, IL 61614                | MANAGED CARE<br>ADMINISTRATION  | IL  | N/A                                 | C CORP   | N/A                             | N/A                                      | N/A                            |   | X  |

**Part III** Continuation of Identification of Related Organizations Taxable as a Partnership

| (a)<br>Name, address, and EIN<br>of related organization   | (b)<br>Primary activity                                | (c)<br>Legal<br>domicile<br>(state or<br>foreign<br>country) | (d)<br>Direct controlling<br>entity | (e)<br>Predominant income<br>(related, unrelated,<br>excluded from tax under<br>sections 512-514) | (f)<br>Share of total<br>income | (g)<br>Share of<br>end-of-year<br>assets | (h)<br>Disproportion-<br>ate allocations? |    | (i)<br>Code V-UBI<br>amount in box<br>20 of Schedule<br>K-1 (Form 1065) | (j)<br>General or<br>managing<br>partner? |    | (k)<br>Percentage<br>ownership |
|--|--|--|-------------------------------------|---|---------------------------------|--|---|----|---|---|----|--------------------------------|
|  |  |  |                                     |   |                                 |  | Yes                                       | No |   | Yes                                       | No |                                |
| CENTRAL IOWA SURGICAL<br>SERVICES CO-MANAGEMENT CO.,<br>L.L.C. - 47-1608704, 1200<br>PLEASANT ST, DES MOINES, IA     | SURGICAL<br>MANAGEMENT &<br>ADMINISTRATIVE<br>SERVICES | IA   | N/A                                 | N/A   | N/A                             | N/A                                      | N/A                                       |    | N/A   | N/A                                       |    | N/A                            |
| DUBUQUE ENDOSCOPY CENTER,<br>L.C. - 20-1597161, 1515 DELHI<br>STREET, SUITE 500, DUBUQUE,<br>IA 52001                | AMBULATORY<br>SURGERY CENTER                           | IA   | N/A                                 | N/A   | N/A                             | N/A                                      | N/A                                       |    | N/A   | N/A                                       |    | N/A                            |
| ENSEVA - HIAWATHA, L.L.C. -<br>45-3437363, 755 METZGER<br>DRIVE, HIAWATHA, IA 52233                                  | COLLOCATION<br>FACILITY<br>SURGERY                     | IA   | N/A                                 | N/A   | N/A                             | N/A                                      | N/A                                       |    | N/A   | N/A                                       |    | N/A                            |
| FINLEY DEPT. OF SURGERY<br>CO-MGMT. CO., LLC -<br>42-2808785, 350 N GRANDVIEW<br>AVE, DUBUQUE, IA 52001              | DEPARTMENT<br>MANAGEMENT<br>SERVICES                   | IA   | N/A                                 | N/A   | N/A                             | N/A                                      | N/A                                       |    | N/A   | N/A                                       |    | N/A                            |
| HEALTH CARE AFFILIATES OF THE<br>TRI-STATES, L.L.C. -<br>42-1428503, 350 N. GRANDVIEW<br>AVE, DUBUQUE, IA 52001      | PROVIDE ACCESS<br>TO LICENSED<br>SOFTWARE              | IA   | N/A                                 | N/A   | N/A                             | N/A                                      | N/A                                       |    | N/A   | N/A                                       |    | N/A                            |
| IOWA DIAGNOSTIC IMAGING AND<br>PROCEDURE CENTER, L.C. -<br>03-0482623, 1200 PLEASANT<br>STREET, DES MOINES, IA 50309 | OUTPATIENT<br>DIAGNOSTIC<br>IMAGING                    | IA   | N/A                                 | N/A   | N/A                             | N/A                                      | N/A                                       |    | N/A   | N/A                                       |    | N/A                            |
| IOWA HEALTH SYSTEM<br>CONTRACTING SERVICES LC -<br>42-1511142, 1776 WEST LAKES<br>PKWY, #400, WEST DES MOINES,       | GROUP<br>PURCHASING                                    | IA   | N/A                                 | N/A   | N/A                             | N/A                                      | N/A                                       |    | N/A   | N/A                                       |    | N/A                            |
| LAKEVIEW SURGERY CENTER, L.C.<br>- 42-1516120, 1200 PLEASANT<br>STREET, DES MOINES, IA 50309                         | SURGERY CENTER   | IA   | N/A                                 | N/A   | N/A                             | N/A                                      | N/A                                       |    | N/A   | N/A                                       |    | N/A                            |
| MERITER UW PHYSICIANS<br>CONTRACTING COMPANY, LLC -<br>39-1998819, 202 SOUTH PARK<br>STREET, MADISON, WI 53715       | HEALTH SERVICES  | WI   | N/A                                 | N/A   | N/A                             | N/A                                      | N/A                                       |    | N/A   | N/A                                       |    | N/A                            |

