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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 private foundations)

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

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

OMB No 1545-0047

2014

Open to Public Inspection

A For the 2014 calendar year, or tax year beginning 01-01-2014 , and ending 12-31-2014

B Check if applicable <input checked="" type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization PRESENCE HOSPITALS PRV		D Employer identification number 36-4195126
	% ANTHONY J FILER Doing business as		
	Number and street (or P O box if mail is not delivered to street address)	Room/suite	E Telephone number (630) 914-2791
	1000 REMINGTON BOULEVARD SUITE 100		
	City or town, state or province, country, and ZIP or foreign postal code BOLINGBROOK, IL 60440		G Gross receipts \$ 1,072,306,921
	F Name and address of principal officer SANDRA BRUCE 200 SOUTH WACKER CHICAGO, IL 60606		
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		H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
J Website: ▶ WWW.PRESENCEHEALTH.ORG		H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list (see instructions)	
		H(c) Group exemption number ▶	

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
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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 AVOIDS ILLNESS USING PREVENTIVE CARE AND ADVANCED TECHNOLOGIES																								
	2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets																								
	<table><tr><td>3 Number of voting members of the governing body (Part VI, line 1a)</td><td>3</td><td>19</td></tr><tr><td>4 Number of independent voting members of the governing body (Part VI, line 1b)</td><td>4</td><td>18</td></tr><tr><td>5 Total number of individuals employed in calendar year 2014 (Part V, line 2a)</td><td>5</td><td>7,637</td></tr><tr><td>6 Total number of volunteers (estimate if necessary)</td><td>6</td><td>1,925</td></tr><tr><td>7a Total unrelated business revenue from Part VIII, column (C), line 12</td><td>7a</td><td>3,618,365</td></tr><tr><td>b Net unrelated business taxable income from Form 990-T, line 34</td><td>7b</td><td>1,345,563</td></tr></table>	3 Number of voting members of the governing body (Part VI, line 1a)	3	19	4 Number of independent voting members of the governing body (Part VI, line 1b)	4	18	5 Total number of individuals employed in calendar year 2014 (Part V, line 2a)	5	7,637	6 Total number of volunteers (estimate if necessary)	6	1,925	7a Total unrelated business revenue from Part VIII, column (C), line 12	7a	3,618,365	b Net unrelated business taxable income from Form 990-T, line 34	7b	1,345,563						
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Revenue	<table><tr><td>8 Contributions and grants (Part VIII, line 1h)</td><td>Prior Year</td><td>Current Year</td></tr><tr><td>9 Program service revenue (Part VIII, line 2g)</td><td>3,718,307</td><td>4,593,403</td></tr><tr><td>10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)</td><td>1,078,216,341</td><td>1,049,160,317</td></tr><tr><td>11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)</td><td>8,158,071</td><td>3,097,577</td></tr><tr><td>12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)</td><td>13,355,378</td><td>14,639,842</td></tr><tr><td></td><td>1,103,448,097</td><td>1,071,491,139</td></tr></table>	8 Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year	9 Program service revenue (Part VIII, line 2g)	3,718,307	4,593,403	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	1,078,216,341	1,049,160,317	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	8,158,071	3,097,577	12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	13,355,378	14,639,842		1,103,448,097	1,071,491,139						
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Expenses	<table><tr><td>13 Grants and similar amounts paid (Part IX, column (A), lines 1–3)</td><td>164,223</td><td>148,930</td></tr><tr><td>14 Benefits paid to or for members (Part IX, column (A), line 4)</td><td>0</td><td>0</td></tr><tr><td>15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)</td><td>431,049,556</td><td>412,539,891</td></tr><tr><td>16a Professional fundraising fees (Part IX, column (A), line 11e)</td><td>24,383</td><td>25,231</td></tr><tr><td>b Total fundraising expenses (Part IX, column (D), line 25) ▶ 2,352,275</td><td></td><td></td></tr><tr><td>17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)</td><td>638,854,140</td><td>622,033,586</td></tr><tr><td>18 Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)</td><td>1,070,092,302</td><td>1,034,747,638</td></tr><tr><td>19 Revenue less expenses Subtract line 18 from line 12</td><td>33,355,795</td><td>36,743,501</td></tr></table>	13 Grants and similar amounts paid (Part IX, column (A), lines 1–3)	164,223	148,930	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)	431,049,556	412,539,891	16a Professional fundraising fees (Part IX, column (A), line 11e)	24,383	25,231	b Total fundraising expenses (Part IX, column (D), line 25) ▶ 2,352,275			17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	638,854,140	622,033,586	18 Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	1,070,092,302	1,034,747,638	19 Revenue less expenses Subtract line 18 from line 12	33,355,795	36,743,501
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Net Assets or Fund Balances	<table><tr><td></td><td>Beginning of Current Year</td><td>End of Year</td></tr><tr><td>20 Total assets (Part X, line 16)</td><td>801,911,028</td><td>790,635,498</td></tr><tr><td>21 Total liabilities (Part X, line 26)</td><td>236,910,724</td><td>247,609,118</td></tr><tr><td>22 Net assets or fund balances Subtract line 21 from line 20</td><td>565,000,304</td><td>543,026,380</td></tr></table>		Beginning of Current Year	End of Year	20 Total assets (Part X, line 16)	801,911,028	790,635,498	21 Total liabilities (Part X, line 26)	236,910,724	247,609,118	22 Net assets or fund balances Subtract line 21 from line 20	565,000,304	543,026,380												
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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	<div>*****</div> <div>Signature of officer</div>	<div>2015-11-16</div> <div>Date</div>
	<div>Anthony Filer CFO</div> <div>Type or print name and title</div>	

Paid Preparer Use Only	Print/Type preparer's name Manager	Preparer's signature Manager	Date 2015-11-16	Check <input type="checkbox"/> if self-employed	PTIN P00294881
	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) ☒ Yes ☐ No

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

THE ORGANIZATION STRIVES TO MAKE AVAILABLE A FULL CONTINUUM OF SERVICES, BOTH PRIMARY AND SPECIALITY, 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.

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

If "Yes," describe these changes on Schedule O





















4a	(Code) (Expenses \$ 645,340,764 including grants of \$ 148,930) (Revenue \$ 1,047,828,393)
	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

[illegible][illegible]

4e	Total program service expenses	645,340,764
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Part IV

Checklist of Required Schedules

	Yes	No
1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A 	1 Yes	
2 Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)? 	2 Yes	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I	3	No
4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II	4	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	No
6 Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes," complete Schedule D, Part I 	6	No
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II 	7	No
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III 	8	No
9 Did the organization report an amount in Part X, line 21 for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? If "Yes," complete Schedule D, Part IV 	9	No
10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? If "Yes," complete Schedule D, Part V 	10 Yes	
11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable		
a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI 	11a Yes	
b Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII 	11b	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 Yes	
e Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X 	11e Yes	
f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part X 	11f Yes	
12a Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII 	12a	No
b Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional 	12b Yes	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	13	No
14a Did the organization maintain an office, employees, or agents outside of the United States?	14a	No
b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV	14b	No
15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? If "Yes," complete Schedule F, Parts II and IV	15	No
16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? If "Yes," complete Schedule F, Parts III and IV	16	No
17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I (see instructions) 	17 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 hospital facilities? If "Yes," complete Schedule H 	20a Yes	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? 	20b Yes	

Part IV

Checklist of Required Schedules (continued)

21	Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i>	21	Yes	
22	Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i>	22	Yes	
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i>	23	Yes	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i>	24a		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), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i>	25a		No
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i>	25b		No
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? <i>If "Yes," complete Schedule L, Part II</i>	26		No
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i>	27		No
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions)			
a	A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>	28a		No
b	A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>	28b		No
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV</i>	28c		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, Part II, III, or IV, and Part V, line 1</i>	34	Yes	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	Yes	
b	If 'Yes' to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i>	35b	Yes	
36	Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i>	36		No
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i>	37		No
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? Note. All Form 990 filers are required to complete Schedule O	38	Yes	

Part V

Statements Regarding Other IRS Filings and Tax Compliance

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

		Yes	No
1a	Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable	1,404	
1b	Enter the number of Forms W-2G included in line 1a Enter -0- if not applicable	0	
c Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?		1c	Yes
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	7,637
b If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)		2b	Yes
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? <i>If "No" to line 3b, provide an explanation in Schedule O</i>		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 FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)			
5a Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		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 as charitable contributions?		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. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?		8	
9a Did the sponsoring organization make any taxable distributions under section 4966?		9a	
b Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?		9b	
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? <i>If "No," provide an explanation in Schedule O</i>		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 or note to any line in this Part VI

Section A. Governing Body and Management

		Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	19	
If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O			
1b	Enter the number of voting members included in line 1a, above, who are independent	18	
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2	No
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?	3	No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4	No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5	No
6	Did the organization have members or stockholders?	6	Yes
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a	Yes
7b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b	Yes
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following		
8a	a The governing body?	8a	Yes
8b	b Each committee with authority to act on behalf of the governing body?	8b	Yes
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O	9	No

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

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

Section C. Disclosure

17	List the States with which a copy of this Form 990 is required to be filed▶
18	Section 6104 requires an organization to make its Form 1023 (or 1024 if applicable), 990, and 990-T (501(c) (3)s only) available for public inspection. Indicate how you made these available. Check all that apply. <input type="checkbox"/> Own website <input type="checkbox"/> Another's website <input checked="" type="checkbox"/> Upon request <input type="checkbox"/> Other (explain in Schedule O)
19	Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year
20	State the name, address, and telephone number of the person who possesses the organization's books and records ▶ANTHONY J FILER 200 SOUTH WACKER CHICAGO,IL 60606 (312) 308-3289

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

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

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

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

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

[illegible]

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			

1b	Sub-Total			
c	Total from continuation sheets to Part VII, Section A			
d	Total (add lines 1b and 1c)	5,498,966	3,264,194	722,798

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization ▶298

		Yes	No
3	Did the organization list any former officer, director or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i>	3 Yes	
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>	4 Yes	
5	Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? <i>If "Yes," complete Schedule J for such person</i>	5	No

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
MADISON AVENUE ANESTHESIA PLACEMENT, 20201 S CRAWFORD AVE OLYMPIA FIELDS, IL 60461	ANESTHESIA SERVICES	3,778,674
CENTER FOR WOUND HEALING, 8859 VENTURY WAY NAPLES, FL 34109	medical services	1,184,498
CHRISTIE CLINIC, 101 W UNIVERSITY AVE CHAMPAIGN, IL 61820	HOSPITALIST SERVICES	2,388,061
NEW LENOX INVESTORS, 661 UNIVERSITY BLVD SUITE 200 JUPITER, FL 33458	RENT	1,242,313
Joliet Investors LLP, 661 University Blvd Suite 200 JUPITER, FL 33458	RENT	1,070,294

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization ▶58

Part VIII

Statement of Revenue

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns 1a				
	b	Membership dues 1b				
	c	Fundraising events 1c	1,275,227			
	d	Related organizations 1d				
	e	Government grants (contributions) 1e	149,597			
	f	All other contributions, gifts, grants, and similar amounts not included above 1f	3,168,579			
	g	Noncash contributions included in lines 1a-1f \$	307,678			
	h	Total. Add lines 1a-1f	4,593,403			
Program Service Revenue	2a	NET PATIENT REVENUE				
		Business Code				
		900099	1,034,042,165	1,034,042,165		
	b	PHARMACY REVENUE	3,431,193	2,093,907	1,337,286	
	c	MEDICAL OFFICE BUILDING RENT	531120	2,229,330		
	d	MEDICAID MEANINGFUL USE	517000	9,457,629		
	e					
	f	All other program service revenue				
Other Revenue	g	Total. Add lines 2a-2f	1,049,160,317			
	3	Investment income (including dividends, interest, and other similar amounts)	2,780,090		823,730	1,956,360
	4	Income from investment of tax-exempt bond proceeds	0			
	5	Royalties	0			
	6a	(i) Real				
		(ii) Personal				
		216,208				
	b	Less rental expenses				
	c	Rental income or (loss)	216,208			0
	d	Net rental income or (loss)	216,208		216,208	
	7a	(i) Securities				
		(ii) Other				
		507,737				
	b	Less cost or other basis and sales expenses				190,250
	c	Gain or (loss)	507,737			-190,250
	d	Net gain or (loss)	317,487			317,487
	8a	Gross income from fundraising events (not including \$ 1,275,227 of contributions reported on line 1c) See Part IV, line 18				
	a	623,655				
	b	Less direct expenses b	625,532			
	c	Net income or (loss) from fundraising events	-1,877			-1,877
	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	EDUCATION SEMINAR	517000	270,393		270,393
	b	CAFETERIA SALES		3,965,882		3,965,882
	c	GIFT SHOP & AUXILIARY	453220	683,602		683,602
	d	All other revenue	9,505,634	5,362	1,241,141	8,259,131
	e	Total. Add lines 11a-11d	14,425,511			
	12	Total revenue. See Instructions	1,071,491,139	1,047,828,393	3,618,365	15,450,978

Part IX

Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.		(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1	Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21.	89,719	89,719		
2	Grants and other assistance to domestic individuals. See Part IV, line 22.	59,211	59,211		
3	Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. 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.	3,532,087	0	3,532,087	0
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.	335,328,357	317,186,527	16,944,903	1,196,927
8	Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions).	0			
9	Other employee benefits.	49,415,299	748,228	48,667,071	
10	Payroll taxes.	24,264,148	27,313	24,236,835	
11	Fees for services (non-employees):				
a	Management.	0			
b	Legal.	147,224	2,574	144,650	
c	Accounting.	6,948	6,948		
d	Lobbying.	0			
e	Professional fundraising services. See Part IV, line 17.	25,231			25,231
f	Investment management fees.	0			
g	Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	288,505	225,582	62,923	
12	Advertising and promotion.	184,167	65,397	91,946	26,824
13	Office expenses.	184,046,905	179,631,202	4,251,133	164,570
14	Information technology.	15,471,731	13,800,539	1,653,766	17,426
15	Royalties.	0			
16	Occupancy.	22,732,298	8,769,430	13,959,402	3,466
17	Travel.	461,665	229,749	217,929	13,987
18	Payments of travel or entertainment expenses for any federal, state, or local public officials.	0			
19	Conferences, conventions, and meetings.	240,568	196,095	33,032	11,441
20	Interest.	25,091,176		25,091,176	
21	Payments to affiliates.	0			
22	Depreciation, depletion, and amortization.	54,257,873	2,852,362	51,405,351	160
23	Insurance.	27,277,568	99,051	27,178,517	
24	Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O).				
a	INTERNAL PURCHASED SERVICES	105,646,291	3,599,477	102,046,814	
b	OTHER PURCHASED SERVICES	90,509,120	79,812,252	10,363,786	333,082
c	TAXES	54,117,735	956,844	53,160,891	
d	FOOD	6,370,905	6,264,727	73,516	32,662
e	All other expenses	35,182,907	30,717,537	3,938,871	526,499
25	Total functional expenses. Add lines 1 through 24e.	1,034,747,638	645,340,764	387,054,599	2,352,275
26	Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

Part X

Balance Sheet

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

				(A)		(B)
				Beginning of year		End of year
Assets	1	Cash—non-interest-bearing		0	1	0
	2	Savings and temporary cash investments		54,679,874	2	37,736,241
	3	Pledges and grants receivable, net		0	3	0
	4	Accounts receivable, net		204,303,593	4	223,684,989
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L		0	5	0
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L		0	6	0
	7	Notes and loans receivable, net		0	7	0
	8	Inventories for sale or use		25,914,482	8	28,182,384
	9	Prepaid expenses and deferred charges		8,509,718	9	3,449,564
	10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	10a1,060,440,034			
	b	Less accumulated depreciation	10b604,436,683	461,503,553	10c	456,003,351
	11	Investments—publicly traded securities		0	11	0
	12	Investments—other securities See Part IV, line 11		0	12	0
	13	Investments—program-related See Part IV, line 11		0	13	0
	14	Intangible assets		0	14	0
	15	Other assets See Part IV, line 11		46,999,808	15	41,578,969
	16	Total assets. Add lines 1 through 15 (must equal line 34)		801,911,028	16	790,635,498
Liabilities	17	Accounts payable and accrued expenses		77,367,940	17	80,724,559
	18	Grants payable		0	18	0
	19	Deferred revenue		0	19	0
	20	Tax-exempt bond liabilities		0	20	0
	21	Escrow or custodial account liability Complete Part IV of Schedule D		0	21	0
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L		0	22	0
	23	Secured mortgages and notes payable to unrelated third parties		0	23	0
	24	Unsecured notes and loans payable to unrelated third parties		0	24	0
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24) Complete Part X of Schedule D		159,542,784	25	166,884,559
	26	Total liabilities. Add lines 17 through 25		236,910,724	26	247,609,118
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.					
	27	Unrestricted net assets		551,735,386	27	530,928,782
	28	Temporarily restricted net assets		11,710,230	28	10,562,188
	29	Permanently restricted net assets		1,554,688	29	1,535,410
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.					
	30	Capital stock or trust principal, or current funds			30	
	31	Paid-in or capital surplus, or land, building or equipment fund			31	
	32	Retained earnings, endowment, accumulated income, or other funds			32	
	33	Total net assets or fund balances		565,000,304	33	543,026,380
	34	Total liabilities and net assets/fund balances		801,911,028	34	790,635,498

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	1,071,491,139
2	Total expenses (must equal Part IX, column (A), line 25)	2	1,034,747,638
3	Revenue less expenses Subtract line 2 from line 1	3	36,743,501
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	565,000,304
5	Net unrealized gains (losses) on investments	5	-157,149
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-58,560,276
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	543,026,380

Part XII Financial Statements and Reporting

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

		Yes	No
1	Accounting method used to prepare the Form 990 <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O		
2a	Were the organization's financial statements compiled or reviewed by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	2a	No
b	Were the organization's financial statements audited by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	2b	Yes
c	If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O	2c	Yes
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	3a	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	3b	Yes

Additional Data

Software ID:

Software Version:

EIN: 36-4195126

Name: PRESENCE HOSPITALS PRV

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
(1) SANDRA BRUCE PRESIDENT/CEO & DIRECTOR	1 0 50 0	X		X				0	1,452,978	25,664
(1) HAVEN COCKERHAM DIRECTOR	1 0 3 0	X						0	0	0
(2) BRUCE HAMORY MD DIRECTOR	1 0 3 0	X						0	0	0
(3) MARK HANSON DIRECTOR	1 0 3 0	X						0	0	0
(4) THOMAS HUBERTY MD DIRECTOR	1 0 3 0	X						0	0	0
(5) SR PATRICIA ANN KOSCHALKE CSFN DIRECTOR	1 0 3 0	X						0	0	0
(6) SR CLARA FRANCES KUSEK CR DIRECTOR	1 0 3 0	X						0	0	0
(7) MARSHA LADENBURGER DIRECTOR	1 0 3 0	X						0	0	0
(8) LAURIE LAFONTAINE DIRECTOR	1 0 3 0	X						0	0	0
(9) SR TERRY MALTBY RSM DIRECTOR	1 0 3 0	X						0	0	0
(10) SUSAN MCDONOUGH DIRECTOR	1 0 3 0	X						0	0	0
(11) VICTOR ORLER DIRECTOR	1 0 3 0	X						0	0	0
(12) KENT RUSSELL DIRECTOR	1 0 3 0	X						0	0	0
(13) JOSE SANTIAGO MD DIRECTOR	1 0 3 0	X						0	0	0
(14) THOMAS SETTLES DIRECTOR, VICE CHAIR	1 0 4 0	X		X				0	0	0
(15) SR MARY SHINNICK DIRECTOR	1 0 3 0	X						0	0	0
(16) SR EVELYN VARBONCOEUR SSCM DIRECTOR	1 0 3 0	X						0	0	0
(17) GUY WIEBKING DIRECTOR, CHAIR	1 0 3 0	X		X				0	0	0
(18) JAMES WINIKATES DIRECTOR	1 0 3 0	X						0	0	0
(19) ANTHONY J FILER TREASURER	1 0 50 0			X				0	806,181	185,879
(20) JEANNIE FREY SECRETARY	1 0 50 0			X				0	538,312	132,604
(21) PATRICK QUINN ASSISTANT TREASURER	1 0 40 0			X				0	270,651	48,603
(22) JULIE ROKNICH ASSISTANT SECRETARY	1 0 40 0			X				0	196,072	28,035
(23) JARED ROGERS MD CMO	40 0 0 0				X			366,770	0	12,484
(24) JACQUELINE MEDLAND REGIONAL CHIEF NURSING OFFICER	40 0 0 0				X			250,392	0	19,806

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
(26) JANICE NEMRI CAO	40 0 0 0				X			287,132	0	12,449
(1) CATHERINE EMANUEL REG VP STRATEGIC PLG BUS DEV	40 0 0 0				X			252,682	0	639
(2) MOLLY NICHOLSON REGIONAL CNO	40 0 0 0				X			213,431	0	18,655
(3) CARMEN ROCCO MD ANESTHESIOLOGIST	40 0 0 0				X			160,082	0	0
(4) JENNIFER CORD REGIONAL VP OPERATIONS	40 0 0 0				X			175,294	0	21,133
(5) LISA LAGGER REGIONAL CHIEF REL OFFICER	40 0 0 0				X			264,185	0	13,333
(6) DAVID FRANZBLAU MD REGIONAL CMO	40 0 0 0				X			378,225	0	13,400
(7) CONNIE NOLTEMEYER REGIONAL QUALITY LEADER	40 0 0 0				X			150,572	0	1,772
(8) ANIL GOPINATH MD REGIONAL CHIEF MEDICAL OFFICER	40 0 0 0				X			195,732	0	9,366
(9) GRACE MCBRIDE REGIONAL CHIEF NURSING OFFICER	40 0 0 0				X			200,872	0	8,005
(10) JOSEPH DANNA MD REGIONAL MEDICAL DIRECTOR	40 0 0 0				X			281,906	0	20,597
(11) TIMOTHY DAUGHTERY REGIONAL CHIEF GROWTH OFFICER	40 0 0 0				X			189,896	0	13,277
(12) SURENDRA GULATI MD PHYSICIAN	40 0 0 0					X		475,054	0	13,944
(13) LESLIE MASOOD MD NEUROLOGIST	40 0 0 0					X		350,590	0	20,475
(14) MICHAEL PANUSKA MD MEDICAL DIRECTOR	40 0 0 0					X		294,232	0	14,603
(15) MOUHANNAD KANTAR MD FAMILY MEDICINE	40 0 0 0					X		315,400	0	18,914
(16) ZIAD ALAANI MD NEUROLOGIST	40 0 0 0					X		282,354	0	22,195
(17) AMY STEVENS FORMER - COO	0 0 0 0						X	306,561	0	35,239
(18) EILEEN GILLESPIE FMR -VP OF OPERATIONS/CNO	0 0 0 0						X	107,604	0	11,727

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.
▶ Information about Schedule A (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization PRESENCE HOSPITALS PRV	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 in lines 11a through 11d that describes the type of supporting organization and complete lines 11e, 11f, and 11g

a

☐

Type I. A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization **You must complete Part IV, Sections A and B.**

b

☐

Type II. A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s) **You must complete Part IV, Sections A and C.**

c

☐

Type III functionally integrated. A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions) **You must complete Part IV, Sections A, D, and E.**

d

☐

Type III non-functionally integrated. A supporting organization operated in connection with its supported organization(s) that is not functionally integrated The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions) **You must complete Part IV, Sections A and D, and Part V.**

e

☐

Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization

f

Enter the number of supported organizations _____

g

Provide the following information about the supported organization(s)

(i)Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1- 9 above or IRC section (see instructions))	(iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
Total						

Part II

Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)
(Complete only if you checked the box on line 5, 7, 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) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(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) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI)						
11 Total support Add lines 7 through 10						
12 Gross receipts from related activities, etc (see instructions)					12	
13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here						▶

Section C. Computation of Public Support Percentage						
14 Public support percentage for 2014 (line 6, column (f) divided by line 11, column (f))		14				
15 Public support percentage for 2013 Schedule A, Part II, line 14		15				
16a 33 1/3% support test—2014. 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—2013. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization						▶
17a 10%-facts-and-circumstances test—2014. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization						▶
b 10%-facts-and-circumstances test—2013. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization						▶
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions						▶

Part IIISupport 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) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(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) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						
14 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here ▶						

Section C. Computation of Public Support Percentage		
15 Public support percentage for 2014 (line 8, column (f) divided by line 13, column (f))	15	
16 Public support percentage from 2013 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage		
17 Investment income percentage for 2014 (line 10c, column (f) divided by line 13, column (f))	17	
18 Investment income percentage from 2013 Schedule A, Part III, line 17	18	
19a 33 1/3% support tests—2014. 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—2013. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and stop here. The organization qualifies as a publicly supported organization ▶		
20 Private foundation. If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ▶		

Part IV

Supporting Organizations

(Complete only if you checked a box on line 11 of Part I. If you checked 11a of Part I, complete Sections A and B. If you checked 11b of Part I, complete Sections A and C. If you checked 11c of Part I, complete Sections A, D, and E. If you checked 11d of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

	Yes	No
1 Are all of the organization's supported organizations listed by name in the organization's governing documents? If "No," describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.	1	
2 Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).	2	
3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? If "Yes," answer (b) and (c) below.	3a	
b Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? If "Yes," describe in Part VI when and how the organization made the determination.	3b	
c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? If "Yes," explain in Part VI what controls the organization put in place to ensure such use.	3c	
4a Was any supported organization not organized in the United States ("foreign supported organization")? If "Yes" and if you checked 11a or 11b in Part I, answer (b) and (c) below.	4a	
b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations. . . .	4b	
c Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.	4c	
5a Did the organization add, substitute, or remove any supported organizations during the tax year? If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in Part VI, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed, (ii) the reasons for each such action, (iii) the authority under the organization's organizing document authorizing such action, and (iv) how the action was accomplished (such as by amendment to the organizing document).	5a	
b Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document?	5b	
c Substitutions only. Was the substitution the result of an event beyond the organization's control?	5c	
6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (a) its supported organizations, (b) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (c) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? If "Yes," provide detail in Part VI .	6	
7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in IRC 4958(c)(3)(C)), a family member of a substantial contributor, or a 35-percent controlled entity with regard to a substantial contributor? If "Yes," complete Part I of Schedule L (Form 990) .	7	
8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? If "Yes," complete Part II of Schedule L (Form 990).	8	
9a Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? If "Yes," provide detail in Part VI .	9a	
b Did one or more disqualified persons (as defined in line 9(a)) hold a controlling interest in any entity in which the supporting organization had an interest? If "Yes," provide detail in Part VI .	9b	
c Did a disqualified person (as defined in line 9(a)) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? If "Yes," provide detail in Part VI .	9c	
10a Was the organization subject to the excess business holdings rules of IRC 4943 because of IRC 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? If "Yes," answer b below.	10a	
b Did the organization have any excess business holdings in the tax year? (Use Schedule C, Form 4720, to determine whether the organization had excess business holdings).	10b	
11 Has the organization accepted a gift or contribution from any of the following persons?		
a A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization?	11a	
b A family member of a person described in (a) above?	11b	
c A 35% controlled entity of a person described in (a) or (b) above? If "Yes" to a, b, or c, provide detail in Part VI.	11c	

Part IV

Supporting Organizations (continued)

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions)			
a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.			
b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.			
c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).			
2 <u>Activities Test</u> Answer (a) and (b) below.			
a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.			
b Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.			
3 <u>Parent of Supported Organizations</u> Answer (a) and (b) below.			
a Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? Provide details in Part VI.			
b Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? If "Yes," describe in Part VI the role played by the organization in this regard.			

