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Form 990  Department of the Treasury Internal Revenue Service	Return of Organization Exempt From Income Tax Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except black lung benefit trust or private foundation) The organization may have to use a copy of this return to satisfy state reporting requirements	OMB No 1545-0047 2010 Open to Public Inspection
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A For the 2010 calendar year, or tax year beginning 01-01-2010 and ending 12-31-2010		
B Check if applicable <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization PROVENA HOSPITALS Doing Business As Number and street (or P O box if mail is not delivered to street address) 9223 WEST ST FRANCIS ROAD Room/suite City or town, state or country, and ZIP + 4 FRANKFORT, IL 60423	D Employer identification number 36-4195126 E Telephone number (815) 469-4888 G Gross receipts \$ 1,118,705,459
	F Name and address of principal officer Anthony Filer 19065 Hickory Creek Drive Mokena,IL 60448	H(a) Is this a group return for affiliates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all affiliates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list (see instructions) H(c) Group exemption number ▶
	I Tax-exempt status <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () ◀(Insert no) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527	
	J Website: ▶ www.provena.org	
	K Form of organization <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶	
L Year of formation 1997		
M State of legal domicile IL		

Part I		Summary	
Activities & Governance	1 Briefly describe the organization’s mission or most significant activities THE ORGANIZATION STRIVES TO MAINTAIN AND IMPROVE THE HEALTH OF THE COMMUNITIES IT SERVES BY PROVIDING SERVICES THAT EMPHASIZE AVOIDING ILLNESS THROUGH PREVENTIVE CARE AND STATE-OF-THE-ART TECHNOLOGIES		
	2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets		
	3 Number of voting members of the governing body (Part VI, line 1a)	3	15
	4 Number of independent voting members of the governing body (Part VI, line 1b)	4	14
	5 Total number of individuals employed in calendar year 2010 (Part V, line 2a)	5	8,333
	6 Total number of volunteers (estimate if necessary)	6	2,133
	7a Total unrelated business revenue from Part VIII, column (C), line 12	7a	3,006,522
	b Net unrelated business taxable income from Form 990-T, line 34	7b	0
Revenue	8 Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
	9 Program service revenue (Part VIII, line 2g)	3,727,459	3,897,876
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	1,132,832,621	1,099,490,773
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	1,369,419	2,331,917
	12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	6,462,913	12,139,052
		1,144,392,412	1,117,859,618
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1–3)	0	108,667
	14 Benefits paid to or for members (Part IX, column (A), line 4)	0	0
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	439,668,163	455,649,344
	16a Professional fundraising fees (Part IX, column (A), line 11e)	48,510	36,015
	b Total fundraising expenses (Part IX, column (D), line 25) <input type="checkbox"/> 2,832,565		
	17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24f)	684,372,474	651,770,742
	18 Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	1,124,089,147	1,107,564,768
	19 Revenue less expenses Subtract line 18 from line 12	20,303,265	10,294,850
Net Assets or Fund Balances		Beginning of Current Year	End of Year
	20 Total assets (Part X, line 16)	841,206,423	850,791,814
	21 Total liabilities (Part X, line 26)	222,379,525	226,154,854
	22 Net assets or fund balances Subtract line 21 from line 20	618,826,898	624,636,960

Part II Signature Block					
Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.					
Sign Here	Signature of officer			2011-10-26 Date	
	ANTHONY J FILER SENIOR VICE PRESIDENT, COO Type or print name and title				
Paid Preparer Use Only	Print/Type preparer's name	Preparer's signature	Date	Check if self-employed <input type="checkbox"/>	PTIN
	Firm's name ▶ KPMG LLP				Firm's EIN ▶
	Firm's address ▶ 191 West Nationwide Blvd Ste 500 Columbus, OH 432152568				Phone no ▶ (614) 249-2300
May the IRS discuss this return with the preparer shown above? (see instructions)					

Part IIIS

Statement of Program Service Accomplishments

Check if Schedule O contains a response to any question in this Part III

1

Briefly describe the organization's mission

THE ORGANIZATION STRIVES TO MAKE AVAILABLE A FULL CONTINUUM OF SERVICES, BOTH PRIMARY AND SPECIALTY, APPROPRIATE TO MAINTAIN AND IMPROVE THE HEALTH OF THE COMMUNITIES IT SERVES THESE SERVICES EMPHASIZE AVOIDING ILLNESS THROUGH PREVENTIVE PRIMARY CARE, AS WELL AS OFFERING ACCESS TO THE ADVANCED AND STATE-OF-THE-ART TECHNOLOGIES NECESSARY TO RESTORE HEALTH

2

Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ?

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

3

Did the organization cease conducting, or make significant changes in how it conducts, any program services?

If "Yes," describe these changes on Schedule O

4

Describe the exempt purpose achievements for each of the organization's three largest program services by expenses

Section 501(c)(3) and 501(c)(4) organizations and section 4947(a)(1) trusts are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported

4a

(Code) (Expenses \$ 906,358,227 including grants of \$ 108,667) (Revenue \$ 1,099,490,773)

THE HOSPITALS PROVIDED INPATIENT MEDICAL CARE, MATERNITY SERVICES AND CHARITY CARE THE HOSPITALS SERVED BOTH THE AGED AND THE POOR BY PARTICIPATION IN THE MEDICARE AND MEDICAID PROGRAMS THE HOSPITALS PROVIDED OUTPATIENT SERVICES TO MEMBERS OF THE COMMUNITY REGARDLESS OF ABILITY TO PAY

4b

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

4c

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

4d

Other program services (Describe in Schedule O)




















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

4e

Total program service expenses \$ 906,358,227

Part IV

Checklist of Required Schedules

		Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A 	1	Yes
2	Is the organization required to complete Schedule B, Schedule of Contributors (see instruction)? 	2	Yes
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I	3	No
4	Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II	4	No
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? If "Yes," complete Schedule C, Part III	5	
6	Did the organization maintain any donor advised funds or any similar funds or accounts where donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes," complete Schedule D, Part I 	6	No
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas or historic structures? If "Yes," complete Schedule D, Part II 	7	No
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III 	8	No
9	Did the organization report an amount in Part X, line 21, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? If "Yes," complete Schedule D, Part IV 	9	No
10	Did the organization, directly or through a related organization, hold assets in term, permanent, or quasi-endowments? If "Yes," complete Schedule D, Part V 	10	Yes
11	If the organization's answer to any of the following questions is 'Yes,' then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable		
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI. 	11a	Yes
b	Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII. 	11b	No
c	Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII. 	11c	No
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part IX. 	11d	No
e	Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X. 	11e	Yes
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part X. 	11f	Yes
12a	Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI, XII, and XIII 	12a	No
b	Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered 'No' to line 12a, then completing Schedule D, Parts XI, XII, and XIII is optional 	12b	Yes
13	Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	13	No
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a	No
b	Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, and program service activities outside the United States? If "Yes," complete Schedule F, Parts I and IV	14b	No
15	Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or assistance to any organization or entity located outside the U S ? If "Yes," complete Schedule F, Parts II and IV	15	No
16	Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or assistance to individuals located outside the U S ? If "Yes," complete Schedule F, Parts III and IV	16	No
17	Did the organization report a total of more than \$15,000, of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I (see instructions) 	17	Yes
18	Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II 	18	Yes
19	Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III 	19	No
20a	Did the organization operate one or more hospitals? If "Yes," complete Schedule H 	20a	Yes
b	If "Yes" to line 20a, did the organization attach its audited financial statement to this return? Note. Some Form 990 filers that operate one or more hospitals must attach audited financial statements (see instructions)	20b	Yes

Part IV

Checklist of Required Schedules (continued)

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

Part V Statements Regarding Other IRS Filings and Tax Compliance					
Check if Schedule O contains a response to any question in this Part V <input type="checkbox"/>					
			Yes	No	
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable.	1a	634		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable.	1b	3		
c Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?			1c		
2a	Enter the number of employees reported on Form W-3, <i>Transmittal of Wage and Tax Statements</i> filed for the calendar year ending with or within the year covered by this return.	2a	8,333		
b If at least one is reported on line 2a, did the organization file all required federal employment tax returns?			2b		Yes
Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions).					
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?	3a	Yes		
b	If "Yes," has it filed a Form 990-T for this year? If "No," provide an explanation in Schedule O.	3b	Yes		
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a		No	
b	If "Yes," enter the name of the foreign country: See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a		No	
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b		No	
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?	5c			
6a	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible?	6a		No	
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b			
7 Organizations that may receive deductible contributions under section 170(c).					
a	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?	7a	Yes		
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b	Yes		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c		No	
d	If "Yes," indicate the number of Forms 8282 filed during the year.	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e		No	
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f		No	
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h			
8	Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations. Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?	8		No	
9	Sponsoring organizations maintaining donor advised funds.				
a	Did the organization make any taxable distributions under section 4966?	9a		No	
b	Did the organization make a distribution to a donor, donor advisor, or related person?	9b		No	
10 Section 501(c)(7) organizations. Enter					
a	Initiation fees and capital contributions included on Part VIII, line 12.	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities.	10b			
11 Section 501(c)(12) organizations. Enter					
a	Gross income from members or shareholders.	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them).	11b			
12a	Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?	12a			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year.	12b			
13 Section 501(c)(29) qualified nonprofit health insurance issuers.					
a	Is the organization licensed to issue qualified health plans in more than one state? Note. See the instructions for additional information the organization must report on Schedule O.	13a			
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans.	13b			
c	Enter the amount of reserves on hand.	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a		No	
b	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O.	14b			

Part VI

Governance, Management, and Disclosure

For each "Yes" response to lines 2 through 7b below, and for a "No" response to lines 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.
Check if Schedule O contains a response to any question in this Part VI

Section A. Governing Body and Management			Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	15		
b	Enter the number of voting members included in line 1a, above, who are independent	14		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2	Yes	
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?	3		No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4		No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5		No
6	Does the organization have members or stockholders?	6		No
7a	Does the organization have members, stockholders, or other persons who may elect one or more members of the governing body?	7a	Yes	
b	Are any decisions of the governing body subject to approval by members, stockholders, or other persons?	7b	Yes	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following			
a	The governing body?	8a	Yes	
b	Each committee with authority to act on behalf of the governing body?	8b	Yes	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O	9		No

Section B. Policies (This Section B requests information about policies not required by the Internal Revenue Code.)			Yes	No
10a	Does the organization have local chapters, branches, or affiliates?	10a	Yes	
b	If "Yes," does the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with those of the organization?	10b	Yes	
11a	Has the organization provided a copy of this Form 990 to all members of its governing body before filing the form?	11a	Yes	
b	Describe in Schedule O the process, if any, used by the organization to review this Form 990			
12a	Does the organization have a written conflict of interest policy? If "No," go to line 13	12a	Yes	
b	Are officers, directors or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	Yes	
c	Does the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this is done	12c	Yes	
13	Does the organization have a written whistleblower policy?	13	Yes	
14	Does the organization have a written document retention and destruction policy?	14	Yes	
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?			
a	The organization's CEO, Executive Director, or top management official	15a	Yes	
b	Other officers or key employees of the organization	15b	Yes	
	If "Yes" to line 15a or 15b, describe the process in Schedule O (See instructions)			
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a	Yes	
b	If "Yes," has the organization adopted a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and taken steps to safeguard the organization's exempt status with respect to such arrangements?	16b	Yes	

Section C. Disclosure	
17	List the States with which a copy of this Form 990 is required to be filedIL
18	Section 6104 requires an organization to make its Form 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you make these available. Check all that apply. <input checked="" type="checkbox"/> Own website <input type="checkbox"/> Another's website <input checked="" type="checkbox"/> Upon request
19	Describe in Schedule O whether (and if so, how), the organization makes its governing documents, conflict of interest policy, and financial statements available to the public. See Additional Data Table.
20	State the name, physical address, and telephone number of the person who possesses the books and records of the organization. PATRICK QUINN 9223 WEST ST FRANCIS ROAD FRANKFORT, IL 60423 (815) 806-2328

Check if Schedule O contains a response to any question in this Part VII ☐ ☒

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

Form **990** (2010)

Part VII

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 in reportable compensation from the organization 186

3	Did the organization list any former officer, director or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i>
4	For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? <i>If "Yes," complete Schedule J for such individual</i>
5	Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? <i>If "Yes," complete Schedule J for such person</i>

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		
(A) Name and business address	(B) Description of services	(C) Compensation
LAKE IN THE HILLS VENTURE 8700 W BRYN MAWR STE 810 NORTH CHICAGO, IL 60631	RENTS	738,746
SHALES MCNUTT CONSTRUCTION 425 RENNER DRIVE ELGIN, IL 60123	CONSTRUCTION	1,779,549
MADISON AVENUE ANESTHESIA PLACEMENT 19627 S LAGRANGE RD MOKENA, IL 60448	ANESTHESIA SERVICES	4,422,579
PH PROPERTY INTERESTS 340 WEST PASSAIC STREET ROCHELLE PARK, NJ 07662	RENTS	984,497
OPTIMUS HOSPITALS PEDIATRIC 900 JORIE BLVD STE 186 OAK BROOK, IL 60523	PHYSICIAN MANAGEMENT	753,683
2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization 58		

Part VIII

Statement of Revenue

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514
Contributions, gifts, grants and other similar amounts	1a Federated campaigns 1a					
	b Membership dues 1b					
	c Fundraising events 1c	646,182				
	d Related organizations 1d					
	e Government grants (contributions) 1e	538,059				
	f All other contributions, gifts, grants, and similar amounts not included above 1f	2,713,635				
	g Noncash contributions included in lines 1a-1f \$	233,562				
	h Total. Add lines 1a-1f		3,897,876			
Program Service Revenue	2a	Business Code				
	NET PATIENT REVENUE	900099	1,099,490,773	1,099,490,773		
	b					
	c					
	d					
	e					
	f All other program service revenue					
	g Total. Add lines 2a-2f		1,099,490,773			
Other Revenue	3 Investment income (including dividends, interest and other similar amounts)					
	4 Income from investment of tax-exempt bond proceeds		2,449,742		641,173	1,808,569
	5 Royalties		0			
			0			
	6a Gross Rents	(i) Real 2,166,710	(ii) Personal			
	b Less rental expenses					
	c Rental income or (loss)	2,166,710				
	d Net rental income or (loss)		2,166,710		323,870	1,842,840
	7a Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other			
	b Less cost or other basis and sales expenses		117,825			
	c Gain or (loss)		-117,825			
	d Net gain or (loss)		-117,825			-117,825
	8a Gross income from fundraising events (not including \$ 646,182 of contributions reported on line 1c) See Part IV, line 18	a	862,906			
	b Less direct expenses b		728,016			
	c Net income or (loss) from fundraising events		134,890			134,890
	9a Gross income from gaming activities See Part IV, line 19 a					
	b Less direct expenses b					
	c Net income or (loss) from gaming activities		0			
	10a Gross sales of inventory, less returns and allowances	a				
	b Less cost of goods sold b					
c Net income or (loss) from sales of inventory		0				
Miscellaneous Revenue	Business Code					
11a CAFETERIA SALES	722100	4,319,375			4,319,375	
b PHARMACY APOTHECARY	446110	1,616,051			1,616,051	
c PHARMACY REVENUE	446110	1,162,073		1,162,073		
d All other revenue		2,739,953	8,055	879,406	1,852,492	
e Total. Add lines 11a-11d		9,837,452				
12 Total revenue. See Instructions		1,117,859,618	1,099,498,828	3,006,522	11,456,392	

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) but are not required to complete columns (B), (C), and (D).

