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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](http://www.irs.gov/form990)

OMB No 1545-0047

2014

Open to Public Inspection

A For the 2014 calendar year, or tax year beginning 10-01-2014, and ending 09-30-2015

B Check if applicable

☐ Address change

☐ Name change

☐ Initial return

☐ Final return/terminated

☐ Amended return

☐ Application pending

C Name of organization  
OSF HEALTHCARE SYSTEM

% MR MICHAEL ALLEN

Doing business as

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

800 NE GLEN OAK AVE

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

PEORIA, IL 61603

F Name and address of principal officer

MICHAEL ALLEN

800 NE GLEN OAK AVENUE

PEORIA,IL 61603

D Employer identification number

37-0813229

E Telephone number

(309) 655-2850

G Gross receipts \$ 2,164,280,745

I Tax-exempt status

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

J Website: WWW.OSFHEALTHCARE.ORG

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

L Year of formation 1880

M State of legal domicile IL

Part I Summary		
Activities & Governance	1 Briefly describe the organization's mission or most significant activities See Schedule O	
	2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets	
Revenue	3 Number of voting members of the governing body (Part VI, line 1a)	3 11
	4 Number of independent voting members of the governing body (Part VI, line 1b)	4 7
	5 Total number of individuals employed in calendar year 2014 (Part V, line 2a)	5 15,333
	6 Total number of volunteers (estimate if necessary)	6 1,740
	7a Total unrelated business revenue from Part VIII, column (C), line 12	7a 12,821,356
	b Net unrelated business taxable income from Form 990-T, line 34	7b 4,274,453
Expenses	8 Contributions and grants (Part VIII, line 1h)	Prior Year 14,475,010Current Year 11,379,529
	9 Program service revenue (Part VIII, line 2g)	1,853,970,0062,056,021,174
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	36,459,02532,332,165
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	53,432,28161,836,476
	12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	1,958,336,3222,161,569,344
	13 Grants and similar amounts paid (Part IX, column (A), lines 1–3)	888,1781,580,471
Net Assets or Fund Balances	14 Benefits paid to or for members (Part IX, column (A), line 4)	00
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	971,235,5001,057,125,886
	16a Professional fundraising fees (Part IX, column (A), line 11e)	00
	b Total fundraising expenses (Part IX, column (D), line 25) 6,133,033	
	17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	815,685,912888,968,263
	18 Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	1,787,809,5901,947,674,620
	19 Revenue less expenses Subtract line 18 from line 12	170,526,732213,894,724
		Beginning of Current YearEnd of Year
	20 Total assets (Part X, line 16)	2,692,360,0063,078,467,872
	21 Total liabilities (Part X, line 26)	1,758,257,6782,073,361,611
	22 Net assets or fund balances Subtract line 21 from line 20	934,102,3281,005,106,261

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge

Sign Here

Signature of officer

SISTER DIANE MARIE MCGREW OSF TREASURER

Date

2016-08-13

Print/Type preparer's name

MOLLIE P LONGHOUSE

Preparer's signature

MOLLIE P LONGHOUSE

Date

Check ☐ 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

For Paperwork Reduction Act Notice, see the separate instructions.

Cat No 11282Y

Form 990 (2014)

Part III

Statement of Program Service Accomplishments

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

☐ ☒

1

Briefly describe the organization’s mission

OSF HEALTHCARE SYSTEM IS A CATHOLIC INTEGRATED HEALTH CARE DELIVERY SYSTEM WHICH DURING ITS FISCAL YEAR 2015 OPERATED 11 HOSPITALS (9 INCLUDED IN THIS RETURN AND 2 THAT FILE SEPARATE RETURNS), 5 HOME HEALTH AGENCIES, 4 HOSPICES, AND EMPLOYED APPROXIMATELY 690 PHYSICIANS ALL PATIENTS ARE ACCEPTED REGARDLESS OF THEIR ABILITY TO PAY ALL FACILITIES, SERVICES, PHYSICIANS AND OTHER PROFESSIONAL STAFF OF OSF HEALTHCARE SYSTEM SERVE ALL PATIENTS WITHOUT REGARD TO RACE, RELIGION, AGE, SEX, NATIONAL ORIGIN, PAYER SOURCE OR ABILITY TO PAY THE BOARD OF DIRECTORS HAS ADOPTED CHARITY CARE POLICIES AND PROCEDURES WHICH APPLY FOR ALL FACILITIES AND SERVICES OF THE CORPORATION THE AVAILABILITY OF CHARITY CARE IS COMMUNICATED TO PATIENTS IN NUMEROUS WAYS, INCLUDING USE OF FINANCIAL COUNSELORS, PATIENT INFORMATION BROCHURES, AND NOTICES ON PATIENT BILLINGS CHARITY CARE APPLICATIONS AND INSTRUCTIONS ARE AVAILABLE ON WEBSITES MAINTAINED BY THE CORPORATION AND UPON A REQUEST MADE TO ANY OF THE CORPORAT