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

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

Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1	Net short-term capital gain	1	
2	Recoveries of prior-year distributions	2	
3	Other gross income (see instructions)	3	
4	Add lines 1 through 3	4	
5	Depreciation and depletion	5	
6	Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6	
7	Other expenses (see instructions)	7	
8	Adjusted Net Income (subtract lines 5, 6 and 7 from line 4)	8	

Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year)	1	
a	Average monthly value of securities	1a	
b	Average monthly cash balances	1b	
c	Fair market value of other non-exempt-use assets	1c	
d	Total (add lines 1a, 1b, and 1c)	1d	
e	Discount claimed for blockage or other factors (explain in detail in Part VI) _____		
2	Acquisition indebtedness applicable to non-exempt use assets	2	
3	Subtract line 2 from line 1d	3	
4	Cash deemed held for exempt use Enter 1-1/2% of line 3 (for greater amount, see instructions)	4	
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5	
6	Multiply line 5 by .035	6	
7	Recoveries of prior-year distributions	7	
8	Minimum Asset Amount (add line 7 to line 6)	8	

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

Section D - Distributions	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI) See instructions	
7 Total annual distributions. Add lines 1 through 6	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI) See instructions	
9 Distributable amount for 2014 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2014	(iii) Distributable Amount for 2014
1 Distributable amount for 2014 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2014 (reasonable cause required--see instructions)			
3 Excess distributions carryover, if any, to 2014			
a From 2009.			
b From 2010.			
c From 2011.			
d From 2012.			
e From 2013.			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2014 distributable amount			
i Carryover from 2009 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2014 from Section D, line 7 \$			
a Applied to underdistributions of prior years			
b Applied to 2014 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2014, if any Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions)			
6 Remaining underdistributions for 2014 Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions)			
7 Excess distributions carryover to 2015. Add lines 3j and 4c			
8 Breakdown of line 7			
a From 2010.			
b From 2011.			
c From 2012.			
d From 2013.			
e From 2014.			

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

Facts And Circumstances Test

Return Reference

Explanation

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

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

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization PRESENCE HOSPITALS PRV	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 value of contributions to (during year)	
3	Aggregate value of grants from (during year)	
4	Aggregate value at end of year	
5	Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>	
6	Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</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)

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

2

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

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

3

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

4

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

5

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

☐ Yes ☐ No

6

Staff and volunteer hours devoted to monitoring, inspecting, 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 section 170(h)(4)(B)(ii)?

☐ Yes ☐ No

9

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

Part III

Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets. Complete if the organization answered "Yes" to Form 990, Part IV, line 8.

1a

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

b

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

(i) Revenue included 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 (ASC 958) relating to these items

a

Revenue 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 acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply)
- a

☐ Public exhibition

b

☐ Scholarly research

c

☐ Preservation for future generations

d

☐ Loan or exchange programs

e

☐ Other
- 4

Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII
- 5

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

☐ Yes

☐ No

Part IV Escrow and Custodial Arrangements. Complete if the organization answered "Yes" 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 XIII and complete the following table
- | | |
|----|--------|
| | Amount |
| 1c | |
| 1d | |
| 1e | |
| 1f | |

c

Beginning balance

d

Additions during the year

e

Distributions during the year

f

Ending balance
- 2a

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

☐ Yes

☐ No
- b

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

☐

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

	(a)Current year	(b)Prior year	b (c)Two years back	(d)Three years back	(e)Four years back
1a Beginning of year balance	2,848,100	2,744,115	1,885,241	1,823,675	1,671,727
b Contributions	2,872	4,756	765,424	61,758	104,516
c Net investment earnings, gains, and losses	104,946	122,906	108,794	43,217	83,936
d Grants or scholarships	55,109	21,530	13,844	26,673	12,960
e Other expenditures for facilities and programs	1,602	2,147	1,500	16,425	19,544
f Administrative expenses				311	4,000
g End of year balance	2,899,207	2,848,100	2,744,115	1,885,241	1,823,675

- 2

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

Board designated or quasi-endowment

34 400 %
- b

Permanent endowment

65 600 %
- c

Temporarily restricted endowment

0 %
- The percentages in lines 2a, 2b, and 2c should equal 100%
- 3a

Are there endowment funds not in the possession of the organization that are held and administered for the organization by
- (i) unrelated organizations

3a(i)

Yes

(ii) related organizations

3a(ii)

Yes
- b

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

3b

Yes
- 4

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

Part VI Land, Buildings, and Equipment. Complete if the organization answered 'Yes' to Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b)Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		22,511,153		22,511,153
b Buildings		689,237,564	354,894,795	334,342,769
c Leasehold improvements		1,459,011	714,512	744,499
d Equipment		311,508,645	229,706,048	81,802,597
e Other		35,723,662	19,121,329	16,602,333
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c).)				456,003,351

Part XI

Reconciliation of Revenue per Audited Financial Statements With Revenue per Return

Complete if the organization answered 'Yes' to Form 990, Part IV, line 12a.

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

Part XII

Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.

Complete if the organization answered 'Yes' to Form 990, Part IV, line 12a.

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

Part XIII

Supplemental Information

Provide the descriptions required for Part II, lines 3, 5, and 9, Part III, lines 1a and 4, Part IV, lines 1b and 2b, Part V, line 4, Part X, line 2, Part XI, lines 2d and 4b, and Part XII, lines 2d and 4b. Also complete this part to provide any additional information.

Return Reference	Explanation
SCHEDULE D, PART V, LINE 4	ENDOWMENT FUND USES THE INTENDED USES OF THE ENDOWMENT FUND INCLUDE THE FOLLOWING SUPPLEMENTAL HOSPITAL INCOME, EDUCATION, TECHNOLOGY, HEALTH AND HUMAN SERVICES FOR THE POOR, SCHOLARSHIPS, AND DIABETES WELLNESS CENTER
SCHEDULE D, Part X, LINE 2	PRESENCE HEALTH RECOGNIZES 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. AS OF DECEMBER 31, 2014 AND 2013, PRESENCE HEALTH DOES NOT HAVE ANY LIABILITIES FOR UNRECOGNIZED TAX BENEFITS

[illegible]

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.

▶ Information about Schedule G (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2014

Open to Public
Inspection

Name of the organization
PRESENCE HOSPITALS PRV

Employer identification number

36-4195126

Part I Fundraising Activities. Complete if the organization answered "Yes" to Form 990, Part IV, line 17. Form 990-EZ filers are not required to complete this part.

- 1

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

☒ Mail solicitations

b

☒ Internet and email solicitations

c

☒ Phone solicitations

d

☒ In-person solicitations

e

☒ Solicitation of non-government grants

f

☒ Solicitation of government grants

g

☒ Special fundraising events
- 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.

(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			
1 CENTRAL IL BOOKS	BOOK FAIR	Yes		10,765	8,612	2,153
2 MASQUERADE FUNDRAISING	\$5 SALE	Yes		6,911	5,640	1,271
3 GOLD COAST	JEWELRY	Yes		6,595	5,989	606
4 DANVILLE GARDENS	FLOWER SALE		No	6,683	4,990	1,693
5						
6						
7						
8						
9						
10						
Total ▶				30,954	25,231	5,723

3 List all states in which the organization is registered or licensed to solicit contributions 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 of fundraising event contributions and gross income on Form 990-EZ, lines 1 and 6b. List events with gross receipts greater than \$5,000.

Revenue			(a) Event #1	(b) Event #2	(c) Other events	(d) Total events	
			<u>FESTIVAL OF TRE</u>	<u>GALA</u>	<u>10</u>	(add col (a) through	
			(event type)	(event type)	(total number)	col (c))	
1	Gross receipts	. . .	435,914	351,389	1,111,579	1,898,882	
2	Less Contributions	. .	435,914	351,389	487,924	1,275,227	
3	Gross income (line 1 minus line 2)	. . .			623,655	623,655	
Direct Expenses	4	Cash prizes	. . .		6,800	6,800	
	5	Noncash prizes	. .		35,181	35,181	
	6	Rent/facility costs	. .	14,000	67,133	81,133	
	7	Food and beverages	.				
	8	Entertainment	. . .				
	9	Other direct expenses	.	143,897	113,493	245,028	502,418
	10	Direct expense summary Add lines 4 through 9 in column (d) ▶					(625,532)
	11	Net income summary Subtract line 10 from line 3, column (d) ▶					-1,877

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><input type="checkbox"/> Yes_____ %</div> <div><input type="checkbox"/> No</div>	<div><input type="checkbox"/> Yes_____ %</div> <div><input type="checkbox"/> No</div>	<div><input type="checkbox"/> Yes_____ %</div> <div><input type="checkbox"/> No</div>	
	7 Direct expense summary Add lines 2 through 5 in column (d) .				

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

a Is the organization licensed to conduct 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 _____

11

Does the organization conduct 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 activities conducted in

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

14

Enter 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

\$ and the \$

c

If "Yes," enter name and address of the third party

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 Supplemental Information. Provide the explanations required by Part I, line 2b, columns (iii) and (v), and Part III, lines 9, 9b, 10b, 15b, 15c, 16, and 17b, as applicable. Also provide any additional information (see instructions).

Return Reference	Explanation
------------------	-------------

Schedule G (Form 990 or 990-EZ) 2014

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.
► Information about Schedule H (Form 990) and its instructions is at *www.irs.gov/form990*.

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization
PRESENCE HOSPITALS PRV

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

7

Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)		25,846	28,396,292	0	28,396,292	2 740 %
b Medicaid (from Worksheet 3, column a)		151,177	215,653,983	180,835,921	34,818,062	3 370 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs		177,023	244,050,275	180,835,921	63,214,354	6 110 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	105	87,564	3,105,717	201,736	2,903,981	0 280 %
f Health professions education (from Worksheet 5)	12	4,565	4,918,067	517,289	4,400,778	0 430 %
g Subsidized health services (from Worksheet 6)			15,239,718	13,668,989	1,570,729	0 150 %
h Research (from Worksheet 7)	2		402,406	0	402,406	0 040 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)	114	8,924	737,473	0	737,473	0 070 %
j Total. Other Benefits	233	101,053	24,403,381	14,388,014	10,015,367	0 970 %
k Total. Add lines 7d and 7j	233	278,076	268,453,656	195,223,935	73,229,721	7 080 %

Part IICommunity Building Activities

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1Physical improvements and housing						
2Economic development						
3Community support	7	6,543	212,970	0	212,970	
4Environmental improvements						
5Leadership development and training for community members						
6Coalition building						
7Community health improvement advocacy						
8Workforce development						
9Other						
10Total	7	6,543	212,970	0	212,970	

Part IIIBad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

1Did the organization report bad debt expense in accordance with Heathcare Financial Management Association Statement No. 15?

1Yes

No

2Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.

239,824,223

3Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.

3

4Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.

Section B. Medicare

5Enter total revenue received from Medicare (including DSH and IME).

5430,668,857

6Enter Medicare allowable costs of care relating to payments on line 5.

6454,852,145

7Subtract line 6 from line 5. This is the surplus (or shortfall).

7-24,183,288

8Describe 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.

☐ Cost accounting system

☒ Cost to charge ratio

☐ Other

Section C. Collection Practices

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

9aYes

No

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

9bYes

No

Part IVManagement Companies and Joint Ventures

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

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1Alliance PHO	Physician Hospital Org	50.000 %		50.000 %
2KANKAKEE VALLEY DLY	Dialysis Center	50.000 %		50.000 %
3Kendall PT Surgery	Surgery Center	15.000 %		50.000 %
4Dreyer Provena Amb	Ambulatory Care Center	40.000 %		60.000 %
5Ctr Digestive Dis	Digestive Health Center	10.000 %		80.000 %
6				
7				
8				
9				
10				
11				
12				
13				

Part V

Facility Information

Section A. Hospital Facilities

(list in order of size from largest to smallest—see instructions)
How many hospital facilities did the organization operate during the tax year?

6
Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)

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

Part V

Facility Information (continued)

Section B. Facility Policies and Practices

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

PRESENCE ST JOSEPH MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

1

	Yes	No
Community Health Needs Assessment		
1 Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3	Yes
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA 20 14		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	Yes
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a <input checked="" type="checkbox"/> Hospital facility's website (list url) www.presencehealth.org/community-reports		
b <input type="checkbox"/> Other website (list url)		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 13		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes
a If "Yes" (list url) www.presencehealth.org/community-reports		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	No
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V

Facility Information (continued)

Name of hospital facility or letter of facility reporting group

PRESENCE ST JOSEPH MEDICAL CENTER

		Yes	No
Financial Assistance Policy (FAP)			
13	Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13	Yes
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>600</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input checked="" type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance discount		
g	<input checked="" type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	14	Yes
15	Explained the method for applying for financial assistance?	15	Yes
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)		
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Included measures to publicize the policy within the community served by the hospital facility?	16	Yes
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)		
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>X</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>X</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>X</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input type="checkbox"/> Other (describe in Section C)		
Billing and Collections			
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment?	17	Yes
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Actions that require a legal or judicial process		
d	<input type="checkbox"/> Other similar actions (describe in Section C)		
e	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		

Part V

Facility Information (continued)

PRESENCE ST JOSEPH MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

		Yes	No
19	Did the hospital facility or other authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Actions that require a legal or judicial process d <input type="checkbox"/> Other similar actions (describe in Section C) 20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (check all that apply) a <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission b <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge c <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills d <input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy e <input type="checkbox"/> Other (describe in Section C) f <input type="checkbox"/> None of these efforts were made	19	No
Policy Relating to Emergency Medical Care			
21	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? If "No," indicate why a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions b <input type="checkbox"/> The hospital facility's policy was not in writing c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) d <input type="checkbox"/> Other (describe in Section C)	21	Yes
Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)			
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care a <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged b <input checked="" type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged c <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged d <input type="checkbox"/> Other (describe in Section C) 23 During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C	23	No
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C	24	No

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

PRESENCE MERCY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

2

	Yes	No
Community Health Needs Assessment		
1 Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3	Yes
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA 20 12		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	No
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a <input checked="" type="checkbox"/> Hospital facility's website (list url) www.presencehealth.org/community-reports		
b <input type="checkbox"/> Other website (list url)		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 13		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes
a If "Yes" (list url) www.presencehealth.org/community-reports		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	No
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V

Facility Information (continued)

Name of hospital facility or letter of facility reporting group

PRESENCE MERCY MEDICAL CENTER

		Yes	No
Financial Assistance Policy (FAP)			
13	Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13	Yes
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>600</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input checked="" type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance discount		
g	<input checked="" type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	14	Yes
15	Explained the method for applying for financial assistance?	15	Yes
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)		
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Included measures to publicize the policy within the community served by the hospital facility?	16	Yes
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)		
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>X</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>X</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>X</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input type="checkbox"/> Other (describe in Section C)		
Billing and Collections			
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment?	17	Yes
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Actions that require a legal or judicial process		
d	<input type="checkbox"/> Other similar actions (describe in Section C)		
e	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		

Part V

Facility Information (continued)

PRESENCE MERCY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

		Yes	No
19	Did the hospital facility or other authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Actions that require a legal or judicial process d <input type="checkbox"/> Other similar actions (describe in Section C) 20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (check all that apply) a <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission b <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge c <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills d <input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy e <input type="checkbox"/> Other (describe in Section C) f <input type="checkbox"/> None of these efforts were made	19	No
Policy Relating to Emergency Medical Care			
21	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? If "No," indicate why a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions b <input type="checkbox"/> The hospital facility's policy was not in writing c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) d <input type="checkbox"/> Other (describe in Section C)	21	Yes
Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)			
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care a <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged b <input checked="" type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged c <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged d <input type="checkbox"/> Other (describe in Section C) 23 During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C	23	No
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C	24	No

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

PRESENCE ST JOSEPH HOSPITAL

Name of hospital facility or letter of facility reporting group

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

3

	Yes	No
Community Health Needs Assessment		
1 Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3	Yes
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA 20 <u>12</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	6b	No
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>www.presencehealth.org/community-reports</u>		
b <input type="checkbox"/> Other website (list url) _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>13</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes
a If "Yes" (list url) <u>www.presencehealth.org/community-reports</u>		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	No
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V

Facility Information (continued)

Name of hospital facility or letter of facility reporting group

PRESENCE ST JOSEPH HOSPITAL

		Yes	No
Financial Assistance Policy (FAP)			
13	Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13	Yes
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>600</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input checked="" type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance discount		
g	<input checked="" type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	14	Yes
15	Explained the method for applying for financial assistance?	15	Yes
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)		
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Included measures to publicize the policy within the community served by the hospital facility?	16	Yes
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)		
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>X</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>X</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>X</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input type="checkbox"/> Other (describe in Section C)		
Billing and Collections			
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment?	17	Yes
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Actions that require a legal or judicial process		
d	<input type="checkbox"/> Other similar actions (describe in Section C)		
e	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		

Part V

Facility Information (continued)

PRESENCE ST JOSEPH HOSPITAL

Name of hospital facility or letter of facility reporting group			Yes	No
19	Did the hospital facility or other authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Actions that require a legal or judicial process d <input type="checkbox"/> Other similar actions (describe in Section C) 20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (check all that apply) a <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission b <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge c <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills d <input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy e <input type="checkbox"/> Other (describe in Section C) f <input type="checkbox"/> None of these efforts were made	19		No
Policy Relating to Emergency Medical Care				
21	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? If "No," indicate why a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions b <input type="checkbox"/> The hospital facility's policy was not in writing c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) d <input type="checkbox"/> Other (describe in Section C)	21	Yes	
Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)				
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care a <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged b <input checked="" type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged c <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged d <input type="checkbox"/> Other (describe in Section C) 23 During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C	23		No
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C	24		No

Part V

Facility Information (continued)

Section B. Facility Policies and Practices

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

PRESENCE ST MARY'S HOSPITAL

Name of hospital facility or letter of facility reporting group

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

4

	Yes	No
Community Health Needs Assessment		
1 Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3	Yes
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA 20 12		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	No
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a <input checked="" type="checkbox"/> Hospital facility's website (list url) www.presencehealth.org/community-reports		
b <input type="checkbox"/> Other website (list url)		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 13		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes
a If "Yes" (list url) www.presencehealth.org/community-reports		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	No
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V

Facility Information (continued)

Name of hospital facility or letter of facility reporting group

PRESENCE ST MARY'S HOSPITAL

		Yes	No
Financial Assistance Policy (FAP)			
13	Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13	Yes
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>600</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input checked="" type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance discount		
g	<input checked="" type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	14	Yes
15	Explained the method for applying for financial assistance?	15	Yes
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)		
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Included measures to publicize the policy within the community served by the hospital facility?	16	Yes
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)		
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>X</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>X</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>X</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input type="checkbox"/> Other (describe in Section C)		
Billing and Collections			
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment?	17	Yes
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Actions that require a legal or judicial process		
d	<input type="checkbox"/> Other similar actions (describe in Section C)		
e	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		

Part V

Facility Information (continued)

PRESENCE ST MARY'S HOSPITAL

Name of hospital facility or letter of facility reporting group		Yes	No
19 Did the hospital facility or other authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged		19	No
a <input type="checkbox"/> Reporting to credit agency(ies)			
b <input type="checkbox"/> Selling an individual's debt to another party			
c <input type="checkbox"/> Actions that require a legal or judicial process			
d <input type="checkbox"/> Other similar actions (describe in Section C)			
20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (check all that apply)			
a <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission			
b <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge			
c <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills			
d <input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy			
e <input type="checkbox"/> Other (describe in Section C)			
f <input type="checkbox"/> None of these efforts were made			
Policy Relating to Emergency Medical Care			
21 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? If "No," indicate why		21	Yes
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions			
b <input type="checkbox"/> The hospital facility's policy was not in writing			
c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
d <input type="checkbox"/> Other (describe in Section C)			
Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)			
22 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care			
a <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged			
b <input checked="" type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged			
c <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged			
d <input type="checkbox"/> Other (describe in Section C)			
23 During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C		23	No
24 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C		24	No

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

PRESENCE COVENANT MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

5

	Yes	No
Community Health Needs Assessment		
1 Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	Yes
If "Yes," indicate what the CHNA report describes (check all that apply)		
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA 20 14		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	No
7 Did the hospital facility make its CHNA report widely available to the public?	7	Yes
If "Yes," indicate how the CHNA report was made widely available (check all that apply)		
a <input checked="" type="checkbox"/> Hospital facility's website (list url) www.presencehealth.org/community-reports		
b <input type="checkbox"/> Other website (list url)		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 13		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes
a If "Yes" (list url) www.presencehealth.org/community-reports		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	No
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V

Facility Information (continued)

Name of hospital facility or letter of facility reporting group		PRESENCE COVENANT MEDICAL CENTER	
		Yes	No
Financial Assistance Policy (FAP)			
13 Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP		13	Yes
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 % and FPG family income limit for eligibility for discounted care of 600 %			
b <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input checked="" type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input checked="" type="checkbox"/> Underinsurance discount			
g <input checked="" type="checkbox"/> Residency			
h <input type="checkbox"/> Other (describe in Section C)			
14 Explained the basis for calculating amounts charged to patients?		14	Yes
15 Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)		15	Yes
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e <input type="checkbox"/> Other (describe in Section C)			
16 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)		16	Yes
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) X			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) X			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) X			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g <input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility			
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i <input type="checkbox"/> Other (describe in Section C)			
Billing and Collections			
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment?		17	Yes
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP			
a <input type="checkbox"/> Reporting to credit agency(ies)			
b <input type="checkbox"/> Selling an individual's debt to another party			
c <input type="checkbox"/> Actions that require a legal or judicial process			
d <input type="checkbox"/> Other similar actions (describe in Section C)			
e <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted			

Part V

Facility Information (continued)

PRESENCE COVENANT MEDICAL CENTER

Name of hospital facility or letter of facility reporting group			Yes	No
19	Did the hospital facility or other authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Actions that require a legal or judicial process d <input type="checkbox"/> Other similar actions (describe in Section C) 20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (check all that apply) a <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission b <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge c <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills d <input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy e <input type="checkbox"/> Other (describe in Section C) f <input type="checkbox"/> None of these efforts were made	19		No
Policy Relating to Emergency Medical Care				
21	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? If "No," indicate why a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions b <input type="checkbox"/> The hospital facility's policy was not in writing c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) d <input type="checkbox"/> Other (describe in Section C)	21	Yes	
Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)				
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care a <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged b <input checked="" type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged c <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged d <input type="checkbox"/> Other (describe in Section C) 23 During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C	23		No
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C	24		No

Part V

Facility Information (continued)

Section B. Facility Policies and Practices

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

PRESENCE UNITED SAMARITANS MED CNTR

Name of hospital facility or letter of facility reporting group

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

6

	Yes	No
Community Health Needs Assessment		
1 Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3	Yes
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA 20 12		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	No
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a <input checked="" type="checkbox"/> Hospital facility's website (list url) www.presencehealth.org/community-reports		
b <input type="checkbox"/> Other website (list url)		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 13		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes
a If "Yes" (list url) www.presencehealth.org/community-reports		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	No
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V

Facility Information (continued)

Name of hospital facility or letter of facility reporting group

PRESENCE UNITED SAMARITANS MED CNTR

		Yes	No
Financial Assistance Policy (FAP)			
13	Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13	Yes
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>600</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input checked="" type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance discount		
g	<input checked="" type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	14	Yes
15	Explained the method for applying for financial assistance?	15	Yes
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)		
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Included measures to publicize the policy within the community served by the hospital facility?	16	Yes
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)		
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>X</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>X</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>X</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input type="checkbox"/> Other (describe in Section C)		
Billing and Collections			
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment?	17	Yes
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Actions that require a legal or judicial process		
d	<input type="checkbox"/> Other similar actions (describe in Section C)		
e	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		

Part V

Facility Information (continued)

PRESENCE UNITED SAMARITANS MED CNTR

Name of hospital facility or letter of facility reporting group			Yes	No
19	Did the hospital facility or other authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Actions that require a legal or judicial process d <input type="checkbox"/> Other similar actions (describe in Section C) 20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (check all that apply) a <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission b <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge c <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills d <input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy e <input type="checkbox"/> Other (describe in Section C) f <input type="checkbox"/> None of these efforts were made	19		No
Policy Relating to Emergency Medical Care				
21	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? If "No," indicate why a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions b <input type="checkbox"/> The hospital facility's policy was not in writing c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) d <input type="checkbox"/> Other (describe in Section C)	21	Yes	
Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)				
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care a <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged b <input checked="" type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged c <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged d <input type="checkbox"/> Other (describe in Section C) 23 During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C	23		No
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C	24		No

Part V

Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

Form and Line Reference	Explanation
See Additional Data Table	

Part V

Facility Information *(continued)*

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility
(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? **35**

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

Part VI

Supplemental Information

Provide the following information

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

Form and Line Reference	Explanation
PART I FINANCIAL ASSISTANCE AND CERTAIN OTHER COMMUNITY BENEFITS AT COST	PART I LINC 3C THIS QUESTION IS NOT APPLICABLE BECAUSE PRESENCE HEALTH USES THE FEDERAL POVERTY GUIDELINES

Form and Line Reference	Explanation
PART I LINE 6A	PRESENCE HEALTH PUBLISHED A COMMUNITY BENEFIT REPORT WITH 2014 DATA, WHICH DETAILS THE COMBINED CHARITABLE IMPACT OUR MINISTRIES HAVE WITHIN THE COMMUNITIES WE SERVE EACH MINISTRY CREATES MINISTRY-SPECIFIC IMPLEMENTATION STRATEGIES WHICH OUTLINE THE GOALS AND OBJECTIVES THEY HAVE ESTABLISHED TO ADDRESS THE PRIORITIZED NEEDS OF THEIR COMMUNITIES

Form and Line Reference	Explanation
PART I LINE 6B	THE 2014 PRESENCE HEALTH COMMUNITY BENEFIT REPORT WAS MADE PUBLICLY AVAILABLE THROUGH A VARIETY OF WAYS TO SHARE THE INFORMATION WITH THE COMMUNITY AT LARGE *PRINT VERSION OF REPORT - THE REPORT WILL BE MAILED FROM THE SYSTEM OFFICE TO COMMUNITY PARTNERS, ELECTED OFFICIALS, AND LOCAL LEADERS *WEBSITE - A ROBUST COMMUNITY SECTION HAS BEEN DEVELOPED AND CAN BE FOUND ONLINE AT WWW.PRESENCEHEALTH.ORG/COMMUNITY THIS SECTION INCLUDES AN ONLINE, DOWNLOADABLE FILE OF THE 2014 COMMUNITY BENEFIT REPORT EACH MINISTRY HAS ITS OWN LINK ON THIS PAGE THROUGH THIS LINK, COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) DOCUMENTS SPECIFIC TO THE HOSPITAL CAN BE DOWNLOADED, INCLUDING A COMMUNITY-FRIENDLY CHNA FLIPBOOK, THE SOURCE DOCUMENTS OF ALL DATA REVIEWED, AN OVERALL CHNA REPORT, AND AN IMPLEMENTATION STRATEGY *POWERPOINT PRESENTATION - A STANDARD POWERPOINT OF THE ENTIRE 2014 COMMUNITY BENEFIT REPORT HAS BEEN MADE AVAILABLE A CUSTOMIZED VERSION OF THIS PRESENTATION HAS ALSO BEEN CREATED FOR EACH MINISTRY TO SHARE WITH THE COMMUNITY, WHICH SHOWS THE LOCAL COMMUNITY BENEFIT CONTRIBUTIONS, PERSONS SERVED, AND THE 2014 PRIORITIZED COMMUNITY NEEDS