**Part III** Continuation of Identification of Related Organizations Taxable as a Partnership

| (a)<br>Name, address, and EIN<br>of related organization  | (b)<br>Primary activity                                      | (c)<br>Legal<br>domicile<br>(state or<br>foreign<br>country) | (d)<br>Direct controlling<br>entity        | (e)<br>Predominant income<br>(related, unrelated,<br>excluded from tax under<br>sections 512-514) | (f)<br>Share of total<br>income | (g)<br>Share of<br>end-of-year<br>assets | (h)<br>Disproportion-<br>ate allocations? |    | (i)<br>Code V-UBI<br>amount in box<br>20 of Schedule<br>K-1 (Form 1065) | (j)<br>General or<br>managing<br>partner? |    | (k)<br>Percentage<br>ownership |
|---|--|--|--|---|---------------------------------|--|---|----|---|---|----|--------------------------------|
|   |  |  |  |   |                                 |  | Yes                                       | No |   | Yes                                       | No |                                |
| MISSISSIPPI VALLEY SLEEP<br>DISORDER CENTER, L.C. -<br>42-1489697, 3400 DEXTER<br>COURT, DAVENPORT, IA 52807              | MEDICAL<br>LABORATORY<br>SERVICES                            | IA   | N/A  | N/A   | N/A                             | N/A                                      | N/A                                       |    | N/A   | N/A                                       |    | N/A                            |
| MMCI ORTHOPEDIC CO-MANAGEMENT<br>COMPANY, L.L.C. - 46-1219459,<br>221 NE GLEN OAK AVE, PEORIA,<br>IL 61636                | ORTHOPEDIC<br>MANAGEMENT &<br>ADMINISTRATIVE<br>SERVICES     | IL   | METHODIST<br>MEDICAL CENTER<br>OF ILLINOIS | RELATED   | 278,931.                        | 191,162.                                 |   | X  | N/A   | X   |    | 20.25%                         |
| MMCI SURGERY CO-MANAGEMENT<br>COMPANY, L.L.C. - 47-1323385,<br>221 NE GLEN OAK AVE, PEORIA,<br>IL 61636                   | SURGERY<br>MANAGEMENT &<br>ADMINISTRATIVE<br>SERVICES        | IL   | METHODIST<br>MEDICAL CENTER<br>OF ILLINOIS | RELATED   | 178,713.                        | 60,127.                                  |   | X  | N/A   | X   |    | 21.17%                         |
| MR ASSOCIATES, LLP -<br>42-1260463, 1956 1ST AVENUE<br>NE, CEDAR RAPIDS, IA 52402   | OWN AND OPERATE<br>MR UNIT                                   | IA   | N/A  | N/A   | N/A                             | N/A                                      | N/A                                       |    | N/A   | N/A                                       |    | N/A                            |
| ORTHOPAEDIC OUTPATIENT<br>SURGERY CENTER, L.C. -<br>42-1508092, 1200 PLEASANT<br>STREET, DES MOINES, IA 50309             | AMBULATORY<br>SURGERY CENTER                                 | IA   | N/A  | N/A   | N/A                             | N/A                                      | N/A                                       |    | N/A   | N/A                                       |    | N/A                            |
| REGIONAL HEALTH PARTNERS, LLC<br>- 80-0899158, 1258 W SOUTH<br>ST, KEWANEE, IL 61443                                      | AMBULATORY<br>HEALTH CLINICS                                 | IL   | N/A  | N/A   | N/A                             | N/A                                      | N/A                                       |    | N/A   | N/A                                       |    | N/A                            |
| REHABILITATION THERAPY<br>SERVICES, L.L.C. -<br>81-0584193, 416 ST. MARK'S<br>CT, #110, PEORIA, IL 61603                  | REHABILITATION<br>THERAPY                                    | IL   | METHODIST<br>MEDICAL CENTER<br>OF ILLINOIS | RELATED   | 761,753.                        | 1,109,279.                               |   | X  | N/A   | X   |    | 60.04%                         |
| SLRMC CARDIOVASCULAR<br>CO-MANAGEMENT COMPANY, LLC. -<br>45-5322324, 2720 STONE PARK<br>BLVD, SIOUX CITY, IA 51104        | CARDIOVASCULAR<br>MANAGEMENT &<br>ADMINISTRATIVE<br>SERVICES | IA   | N/A  | N/A   | N/A                             | N/A                                      | N/A                                       |    | N/A   | N/A                                       |    | N/A                            |
| THE OUTPATIENT SURGERY CENTER<br>OF CEDAR RAPIDS, L.L.C. -<br>72-1550812, 1075 FIRST AVENUE<br>SE, CEDAR RAPIDS, IA 52403 | AMBULATORY<br>SURGERY CENTER.                                | IA   | N/A  | N/A   | N/A                             | N/A                                      | N/A                                       |    | N/A   | N/A                                       |    | N/A                            |