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.		(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1	Grants and other assistance to governments and organizations in the U S See Part IV, line 21	0			
2	Grants and other assistance to individuals in the U S See Part IV, line 22	108,667	108,667		
3	Grants and other assistance to governments, organizations, and individuals outside the U S See Part IV, lines 15 and 16	0			
4	Benefits paid to or for members	0			
5	Compensation of current officers, directors, trustees, and key employees	5,097,601		5,097,601	
6	Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0			
7	Other salaries and wages	351,505,475	334,159,595	15,772,511	1,573,369
8	Pension plan contributions (include section 401(k) and section 403(b) employer contributions)	0			
9	Other employee benefits	73,772,738	63,085,818	10,634,487	52,433
10	Payroll taxes	25,273,530	22,259,578	3,013,952	
a	Fees for services (non-employees)				
	Management	0			
b	Legal	354,912	19,416	335,496	
c	Accounting	1,001,614	26,979	974,635	
d	Lobbying	0			
e	Professional fundraising services See Part IV, line 17	36,015			36,015
f	Investment management fees	0			
g	Other	132,323,213	96,213,958	35,631,504	477,751
12	Advertising and promotion	4,749,511	302,870	4,410,979	35,662
13	Office expenses	165,348,716	161,179,626	3,966,700	202,390
14	Information technology	39,504,368	9,145,360	30,348,550	10,458
15	Royalties	0			
16	Occupancy	16,373,551	15,648,077	696,125	29,349
17	Travel	250,491	146,068	95,708	8,715
18	Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19	Conferences, conventions, and meetings	473,204	303,643	163,271	6,290
20	Interest	32,125,872	2,211	32,123,661	
21	Payments to affiliates	0			
22	Depreciation, depletion, and amortization	53,230,883	52,810,580	420,143	160
23	Insurance	29,589,768	14,575,639	15,014,129	
24	Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24f If line 24f amount exceeds 10% of line 25, column (A) amount, list line 24f expenses on Schedule O)				
a	BAD DEBT EXPENSE	108,273,891	108,233,707	40,184	
b	TAXES	37,151,150	671,927	36,479,223	
c	FOOD	6,611,202	6,414,967	153,726	42,509
d	REPAIRS & MAINTENANCE	5,398,522	5,159,711	231,262	7,549
e	DUES & SUBSCRIPTIONS	1,184,727	174,191	1,003,443	7,093
f	All other expenses	17,825,147	15,715,639	1,766,686	342,822
25	Total functional expenses. Add lines 1 through 24f	1,107,564,768	906,358,227	198,373,976	2,832,565
26	Joint costs. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720) Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation				

Part X

Balance Sheet

					(A)		(B)
					Beginning of year		End of year
Assets	1	Cash—non-interest-bearing				1	
	2	Savings and temporary cash investments			33,847,887	2	42,301,204
	3	Pledges and grants receivable, net				3	
	4	Accounts receivable, net			173,253,647	4	160,016,149
	5	Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L				5	
	6	Receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers, and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Schedule L				6	
	7	Notes and loans receivable, net				7	
	8	Inventories for sale or use			21,091,774	8	23,132,697
	9	Prepaid expenses and deferred charges			7,110,611	9	23,408,845
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a	1,273,417,388	577,792,402	10c	574,654,482
	b	Less: accumulated depreciation	10b	698,762,906			
	11	Investments—publicly traded securities				11	
	12	Investments—other securities. See Part IV, line 11				12	
	13	Investments—program-related. See Part IV, line 11				13	
	14	Intangible assets				14	
	15	Other assets. See Part IV, line 11			28,110,102	15	27,278,437
16	Total assets. Add lines 1 through 15 (must equal line 34)			841,206,423	16	850,791,814	
Liabilities	17	Accounts payable and accrued expenses			95,681,629	17	84,431,743
	18	Grants payable				18	
	19	Deferred revenue				19	
	20	Tax-exempt bond liabilities				20	
	21	Escrow or custodial account liability. Complete Part IV of Schedule D				21	
	22	Payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L				22	
	23	Secured mortgages and notes payable to unrelated third parties				23	
	24	Unsecured notes and loans payable to unrelated third parties				24	
	25	Other liabilities. Complete Part X of Schedule D			126,697,896	25	141,723,111
	26	Total liabilities. Add lines 17 through 25			222,379,525	26	226,154,854
Net Assets or Fund Balances	Organizations that follow SFAS 117, check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.						
	27	Unrestricted net assets			611,663,886	27	616,558,786
	28	Temporarily restricted net assets			5,858,110	28	6,666,863
	29	Permanently restricted net assets			1,304,902	29	1,411,309
	Organizations that do not follow SFAS 117, check here <input type="checkbox"/> and complete lines 30 through 34.						
	30	Capital stock or trust principal, or current funds				30	
	31	Paid-in or capital surplus, or land, building or equipment fund				31	
	32	Retained earnings, endowment, accumulated income, or other funds				32	
	33	Total net assets or fund balances			618,826,898	33	624,636,958
	34	Total liabilities and net assets/fund balances			841,206,423	34	850,791,814

Part XI Reconciliation of Net Assets

Check if Schedule O contains a response to any question in this Part XI

1	Total revenue (must equal Part VIII, column (A), line 12)	1	1,117,859,618
2	Total expenses (must equal Part IX, column (A), line 25)	2	1,107,564,768
3	Revenue less expenses Subtract line 2 from line 1	3	10,294,850
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	618,826,898
5	Other changes in net assets or fund balances (explain in Schedule O)	5	-4,484,790
6	Net assets or fund balances at end of year Combine lines 3, 4, and 5 (must equal Part X, line 33, column (B))	6	624,636,958

Part XII Financial Statements and Reporting

Check if Schedule O contains a response to any question 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?		No
b	Were the organization's financial statements audited by an independent accountant?	Yes	
c	If "Yes," to 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O	Yes	
d	If "Yes" to line 2a or 2b, check a box below to indicate whether the financial statements for the year were issued 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 separated basis		
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?	Yes	
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits	Yes	

SCHEDULE A

(Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

OMB No 1545-0047

2010

Open to Public
Inspection

Name of the organization PROVENA HOSPITALS	Employer identification number 36-4195126
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Part I

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

The organization is not a private foundation because it is (For lines 1 through 11, check only one box)

- 1

☐

A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
- 2

☐

A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E)
- 3

☒

A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- 4

☐

A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state
- 5

☐

An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II)
- 6

☐

A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- 7

☐

An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi)** (Complete Part II)
- 8

☐

A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II)
- 9

☐

An organization that normally receives (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2).** (Complete Part III)
- 10

☐

An organization organized and operated exclusively to test for public safety See**section 509(a)(4).**
- 11

☐

An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2) See **section 509(a)(3).** Check the box that describes the type of supporting organization and complete lines 11e through 11h

a

☐

Type I

b

☐

Type II

c

☐

Type III - Functionally integrated

d

☐

Type III - Other
- e

☐

By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2)
- f

☐

If the organization received a written determination from the IRS that it is a Type I, Type II or Type III supporting organization, check this box
- g

☐

Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?
(i) a person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the the supported organization?
(ii) a family member of a person described in (i) above?
(iii) a 35% controlled entity of a person described in (i) or (ii) above?
- h

☐

Provide the following information about the supported organization(s)

	Yes	No
11g(i)		
11g(ii)		
11g(iii)		

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1- 9 above or IRC section (see instructions))	(iv) Is the organization in col (i) listed in your governing document?		(v) Did you notify the organization in col (i) of your support?		(vi) Is the organization in col (i) organized in the U S ?		(vii) Amount of support
			Yes	No	Yes	No	Yes	No	
Total									

Part II

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

(Complete only if you checked the box on line 5, 7, 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) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 Public Support. Subtract line 5 from line 4						

Section B. Total Support						
Calendar year (or fiscal year beginning in) ▶	(a) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income Do not include gain or loss from the sale of capital assets (Explain in Part IV)						
11 Total support (Add lines 7 through 10)						
12 Gross receipts from related activities, etc (See instructions)					12	

13 First Five Years If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a 501(c)(3) organization, check this box and stop here

▶

Section C. Computation of Public Support Percentage		
14 Public Support Percentage for 2010 (line 6 column (f) divided by line 11 column (f))	14	
15 Public Support Percentage for 2009 Schedule A, Part II, line 14	15	
16a 33 1/3% support test—2010. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization		▶
b 33 1/3% support test—2009. If the organization did not check the box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization		▶
17a 10%-facts-and-circumstances test—2010. If the organization did not check a box on line 13, 16a, or 16b and line 14 is 10% or more, and if the organization meets the "facts and circumstances" test, check this box and stop here. Explain in Part IV how the organization meets the "facts and circumstances" test The organization qualifies as a publicly supported organization		▶
b 10%-facts-and-circumstances test—2009. If the organization did not check a box on line 13, 16a, 16b, or 17a and line 15 is 10% or more, and if the organization meets the "facts and circumstances" test, check this box and stop here. Explain in Part IV how the organization meets the "facts and circumstances" test The organization qualifies as a publicly supported organization		▶
18 Private Foundation If the organization did not check a box on line 13, 16a, 16b, 17a or 17b, check this box and see instructions		▶

Part IIIPart III

Support Schedule for Organizations Described in Section 509(a)(2)
(Complete only if you checked the box on line 9 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) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 Public Support (Subtract line 7c from line 6)						

Section B. Total Support						
Calendar year (or fiscal year beginning in) 	(a) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
13 Total support (Add lines 9, 10c, 11 and 12.)						
14 First Five Years If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here 						

Section C. Computation of Public Support Percentage		
15 Public Support Percentage for 2010 (line 8 column (f) divided by line 13 column (f))	15	
16 Public support percentage from 2009 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage		
17 Investment income percentage for 2010 (line 10c column (f) divided by line 13 column (f))	17	
18 Investment income percentage from 2009 Schedule A, Part III, line 17	18	
19a 33 1/3% support tests—2010. 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—2009. 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

Supplemental Information. Supplemental Information. Complete this part to provide the explanations required by Part II, line 10; Part II, line 17a or 17b; and Part III, line 12. Also complete this part for any additional information. (See instructions).

Facts And Circumstances Test

SCHEDULE D
(Form 990)

Supplemental Financial Statements

► Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11, or 12.
► Attach to Form 990. ► See separate instructions.

OMB No 1545-0047

2010

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization PROVENA HOSPITALS	Employer identification number 36-4195126
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Part I

Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" to Form 990, Part IV, line 6.

	(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year	
2	Aggregate contributions to (during year)	
3	Aggregate grants from (during year)	
4	Aggregate value at end of year	
5	Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? <div>YesNo</div>	
6	Did the organization inform all grantees, donors, and donor advisors in writing that grant funds may be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit <div>YesNo</div>	

Part II

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

1	Purpose(s) of conservation easements held by the organization (check all that apply) <div><div><input type="checkbox"/> Preservation of land for public use (e g , recreation or pleasure)</div><div><input type="checkbox"/> Preservation of an historically importantly land area</div><div><input type="checkbox"/> Protection of natural habitat</div><div><input type="checkbox"/> Preservation of a certified historic structure</div><div><input type="checkbox"/> Preservation of open space</div></div>											
2	Complete lines 2a–2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year											
		<table><tr><td></td><td>Held at the End of the Year</td></tr><tr><td>2a</td><td></td></tr><tr><td>2b</td><td></td></tr><tr><td>2c</td><td></td></tr><tr><td>2d</td><td></td></tr></table>		Held at the End of the Year	2a		2b		2c		2d	
	Held at the End of the Year											
2a												
2b												
2c												
2d												
a	Total number of conservation easements											
b	Total acreage restricted by conservation easements											
c	Number of conservation easements on a certified historic structure included in (a)											
d	Number of conservation easements included in (c) acquired after 8/17/06											
3	Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the taxable year ►_____											
4	Number of states where property subject to conservation easement is located ►_____											
5	Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? <div>YesNo</div>											
6	Staff and volunteer hours devoted to monitoring, inspecting and enforcing conservation easements during the year ►_____											
7	Amount of expenses incurred in monitoring, inspecting, 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 170(h)(4)(B)(ii)? <div>YesNo</div>											
9	In Part XIV, 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" to Form 990, Part IV, line 8.

1a	If the organization elected, as permitted under SFAS 116, 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 XIV, the text of the footnote to its financial statements that describes these items	
b	If the organization elected, as permitted under SFAS 116, 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) Revenues included in 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 relating to these items	
a	Revenues included in Form 990, Part VIII, line 1	► \$ _____
b	Assets included in Form 990, Part X	► \$ _____

Part III

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

3

Using the organization's 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 XIV

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" to 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 XIV and complete the following table

	Amount
1c	
1d	
1e	
1f	

2a

Did the organization include an amount on Form 990, Part X, line 21?

☐ Yes

☐ No

b

If "Yes," explain the arrangement in Part XIV

Part V

Endowment Funds. Complete if the organization answered "Yes" to 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	1,507,757	1,569,474	1,071,590	
b	Contributions	104,516	26,655	489,327	
c	Investment earnings or losses	83,936	-2,254	11,557	
d	Grants or scholarships	12,960	0	3,000	
e	Other expenditures for facilities and programs	19,544	81,988	0	
f	Administrative expenses	4,000	4,136	0	
g	End of year balance	1,659,705	1,507,751	1,569,474	

2

Provide the estimated percentage of the year end balance held as

a

Board designated or quasi-endowment ▶ 20 000 %

b

Permanent endowment ▶ 80 000 %

c

Term endowment ▶

3a

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

(i) unrelated organizations

3a(i)

No

(ii) related organizations

3a(ii)

No

b

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

3b

4

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

Part VI

Investments—Land, Buildings, and Equipment. See Form 990, Part X, line 10.