Form and Line Reference	Explanation
PART I LINE 7, COLUMN G	COSTS FROM PHYSICIAN CLINICS ARE NOT INCLUDED IN SUBSIDIZED SERVICE TOTALS

Form and Line Reference	Explanation
PART I, LINE 7 - EXPLANATION OF COSTING METHODOLOGY	THE COST-TO-CHARGE RATIO WAS USED TO DETERMINE SCHEDULE H, PART I, LINE 7A, FINANCIAL ASSISTANCE AT COST SCHEDULE H, PART I, LINE 7B, UNREIMBURSED MEDICAID, WAS DERIVED FROM WORKSHEET 2, RATIO OF PATIENT CARE COST TO CHARGES THE REMAINING AMOUNTS REPORTED ON LINE 7 ARE REPORTED AT COST

Form and Line Reference	Explanation
PART II COMMUNITY BUILDING ACTIVITIES	COMMUNITY BUILDING ACTIVITIES INCLUDE PROGRAMS THAT IMPROVE THE COMMUNITY'S HEALTH AND SAFETY BY ADDRESSING THE ROOT CAUSES OF HEALTH PROBLEMS, SUCH AS POVERTY, HOMELESSNESS AND ENVIRONMENTAL HAZARDS PARTICIPATION IN COLLABORATIVE COMMUNITY EFFORTS TO PROMOTE PUBLIC HEALTH INITIATIVES IS ALSO INCLUDED, SUCH AS ENGAGEMENT IN COALITIONS AND ADVOCACY FOR HEALTH IMPROVEMENT THESE ACTIVITIES STRENGTHEN THE COMMUNITY'S CAPACITY TO PROMOTE THE HEALTH AND WELL-BEING OF ITS RESIDENTS BY OFFERING THE EXPERTISE AND RESOURCES OF THE HEALTH CARE ORGANIZATION PRESENCE HEALTH HOSPITAL MINISTRIES ENGAGE IN A VARIETY OF COMMUNITY-BUILDING ACTIVITIES WHICH ULTIMATELY IMPROVE THE HEALTH AND WELL-BEING OF THE COMMUNITIES WE ARE PRIVILEGED TO SERVE, EVEN THOUGH THEY ARE NOT SPECIFIC HEALTH ACTIVITIES 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 *COMMUNITY SUPPORT DONATIONS FROM OUR MINISTRIES TO ORGANIZATIONS ADDRESSING THE ROOT CAUSES OF HEALTH PROBLEMS *COALITION BUILDING PRESENCE SAINT JOSEPH MEDICAL CENTER LEADS A COMMUNITY COALITION, JOLIET PARTNERS FOR HEALTHY FAMILIES (JPHF), WITH THE GOAL OF MAKING WILL COUNTY A HEALTHIER PLACE TO LIVE JPHF IS WORKING WITH LOCAL LEGISLATORS ON POLICY, SYSTEMS AND ENVIRONMENTAL CHANGES *WORKFORCE DEVELOPMENT PRESENCE ST MARY'S HOSPITAL PARTNERS WITH THE KANKAKEE REGIONAL VOLUNTEER SERVICES COALITION THIS COALITION ALLOWS LOCAL TEEN PARTICIPANTS THE OPPORTUNITY TO USE THEIR TIME AND TALENTS FOR THOSE IN NEED, WHILE PROVIDING THEMSELVES WITH EXCELLENT EXPOSURE TO MANY HEALTH-RELATED CAREERS, AS WELL AS BUSINESS COMMUNICATIONS AND EARLY CHILDHOOD TEACHING

Form and Line Reference	Explanation
PART III BAD DEBT, MEDICARE, & COLLECTION PRACTICES	PART III, SECTION A, LINE 2 THERE ARE NO ESTIMATES OF BAD DEBT INCLUDED BAD DEBT IS AT TOTAL EXPENSE

Form and Line Reference	Explanation
PART III, SECTION A, LINE 3	THE PROVISION FOR 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, ALTHOUGH THE EXACT PERCENTAGE IS UNKNOWN AS WE DO NOT HAVE THE APPROPRIATE TOOLS TO DETERMINE THIS PERCENTAGE ACCURATELY

Form and Line Reference	Explanation
PART III, SECTION A, LINE 4	<p>FOR TAX RETURN PURPOSES THE BAD DEBT EXPENSE IS SHOWN ON PART IX, STATEMENT OF FUNCTIONAL EXPENSE FOR AUDIT PURPOSES THE ORGANIZATION FOLLOWS ASU 2011-07 PRESENTATION PATIENTS' ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS IN EVALUATING THE COLLECTIBILITY OF PATIENTS' ACCOUNTS RECEIVABLE, PRESENCE HEALTH ANALYZES ITS PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYOR SOUCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS AND PROVISION FOR UNCOLLECTIBLE ACCOUNTS RECEIVABLE MANAGEMENT REGULARLY REVIEWS DATA ABOUT THESE MAJOR PAYOR SOURCES OF REVENUE IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, PRESENCE HEALTH ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS AND A PROVISION FOR UNCOLLECTIBLE ACCOUNTS RECEIVABLE, IF NECESSARY FOR RECEIVABLES ASSOCIATED WITH PATIENT RESPONSIBILITY (WHICH INCLUDES BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND COPAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL), THE PATIENTS ARE SCREENED AGAINST PRESENCE HEALTH CHARITY CARE POLICY AND UNINSURED DISCOUNT POLICY FOR ANY REMAINING PATIENT RESPONSIBILITY BALANCE, PRESENCE HEALTH RECORDS A PROVISION FOR UNCOLLECTIBLE ACCOUNTS RECEIVABLE IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATES THAT MANY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE THE DIFFERENCE BETWEEN THE STANDARD RATE (OR DISCOUNTED RATES IF NEGOTIATED) AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS CHARGED OFF AGAINST THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS</p>

Form and Line Reference	Explanation
PART III, SECTION B, LINE 8	PRESENCE HEALTH COMPUTES THE MEDICARE SHORTFALL BASED ON A RATIO OF COST TO CHARGES PRESENCE HEALTH BELIEVES IT IS IMPORTANT FOR THE COMMUNITY AND THE IRS TO BE MADE AWARE OF GOVERNMENT SHORTFALLS, SPECIFICALLY MEDICARE HOWEVER, WE ACKNOWLEDGE THAT MEDICARE SHORTFALLS MAY BE EXPERIENCED BY OTHER THAN NON-PROFIT HEALTHCARE ORGANIZATIONS AS SUCH, PRESENCE HEALTH DOES NOT BELIEVE THAT MEDICARE SHORTFALL SHOULD BE CONSIDERED COMMUNITY BENEFIT

Form and Line Reference	Explanation
PART III, SECTION C, LINE 9B	<p>COLLECTION POLICIES ARE THE SAME FOR ALL PRESENCE HEALTH ENTITIES PATIENTS ARE NOTIFIED OF THE FINANCIAL ASSISTANCE POLICY AT THE TIME OF REGISTRATION VIA POSTED NOTIFICATIONS AND ON EVERY ACCOUNT STATEMENT THAT IS SENT TO THEM THIS INFORMATION IS AVAILABLE IN A NUMBER OF LANGUAGES PATIENTS MAY APPLY FOR FINANCIAL ASSISTANCE AT ANY TIME DURING THE REVENUE CYCLE PER THE PROVISION FOR FINANCIAL ASSISTANCE POLICY, THE COLLECTION PROCESS IS AS FOLLOWS 1 PRE-LITIGATION REVIEW PRIOR TO AN ACCOUNT BEING AUTHORIZED FOR THE FILING OF SUIT FOR NON-PAYMENT OF A PATIENT BILL, A FINAL REVIEW OF THE ACCOUNT WILL BE CONDUCTED AND APPROVED BY THE FINANCIAL COUNSELING REPRESENTATIVE (OR DESIGNEE) TO MAKE SURE THAT NO APPLICATION OF FINANCIAL ASSISTANCE WAS EVER RECEIVED AND THAT THERE EXISTS OBJECTIVE EVIDENCE THAT THE PATIENT DOES HAVE SUFFICIENT FINANCIAL MEANS TO PAY ALL OR PART OF HIS/HER BILL PRIOR TO A COLLECTIONS SUIT BEING FILED, THE SELF-PAY COLLECTIONS DIRECTOR MUST REVIEW AND APPROVE 2 RESIDENTIAL LIENS NO HOSPITAL WILL PLACE A LIEN ON THE PRIMARY RESIDENCE OF A PATIENT WHO HAS BEEN DETERMINED TO BE ELIGIBLE FOR FINANCIAL ASSISTANCE/CHARITY CARE, FOR PAYMENT OF THE PATIENT'S UNDISCOUNTED BALANCE DUE FURTHER, IN NO CASE WILL ANY HOSPITAL EXECUTE A LIEN BY FORCING THE SALE OR FORECLOSURE OF THE PRIMARY RESIDENCE OF ANY PATIENT TO PAY FOR ANY OUTSTANDING MEDICAL BILL 3 NO USE OF BODY ATTACHMENTS NO HOSPITAL WILL USE BODY ATTACHMENT TO REQUIRE ANY PERSON, WHETHER RECEIVING FINANCIAL ASSISTANCE/CHARITY CARE DISCOUNTS OR NOT, TO APPEAR IN COURT 4 COLLECTION AGENCY REFERRALS EACH HOSPITAL FINANCE ACCOUNTING WILL ENSURE THAT ALL COLLECTION AGENCIES USED TO COLLECT PATIENT BILLS PROMPTLY REFER ANY PATIENT WHO INDICATES FINANCIAL NEED, OR OTHERWISE APPEARS TO QUALIFY FOR FINANCIAL ASSISTANCE/CHARITY CARE DISCOUNTS, TO A FINANCIAL COUNSELOR TO DETERMINE IF THE PATIENT IS ELIGIBLE FOR SUCH A CHARITABLE DISCOUNT FOR MORE INFORMATION ABOUT PRESENCE HEALTH'S FINANCIAL ASSISTANCE PROGRAM, VISIT HTTP //PRESENCEHEALTH.ORG/PATIENTS-AND-VISITORS/FINANCIAL-ASSISTANCE</p>

Form and Line Reference	Explanation
PART VI, 2	<p>PRESENCE HEALTH MINISTRIES JOIN FORCES WITH LOCAL COMMUNITY ORGANIZATIONS TO ASSESS THE HEALTH NEEDS OF THE COMMUNITY COMMUNITY HEALTH NEEDS ASSESSMENTS (CHNAS) ARE COMPLETED FOR THE INDIVIDUAL COUNTIES WE SERVE WITH COMMUNITY PARTNERS EVERY 3 YEARS AS REQUIRED TO SUPPLEMENT THE CHNA, PRESENCE 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, PRESENCE 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 CHNA 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 ANNUAL IMPLEMENTATION STRATEGY THIS PLAN IDENTIFIES THE PRIORITIES AND ACTION THAT WILL TAKE PLACE OVER THE NEXT YEAR</p>

Form and Line Reference	Explanation
PART VI, 3	<p> PRESENCE HEALTH HOSPITAL MINISTRIES PROACTIVELY COMMUNICATE THE AVAILABILITY OF OUR FINANCIAL ASSISTANCE/CHARITY CARE PROGRAMS BY USING MULTIPLE TYPES OF APPROPRIATE MEDIA AND IN MULTIPLE APPROPRIATE LANGUAGES THE MECHANISMS USED BY PRESENCE HEALTH HOSPITALS TO COMMUNICATE THE AVAILABILITY OF FINANCIAL ASSISTANCE/CHARITY CARE INCLUDE, BUT ARE NOT LIMITED TO THE FOLLOWING 1 SIGNAGE SIGNS ARE POSTED PROMINENTLY THROUGHOUT HIGH TRAFFIC AREAS OF OUR MINISTRIES, AS WELL AS WITHIN OUR INPATIENT AND OUTPATIENT REGISTRATION/PATIENT ADMITTING AREAS AND EMERGENCY DEPARTMENTS SIGNS STATE THAT PATIENTS MAY BE ELIGIBLE FOR FINANCIAL ASSISTANCE/CHARITY CARE DISCOUNTS, AND DESCRIBE HOW TO OBTAIN MORE INFORMATION, INCLUDING IDENTIFICATION OF APPROPRIATE HOSPITAL REPRESENTATIVES BY TITLE SIGNS ARE IN MULTIPLE LANGUAGES 2 PROVISION OF FINANCIAL ASSISTANCE MATERIALS TO UNINSURED PATIENTS PRESENCE HEALTH HOSPITALS PROVIDE A SUMMARY OF ITS FINANCIAL ASSISTANCE PROGRAMS AND A FINANCIAL ASSISTANCE APPLICATION TO ALL PERSONS RECEIVING HOSPITAL CARE THAT IT IDENTIFIES AS UNINSURED PATIENTS AT THE TIME OF IN-PERSON REGISTRATION, ADMISSION, OR SUCH LATER TIME THAT THE PATIENT IS FIRST IDENTIFIED AS AN UNINSURED PATIENT FOR PATIENTS PRESENTING IN THE EMERGENCY DEPARTMENT, ALL PRESENCE HEALTH HOSPITALS PROVIDE SUCH FINANCIAL ASSISTANCE MATERIALS AT SUCH TIME AND IN SUCH MANNER AS IS CONSISTENT WITH THEIR OBLIGATIONS UNDER EMTALA TO ACCESS AND STABILIZE THE PATIENT BEFORE MAKING INQUIRY OF THE PATIENT'S ABILITY TO PAY 3 BROCHURES BROCHURES, INFORMATION SHEETS AND SIMILAR FORMS OF WRITTEN COMMUNICATION REGARDING THE HOSPITAL'S FINANCIAL ASSISTANCE/CHARITY CARE POLICY ARE MAINTAINED IN APPROPRIATE AREAS OF THE HOSPITAL (E G EMERGENCY DEPARTMENT, ORGANIZED REGISTRATION AREAS, THE BUSINESS OFFICE) THESE COMMUNICATIONS STATE IN MULTIPLE LANGUAGES THAT THE HOSPITAL OFFERS FINANCIAL ASSISTANCE/CHARITY CARE DISCOUNTS AND DESCRIBES HOW TO OBTAIN MORE INFORMATION 4 WEBSITE COMPREHENSIVE INFORMATION ABOUT OUR FINANCIAL ASSISTANCE PROGRAMS - INCLUDING ELIGIBILITY CRITERIA, APPLICATION DETAILS, AND CONTACT INFORMATION - IS ALSO AVAILABLE ON OUR CONSUMER WEB SITE (HTTP //PRESENCEHEALTH.ORG/PATIENTS-AND-VISITORS/FINANCIAL-ASSISTANCE) 5 BILLING NOTICES EACH PRESENCE HEALTH HOSPITAL INCLUDES A NOTE ON OR WITH THE HOSPITAL BILL AND/OR STATEMENT REGARDING THE HOSPITAL'S FINANCIAL ASSISTANCE/CHARITY CARE PROGRAM AND HOW THE PATIENT MAY APPLY FOR CONSIDERATION UNDER THIS PROGRAM 6 FINANCIAL COUNSELORS EACH PRESENCE HEALTH HOSPITAL HAS ONE OR MORE FINANCIAL COUNSELORS WHOSE CONTACT INFORMATION IS LISTED OR PROVIDED WITH OTHER INFORMATION CONCERNING THE FINANCIAL ASSISTANCE/CHARITY CARE DISCOUNT PROGRAM THESE COUNSELORS ARE AVAILABLE TO DISCUSS ELIGIBILITY AND OTHER QUESTIONS CONCERNING THE PROGRAM, AND PROVIDE ASSISTANCE WITH APPLICATIONS THEY 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 7 NOTIFICATION OF DETERMINATION WHEN A PRESENCE HEALTH HOSPITAL MAKES A DETERMINATION THAT A PATIENT'S BILL IS DISCOUNTED OR ADJUSTED BASED ON A DETERMINATION OF FINANCIAL NEED, THE HOSPITAL NOTIFIES THE PATIENT OF SUCH ELIGIBILITY DETERMINATION AND THAT THERE IS NO FURTHER COLLECTION ACTION TAKEN ON THE DISCOUNTED PORTION OF THE PATIENT'S BILL </p>

Form and Line Reference	Explanation
PART VI, 4	<p>PRESENCE HOSPITAL MINISTRIES PROVIDE SERVICES AT 150 SITES, INCLUDING TWELVE ACUTE CARE HOSPITALS WITH A TOTAL OF 2,997 STAFFED BEDS AND OVER 90 PRIMARY AND SPECIALTY CARE CLINIC. THESE MINISTRIES OFFER A BROAD RANGE OF SERVICES FROM HIGHLY SPECIALIZED TERTIARY SERVICES TO AN EXTENDED NETWORK OF PRIMARY AND AMBULATORY CARE. PRESENCE HEALTH 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. MANY OF THE PRESENCE HEALTH 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 1.9% ANNUALLY BETWEEN 2012 AND 2017, COMPARED WITH A GROWTH RATE OF 1.3% AND 1.6% PER YEAR IN THE CHICAGO MSA AND IN ILLINOIS, RESPECTIVELY. OF PRESENCE'S TOTAL SERVICE AREA POPULATION, 10.7% IS OVER THE AGE OF 65, COMPARED TO 11.1% AND 12.3% IN THE CHICAGO MSA AND IN ILLINOIS, RESPECTIVELY. PRESENCE COVENANT MEDICAL CENTER, CHAMPAIGN, IL (PCMC). CHAMPAIGN COUNTY IS THE TENTH LARGEST COUNTY IN THE STATE OF ILLINOIS WITH A 2013 POPULATION OF 203,276. IN THE PRIMARY SERVICE AREA, 11% OF THE POPULATION IS OVER THE AGE 65 AND THE MEDIAN HOUSEHOLD INCOME IS \$46,708. THE PRIMARY DEMOGRAPHIC MAKE-UP OF CHAMPAIGN COUNTY IS AS FOLLOWS: 74.1% WHITE, 12.2% BLACK OR AFRICAN AMERICAN, 9.1% ASIAN, 5.1% HISPANIC/LATINO. JUST UNDER 22% OF FAMILIES IN CHAMPAIGN COUNTY LIVE BELOW THE POVERTY LEVEL. THE PCMC SERVICE AREA IS DEFINED BY ZIP CODES BELOW. SERVICE AREA: PRIMARY MARKET - ZIP CODE CITY 61821 CHAMPAIGN 61801 URBANA 61820 CHAMPAIGN 61866 RANTOUL 61802 URBANA 61953 TUSCOLA 61880 TOLONO 61873 SAINT JOSEPH 61956 VILLA GROVE 61874 SAVOY 61849 HORNER 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 - ZIP CODE CITY 60948 LODA 60957 PAXTON 61856 MONTICELLO 61853 MAHOMET 61938 MATTOON 61910 ARCOLA 60936 GIBSON CITY 61920 CHARLESTON 61942 NEWMAN 61813 BEMENT. PRESENCE UNITED SAMARITANS MEDICAL CENTER (PUSMC), DANVILLE, IL. PUSMC'S PRIMARY AND SECONDARY SERVICE AREAS HAVE AN ESTIMATED POPULATION OF 81,625 RESIDENTS. IN THE PRIMARY SERVICE AREA, 16.7% OF THE POPULATION IS OVER THE AGE 65 AND THE AVERAGE HOUSEHOLD INCOME IS \$40,463. THE PRIMARY DEMOGRAPHIC MAKE-UP OF VERMILLION COUNTY IS AS FOLLOWS: 83.6% WHITE, 13.3% BLACK OR AFRICAN AMERICAN, 4.5% HISPANIC/LATINO. 18.8% OF FAMILIES IN VERMILLION COUNTY LIVE BELOW THE POVERTY LEVEL. THE PUSMC SERVICE AREA IS DEFINED BY ZIP CODES BELOW. SERVICE AREA: PRIMARY MARKET - ZIP CODE CITY 61832 DANVILLE 61834 DANVILLE 61846 GEORGETOWN 61883 WESTVILLE 61833 TILTON. SERVICE AREA: SECONDARY MARKET - ZIP CODE CITY 47932 COVINGTON, IN 60942 HOOPESTON 61817 CATLIN 61858 OAKWOOD 61870 RIDGE FARM 61924 CHRISMAN 60963 ROSSVILLE 47987 VEEDERSBURG, IN 61841 FAIRMONT 47974 PERRYSVILLE, IN 47993 WILLIAMSPORT, IN 61814 BISMARK 61865 POTOMAC 47928 CAYUGA, IN 47952 KINGMAN, IN 61876 SIDELL 61811 ALVIN 61844 FITHIAN 61850 INDIANOLA 47991 WEST LEBANON, IN 61848 HENNING 47982 STATE LINE, IN 60960 RANKIN 47918 ATTICA, IN 61812 ARMSTRONG 60973 WELLINGTON 61940 METCALF 61831 COLLISION. PRESENCE SAINT JOSEPH MEDICAL CENTER (PSJMC), JOLIET, IL. PSJMC'S PRIMARY SERVICE HAS AN ESTIMATED POPULATION OF 677,560 ACCORDING TO THE 2010 CENSUS. IN THE PRIMARY SERVICE AREA, 9.3% OF THE POPULATION IS OVER THE AGE 65 AND THE MEDIAN HOUSEHOLD INCOME IS \$75,906. APPROXIMATELY, 7.1% OF THE POPULATION IN JOLIET LIVES BELOW THE POVERTY LEVEL. THE RACIAL MAKEUP OF THE CITY IS 76.0% WHITE, 11.2% AFRICAN AMERICAN, 4.6% ASIAN, AND 7.9% MULTI-RACIAL/OTHER. THE 2014 POPULATION ALSO ESTIMATES THAT 22.5% ARE HISPANIC OR LATINO. THE PRESENCE SAINT JOSEPH MEDICAL CENTER SERVICE AREA IS DEFINED BY ZIP CODES BELOW. SERVICE AREA: PRIMARY MARKET - ZIP CODE CITY 60435 JOLIET 60436 JOLIET 60544 PLAINFIELD 60433 JOLIET 60431 JOLIET 60432 JOLIET 60434 JOLIET 60585 PLAINFIELD 60586 P.</p>

Form and Line Reference	Explanation
PART VI, 4	<p>LAINFIELD 60403 CREST HILL 60404 SHOREWOOD SERVICE AREA SECONDARY MARKET - ZIP CODE CITY 60451 NEW LENOX 60481 WILMINGTON 60450 MORRIS 60410 CHANNAHON 60446 ROMEOVILLE 60447 MINOO KA 60416 COAL CITY 60408 BRAIDWOOD 60421 ELWOOD 60441 LOCKPORT 60448 MOKENA 60442 MANHATTA N 60423 FRANKFORT 60440 BOLINGBROOK 60424 GARDNER 60439 LEMONT 60407 BRACEVILLE 60474 SOUT H WILMINGTON 60491 HOMER GLEN PRESENCE ST MARY'S HOSPITAL (PSMH), KANKAKEE, IL PSMH'S PRIMARY SERVICE HAS AN ESTIMATED POPULATION OF 113,449, ACCORDING TO THE 2010 CENSUS IN THE PRIMARY SERVICE AREA 14 1% OF THE POPULATION IS OVER THE AGE 65 AND THE AVERAGE HOUSEHOLD INCOME IS \$49,266 15% OF THE POPULATION IN KANKAKEE LIVES BELOW THE POVERTY LEVEL THE R ACIAL MAKEUP OF THE CITY IS 81 3% WHITE, 15 5% AFRICAN AMERICAN, 9 3% HISPANIC THE PSMH S ERVICE AREA IS DEFINED BY ZIP CODES BELOW SERVICE AREA PRIMARY MARKET - ZIP CODE CITY 60 901 KANKAKEE 60914 BOURBONNAIS 60915 BRADLEY 60954 MOMENCE 60950 MANTENO SERVICE AREA SEC ONDARY MARKET - ZIP CODE CITY 60964 SAINT ANNE 60927 CLIFTON 60922 CHEBANSE 60940 GRANT PA RK 60970 WATSEKA 60941 HERSCHER 60913 BONFIELD 60938 GILMAN 60911 ASHKUM 60955 ONARGA 6094 4 HOPKINS PARK 60951 MARTINTON 60930 DANFORTH 60910 AROMA PARK 60912 BEAVERVILLE 60919 CAB ERY 60961 REDDICK 60917 BUCKINGHAM 60935 ESSEX 60928 CRESCENT CITY 60481 WILMINGTON 60468 PEOTONE 60420 DWIGHT 60958 PEMBROKE TOWNSHIP PRESENCE MERCY MEDICAL CENTER (PMMC), AURORA, IL AURORA, WHERE PMMC RESIDES, IS THE SECOND LARGEST CITY IN ILLINOIS AND ACCOUNTS FOR M OST OF THE HOSPITAL'S PRIMARY SERVICE AREA KANE COUNTY'S POPULATION ACCORDING TO THE 2010 CENSUS IS 515,269 IN THE PRIMARY SERVICE AREA, 10 7% OF THE POPULATION IS OVER THE AGE 6 5 AND THE AVERAGE HOUSEHOLD INCOME IS \$69,496 WITHIN THE PRIMARY SERVICE AREA (AURORA), A PPROXIMATELY 35,000 INDIVIDUALS (21 3%) RESIDE IN MEDICALLY UNDERSERVED AREAS (MUAS) OF T HAT POPULATION, ABOUT 30% FALL 200% BELOW THE FEDERAL POVERTY LEVEL WITHIN THE MUA, 68% O F THE POPULATION IS HISPANIC AND 11% IS AFRICAN AMERICAN FIFTY-THREE PER CENT ARE UNDERIN SURED AND 47% ARE MEDICAID RECIPIENTS 10 1% OF RESIDENTS IN KANE COUNTY LIVE BELOW THE PO VERTY LEVEL PMMC'S SERVICE AREA IS DEFINED BY ZIP CODES BELOW SERVICE AREA PRIMARY MARK ET - ZIP CODE CITY 60506 AURORA 60505 AURORA 60542 NORTH AURORA 60538 MONTGOMERY 60504 AUR ORA 60507 AURORA 60502 AURORA SERVICE AREA SECONDARY MARKET - ZIP CODE CITY 60510 BATAVIA 60543 OSWEGO 60560 YORKVILLE 60548 SANDWICH 60545 PLANO 60174 SAINT CHARLES 60554 SUGAR G ROVE 60134 GENEVA 60552 SOMONAUK 60503 AURORA 60511 BIG ROCK 60520 HINCKLEY 60119 ELBURN 6 0115 DEKALB 60541 NEWARK 60512 BRISTOL 60531 LELAND 60556 WATERMAN 60539 MOOSEHEART PRESEN CE SAINT JOSEPH HOSPITAL (PSJH), ELGIN, IL KANE COUNTY'S POPULATION ACCORDING TO THE 2010 CENSUS IS 515,269 IN THE PRIMARY SERVICE AREA, 8 6% OF THE POPULATION IS OVER THE AGE 65 AND THE AVERAGE HOUSEHOLD INCOME IS \$59,032 12 3% OF FAMILIES IN ELGIN LIVE BELOW THE PO VERTY LEVEL THE RACIAL MAKEUP OF THE CITY IS 65 9% WHITE, 7 4% AFRICAN AMERICAN, 5 4% ASI AN, AND 3 6% FROM TWO OR MORE RACES 43 6% OF THE POPULATION ARE HISPANIC OR LATINO OF ANY RACE THE PSJH'S SERVICE AREA IS DEFINED BY ZIP CODE BELOW SERVICE AREA PRIMARY MARKET - ZIP CODE CITY 60123 ELGIN 60120 ELGIN 60124 ELGIN 60121 ELGIN 60110 CARPENTERSVILLE 6017 7 SOUTH ELGIN 60140 HAMPSHIRE 60118 DUNDEE SERVICE AREA SECONDARY MARKET - ZIP CODE CITY 60102 ALGONQUIN 60103 BARTLETT 60174 SAINT CHARLES 60014 CRYSTAL LAKE 60107 STREAMWOOD 601 42 HUNTLEY 60098 WOODSTOCK 60050 MCHENRY 60051 MCHENRY 60156 LAKE IN THE HILLS 60175 SAINT CHARLES 60136 GILBERTS 60134 GENEVA 60013 CARY 60152 MARENGO 60135 GENOA 60109 BURLINGTON 60012 CRYSTAL LAKE 60180 UNION</p>