2

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

☐ Yes ☒ No

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

3

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

☐ Yes ☒ No

If "Yes," describe these changes on Schedule O

4

Describe the organization’s program service accomplishments for each of its three largest program services, as measured by expenses Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported

4a

(Code ) (Expenses \$ 580,857,631 including grants of \$ 1,326,792 ) (Revenue \$ 919,792,072 )

INPATIENT SERVICES - SEE SCHEDULE O

4b

(Code ) (Expenses \$ 549,644,152 including grants of \$ ) (Revenue \$ 872,158,783 )

OUTPATIENT SERVICES - SEE SCHEDULE O

4c

(Code ) (Expenses \$ 296,266,311 including grants of \$ ) (Revenue \$ 112,298,525 )

PHYSICIAN SERVICES - SEE SCHEDULE O

4d





















Other program services (Describe in Schedule O )

(Expenses \$ 245,261,458 including grants of \$ 253,679 ) (Revenue \$ 197,205,760 )

4e

Total program service expenses 1,672,029,552

Part IV Checklist of Required Schedules

	Yes	No
1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A 	1 Yes	
2 Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)? 	2 Yes	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I 	3	No
4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II 	4 Yes	
5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? If "Yes," complete Schedule C, Part III 	5	No
6 Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes," complete Schedule D, Part I 	6	No
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II 	7	No
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III 	8	No
9 Did the organization report an amount in Part X, line 21 for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? If "Yes," complete Schedule D, Part IV 	9	No
10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? If "Yes," complete Schedule D, Part V 	10 Yes	
11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable		
a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI 	11a Yes	
b Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII 	11b	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	No
18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II	18	No
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III	19	No
20a Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H 	20a Yes	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? 	20b Yes	

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	Yes	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? . . . .	24b		No
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? . . . . .	24c		No
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? . . . .	24d		No
25a	<b>Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.</b> Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i> . . . . .	25a		No
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i> . . . . .	25b		No
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? <i>If "Yes," complete Schedule L, Part II</i> . . . . .	26		No
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i> . . . . .	27		No
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions)			
a	A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> . . . . .	28a		No
b	A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> . . . . .	28b		No
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV</i> . . . . .	28c	Yes	
29	Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i> . . . .	29		No
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i> . . . . .	30		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	<b>Section 501(c)(3) organizations.</b> Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i> . . . . .	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? <b>Note.</b> 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	521	
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	15,333
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? <b>Note.</b> 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? If "No" to line 3b, provide an explanation in Schedule O	3b	Yes
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a	No
b	If "Yes," enter the name of the foreign country See instructions for filing requirements for 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	
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b	
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? <b>Note.</b> See the instructions for additional information the organization must report on Schedule O	13a	
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b	
c	Enter the amount of reserves on hand	13c	
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a	No
b	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O	14b	

Part VI

Governance, Management, and Disclosure

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

Check if Schedule O contains a response 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 . . . . .	11	
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 . . . . .	7	
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	Yes

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

		Yes	No
10a	Did the organization have local chapters, branches, or affiliates? . . . . .	10a	No
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	
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▶IL
18	Section 6104 requires an organization to make its Form 1023 (or 1024 if applicable), 990, and 990-T (501(c) (3)s only) available for public inspection. Indicate how you made these available. Check all that apply. <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 ▶MR MICHAEL ALLEN 800 NE Glen Oak Ave Peoria, IL 61603 (309) 655-7708