Description of investment	(a) Cost or other basis (investment)	(b)Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		22,508,111		22,508,111
b Buildings		768,344,868	348,224,703	420,120,165
c Leasehold improvements		4,230,124	2,013,651	2,216,473
d Equipment		429,216,220	329,525,236	99,690,984
e Other		49,118,065	18,999,316	30,118,749
Total. Add lines 1a-1e (Column (d) should equal Form 990, Part X, column (B), line 10(c).) ▶				574,654,482

Schedule D (Form 990) 2010

Part XI Reconciliation of Change in Net Assets from Form 990 to Financial Statements		
1	Total revenue (Form 990, Part VIII, column (A), line 12)	1
2	Total expenses (Form 990, Part IX, column (A), line 25)	2
3	Excess or (deficit) for the year Subtract line 2 from line 1	3
4	Net unrealized gains (losses) on investments	4
5	Donated services and use of facilities	5
6	Investment expenses	6
7	Prior period adjustments	7
8	Other (Describe in Part XIV)	8
9	Total adjustments (net) Add lines 4 - 8	9
10	Excess or (deficit) for the year per financial statements Combine lines 3 and 9	10

Part XII Reconciliation of Revenue per Audited Financial Statements With Revenue per Return		
1	Total revenue, gains, and other support per audited financial statements	1
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12	
a	Net unrealized gains on investments	2a
b	Donated services and use of facilities	2b
c	Recoveries of prior year grants	2c
d	Other (Describe in Part XIV)	2d
e	Add lines 2a through 2d	2e
3	Subtract line 2e from line 1	3
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1	
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a
b	Other (Describe in Part XIV)	4b
c	Add lines 4a and 4b	4c
5	Total Revenue Add lines 3 and 4c. (This should equal Form 990, Part I, line 12)	5

Part XIII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return		
1	Total expenses and losses per audited financial statements	1
2	Amounts included on line 1 but not on Form 990, Part IX, line 25	
a	Donated services and use of facilities	2a
b	Prior year adjustments	2b
c	Other losses	2c
d	Other (Describe in Part XIV)	2d
e	Add lines 2a through 2d	2e
3	Subtract line 2e from line 1	3
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:	
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a
b	Other (Describe in Part XIV)	4b
c	Add lines 4a and 4b	4c
5	Total expenses Add lines 3 and 4c. (This should equal Form 990, Part I, line 18)	5

Part XIV Supplemental Information

Complete this part to 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, Part XI, line 8, Part XII, lines 2d and 4b, and Part XIII, lines 2d and 4b. Also complete this part to provide any additional information.

Identifier	Return Reference	Explanation
Supplemental Information		On January 1, 2008, Provena adopted ASC Subtopic 740-10 Income Taxes- Overall, which addresses the determination of how tax benefits claimed or expected to be claimed on a tax return should be recorded in the consolidated financial statements. Under ASC Subtopic 740-10, Provena may recognize the tax benefit from an uncertain tax position only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position. The tax benefits recognized in the consolidated financial statements from such a position are measured based on the largest benefit that has a greater than 50% likelihood of being realized upon ultimate settlement. ASC Subtopic 740-10 also provides guidance on derecognition, classification, interest and penalties on income taxes, and accounting in interim periods and requires increased disclosures. At the date of adoption, and as of December 31, 2010, Provena does not have any liabilities for any unrecognized tax benefits.

SCHEDULE G
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information Regarding
Fundraising or Gaming Activities

Complete if the organization answered "Yes" to Form 990, Part IV, lines 17, 18, or 19,
or if the organization entered more than \$15,000 on Form 990-EZ, line 6a.
▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

OMB No 1545-0047

2010

Open to Public
Inspection

Name of the organization
PROVENA HOSPITALS

Employer identification number

36-4195126

Part I Fundraising Activities. Complete if the organization answered "Yes" to Form 990, Part IV, line 17.

- 1

Indicate whether the organization raised funds through any of the following activities. Check all that apply.

a

☒

Mail solicitations

e

☒

Solicitation of non-government grants

b

☒

Internet and e-mail solicitations

f

☒

Solicitation of government grants

c

☒

Phone solicitations

g

☒

Special fundraising events

d

☒

In-person solicitations
- 2a

Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services?

☒ Yes

☐ No
- b

If "Yes," list the ten highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least \$5,000 by the organization. Form 990-EZ filers are not required to complete this table.

(i) Name and address of individual or entity (fundraiser)	(ii) Activity	(iii) Did fundraiser have custody or control of contributions?		(iv) Gross receipts from activity	(v) Amount paid to (or retained by) fundraiser listed in col (i)	(vi) Amount paid to (or retained by) organization
		Yes	No			
SR MARGARET MARY KNITTEL	GRANT WRITING		No	5,500	36,015	-30,515
Total ▶				5,500	36,015	-30,515

- 3

List all states in which the organization is registered or licensed to solicit funds or has been notified it is exempt from registration or licensing.

IL, IN

Part II Fundraising Events. Complete if the organization answered "Yes" to Form 990, Part IV, line 18, or reported more than \$15,000 on Form 990-EZ, line 6a. List events with gross receipts greater than \$5,000.

Revenue			(a) Event #1	(b) Event #2	(c) Other Events	(d) Total Events	
			<u>FEST.OF TREES</u>	<u>GALA</u>	<u>18</u>	(Add col (a) through	
			(event type)	(event type)	(total number)	col (c))	
	1	Gross receipts	398,412	166,170	944,506	1,509,088	
	2	Less Charitable contributions	398,412		247,770	646,182	
3	Gross income (line 1 minus line 2)		166,170	696,736	862,906		
Direct Expenses	4	Cash prizes			6,915	6,915	
	5	Non-cash prizes					
	6	Rent/facility costs	13,500		68,455	81,955	
	7	Food and beverages					
	8	Entertainment					
	9	Other direct expenses	240,446	57,994	340,706	639,146	
	10	Direct expense summary Add lines 4 through 9 in column (d) ▶					728,016
	11	Net income summary Combine lines 3 and 10 in column (d). ▶					134,890

Part III Gaming. Complete if the organization answered "Yes" to Form 990, Part IV, line 19, or reported more than \$15,000 on Form 990-EZ, line 6a.

Revenue		(a) Bingo	(b) Pull tabs/Instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (Add col (a) through col (c))
	1 Gross revenue				
Direct Expenses	2 Cash prizes				
	3 Non-cash prizes				
	4 Rent/facility costs				
	5 Other direct expenses				
	6 Volunteer labor	<div><div><input type="checkbox"/> Yes % <input type="checkbox"/> No</div></div>	<div><div><input type="checkbox"/> Yes % <input type="checkbox"/> No</div></div>	<div><div><input type="checkbox"/> Yes % <input type="checkbox"/> No</div></div>	
7 Direct expense summary Add lines 2 through 5 in column (d)					
8 Net gaming income summary Combine lines 1 and 7 in column (d)					

9 Enter the state(s) in which the organization operates gaming activities _____

a Is the organization licensed to operate gaming activities in each of these states? ☐ Yes ☐ No

b If "No," Explain _____

10a Were any of the organization's gaming licenses revoked, suspended or terminated during the tax year? ☐ Yes ☐ No

b If "Yes," Explain _____

ALLIANCE PHO

11

Does the organization operate gaming activities with nonmembers?

☐ Yes ☐ No

12

Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming?

☐ Yes ☐ No

13

Indicate the percentage of gaming activity operated in

a	The organization's facility	13a
b	An outside facility	13b

14

Provide the name and address of the person who prepares the organization's gaming/special events books and records

Name

Address 1400 W PARK
URBANA, IL 61801

15a

Does the organization have a contract with a third party from whom the organization receives gaming revenue?

☐ Yes ☐ No

b

If "Yes," enter the amount of gaming revenue received by the organization \$ and the amount of gaming revenue retained by the third party \$

c

If "Yes," enter name and address

Name

Address

16 Gaming manager information

Name

Gaming manager compensation \$

Description of services provided

☐ Director/officer ☐ Employee ☐ Independent contractor

17

Mandatory distributions

a

Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license?

☐ Yes ☐ No

b

Enter the amount of distributions required under state law distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year \$

Part IV Complete this part to provide additional information for responses to question on Schedule G (see instructions.)

Identifier	ReturnReference	Explanation
Schedule G, Part I Line 2(b)		Sr Margaret Mary Knittel Is a grant writer that specializes in fund raising activities with private foundations that promote the ministry

SCHEDULE H
(Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ **Complete if the organization answered "Yes" to Form 990, Part IV, question 20.**
▶ **Attach to Form 990.** ▶ **See separate instructions.**

OMB No 1545-0047

2010

Open to Public
Inspection

Name of the organization
PROVENA HOSPITALS

Employer identification number
36-4195126

Part I

Financial Assistance and Certain Other Community Benefits at Cost

		Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	Yes	
1b	If "Yes," is it a written policy?	Yes	
2	If the organization has multiple hospitals, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year <input checked="" type="checkbox"/> Applied uniformly to all hospitals <input type="checkbox"/> Applied uniformly to most hospitals <input type="checkbox"/> Generally tailored to individual hospitals		
3	Answer the following based on the the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year a Does the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing <i>free</i> care to low income individuals? If "Yes," indicate which of the following is the FPG family income limit for eligibility for free care <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ % b Does the organization use FPG to determine eligibility for providing <i>discounted</i> care to low income individuals? If "Yes," indicate which of the following is the family income limit for eligibility for discounted care <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other 600. % c If the organization does not use FPG to determine eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care Include in the description whether the organization uses an asset test or other threshold, regardless of income, to determine eligibility for free or discounted care 4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?		
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	Yes	
5b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	Yes	
5c	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?		No
6a	Does the organization prepare a community benefit report during the tax year?	Yes	
6b	If "Yes," did the organization make it available to the public? Complete the following table using the worksheets provided in the Schedule H instructions Do not submit these worksheets with the Schedule H	Yes	

7

Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheets 1 and 2)		21,210	34,432,223	0	34,432,223	3 440 %
b Unreimbursed Medicaid (from Worksheet 3, column a)		152,860	163,194,523	127,748,683	35,445,840	3 540 %
c Unreimbursed costs—other means-tested government programs (from Worksheet 3, column b)		0	0	0	0	0 %
d Total Financial Assistance and Means-Tested Government Programs		174,070	197,626,746	127,748,683	69,878,063	6 980 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	158	83,076	3,719,092	162,851	3,556,241	0 360 %
f Health professions education (from Worksheet 5)	21	5,726	5,472,674	579,134	4,893,540	0 490 %
g Subsidized health services (from Worksheet 6)	2	0	25,249,335	23,381,312	1,868,023	0 190 %
h Research (from Worksheet 7)		0	0	0	0	0 %
i Cash and in-kind contributions to community groups (from Worksheet 8)	44	6,442	757,990	0	757,990	0 080 %
j Total Other Benefits	225	95,244	35,199,091	24,123,297	11,075,794	1 120 %
k Total. Add lines 7d and 7j	225	269,314	232,825,837	151,871,980	80,953,857	8 100 %

Part II

Community Building Activities during the tax year, and describe in Part VI how its 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
1Physical improvements and housing	2	22	14,662	8,106	6,556	0 %
2Economic development		2	0	0	0	0 %
3Community support	18	14,396	239,508	33,963	205,545	0 020 %
4Environmental improvements	4	0	42,719	0	42,719	0 %
5Leadership development and training for community members		0	0	0	0	0 %
6Coalition building	3	118	5,106	0	5,106	0 %
7Community health improvement advocacy		0	0	0	0	0 %
8Workforce development	1	1,226	1,523	0	1,523	0 %
9Other		0	0	0	0	0 %
10Total	28	15,764	303,518	42,069	261,449	0 020 %

Part III

Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

		Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No 15?	1	Yes
2	Enter the amount of the organization's bad debt expense (at cost)	2	24,808,000
3	Enter the estimated amount of the organization's bad debt expense (at cost) attributable to patients eligible under the organization's financial assistance policy	3	
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense. In addition, describe the costing methodology used in determining the amounts reported on lines 2 and 3, and rationale for including a portion of bad debt amounts as community benefit.		

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	476,215,045
6	Enter Medicare allowable costs of care relating to payments on line 5	6	541,322,045
7	Subtract line 6 from line 5. This is the surplus or (shortfall)	7	-65,107,000
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input type="checkbox"/> Cost to charge ratio <input checked="" type="checkbox"/> Other		

Section C. Collection Practices

9a	Does the organization have a written debt collection policy?	9a	Yes
9b	If "Yes," does the organization's collection policy contain provisions on the collection practices to be followed for patients who are known to qualify for charity care or financial assistance? Describe in Part VI	9b	Yes

Part IV

Management Companies and Joint Ventures

(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 %
1Alliance PHO	Physician Hospital Org	50 000 %	0 %	50 000 %
2Kankakee Valley Dial	Dialysis Center	50 000 %	0 %	50 000 %
3Kendail PT Surgery	Surgery Center	15 000 %	0 %	50 000 %
4Dreyer Provena Ambul	Ambulatory Care Center	40 000 %	0 %	60 000 %
5Provena Service Corp	Physicians Practices	100 000 %	0 %	0 %
6Center Digestive Dis	Digestive Health Center	10 000 %	0 %	80 000 %
7				
8				
9				
10				
11				
12				
13				

Section A. Hospital Facilities

How many hospital facilities did the organization operate during the tax year? 6

Schedule H (Form 990) 2010

Part V

Facility Information (continued)

Section B. Facility Policies and Practices.

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

Name of Hospital Facility: PROVENA ST JOSEPH Medical Center

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 1

	Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)		
1 During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment ("Needs Assessment")? If "No," skip to question 8 If "Yes," indicate what the Needs Assessment 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 health needs of the community f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests i <input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess all of the community's health needs j <input type="checkbox"/> Other (describe in Part VI)	1	Yes
2 Indicate the tax year the hospital facility last conducted a Needs Assessment 20 <u>07</u>		
3 In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3	Yes
4 Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4	Yes
5 Did the hospital facility make its Needs Assessment widely available to the public? If "Yes," indicate how the Needs Assessment was made widely available (check all that apply) a <input type="checkbox"/> Hospital facility's website b <input checked="" type="checkbox"/> Available upon request from the hospital facility c <input type="checkbox"/> Other (describe in Part VI)	5	Yes
6 If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply) a <input checked="" type="checkbox"/> Adoption of an implementation strategy to address the health needs of the hospital facility's community b <input checked="" type="checkbox"/> Execution of the implementation strategy c <input type="checkbox"/> Participation in the development of a community-wide community benefit plan d <input type="checkbox"/> Participation in the execution of a community-wide community benefit plan e <input checked="" type="checkbox"/> Inclusion of a community benefit section in operational plans f <input type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the Needs Assessment g <input checked="" type="checkbox"/> Prioritization of health needs in the community h <input checked="" type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community i <input type="checkbox"/> Other (describe in Part VI)		
7 Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed together with the reasons why it has not addressed such needs	7	Yes
Financial Assistance Policy		
Did the hospital facility have in place during the tax year a written financial assistance policy that		
8 Explains eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8	Yes
9 Used federal poverty guidelines (FPG) to determine eligibility for providing free care to low income individuals? . . . If "Yes," indicate the FPG family income limit for eligibility for free care <u>200</u> %	9	Yes

Part V

Facility Information (continued)

		Yes	No	
10	Used FPG to determine eligibility for providing <i>discounted</i> care to low income individuals? If “Yes,” indicate the FPG family income limit for eligibility for discounted care <u>600</u> %	10	Yes	
11	Explained the basis for calculating amounts charged to patients? If “Yes,” indicate the factors used in determining such amounts (check all that apply) a <input checked="" type="checkbox"/> Income level b <input type="checkbox"/> Asset level c <input checked="" type="checkbox"/> Medical indigency d <input checked="" type="checkbox"/> Insurance status e <input checked="" type="checkbox"/> Uninsured discount f <input checked="" type="checkbox"/> Medicaid/Medicare g <input type="checkbox"/> State regulation h <input type="checkbox"/> Other (describe in Part VI)	11	Yes	
12	Explained the method for applying for financial assistance?	12	Yes	
13	Included measures to publicize the policy within the community served by the hospital facility? If “Yes,” indicate how the hospital facility publicized the policy (check all that apply) a <input checked="" type="checkbox"/> The policy was posted at all times on the hospital facility’s web site b <input type="checkbox"/> The policy was attached to all billing invoices c <input checked="" type="checkbox"/> The policy was posted in the hospital facility’s emergency rooms or waiting rooms d <input checked="" type="checkbox"/> The policy was posted in the hospital facility’s admissions offices e <input type="checkbox"/> The policy was provided, in writing, to patients upon admission to the hospital facility f <input checked="" type="checkbox"/> The policy was available upon request g <input type="checkbox"/> Other (describe in Part VI)	13	Yes	