**Part III** Continuation of Identification of Related Organizations Taxable as a Partnership

| (a)<br>Name, address, and EIN<br>of related organization   | (b)<br>Primary activity                                       | (c)<br>Legal<br>domicile<br>(state or<br>foreign<br>country) | (d)<br>Direct controlling<br>entity | (e)<br>Predominant income<br>(related, unrelated,<br>excluded from tax under<br>sections 512-514) | (f)<br>Share of total<br>income | (g)<br>Share of<br>end-of-year<br>assets | (h)<br>Disproportion-<br>ate allocations? |    | (i)<br>Code V-UBI<br>amount in box<br>20 of Schedule<br>K-1 (Form 1065) | (j)<br>General or<br>managing<br>partner? |    | (k)<br>Percentage<br>ownership |
|--|---|--|-------------------------------------|---|---------------------------------|--|---|----|---|---|----|--------------------------------|
|  |   |  |                                     |   |                                 |  | Yes                                       | No |   | Yes                                       | No |                                |
| TRINITY ANESTHESIOLOGY<br>SERVICES CO-MANAGEMENT<br>COMPANY, LLC - 30-0932074,<br>2701 17TH STREET, ROCK               | ANESTHESIOLOGY<br>SERVICE LINES<br>ADMINISTRATIVE<br>SERVICES | IL   | N/A                                 | N/A   | N/A                             | N/A                                      | N/A                                       |    | N/A   | N/A                                       |    | N/A                            |
| TRINITY ONCOLOGY SERVICES<br>CO-MANAGEMENT COMPANY, L.L.C.<br>- 90-0953327, 500 JOHN DEERE<br>ROAD, MOLINE, IL 61265   | ONCOLOGY<br>MANAGEMENT<br>SERVICES                            | IL   | N/A                                 | N/A   | N/A                             | N/A                                      | N/A                                       |    | N/A   | N/A                                       |    | N/A                            |
| UNITYPOINT AT WORK, L.C. -<br>47-2181113, 1825 LOGAN AVE,<br>WATERLOO, IA 50703  | OCCUPATIONAL<br>MEDICINE                                      | IA   | N/A                                 | N/A   | N/A                             | N/A                                      | N/A                                       |    | N/A   | N/A                                       |    | N/A                            |
| UPHT-SCA HOLDINGS, LLC -<br>47-3564984, 569 BROOKWOOD<br>VILLAGE, SUITE 901,<br>BIRMINGHAM, AL 35209                   | AMBULATORY<br>SURGERY CENTER<br>INVESTMENT                    | DE   | N/A                                 | N/A   | N/A                             | N/A                                      | N/A                                       |    | N/A   | N/A                                       |    | N/A                            |
| WEST HOSPITAL ORTHOPEDIC<br>CO-MANAGEMENT COMPANY, LLC -<br>27-1414600, 1660 60TH STREET,<br>WEST DES MOINES, IA 50266 | ORTHOPEDIC<br>SERVICE LINES<br>MANAGEMENT                     | IA   | N/A                                 | N/A   | N/A                             | N/A                                      | N/A                                       |    | N/A   | N/A                                       |    | N/A                            |
| WEST LAKES SLEEP CENTER, LLC<br>- 26-3193923, 5950 UNIVERSITY<br>AVENUE SUITE 2, WEST DES<br>MOINES, IA 50266          | SLEEP DISORDER<br>DIAGNOSTIC<br>TESTING<br>FACILITY           | IA   | N/A                                 | N/A   | N/A                             | N/A                                      | N/A                                       |    | N/A   | N/A                                       |    | N/A                            |
|  |   |  |                                     |   |                                 |  |   |    |   |   |    |                                |
|  |   |  |                                     |   |                                 |  |   |    |   |   |    |                                |
|  |   |  |                                     |   |                                 |  |   |    |   |   |    |                                |
|  |   |  |                                     |   |                                 |  |   |    |   |   |    |                                |
|  |   |  |                                     |   |                                 |  |   |    |   |   |    |                                |
|  |   |  |                                     |   |                                 |  |   |    |   |   |    |                                |
|  |   |  |                                     |   |                                 |  |   |    |   |   |    |                                |
|  |   |  |                                     |   |                                 |  |   |    |   |   |    |                                |
|  |   |  |                                     |   |                                 |  |   |    |   |   |    |                                |