Form and Line Reference	Explanation
PART VI, 5	<p>PRESENCE HEALTH HOSPITALS ARE FAITH-BASED MINISTRIES THAT PROVIDE SERVICES BASED UPON THE ETHICAL AND RELIGIOUS DIRECTIVES OF THE CATHOLIC CHURCH PRESENCE HEALTH HOSPITALS ENHANCE THE PUBLIC HEALTH OF OUR COMMUNITIES BY 1 ENSURING OUR MEDICAL STAFF IS OPEN TO ALL QUALIFIED PHYSICIANS, 2 ALL OF OUR HOSPITALS ARE ACCREDITED AND IN GOOD STANDING WITH THE JOINT COMMISSION ACCREDITATION OF HEALTHCARE ORGANIZATIONS 3 ENSURING OUR BOARD OF DIRECTORS IS DIVERSE AND ABLE TO PROVIDE EXPERTISE, AND MADE UP OF INDEPENDENT MEMBERS OF THE COMMUNITIES WE SERVE OUR BOARD MEMBERS MUST FOLLOW A CONFLICT OF INTEREST POLICY 4 REINVESTING SURPLUS FUNDS INTO THE ORGANIZATION TO IMPROVE PATIENT CARE THROUGH NEW PROGRAMS AND TECHNOLOGY 5 PROVIDING FINANCIAL ASSISTANCE, SLIDING SCALE DISCOUNTS AND HAS COLLECTION PRACTICES THAT ARE IN COMPLIANCE WITH STATE AND FEDERAL GUIDELINES IN ADDITION, WE FOLLOW THE FINANCIAL ASSISTANCE AND CHARITY GUIDELINES OF THE CATHOLIC HEALTH ASSOCIATION 6 PARTICIPATING IN ALL GOVERNMENT SPONSORED HEALTH CARE PROGRAMS, MEDICARE, MEDICAID, CHAMPUS, TRICARE, SCHIP AND OTHERS 7 PROVIDING EMERGENCY ROOM SERVICES IN ALL OF OUR COMMUNITIES AND PROVIDING TRAINING TO LOCAL FIRE DEPARTMENTS AND AMBULANCES OUR EMERGENCY ROOM PARTICIPATES WITH LOCAL POLICE AND FIRE DEPARTMENTS IN DISASTER DRILLS 8 STAFFING BOARD CERTIFIED EMERGENCY ROOM PHYSICIANS IN OUR EMERGENCY ROOM AND URGENT CARE SERVICES WE TREAT PATIENTS ACCORDING TO EMTALA GUIDELINES AND SERVE ALL PATIENTS REGARDLESS OF ABILITY TO PAY IN ADDITION, WE ARE COMMITTED TO DETERMINING THE NEEDS OF OUR COMMUNITIES AND CREATING WAYS TO MEET THOSE NEEDS THE OBLIGATION TO REACH OUT TO THOSE IN NEED AND IMPROVE HEALTH FLOWS DIRECTLY FROM OUR CATHOLIC IDENTITY AND THE HERITAGE OF OUR FOUNDING CONGREGATIONS IN EACH OF THE COMMUNITIES WE SERVE, WE WORK WITH OTHERS - INCLUDING CHARITABLE ORGANIZATIONS, COMMUNITY HEALTH PROVIDERS, ELECTED OFFICIALS, BUSINESS LEADERS, SCHOOLS, CHURCHES, AND RESIDENTS - TO LOOK AT THE OVERALL HEALTH OF THE COMMUNITY AND IDENTIFY THE GREATEST NEEDS WE THEN MAKE A PLAN AND DEVELOP STRATEGIES TOGETHER WITH OUR COMMUNITIES TO ADDRESS THE HIGHEST PRIORITY HEALTH NEEDS THE HIGHEST PRIORITY NEEDS AND THE PROGRAMS WE'VE DEVELOPED TO MEET THESE NEEDS ARE IDENTIFIED BELOW FOR EACH HOSPITAL</p> <p>PRESENCE COVENANT MEDICAL CENTER, CHAMPAIGN, IL (PCMC) CHNA - ADDRESSING THE NEEDS IDENTIFIED NEED ACCESS TO CARE SMILEHEALTHY PARTNERSHIP ALMOST 2,000 PEOPLE PER YEAR PRESENT TO THE EMERGENCY DEPARTMENT (ED) WITH DENTAL ISSUES IN CHAMPAIGN/URBANA OVER 1,000 REFERRALS ARE ON AN ACTIVE WAITING LIST (CONSENT FORMS/MEDICAL HISTORY COMPLETED) AT THE NON-PROFIT SMILEHEALTHY PATIENTS WHO ARE SEEN IN THE ED ARE REFERRED TO THE NUTRITION DENTAL EDUCATION PROGRAM FOR NUTRITIONAL EDUCATION TO AID IN HEALTHY FOOD CHOICE ON A BUDGET AND IMPORTANCE OF THE FOOD GROUP TO HAVE GOOD ORAL HEALTH THIS FREE SERVICE IS HELD IN A PCMC MEETING ROOM TWICE A MONTH ONCE THE EDUCATION IS COMPLETE, PATIENTS THEN RECEIVE ASSISTANCE TO FIND TREATMENT IN THE CHAMPAIGN AREA, EITHER AT FRANCES NELSON DENTAL CENTER (FNDC) OR TO A PCMC-SPONSORED MOBILE DENTAL CLINIC SMILEHEALTHY TREATED OVER 100 PATIENTS WITH DENTAL SERVICES AT 12 MOBILE CLINICS IN 2012 FUNDED BY PCMC 25 WERE REFERRALS FROM THE NUTRITION AND DENTAL EDUCATION PROGRAM AND WERE PREVIOUSLY PCMC ED PATIENTS THIS NUTRITION AND DENTAL EDUCATION PROGRAM HELPS NAVIGATE LOW INCOME PATIENTS TO THE AGENCY THAT CAN BEST SERVE THEIR DENTAL TREATMENT NEEDS AND IMPROVE FOOD HABITS THE DENTAL ADVISORY COMMITTEE, COMPOSED OF FRANCES NELSON HEALTH CENTER, PARKLAND COLLEGE, SMILEHEALTHY, PCMC, AND OTHER COMMUNITY MEMBERS WILL MEET TO ENSURE THE VIABILITY OF SMILEHEALTHY GENERAL ANESTHESIA WILL ALSO BE PROVIDED TO 3 CHILDREN A MONTH IN THE OPERATORIES AT PCMC FOR SEVERE DENTAL TREATMENT FOR CHILDREN THROUGH A PARTNERSHIP WITH SMILEHEALTHY</p> <p>2014 OBJECTIVES *PROVIDE 200 PEOPLE WITH 600 DENTAL TREATMENTS TO REDUCE REPEATED VISITS FOR DENTAL CONDITIONS *PROVIDE CARE FOR 36 CHILDREN WITH APPROXIMATELY 12 TREATMENTS PER CHILD *INCREASE THE NUMBER OF PATIENTS WHO RECEIVE DENTAL EDUCATION THROUGH THE DENTAL EMERGENCY EDUCATION REFERRAL PROGRAM (DEERP) 2014 MEASURABLE OUTCOMES *IN 2014, PCMC SPONSORED DENTAL CLINICS (9 MONTHLY AND 2 FOR RANTOUL) AND ONE ST THOMAS MORE SPONSORED CLINIC 243 PATIENTS SEEN, 672 TREATMENTS PROVIDED *THERE WILL BE 3 PCMC-SPONSORED CLINICS BETWEEN (OCT-DEC) WITH AN ESTIMATED 60 MORE PATIENTS TO BE SEEN AND 150 TREATMENTS PROVIDED TO COMPLETE THE YEAR *AT LEAST 33 PATIENTS WHO HAVE BEEN TO THE PCMC EMERGENCY DEPARTMENT HAVE BEEN TREATED THROUGH PCMC-SPONSORED CLINICS *IN 2014, PCMC PROVIDED CARE FOR 25 CHILDREN WITH 322 TREATMENTS ESTIMATE TO PROVIDE CARE TO ADDITIONAL 8-11 CHILDREN WITH APPROXIMATELY 81-115 TREATMENTS BETWEEN OCT-DEC *IN 2014, 52 PEOPLE ATTENDED THE DENTAL NUTRITIONAL REFERRAL PROGRAM (JAN-SEPT) THERE WILL BE 6 DEERP SEMINARS REMAINING FOR THE YEAR WITH AN ESTIMATED 24 MONTHS</p>

Form and Line Reference	Explanation
PART VI, 5	<p>RE PEOPLE ATTENDING *ALL OF THE PATIENTS WHO ATTEND DEERP ARE OFFERED A DENTAL APPOINTMEN T AT EITHER THE MOBILE DENTAL CLINIC OR AT THE SMILEHEALTHY DENTAL CENTER FAITH IN ACTION THE FAITH IN ACTION PROGRAM IS AN INTERFAITH VOLUNTEER CARE GIVING MINISTRY THAT PROVIDES PRACTICAL ASSISTANCE TO ADULTS 55 AND OVER WHO ARE CHRONICALLY ILL, FRAIL, OR HAVE LONG T ERM HEALTH NEEDS THE TYPES OF SERVICES PROVIDED BY THE TRAINED VOLUNTEERS INCLUDES ESCORT ED TRANSPORTATION TO MEDICAL APPOINTMENTS AND SHOPPING, FRIENDLY HOME AND PHONE VISITS, IN DOOR/OUTDOOR CHORES, AND SMALL HOME REPAIRS 2014 OBJECTIVES *SENIORS ARE DIRECTLY ASSIST ED BY THE FIA MINISTRY TO REMAIN SAFELY IN THEIR HOME *WORK WITH FAMILY TO FILL IN GAPS WITH WHAT FAMILY IS ABLE TO DO *INCREASE THE NUMBER OF FAITH IN ACTION VOLUNTEERS 2014 ME ASURABLE OUTCOMES *2014 TO DATE AT PCMC 1,723 TRANSPORT SERVICES WERE PROVIDED TO MEDICAL APPOINTMENTS AND ERRANDS *2014 TO DATE NO CHORES WERE COMPLETED DUE TO LIMITED DESIGNATE D FULL TIME STAFF AND VOLUNTEERS *2014 TO DATE 64 HOME/PHONE ASSESSMENTS HAVE BEEN COMPLE TED *TWO ADDITIONAL OFFICE VOLUNTEERS HAVE BEEN ADDED, AS WELL AS TWO ADDITIONAL DRIVERS *TO DATE IN 2014 SERVICES WERE PROVIDED TO 75 CARE RECEIVERS BY AN AVERAGE OF 61 ACTIVE V OLUNTEERS *ADDITIONAL NUMBER OF VOLUNTEERS WILL ASSIST WITH A FALL CHORE DAY CHAMPAIGN C OUNTY OFFICE OF PROBATION, WCIA, BUSEY BANK, PCMC EMPLOYEES, WITH POTENTIAL FROM VINEYARD CHURCH, CHRISTIE CLINIC, AND ST PATRICK'S CHURCH IN URBANA FAITH2 THE PURPOSE OF FAITH2 "FUND TO ACCELERATE INNOVATION TOWARDS HEALING AND HOPE," IS TO SERVE AS A CATALYST FOR I NNOVATION AND ACCELERATION OF COMMUNITY PARTNERSHIP AND PROGRAMS TO IMPROVE THE HEALTH OF THE COMMUNITIES WE SERVE CONSISTENT WITH THE MISSION, VISION, AND VALUES OF OUR MINISTRY THE GUIDING PHILOSOPHY OF FAITH2 IS TO EXTEND THE MISSION OF OUR MINISTRY BEYOND OUR FACIL ITIES AND INTO THE COMMUNITIES AND NEIGHBORHOODS WE SERVE THROUGH THE PROGRAM OF FAITH2 WE HELP ACHIEVE THIS BY PROVIDING GRANTS TO NON-PROFIT ORGANIZATIONS IN THE CHAMPAIGN/URBAN A COMMUNITY TO FUND PROGRAMS THAT WILL CONTRIBUTE TO THE IDENTIFIED NEEDS AS DEFINED BY TH E PCMC IMPLEMENTATION STRATEGY *ACCESS TO CARE *OBESITY *DOMESTIC VIOLENCE/ABUSE THE ILL INOIS BUSINESS CONSULTING (IBC), A STUDENT-RUN ORGANIZATION IS COMPRISED OF 250-300 OF THE UNIVERSITY OF ILLINOIS URBANA-CHAMPAIGN'S TOP TALENT IBC OPERATES UNDER THE COLLEGE OF B USINESS WITH PROFESSIONAL GUIDANCE FROM UNIVERSITY FACULTY AND STAFF, AND HAS ACCESS TO TH E ABUNDANCE OF RESEARCH AND ANALYSIS RESOURCES THAT THE UNIVERSITY HAS TO OFFER (MAY 2014)-OVER THE PAST TWO YEARS STUDENTS WITH THE IBC FROM THE UNIVERSITY OF ILLINOIS, ESTIMATED THAT MORE THAN \$450,000 IN COMMUNITY BENEFIT HAS BEEN REALIZED FROM \$150,000 IN COMMUNITY IMPACT GRANTS AWARDED BY PCMC IN 2014, THE FOUNDATION'S FAITH2 GRANTS PROVIDED \$149,500 TO THE FOLLOWING THREE LOCAL AGENCIES FOR PROGRAMS THAT IMPACT IDENTIFIED AND DEMONSTRATED COMMUNITY HEALTH NEEDS *PROMISE HEALTHCARE *CHAMPAIGN COUNTY HEALTHCARE CONSUMERS *PROSP ERITY GARDENS IDENTIFIED NEED VIOLENCE CRISIS NURSERY SUPPORT CRISIS NURSERY IS LOCATED O N THE GROUNDS OF PCMC SINCE INCEPTION, CRISIS NURSERY HAS PROVIDED A SAFE HAVEN FOR CHILD REN FROM BIRTH TO AGE FIVE, WORKING TO PREVENT CHILD ABUSE AND NEGLECT IMMEDIATE RESPONSE IS NEEDED IN EXTREME SITUATIONS WHERE CHILDREN ARE AT RISK OF HARM AND ASSISTANCE CANNOT WAIT 85% OF THESE CHILDREN LIVED IN A SINGLE, SEPARATED, DIVORCED OR WIDOWED HOUSEHOLD C RISIS NURSERY OPERATES WITH NO INCOME ELIGIBILITY OR WAIT LIST OVER 46% OF ADMISSIONS ARE DUE TO PARENTAL STRESS 3% REPORT DOMESTIC VIOLENCE OR SUBSTANCE ABUSE AS THE REASON THE CRISIS NURSERY WAS UTILIZED 2014 OBJECTIVES *DECREASE CHILD ABUSE AND NEGLECT *IMPROVE PARENTING SKILLS *DECREASE PARENTAL STRESS LEVELS 2014 MEASURABLE OUTCOMES *840 CHILDRE N WERE SERVED WITH 33,173 HOURS OF CRISIS CARE *93% OF CAREGIVERS SURVEYED INDICATED REDU CED RISK OF MALTREATMENT *98% OF CAREGI</p>

Form and Line Reference	Explanation
PRESENCE SAINT JOSEPH MEDICAL CENTER (PSJMC), JOLIET, IL	<p>CHNA - ADDRESSING THE NEEDS IDENTIFIED NEED PRIMARY HEALTH CARE PARTNERSHIP WITH THE WILL -GRUNDY MEDICAL CLINIC (WGMC) & AUNT MARTHA'S YOUTH SERVICES CENTER THE WGMC IS A NOT-FOR- PROFIT 501(C)(3) ORGANIZATION THAT PROVIDES FREE MEDICAL AND DENTAL CARE TO ADULTS WHO HAV E NO HEALTH INSURANCE OR MEDICAL CARE ENTITLEMENTS AND MEET PRESCRIBED INCOME GUIDELINES CARE IS PROVIDED BY PHYSICIANS, DENTISTS, AND OTHER PROFESSIONALS WHO VOLUNTEER THEIR TIME AND EXPERTISE TO WGMC AUNT MARTHA'S YOUTH CENTER'S IS A NON-FOR-PROFIT 501(C)(3) ORGANIZ ATION THAT PROVIDES AN ARRAY OF SOCIAL SERVICES THAT OFFER A SAFE HAVEN FOR YOUTH IN CRISI S AND EMPOWER THEM TO SUCCEED AND HIGH QUALITY AND ACCESSIBLE HEALTHCARE FOR THE WHOLE FAM ILY REGARDLESS OF ABILITY TO PAY 2014 OBJECTIVES *TO CONTINUE TO PARTNERSHIP WITH WGMC & AUNT MARTHA'S TO INCREASE NUMBER OF PATIENTS WHO CAN RECEIVE FREE OR REDUCED HEALTHCARE 2014 MEASURABLE OUTCOMES *NUMBER OF PATIENT VISITS FOR 2014 INCLUSIVE HEALTH COALITION E ASTER SEALS JOLIET REGION (ESJR) HAS BEEN DESIGNATED TO TAKE A LEAD IN THE DEVELOPMENT OF AN INCLUSIVE HEALTH COALITION FOR THE GREATER JOLIET AREA THE NATIONAL CENTER ON HEALTH, PHYSICAL ACTIVITY AND DISABILITY (NCHPAD), FUNDED BY THE CDC, IN PARTNERSHIP WITH EASTER S SEALS AND OTHERS, IS WORKING TO CORRECT THE BARRIERS THAT EXIST TO IMPROVE HEALTH AND HEALT H OUTCOMES FOR PEOPLE WITH DISABILITIES RATHER THAN DEVELOPING A SEPARATE COALITION, ESJR IS PARTNERING WITH EXISTING ENTITIES WITH A GOAL TO 1) ASSESS THE COMMUNITIES' LEVEL OF A CCESSIBILITY IN PHYSICAL ACTIVITY AND NUTRITION, 2) DETERMINE WHAT LEVEL OF INCLUSION/EXCL USION EXISTS CURRENTLY IN HEALTH AND WELLNESS POLICIES AND PROGRAMS, AND 3) DECIDE THE BES T PATHS TO IMPROVE ACCESSIBILITY FOR PEOPLE WITH DISABILITIES 2014 OBJECTIVES *FORM INCL USIVE HEALTH COALITION AND PLAN STRATEGIES 2014 MEASURABLE OUTCOMES *COLLECTION OF BASEL INE DATA IDENTIFIED NEED CHRONIC CARE JOLIET PARTNERS FOR HEALTHY FAMILIES COALITION IN 2007, PSJMC CREATED THE COALITION TO HELP COMBAT CHILDHOOD OBESITY IN WILL COUNTY THE PAR TNERSHIP INCLUDES THE THE JOLIET PARK DISTRICT, GREATER JOLIET AREA YMCA, HARVEY BROOKS FO UNDAATION, UNIVERSITY OF ST FRANCIS, THE UNIVERSITY OF ILLINOIS EXTENSION AND THE WILL COU NTY HEALTH DEPARTMENT THE MISSION OF JPHF IS TO ENHANCE THE QUALITY OF LIFE AND IMPROVE T HE OVERALL HEALTH AND WELLNESS OF OUR COMMUNITY FOR PEOPLE OF ALL AGES, ABILITIES AND DIVE RSE BACKGROUNDS 2014 OBJECTIVES *IN CAMP FITNESS, STUDENTS WILL INCREASE FLEXIBILITY, ST RENGTH, ENDURANCE AND KNOWLEDGE *FOR KIDS 'N NATURE (KNN), THE PROGRAM MEASURES THE AMOUN T OF CALORIES BURNED IN THE ACTIVITIES AS WELL AS THE SOFT SKILLS LEARNED (LEADERSHIP, TEA M BUILDING, SOCIALIZATION, ETC) *IN SOAR, STUDENTS WILL ADVANCE TO THE NEXT SWIM LEVEL TH ROUGH TARGETED INSTRUCTION *TO ENCOURAGE WILL COUNTY STUDENTS TO INCORPORATE MORE PHYSICA L ACTIVITY INTO THEIR DAILY LIVES 2014 MEASURABLE OUTCOMES *FOR THE 2013-14 SCHOOL YEAR, 54% THE STUDENT SAMPLE PARTICIPATING IN CAMP FITNESS INCREASED IN FIVE ASSESSMENT AREAS (SIT-UPS, PACER, QUIZ, SIT/REACH & BMI) *FOR THE 2013-14 SCHOOL YEAR, THE 326 STUDENTS BUR NED APPROXIMATELY 1,564 CALORIES EACH AS WELL AS INCREASED SOCIAL SKILLS AND KNOWLEDGE FOR HEALTH LIVING CULTIVATION *STUDENTS ARE GIVEN A SWIM APTITUDE TEST AT THE BEGINNING AND END OF EACH SESSION FOR THE 2013-14 SCHOOL YEAR, SOAR HAD 292 PARTICIPANTS, 88% OF WHICH MET THE GOALS SET FOR SOAR AND 36% OF PARTICIPANTS PASSED TO THE NEXT SWIM LESSON LEVEL * THIRTY SCHOOLS PARTICIPATED IN THE CONTEST IN 2014 LOGGING 519,749 MINUTES OF PHYSICAL ACT IVITY, FOUR TIMES THE MINUTES LOGGED IN 2013 BY NINETEEN PARTICIPATING SCHOOLS WEWILL WOR KHEALTHY AWARD PROGRAM THE WEWILL WORKHEALTHY AWARD PROGRAM WAS CREATED BY THE MAPP PREVEN TION AND MANAGEMENT OF CHRONIC CARE (PMCCI) ACTION TEAM TO RECOGNIZE WILL COUNTY WORKPLACE S THAT ARE COMMITTED TO IMPROVING EMPLOYEE HEALTH AND WELL-BEING THROUGH SIX MAIN AREAS OF WORKSITE WELLNESS 1 HEALTH PROMOTION/EDUCATION 2 PHYSICAL ACTIVITY 3 MENTAL HEALTH 4 ENVIRONMENTAL HEALTH 5 NUTRITION 6 SAFETY THIS AWARD PROGRAM WILL EVENTUALLY INCLUDE FI VE DIFFERENT SECTORS WORKSITES, SCHOOLS, RESTAURANTS, EARLY CHILDHOOD PROGRAMS AND AFTER- SCHOOL PROGRAMS THE GOAL IS TO HIGHLIGHT THE SUCCESSFUL WELLNESS INITIATIVES IN ALL SECTO RS OF THE COUNTY AND TO HELP ORGANIZATIONS WHO WOULD LIKE TO IMPLEMENT SIMILAR PROGRAMS TO IMPROVE THE HEALTH OF THOSE THEY SERVE 2014 OBJECTIVES *TO IMPLEMENT THE WEWILL WORK HE ALTHY AWARD, THE FIRST WORKSITE WELLNESS RECOGNITION PROGRAM IN WILL COUNTY 2014 MEASURAB LE OUTCOMES *DUE TO CHANGE TO BI-ANNUAL AWARD, NO MEASURES WERE TAKEN IN 2014 INCLUSIVE HEALTH COALITION EASTER SEALS JOLIET REGION (ESJR) HAS BEEN DESIGNATED TO TAKE A LEAD IN T HE DEVELOPMENT OF AN INCLUSIVE HEALTH COALITION FOR THE GREATER JOLIET AREA THE NATIONAL CENTER ON HEALTH, PHYSICAL ACTIVITY AND DISABILITY (NCHPAD), FUNDED BY THE CDC, IN PARTNER SHIP WITH EASTER SEALS AND OTHERS, IS WORKING TO C</p>