Billing and Collections

14	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	14	Yes	
15	Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year a <input checked="" type="checkbox"/> Reporting to credit agency b <input checked="" type="checkbox"/> Lawsuits c <input checked="" type="checkbox"/> Liens on residences d <input type="checkbox"/> Body attachments e <input type="checkbox"/> Other (describe in Part VI)			
16	Did the hospital facility engage in or authorize a third party to engage in any of the following collection actions during the tax year? If “Yes,” check all collection actions in which the hospital facility or a third party engaged (check all that apply) a <input checked="" type="checkbox"/> Reporting to credit agency b <input checked="" type="checkbox"/> Lawsuits c <input checked="" type="checkbox"/> Liens on residences d <input type="checkbox"/> Body attachments e <input type="checkbox"/> Other (describe in Part VI)	16	Yes	
17	Indicate which actions the hospital facility took before initiating any of the collection actions checked in question 16 (check all that apply) a <input checked="" type="checkbox"/> Notified patients of the financial assistance policy upon admission b <input checked="" type="checkbox"/> Notified patients of the financial assistance policy prior to discharge c <input checked="" type="checkbox"/> Notified patients of the financial assistance policy in communications with the patients regarding the patients’ bills d <input checked="" type="checkbox"/> Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance e <input type="checkbox"/> Other (describe in Part VI)			

Part V

Facility Information (continued)

Policy Relating to Emergency Medical Care

		Yes	No
18	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires 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? If "No," indicate the reasons why (check all that apply)	Yes	
a	<input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b	<input type="checkbox"/> The hospital facility did not have a policy relating to emergency medical care		
c	<input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)		
d	<input type="checkbox"/> Other (describe in Part VI)		

Charges for Medical Care

19	Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply)			
a	<input type="checkbox"/> The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility			
b	<input type="checkbox"/> The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility			
c	<input type="checkbox"/> The hospital facility used the Medicare rate for those services			
d	<input type="checkbox"/> Other (describe in Part VI)			
20	Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Part VI	20		No
21	Did the hospital facility charge any of its patients an amount equal to the gross charge for services provided to that patient? If "Yes," explain in Part VI	21		No

Part V

Facility Information (continued)

Section B. Facility Policies and Practices.

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

Name of Hospital Facility: Provena Mercy Medical Center

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 2

	Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)		
1 During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment ("Needs Assessment")? If "No," skip to question 8 If "Yes," indicate what the Needs Assessment 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 health needs of the community f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests i <input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess all of the community's health needs j <input type="checkbox"/> Other (describe in Part VI)	1	Yes
2 Indicate the tax year the hospital facility last conducted a Needs Assessment 20 <u>06</u>		
3 In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3	Yes
4 Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4	Yes
5 Did the hospital facility make its Needs Assessment widely available to the public? If "Yes," indicate how the Needs Assessment was made widely available (check all that apply) a <input type="checkbox"/> Hospital facility's website b <input checked="" type="checkbox"/> Available upon request from the hospital facility c <input type="checkbox"/> Other (describe in Part VI)	5	Yes
6 If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply) a <input checked="" type="checkbox"/> Adoption of an implementation strategy to address the health needs of the hospital facility's community b <input checked="" type="checkbox"/> Execution of the implementation strategy c <input type="checkbox"/> Participation in the development of a community-wide community benefit plan d <input type="checkbox"/> Participation in the execution of a community-wide community benefit plan e <input type="checkbox"/> Inclusion of a community benefit section in operational plans f <input type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the Needs Assessment g <input checked="" type="checkbox"/> Prioritization of health needs in the community h <input checked="" type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community i <input type="checkbox"/> Other (describe in Part VI)		
7 Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed together with the reasons why it has not addressed such needs	7	No
Financial Assistance Policy		
Did the hospital facility have in place during the tax year a written financial assistance policy that		
8 Explains eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8	Yes
9 Used federal poverty guidelines (FPG) to determine eligibility for providing free care to low income individuals? . . . If "Yes," indicate the FPG family income limit for eligibility for free care <u>200</u> %	9	Yes

Part V

Facility Information (continued)

	Yes	No
10 Used FPG to determine eligibility for providing <i>discounted</i> care to low income individuals? If “Yes,” indicate the FPG family income limit for eligibility for discounted care <u>600</u> %	10 Yes	
11 Explained the basis for calculating amounts charged to patients? If “Yes,” indicate the factors used in determining such amounts (check all that apply) a <input type="checkbox"/> Income level b <input type="checkbox"/> Asset level c <input checked="" type="checkbox"/> Medical indigency d <input checked="" type="checkbox"/> Insurance status e <input checked="" type="checkbox"/> Uninsured discount f <input checked="" type="checkbox"/> Medicaid/Medicare g <input type="checkbox"/> State regulation h <input type="checkbox"/> Other (describe in Part VI)	11 Yes	
12 Explained the method for applying for financial assistance?	12 Yes	
13 Included measures to publicize the policy within the community served by the hospital facility? If “Yes,” indicate how the hospital facility publicized the policy (check all that apply) a <input checked="" type="checkbox"/> The policy was posted at all times on the hospital facility’s web site b <input type="checkbox"/> The policy was attached to all billing invoices c <input checked="" type="checkbox"/> The policy was posted in the hospital facility’s emergency rooms or waiting rooms d <input checked="" type="checkbox"/> The policy was posted in the hospital facility’s admissions offices e <input type="checkbox"/> The policy was provided, in writing, to patients upon admission to the hospital facility f <input checked="" type="checkbox"/> The policy was available upon request g <input type="checkbox"/> Other (describe in Part VI)	13 Yes	

Billing and Collections

14 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	14 Yes	
15 Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year a <input checked="" type="checkbox"/> Reporting to credit agency b <input checked="" type="checkbox"/> Lawsuits c <input checked="" type="checkbox"/> Liens on residences d <input type="checkbox"/> Body attachments e <input type="checkbox"/> Other (describe in Part VI)		
16 Did the hospital facility engage in or authorize a third party to engage in any of the following collection actions during the tax year? If “Yes,” check all collection actions in which the hospital facility or a third party engaged (check all that apply) a <input checked="" type="checkbox"/> Reporting to credit agency b <input checked="" type="checkbox"/> Lawsuits c <input checked="" type="checkbox"/> Liens on residences d <input type="checkbox"/> Body attachments e <input type="checkbox"/> Other (describe in Part VI)	16 Yes	
17 Indicate which actions the hospital facility took before initiating any of the collection actions checked in question 16 (check all that apply) a <input checked="" type="checkbox"/> Notified patients of the financial assistance policy upon admission b <input checked="" type="checkbox"/> Notified patients of the financial assistance policy prior to discharge c <input checked="" type="checkbox"/> Notified patients of the financial assistance policy in communications with the patients regarding the patients’ bills d <input checked="" type="checkbox"/> Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance e <input type="checkbox"/> Other (describe in Part VI)		

Part V

Facility Information (continued)

Policy Relating to Emergency Medical Care

	Yes	No
18 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires 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? If "No," indicate the reasons why (check all that apply)	18 Yes	
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b <input type="checkbox"/> The hospital facility did not have a policy relating to emergency medical care		
c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)		
d <input type="checkbox"/> Other (describe in Part VI)		

Charges for Medical Care

19 Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply)			
a <input type="checkbox"/> The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility			
b <input type="checkbox"/> The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility			
c <input type="checkbox"/> The hospital facility used the Medicare rate for those services			
d <input type="checkbox"/> Other (describe in Part VI)			
20 Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Part VI	20		No
21 Did the hospital facility charge any of its patients an amount equal to the gross charge for services provided to that patient? If "Yes," explain in Part VI	21		No

Part V Facility Information (continued)

Section B. Facility Policies and Practices.

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

Name of Hospital Facility: Provena Covenant Medical Center

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 3

	Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)		
1 During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment ("Needs Assessment")? If "No," skip to question 8 If "Yes," indicate what the Needs Assessment 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 health needs of the community f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests i <input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess all of the community's health needs j <input type="checkbox"/> Other (describe in Part VI)	1 Yes	
2 Indicate the tax year the hospital facility last conducted a Needs Assessment 20 <u>06</u>		
3 In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3 Yes	
4 Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4 Yes	
5 Did the hospital facility make its Needs Assessment widely available to the public? If "Yes," indicate how the Needs Assessment was made widely available (check all that apply) a <input type="checkbox"/> Hospital facility's website b <input checked="" type="checkbox"/> Available upon request from the hospital facility c <input type="checkbox"/> Other (describe in Part VI)	5 Yes	
6 If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply) a <input checked="" type="checkbox"/> Adoption of an implementation strategy to address the health needs of the hospital facility's community b <input checked="" type="checkbox"/> Execution of the implementation strategy c <input type="checkbox"/> Participation in the development of a community-wide community benefit plan d <input type="checkbox"/> Participation in the execution of a community-wide community benefit plan e <input type="checkbox"/> Inclusion of a community benefit section in operational plans f <input type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the Needs Assessment g <input checked="" type="checkbox"/> Prioritization of health needs in the community h <input checked="" type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community i <input type="checkbox"/> Other (describe in Part VI)		
7 Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed together with the reasons why it has not addressed such needs	7	No
Financial Assistance Policy		
Did the hospital facility have in place during the tax year a written financial assistance policy that		
8 Explains eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8 Yes	
9 Used federal poverty guidelines (FPG) to determine eligibility for providing free care to low income individuals? . . . If "Yes," indicate the FPG family income limit for eligibility for free care <u>200</u> %	9 Yes	

Part V

Facility Information (continued)

		Yes	No	
10	Used FPG to determine eligibility for providing <i>discounted</i> care to low income individuals? If “Yes,” indicate the FPG family income limit for eligibility for discounted care <u>600</u> %	10	Yes	
11	Explained the basis for calculating amounts charged to patients? If “Yes,” indicate the factors used in determining such amounts (check all that apply) a <input checked="" type="checkbox"/> Income level b <input type="checkbox"/> Asset level c <input checked="" type="checkbox"/> Medical indigency d <input checked="" type="checkbox"/> Insurance status e <input checked="" type="checkbox"/> Uninsured discount f <input checked="" type="checkbox"/> Medicaid/Medicare g <input type="checkbox"/> State regulation h <input type="checkbox"/> Other (describe in Part VI)	11	Yes	
12	Explained the method for applying for financial assistance?	12	Yes	
13	Included measures to publicize the policy within the community served by the hospital facility? If “Yes,” indicate how the hospital facility publicized the policy (check all that apply) a <input checked="" type="checkbox"/> The policy was posted at all times on the hospital facility’s web site b <input type="checkbox"/> The policy was attached to all billing invoices c <input checked="" type="checkbox"/> The policy was posted in the hospital facility’s emergency rooms or waiting rooms d <input checked="" type="checkbox"/> The policy was posted in the hospital facility’s admissions offices e <input type="checkbox"/> The policy was provided, in writing, to patients upon admission to the hospital facility f <input checked="" type="checkbox"/> The policy was available upon request g <input type="checkbox"/> Other (describe in Part VI)	13	Yes	

Billing and Collections

14	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	14	Yes	
15	Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year a <input checked="" type="checkbox"/> Reporting to credit agency b <input checked="" type="checkbox"/> Lawsuits c <input checked="" type="checkbox"/> Liens on residences d <input type="checkbox"/> Body attachments e <input type="checkbox"/> Other (describe in Part VI)			
16	Did the hospital facility engage in or authorize a third party to engage in any of the following collection actions during the tax year? If “Yes,” check all collection actions in which the hospital facility or a third party engaged (check all that apply) a <input checked="" type="checkbox"/> Reporting to credit agency b <input checked="" type="checkbox"/> Lawsuits c <input checked="" type="checkbox"/> Liens on residences d <input type="checkbox"/> Body attachments e <input type="checkbox"/> Other (describe in Part VI)	16	Yes	
17	Indicate which actions the hospital facility took before initiating any of the collection actions checked in question 16 (check all that apply) a <input checked="" type="checkbox"/> Notified patients of the financial assistance policy upon admission b <input checked="" type="checkbox"/> Notified patients of the financial assistance policy prior to discharge c <input checked="" type="checkbox"/> Notified patients of the financial assistance policy in communications with the patients regarding the patients’ bills d <input checked="" type="checkbox"/> Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance e <input type="checkbox"/> Other (describe in Part VI)			

Part V

Facility Information (continued)

Policy Relating to Emergency Medical Care

		Yes	No
18	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires 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? If "No," indicate the reasons why (check all that apply)	Yes	
a	<input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b	<input type="checkbox"/> The hospital facility did not have a policy relating to emergency medical care		
c	<input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)		
d	<input type="checkbox"/> Other (describe in Part VI)		

Charges for Medical Care

19	Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply)			
a	<input type="checkbox"/> The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility			
b	<input type="checkbox"/> The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility			
c	<input type="checkbox"/> The hospital facility used the Medicare rate for those services			
d	<input type="checkbox"/> Other (describe in Part VI)			
20	Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Part VI	20		No
21	Did the hospital facility charge any of its patients an amount equal to the gross charge for services provided to that patient? If "Yes," explain in Part VI	21		No

Part V Facility Information (continued)

Section B. Facility Policies and Practices.