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

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

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

- 1a Complete this table for all persons required to be listed Report compensation for the calendar year ending with or within the organization's tax year
- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation Enter -0- in columns (D), (E), and (F) if no compensation was paid

List all of the organization's **current** key employees, if any See instructions for definition of "key employee "

List the organization's five **current** highest compensated employees (other than an officer, director, trustee or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations

List all of the organization's **former** officers, key employees, 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

(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) GERALD J MCSHANE MD ..... BOARD MEMBER	40 0 ..... 5 0	X						655,666	0	48,544
(2) JAMES W GIRARDY MD ..... BOARD MEMBER	40 0 ..... 3 0	X						165,750	0	0
(3) KEVIN D SCHOEPLEIN ..... VICE CHAIRPERSON, CEO	40 0 ..... 5 0	X		X				1,260,425	0	52,320
(4) SISTER AGNES JOSEPH WILLIAMS ..... ASSISTANT SECRETARY	40 0 ..... 0 5	X		X				4,800	0	0
(5) SISTER DIANE MARIE MCGREW OSF ..... PRESIDENT/TREASURER	40 0 ..... 1 0	X		X				4,800	0	0
(6) SISTER JUDITH ANN DUVALL OSF ..... CHAIRPERSON	40 0 ..... 0 5	X		X				4,800	0	0
(7) SISTER MARIA ELENA PADILLA ..... BOARD MEMBER	40 0 ..... 0 0	X						0	0	0
(8) SISTER ROSE THERESE MANN OSF ..... BOARD MEMBER	40 0 ..... 0 0	X						0	0	0
(9) SISTER THERESA ANN BRAZEAU ..... SECRETARY	40 0 ..... 1 0	X		X				4,800	0	0
(10) SISTER M MIKELA MEIDL FSGM ..... BOARD MEMBER	40 0 ..... 0 0	X						0	0	0
(11) BRIAN J SILVERSTEIN MD ..... BOARD MEMBER	3 0 ..... 0 0	X						41,486	0	0
(12) DANIEL E BAKER ..... SENIOR VP, CFO	40 0 ..... 5 0			X				579,882	0	50,061
(13) MICHAEL ALLEN ..... SENIOR VP, CFO	40 0 ..... 0 0			X				0	0	0
(14) DANIEL R FASSETT MD ..... PHYSICIAN, NEUROSURGERY	40 0 ..... 0 0					X		2,029,275	0	18,165

Part VII

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
(15) JEFFREY D KLOPPENSTEIN MD ..... PHYSICIAN, NEUROSURGERY	40 0 ..... 0 0					X		1,134,346	0	34,035
(16) ANDREW J TSUNG MD ..... PHYSICIAN, NEUROSURGERY	40 0 ..... 0 0					X		1,117,878	0	29,378
(17) BRIAN D SIPE MD ..... PHYSICIAN, ORTHOPEDICS	40 0 ..... 0 0					X		1,066,529	0	34,035
(18) JAMES L MCGEE ..... PHYSICIAN, ONCOLOGY	40 0 ..... 0 0					X		944,010	0	42,159

1b	Sub-Total . . . . .	▶			
c	Total from continuation sheets to Part VII, Section A . . . . .	▶			
d	Total (add lines 1b and 1c) . . . . .	▶	9,014,447	0	308,697

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▶1,209

		Yes	No
3	Did the organization list any <b>former</b> officer, director or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i> . . . . .	3	No
4	For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? <i>If "Yes," complete Schedule J for such individual</i> . . . . .	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
UNIV OF IL COLLEGE OF MEDICINE, PO BOX 4196 SPRINGFIELD, IL 627084196	TEACHING PHYSICIANS	21,389,559
HINSHAW CULBERTSON LLP, 8142 SOLUTIONS CENTER DR CHICAGO, IL 606778001	LEGAL	3,488,269
ASSOC ANESTHESIOLOGISTS SC, 8600 N STATE RT 91 SUITE 250 PEORIA, IL 616159452	ANESTHESIOLOGY SVS	2,700,113
PEPPER HAMILTON LLP, 300 TWO LOGAN SQUARE PHILADELPHIA, PA 191032799	LEGAL	2,080,579
MAYO CLINIC, PO BOX 4006 ROCHESTER, MN 55903	MEDICAL SERVICES	2,064,388
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 ▶74	