**Part IV** Continuation of Identification of Related Organizations Taxable as a Corporation or Trust

| (a)<br>Name, address, and EIN<br>of related organization   | (b)<br>Primary activity              | (c)<br>Legal domicile<br>(state or<br>foreign<br>country) | (d)<br>Direct controlling<br>entity | (e)<br>Type of entity<br>(C corp, S corp,<br>or trust) | (f)<br>Share of total<br>income | (g)<br>Share of<br>end-of-year<br>assets | (h)<br>Percentage<br>ownership | (i)<br>Section<br>512(b)(13)<br>controlled<br>entity? |    |
|--|--------------------------------------|---|-------------------------------------|--|---------------------------------|--|--------------------------------|---|----|
|  |                                      |   |                                     |  |                                 |  |                                | Yes   | No |
| HNC SERVICES - 27-0987243<br>1776 WEST LAKES PKWY, #400<br>WEST DES MOINES, IA 50266                           | FIBER OPTIC NETWORK<br>SERVICES      | IA  | N/A                                 | C CORP   | N/A                             | N/A                                      | N/A                            |   | X  |
| HOME HEALTH PLUS SERVICES, INC. - 36-4053068<br>P.O. BOX 87<br>PEORIA, IL 61650                                | HOME HEALTH SERVICES                 | IL  | N/A                                 | C CORP   | N/A                             | N/A                                      | N/A                            |   | X  |
| MEDIMORE, INC. - 42-1414390<br>1776 WEST LAKES PKWY, #400<br>WEST DES MOINES, IA 50266                         | MANAGED CARE                         | IA  | N/A                                 | C CORP   | N/A                             | N/A                                      | N/A                            |   | X  |
| MERITER HEALTH ENTERPRISES, INC. -<br>39-1293620, 202 SOUTH PARK STREET, MADISON,<br>WI 53715                  | MANAGEMENT SERVICES                  | WI  | N/A                                 | C CORP   | N/A                             | N/A                                      | N/A                            |   | X  |
| MERITER MANAGEMENT SERVICES, INC. -<br>39-1458235, 202 SOUTH PARK STREET, MADISON,<br>WI 53715                 | ADMINISTRATIVE<br>SERVICES           | WI  | N/A                                 | C CORP   | N/A                             | N/A                                      | N/A                            |   | X  |
| METHODIST HEALTH VENTURES, INC. - 37-1140939<br>P.O. BOX 87<br>PEORIA, IL 61650                                | PHARMACY/OFFICE<br>STAFFING          | IL  | N/A                                 | C CORP   | N/A                             | N/A                                      | N/A                            |   | X  |
| METHODIST PHYSICIAN SERVICES, INC. -<br>36-3858550, P.O. BOX 87, PEORIA, IL 61650                              | MEDICAL SERVICES                     | IL  | N/A                                 | C CORP   | N/A                             | N/A                                      | N/A                            |   | X  |
| PRECEDENCE, INC. - 37-1288604<br>4622 PROGRESS DRIVE, STE A<br>DAVENPORT, IA 52807                             | MANAGED MENTAL CARE                  | IA  | N/A                                 | C CORP   | N/A                             | N/A                                      | N/A                            |   | X  |
| PROVIDER RESOURCE MANAGEMENT, INC. -<br>37-1223550, P.O. BOX 87, PEORIA, IL 61650                              | RESOURCE MANAGEMENT                  | IL  | N/A                                 | C CORP   | N/A                             | N/A                                      | N/A                            |   | X  |
| PHYSICIANS PLUS INSURANCE CORPORATION -<br>39-1565691, 2650 NOVATION PARKWAY, SUITE<br>400, MADISON, WI 53713  | FEDERALLY QUALIFIED<br>HMO           | WI  | N/A                                 | C CORP   | N/A                             | N/A                                      | N/A                            |   | X  |
| RURAL IOWA SPECIALTY PHYSICIAN CONSORTIUM,<br>INC. - 26-1271143, 700 E UNIVERSITY AVE, DES<br>MOINES, IA 50316 | SPECIALTY PHYSICIANS<br>MEDICAL CARE | IA  | N/A                                 | C CORP   | N/A                             | N/A                                      | N/A                            |   | X  |
| STL HEALTH RESOURCES CO. - 42-1193499<br>1026 A AVE NE<br>CEDAR RAPIDS, IA 52402                               | PHYSICIAN OFFICE<br>RENTAL           | IA  | N/A                                 | C CORP   | N/A                             | N/A                                      | N/A                            |   | X  |