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

Name of Hospital Facility: Provena St Joseph Hospital

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 4

	Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)		
1 During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment ("Needs Assessment")? If "No," skip to question 8 If "Yes," indicate what the Needs Assessment 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 health needs of the community f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests i <input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess all of the community's health needs j <input type="checkbox"/> Other (describe in Part VI)	1 Yes	
2 Indicate the tax year the hospital facility last conducted a Needs Assessment 20 <u>06</u>		
3 In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3 Yes	
4 Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4 Yes	
5 Did the hospital facility make its Needs Assessment widely available to the public? If "Yes," indicate how the Needs Assessment was made widely available (check all that apply) a <input type="checkbox"/> Hospital facility's website b <input checked="" type="checkbox"/> Available upon request from the hospital facility c <input type="checkbox"/> Other (describe in Part VI)	5 Yes	
6 If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply) a <input checked="" type="checkbox"/> Adoption of an implementation strategy to address the health needs of the hospital facility's community b <input checked="" type="checkbox"/> Execution of the implementation strategy c <input type="checkbox"/> Participation in the development of a community-wide community benefit plan d <input type="checkbox"/> Participation in the execution of a community-wide community benefit plan e <input type="checkbox"/> Inclusion of a community benefit section in operational plans f <input type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the Needs Assessment g <input checked="" type="checkbox"/> Prioritization of health needs in the community h <input checked="" type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community i <input type="checkbox"/> Other (describe in Part VI)		
7 Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed together with the reasons why it has not addressed such needs	7	No
Financial Assistance Policy		
Did the hospital facility have in place during the tax year a written financial assistance policy that		
8 Explains eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8 Yes	
9 Used federal poverty guidelines (FPG) to determine eligibility for providing free care to low income individuals? . . . If "Yes," indicate the FPG family income limit for eligibility for free care <u>200</u> %	9 Yes	

Part V

Facility Information (continued)

		Yes	No	
10	Used FPG to determine eligibility for providing <i>discounted</i> care to low income individuals? If “Yes,” indicate the FPG family income limit for eligibility for discounted care <u>600</u> %	10	Yes	
11	Explained the basis for calculating amounts charged to patients? If “Yes,” indicate the factors used in determining such amounts (check all that apply) a <input checked="" type="checkbox"/> Income level b <input type="checkbox"/> Asset level c <input checked="" type="checkbox"/> Medical indigency d <input checked="" type="checkbox"/> Insurance status e <input checked="" type="checkbox"/> Uninsured discount f <input checked="" type="checkbox"/> Medicaid/Medicare g <input type="checkbox"/> State regulation h <input type="checkbox"/> Other (describe in Part VI)	11	Yes	
12	Explained the method for applying for financial assistance?	12	Yes	
13	Included measures to publicize the policy within the community served by the hospital facility? If “Yes,” indicate how the hospital facility publicized the policy (check all that apply) a <input checked="" type="checkbox"/> The policy was posted at all times on the hospital facility’s web site b <input type="checkbox"/> The policy was attached to all billing invoices c <input checked="" type="checkbox"/> The policy was posted in the hospital facility’s emergency rooms or waiting rooms d <input checked="" type="checkbox"/> The policy was posted in the hospital facility’s admissions offices e <input type="checkbox"/> The policy was provided, in writing, to patients upon admission to the hospital facility f <input checked="" type="checkbox"/> The policy was available upon request g <input type="checkbox"/> Other (describe in Part VI)	13	Yes	

Billing and Collections

14	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	14	Yes	
15	Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year a <input checked="" type="checkbox"/> Reporting to credit agency b <input checked="" type="checkbox"/> Lawsuits c <input checked="" type="checkbox"/> Liens on residences d <input type="checkbox"/> Body attachments e <input type="checkbox"/> Other (describe in Part VI)			
16	Did the hospital facility engage in or authorize a third party to engage in any of the following collection actions during the tax year? If “Yes,” check all collection actions in which the hospital facility or a third party engaged (check all that apply) a <input checked="" type="checkbox"/> Reporting to credit agency b <input checked="" type="checkbox"/> Lawsuits c <input checked="" type="checkbox"/> Liens on residences d <input type="checkbox"/> Body attachments e <input type="checkbox"/> Other (describe in Part VI)	16	Yes	
17	Indicate which actions the hospital facility took before initiating any of the collection actions checked in question 16 (check all that apply) a <input checked="" type="checkbox"/> Notified patients of the financial assistance policy upon admission b <input checked="" type="checkbox"/> Notified patients of the financial assistance policy prior to discharge c <input checked="" type="checkbox"/> Notified patients of the financial assistance policy in communications with the patients regarding the patients’ bills d <input checked="" type="checkbox"/> Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance e <input type="checkbox"/> Other (describe in Part VI)			

Part V

Facility Information (continued)

Policy Relating to Emergency Medical Care

	Yes	No
18 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires 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? If "No," indicate the reasons why (check all that apply)	Yes	
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b <input type="checkbox"/> The hospital facility did not have a policy relating to emergency medical care		
c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)		
d <input type="checkbox"/> Other (describe in Part VI)		

Charges for Medical Care

19 Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply)		
a <input type="checkbox"/> The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility		
b <input type="checkbox"/> The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility		
c <input type="checkbox"/> The hospital facility used the Medicare rate for those services		
d <input type="checkbox"/> Other (describe in Part VI)		
20 Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Part VI	20	No
21 Did the hospital facility charge any of its patients an amount equal to the gross charge for services provided to that patient? If "Yes," explain in Part VI	21	No

Part V

Facility Information (continued)

Section B. Facility Policies and Practices.

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

Name of Hospital Facility: Provena St Mary's Hospital

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 5

	Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)		
1 During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment ("Needs Assessment")? If "No," skip to question 8 If "Yes," indicate what the Needs Assessment describes (check all that apply)	1 Yes	
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input 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 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 type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess all of the community's health needs		
j <input type="checkbox"/> Other (describe in Part VI)		
2 Indicate the tax year the hospital facility last conducted a Needs Assessment 20 <u>07</u>		
3 In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3	No
4 Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4 Yes	
5 Did the hospital facility make its Needs Assessment widely available to the public? If "Yes," indicate how the Needs Assessment was made widely available (check all that apply)	5 Yes	
a <input type="checkbox"/> Hospital facility's website		
b <input checked="" type="checkbox"/> Available upon request from the hospital facility		
c <input type="checkbox"/> Other (describe in Part VI)		
6 If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply)		
a <input checked="" type="checkbox"/> Adoption of an implementation strategy to address the health needs of the hospital facility's community		
b <input checked="" type="checkbox"/> Execution of the implementation strategy		
c <input type="checkbox"/> Participation in the development of a community-wide community benefit plan		
d <input type="checkbox"/> Participation in the execution of a community-wide community benefit plan		
e <input type="checkbox"/> Inclusion of a community benefit section in operational plans		
f <input type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the Needs Assessment		
g <input type="checkbox"/> Prioritization of health needs in the community		
h <input checked="" type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community		
i <input type="checkbox"/> Other (describe in Part VI)		
7 Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed together with the reasons why it has not addressed such needs	7	No
Financial Assistance Policy		
Did the hospital facility have in place during the tax year a written financial assistance policy that		
8 Explains eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8 Yes	
9 Used federal poverty guidelines (FPG) to determine eligibility for providing free care to low income individuals? . . . If "Yes," indicate the FPG family income limit for eligibility for free care <u>200</u> %	9 Yes	

Part V

Facility Information (continued)

		Yes	No	
10	Used FPG to determine eligibility for providing <i>discounted</i> care to low income individuals? If “Yes,” indicate the FPG family income limit for eligibility for discounted care <u>600</u> %	10	Yes	
11	Explained the basis for calculating amounts charged to patients? If “Yes,” indicate the factors used in determining such amounts (check all that apply) a <input checked="" type="checkbox"/> Income level b <input type="checkbox"/> Asset level c <input checked="" type="checkbox"/> Medical indigency d <input checked="" type="checkbox"/> Insurance status e <input checked="" type="checkbox"/> Uninsured discount f <input checked="" type="checkbox"/> Medicaid/Medicare g <input type="checkbox"/> State regulation h <input type="checkbox"/> Other (describe in Part VI)	11	Yes	
12	Explained the method for applying for financial assistance?	12	Yes	
13	Included measures to publicize the policy within the community served by the hospital facility? If “Yes,” indicate how the hospital facility publicized the policy (check all that apply) a <input checked="" type="checkbox"/> The policy was posted at all times on the hospital facility’s web site b <input type="checkbox"/> The policy was attached to all billing invoices c <input checked="" type="checkbox"/> The policy was posted in the hospital facility’s emergency rooms or waiting rooms d <input checked="" type="checkbox"/> The policy was posted in the hospital facility’s admissions offices e <input type="checkbox"/> The policy was provided, in writing, to patients upon admission to the hospital facility f <input checked="" type="checkbox"/> The policy was available upon request g <input type="checkbox"/> Other (describe in Part VI)	13	Yes	

Billing and Collections

14	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	14	Yes	
15	Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year a <input checked="" type="checkbox"/> Reporting to credit agency b <input checked="" type="checkbox"/> Lawsuits c <input checked="" type="checkbox"/> Liens on residences d <input type="checkbox"/> Body attachments e <input type="checkbox"/> Other (describe in Part VI)			
16	Did the hospital facility engage in or authorize a third party to engage in any of the following collection actions during the tax year? If “Yes,” check all collection actions in which the hospital facility or a third party engaged (check all that apply) a <input checked="" type="checkbox"/> Reporting to credit agency b <input checked="" type="checkbox"/> Lawsuits c <input checked="" type="checkbox"/> Liens on residences d <input type="checkbox"/> Body attachments e <input type="checkbox"/> Other (describe in Part VI)	16	Yes	
17	Indicate which actions the hospital facility took before initiating any of the collection actions checked in question 16 (check all that apply) a <input checked="" type="checkbox"/> Notified patients of the financial assistance policy upon admission b <input checked="" type="checkbox"/> Notified patients of the financial assistance policy prior to discharge c <input checked="" type="checkbox"/> Notified patients of the financial assistance policy in communications with the patients regarding the patients’ bills d <input checked="" type="checkbox"/> Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance e <input type="checkbox"/> Other (describe in Part VI)			

Part V

Facility Information (continued)

Policy Relating to Emergency Medical Care

	Yes	No
18 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires 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? If "No," indicate the reasons why (check all that apply)	18 Yes	
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b <input type="checkbox"/> The hospital facility did not have a policy relating to emergency medical care		
c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)		
d <input type="checkbox"/> Other (describe in Part VI)		

Charges for Medical Care

19 Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply)			
a <input type="checkbox"/> The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility			
b <input type="checkbox"/> The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility			
c <input type="checkbox"/> The hospital facility used the Medicare rate for those services			
d <input type="checkbox"/> Other (describe in Part VI)			
20 Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Part VI	20		No
21 Did the hospital facility charge any of its patients an amount equal to the gross charge for services provided to that patient? If "Yes," explain in Part VI	21		No

Part V

Facility Information (continued)

Section B. Facility Policies and Practices.

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

Name of Hospital Facility: Provena United Samaritans Medical Center

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 6

	Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)		
1 During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment ("Needs Assessment")? If "No," skip to question 8 If "Yes," indicate what the Needs Assessment 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 health needs of the community f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests i <input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess all of the community's health needs j <input type="checkbox"/> Other (describe in Part VI)	1	Yes
2 Indicate the tax year the hospital facility last conducted a Needs Assessment 20 <u>07</u>		
3 In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3	Yes
4 Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4	Yes
5 Did the hospital facility make its Needs Assessment widely available to the public? If "Yes," indicate how the Needs Assessment was made widely available (check all that apply) a <input type="checkbox"/> Hospital facility's website b <input checked="" type="checkbox"/> Available upon request from the hospital facility c <input type="checkbox"/> Other (describe in Part VI)	5	Yes
6 If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply) a <input checked="" type="checkbox"/> Adoption of an implementation strategy to address the health needs of the hospital facility's community b <input checked="" type="checkbox"/> Execution of the implementation strategy c <input type="checkbox"/> Participation in the development of a community-wide community benefit plan d <input type="checkbox"/> Participation in the execution of a community-wide community benefit plan e <input type="checkbox"/> Inclusion of a community benefit section in operational plans f <input type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the Needs Assessment g <input checked="" type="checkbox"/> Prioritization of health needs in the community h <input checked="" type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community i <input type="checkbox"/> Other (describe in Part VI)		
7 Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed together with the reasons why it has not addressed such needs	7	No
Financial Assistance Policy		
Did the hospital facility have in place during the tax year a written financial assistance policy that		
8 Explains eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8	Yes
9 Used federal poverty guidelines (FPG) to determine eligibility for providing free care to low income individuals? . . . If "Yes," indicate the FPG family income limit for eligibility for free care <u>200</u> %	9	Yes

Part V

Facility Information (continued)

	Yes	No
10 Used FPG to determine eligibility for providing <i>discounted</i> care to low income individuals? If “Yes,” indicate the FPG family income limit for eligibility for discounted care <u>600</u> %	10 Yes	
11 Explained the basis for calculating amounts charged to patients? If “Yes,” indicate the factors used in determining such amounts (check all that apply) a <input checked="" type="checkbox"/> Income level b <input type="checkbox"/> Asset level c <input checked="" type="checkbox"/> Medical indigency d <input checked="" type="checkbox"/> Insurance status e <input checked="" type="checkbox"/> Uninsured discount f <input checked="" type="checkbox"/> Medicaid/Medicare g <input type="checkbox"/> State regulation h <input type="checkbox"/> Other (describe in Part VI)	11 Yes	
12 Explained the method for applying for financial assistance?	12 Yes	
13 Included measures to publicize the policy within the community served by the hospital facility? If “Yes,” indicate how the hospital facility publicized the policy (check all that apply) a <input checked="" type="checkbox"/> The policy was posted at all times on the hospital facility’s web site b <input type="checkbox"/> The policy was attached to all billing invoices c <input checked="" type="checkbox"/> The policy was posted in the hospital facility’s emergency rooms or waiting rooms d <input checked="" type="checkbox"/> The policy was posted in the hospital facility’s admissions offices e <input type="checkbox"/> The policy was provided, in writing, to patients upon admission to the hospital facility f <input checked="" type="checkbox"/> The policy was available upon request g <input type="checkbox"/> Other (describe in Part VI)	13 Yes	

Billing and Collections

14 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	14 Yes	
15 Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year a <input checked="" type="checkbox"/> Reporting to credit agency b <input checked="" type="checkbox"/> Lawsuits c <input checked="" type="checkbox"/> Liens on residences d <input type="checkbox"/> Body attachments e <input type="checkbox"/> Other (describe in Part VI)		
16 Did the hospital facility engage in or authorize a third party to engage in any of the following collection actions during the tax year? If “Yes,” check all collection actions in which the hospital facility or a third party engaged (check all that apply) a <input checked="" type="checkbox"/> Reporting to credit agency b <input checked="" type="checkbox"/> Lawsuits c <input checked="" type="checkbox"/> Liens on residences d <input type="checkbox"/> Body attachments e <input type="checkbox"/> Other (describe in Part VI)	16 Yes	
17 Indicate which actions the hospital facility took before initiating any of the collection actions checked in question 16 (check all that apply) a <input checked="" type="checkbox"/> Notified patients of the financial assistance policy upon admission b <input checked="" type="checkbox"/> Notified patients of the financial assistance policy prior to discharge c <input checked="" type="checkbox"/> Notified patients of the financial assistance policy in communications with the patients regarding the patients’ bills d <input checked="" type="checkbox"/> Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance e <input type="checkbox"/> Other (describe in Part VI)		

Part V

Facility Information (continued)

Policy Relating to Emergency Medical Care

		Yes	No
18 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires 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? If "No," indicate the reasons why (check all that apply)	18		
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions			
b <input type="checkbox"/> The hospital facility did not have a policy relating to emergency medical care			
c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)			
d <input type="checkbox"/> Other (describe in Part VI)			

Charges for Medical Care

19 Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply)			
a <input type="checkbox"/> The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility			
b <input type="checkbox"/> The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility			
c <input type="checkbox"/> The hospital facility used the Medicare rate for those services			
d <input type="checkbox"/> Other (describe in Part VI)			
20 Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Part VI	20		No
21 Did the hospital facility charge any of its patients an amount equal to the gross charge for services provided to that patient? If "Yes," explain in Part VI	21		No