Form and Line Reference	Explanation
PRESENCE SAINT JOSEPH MEDICAL CENTER (PSJMC), JOLIET, IL	<p>ORRECT THE BARRIERS THAT EXIST TO IMPROVE HEALTH AND HEALTH OUTCOMES FOR PEOPLE WITH DISABILITIES RATHER THAN DEVELOPING A SEPARATE COALITION, ESJR IS PARTNERING WITH EXISTING ENT ITIES WITH A GOAL TO 1)ASSESS THE COMMUNITIES' LEVEL OF ACCESSIBILITY IN PHYSICAL ACTIVIT Y AND NUTRITION, 2) DETERMINE WHAT LEVEL OF INCLUSION/EXCLUSION EXISTS CURRENTLY IN HEALTH AND WELLNESS POLICIES AND PROGRAMS, AND 3) DECIDE THE BEST PATHS TO IMPROVE ACCESSIBILITY FOR PEOPLE WITH DISABILITIES 2014 OBJECTIVES *FORM INCLUSIVE HEALTH COALITION AND PLAN STRATEGIES 2014 MEASURABLE OUTCOMES *COLLECTION OF BASELINE DATA BEHAVIORAL HEALTH (MENT AL HEALTH) AND ENROLLMENT STRATEGIES ARE DISCUSSED BELOW IN THE SYSTEM-WIDE PROGRAMS AT TH E END OF PART V *OTHER COMMUNITY PROGRAMS KNOW WHERE TO GO MEDICAL HOME MEDIA CAMPAIGN T HE PRIMARY HEALTH CARE ACTION TEAM OF THE WILL COUNTY MAPP COLLABORATIVE IS FORMING AN EDU CATION MEDIA CAMPAIGN ON WHAT THE DEFINITION OF A MEDICAL HOME IS AS WELL AS WHEN AND WHEN NOT TO SEEK TREATMENT AT AN EMERGENCY DEPARTMENT THE CAMPAIGN IS IN THE CREATIVE STAGES WORKING WITH AN AGENCY THERE ARE PLANS TO UTILIZE GRANT FUNDING TO EMPLOY HEALTH PROMOTER (PROMOTORA) TO HELP SPREAD MESSAGE THROUGH COUNTY WE WILL TARGET DISTRIBUTION OF MEDIA BASED ON THE HOSPITAL ED DATA COLLECTED CATCH KIDS CLUB OF WILL COUNTY (WILL COUNTY PARTNE RS FOR HEALTHY FAMILIES WILL COUNTY PARTNERS FOR HEALTHY FAMILIES PROMOTES THE AVAILABILITY FOR FUNDS FOR CATCH KIDS CLUB OF WILL COUNTY THESE FUNDS SUPPORT A COMMUNITY PROGRAM ADD RESSING OBESITY THROUGH NUTRITION EDUCATION AND PHYSICAL ACTIVITY IN SCHOOL-AGE CHILDREN G RADES K-5) PARTICIPATING IN AFTER SCHOOL AND COMMUNITY RECREATION PROGRAMS IN 2015, TWO G RANT PROGRAMS WERE OFFERED FOR THREE YEAR PARTNERSHIPS JOLIET AREA ASTHMA CAMP AT JOLIET AREA ASTHMA CAMP, CHILDREN PARTICIPATE IN FUN ACTIVITIES WHILE LEARNING TO PREVENT AND CONT ROL THEIR ASTHMA AT THE END OF CAMP, THEY HAVE INCREASED CONFIDENCE AND IMPROVED AWARENE SS OF THEIR ASTHMA AND HAVE LEARNED NEW WAYS TO COPE WITH THEIR CONDITION TOPICS INCLUDE ASTHMA TRIGGERS, NUTRITION, EQUIPMENT, MEDICATION, ANATOMY, FEELINGS & COPING PARENT EDU CATION IS ALSO PROVIDED UNIVERSITY OF ILLINOIS EXTENSION JUNIOR MASTER GARDENER (JMG) PRO GRAM IN WILL COUNTY (WILL COUNTY PARTNERS FOR HEALTHY COMMUNITIES) WILL COUNTY PARTNERSHIP FOR HEALTHY FAMILIES PROMOTES THE AVAILABILITY OF FUNDS FOR UNIVERSITY OF ILLINOIS EXTENS ION JUNIOR MASTER GARDENER (JMG) PROGRAM IN WILL COUNTY THESE FUNDS SUPPORT A COMMUNITY P ROGRAM ADDRESSING ACCESS TO HEALTHY NUTRITIONAL CHOICES AND SUSTAINABILITY INITIATIVES IN SCHOOL AGE CHILDREN (K-5) FOR AFTER SCHOOL PROGRAMS IN 2015, TWO GRANT PROGRAMS ARE OFFER ED FOR THREE YEAR PARTNERSHIPS THAT HELP IN YEAR ONE TO CREATE THE GARDEN, PROVIDE THE MAN UAL, DATA AND MASTER GARDENER TO KICK OFF THE PROJECT, IN YEAR TWO ALL THE RESULTS FROM TH E STUDENTS ARE PRESENTED BACK TO THE COLLABORATIVE WITH A NARRATIVE OF EFFECT WITH A PROGR AM PLAN FOR SUSTAINABILITY, IN YEAR THREE THE RECIPIENTS ARE ASSISTED IN MAKING A RELATED POLICY CHANGE TO PROMOTE ACCESS TO HEALTHY FOODS RE-THINK YOUR DRINK MEDIA CAMPAIGN IMPLE MENT "RETHINK YOUR DRINK" EDUCATION AND COMMUNICATION CAMPAIGN TO EDUCATE STAKEHOLDER ORGA NIZATIONS AND COMMUNITY RESIDENTS ABOUT THE HARMS OF SUGAR SWEETENED BEVERAGE (SSB) CONSUM PTION PARTNER WITH ILLINOIS ALLIANCE TO PREVENT OBESITY TO CO-BRAND MESSAGES WITH WILL CO UNTY MAPP LOGO & PROVIDE MATERIALS TO HOLD RETHINK YOUR DRINK EVENTS IN THE COUNTY TRACK THE NUMBER OF EVENTS & NEW POLICIES REGARDING THE REDUCTION OF SSB IN THE COUNTY COMMIT T O BE FIT CONTEST THE JPHF COALITION STARTED A THREE MONTH PHYSICAL ACTIVITY CONTEST IN THE SPRING OF 2013 WITH THE PURPOSE OF ENCOURAGING WILL COUNTY STUDENTS TO INCORPORATE MORE P HYSICAL ACTIVITY INTO THEIR DAILY LIVES SIMILAR TO READING CONTESTS WITHIN THE SCHOOLS, T HE COMMIT TO BE FIT CONTEST WAS OFFERED TO ALL WILL COUNTY STUDENTS STUDENTS WILL NEED TO "COMMIT" TO THE PROGRAM BY SIGNING UP A</p>

Form and Line Reference	Explanation
PART VI, 6 AFFILIATED HEALTH CARE SYSTEM	<p>The Provena Health and Resurrection Health Care systems combined TO FORM A NEW HEALTH SYSTEM, PRESENCE HEALTH, CREATING A COMPREHENSIVE FAMILY OF NOT-FOR-PROFIT HEALTH CARE SERVICES AND THE SINGLE LARGEST CATHOLIC HEALTH SYSTEM IN ILLINOIS PRESENCE HEALTH EMBODIES THE ACT OF BEING PRESENT IN EVERY MOMENT WE SHARE WITH THOSE WE SERVE AND IS THE CORNERSTONE OF A PATIENT, RESIDENT AND FAMILY-CENTERED CARE ENVIRONMENT "PRESENCE" HEALTH EMBODIES THE WAY WE CHOOSE TO BE PRESENT IN OUR COMMUNITIES, AS WELL AS WITH ONE ANOTHER AND THOSE WE SERVE PRESENCE HEALTH IS SPONSORED BY FIVE CONGREGATIONS OF CATHOLIC RELIGIOUS WOMEN THE FRANCISCAN SISTERS OF THE SACRED HEART, THE SERVANTS OF THE HOLY HEART OF MARY, THE SISTERS OF THE HOLY FAMILY OF NAZARETH, SISTERS OF MERCY OF THE AMERICAS AND THE SISTERS OF THE RESURRECTION AS WAS THE CASE FROM OUR VERY BEGINNINGS, PRESENCE HEALTH IS CALLED TO BE MUCH MORE THAN JUST A PROVIDER OF HEALTH SERVICES PRESENCE HEALTH HAS INSTILLED WITHIN ALL OF ITS MINISTRIES THAT ARE COMMITTED 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 AS A NOT-FOR-PROFIT HEALTH SYSTEM, PRESENCE HEALTH INVESTS A SIGNIFICANT PORTION OF ITS OPERATING CAPITAL INTO THE COMMUNITY THROUGH PROGRAMS TO SERVE VULNERABLE POPULATIONS, SUCH AS THE POOR AND UNINSURED, MANAGE CHRONIC CONDITIONS, AND PROMOTE HEALTH EDUCATION AND PROMOTION OUTREACH AND INITIATIVES IN FISCAL YEAR 2014, THIS INCLUDED \$180 MILLION IN COMMUNITY BENEFIT ACTIVITIES PRESENCE HEALTH THUS TAKES A SYSTEMS APPROACH TO ITS COMMUNITY BENEFIT EFFORTS, AND THEREFORE ENSURES ITS MEMBER HOSPITALS AND OTHER ENTITIES AND AFFILIATES ARE HELPING TO PROMOTE AND ADDRESS THE HEALTH NEEDS OF THE COMMUNITIES THEY SERVE FOR MORE INFORMATION ON PRESENCE HEALTH, VISIT WWW.PRESENCEHEALTH.ORG</p>

Form and Line Reference	Explanation
PART VI, 7	PRESENCE HEALTH FILES ITS ANNUAL COMMUNITY BENEFIT REPORT IN ILLINOIS

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

Form and Line Reference	Explanation
PART V FACILITY INFORMATION	<p>PRESENCE SAINT JOSEPH MEDICAL CENTER (1) PART V, SECTION B, LINE 5 PRESENCE SAINT JOSEPH MEDICAL CENTER (PSJMC) USED THE MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP) PROCESS TO CONDUCT ITS CHNA. THIS PROCESS IS A THOROUGH, COLLABORATIVE PROCESS WHICH INCLUDES FOUR SEPARATE ASSESSMENTS THAT ENGAGE REPRESENTATIVES FROM ALL COMMUNITY SECTORS TO OBTAIN INPUT AND FEEDBACK ON WHAT THE IDENTIFIED NEEDS ARE IN THE COMMUNITY. THE ASSESSMENTS ARE LISTED BELOW, INCLUDING THE AGENCIES WHO PROVIDED INPUT. COMMUNITY HEALTH STATUS ASSESSMENT. THE CHNA COMMITTEE WAS COMPRISED OF MAPP EXECUTIVE COMMITTEE MEMBERS, DATA AND PLANNING STAFF FROM THE THREE LOCAL HOSPITALS AND THE HEALTH DEPARTMENT'S EPIDEMIOLOGIST. THIS TEAM REVIEWED KEY HEALTH INDICATORS AND THE HEALTH DEPARTMENT'S EPIDEMIOLOGIST ANALYZED THE DATA GATHERED TO PROVIDE INSIGHT INTO THE TRENDS AND TOP ISSUES. LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT (LPHSA). OVER 100 PUBLIC HEALTH SYSTEM PARTNERS WERE INVITED TO PARTICIPATE IN THE WILL COUNTY PUBLIC HEALTH SYSTEM FORUM HELD IN DECEMBER 2013 AT NEW LIFE CHURCH IN NEW LENOX. APPROXIMATELY 70 PARTNERS PARTICIPATED IN ASSESSING HOW WELL THE WILL COUNTY PUBLIC HEALTH SYSTEM PROVIDES THE TEN ESSENTIAL PUBLIC HEALTH SERVICES (EPHS) IN WILL COUNTY. COMMUNITY THEMES AND STRENGTHS ASSESSMENT (CTSA). THREE SEPARATE METHODS OF DATA COLLECTION WERE USED IN CONDUCTING THE CTSA: RANDOM AND TARGETED COMMUNITY SURVEYS AND PHOTOVOICE. *RANDOM SURVEY. IN A COUNTY-WIDE RANDOM SAMPLE, 5,000 RESIDENTS WERE MAILED A COMMUNITY SURVEY BETWEEN SEPTEMBER AND NOVEMBER 2013. THE SURVEY WAS 10 PAGES IN LENGTH AND TOOK ABOUT 20 MINUTES TO COMPLETE. IT ASKED QUESTIONS ABOUT RESIDENTS' PERCEPTIONS ON THE QUALITY OF LIFE IN WILL COUNTY. THERE WERE 496 RESPONDENTS. *TARGETED SURVEY. AFTER SURVEY RESULTS WERE COLLECTED, THE MAPP EXECUTIVE COMMITTEE REALIZED THAT THE SURVEY RESPONDENTS DID NOT REFLECT THE DEMOGRAPHICS OF WILL COUNTY. IN ORDER TO OBTAIN THE PERSPECTIVE OF RESIDENTS UNDERREPRESENTED IN THE RANDOM SURVEY, TARGETED SURVEYS WERE DISTRIBUTED IN JANUARY 2014 TO GATHER ADDITIONAL INFORMATION FROM VULNERABLE POPULATIONS. EIGHTY-THREE PARTICIPANTS GAVE THEIR INPUT ON STRENGTHS AND ASSETS OF THEIR COMMUNITY AND THEIR PERCEPTION ABOUT THE QUALITY OF LIFE IN WILL COUNTY THROUGH THESE TARGETED SURVEYS. *PHOTOVOICE. THE THIRD METHOD USED FOR DATA COLLECTION. PHOTOVOICE IS A TECHNIQUE THAT ENABLES COMMUNITY RESIDENTS OF ALL AGES AND LANGUAGES TO SHARE INFORMATION ABOUT THEIR COMMUNITIES THROUGH PICTURES. TWENTY-EIGHT PHOTOS WERE RECEIVED FROM A NUMBER OF RESIDENTS IN WILL COUNTY. FORCES OF CHANGE ASSESSMENT (FOCA). THE FOCA WAS COMPLETED IN SEPTEMBER 2013 WITH 41 PARTICIPANTS, CONSISTING OF MAPP EXECUTIVE COMMITTEE MEMBERS AND OTHER COMMUNITY LEADERS. FACTORS AND TRENDS MOST IMPACTING WILL COUNTY INCLUDES THE CURRENT ECONOMY WITH RISING UNEMPLOYMENT, LOSS OF SERVICES AND PROGRAMS, AND INCREASED NEED FOR MENTAL HEALTH SERVICES. PSJMC ENGAGED THE FOLLOWING AGENCIES AS PART OF ITS CHNA PROCESS: ADVENTIST BOLINGBROOK HOSPITAL, AMERICAN CANCER SOCIETY, AUNT MARTHA'S YOUTH SERVICE/CENTER BRIDGES TO A NEW DAY, NFP, CATHOLIC CHARITIES, CASA OF WILL COUNTY, CENTER FOR ECONOMIC DEVELOPMENT (THREE RIVERS EDUCATIONAL PARTNERSHIP - TREP), CHESTNUT HEALTH SYSTEMS, CHILD CARE RESOURCE AND REFERRAL AGENCY, COMMUNITY SERVICE COUNCIL OF WILL COUNTY, INC., CRETE-MONEE SCHOOL DISTRICT 201, CRISIS LINE OF WILL AND GRUNDY COUNTY, EASTER SEALS OF JOLIET REGION, INC., EDWARD HOSPITAL, GREATER JOLIET AREA YMCA, GOVERNOR'S STATE UNIVERSITY, GUARDIAN ANGEL COMMUNITY SERVICES, HARVEY BROOKS FOUNDATION, HOUSING AUTHORITY OF JOLIET, JOLIET JUNIOR COLLEGE, JOLIET TOWNSHIP, JOLIET TOWNSHIP HIGH SCHOOL /YESS (YOUTH EXPERIENCING SUCCESS IN SCHOOL), LEWIS UNIVERSITY, LINDEN OAKS AT EDWARDS HOSPITAL, LUTHERAN SOCIAL SERVICES OF ILLINOIS, MARIAN VILLAGE, MOUNT ZION BAPTIST CHURCH, MORNINGS TAR MISSION, NATIONAL ASSOCIATION OF MENTAL ILLNESS (NAMI), WILL COUNTY NATIONAL HOOK-UP OF BLACK WOMEN, INC., NEW LIFE CHURCH, PROVENA HOME CARE, PRESENCE HEALTH SYSTEM, PRESENCE SAINT JOSEPH MEDICAL CENTER, PRESENCE VILLA FRANCISCAN - PRESENCE LIFE CONNECTIONS, SENIOR SERVICES CENTER OF WILL COUNTY, SERVICE INC., CHILD AND FAMILY CONNECTIONS #15, SILVER CROSS HOSPITAL, STEPPING STONES, INC., THREE RIVERS MANUFACTURE'S ASSOCIATION, TRINITY SERVICES, INC., UOFI EXTENSION - KANKAKEE, WILL, GRUNDY CO., UNITED WAY OF WILL COUNTY, UNIVERSITY OF ST. FRANCIS, WARREN-SHARPE COMMUNITY CENTER, WILL COUNTY COMMUNITY CONCERNS, WILL COUNTY COMMUNITY FOUNDATION, WILL COUNTY COMMUNITY HEALTH CENTER, WILL COUNTY EMA, WILL COUNTY EXECUTIVE'S OFFICE, WILL COUNTY FOREST PRESERVE, DISTRICT, WILL COUNTY HEALTH DEPARTMENT, WILL COUNTY LOCAL ARE A NETWORK (LAN), WILL COUNTY LAND USE COMMUNITY DEVELOPMENT, WILL COUNTY REGIONAL OFFICE OF EDUCATION, WILL COUNTY RESIDENTS, WILL, GRUNDY CENTER FOR INDEPENDENT LIVING, WILL-GRUNDY MEDICAL CLINIC. PART V, SECTION B, LINE 6A AND 6B PSJMC PARTNERED WITH SILVER CROSS HOSPITAL, ADVENTIST BOLINGBROOK HOSPITAL AND EDWARD HOSPITAL.</p>

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

Form and Line Reference	Explanation
PART V FACILITY INFORMATION	TO COMPLETE THEIR CHNA PART V, SECTION B, LINE 7D PSJMC HAS WORKED WITH ITS CHNA PARTNERS TO DEVELOP A COMMUNITY-FRIENDLY DOCUMENT HIGHLIGHTING PERTINENT CHNA INFORMATION COPIES WILL BE MAILED AND/OR E-MAILED TO COMMUNITY PARTNERS WHO PARTICIPATED IN THE CHNA PROCESS PARTNERS WILL ALSO BE PROVIDED LINKS TO THE WEBSITE FOR DISSEMINATION TO THEIR MAILING LI STS AND RESPECTIVE CONSTITUENTS PART V, SECTION B, LINE 11 AFTER CONSOLIDATING OVERLAPPIN G ISSUES IDENTIFIED IN THE MAPP CHNA, THE TOP IDENTIFIED NEEDS IN WILL COUNTY ARE *BEHAVO RIAL HEALTH *CHRONIC CARE *PRIMARY HEALTH CARE PSJMC WILL CONTINUE TO SERVE ON THE MAPP EX ECUTIVE COMMITTEE AND MAPP ACTION TEAMS TO ADDRESS THE IDENTIFIED NEEDS IN WILL COUNTY WIT HIN THE NEXT THREE TO FIVE YEARS PLEASE SEE PART VI, LINE 5 FOR THE DESCRIPTION OF PROGRA MS IN PLACE TO ADDRESS THESE IDENTIFIED NEEDS ALONG WITH 2014 OBJECTIVES AND 2014 MEASURAB LE OUTCOMES PART VI, LINE 5 ALSO INCLUDES THE SYSTEM-WIDE MENTAL HEALTH AND ENROLLMENT ST RATEGIES THAT ARE BEING USED BY EACH HOSPITAL IN THE SYSTEM IN ITS MOST RECENT CHNA, 3-5 NEEDS WERE ADDRESSED, AND THEN AN IMPLEMENTATION STRATEGY WAS CREATED TO ADDRESS THOSE NEE DS THERE ARE NO NEEDS THAT ARE NOT BEING ADDRESSED SOME OF THEM ARE BEING ADDRESSED BY P ROGRAMS THAT DO NOT YET HAVE RESULTS TO REPORT, BUT THEY ARE STILL BEING ADDRESSED

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

Form and Line Reference	Explanation
PRESENCE MERCY MEDICAL CENTER (2)	<p>PART V, SECTION B, LINE 5 THE CHNA PROCESS WAS INITIATED BY PMMC AND PSJH IN COLLABORATION WITH THE COMMUNITY THEY SERVE AND THE KANE COUNTY HEALTH DEPARTMENT, DELNOR HOSPITAL, RUSH-COPLEY MEDICAL CENTER, SHERMAN HOSPITAL, FOX VALLEY UNITED WAY AND THE UNITED WAY OF ELGIN ENGAGEMENT OF PUBLIC HEALTH EXPERTISE THE KANE COUNTY HEALTH DEPARTMENT FACILITATED THE CHNA PROCESS BY USING THE MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP) TOOL PMMC SERVED AS ONE OF EIGHT PARTNERS THAT PARTICIPATED IN THE KANE COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT THIS PROVIDED THE OPPORTUNITY FOR PMMC TO ACTIVELY PROVIDE EXPERTISE, INPUT, AND FINANCIAL SUPPORT PARTNERS ALSO INVOLVED IN THIS PROCESS INCLUDED THE FOUR OTHER HOSPITALS IN KANE COUNTY INCLUDING DELNOR HOSPITAL, PRESENCE SAINT JOSEPH HOSPITAL, RUSH-COPLEY MEDICAL CENTER, SHERMAN HOSPITAL, AS WELL AS FOX VALLEY UNITED WAY AND THE UNITED WAY OF ELGIN CHIP COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) COMMITTEE TO PROVIDE COMMUNITY LEVEL OVERSIGHT FOR THE PROCESS, A DIVERSE GROUP OF COMMUNITY STAKEHOLDERS AND PMMC REPRESENTATIVES WERE INVITED TO PARTICIPATE ON THE CHIP STEERING COMMITTEE TO ENSURE REPRESENTATIVE ENGAGEMENT, PERSONAL INVITATIONS WERE SENT TO ORGANIZATIONS REPRESENTING CULTURAL, LINGUISTIC, RACIAL, ETHNIC, AND OTHER MINORITY GROUPS IN ADDITION, INDIVIDUALS WITH SPECIALIZED QUALIFICATIONS IN DEALING WITH SPECIAL POPULATIONS OR CLINICAL GROUPS WERE SOLICITED FOR THEIR PARTICIPATION FINALLY, EFFORTS WERE MADE TO INCLUDE INDIVIDUALS ON THE CHIP STEERING COMMITTEE WITH PUBLIC HEALTH EXPERTISE THOSE WHO COMMITTED TO THE ASSESSMENT AND PLANNING PROCESS BECAME THE EIGHT MEMBERS OF THE CHNA STEERING COMMITTEE, WHICH CONTINUES TO MEET REGULARLY TO PROVIDE FEEDBACK AND OVERSIGHT, ASSESS PROGRESS, AND MODIFY PLANS AS NEEDED THE KANE COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) STEERING COMMITTEE MEMBERS ARE LISTED BELOW KANE COUNTY HEALTH DEPARTMENT UNITED WAY OF ELGIN PRESENCE MERCY MEDICAL CENTER PRESENCE SAINT JOSEPH HOSPITAL SHERMAN HOSPITAL FOX VALLEY UNITED WAY INC BOARD CADENCE HEALTH RUSH-COPLEY MEDICAL CENTER APPROACH KANE COUNTY APPROACHED THE 2011 COMMUNITY HEALTH NEEDS ASSESSMENT DIFFERENTLY THAN IN YEARS PAST IN LATE 2010, THE KANE COUNTY HEALTH DEPARTMENT (KCHD) ENGAGED THE FIVE HOSPITALS IN THE COUNTY AND THE INC BOARD IN A FORMAL COMMUNITY HEALTH ASSESSMENT COMMITTEE TO FUND AND LEAD THE ASSESSMENT EFFORT IN EARLY 2011, THE FOX VALLEY UNITED WAY AND THE UNITED WAY OF ELGIN BOTH FORMALLY AGREED TO FUND AND SUPPORT THE ASSESSMENT PROCESS AS WELL THIS PARTNERSHIP ALLOWED ALL AGENCIES TO MEET THEIR COMMUNITY ASSESSMENT REQUIREMENTS AND PROVIDED AN EFFICIENT USE OF ASSESSMENT AND PLANNING RESOURCES FROM ALL INVOLVED AGENCIES METHODOLOGY THE ASSESSMENT PARTNERSHIP FUNDED A COMPREHENSIVE TELEPHONE SURVEY OF KANE COUNTY RESIDENTS TO COLLECT HEALTH STATUS INFORMATION FOR OVER 1,500 ADULTS AND THE CAREGIVERS OF OVER 400 CHILDREN THE SURVEY QUESTIONS WERE CREATED BASED ON THE BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM SURVEY, ALLOWING THE RESULTS TO BE COMPARED WITH STATE AND NATIONAL FIGURES THE NORTHERN ILLINOIS UNIVERSITY PUBLIC OPINION LABORATORY WAS CONTRACTED TO CONDUCT THE PHONE SURVEY BETWEEN MARCH AND JULY OF 2011 IN ADDITION TO QUANTITATIVE DATA, THE DEPARTMENT GATHERED QUALITATIVE INFORMATION FROM RESIDENTS ABOUT THE HEALTH OF THE COMMUNITY THROUGH THE QUALITY OF KANE PUBLIC MEETINGS, FOCUS GROUPS, COMMUNITY CAFES AND COMMUNITY MEETINGS THESE EVENTS PROVIDED AN OPPORTUNITY TO HEAR DIRECTLY FROM RESIDENTS ABOUT THE FACTORS MOST INFLUENCING HEALTH IN THEIR COMMUNITIES THIS INFORMATION WAS USED TO HELP PLANNERS UNDERSTAND THE HEALTH DATA COLLECTED OVER 200 RESIDENTS PARTICIPATED IN AT LEAST ONE OF THESE EVENTS COMMUNITY AND STAKEHOLDER PARTICIPATION COMMUNITY AND STAKEHOLDER INPUT WERE OBTAINED TO DETERMINE THE NEEDS OF THE COMMUNITY THE QUALITY OF KANE PUBLIC MEETINGS WERE HELD IN APRIL, MAY, AND NOVEMBER 2011 THESE MEETINGS PROVIDED COMMUNITY MEMBERS AN OPPORTUNITY TO HEAR ABOUT AND PROVIDE THEIR INPUT ON PLANNING INITIATIVES IN KANE COUNTY FROM DIFFERENT PLANNING DISCIPLINES HEALTH, LAND USE, AND TRANSPORTATION THERE WERE SIX MEETINGS TOTAL, TWO FROM EACH OF THE THREE PLANNING AREAS IN THE COUNTY THE PLANNING AREAS ARE DEFINED BY THE COUNTY AND ARE USED BY ALL DEPARTMENTS PART V, SECTION B, LINE 6 PMMC PARTNERED WITH SHERMAN HOSPITAL, CADENCE HEALTH, PRESENCE SAINT JOSEPH HOSPITAL AND RUSH-COPLEY MEDICAL CENTER TO COMPLETE THEIR CHNA PART V, SECTION B, LINE 7D PMMC WORKED WITH ITS CHNA PARTNERS TO DEVELOP A COMMUNITY-FRIENDLY DOCUMENT HIGHLIGHTING PERTINENT CHNA INFORMATION COPIES WERE MAILED AND/OR E-MAILED TO COMMUNITY PARTNERS WHO PARTICIPATED IN THE CHNA PROCESS PARTNERS WERE ALSO PROVIDED LINKS TO THE WEBSITE FOR DISSEMINATION TO THEIR MAILING LISTS AND RESPECTIVE CONSTITUENTS PART V, SECTION B, LINE 11 BASED ON THE CHNA FINDINGS, INTERNAL RESOURCES, AND INTERNAL EXPERTISE THE AREAS OF FOCUS FOR THE</p>

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

Form and Line Reference	Explanation
PRESENCE MERCY MEDICAL CENTER (2)	IMPLEMENTATION STRATEGY PLAN THAT PMMC WILL HELP ADDRESS INCLUDE *OBESITY *CHRONIC DISEAS E *POOR SOCIAL AND EMOTIONAL WELLNESS PLEASE SEE PART VI, LINE 5 FOR THE DESCRIPTION OF PR OGRAMS IN PLACE TO ADDRESS THESE IDENTIFIED NEEDS ALONG WITH 2014 OBJECTIVES AND 2014 MEAS URABLE OUTCOMES PART VI, LINE 5 ALSO INCLUDES THE SYSTEM-WIDE MENTAL HEALTH AND ENROLLMEN T STRATEGIES THAT ARE BEING USED BY EACH HOSPITAL IN THE SYSTEM IN ITS MOST RECENT CHNA, 3-5 NEEDS WERE ADDRESSED, AND THEN AN IMPLEMENTATION STRATEGY WAS CREATED TO ADDRESS THOSE NEEDS THERE ARE NO NEEDS THAT ARE NOT BEING ADDRESSED SOME OF THEM ARE BEING ADDRESSED BY PROGRAMS THAT DO NOT YET HAVE RESULTS TO REPORT, BUT THEY ARE STILL BEING ADDRESSED