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				
	d	Related organizations . . . . . 1d	8,318,089			
	e	Government grants (contributions) 1e	2,789,299			
	f	All other contributions, gifts, grants, and similar amounts not included above 1f	272,141			
	g	Noncash contributions included in lines 1a-1f \$				
	h	Total. Add lines 1a-1f . . . . .	11,379,529			
Program Service Revenue	2a	NET PATIENT SERVICE REVENUE				
		Business Code				
		900099	2,043,277,835	2,043,277,835		
	b	LAB	4,566,893		4,566,893	
	c	AFFILIATED PURCHASING PROGRAM	561499	1,778,048	1,778,048	
	d	CONSULTING REVENUE	900099	6,230,610	6,230,610	
	e	INTEREST	900099	105,097	105,097	
	f	All other program service revenue	62,691		62,691	
	g	Total. Add lines 2a-2f . . . . .	2,056,021,174			
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts) . . . . .	31,940,825			31,940,825
	4	Income from investment of tax-exempt bond proceeds . . . . .	0			
	5	Royalties . . . . .	0			
	6a	Gross rents				
	b	Less rental expenses				
	c	Rental income or (loss)				
	d	Net rental income or (loss) . . . . .	223,557			223,557
	7a	Gross amount from sales of assets other than inventory				
	b	Less cost or other basis and sales expenses				
	c	Gain or (loss)				
	d	Net gain or (loss) . . . . .	391,340			391,340
	8a	Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18 . . . . .				
	b	Less direct expenses . . . . .				
	c	Net income or (loss) from fundraising events . . . . .	0			
	9a	Gross income from gaming activities See Part IV, line 19 . . . . .				
	b	Less direct expenses . . . . .				
	c	Net income or (loss) from gaming activities . . . . .	0			
	10a	Gross sales of inventory, less returns and allowances . . . . .				
	b	Less cost of goods sold . . . . .				
	c	Net income or (loss) from sales of inventory . . . . .	0			
		Miscellaneous Revenue				
	11a	CONTRACT PHARMACY	900099	13,743,647	13,743,647	
	b	TUITION	900099	13,141,619	13,141,619	
	c	CONTRACT SERVICES	900099	4,610,849	4,610,849	
	d	All other revenue . . . . .	30,116,804	26,681,190	78,017	3,357,597
	e	Total. Add lines 11a-11d . . . . .	61,612,919			
	12	Total revenue. See Instructions . . . . .	2,161,569,344	2,101,455,140	12,821,356	35,913,319

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.	1,326,792	1,326,792		
2	Grants and other assistance to domestic individuals. See Part IV, line 22.	253,679	253,679		
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.	1,942,688		1,942,688	
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.	820,455,067	719,149,384	99,906,173	1,399,510
8	Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions).	66,709,120	55,856,152	10,852,968	
9	Other employee benefits.	113,611,468	98,978,330	14,633,138	
10	Payroll taxes.	54,407,543	46,448,801	7,958,742	
11	Fees for services (non-employees):				
a	Management.	0			
b	Legal.	9,354,048	371,535	8,982,513	
c	Accounting.	485,100	336,772	148,328	
d	Lobbying.	0			
e	Professional fundraising services. See Part IV, line 17.	0			
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).	107,926,379	73,612,352	34,314,027	
12	Advertising and promotion.	5,077,202	4,555,916	436,753	84,533
13	Office expenses.	10,407,476	9,004,155	1,348,694	54,627
14	Information technology.	25,035,483	3,169,739	21,865,744	
15	Royalties.	0			
16	Occupancy.	15,961,903	15,214,155	740,614	7,134
17	Travel.	6,438,935	4,442,140	1,957,028	39,767
18	Payments of travel or entertainment expenses for any federal, state, or local public officials.	0			
19	Conferences, conventions, and meetings.	2,219,193	1,495,901	705,507	17,785
20	Interest.	35,698,120	270,864	35,427,256	
21	Payments to affiliates.	-68,735,947	-48,980,664	-19,755,283	
22	Depreciation, depletion, and amortization.	88,649,024	66,518,288	22,130,736	
23	Insurance.	24,530,661	24,078,868	451,793	
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	SUPPLIES	295,983,809	295,508,168	231,732	243,909
b	EQUIP RENTAL & MAINT	152,132,494	143,326,051	8,488,025	318,418
c	BAD DEBT	54,225,436	54,225,436		
d	MEDICAID FEES	55,417,715	55,417,715		
e	All other expenses	68,161,232	47,449,023	16,744,859	3,967,350
25	Total functional expenses. Add lines 1 through 24e.	1,947,674,620	1,672,029,552	269,512,035	6,133,033
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 checked="" type="checkbox"/> if following SOP 98-2 (ASC 958-720).	2,028,087	1,828,175	198,579	1,333