Part V

Facility Information (continued)

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

(list in order of size, measured by total revenue per facility, from largest to smallest)

How many non-hospital facilities did the organization operate during the tax year? 36

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

Part VI Supplemental Information

Complete this part to provide the following information

- 1
- Required descriptions.** Provide the description required for Part I, lines 3c, 6a, and 7, Part II, Part III, lines 4, 8, and 9b, and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21
- 2
- Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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

Identifier	ReturnReference	Explanation
Schedule H		<p>Part I, Line 5B Provena Hospital Ministries budget for charity care is based upon historical projections or trends. However, we do not place a cap or maximum amount on charity care actually given in a year. Part I, line 6a Provena Health, The corporate sponsor of Provena Hospitals, publishes an annual Report to Our Communities, which details the combined charitable impact our ministries have within the communities we serve. This report is inclusive of our Hospitals and Non-Hospital Ministries. The report is distributed to federal, local and state officials, community leaders, religious leaders and other groups, is presented comprehensively on our consumer Web site (www.provena.org/annualreport), and is supported by a consumer-focused direct mail campaign targeting approximately 180,000 households throughout our primary and secondary markets. Part I, Line 7f Per 990, Schedule H Instructions, The bad debt expense of \$108,273,891 has been removed from the denominator in calculating the percentage of total expense. Part I, line 7g Costs from physician clinics are not included in subsidized service totals. Part I, line 7, column (f) Costs included in Part I, Line 7 were calculated using a combination of cost to charge ratio, medicare and medicaid cost reports, a cost accounting system including all patient segments and community benefit software. Worksheet 2 was used for calculating the cost to charge ratio. Per the 990H instructions, the bad debt expense amount of \$108,273,891 has not been included in the denominator in calculating percentage of total expenses for scheduled H Part I line 7. Part II Describe how community building activities promoted the health of the communities it serves. Community Building Activities include programs that address the root causes of health problems, such as poverty, homelessness and environmental problems. They support community assets by offering the expertise and resources of the health care organization. Provena Hospital ministries engage in a variety of community building activities which although are not specifically health activities ultimately improve the health and well-being of the communities we are privileged to serve. Examples of community building activities include: The work of all of our hospitals in support of disaster readiness and emergency preparedness. This work goes above and beyond any licensure requirements to proactively ensure that our communities are safe and prepared if a disaster should present itself. This work assures the safety and health in the community if a disaster presents itself. Ongoing partnership with Hospital Sisters Mission Outreach whose mission is the recovery and responsible redistribution of health care equipment and supplies to developing countries. The commitment improves local community health by being good stewards of our community resources and not contributing to the landfills within our communities. In addition, this activity promotes the health of the community that receives the equipment and supplies by giving them the tools that they need to better meet the health needs of their community. Part III, Line 3 The Financial Assistance Policy allows for accounts in bad debt to be approved for Financial Assistance if the patient meets the criteria. There are possible financial Assistance Accounts in bad debt and we did not record an amount due to the fact we do not have a methodology to determine the dollar amounts. Part III, line 4 Provision for bad debt at cost represents the cost (determined using a cost-to-charge ratio) of providing services to uninsured and underserved patients. Part III, line 8 The organization computes the Medicare shortfall based on a modified ratio of cost to charges due to our organizational structure. Part III, line 9b The collection process consists of using a predictive dialer to contact the patient after discharge along with a series of 4 notifications/statements and a series of collection letters. A patient may apply for financial assistance at any time during the revenue cycle as outlined in the Provena Health Provision for Financial Assistance Policy. A patient balance may be referred to a 3rd party collection agency if one of the following criteria are met: 1) Patient has defaulted on an installment plan agreement and has missed a minimum of two (2) consecutive payments. 2) A minimum of four (4) notifications which may include statements or letters have been sent to the patient with no payments or agreement to pay. 3) The patient has failed to cooperate with the Medical Assistance Application for Public Aid. 4) There has been an inability to locate the patient via phone or mail (e.g., mail returned with no forwarding address). 5) Account is greater than the small balance write off threshold. Patients with an approved financial assistance for 100% will not be referred to a 3rd party collection agency. Patients with partial financial assistance will follow the self-pay process. Patients in bad debt may apply for charity care/financial assistance at any time during the revenue cycle process. Our Financial Counselors, Central Billing Office and outside agencies assist patients with the financial assistance process. As stated in the Debt Collection Policy, "Agencies must follow the Provena Health Provision for Financial Assistance Policy, at any point in the collection process. If the patient requests this as an option, the account will be placed on hold with the agency and referred back to the hospital so that proper follow up can occur. The agency will not pursue the collection process until they are notified to continue activities." For more information about Provena's Financial Assistance Program visit www.provena.org/FinancialAssistance. Part IV, Column D Officers, directors and trustees do not receive compensation. Physician officers, directors and trustees receive distributed gains and losses.</p>
Schedule H, Part V		<p>Provena St. Joseph Medical Center Part V, Line 3 The Will County Community Health Needs Assessment and Plan took into account input from persons who represent the community by conducting: 1) Focus groups with employees from large corporations, service provider organizations and members of special populations. 2) Direct Mail community survey that was distributed randomly to five thousand residents. 3) Service provider survey was conducted to determine the demand for community services. Provena St. Joseph Medical Center Part V, Line 4 Provena St. Joseph Medical Center participated on the Will county community health assessment and plan committee with multiple community stakeholders. Silver Cross Hospital, Joliet, IL, was also a member of the planning committee. Provena St. Joseph Hospital Part V, Line 3 The Kane County community needs assessment and community health plan, 2006, had over 90 organizations and community leaders participate to obtain input from persons who represent the community. Provena St. Joseph Hospital Part V, Line 4 Hospital Members of the Community Needs assessment committee include: Sherman Hospital Rush Copley Medical Center Delnor Community Hospital Provena Saint Joseph Hospital Provena Mercy Medical Center. Provena St. Joseph Hospital Part V, Line 7 In the development of the community Health Plan related to priority issues, resources are strategically allocated for identified needs. Hospitals are not listed as a resource for each identified need. Provena Mercy Medical Center Part V, Line 3 The Kane County community needs assessment and community health plan, 2006, had over 90 organizations and community leaders participate to obtain input from persons who represent the community. Provena Mercy Medical Center Part V, Line 4 Hospital members of the Community needs assessment committee include: Sherman Hospital Rush Copley Medical Center Delnor Community Hospital Provena Saint Joseph Hospital Provena Mercy Medical Center. Provena Mercy Medical Center Part V, Line 7 In the development of the community health plan related to priority issues, resources are strategically allocated for identified needs. Hospitals are not listed as a resource for each identified need. Provena United Samaritans Medical Center Part V, Line 3 The Vermilion County Community Health needs assessment and community health plan utilized a community advisory committee with representation from local government, medical community, social services agencies, education, business, and community residents. Provena United Samaritans Medical Center also conducted a health Assessment survey which was mailed to community residents. Provena United Samaritans Medical Center Part V, Line 4 Hoopston Community Hospital was represented on the community advisory committee. Provena United Samaritans Medical Center Part V, Line 7 Provena United Samaritans Medical Center has focused community benefit programs for both the teen pregnancy and access to care, which are 2 of the 4 top needs in the community. Provena Covenant Medical Center Part V, Line 3 The Champaign County Community Health Plan included a community theme and Strengths assessment. The assessment gathered community input from telephone surveys, focus groups and personal interviews. Provena Covenant Medical Center Part V, Line 4 The Champaign-Urbana Public Health District convened a diverse group of health providers, leaders and community representatives to participate in the process. Provena Covenant Medical Center Part V, Line 7 Provena Covenant Medical Center has specific community benefit programs and resources allocated to four of the top ten community priorities. Additionally Provena Covenant Medical Center provides clinical expertise in the community for another 3 identified needs (cancer, cardio, mental health). Provena Covenant Medical Center represents only one of many healthcare providers that are addressing the identified needs of the community. Provena St. Mary's Hospital Part V, Line 4 Hospital members of the community needs assessment committee included: Riverside Medical Center. Provena St. Mary's Hospital Part V, Line 7 The Kanhaalee County Analysis of community health needs did not identify a prioritized list of community needs. The assessment is a comprehensive overview of Kanhaalee County through secondary sources.</p>
Schedule H, Part VI		<p>Part VI, 2 Needs Assessment Provena Hospital ministries join forces with local community organizations to assess the health needs of the community. Community needs assessments are completed for the individual counties we serve with community partners every 3-5 years depending on the community needs and available resources. To supplement the community needs assessment Provena Hospitals also review and analyze Inpatient and Emergency Department utilization on an annual basis to uncover any new community health trends. In addition to assessing the health needs, Provena Hospital ministries also complete medical staff development plans. The plans are conducted by external consultants, who provide an independent assessment of the need for physicians by specialty within the hospital's primary service area as defined by Stark regulations. Identifying community needs is just one step in the needs assessment process. The most critical step is prioritizing and aligning expertise to make an impact on the identified needs. To facilitate this process, each hospital ministry has a Mission Committee of the Board that is ultimately responsible for the oversight and direction of the community benefit initiatives. On an annual basis this board committee, which is made up of community and board members, recommends approval to the hospital Board of Directors the hospital's community benefit plan. This plan identifies the priorities and action that will take place over the next year. Part VI, 3 Patient Education and Eligibility 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 organizations charity care policy. Provena hospital ministries proactively communicate the availability of our financial assistance programs with bilingual signage and brochures displayed prominently throughout high traffic areas of our ministries, as well as within our inpatient and outpatient registration/patient admitting areas and emergency departments. Comprehensive information about our financial assistance programs - including eligibility criteria, application details, and contact information - is also presented on our consumer Web site (www.provena.org/financialassistance). Financial counselors are also available to meet with patients during their stay if they have questions about their ability to pay for services and our financial assistance programs. Additionally, Provena hospital ministries participate with an outside vendor to assure eligible patients are also receiving benefits from the Medicaid entitlement programs. The vendor works with patients to complete appropriate applications. All self-pay or Medicaid pending patient statements contain information regarding our financial assistance programs and appropriate contact information in a bilingual format. Finally, to ensure the integrity of our financial assistance programs, our financial assistance policy and practices are audited by our internal auditors, CHAN, Health Care Auditors, to assure consistent application of policy and practice across all Provena Hospitals. Part VI, 4 Community Information Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves. Provena Hospital ministries provide services at 43 sites, including six acute care hospitals with a total of 1,317 staffed beds and 39 health centers. These ministries offer a broad range of services from highly specialized tertiary services to an extended network of primary and ambulatory care. Provena Hospital ministries have identified a separate service area for each of its acute care hospitals utilizing a consistent methodology and reflecting a combination of geographic location and market share criteria. The total service area of each ministry represents approximately 80% to 90% of the total inpatient discharges from that facility. The primary service area (the "Primary Service Area") of each facility represents approximately 65 to 75% of such discharges and the secondary service area (the "Secondary Service Area") of each facility represents approximately 15 to 25% of such discharges. The Primary Service Areas and Secondary Service Areas have been determined by utilizing a patient origin analysis to identify those zip codes that represent inpatient discharges. These zip codes are then mapped to identify geographic coverage of the Primary Service Areas and Secondary Service Areas. None of the Provena Hospital ministries share a common Primary Service Area. They are located in adjacent geographies, complementing the services provided by each facility and providing an opportunity for additional synergies throughout the System. Many of the Provena Hospital ministries facilities are located in population growth areas. Based upon population estimates and projections obtained from Claritas, Inc., the population of the our Hospitals combined service area is expected to grow at a rate of 1.7% annually between 2010 and 2015, compared with a growth rate of 0.4% and 0.3% per year in the Chicago MSA (defined below) and in Illinois, respectively. Ten percent of Provena's service area population is over the age of 65, compared to 11% and 13% in the Chicago MSA and in Illinois, respectively. Information related to each ministry is noted below. Provena Covenant Medical Center, Champaign, IL (PCMC). Champaign County is the sixth largest county in the state of Illinois with estimated 2009 population of 184,402 in PCMC's primary service area and 109,226 in the secondary service area. In the primary service area 10% of the population is over the age 65 and the average household income is \$64,446. The primary demographic make-up of Champaign County is as follows: 78.8% white, 11.2% black or African American, 6.5% Asian, 2.9% Hispanic/Latino. 6.9% of families in Champaign County live below the poverty level. The PCMC service area is defined by zip code below. Approximately 63% and 17% of total inpatient discharges to the PCMC-Urbana facility originate from this Primary Service Area and Secondary Service Area. Primary Market - 61821 Champaign, 61801 Urbana, 61820 Champaign, 61866 Rantoul, 61802 Urbana, 61953 Tuscola, 61880 Tolono, 61873 Saint Joseph, 61956 Villa Grove, 61874 Savoy, 61849 Homer, 61878 Thomasboro, 61822 Champaign, 61847 Gifford, 61877 Sidney, 61943 Oakland, 61851 Ivesdale, 61884 White Heath, 61839 De Land, 61931 Humboldt, 61844 Fithian, 61862 Penfield, 61882 Weldon, 61773 Sibley, 61930 Hindsboro, 61812 Armstrong, 60933 Elliott, 61932 Hume, 61871 Royal, 60926 Claytonville, 61845 Foosland, 61941 Murdock Service Area Secondary Market - 60948 Loda, 60957 Paxton, 61856 Monticello, 61853 Mahomet, 61938 Mattoon, 61910 Arcola, 60936 Gibson City, 61920 Charleston, 61942 Newman, 61813 Bement. Identified Community Needs: The Champaign County Health Plan 2006-2011 identified the following top three IPLAN (Illinois Plan for Local Assessment of Need) Priorities: Access to health care, Cancer, and Cardiovascular Disease. Provena United Samaritans Medical Center (PUSMC), Danville, IL. PUSMC's primary and secondary service areas have an estimated population of 110,000 residents. In the primary service area 17% of the population is over the age 65 and the average household income is \$46,467. The primary demographic make-up of Vermillion County is as follows: 86% white, 11% black or African American, 3.0% Hispanic/Latino. 9.7% of families in Vermillion County live below the poverty level. The PUSMC service area is defined by zip code below. Approximately 78% and 20% of total inpatient discharges to the PUSMC-Danville facility originate from this Primary Service Area and Secondary Service Area, respectively. Service Area Primary Market - 61832 Danville, 61834 Danville, 61846 Georgetown, 61883 Westville, 61833 Tilton Service Area Secondary Market - 47932 Covington, IL, 60942 Hoopston, 61817 Catlin, 61858 Oakwood, 61870 Ridge Farm, 61924 Chrisman, 60963 Rossville, 47987 Veederburg, IN, 61841 Fairmont, 47974 Perryville, IN, 47993 Williamsport, IN, 61814 Bismark, 61865 Pottomac, 47928 Cayuga, IN, 47952 Kingman, IN, 61876 Sidell, 61811 Alvin, 61844 Fithian, 61850 Indianapolis, 47991 West Lebanon, IN, 61848 Henning, 47982 State Line, IN, 60960 Rankin, 47918 Attica, IN, 61812 Armstrong, 60973 Wellington, 61940 Metcalf, 61831 Collision. Identified Community Needs: In 2006, PUSMC conducted a community needs assessment to identify the top three health care needs in the community. The report concluded that the top unmet health care needs in our service area are: Access to Healthcare, Community Health Education/Outreach, Affordability of Healthcare and Teen Pregnancy. Provena Saint Joseph Medical Center (PSJMC), Joliet, IL. PSJMC's primary service area has an estimated population of 262,946 and 369,243 in the secondary service area. In the primary</p>
Schedule H, Part VI cont'd		<p>Part VI, 6 Affiliated Health Care System Describe the respective roles of the affiliates in promoting the health of the communities. Effective November 30, 1997, The Franciscan Sisters of the Sacred Heart, The Servants of the Holy Heart of Mary - holy Family Province, and the Sisters of Mercy of the Americas Regional Community of Chicago created a new equally sponsored Catholic healthcare system called Provena Health in order to assure the provision of ongoing quality healthcare services to the communities served by the sponsors. Provena Health is the sole corporate sponsor of Provena Hospitals, Provena Senior Services, Provena Home Health, Provena Care @ Home, and Provena Health Assurance SPC, and owns 100% of Provena Ventures, Inc. These organizations include all of the healthcare operations of the Sponsors. Provena provides healthcare and long-term care services to communities primarily located in northern and central Illinois. As was the case from our very beginnings, Provena Health is called to be much more than a just a provider of health services. Provena Health has instilled within all of its ministries a commitment to responding to the needs of those we are privileged to serve, delivering high quality care that is accessible to all. It is this culture of caring and giving that drives our diligent efforts to ensure we return the optimal value of our charitable assets to our local communities. To ensure the commitment to the health of our communities was a top priority for all Provena Health ministries, the Provena Health Board of Directors adopted a Board Philosophy Statement in December 2007. The Community Benefit Board Philosophy Statement provides guidance for policies, practices and community benefit programs. The philosophy ensures that Provena Ministries pay special attention to the poor, vulnerable and underserved as well as continuing to effectively collaborate with the communities we serve on identified community needs. Part VI, 7 Filing Community Benefit Report Illinois</p>