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Form and Line Reference	Explanation
PRESENCE SAINT JOSEPH HOSPITAL (3)	<p>PART V, SECTION B, LINE 5 THE CHNA PROCESS WAS INITIATED BY PSJH AND PMMC IN COLLABORATION WITH THE COMMUNITY THEY SERVE AND THE KANE COUNTY HEALTH DEPARTMENT, DELNOR HOSPITAL, RUSH-COPLEY MEDICAL CENTER, SHERMAN HOSPITAL, FOX VALLEY UNITED WAY AND THE UNITED WAY OF ELGIN ENGAGEMENT OF PUBLIC HEALTH EXPERTISE THE KANE COUNTY HEALTH DEPARTMENT FACILITATED THE CHNA PROCESS BY USING THE MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP) TOOL PSJH SERVED AS ONE OF EIGHT PARTNERS THAT PARTICIPATED IN THE KANE COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT THIS PROVIDED THE OPPORTUNITY FOR PSJH TO ACTIVELY PROVIDE EXPERTISE, INPUT, AND FINANCIAL SUPPORT PARTNERS ALSO INVOLVED IN THIS PROCESS INCLUDED THE FOUR OTHER HOSPITALS IN KANE COUNTY INCLUDING DELNOR HOSPITAL, PRESENCE MERCY MEDICAL CENTER, RUSH-COPLEY MEDICAL CENTER, SHERMAN HOSPITAL, AS WELL AS FOX VALLEY UNITED WAY AND THE UNITED WAY OF ELGIN CHIP COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) 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PRESENCE MERCY MEDICAL CENTER PRESENCE SAINT JOSEPH HOSPITAL SHERMAN HOSPITAL FOX VALLEY UNITED WAY INC BOARD CADENCE HEALTH RUSH-COPLEY MEDICAL CENTER APPROACH KANE COUNTY APPROACHED THE 2011 COMMUNITY HEALTH NEEDS ASSESSMENT DIFFERENTLY THAN IN YEARS PAST IN LATE 2010, THE KANE COUNTY HEALTH DEPARTMENT (KCHD) ENGAGED THE FIVE HOSPITALS IN THE COUNTY AND THE INC BOARD IN A FORMAL COMMUNITY HEALTH ASSESSMENT COMMITTEE TO FUND AND LEAD THE ASSESSMENT EFFORT IN EARLY 2011, THE FOX VALLEY UNITED WAY AND THE UNITED WAY OF ELGIN BOTH FORMALLY AGREED TO FUND AND SUPPORT THE ASSESSMENT PROCESS AS WELL THIS PARTNERSHIP ALLOWED ALL AGENCIES TO MEET THEIR COMMUNITY ASSESSMENT REQUIREMENTS AND PROVIDED AN EFFICIENT USE OF ASSESSMENT AND PLANNING RESOURCES FROM ALL INVOLVED AGENCIES METHODOLOGY THE ASSESSMENT PARTNERSHIP FUNDED A COMPREHENSIVE TELEPHONE SURVEY OF KANE COUNTY RESIDENTS TO COLLECT HEALTH STATUS INFORMATION FOR OVER 1,500 ADULTS AND THE CAREGIVERS OF OVER 400 CHILDREN THE SURVEY QUESTIONS WERE CREATED BASED ON THE BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM SURVEY, ALLOWING THE RESULTS TO BE COMPARED WITH STATE AND NATIONAL FIGURES THE NORTHERN ILLINOIS UNIVERSITY PUBLIC OPINION LABORATORY WAS CONTRACTED TO CONDUCT THE PHONE SURVEY BETWEEN MARCH AND JULY OF 2011 IN ADDITION TO QUANTITATIVE DATA, THE DEPARTMENT GATHERED QUALITATIVE INFORMATION FROM RESIDENTS ABOUT THE HEALTH OF THE COMMUNITY THROUGH THE QUALITY OF KANE PUBLIC MEETINGS, FOCUS GROUPS, COMMUNITY CAFES AND COMMUNITY MEETINGS THESE EVENTS PROVIDED AN OPPORTUNITY TO HEAR DIRECTLY FROM RESIDENTS ABOUT THE FACTORS MOST INFLUENCING HEALTH IN THEIR COMMUNITIES THIS INFORMATION WAS USED TO HELP PLANNERS UNDERSTAND THE HEALTH DATA COLLECTED OVER 200 RESIDENTS PARTICIPATED IN AT LEAST ONE OF THESE EVENTS COMMUNITY AND STAKEHOLDER PARTICIPATION COMMUNITY AND STAKEHOLDER INPUT WERE OBTAINED TO DETERMINE THE NEEDS OF THE COMMUNITY THE QUALITY OF KANE PUBLIC MEETINGS WERE HELD IN APRIL, MAY, AND NOVEMBER 2011 THESE MEETINGS PROVIDED COMMUNITY MEMBERS AN OPPORTUNITY TO HEAR ABOUT AND PROVIDE THEIR INPUT ON PLANNING INITIATIVES IN KANE COUNTY FROM DIFFERENT PLANNING DISCIPLINES HEALTH, LAND USE, AND TRANSPORTATION THERE WERE SIX MEETINGS TOTAL, TWO FROM EACH OF THE THREE PLANNING AREAS IN THE COUNTY THE PLANNING AREAS ARE DEFINED BY THE COUNTY AND ARE USED BY ALL DEPARTMENTS PART V, SECTION B, LINE 6 PSJH PARTNERED WITH SHERMAN HOSPITAL, PRESENCE MERCY MEDICAL CENTER, CADENCE HEALTH AND RUSH-COPLEY MEDICAL CENTER TO COMPLETE THEIR CHNA PART V, SECTION B, LINE 7D PSJH-E WORKED WITH ITS CHNA PARTNERS TO DEVELOP A COMMUNITY-FRIENDLY DOCUMENT HIGHLIGHTING PERTINENT CHNA INFORMATION COPIES WERE MAILED AND/OR E-MAILED TO COMMUNITY PARTNERS WHO PARTICIPATED IN THE CHNA PROCESS PARTNERS WERE ALSO PROVIDED LINKS TO THE WEBSITE FOR DISSEMINATION TO THEIR MAILING LISTS AND RESPECTIVE CONSTITUENTS PART V, SECTION B, LINE 11 BASED ON THE CHNA FINDINGS, INTERNAL RESOURCES, AND INTERNAL EXPERTISE THE AREAS OF FOCUS FOR THE</p>

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

Form and Line Reference	Explanation
PRESENCE SAINT JOSEPH HOSPITAL (3)	IMPLEMENTATION STRATEGY PLAN THAT PSJH WILL HELP ADDRESS INCLUDE *OBESITY *CHRONIC DISEASE *POOR SOCIAL AND EMOTIONAL WELLNESS PLEASE SEE PART VI, LINE 5 FOR THE DESCRIPTION OF PROGRAMS IN PLACE TO ADDRESS THESE IDENTIFIED NEEDS ALONG WITH 2014 OBJECTIVES AND 2014 MEASURABLE OUTCOMES PART VI, LINE 5 ALSO INCLUDES THE SYSTEM-WIDE MENTAL HEALTH AND ENROLLMENT STRATEGIES THAT ARE BEING USED BY EACH HOSPITAL IN THE SYSTEM IN ITS MOST RECENT CHNA, 3 -5 NEEDS WERE ADDRESSED, AND THEN AN IMPLEMENTATION STRATEGY WAS CREATED TO ADDRESS THOSE NEEDS THERE ARE NO NEEDS THAT ARE NOT BEING ADDRESSED SOME OF THEM ARE BEING ADDRESSED BY PROGRAMS THAT DO NOT YET HAVE RESULTS TO REPORT, BUT THEY ARE STILL BEING ADDRESSED

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

Form and Line Reference	Explanation
PRESENCE ST MARY'S HOSPITAL (4)	<p>PART V, SECTION B, LINE 5 THE CHNA PROCESS WAS INITIATED BY PSMH IN COLLABORATION WITH THE COMMUNITY IT SERVES AND RIVERSIDE MEDICAL CENTER, THE UNITED WAY AND THE KANKAKEE COUNTY HEALTH DEPARTMENT ENGAGEMENT OF PUBLIC HEALTH EXPERTISE THE KANKAKEE COUNTY HEALTH DEPARTMENT AND PSMH CO-FACILITATED THE CHNA PROCESS BY USING THE MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP) TOOL THE PARTNERSHIP FOR A HEALTHY COMMUNITY FORMALLY ENGAGED THE ILLINOIS PUBLIC HEALTH INSTITUTE (IPHI) FOR ASSISTANCE IN PLANNING AND EXECUTING THE CHNA PROCESS IPHI SERVED AS AN EXPERT PUBLIC HEALTH CONSULTANT THROUGHOUT THE CHNA TIMELINE CHNA STEERING COMMITTEE TO PROVIDE COMMUNITY LEVEL OVERSIGHT FOR THE PROCESS, A DIVERSE GROUP OF COMMUNITY STAKEHOLDERS AND PSMH REPRESENTATIVES WERE INVITED TO PARTICIPATE ON THE CHNA STEERING COMMITTEE TO ENSURE REPRESENTATIVE ENGAGEMENT, PERSONAL INVITATIONS WERE SENT TO ORGANIZATIONS REPRESENTING CULTURAL, LINGUISTIC, RACIAL, ETHNIC, AND OTHER MINORITY GROUPS IN ADDITION, INDIVIDUALS WITH SPECIALIZED QUALIFICATIONS IN DEALING WITH SPECIAL POPULATIONS OR CLINICAL GROUPS WERE SOLICITED FOR THEIR PARTICIPATION FINALLY, EFFORTS WERE MADE TO INCLUDE INDIVIDUALS ON THE CHNA STEERING COMMITTEE WITH PUBLIC HEALTH EXPERTISE THOSE WHO COMMITTED TO THE ASSESSMENT AND PLANNING PROCESS BECAME THE 16 MEMBERS OF THE CHNA STEERING COMMITTEE, WHICH CONTINUES TO MEET REGULARLY TO PROVIDE FEEDBACK AND OVERSIGHT, ASSESS PROGRESS, AND MODIFY PLANS AS NEEDED THE AGENCIES REPRESENTED ON THE CHNA STEERING COMMITTEE ARE LISTED BELOW KANKAKEE COMMUNITY COLLEGE UNITED WAY OF KANKAKEE COUNTY PRESENCE ST MARY'S HOSPITAL I KAN REGIONAL OFFICE OF EDUCATION & NAACP RIVERSIDE MEDICAL CENTER NEW LIFE PENTECOSTAL CHURCH & HISPANIC PARTNERSHIP PRESENCE HOME HEALTH CARE THE HELEN WHEELER CENTER FOR COMMUNITY MENTAL HEALTH CATHOLIC CHARITES OLIVET NAZARENE UNIVERSITY KANKAKEE COUNTY NAACP KANKAKEE COUNTY HEALTH DEPARTMENT PROCESS USED TO IDENTIFY COMMUNITY NEEDS IN OCTOBER OF 2011, PSMH INVITED RIVERSIDE MEDICAL CENTER, THE KANKAKEE COUNTY HEALTH DEPARTMENT AND THE UNITED WAY OF KANKAKEE COUNTY TO INVESTIGATE A PROCESS FOR COMPLETING A CHNA THE ILLINOIS PUBLIC HEALTH INSTITUTE (IPHI) LED THIS TEAM THROUGH THE MAPP PROCESS A CORE GROUP OF PARTNERS MET IN NOVEMBER, 2011 TO REVIEW THE MAPP PROCESS, THE BENEFITS OF ENGAGING IN MAPP AND THE INITIAL LIST OF POTENTIAL PARTNERS TO PARTICIPATE ON THE STEERING COMMITTEE ADDITIONAL PARTNERS WERE IDENTIFIED AND INVITED TO PARTICIPATE FROM JANUARY THROUGH JUNE 2012 FOUR SEPARATE ASSESSMENTS WERE CONDUCTED *LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT (LPHSA) OVER 75 PUBLIC HEALTH SYSTEM PARTNERS WERE INVITED TO PARTICIPATE IN THE KANKAKEE COUNTY PUBLIC HEALTH SYSTEM FORUM HELD IN FEBRUARY 2012 AT KANKAKEE COMMUNITY COLLEGE IN KANKAKEE SIXTY-FOUR PARTNERS PARTICIPATED IN ASSESSING HOW WELL THE KANKAKEE PUBLIC HEALTH SYSTEM PROVIDES THE TEN ESSENTIAL PUBLIC HEALTH SERVICES IN KANKAKEE THE SCORES FROM THAT ASSESSMENT ARE LISTED BELOW *COMMUNITY THEMES AND STRENGTHS ASSESSMENT (CTSA) TWO SEPARATE METHODS OF DATA COLLECTION WERE USED IN CONDUCTING CTSA IN A COUNTY-WIDE RANDOM SAMPLE, 5,000 RESIDENTS WERE MAILED A COMMUNITY SURVEY FROM FEBRUARY 13, 2012 THROUGH MARCH, 15, 2012 THERE WERE 399 RETURNED SURVEYS FROM APRIL THROUGH JUNE 2012, FOUR FOCUS GROUPS WERE HELD ACROSS THE COUNTY TO GET A BROADER PERSPECTIVE FROM THOSE UNDER-REPRESENTED IN THE SURVEY THE FOCUS GROUPS WERE HELD WITH THE HISPANIC PARTNERSHIP, THE NAACP, KANKAKEE TRIAD (THOSE OVER 65), AND THE TEEN GROUP OVER SIXTY-FOUR PARTICIPANTS GAVE THEIR INPUT TO STRENGTHS AND ASSETS OF THEIR COMMUNITY AND THEIR PERCEPTION ABOUT THE QUALITY OF LIFE IN KANKAKEE COUNTY *COMMUNITY HEALTH STATUS ASSESSMENT (CHSA) THE CHSA COMMITTEE COMPRISED OF STEERING COMMITTEE MEMBERS, DATA AND PLANNING STAFF FROM THE TWO LOCAL HOSPITALS AND THE HEALTH DEPARTMENT THE ASSESSMENT WAS INITIATED IN JANUARY OF 2012 AND WAS COMPLETED IN AUGUST OF 2012 *FORCES OF CHANGE ASSESSMENT (FOCA) THE FOCA WAS COMPLETED IN APRIL 2011 WITH THIRTY-SEVEN PARTICIPANTS, CONSISTING OF MAPP STEERING COMMITTEE MEMBERS AND OTHER COMMUNITY LEADERS FACTORS AND TRENDS MOST IMPACTING KANKAKEE COUNTY INCLUDE THE CURRENT ECONOMY WITH RISING UNEMPLOYMENT, LOSS OF SERVICES AND PROGRAMS, AND AN INCREASED NEED FOR MENTAL HEALTH SERVICES ADDITIONAL FORCES OF CHANGE NOTED THAT ARE REFLECTIVE OF MANY ISSUES ON THE NATIONAL AGENDA FOR EXAMPLE, HEALTH CARE REFORM, IMMIGRATION REFORM, REGULATION OF MEDICAL MALPRACTICE, USE AND OVERUSE OF TECHNOLOGY, AND NEED FOR SUSTAINABLE ENERGY RESOURCES ARE ISSUES BEING CONSIDERED ON THE NATIONAL LEVEL, BUT THEY WOULD ALSO HAVE AN IMPACT ON LOCAL AND STATE HEALTH CARE AND SOCIAL SERVICE DELIVERY SYSTEMS PART V, SECTION B, LINE 6 PSMH PARTNERED WITH RIVERSIDE MEDICAL CENTER TO COMPLETE THEIR CHNA PART V, SECTION B, LINE 11 AFTER CONSOLIDATING OVERLAPPING ISSUES IDENTIFIED IN THE MAPP CHNA, THE TOP IDENTIFIED NEEDS ON KANKAKEE</p>

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

Form and Line Reference	Explanation
PRESENCE ST MARY'S HOSPITAL (4)	COUNTY ARE *ACCESS TO CARE (PRIMARY, SPECIALITY, BEHAVIORAL HEALTH, SUBSTANCE USE DISORDE RS) *AWARENESS OF SERVICES AND HOWTO ACCESS THEM *COLLABORATION AND LINKAGE WITHIN SYSTEM S FOR 2014, PSMH CONTINUED TO SERVE ON THE MAPP EXECUTIVE COMMITTEE AND MAPP ACTION TEAMS TO ADDRESS THE IDENTIFIED NEEDS IN KANKAKEE COUNTY WITHIN THE NEXT THREE TO FIVE YEARS OU R OVERALL FOCUS WAS ON *ACCESS TO CARE *AWARENESS OF SERVICES AND HOWTO ACCESS THEM *CHR ONIC DISEASE MANAGEMENT PREVENTION AND MANAGEMENT OF CHRONIC CARE ISSUES PLEASE SEE PART V I, LINE 5 FOR THE DESCRIPTION OF PROGRAMS IN PLACE TO ADDRESS THESE IDENTIFIED NEEDS ALONG WITH 2014 OBJECTIVES AND 2014 MEASURABLE OUTCOMES PART VI, LINE 5 ALSO INCLUDES THE SYST EM-WIDE MENTAL HEALTH AND ENROLLMENT STRATEGIES THAT ARE BEING USED BY EACH HOSPITAL IN TH E SYSTEM IN ITS MOST RECENT CHNA, 3-5 NEEDS WERE ADDRESSED, AND THEN AN IMPLEMENTATION ST RATEGY WAS CREATED TO ADDRESS THOSE NEEDS THERE ARE NO NEEDS THAT ARE NOT BEING ADDRESSED SOME OF THEM ARE BEING ADDRESSED BY PROGRAMS THAT DO NOT YET HAVE RESULTS TO REPORT, BUT THEY ARE STILL BEING ADDRESSED

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

Form and Line Reference	Explanation
PRESENCE COVENANT MEDICAL CENTER (5)	<p>PART V, SECTION B, LINE 5 THE 2014-2016 CHAMPAIGN COUNTY ILLINOIS PLANNING FOR LOCAL ASSES SMENT OF NEEDS (IPLAN) WAS ACCOMPLISHED WITH DIRECT CONTRIBUTION FROM OVER 60 INDIVIDUALS REPRESENTING MORE THAN 30 DIFFERENT AGENCIES FROM ACROSS THE COUNTY PCMC ALSO INCORPORATE D THE VOICE OF MORE THAN 1,000 COMMUNITY RESIDENTS THROUGH SURVEYS, FOCUS GROUPS AND COMMU NITY MEETINGS ENGAGEMENT OF PUBLIC HEALTH EXPERTISE PRESENCE COVENANT MEDICAL CENTER WAS A PARTICIPANT AND HELPED FACILITATE SOME ASPECTS OF THE 2014-2016 CHAMPAIGN COUNTY IPLAN THE CHAMPAIGN URBANA PUBLIC HEALTH DEPARTMENT (CUPHD) CHOSE TO UTILIZE THE MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIP (MAPP) MODEL TO HELP ACQUIRE INPUT FROM COMMUNITY PARTNERS, PLANNERS, ELECTED OFFICIALS AND RESIDENTS OF THE COMMUNITY THIS MAPP PROCESS AS SESSED THE CURRENT HEALTH STATUS OF THE COMMUNITY, IDENTIFIED THE NEEDS, AND CREATED A COM PREHENSIVE PLAN TO MAKE THE COMMUNITY HEALTHIER FOUR ASSESSMENTS WERE CONDUCTED AS DETAILED BELOW</p> <p>*COMMUNITY HEALTH STATUS ASSESSMENT (CHSA) EVALUATED THE BASIC DEMOGRAPHICS AND HEALTH-RELATED STATISTICS OF RESIDENTS IN CHAMPAIGN COUNTY WE USED AGGREGATED DATA ACCES SED FROM COUNTYHEALTHRANKINGS ORG AND CITY AND COUNTY AGENCIES INCLUDING THE CHAMPAIGN AND URBANA POLICE DEPARTMENTS *COMMUNITY THEMES AND STRENGTHS ASSESSMENT (CTSA) WE SURVEYED 975 COMMUNITY RESIDENTS AND HELD FOCUS GROUPS WITH 32 RESIDENTS REPRESENTING DIFFERENT CO MMUNITY GROUPS (UNDERGRADUATE AND GRADUATE STUDENTS, INTERNATIONAL STUDENT FAMILY HOUSING RESIDENTS, AND HOMELESS RESIDENTS) TO GET A MORE IN-DEPTH PICTURE OF STRENGTHS AND WEAKNES SES</p> <p>*LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT (LPHSA) INCLUDED ALMOST 60 COMMUNITY LEADERS FROM OVER 30 DIFFERENT AGENCIES, INCLUDING LOCAL GOVERNMENT, COMMUNITY PLANNERS, PUBLIC HE ALTH PROFESSIONALS, CLINICIANS, POLICE AND FIRE, EMERGENCY PREPAREDNESS, AND THE UNIVERSIT Y OF ILLINOIS THIS MEASURED HOWTHE LOCAL PUBLIC HEALTH SYSTEM IS ADDRESSING THE 10 ESSEN TIAL PUBLIC HEALTH SERVICES *FORCES OF CHANGE ASSESSMENT IDENTIFIED THE AFFORDABLE CARE ACT (ACA) AS A FORCE IMPACTING MANY SECTORS, MEETING THE NEEDS OF INCREASING POPULATIONS O F UNDOCUMENTED IMMIGRANTS, ADDRESSING WIDENING HEALTH DISPARITIES AND THE LACK OF ECONOMIC OPPORTUNITIES, AND THE INCREASED USE OF TECHNOLOGY IN HEALTHCARE (E G TELEMEDICINE AND E LECTRONIC MEDICAL RECORDS) AND USING SOCIAL MEDIA AND TECHNOLOGY TO PROMOTE GENERAL HEALTH WERE IDENTIFIED AS MAJOR FORCES OF CHANGE IPLAN COMMUNITY ADVISORY COMMITTEE TO PROVIDE COMMUNITY LEVEL OVERSIGHT FOR THE PROCESS, A DIVERSE GROUP OF COMMUNITY STAKEHOLDERS AND P CMC REPRESENTATIVES WERE INVITED TO PARTICIPATE ON THE IPLAN COMMUNITY ADVISORY COMMITTEE TO ENSURE REPRESENTATIVE ENGAGEMENT, PERSONAL INVITATIONS WERE SENT TO ORGANIZATIONS REPR ESENTING CULTURAL, LINGUISTIC, RACIAL, ETHNIC, AND OTHER MINORITY GROUPS IN ADDITION, INDIVIDUALS WITH SPECIALIZED QUALIFICATIONS IN DEALING WITH SPECIAL POPULATIONS OR CLINICAL G ROUPS WERE SOLICITED FOR THEIR PARTICIPATION FINALLY, EFFORTS WERE MADE TO INCLUDE INDIVI DUALS ON THE IPLAN COMMUNITY ADVISORY COMMITTEE WITH PUBLIC HEALTH EXPERTISE THOSE WHO CO MMITTED TO THE ASSESSMENT AND PLANNING PROCESS BECAME THE 65 MEMBERS TO INCLUDE THE CUPHD STAFF OF THE IPLAN COMMUNITY ADVISORY COMMITTEE AGENCIES REPRESENTED ON THIS COMMITTEE AR E LISTED BELOW</p> <p>AVICENNA COMMUNITY HEALTH CENTER CARLE FOUNDATION HOSPITAL CHAMPAIGN COUNT Y ADMINISTRATOR CHAMPAIGN COUNTY BOARD CHAIR CHAMPAIGN COUNTY CHAMBER OF COMMERCE CHAMPAIGN COUNTY CORONER CHAMPAIGN COUNTY HEALTHCARE CONSUMERS CHAMPAIGN COUNTY REGIONAL PLANNING COMMISSION CHAMPAIGN FIRE DEPARTMENT CHAMPAIGN PARK DISTRICT CHAMPAIGN POLICE DEPARTMENT C HAMPAIGN UNIT 4 SCHOOL DISTRICT CHAMPAIGN URBANA PUBLIC HEALTH DISTRICT CHRISTIE CLINIC CI TY OF CHAMPAIGN FIRE DEPARTMENT CITY OF URBANA COMMUNITY DEVELOPMENT SERVICES CITY OR URBA NA COMMUNITY ELEMENTS CU MASS TRANSIT DISTRICT CUPHD-INFECTIOUS DISEASE HOUSING AUTHORITY OF CHAMPAIGN COUNTY LAND OF LINCOLN MCKINLEY HEALTH CENTER NATIONAL ALLIANCE ON MENTAL ILL NESS PARKLAND COLLEGE PRESENCE COVENANT CENTER FOR HEALTHY LIVING PRESENCE COVENANT MEDICA L CENTER PROMISE HEALTHCARE PROSPERITY GARDENS INC SOIL AND WATER CONSERVATION DISTRICT U NITED WAY OF CHAMPAIGN COUNTY UNIVERSITY OF ILLINOIS UNIVERSITY OF ILLINOIS NCSA UNIVERSIT Y OF ILLINOIS POLICE UNIVERSITY OF ILLINOIS-CPRD URBANA MARKET AT THE SQUARE URBANA PARK D ISTRICT URBANA SCHOOL DISTRICT 116</p> <p>PART V, SECTION B, LINE 6 PCMC PARTNERED WITH CARLE FOU NDATION HOSPITAL TO COMPLETE THEIR CHNA PART V, SECTION B, LINE 7D PCMC HAS WORKED WITH I TS CHNA PARTNERS TO DEVELOP A COMMUNITY-FRIENDLY DOCUMENT HIGHLIGHTING PERTINENT CHNA INFO RMATION COPIES WILL BE MAILED AND/OR E-MAILED TO COMMUNITY PARTNERS WHO PARTICIPATED IN T HE CHNA PROCESS PARTNERS WILL ALSO BE PROVIDED LINKS TO THE WEBSITE FOR DISSEMINATION TO THEIR MAILING LISTS AND RESPECTIVE CONSTITUENTS PART V, SECTION B, LINE 11 RESULTS OF THE 2014-2017 COMMUNITY HEALTH NEEDS ASSESSMENT BASED</p>