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 . . . . .			233,150,989	2	303,450,395
	3	Pledges and grants receivable, net . . . . .			0	3	0
	4	Accounts receivable, net . . . . .			370,176,513	4	389,422,978
	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 . . . . .			19,898,680	8	26,320,539
	9	Prepaid expenses and deferred charges . . . . .			7,360,958	9	38,173,880
	10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	10a	2,120,414,095			
	b	Less accumulated depreciation . . . . .	10b	1,245,775,451	851,700,965	10c	874,638,644
	11	Investments—publicly traded securities . . . . .			885,189,503	11	946,078,388
	12	Investments—other securities See Part IV, line 11 . . . . .			0	12	0
	13	Investments—program-related See Part IV, line 11 . . . . .			25,743,529	13	41,807,367
	14	Intangible assets . . . . .			22,031,356	14	27,587,783
	15	Other assets See Part IV, line 11 . . . . .			277,107,513	15	430,987,898
	16	Total assets. Add lines 1 through 15 (must equal line 34) . . . . .			2,692,360,006	16	3,078,467,872
Liabilities	17	Accounts payable and accrued expenses . . . . .			198,507,573	17	289,707,375
	18	Grants payable . . . . .			0	18	0
	19	Deferred revenue . . . . .			0	19	0
	20	Tax-exempt bond liabilities . . . . .			861,521,637	20	1,099,184,657
	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 . . . . .			698,228,468	25	684,469,579
	26	Total liabilities. Add lines 17 through 25 . . . . .			1,758,257,678	26	2,073,361,611
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 . . . . .			874,653,387	27	937,430,687
	28	Temporarily restricted net assets . . . . .			36,651,689	28	39,482,239
	29	Permanently restricted net assets . . . . .			22,797,252	29	28,193,335
	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 . . . . .			934,102,328	33	1,005,106,261
	34	Total liabilities and net assets/fund balances . . . . .			2,692,360,006	34	3,078,467,872

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	2,161,569,344
2	Total expenses (must equal Part IX, column (A), line 25) . . . . .	2	1,947,674,620
3	Revenue less expenses Subtract line 2 from line 1 . . . . .	3	213,894,724
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) . . . . .	4	934,102,328
5	Net unrealized gains (losses) on investments . . . . .	5	-32,848,438
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	-110,042,353
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	1,005,106,261

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		No
2b	Were the organization's financial statements audited by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	Yes	
2c	If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O	Yes	
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133? . . . . .	Yes	
3b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits	Yes	

SCHEDULE A  
(Form 990 or 990EZ)

Department of the  
Treasury  
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.  
▶ Attach to Form 990 or Form 990-EZ.  
▶ Information about Schedule A (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization OSF HEALTHCARE SYSTEM	Employer identification number 37-0813229
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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 <b>Part VI</b> 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 <b>Part VI</b> 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 <b>Part VI</b> 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 <b>Part VI</b> 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 <b>Type I or Type II only.</b> Was any added or substituted supported organization part of a class already designated in the organization's organizing document?	5b	
c <b>Substitutions only.</b> 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 <b>Part VI</b> .	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 <b>Part VI</b> .	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 <b>Part VI</b> .	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 <b>Part VI</b> .	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 <b>Part VI</b> 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 <b>Part VI</b> 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 <b>Part VI</b> 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 <b>Part VI</b> 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 <b>Part VI</b> 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 <b>line 2</b> below.			
b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete <b>line 3</b> 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> <b>Answer (a) and (b) below.</b>			
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 <b>Part VI identify those supported organizations and explain</b> 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 <b>Part VI</b> 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> <b>Answer (a) and (b) below.</b>			
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	<b>Adjusted Net Income</b> (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	<b>Total</b> (add lines 1a, 1b, and 1c)	1d	
e	<b>Discount</b> 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	<b>Minimum Asset Amount</b> (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	<b>Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	
7	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)		