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

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

|  | Yes | No |
|--|-----|----|
| <b>1</b> 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? |     |    |
| <b>a</b> Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity .....   |     | X  |
| <b>b</b> Gift, grant, or capital contribution to related organization(s) .....   |     | X  |
| <b>c</b> Gift, grant, or capital contribution from related organization(s) .....   | X   |    |
| <b>d</b> Loans or loan guarantees to or for related organization(s) .....  | X   |    |
| <b>e</b> Loans or loan guarantees by related organization(s) .....   |     | X  |
| <b>f</b> Dividends from related organization(s) .....  |     | X  |
| <b>g</b> Sale of assets to related organization(s) .....   |     | X  |
| <b>h</b> Purchase of assets from related organization(s) .....   |     | X  |
| <b>i</b> Exchange of assets with related organization(s) .....   |     | X  |
| <b>j</b> Lease of facilities, equipment, or other assets to related organization(s) .....  |     | X  |
| <b>k</b> Lease of facilities, equipment, or other assets from related organization(s) .....  | X   |    |
| <b>l</b> Performance of services or membership or fundraising solicitations for related organization(s) .....  |     | X  |
| <b>m</b> Performance of services or membership or fundraising solicitations by related organization(s) .....   |     | X  |
| <b>n</b> Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) .....   |     | X  |
| <b>o</b> Sharing of paid employees with related organization(s) .....  | X   |    |
| <b>p</b> Reimbursement paid to related organization(s) for expenses .....  |     | X  |
| <b>q</b> Reimbursement paid by related organization(s) for expenses .....  |     | X  |
| <b>r</b> Other transfer of cash or property to related organization(s) .....   | X   |    |
| <b>s</b> Other transfer of cash or property from related organization(s) .....   | X   |    |

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

| (a)<br>Name of related organization         | (b)<br>Transaction type (a-s) | (c)<br>Amount involved | (d)<br>Method of determining amount involved |
|---|-------------------------------|------------------------|--|
| (1) REHABILITATION THERAPY SERVICES, L.L.C. | S                             | 1,020,000.             | BASED ON GAAP, CASH, AND/OR FMV.             |
| (2)   |                               |                        |  |
| (3)   |                               |                        |  |
| (4)   |                               |                        |  |
| (5)   |                               |                        |  |
| (6)   |                               |                        |  |





**Part VII** Supplemental Information.

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

SCHEDULE R, PARTS I - IV:

IOWA HEALTH SYSTEM AND SUBSIDIARIES (D/B/A UNITYPOINT HEALTH)

IOWA HEALTH SYSTEM IS AN IOWA NONPROFIT CORPORATION FORMED IN DECEMBER 1994. IOWA HEALTH SYSTEM AND ITS SUBSIDIARIES PROVIDE INPATIENT AND OUTPATIENT CARE AND PHYSICIAN SERVICES FROM 33 HOSPITAL FACILITIES AND OVER 400 OUTPATIENT SITES IN IOWA, ILLINOIS AND WISCONSIN. PRIMARY, SECONDARY AND TERTIARY CARE SERVICES ARE PROVIDED TO RESIDENTS OF IOWA, ILLINOIS, WISCONSIN AND ADJACENT STATES.

ON APRIL 16, 2013, IOWA HEALTH SYSTEM BEGAN BEING PUBLICLY KNOWN AS UNITYPOINT HEALTH (THE SYSTEM). THIS NAME CHANGE REFLECTS THE TRANSFORMATION OF CLINICAL PROCESSES UNDERWAY WITHIN THE SYSTEM AND THE ADAPTATION TO BETTER ADDRESS THE HEALTH CARE NEEDS OF COMMUNITIES, INCLUDING BUILDING A MODEL OF DELIVERING HEALTH CARE THAT COORDINATES CARE AROUND THE PATIENT WHILE FOCUSING ON IMPROVING THE QUALITY OF CARE AND REDUCING COSTS. THE LEGAL NAME OF THE PARENT REMAINS IOWA HEALTH SYSTEM, WITH THE UNITYPOINT HEALTH NAME REFLECTING A DOING BUSINESS AS (D/B/A).