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

Form and Line Reference	Explanation
PRESENCE COVENANT MEDICAL CENTER (5)	<p>ON THE FOUR MAPP ASSESSMENTS, COMMUNITY LEADERS CONVENED TO IDENTIFY PRIORITIES AFTER IDENTIFYING OVER 30 HEALTH CONCERNS, PARTICIPANTS VOTED TO NARROW DOWN THE LIST TO FOUR PRIORITIES TO ADDRESS IN 2014-2017. BASED ON THE CDC'S MODEL, SMART OBJECTIVES WERE USED TO IDENTIFY GOALS AND OBJECTIVES WITHIN EACH PRIORITY THAT WERE FEASIBLE, ACTIONABLE, AND COULD BE IMPLEMENTED IN THE UPCOMING YEARS. WORKGROUPS THEN FORMED AND MET SEPARATELY TO ADDRESS EACH OF THE FOUR PRIORITIES, AND FORMULATE GOALS AND ACTION PLANS TO ADDRESS THEM.</p> <p>*ACCESS TO CARE (MEDICAL, MENTAL AND DENTAL HEALTH) RESOURCE MAPPING AND FORMING A COMMUNITY RESOURCE CENTER, INCREASING MEDICAID ENROLLMENT FOR ELIGIBLE PATIENTS, INCREASING CAPACITY, AND INCREASING COMMUNICATION AND COLLABORATION. GOAL: CHAMPAIGN COUNTY WILL DEVELOP OPPORTUNITIES TO IMPROVE ACCESS TO AND AFFORDABILITY OF MEDICAL, BEHAVIORAL HEALTH (MENTAL HEALTH AND/OR SUBSTANCE USE), AND DENTAL SERVICES FOR THOSE LIVING BELOW 200% OF THE FEDERAL POVERTY LEVEL.</p> <p>*BEHAVIORAL HEALTH RESOURCE CENTER, PROMOTING EDUCATION AND TRAINING ON MENTAL AND BEHAVIORAL HEALTH FOR TEACHERS AND OFFICERS. GOAL: CHAMPAIGN COUNTY WILL IMPROVE BEHAVIORAL HEALTH AND WELLNESS BY INCREASING CAPACITY AND ACCESS TO CARE, PROVIDING EDUCATIONAL OPPORTUNITIES, INCREASING PREVENTION ACTIVITIES AND ADVOCATING THAT TREATMENT WORKS AND RECOVERY IS POSSIBLE.</p> <p>*VIOLENCE (DOMESTIC VIOLENCE, RELATIONSHIP BETWEEN DRUG & ALCOHOL ABUSE AND VIOLENCE) IMPROVING MENTAL HEALTH SERVICES, LINKING PAROLEES AND THOSE INCARCERATED TO RESOURCES INCLUDING HOUSING, JOBS, HEALTHCARE, COUNSELING, TAKING MEDICATION, DEVELOPING AND MAINTAINING SPECIALTY COURTS. GOAL: PREVENT VIOLENCE IN CHAMPAIGN COUNTY BY PROVIDING LINKAGES TO SERVICES AND ACCESS TO RESOURCES FOR INDIVIDUALS WITH BEHAVIORAL HEALTH NEEDS, AND INCREASING OPTIONS FOR YOUTH TO PARTICIPATE IN HEALTHY AFTERSCHOOL AND SUMMER ACTIVITIES.</p> <p>*OBESITY (NUTRITION, DIET AND EXERCISE, RISK FACTORS & COMPLICATIONS) IMPROVING NUTRITION AND INCREASING PHYSICAL ACTIVITY BY INCREASING STREET LIGHTING AND SAFETY. GOAL: INCREASE THE PROPORTION OF ADULTS WHO REPORT BEING AT A HEALTHY WEIGHT BY 5%.</p> <p>PCMC'S REVIEW OF CURRENT COMMUNITY BENEFIT PROGRAMS FOUND THAT THE HOSPITAL IS MEETING EXISTING COMMUNITY NEEDS THROUGH THE FOLLOWING PROGRAMS: THE SMILEHEALTHY PARTNERSHIP, FAITH IN ACTION, CRISIS NURSERY, DIABETES COALITION, FAITH2 AND TRANSITIONS. PLEASE SEE PART VI, LINE 5 FOR THE DESCRIPTION OF PROGRAMS IN PLACE TO ADDRESS THESE IDENTIFIED NEEDS ALONG WITH 2014 OBJECTIVES AND 2014 MEASURABLE OUTCOMES. PART VI, LINE 5 ALSO INCLUDES THE SYSTEM-WIDE MENTAL HEALTH AND ENROLLMENT STRATEGIES THAT ARE BEING USED BY EACH HOSPITAL IN THE SYSTEM. IN ITS MOST RECENT CHNA, 3-5 NEEDS WERE ADDRESSED, AND THEN AN IMPLEMENTATION STRATEGY WAS CREATED TO ADDRESS THOSE NEEDS. THERE ARE NO NEEDS THAT ARE NOT BEING ADDRESSED. SOME OF THEM ARE BEING ADDRESSED BY PROGRAMS THAT DO NOT YET HAVE RESULTS TO REPORT, BUT THEY ARE STILL BEING ADDRESSED.</p>

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

Form and Line Reference	Explanation
PRESENCE UNITED SAMARITANS MEDICAL CENTER (6)	<p>PART V, SECTION B, LINE 5 THE CHNA PROCESS WAS INITIATED BY THE VERMILION COUNTY HEALTH DEPARTMENT IN COLLABORATION WITH PUSMC IN ADDITION TO COMMUNITY PARTNERS REPRESENTING MANY SECTORS THE VERMILION COUNTY HEALTH DEPARTMENT FACILITATED THE OVERALL PROCESS WITH GUIDANCE AND FEEDBACK FROM PUSMC AND COMMUNITY PARTNERS ENGAGEMENT OF PUBLIC HEALTH EXPERTISE THE VERMILION COUNTY HEALTH DEPARTMENT, AS A CERTIFIED LOCAL HEALTH DEPARTMENT FOR VERMILION COUNTY, ILLINOIS IS CHARGED TO ASSESS THE HEALTH AND WELL-BEING OF THE COMMUNITY BY RETRIEVING AND PRESENTING RELEVANT DATA, SEEKING COMMUNITY INPUT, GENERATING DIALOGUE, AND IDENTIFYING EXISTING AND NEEDED RESOURCES THAT LEAD TO THE DEVELOPMENT OF STRATEGIES WITH MEASURABLE OUTCOMES TO ADDRESS THE IDENTIFIED PRIORITIES THE ILLINOIS PROJECT FOR LOCAL ASSESSMENT OF NEEDS (IPLAN) PROCESS BEGAN ON DECEMBER 7, 2011 WHEN AN IPLAN TEAM WAS FORMED A CONTRACTUAL IPLAN CONSULTANT, DR KRISTA JONES, WAS ADDED TO THE TEAM DR JONES, UNIVERSITY OF ILLINOIS NURSING INSTRUCTOR, WAS ADDED TO THE TEAM TO PROVIDE GUIDANCE, TECHNICAL ASSISTANCE, AND FACILITATION THE TEAM BEGAN DISCUSSIONS TO IDENTIFY COMMUNITY STAKEHOLDERS AND INVITED THEM TO BE A PART OF THE COMMUNITY ADVISORY COMMITTEE AND HOW PUSMC MIGHT BEST ENGAGE AND ELICIT THEIR INPUT A LIST OF STAKEHOLDERS WAS COMPILED AND A SCHEDULE FOR COMMUNITY MEETINGS WAS DEVELOPED IPLAN COMMUNITY ADVISORY COMMITTEE TO PROVIDE COMMUNITY LEVEL OVERSIGHT FOR THE PROCESS, A DIVERSE GROUP OF COMMUNITY STAKEHOLDERS AND PUSMC REPRESENTATIVES WERE INVITED TO PARTICIPATE ON THE IPLAN COMMUNITY ADVISORY COMMITTEE TO ENSURE REPRESENTATIVE ENGAGEMENT, PERSONAL INVITATIONS WERE SENT TO ORGANIZATIONS REPRESENTING CULTURAL, LINGUISTIC, RACIAL, ETHNIC, AND OTHER MINORITY GROUPS IN ADDITION, INDIVIDUALS WITH SPECIALIZED QUALIFICATIONS IN DEALING WITH SPECIAL POPULATIONS OR CLINICAL GROUPS WERE SOLICITED FOR THEIR PARTICIPATION FINALLY, EFFORTS WERE MADE TO INCLUDE INDIVIDUALS ON THE IPLAN COMMUNITY ADVISORY COMMITTEE WITH PUBLIC HEALTH EXPERTISE THOSE WHO COMMITTED TO THE ASSESSMENT AND PLANNING PROCESS BECAME THE 50 MEMBERS OF THE IPLAN COMMUNITY ADVISORY COMMITTEE THE MEMBERS OF THIS COMMITTEE ARE LISTED BELOW</p> <p>708 MENTAL HEALTH BOARD ASSOCIATION HOUSE AUNT MARTHA'S HEALTH CENTER (FQHC) BIG BROTHERS/BIG SISTERS CARLE CLINIC DANVILLE CENTER FOR CHILDREN SERVICES CENTRAL CHRISTIAN CHURCH CHANNEL 3 NEWS CRIS HEALTHY AGING CENTER CROSSPOINT/YRFC DANVILLE AREA COMMUNITY COLLEGE DANVILLE AREA COMMUNITY COLLEGE- SCHOOL OF NURSING DANVILLE FAMILY YMCA DANVILLE MASS TRANSIT DANVILLE SCHOOL DISTRICT 118 FAITH IN ACTION FITHIAN (VILLAGE OF) HOOPESTON (CITY OF)- VOLUNTEER HOOPESTON MULTI-AGENCY ILLINOIS HOUSE OF REPRESENTATIVES- CHAD HAYS INSURING THE BODY ELECTRIC (PUSMC FOUNDATION) LAKEVIEW COLLEGE OF NURSING NEW LIFE CHURCH OF FAITH OAKWOOD (VILLAGE OF)- MAYOR PRESENCE REGIONAL EMS PROJECT SUCCESS PROJECT SUCCESS/CAPIT PUSMC- COMMUNITY BENEFIT COORDINATOR PUSMC FOUNDATION, HALO SALVATION ARMY UNITED WAY UNIVERSITY OF ILLINOIS-CHICAGO COLLEGE OF NURSING UNIVERSITY OF ILLINOIS EXTENSION OFFICE (LEIA WESTON KEDEM) VAILLIANA HEALTHCARE VERMILLION ADVANTAGE VERMILLION COUNTY BOARD VERMILLION COUNTY BOARD OF HEALTH- PRESIDENT AND MEMBERS VERMILLION COUNTY HEALTH DEPARTMENT- ADMINISTRATION VERMILLION COUNTY HEALTH DEPARTMENT- COMMUNITY HEALTH SERVICES VERMILLION COUNTY HEALTH DEPARTMENT- EMERGENCY PREPAREDNESS FOR THE 2011 ASSESSMENT AND PLANNING PROCESS, THE VERMILION COUNTY HEALTH DEPARTMENT USED THE ASSESSMENT PROTOCOL FOR EXCELLENCE IN PUBLIC HEALTH (APEXPH) AS AN EQUIVALENT FOR IPLAN THE VERMILION COUNTY HEALTH DEPARTMENT AND PUSMC PARTNERED TO FACILITATE THE APEXPH PROCESS APEXPH IS A FLEXIBLE PLANNING TOOL DEVELOPED FOR LOCAL HEALTH OFFICIALS TO *ASSESS THE ORGANIZATION AND MANAGEMENT OF THE HEALTH DEPARTMENT, *PROVIDE A FRAMEWORK FOR WORKING WITH COMMUNITY MEMBERS AND OTHER ORGANIZATIONS TO ASSESS THE HEALTH STATUS OF THE COMMUNITY, AND *ESTABLISH THE LEADERSHIP ROLE OF THE HEALTH DEPARTMENT IN THE COMMUNITY IT IS A THREE-PART PROCESS THAT INVOLVES THE FOLLOWING</p> <p>1 PART I ORGANIZATIONAL CAPACITY ASSESSMENT CALLS FOR AN INTERNAL REVIEW OF A LOCAL HEALTH DEPARTMENT IT PROVIDES FOR AN ASSESSMENT OF A HEALTH DEPARTMENT'S BASIC ADMINISTRATIVE CAPACITY AND OF ITS CAPACITY TO UNDERTAKE PART II IT IS CONDUCTED BY THE HEALTH DEPARTMENT DIRECTOR AND A TEAM OF KEY STAFF MEMBERS</p> <p>2 PART II THE COMMUNITY PROCESS IS INTENDED TO BE A MORE PUBLIC ENDEAVOR, INVOLVING KEY MEMBERS OF A COMMUNITY AS WELL AS DEPARTMENT STAFF IN ASSESSING THE HEALTH OF THE COMMUNITY AND IDENTIFYING THE ROLE OF THE HEALTH DEPARTMENT IN RELATION TO COMMUNITY STRENGTHS AND HEALTH PROBLEMS IT PROVIDES FOR THE USE OF BOTH OBJECTIVE HEALTH DATA AND THE COMMUNITY'S PERCEPTIONS OF COMMUNITY HEALTH PROBLEMS</p> <p>3 PART III COMPLETING THE CYCLE INTEGRATES THE PLANS DEVELOPED DURING THE ORGANIZATIONAL CAPACITY ASSESSMENT AND THE COMMUNITY PROCESS INTO THE ONGOING ACTIVITIES OF A HEALTH</p>

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

Form and Line Reference	Explanation
PRESENCE UNITED SAMARITANS MEDICAL CENTER (6)	H DEPARTMENT AND THE COMMUNITY IT SERVES IT DISCUSSES POLICY DEVELOPMENT, ASSURANCE, MONITORING, AND EVALUATION OF PLANS DEVELOPED IN CONDUCTING PARTS I AND II THE COMMUNITY PROCESS BEGAN WELL BEFORE THE FIRST FACE-TO-FACE COMMUNITY STAKEHOLDERS MEETING COLLECTION OF DATA BEGAN IN THE FALL OF 2011 AS THE VCHD DIRECTOR OF COMMUNITY HEALTH SERVICES BEGAN WORKING COLLABORATIVELY WITH LAKEVIEW COLLEGE OF NURSING IN RESEARCHING, COMPILING AND ORGANIZING DATA DATA ANALYSIS BEGAN IN JANUARY 2012 WITH THE APPOINTMENT OF THE VCHD IPLAN TEAM MEMBERS AND THE PLAN WAS MADE PUBLICLY AVAILABLE MARCH 27, 2012 PART V, SECTION B, LINE 6 PUSMC PARTNERED WITH HOOPESTON HOSPITAL TO COMPLETE THEIR CHNA PART V, SECTION B, LINE 11 THE TOP THREE COMMUNITY HEALTH PRIORITIES TO BE ADDRESSED IN THE 2012-2017 PLAN ARE * TEEN PREGNANCY *ALCOHOL/SUBSTANCE ABUSE, AND *OBESITY PLEASE SEE PART VI, LINE 5 FOR THE DESCRIPTION OF PROGRAMS IN PLACE TO ADDRESS THESE IDENTIFIED NEEDS ALONG WITH 2014 OBJECTIVES AND 2014 MEASURABLE OUTCOMES PART VI, LINE 5 ALSO INCLUDES THE SYSTEM-WIDE MENTAL HEALTH AND ENROLLMENT STRATEGIES THAT ARE BEING USED BY EACH HOSPITAL IN THE SYSTEM IN ITS MOST RECENT CHNA, 3-5 NEEDS WERE ADDRESSED, AND THEN AN IMPLEMENTATION STRATEGY WAS CREATED TO ADDRESS THOSE NEEDS THERE ARE NO NEEDS THAT ARE NOT BEING ADDRESSED SOME OF THEM ARE BEING ADDRESSED BY PROGRAMS THAT DO NOT YET HAVE RESULTS TO REPORT, BUT THEY ARE STILL BEING ADDRESSED

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

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

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

Name and address	Type of Facility (describe)
PRESENCE CATON FARM IMMEDIATE CARE 7000 CATON FARM ROAD PLAINFIELD,IL 60586	IMMEDIATE CARE CTR
PRESENCE CATON FARM IMAGING CENTER 7000 CATON FARM ROAD PLAINFIELD,IL 60586	IMMEDIATE CARE CTR
PRESENCE PHYSICAL THERAPY 3000 W JEFFERSON ST JOLIET,IL 60435	IMMEDIATE CARE CTR
PRESENCE PHYSICAL THERAPY SERVICES 1280 WINDHAM PARKWAY ROMEOVILLE,IL 60446	IMMEDIATE CARE CTR
PRESENCE CENTER FOR WOUND CARE 301 NORTH MADISON ST JOLIET,IL 60435	IMMEDIATE CARE CTR
PRESENCE PHYSICAL THERAPYINDUSTRIAL REH 852 SHARP AVENUE SHOREWOOD,IL 60404	IMMEDIATE CARE CTR
PRESENCE HEALTH CTR-DIAGNOSTIC IMAGING 1416 SOUTH RANDALL ROAD GENEVA,IL 60134	IMMEDIATE CARE CTR
PRESENCE OCCUPATIONAL HEALTHDIABETES CT 87 NORTH AIRLITE STREET SUITE 130 ELGIN,IL 60123	IMMEDIATE CARE CTR
PRESENCE OUTPATIENT REHAB SERVICES 87 NORTH AIRLITE STREET ELGIN,IL 60123	IMMEDIATE CARE CTR
PRESENCE OCCUPATIONAL HEALTH 1320 N HIGHLAND SUITE B AURORA,IL 60506	IMMEDIATE CARE CTR
PRESENCE PHYSICAL THERAPY 1975 MELISSA LANE AURORA,IL 60506	IMMEDIATE CARE CTR
PRESENCE HEALTH INSTITUTE 1975 MELISSA LANE AURORA,IL 60506	IMMEDIATE CARE CTR
MERCY PROFESSIONAL BUILDING PHARMACY 1315 N HIGHLAND AURORA,IL 60506	IMMEDIATE CARE CTR
PRESENCE PHYSICAL REHAB & SPORT INJURY 2132 JEFFERSON STREET JOLIET,IL 60435	IMMEDIATE CARE CTR
PRESENCE PHYSICAL THERAPY SERVICES 1812 LINCOLN HIGHWAY NEW LENOX,IL 60451	IMMEDIATE CARE CTR

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility
(list in order of size, from largest to smallest)

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

Name and address	Type of Facility (describe)
PRESENCE PHYSICAL THERAPY SERVICES 15120 WALLIN DRIVE PLAINFIELD,IL 60544	IMMEDIATE CARE CTR
PRESENCE SLEEP DISORDER CENTER 2132 JEFFERSON STREET JOLIET,IL 60435	IMMEDIATE CARE CTR
PRESENCE PHYSICAL THERAPY SERVICES 7000 CATON FARM ROAD PLAINFIELD,IL 60586	IMMEDIATE CARE CTR
MEDCARE 24 HOUR ACUTE CARE 2250 WEST ALGONQUIN ROAD LAKE IN THE HILLS,IL 60156	IMMEDIATE CARE CTR
PRESENCE SLEEP LAB 412 SHERIDAN DANVILLE,IL 61832	IMMEDIATE CARE CTR
PRESENCE UNITED SAMARITANS OPEN MRI 412 SHERIDAN DANVILLE,IL 61832	IMMEDIATE CARE CTR
PRESENCE UNITED SAMARITANS ONCOLOGY CTR 806 NORTH LOGAN AVENUE DANVILLE,IL 61832	IMMEDIATE CARE CTR
PRESENCE YORKVILLE MEDICAL OFFICE BLDG 1500 SYCAMORE ROAD YORKVILLE,IL 60560	IMMEDIATE CARE CTR
PRESENCE MANTENO MEDCENTRE 501 S LOCUST STREET MANTENO,IL 60950	IMMEDIATE CARE CTR
PRESENCE MEDCENTRE EAST 455 WEST COURT STREET KANKAKEE,IL 60901	IMMEDIATE CARE CTR
PRESENCE MEDCENTRE WEST 555 WEST COURT STREET KANKAKEE,IL 60901	IMMEDIATE CARE CTR
PRESENCE MOMENCE MEDCENTRE 739 NORTH DIXIE HIGHWAY MOMENCE,IL 60954	IMMEDIATE CARE CTR
PRESENCE PEOTONE MEDCENTRE 117 SOUTH HARLEM AVENUE PEOTONE,IL 60468	IMMEDIATE CARE CTR
PRESENCE ST MARY'S REGIONAL CANCER CTR 100 PROVENA WAY BOURBONNAIS,IL 60914	IMMEDIATE CARE CTR
PRESENCE ST MARY'S IMAGING CENTER 100 PROVENA WAY BOURBONNAIS,IL 60914	IMMEDIATE CARE CTR

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility
(list in order of size, from largest to smallest)

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

Name and address	Type of Facility (describe)
PRESENCE ST MARY'S OCCUPATIONAL HEALTH 230 W JOHN CASEY ROAD BOURBONNAIS,IL 60914	IMMEDIATE CARE CTR
PRESENCE WELLNESS CENTER 21 HERITAGE DRIVE BOURBANNAIS,IL 60914	IMMEDIATE CARE CTR
PRESENCE CENTER FOR HEALTHY AGING 401 EAST UNIVERSITY SUITE 102 CHAMPAIGN,IL 61820	IMMEDIATE CARE CTR
PRESENCE REGIONAL EMS 408 S NEIL STREET CHAMPAIGN,IL 61820	IMMEDIATE CARE CTR
PRO AMBULANCE SERVICES 408 S NEIL STREET CHAMPAIGN,IL 61820	IMMEDIATE CARE CTR

Schedule I
(Form 990)

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

OMB No 1545-0047
2014
Open to Public
Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
PRESENCE HOSPITALS PRV

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
(1) SmileHealthy 819 Bloomington Rd Champaign,IL 61820	14-1880824	501(c)3	30,925				Donation
(2) C-U Marathon Clinic LLC 204 S State St Champaign,IL 61820	36-2166964	501(c)3	30,000				Donation
(3) Aseptico Inc 8333 216th Street SE woodinville,WA 98072			8,804				Donation
(4) Aurora University 347 South Gladstone Avenue Aurora,IL 60506		501(c)3	6,634				Donation

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

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

Part III

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

(a)Type of grant or assistance	(b)Number of recipients	(c)Amount of cash grant	(d)Amount of non-cash assistance	(e)Method of valuation (book, FMV, appraisal, other)	(f)Description of non-cash assistance
(1) SCHOLARSHIPS	37	59,211			

Part IV

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

Return Reference	Explanation
Form Sch 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 PRESENCE 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 PRESENCE 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 PRESENCE 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)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

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

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

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization
PRESENCE HOSPITALS PRV

Employer identification number

36-4195126

Part I

Questions Regarding Compensation

	Yes	No
<div><div>1a</div><div>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><div><div><input type="checkbox"/> First-class or charter travel</div><div><input type="checkbox"/> Travel for companions</div><div><input type="checkbox"/> Tax idemnification and gross-up payments</div><div><input type="checkbox"/> Discretionary spending account</div></div><div><div><input type="checkbox"/> Housing allowance or residence for personal use</div><div><input type="checkbox"/> Payments for business use of personal residence</div><div><input type="checkbox"/> Health or social club dues or initiation fees</div><div><input type="checkbox"/> Personal services (e g , maid, chauffeur, chef)</div></div></div></div>		
<div><div>b</div><div>If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain.</div></div>	1b	
<div><div>2</div><div>Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?</div></div>	2	
<div><div>3</div><div>Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.</div><div><div><div><input checked="" type="checkbox"/> Compensation committee</div><div><input checked="" type="checkbox"/> Independent compensation consultant</div><div><input type="checkbox"/> Form 990 of other organizations</div></div><div><div><input type="checkbox"/> Written employment contract</div><div><input checked="" type="checkbox"/> Compensation survey or study</div><div><input checked="" type="checkbox"/> Approval by the board or compensation committee</div></div></div></div>		
<div><div>4</div><div>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:</div></div>		
<div><div>a</div><div>Receive a severance payment or change-of-control payment?</div></div>	4a	No
<div><div>b</div><div>Participate in, or receive payment from, a supplemental nonqualified retirement plan?</div></div>	4b	No
<div><div>c</div><div>Participate in, or receive payment from, an equity-based compensation arrangement?</div></div> <div>If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.</div>	4c	No
<div><div></div><div>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</div></div>		
<div><div>5</div><div>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:</div></div>		
<div><div>a</div><div>The organization?</div></div>	5a	No
<div><div>b</div><div>Any related organization?</div></div> <div>If "Yes," to line 5a or 5b, describe in Part III.</div>	5b	No
<div><div>6</div><div>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:</div></div>		
<div><div>a</div><div>The organization?</div></div>	6a	No
<div><div>b</div><div>Any related organization?</div></div> <div>If "Yes," to line 6a or 6b, describe in Part III.</div>	6b	No
<div><div>7</div><div>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.</div></div>	7	No
<div><div>8</div><div>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 Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III.</div></div>	8	No
<div><div>9</div><div>If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?</div></div>	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) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual

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

Part III **Supplemental Information**

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

Return Reference	Explanation
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Additional Data

Software ID:

Software Version:

EIN: 36-4195126

Name: PRESENCE HOSPITALS PRV

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred in prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 SANDRA BRUCE, PRESIDENT/CEO & DIRECTOR	(i)	0	0	0	0	0	0	0
	(ii)	1,097,653	0	355,325	5,200	20,464	1,478,642	0
1 ANTHONY J FILER, TREASURER	(i)	0	0	0	0	0	0	0
	(ii)	682,424	0	123,757	146,460	39,419	992,060	78,612
2 JEANNIE FREY, SECRETARY	(i)	0	0	0	0	0	0	0
	(ii)	474,603	0	63,709	104,089	28,515	670,916	43,893
3 PATRICK QUINN, ASSISTANT TREASURER	(i)	0	0	0	0	0	0	0
	(ii)	239,708	0	30,943	23,958	24,645	319,254	18,512
4 JULIE ROKNICH, ASSISTANT SECRETARY	(i)	0	0	0	0	0	0	0
	(ii)	196,072	0	0	7,126	20,909	224,107	0
5 JARED ROGERS MD, CMO	(i)	350,249	0	16,521	0	12,484	379,254	0
	(ii)	0	0	0	0	0	0	0
6 JACQUELINE MEDLAND, REGIONAL CHIEF NURSING OFFICER	(i)	249,824	0	568	0	19,806	270,198	0
	(ii)	0	0	0	0	0	0	0
7 JANICE NEMRI, CAO	(i)	264,892	0	22,240	0	12,449	299,581	27,959
	(ii)	0	0	0	0	0	0	0
8 CATHERINE EMANUEL, REG VP STRATEGIC PLG BUS DEV	(i)	249,428	0	3,254	0	639	253,321	0
	(ii)	0	0	0	0	0	0	0
9 MOLLY NICHOLSON, REGIONAL CNO	(i)	199,021	0	14,410	0	18,655	232,086	0
	(ii)	0	0	0	0	0	0	0
10 CARMEN ROCCO MD, ANESTHESIOLOGIST	(i)	160,082	0	0	0	0	160,082	0
	(ii)	0	0	0	0	0	0	0
11 JENNIFER CORD, REGIONAL VP OPERATIONS	(i)	160,877	0	14,417	0	21,133	196,427	0
	(ii)	0	0	0	0	0	0	0
12 LISA LAGGER, REGIONAL CHIEF REL OFFICER	(i)	211,545	0	52,640	0	13,333	277,518	0
	(ii)	0	0	0	0	0	0	0
13 DAVID FRANZBLAU MD, REGIONAL CMO	(i)	375,326	0	2,899	0	13,400	391,625	0
	(ii)	0	0	0	0	0	0	0
14 CONNIE NOLTEMEYER, REGIONAL QUALITY LEADER	(i)	146,616	2,851	1,105	0	1,772	152,344	0
	(ii)	0	0	0	0	0	0	0
15 ANIL GOPINATH MD, REGIONAL CHIEF MEDICAL OFFICER	(i)	156,326	25,000	14,406	0	9,366	205,098	0
	(ii)	0	0	0	0	0	0	0
16 GRACE MCBRIDE, REGIONAL CHIEF NURSING OFFICER	(i)	138,736	12,500	49,636	0	8,005	208,877	0
	(ii)	0	0	0	0	0	0	0
17 JOSEPH DANNA MD, REGIONAL MEDICAL DIRECTOR	(i)	280,019	0	1,887	0	20,597	302,503	0
	(ii)	0	0	0	0	0	0	0
18 TIMOTHY DAUGHTERY, REGIONAL CHIEF GROWTH OFFICER	(i)	189,420	0	476	0	13,277	203,173	0
	(ii)	0	0	0	0	0	0	0
19 SURENDRA GULATI MD, PHYSICIAN	(i)	471,756	0	3,298	0	13,944	488,998	0
	(ii)	0	0	0	0	0	0	0