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 C

(Form 990 or 990-EZ)

Department of the Treasury

Internal Revenue Service

Political Campaign and Lobbying Activities

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

▶ **Complete if the organization is described below. ▶ Attach to Form 990 or Form 990-EZ.**

▶ **Information about Schedule C (Form 990 or 990-EZ) and its instructions is at**

***www.irs.gov/form990.***

OMB No 1545-0047

2014

Open to Public Inspection

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

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

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

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

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

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

Name of the organization OSF HEALTHCARE SYSTEM	Employer identification number 37-0813229
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Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

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

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

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

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

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

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

Part II-A

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

- A
- Check ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures)
- B
- Check ☐ if the filing organization checked box A and "limited control" provisions apply

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)		(a) Filing organization's totals	(b) Affiliated group totals												
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)															
b Total lobbying expenditures to influence a legislative body (direct lobbying)															
c Total lobbying expenditures (add lines 1a and 1b)															
d Other exempt purpose expenditures															
e Total exempt purpose expenditures (add lines 1c and 1d)															
f Lobbying nontaxable amount Enter the amount from the following table in both columns															
<table><tr><td>If the amount on line 1e, column (a) or (b) is:</td><td>The lobbying nontaxable amount is:</td></tr><tr><td>Not over \$500,000</td><td>20% of the amount on line 1e</td></tr><tr><td>Over \$500,000 but not over \$1,000,000</td><td>\$100,000 plus 15% of the excess over \$500,000</td></tr><tr><td>Over \$1,000,000 but not over \$1,500,000</td><td>\$175,000 plus 10% of the excess over \$1,000,000</td></tr><tr><td>Over \$1,500,000 but not over \$17,000,000</td><td>\$225,000 plus 5% of the excess over \$1,500,000</td></tr><tr><td>Over \$17,000,000</td><td>\$1,000,000</td></tr></table>		If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:	Not over \$500,000	20% of the amount on line 1e	Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000	Over \$17,000,000	\$1,000,000		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:														
Not over \$500,000	20% of the amount on line 1e														
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000														
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000														
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000														
Over \$17,000,000	\$1,000,000														
g Grassroots nontaxable amount (enter 25% of line 1f)															
h Subtract line 1g from line 1a If zero or less, enter -0-															
i Subtract line 1f from line 1c If zero or less, enter -0-															
j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?		<input type="checkbox"/> Yes <input type="checkbox"/> No													

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

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

Part II-B

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

For each "Yes" response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.		(a)		(b)
		Yes	No	Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
a	Volunteers?		No	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?	Yes		
c	Media advertisements?		No	
d	Mailings to members, legislators, or the public?	Yes		
e	Publications, or published or broadcast statements?		No	
f	Grants to other organizations for lobbying purposes?		No	
g	Direct contact with legislators, their staffs, government officials, or a legislative body?	Yes		674,506
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?		No	
j	Total. Add lines 1c through 1i.			674,506
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b	If "Yes," enter the amount of any tax incurred under section 4912.			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912.			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?		No	