Additional Data

Software ID:

Software Version:

EIN: 36-4195126

Name: PROVENA HOSPITALS

Form 990 Schedule H, Part V Section C. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

Section C. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility (list in order of size, measured by total revenue per facility, from largest to smallest)	
How many non-hospital facilities did the organization operate during the tax year? <u>36</u>	
Name and address	Type of Facility (Describe)
Provena Caton Farm Immediate Care 7000 Caton Farm Road Plainfield,IL 60586	Immediate Care Ctr
Provena Caton Farm Imaging Center 7000 Caton Farm Road Plainfield,IL 60586	Imaging Center
Provena Physical Therapy 3000 W Jefferson St Joliet,IL 60435	Physical Therapy
Provena Physical Therapy Services 1280 Windham Parkway Romeoville,IL 60446	Physical Therapy
Provena Center for Wound Care 301 North Madison St Joliet,IL 60435	Wound Care Center
Provena Physical TherapyIndustrial Reha 852 Sharp Avenue Shorewood,IL 60404	physical therapy
Provena Health Ctr-Diagnostic Imaging 1416 South Randall Road Geneva,IL 60134	Imaging Center
Provena Occupational HealthDiabetes Ctr 87 North Airlite Street Suite 130 Elgin,IL 60123	Occupational Health
Provena Outpatient Rehab Services 87 North Airlite Street Elgin,IL 60123	Rehabilitation Services
Provena Occupational Health 1320 N Highland Suite B Aurora,IL 60506	Occupational Med
Provena Physical Therapy 1975 Melissa Lane Aurora,IL 60506	Physical Therapy
Provena Health Institute 1975 Melissa Lane Aurora,IL 60506	outpatient clinic
Mercy Professional Building Pharmacy 1315 N Highland Aurora,IL 60506	Outpatient Pharmacy
Provena Physical Rehab & Sport Injury 2132 Jefferson Street Joliet,IL 60435	Physical Therapy
Provena Physical Therapy Services 1812 Lincoln Highway New Lenox,IL 60451	Physical Therapy
Provena Physical Therapy Services 15120 Wallin Drive Plainfield,IL 60544	Physical Therapy
Provena Sleep Disorder Center 2132 Jefferson Street Joliet,IL 60435	Sleep Disorder Center
Provena Physical Therapy Services 7000 Caton Farm Road Plainfield,IL 60586	Physical Therapy
Medcare 24 hour Acute Care 2250 West Algonquin Road Lake in the Hills,IL 60156	Immediate Care Center
Provena Sleep Lab 412 Sheridan Danville,IL 61832	Sleep Disorder Center
Provena United Samaratins Open MRI 412 Sheridan Danville,IL 61832	Imaging Center
Provena United Samartins Med Ctr Fndtn 801 W Fairchild Danville,IL 61832	Foundation Office
Provena United Samaratins Oncology Ctr 806 North Logan Avenue Danville,IL 61832	Oncology Center
Provena Yorkville Medical Office Bldg 1500 Sycamore Road Yorkville,IL 60560	Medical Office Building
Provena Manteno Medcentre 501 S Locust Street Manteno,IL 60950	Medical Office Building
Provena Medcentre East 455 West Court Street Kankakee,IL 60901	Medical Office Building
Provena Medcentre West 555 West Court Street Kankakee,IL 60901	Medical Office Building
Provena Momence Medcentre 739 North Dixie Highway Momence,IL 60954	Medical Office Building
Provena Peotone Medcentre 117 South Harlem Avenue Peotone,IL 60468	Medical Office Building
Provena St Mary's Regional Cancer Center 100 Provena Way Bourbonnais,IL 60914	Regional Oncology Center
Provena St Mary's Imaging Center 100 Provena Way Bourbonnais,IL 60914	Imaging Center
Provena St Mary's Occupational Health 230 W John Casey Road Bourbonnais,IL 60914	Occupational Medicine
Provena Wellness Center 21 Heritage Drive Bourbonnais,IL 60914	Health And Fitness Center
Provena Center For Healthy Aging 401 East University Suite 102 Champaign,IL 61820	Senior Health Center
Provena Regional EMS 408 S Neil Street Champaign,IL 61820	EMS Paramedic Services
Pro Ambulance Services 408 S Neil Street Champaign,IL 61820	Ambulance Services

Schedule I
(Form 990)

Department of the Treasury
Internal Revenue Service

Name of the organization
PROVENA HOSPITALS

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

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

OMB No 1545-0047

2010

Open to Public
Inspection

Employer identification number
36-4195126

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 Governments and Organizations in the United States. Complete if the organization answered "Yes" to Form 990, Part IV, line 21 for any recipient that received more than \$5,000. Check this box if no one recipient 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 Code 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

2

Enter total number of section 501(c)(3) and government organizations ▶

3

Enter total number of other organizations ▶

Part III

Grants and Other Assistance to Individuals in the United States. Complete if the organization answered "Yes" to Form 990, Part IV, line 22.
Use Schedule I-1 (Form 990) if additional space is needed.

(a)Type of grant or assistance	(b)Number of recipients	(c)Amount of cash grant	(d)Amount of non-cash assistance	(e)Method of valuation (book, FMV, appraisal, other)	(f)Description of non-cash assistance
(1) Scholarships	45	108,667			

Part IV

Supplemental Information. Complete this part to provide the information required in Part I, line 2, and any other additional information.

Identifier	Return Reference	Explanation
form 990 schedule I, PART I LINE 2		THE FOLLOWING THREE HOSPITALS AWARDED GRANTS AND ASSISTANCE AND USED THE FOLLOWING PROCEDURES FOR MONITORING THE USE OF THE FUNDS DISTRIBUTED Provena Covenant Medical Center Checks for authorized students are sent directly to their respective universities (and made payable to the universities) for disbursement to the studentS for appropriate expenses such as tuition In the case of Parkland College where a good number of nursing scholarships are given, Parkland bills THE MEDICAL CENTER at the conclusion of each semester THE MEDICAL CENTER IS billed for only the dollars used and if a student does not utilize all of the funds made available for HIS OR HER scholarship award, the Auxiliary is not billed and does not incur the expense They also notify THE MEDICAL CENTER if A student drops out or changes curriculums therefore no longer being eligible for the funds given in their healthcare studies Most of the universities have auditing practices which requires them to oversee the distribution of scholarship funds to their students THE MEDICAL CENTER placeS ITS confidence in their practices to ensure that monies given to the students are monitored appropriately Provena Mercy Medical Center Scholarships are handled through THE MEDICAL CENTER'S Foundation The Foundation office receives the applications and distributes the applications to a committee The committee reviews the applications, determines which candidates to interview in person, conducts the interviews, and selects the recipients The Foundation receives the tuition bills and makes the tuition payments directly to the schools (up to the amount of the scholarship award) Some grants are handled through THE Foundation When grant funds are to be expended, a "Disbursement of Foundation Funds" form is completed by the clinical director responsible for handling the grant The Foundation reviews and approves the form, and the funds are expended The Foundation notifies Finance that the funds can be released from restriction The clinical director and Foundation office work together to submit the necessary grant reports to the grantor Federal grants are not handled through the Foundation The clinical director responsible for the grant works with Finance to track the expenses for the grant The clinical director prepares and submits the necessary reports to the grantor PROVENA UNITED SAMARITANS MEDICAL CENTER THE MEDICAL CENTER insureS that the young man or young woman awarded a scholarship through Young Men Aware or Young Women Aware actually enroll in an institution of higher learning and pay the scholarship (generally only \$500 or \$1,000) directly to the institution Thus, eliminating any chance that the SCHOLARSHIP will not actually go towards education

Schedule J
(Form 990)

Compensation Information

OMB No 1545-0047

2010

Open to Public Inspection

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

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

▶ Attach to Form 990. ▶ See separate instructions.

Name of the organization
PROVENA HOSPITALS

Employer identification number
36-4195126

Part I

Questions Regarding Compensation

		Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a Complete Part III to provide any relevant information regarding these items		
	<div><div><input type="checkbox"/> First-class or charter travel</div><div><input type="checkbox"/> Housing allowance or residence for personal use</div><div><input checked="" type="checkbox"/> Travel for companions</div><div><input type="checkbox"/> Payments for business use of personal residence</div><div><input type="checkbox"/> Tax idemnification and gross-up payments</div><div><input checked="" type="checkbox"/> Health or social club dues or initiation fees</div><div><input type="checkbox"/> Discretionary spending account</div><div><input type="checkbox"/> Personal services (e g , maid, chauffeur, chef)</div></div>		
b	If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all the expenses described above? If "No," complete Part III to explain	1b	Yes
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all officers, directors, trustees, and the CEO/Executive Director, regarding the items checked in line 1a?	2	Yes
3	Indicate which, if any, of the following the organization uses to establish the compensation of the organization's CEO/Executive Director Check all that apply		
	<div><div><input checked="" type="checkbox"/> Compensation committee</div><div><input checked="" type="checkbox"/> Written employment contract</div><div><input checked="" type="checkbox"/> Independent compensation consultant</div><div><input checked="" type="checkbox"/> Compensation survey or study</div><div><input type="checkbox"/> Form 990 of other organizations</div><div><input checked="" type="checkbox"/> Approval by the board or compensation committee</div></div>		
4	During the year, did any person listed in 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 from the organization or a related organization?	4a	Yes
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b	No
c	Participate in, or receive payment from, an equity-based compensation arrangement?	4c	No
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III		
	Only 501(c)(3) and 501(c)(4) organizations only must complete lines 5-9.		
5	For persons listed in form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of		
a	The organization?	5a	No
b	Any related organization?	5b	No
	If "Yes," to line 5a or 5b, describe in Part III		
6	For persons listed in form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of		
a	The organization?	6a	Yes
b	Any related organization?	6b	Yes
	If "Yes," to line 6a or 6b, describe in Part III		
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III	7	No
8	Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regs section 53 4958-4(a)(3)? If "Yes," describe in Part III	8	No
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53 4958-6(c)?	9	

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

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

Note. The sum of columns (B)(i)-(iii) must equal the applicable column (D) or column (E) amounts on Form 990, Part VII, line 1a

(A) Name		(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 reported in prior Form 990 or Form 990-EZ
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
See Additional Data Table								
(2)								
(3)								
(4)								
(5)								
(6)								
(7)								
(8)								
(9)								
(10)								
(11)								
(12)								
(13)								
(14)								
(15)								
(16)								

Part IIISupplemental Information

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

Identifier	Return Reference	Explanation
FORM 990 SCHEDULE J SUPPLEMENTAL INFORMATION		PART I, QUESTION 4A THE FOLLOWING RECEIVED SEVERANCE PAYMENTS: ILENE GILBERT 151,452; DAVID SELZER 12,608; MATTHEW BROWN 59,539.

Software ID:

Software Version:

EIN: 36-4195126

Name: PROVENA HOSPITALS

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

(A) Name		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported in prior Form 990 or Form 990-EZ
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other compensation				
GUY WIEBKING	(i)	0	0	0	0	0	0	
	(ii)	787,764	0	49,191	12,250	914	850,119	
JOMEL LABAYOG	(i)	496,465	17,582	16,500	17,150	5,918	553,615	
	(ii)							
VICTOR ROSTAPSHOV	(i)	353,946	0	23,032	12,250	8,348	397,576	
	(ii)							
MICHAEL PANUSKA	(i)	229,933	28,000	23,304	19,600	7,008	307,845	
	(ii)							
LENO THOMAS	(i)	244,079	0	15,854	12,250	2,327	274,510	
	(ii)							
JINJENG ZHU	(i)	222,273	0	29,439	14,700	5,141	271,553	
	(ii)							
ANIL GOPINATH	(i)	205,134	28,000	26,640	20,046	12,951	292,771	
	(ii)							
CHAD HAYS	(i)	124,595	0	25,409	21,324	6,898	178,226	
	(ii)							
ELIZABETH HUGHES	(i)	287,785	38,717	44,825	33,735	8,811	413,873	
	(ii)							
GARY PLUNDO	(i)	275,727	34,246	32,972	36,252	9,409	388,606	
	(ii)							
AMY STEVENS	(i)	213,038	34,996	32,106	30,249	3,059	313,448	
	(ii)							
JACQUELINE MEDLAND	(i)	175,207	24,715	41,041	28,768	9,321	279,052	
	(ii)							
ELIZABETH GARROW	(i)	165,792	23,100	49,854	26,188	8,690	273,624	
	(ii)							
TERRENCE WRIGHT	(i)	77,983	19,210	136,562	6,865	1,261	241,881	
	(ii)							
JANICE NEMRI	(i)	144,256	18,419	46,347	23,951	6,513	239,486	
	(ii)							
BABAK PAZOOKI	(i)	206,115	12,178	25,983	23,413	15,362	283,051	
	(ii)							
AMY LAFINE	(i)	152,354	29,864	36,099	33,410	8,105	259,832	
	(ii)							
JOHN BACCHETTI	(i)	193,452	10,114	42,759	28,087	9,716	284,128	
	(ii)							
PAMELA URBANSKI	(i)	191,922	5,388	20,570	26,199	4,204	248,283	
	(ii)							
LAURENCE DRY	(i)	169,292	5,235	33,611	25,075	12,752	245,965	
	(ii)							
INDRANIL BOB SARKAR	(i)	159,740	26,590	12,059	16,934	6,843	222,166	
	(ii)							
DIANE GENTHNER	(i)	108,735	19,349	42,994	17,999	4,211	193,288	
	(ii)							
DANIEL HATCHER	(i)	246,158	14,510	15,789	29,909	7,200	313,566	
	(ii)							
SUZETTE MAHNEKE	(i)	179,367	8,053	13,220	20,648	6,153	227,441	
	(ii)							
DAVID MCNARY	(i)	141,260	8,721	38,149	8,670	2,114	198,914	
	(ii)							
MOLLY NICHOLSON	(i)	125,081	0	24,657	20,421	7,523	177,682	
	(ii)							
Deborah Schimerowski	(i)							
	(ii)	171,388	5,352	11,283	13,591	14,419	216,033	
Gary Gasbarra	(i)							
	(ii)	297,897	38,213	67,041	50,837	33,576	487,564	
Paul Belter	(i)							
	(ii)	276,926	13,352	29,691	34,408	29,230	383,607	

SCHEDULE M
(Form 990)

NonCash Contributions

OMB No 1545-0047

2010

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

►Complete if the organization answered "Yes" on Form 990, Part IV, lines 29 or 30.
► Attach to Form 990.