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

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred in prior Form 990
	(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
21 LESLIE MASOOD MD, NEUROLOGIST	(i) 345,359 (ii) 0	(i) 0 (ii) 0	(i) 5,231 (ii) 0	(i) 0 (ii) 0	(i) 20,475 (ii) 0	(i) 371,065 (ii) 0	(i) 0 (ii) 0
1 MICHAEL PANUSKA MD, MEDICAL DIRECTOR	(i) 288,779 (ii) 0	(i) 0 (ii) 0	(i) 5,453 (ii) 0	(i) 0 (ii) 0	(i) 14,603 (ii) 0	(i) 308,835 (ii) 0	(i) 0 (ii) 0
2 MOUHANNAD KANTAR MD, FAMILY MEDICINE	(i) 186,227 (ii) 0	(i) 128,651 (ii) 0	(i) 522 (ii) 0	(i) 0 (ii) 0	(i) 18,914 (ii) 0	(i) 334,314 (ii) 0	(i) 0 (ii) 0
3 ZIAD ALAANI MD, NEUROLOGIST	(i) 281,090 (ii) 0	(i) 0 (ii) 0	(i) 1,264 (ii) 0	(i) 0 (ii) 0	(i) 22,195 (ii) 0	(i) 304,549 (ii) 0	(i) 0 (ii) 0
4 AMY STEVENS, FORMER - COO	(i) 306,561 (ii) 0	(i) 0 (ii) 0	(i) 0 (ii) 0	(i) 35,239 (ii) 0	(i) 0 (ii) 0	(i) 341,800 (ii) 0	(i) 0 (ii) 0
5 EILEEN GILLESPIE, FMR - VP OF OPERATIONS/CNO	(i) 99,020 (ii) 0	(i) 0 (ii) 0	(i) 8,584 (ii) 0	(i) 0 (ii) 0	(i) 11,727 (ii) 0	(i) 119,331 (ii) 0	(i) 0 (ii) 0

SCHEDULE M
(Form 990)

Department of the Treasury
Internal Revenue Service

Noncash Contributions

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

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization
PRESENCE HOSPITALS PRV

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 noncash contribution amounts
1 Art—Works of art				
2 Art—Historical treasures				
3 Art—Fractional interests				
4 Books and publications				
5 Clothing and household goods				
6 Cars and other vehicles				
7 Boats and planes				
8 Intellectual property				
9 Securities—Publicly traded	X	3	147,602	Stock Price
10 Securities—Closely held stock				
11 Securities—Partnership, LLC, or trust interests				
12 Securities—Miscellaneous				
13 Qualified conservation contribution—Historic structures				
14 Qualified conservation contribution—Other				
15 Real estate—Residential				
16 Real estate—Commercial				
17 Real estate—Other				
18 Collectibles				
19 Food inventory				
20 Drugs and medical supplies				
21 Taxidermy				
22 Historical artifacts				
23 Scientific specimens				
24 Archeological artifacts				
25 Other ▶ (Misc)	X	18	160,076	Cost
26 Other ▶ ()				
27 Other ▶ ()				
28 Other ▶ ()				

29

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

30a

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

30a

Yes

No

b

If "Yes," describe the arrangement in Part II

31

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

31

Yes

No

32a

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

32a

Yes

No

b

If "Yes," describe in Part II

33

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

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

Cat No 51227J

Schedule M (Form 990) (2014)

Part II

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

Return Reference	Explanation
Schedule M, Part I, Line 25	The MISCellaneous contributions amount of \$160,076 consists of the following Equipment - Tent rental 57,000 Electrical services 6,500 Accounting Services 10,000 Produce TAB section for event 6,850 Grocery Raffle 13,000 Gas Cards 500 Tickets to Sporting Events 840 22,000 SF Warehouse space 20,000 weekend stay Wyndam Grant Chicago riverfront 1,400 Promotion / Advertising all year for foundation event 6,800 400 Kids kits, items for grilling, 6 carts, 2 rockers 6,000 week stay in Harbor Springs, MI/tickets 9,000 Print Trayliners (30,000) and Placemats (70,000) 6,131 Sound and Lighting for main stage, keyboard rental 10,255 400 Hot Chocolate, 120 Happy Meals,etc 5,800

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on
Form 990 or 990-EZ or to provide any additional information.
▶ Attach to Form 990 or 990-EZ.
▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at
www.irs.gov/form990.

OMB No 1545-0047

2014

Open to Public
Inspection

Name of the organization PRESENCE HOSPITALS PRV	Employer identification number 36-4195126
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990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990 Part VI SECTION A, QUESTION 6	THE SOLE MEMBER OF PRESENCE HOSPITALS PRV IS PRESENCE PRV HEALTH
Form 990 Part VI SECTION A, QUESTIONS 7A & 7B	PRESENCE PRV HEALTH AS THE SOLE MEMBER OF PRESENCE HOSPITALS PRV HAS THE POWER TO REMOVE A ND APPOINT MEMBERS OF THE BOARD AND RESERVES THE RIGHT TO MAKE GOVERNANCE DECISIONS FOR PRE SENCE HOSPITALS PRV
Form 990 Part VI SECTION B, QUESTION 11B	THE DATA AND INFORMATION NECESSARY TO PREPARE THE FORM 990 WAS COMPILED BY Presence HEALTH 'S ACCOUNTING GROUP KPMG, AS EXTERNAL TAX PREPARERS, USED THIS INFORMATION TO PREPARE THE FORM 990, WHICH IS REVIEWED BY THE PRESENCE HEALTH LEGAL DEPARTMENT THE FINAL FORM 990 I S PROVIDED TO THE CORPORATION'S BOARD OF DIRECTORS FOR REVIEW PRIOR TO FILING
Form 990 Part VI SECTION B, QUESTIONS 12A, 12B, & 12C	THE PURPOSE OF THE CONFLICT OF INTEREST POLICY IS TO PROTECT THE INTERESTS OF PRESENCE HEA LTH NETWORK AND ALL OF ITS AFFILIATED MINISTRIES (COLLECTIVELY "PRESENCE HEALTH") WHEN IT IS CONTEMPLATING ENTERING INTO A TRANSACTION OR ARRANGEMENT THAT MIGHT BENEFIT THE PRIVATE INTEREST OF ANY DIRECTOR, TRUSTEE, OFFICER, CORPORATE MEMBER APPOINTEE, MEMBER OF A COMMI TTEE WITH BOARD-DELEGATED POWERS, SENIOR LEADERS, AND OTHERS IN A RECENT POSITION TO EXERC ISE SUBSTANTIAL INFLUENCE OVER PRESENCE HEALTH ("INTERESTED PERSONS"), AND CLARIFY THE STA NDARDS OF CONDUCT, DUTIES AND OBLIGATIONS OF INTERESTED PERSONS IN THE CONTEXT OF POTENTIA L CONFLICTS OF INTEREST BY PROVIDING A METHOD FOR DISCLOSING AND RESOLVING SUCH POTENTIAL CONFLICTS NO PRESENCE HEALTH ENTITY WILL ENGAGE IN ANY CONTRACT, TRANSACTION OR ARRANGEME NT INVOLVING A CONFLICT OF INTEREST UNLESS DISINTERESTED MEMBERS OF THE APPLICABLE BOARD O F DIRECTORS OR OTHER GOVERNING BODY DETERMINE BY A MAJORITY VOTE THAT APPROPRIATE SAFEGUAR DS TO PROTECT THE CHARITABLE MISSION OF PRESENCE HEALTH HAVE BEEN IMPLEMENTED TO FACILITA TE THIS POLICY , ALL INTERESTED PERSONS HAVE A CONTINUING OBLIGATION TO PROMPTLY DISCLOSE T HE EXISTENCE AND NATURE OF ANY ACTUAL, APPARENT, OR POTENTIAL CONFLICTS OF INTEREST HE/SHE MAY HAVE ALL DISCLOSURES MUST BE PROVIDED TO THE SY STEM COMPLIANCE OFFICER AND GENERAL C OUNSEL IN A WRITTEN DESCRIPTION OF THE MATERIAL FACTS DISCLOSURE SHALL BE ON A CONFLICTS OF INTEREST QUESTIONNAIRE OR SIMILAR FORMAT AS DESCRIBED IN THE CONFLICTS OF INTEREST POLI CY ALL INTERESTED PERSONS SHALL ALSO COMPLETE A QUESTIONNAIRE BASED ON THE ASSUMPTION OF THE BOARD (OR OTHER RELEVANT) POSITION, AND THEREAFTER ON AT LEAST AN ANNUAL BASIS OR WHEN AN ACTUAL, APPARENT, OR POTENTIAL CONFLICT ARISES AT ANY TIME THAT AN ACTUAL, APPARENT O R A POTENTIAL CONFLICT OF INTEREST IS IDENTIFIED TO THE CORPORATION'S BOARD OF DIRECTORS, WHETHER THROUGH THE VOLUNTARY SUBMISSION OF A DISCLOSURE STATEMENT BY AN INTERESTED PERSON , OR BY A DISCLOSURE BY A PERSON OTHER THAN THE SUBJECT INTERESTED PERSON, THE CORPORATION 'S BOARD OR APPLICABLE COMMITTEE SHALL REVIEW THE MATTER AND DETERMINE WHETHER A CONFLICT OF INTEREST EXISTS ONCE ALL NECESSARY INFORMATION HAS BEEN OBTAINED, ONLY DISINTERESTED D IRECTORS/COMMITTEE MEMBERS VOTE TO DETERMINE WHETHER A CONFLICT OF INTEREST EXISTS IF A C ONFLICT IS FOUND TO EXIST THE INTERESTED PERSON WILL GENERALLY BE REQUIRED TO RECUSE HIM O R HERSELF DURING ANY MEETING IN WHICH THE BOARD OF DIRECTORS OR APPLICABLE COMMITTEE CONDU CTS THE EVALUATION OF THE SUBJECT TRANSACTION, EXCEPT TO ANSWER QUESTIONS AS MAY BE NECESS ARY TO ENSURE THAT THE PRESENCE HEALTH OPERATES IN A MANNER CONSISTENT WITH ITS CHARITABL E PURPOSES AND THAT IT DOES NOT ENGAGE IN ACTIVITIES THAT COULD JEOPARDIZE ITS EXEMPT STAT US, TRANSACTIONS INVOLVING INTERESTED PERSONS ARE ONLY APPROVED IF, AFTER EXERCISING REASO NABLE DUE DILIGENCE, THE BOARD DETERMINES THEY ARE FAIR AND REASONABLE, TAKING INTO ACCOUN T FACTORS SUCH AS WHETHER PRESENCE HEALTH COULD OBTAIN A MORE ADVANTAGEOUS CONTRACT, TRANS ACTION OR ARRANGEMENT HOWEVER, LENDING MONEY OR GUARANTYING AN OBLIGATION OF A DIRECTOR, OFFICER, OR EMPLOYEE OF PRESENCE HEALTH (EXCLUSIVE OF CUSTOMARY INSURANCE COVERAGE FOR ACT S DONE IN CONNECTION WITH SUCH INDIVIDUAL'S SERVICE TO OR EMPLOYMENT BY PRESENCE HEALTH) I S STRICTLY PROHIBITED
Form 990 Part VI SECTION B, QUESTIONS 15A & 15B	THE COMPENSATION COMMITTEE OR OTHER AUTHORIZED COMMITTEE OF THE BOARD, NONE OF WHICH HAVE A CONFLICT OF INTEREST WITH RESPECT TO THE COMPENSATION ARRANGEMENT, WAS ACCOUNTABLE FOR S ETTING REASONABLE COMPENSATION PACKAGES FOR THE CEO AND KEY EMPLOYEES THE COMMITTEE DEVEL OPED, CONSISTENT WITH PRESENCE HOSPITAL PRV'S PHILOSOPHY AND PRINCIPLES, THE ANNUAL PERFOR MANCE GOALS AND CRITERIA TO BE USED IN DETERMINING MERIT INCREASES AND VARIABLE COMPENSATI ON CRITERIA FOR THE CEO AND KEY EMPLOYEES THE COMMITTEE ALSO REVIEWED APPROPRIATE COMPARA BILITY DATA PREPARED BY AN INDEPENDENT CONSULTANT THAT UTILIZED NATIONAL NONPROFIT COMPENS ATION SURVEYS IN DETERMINING THE CEO'S AND KEY EMPLOYEES' COMPENSATIONS THE COMMITTEE'S W RITTEN RECORDS INCLUDE THE (1) TERMS OF THE ARRANGEMENT WITH THE DISQUALIFIED PERSON (INCL UDING THE DATE THE ARRANGEMENT WAS APPROVED), AND (2) A DESCRIPTION OF THE COMPARABLE DATA RELIED ON BY THE COMMITTEE KEY DELIBERATIONS OF THE COMMITTEE, INCLUDING (A) THE TERMS OF THE TRANSACTION THAT WAS APPROVED AND THE DATE IT WAS APPROVED, (B) THE MEMBERS OF THE COMMITTEE WHO WERE PRESENT DURING DEBATE ON THE TRANSACTION THAT WAS APPROVED AND THOSE WH O VOTED ON IT, (C) THE COMPARABILITY DATA OBTAINED AND RELIED UPON BY THE COMMITTEE AND HO W THE DATA WAS OBTAINED, AND (D) ANY ACTIONS TAKEN WITH RESPECT TO CONSIDERATION OF THE TR ANSACTION BY ANYONE WHO IS OTHERWISE A MEMBER OF THE COMMITTEE BUT WHO HAD A CONFLICT OF I NTEREST WITH RESPECT TO THE TRANSACTION ARE ALSO DOCUMENTED IN MINUTES, WHICH ARE APPROVED AT THE NEXT COMMITTEE MEETING
Form 990 Part VI SECTION C, QUESTION 19	GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICIES, AND FINANCIAL STATEMENTS ARE AVAILABLE TO THE PUBLIC UPON REQUEST
Form 990 Part XI Line 9, OTHER CHANGE IN NET ASSET OR FUND BALANCE	Decrease in Temporarily Restricted Assets (1,148,000) Decrease in permanently restricted a ssets (20,000) TRANSFERS TO AFFILIATES (60,121,000) BOOK/TAX INCOME DIFFERENCE WITH JOINT VENTURES (598,730) NET ASSETS RELEASED FROM RESTRICTIONS FOR PURCHASE OF LAND, BUILDINGS A ND EQUIPMENT (2,951,000) Income From Unconsolidated Entities (382,996) Other (6,542) --- -- ---- OTHER CHANGES IN NET ASSETS OR FUND BALANCES (LN 9) (58,560,276)

SCHEDULE R
(Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
▶ Attach to Form 990.
▶ Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization
PRESENCE HOSPITALS PRV

Employer identification number
36-4195126

Part I Identification of Disregarded Entities

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) PRESENCE HEALTH MGMT SERV ORG LLC 2380 E DEMPSTER AVE STE 236 DES PLAINES, IL 60016 46-3100255	HEALTH MGMT	IL	0	0	PRHCC
(2) PRESENCE HEALTH PARTNERS LLC 18927 HICKORY CREEK DRIVE MOKENA, IL 60448 46-3111349	MGD CARE CONT	IL	0	0	PR HOSP PRV
(3) VERMILLION COUNTY SURGERY CENTER LLC 26 W NEWELL DANVILLE, IL 61834 80-0811427	MEDICAL SERV	IL	-446,328	4,868,246	PR HOSP PRV

Part II Identification of Related Tax-Exempt Organizations

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
See Additional Data Table							

Part III

Identification of Related Organizations Taxable as a Partnership

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512- 514)	(f) Share of total income	(g) Share of end-of- year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K- 1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) BELMONT HARLEM SURG 41-2237162	MEDICAL SERVICE	IL	PHS	RELATED				No			No	
(2) RES HLTH SLEEP C 26-1519627	MEDICAL SERVICE	IL	PHS	RELATED				No			No	
(3) RES HLTH SLEEP C 26-1519556	MEDICAL SERVICE	IL	PHS	RELATED				No			No	
(4) RES HLTH SLEEP C 26-1519667	MEDICAL SERVICE	IL	PHS	RELATED				No			No	
(5) RES HLTH SLEEP C 26-2189763	MEDICAL SERVICE	IL	PHS	RELATED				No			No	
(6) ALVERNO LAB 20-3240648	MEDICAL SERVICE	IN	PHS	RELATED				No			No	
(7) PROF CLINICIAL LAB 30-0711211	MEDICAL SERVICE	IN	ACL LLC	RELATED				No			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	(i) Section 512 (b)(13) controlled entity?	
								Yes	No
See Additional Data Table									

Part V

Transactions With Related Organizations

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

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

1

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

a

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

b

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

c

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

d

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

e

Loans or loan guarantees by related organization(s)

f

Dividends from related organization(s)

g

Sale of assets to related organization(s)

h

Purchase of assets from related organization(s)

i

Exchange of assets with related organization(s)

j

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

k

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

l

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

m

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

n

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

o

Sharing of paid employees with related organization(s)

p

Reimbursement paid to related organization(s) for expenses

q

Reimbursement paid by related organization(s) for expenses

r

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

s

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

Yes

No

1a

No

1b

No

1c

No

1d

No

1e

Yes

1f

No

1g

No

1h

No

1i

No

1j

No

1k

Yes

1l

No

1m

No

1n

No

1o

Yes

1p

Yes

1q

Yes

1r

No

1s

Yes

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) PRESENCE SERVICE CORPORATION	p	2,663,229	COST OF SERVICE

Part VI **Unrelated Organizations Taxable as a Partnership** Complete if the organization answered "Yes" on Form 990, Part IV, line 37.
Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization See instructions regarding exclusion for certain investment partnerships

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners section 501(c)(3) organizations?		(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		Yes	No	

Part VII

Supplemental Information

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

Return Reference	Explanation
SCHEDULE R, PART III	LISTED BELOW ARE THE COMPLETE NAMES AND STREET ADDRESSES FOR PART III 1) BELMONT HARLEM SURGERY CENTER, 3101 NORTH HARLEM 2) RES HLTH SLEEP C - CHICAGO NORTHWEST, 665 WEST NORTH AVE 3) RES HLTH SLEEP C - EVANSTON, 665 WEST NORTH AVE 4) RES HLTH SLEEP C - LINCOLN PK, 665 WEST NORTH AVE 5) RES HLTH SLEEP C - RIV FOREST, 665 WEST NORTH AVE 6) ALVERNO CLINICAL LABORATORIES, LLC, 2434 INTERSTATE PLAZA DRIVE 7) PROFESSIONAL CLINICAL LABORATORIES, LLC, 113 E 4TH ST

Additional Data

Software ID:

Software Version:

EIN: 36-4195126

Name: PRESENCE HOSPITALS PRV

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c) (3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
(1) PRESENCE HEALTH NETWORK 200 SOUTH WACKER CHICAGO, IL 60606 36-1649520	PARENT CORP	IL	501(C)(3)	11C	NA		
(1) MEDICARE VALUE PARTNERS 100 NORTH RIVER ROAD DES PLAINES, IL 60016 36-3495969	HEALTH CARE	IL	501(C)(3)	3	PRHCC	Yes	
(2) PRESENCE HOLY FAMILY MEDICAL CENTER 100 NORTH RIVER ROAD DES PLAINES, IL 60016 36-2439318	HEALTH CARE	IL	501(C)(3)	3	PRHCC	Yes	
(3) MOUNT LORETTA NURSING HOME INC 302 SWART HILL ROAD AMSTERDAM, NY 12010 14-1363014	Health Care	NY	501(C)(3)	3	RMNY	Yes	
(4) PRESENCE OUR LADY-RESURRECTION MED CTR 5645 WEST ADDISON STREET CHICAGO, IL 60634 36-2644178	HEALTH CARE	IL	501(C)(3)	3	PRHCC	Yes	
(5) PRESENCE CARE HOME 18927 HICKORY CREEK DRIVE 300 MOKENA, IL 60448 46-0483587	HEALTH CARE	IL	501(C)(3)	9	PLC	Yes	
(6) PRESENCE PRV HEALTH 1000 REMINGTON BLVD SUITE 100 BOLINGBROOK, IL 60440 36-3366652	MGMT SUPPORT	IL	501(C)(3)	11B	PHN		No
(7) PRESENCE HOME CARE 18927 HICKORY CREEK DRIVE 300 MOKENA, IL 60448 46-0483581	HEALTH CARE	IL	501(C)(3)	9	PLC	Yes	
(8) LAVERNA TERRACE HOUSING CORPORATION 18927 HICKORY CREEK DRIVE 300 MOKENA, IL 60448 36-3438977	SENIOR LIVING	IL	501(C)(3)	9	PPRVH	Yes	
(9) PROVENA SELF-INSURANCE TRUST 1000 REMINGTON BLVD SUITE 100 BOLINGBROOK, IL 60440 36-2987310	INSURANCE	IL	501(C)(3)	11C	NA	Yes	
(10) PRESENCE LIFE CONNECTIONS 18927 HICKORY CREEK DRIVE 300 MOKENA, IL 60448 37-1127787	HEALTH CARE	IL	501(C)(3)	7	PPRVH	Yes	
(11) PRESENCE BEHAVIORAL HEALTH 1820 SOUTH 25TH AVENUE BROADVIEW, IL 60155 36-2709982	HEALTH CARE	IL	501(C)(3)	3	PHS	Yes	
(12) PRESENCE AMBULATORY SERVICES 100 NORTH RIVER ROAD DES PLAINES, IL 60016 36-4286236	HEALTH CARE	IL	501(C)(3)	3	PRHCC	Yes	
(13) PRESENCE HEALTH FND BRD OF TRUSTEES 100 NORTH RIVER ROAD DES PLAINES, IL 60016 36-3330929	FUNDRAISING	IL	501(C)(3)	7	PRHCC	Yes	
(14) PRESENCE RHC CORPORATION 200 SOUTH WACKER CHICAGO, IL 60606 36-2235165	MGMT SUPPORT	IL	501(C)(3)	11	PHN		No
(15) PRESENCE HOME CARE SERVICES 5747 WEST DEMPSTER MORTON GROVE, IL 60053 36-2893936	HOME CARE	IL	501(C)(3)	3	PRHCC	Yes	
(16) PRESENCE RESURRECTION MEDICAL CENTER 7435 WEST TALCOTT AVENUE CHICAGO, IL 60631 36-3330926	HEALTH CARE	IL	501(C)(3)	3	PRHCC	Yes	
(17) RESURRECTION NURSING HOME INC 90 NORTH MAIN STREET CASTLETON, NY 12033 14-1348691	HEALTH CARE	NY	501(C)(3)	3	RMNY	Yes	
(18) PRESENCE RHC SENIOR SERVICES 100 NORTH RIVER ROAD DES PLAINES, IL 60016 23-7061646	HEALTH CARE	IL	501(C)(3)	3	PRHCC	Yes	
(19) PRESENCE HEALTHCARE SERVICES 100 NORTH RIVER ROAD DES PLAINES, IL 60016 36-3330928	HEALTH CARE	IL	501(C)(3)	3	PRHCC	Yes	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c) (3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity? YesNo	
(21) PRESENCE SAINT FRANCIS HOSPITAL 355 RIDGE AVENUE EVANSTON, IL 60202 36-2167800	HEALTH CARE	IL	501(C)(3)	3	PRHCC	Yes	
(1) ST FRANCIS HOSPITAL AUX OF EVANSTON 355 RIDGE AVENUE EVANSTON, IL 60202 36-6143349	FUNDRAISING	IL	501(C)(3)	7	PSFH	Yes	
(2) PRESENCE SAINTS MARY & ELIZABETH MED CTR 2233 WEST DIVISION STREET CHICAGO, IL 60622 36-2171079	HEALTH CARE	IL	501(C)(3)	3	PRHCC	Yes	
(3) PRESENCE SAINT JOSEPH HOSPITAL CHICAGO 2900 NORTH LAKE SHORE DRIVE CHICAGO, IL 60657 36-3200170	HEALTH CARE	IL	501(C)(3)	3	PRHCC	Yes	
(4) PRESENCE NAZARETHVILLE 300 NORTH RIVER ROAD DES PLAINES, IL 60016 36-2801392	HEALTH CARE	IL	501(C)(3)	11B	PRHC SNR SRV	Yes	
(5) ARTHUR MERKLE-CLARA KNIPPRATH NURSING HO 1190 E 2900 N ROAD CLIFTON, IL 60927 36-2841358	HEALTH CARE	IL	501(C)(3)	9	PLC	Yes	
(6) RAINBOW HOSPICE AND PALLATIVE CARE 1550 BISHOP COURT MOUNT PROSPECT, IL 60056 36-3296367	HEALTH CARE	IL	501(C)(3)	9	PHCS	Yes	

Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership

(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) Disproprrtionate 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	
BELMONT HARLEM SURG 41-2237162	MEDICAL SERVICE	IL	PHS		RELATED				No			No	
RES HLTH SLEEP C 26- 1519627	MEDICAL SERVICE	IL	PHS		RELATED				No			No	
RES HLTH SLEEP C 26- 1519556	MEDICAL SERVICE	IL	PHS		RELATED				No			No	
RES HLTH SLEEP C 26- 1519667	MEDICAL SERVICE	IL	PHS		RELATED				No			No	
RES HLTH SLEEP C 26- 2189763	MEDICAL SERVICE	IL	PHS		RELATED				No			No	
ALVERNO LAB 20- 3240648	MEDICAL SERVICE	IN	PHS		RELATED				No			No	
PROF CLINICIAL LAB 30- 0711211	MEDICAL SERVICE	IN	ACL LLC		RELATED				No			No	

Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal Domicile (State or Foreign Country)	(d) Direct Controlling Entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?
Yes	No							
L GILBRAITH INSURANCE SPC LTD 68 W BAY ROAD PO BOX 1109 GRAND CAYMAN CJ	INSURANCE	CJ	PRHCC	C Corp			Yes	
PROVENA HEALTH ASSURANCE SPC 23 LIME TREE BAY AVE PO BOX 1051 GRAND CAYMAN CJ 98-0420054	INSURANCE	CJ	PPRVH	C Corp			Yes	
PRESENCE PROPERTIES 100 NORTH RIVER ROAD DES PLAINES, IL 60016 36-3520630	MEDICAL	IL	PR VENTURES INC	C Corp			Yes	
PRESENCE SERVICE CORPORATION 2380 E DEMPSTER STREET DES PLAINES, IL 60016 36-4314354	MEDICAL	IL	PHPRV	C Corp	-20,275,655	12,308,935	100 000 %	Yes
PRESENCE VENTURES INC 100 NORTH RIVER ROAD DES PLAINES, IL 60016 37-1168085	MEDICAL	IL	PPRVH	C Corp			Yes	
RESURRECTION MEDICAL CENTER AUXILIARY 7435 WEST TALCOTT AVENUE CHICAGO, IL 60631 36-6109825	FUNDRAISING	IL	PR MED CTR	C Corp			Yes	
RESURRECTION MINISTRIES OF NEW YORK 90 NORTH MAIN STREET CASTLETON, NY 12033 14-1720818	PARENT CORP	NY	PRHCC	C Corp			Yes	
PRESENCE HEALTH CARE PREFERRED 100 NORTH RIVER ROAD DES PLAINES, IL 60016 36-3974620	MGD CARE CONTRACT	IL	PRHCC	C Corp			Yes	