Name of the organization
PROVENA HOSPITALS

Employer identification number
36-4195126

Part I

Types of Property

	(a) Check if applicable	(b) Number of Contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining oncash contribution amounts
1 Art—Works of art . . .				
2 Art—Historical treasures				
3 Art—Fractional interests				
4 Books and publications				
5 Clothing and household goods				
6 Cars and other vehicles . .				
7 Boats and planes . . .				
8 Intellectual property . .				
9 Securities—Publicly traded				
10 Securities—Closely held stock				
11 Securities—Partnership, LLC, or trust interests .				
12 Securities—Miscellaneous				
13 Qualified conservation contribution—Historic structures				
14 Qualified conservation contribution—Other . .				
15 Real estate—Residential .				
16 Real estate—Commercial				
17 Real estate—Other . .				
18 Collectibles				
19 Food inventory				
20 Drugs and medical supplies				
21 Taxidermy				
22 Historical artifacts . .				
23 Scientific specimens . .				
24 Archeological artifacts .				
Dirt for				
25 Other ► (Healing)	X	0	5,000	Cost
GIFTS-IN-				
26 Other ► (KIND)	X	0	206,409	COST
Sound				
27 Other ► (system)	X	0	10,100	cost
28 Other ► (Raffle Items)	X	0	5,000	Cost
29 Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement . . .				29

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

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

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

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

Yes

No

No

No

No

Part II

Supplemental Information. Complete this part to provide the information required by Part I, lines 30b, 32b, and 33. Also complete this part for any additional information.

Identifier	Return Reference	Explanation
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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 to provide any additional information.
▶ Attach to Form 990 or 990-EZ.

OMB No 1545-0047

2010

Open to Public
Inspection

Name of the organization PROVENA HOSPITALS	Employer identification number 36-4195126
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Identifier	Return Reference	Explanation
FORM 990 PART VI SECTION A, QUESTIONS 7A & 7B		The member body consisting of 2 members appointed by the leadership teams of each sponsoring congregation (Franciscan Sisters of the Sacred Heart, Servants of the Holy Heart of Mary, USA Province and Sisters of Mercy, West, Mid-West Region) has the authority to appoint Board members and approve the recommendations of the Board

Identifier	Return Reference	Explanation
FORM 990 PART VI SECTION B, QUESTION 11		THE BOARD REVIEWS THE FORM 990 AND SUPPORTING SCHEDULES AT A MEETING BEFORE SUBMISSION TO THE IRS THE RETURN IS SUBMITTED WITH THE BOARD PACKAGE AND IS ALSO PLACED ON A BOARD MEMBER WEBSITE ANNUAL EDUCATION SESSIONS ON THE 990 ARE ALSO GIVEN TO THE BOARD

Identifier	Return Reference	Explanation
FORM 990 PART VI SECTION B, QUESTIONS 12A, 12B, & 12C		THE ORGANIZATION HAS ADOPTED A POLICY THAT REQUIRES BOARD MEMBERS TO COMPLETE A STATEMENT THAT DISCLOSES ALL ACTIVITIES AND PROHIBITS VOTING ON ANY MATTERS INVOLVING ANY CONFLICTS EVERY AGENDA HAS A STATEMENT THAT PROHIBITS VOTING ON AGENDA ITEMS WHERE BOARD MEMBERS HAVE CONFLICTS VENDOR FILES ARE MATCHED WITH COMPANIES THAT BOARD MEMBERS HAVE AFFILIATIONS WITH TO DETERMINE IF CONFLICTS EXIST

Identifier	Return Reference	Explanation
FORM 990 PART VI SECTION B, QUESTIONS 15A & 15B		AN INDEPENDENT HUMAN RESOURCES COMPANY REVIEWS SALARY SURVEYS FOR CEO'S AND KEY EMPLOYEES DURING THE YEAR AND MAKES RECOMMENDATIONS TO THE BOARD OF DIRECTORS

Identifier	Return Reference	Explanation
FORM 990 PART VI SECTION C, QUESTION 19		GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICIES, AND FINANCIAL STATEMENTS ARE AVAILABLE TO THE PUBLIC UPON REQUEST AND ARE ON THE ORGANIZATION'S WEBSITE

Identifier	Return Reference	Explanation
Part XI, Line 5		Other Changes in Net Assets or Fund Balance Net Unrealized Gains 780,000 Transfers from Affiliates (3,838,000) Impairment Loss (1,164,000) Net Assets Released from Restriction 1,010,000 Contributions Pledged but not yet received (3,549,031) Donations received with Temporary Restrictions 808,753 Donations received with Permanent Restrictions 106,407 Other changes in net assets, net (9,000) Net Assets Released from Restriction 1,042,673 Book/Tax Income Difference on Joint Ventures (508,233) Net Income from Special Events (134,890) Volunteer Hours 970,619 Rounding (88) _____ Total Changes in Net Assets (4,484,790)

SCHEDULE R (Form 990) <small>Department of the Treasury Internal Revenue Service</small>	Related Organizations and Unrelated Partnerships ▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 33, 34, 35, 36, or 37. ▶ Attach to Form 990. ▶ See separate instructions.	OMB No 1545-0047
		2010
		Open to Public Inspection

Name of the organization PROVENA HOSPITALS	Employer identification number 36-4195126
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Part I

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

(a) Name, address, and EIN of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) ALVERNO PROVENA HOSPITAL LABORATORY 2434 INTERSTATE PLAZA DRIVE HAMMOND, IN 46324 20-3238867	Healthcare	IN			

Part II

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled organization	
						Yes	No
(1) PROVENA HEALTH 9223 W ST FRANCIS ROAD FRANKFORT, IL 60423 36-3366652	HEALTHCARE	IL	501(c)(3)	11	N/A		
(2) PROVENA SENIOR SERVICES 19065 HICKORY CREEK DRIVE MOKENA, IL 60448 37-1127787	healthcare	IL	501(c)(3)	7	N/A		
(3) PROVENA CARE HOME 19065 HICKORY CREEK DRIVE Mokena, IL 60448 46-0483587	HEALTHCARE	IL	501(C)(3)	9	N/A		
(4) PROVENA HOME HEALTH 19065 HICKORY CREEK DRIVE Mokena, IL 60448 46-0483581	HEALTHCARE	IL	501(C)(3)	9	N/A		
(5) PROVENA LAVERNA TERRACE 19065 HICKORY CREEK DRIVE Mokena, IL 60448 36-3438977	HEALTHCARE	IL	501(C)(3)	9	NA		
(6) PROVENA SELF INSURANCE TRUST 9223 W ST FRANCIS FRANKFORT, IL 60423 36-2987310	INSURANCE	IL	501(C)(3)	9	N/A		

Part III

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512- 514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V—UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	

Part IV

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership
(1) PROVENA SERVICES CORPORATION 9223 W ST FRANCIS ROAD FRANKFORT, IL60423 36-4314354	medical	IL	na	c corp	-10,277,683	3,654,660	100 000 %
(2) PROVENA VENTURES 9223 west st francis road frankfort, IL60423 37-1168085	medical	IL	provena health	c corp			
(3) provena properties 9223 west st francis road frankfort, IL60423 36-3520630	medical	IL	provena health	c corp			
(4) Provena Assurance Corporation 9223 west st francis road frankfort, IL60423 98-0420054	medical	IL	provena health	c corp			
(5) PROVENA SELF-INSURANCE TRUST 9223 WEST ST FRANCIS ROAD FRANKFORT, IL60423 36-2987310	INSURANCE	IL	PROVENA HEALTH	TRUST			

Part V

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

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

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

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

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

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

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

e Loans or loan guarantees by other organization(s)

f Sale of assets to other organization(s)

g Purchase of assets from other organization(s)

h Exchange of assets

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

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

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

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

m Sharing of facilities, equipment, mailing lists, or other assets

n Sharing of paid employees

o Reimbursement paid to other organization for expenses

p Reimbursement paid by other organization for expenses

q Other transfer of cash or property to other organization(s)

r Other transfer of cash or property from other organization(s)

Yes

No

1a

1b

1c

1d

1e

1f

1g

1h

1i

1j

1k

1l

1m

1n

1o

1p

1q

1r

No

No

No

Yes

No

No

No

No

Yes

No

No

No

No

Yes

Yes

No

Yes

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

(a) Name of other organization	(b) Transaction type(a-r)	(c) Amount involved	(d) Method of determining amount involved
(1) PROVENA SERVICE CORPORATION	P	95,810	
(2)			
(3)			
(4)			
(5)			
(6)			

Schedule R (Form 990) 2010

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

[illegible]

Part VII **Supplemental Information**

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

Identifier	Return Reference	Explanation
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Software ID:
Software Version:
EIN: 36-4195126
Name: PROVENA HOSPITALS

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c) (3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled organization	
						Yes	No
PROVENA HEALTH 9223 W ST FRANCIS ROAD FRANKFORT, IL60423 36-3366652	HEALTHCARE	IL	501(c)(3)	11	N/A		
PROVENA SENIOR SERVICES 19065 HICKORY CREEK DRIVE MOKENA, IL60448 37-1127787	healthcare	IL	501(c)(3)	7	N/A		
PROVENA CARE HOME 19065 HICKORY CREEK DRIVE Mokena, IL60448 46-0483587	HEALTHCARE	IL	501(C)(3)	9	N/A		
PROVENA HOME HEALTH 19065 HICKORY CREEK DRIVE Mokena, IL60448 46-0483581	HEALTHCARE	IL	501(C)(3)	9	N/A		
PROVENA LAVERNA TERRACE 19065 HICKORY CREEK DRIVE Mokena, IL60448 36-3438977	HEALTHCARE	IL	501(C)(3)	9	NA		
PROVENA SELF INSURANCE TRUST 9223 W ST FRANCIS FRANKFORT, IL60423 36-2987310	INSURANCE	IL	501(C)(3)	9	N/A		

Additional Data

Software ID:

Software Version:

EIN: 36-4195126

Name: PROVENA HOSPITALS

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

(A) Name and Title	(B) Average hours per week	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
WILLIAM BERRY PHD DIRECTOR	10	X						0		0
ROBERT BIEDRON CHAIRPERSON	10	X		X				0		0
AIDA GIACHELLO PHD DIRECTOR	10	X						0		0
MARK HANSON VICE CHAIRPERSON	10	X		X				0		0
SISTER LINDA HATTON SSCM SECRETARY	10	X						0		0
THOMAS HUBERTY MD DIRECTOR	10	X						0		0
SISTER MARY ELIZABETH IMLER DIRECTOR	10	X						0		0
BETTINA JOHNSON TREASURER	10	X		X				0		0
LUCIA JONES DIRECTOR	10	X						0		0
SISTER TERRY MALTBY DIRECTOR	10	X						0		0
BECKY MEGGESIN DIRECTOR	10	X						0		0
DANIEL RUSSEL VICE CHAIRPERSON	10	X		X				0		0
KENT RUSSELL DIRECTOR	10	X						0		0
GUY WIEBKING DIRECTOR/ PRESIDENT & CEO	400	X		X				0	836,955	12,250
Marsha Ladenburger Director	10	X								
Deborah Schimerowski Regional VP Finance/CFO	400			X					188,023	27,549
Gary Gasbarra Regional VP Finance/CFO	400			X					403,151	83,499
Paul Belter Regional VP Finance/CFO	400			X					319,969	62,724
ANIL GOPINATH CMO	400				X			259,774		31,923
CHAD HAYS VP FUND DEVELOPMENT	400				X			150,004		27,110
ELIZABETH HUGHES COO	400				X			371,327		41,434
GARY PLUNDO CMO	400				X			342,945		45,661
AMY STEVENS REG VP STRATEGIC PLG & BUS DEV	400				X			280,140		32,218
JACQUELINE MEDLAND VP PATIENT CARE SRVS	400				X			240,963		37,062
ELIZABETH GARROW VP FOUNDATION	400				X			238,746		33,929

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

(A) Name and Title	(B) Average hours per week	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
TERRENCE WRIGHT VP CONSTRUCTION/FACILITY	40 0				X			233,755		7,273
JANICE NEMRI VP CLINICAL SRVS	40 0				X			209,022		29,517
BABAK PAZOOKI CMO	40 0				X			244,276		37,674
AMY LAFINE VP PATIENT CARE SRVS	40 0				X			218,317		40,754
JOHN BACCHETTI REG VP STRATEGIC PLG & BUS DEV	40 0				X			246,325		36,967
PAMELA URBANSKI VP PATIENT CARE SRVS	40 0				X			217,880		29,631
LAURENCE DRY VP AMBULATORY SRVS	40 0				X			208,138		37,075
INDRANIL BOB SARKAR REG VP STRATEGIC PLG & BUS DEV	40 0				X			198,389		22,930
DIANE GENTHNER VP PATIENT CARE SRVS	40 0				X			171,078		21,461
DANIEL HATCHER CMO	40 0				X			276,457		35,997
SUZETTE MAHNEKE VP PATIENT CARE SRVS	40 0				X			200,640		25,867
DAVID MCNARY VP AMBULATORY SRVS	40 0				X			188,130		9,970
JOMEL LABAYOG PHYSICIAN	40 0					X		530,547		22,154
VICTOR ROSTAPSHOV PHYSICIAN	40 0					X		376,978		19,486
MICHAEL PANUSKA MEDICAL DIRECTOR	40 0					X		281,237		25,496
LENO THOMAS PHYSICIAN	40 0					X		259,933		13,681
JINJENG ZHU PHYSICIST	40 0					X		251,712		18,744
MOLLY NICHOLSON VP PATIENT CARE SRVS	40 0						X	149,738		21,945