Part III-A

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

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

Part III-B

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

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

Part IV

Supplemental Information

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

Return Reference	Explanation
MAILING EXPENSES	PART II-B, LINE 1D THE ONLY COST OF MAILING RELATED TO LOBBYING EXPENSES IS RELATED TO THE COST OF STAMPS. THE TOTAL EXPENDITURES RELATED TO MAILING IS MINOR AND THE ACTUAL DOLLAR AMOUNT IS NOT READILY AVAILABLE.
LEGISLATIVE CONTACTS	PART II-B, LINE 1G SCHEDULE C, PART II-B, LINE 1G INCLUDES LOBBYING EXPENSES PAID TO VARIOUS NATIONAL HEALTH ASSOCIATIONS AS PART OF DUES AND SUBSCRIPTIONS IN THE AMOUNT OF \$274,506. IT ALSO INCLUDES DIRECT CONTACT WITH LEGISLATORS, THEIR STAFFS, GOVERNMENT OFFICIALS, AND LEGISLATIVE BODIES RELATING TO THE HOSPITAL, PHYSICIAN PAYMENT REFORM, CRITICAL ACCESS, MDH HOSPITAL RATE PROTECTION, ACO ACTIVITIES AND ADOPTION IN MEDICARE. THIS AMOUNTED TO \$400,000.

[illegible]

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](http://www.irs.gov/form990).

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization OSF HEALTHCARE SYSTEM	Employer identification number  37-0813229
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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 . . . . .                     | 51,788,138      | 37,314,439    | 22,865,122          | 17,139,873          | 7,390,433          |
| b Contributions . . . . .                                  | 9,619,258       | 10,574,853    | 10,590,634          | 2,735,884           | 10,371,045         |
| c Net investment earnings, gains, and losses               | -1,943,315      | 4,207,377     | 4,165,914           | 3,093,976           | -557,661           |
| d Grants or scholarships . . . . .                         | 81,000          | 91,480        | 75,284              | 71,508              | 63,944             |
| e Other expenditures for facilities and programs . . . . . | 937,262         | 217,051       | 231,947             | 33,103              |                    |
| f Administrative expenses . . . . .                        |                 |               |                     |                     |                    |
| g End of year balance . . . . .                            | 58,445,819      | 51,788,138    | 37,314,439          | 22,865,122          | 17,139,873         |
- 2

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

Board designated or quasi-endowment ▶ 57 410 %
- b

Permanent endowment ▶ 39 330 %
- c

Temporarily restricted endowment ▶ 3 260 %

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

☐ No

(ii) related organizations . . . . .

3a(ii)

☐ Yes

☐ No
- b

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

3b

☐

☐
- 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 . . . . .		19,803,479		19,803,479
b Buildings . . . . .		1,185,672,371	577,898,610	607,773,761
c Leasehold improvements . . . . .		8,018,694	7,048,673	970,021
d Equipment . . . . .		825,970,001	633,755,488	192,214,513
e Other . . . . .		80,949,550	27,072,680	53,876,870
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c).)				874,638,644



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	THE ORGANIZATION'S ENDOWMENT FUNDS ARE USED TO PROVIDE SCHOLARSHIPS TO NURSING STUDENTS, ACQUIRE EQUIPMENT AND SUPPORT PROGRAMS OF VARIOUS MEDICAL DEPARTMENTS OF THE OSF HEALTHCARE SYSTEM HOSPITALS
SCHEDULE D - PART X - LINE 2	OSF ADOPTED ASC SUBTOPIC 740-10, ACCOUNTING FOR UNCERTAINTY IN INCOME TAXES - AN INTERPRETATION OF FASB STATEMENT NO. 109. THE INTERPRETATION ADDRESSES THE DETERMINATION OF HOW TAX BENEFITS CLAIMED OR EXPECTED TO BE CLAIMED ON A TAX RETURN SHOULD BE RECORDED IN THE CONSOLIDATED FINANCIAL STATEMENTS. UNDER ASC SUBTOPIC 740-10, OSF MUST RECOGNIZE THE TAX BENEFIT FROM AN UNCERTAIN TAX POSITION ONLY IF IT IS MORE LIKELY THAN NOT THAT THE TAX POSITION WILL BE SUSTAINED ON EXAMINATION BY THE TAXING AUTHORITIES, BASED ON THE TECHNICAL MERITS OF THE POSITION. THE TAX BENEFITS RECOGNIZED IN THE CONSOLIDATED FINANCIAL STATEMENTS FROM SUCH A POSITION ARE MEASURED BASED ON THE LARGEST BENEFIT THAT HAS A GREATER THAN 50% LIKELIHOOD OF BEING REALIZED UPON ULTIMATE SETTLEMENT. ASC SUBTOPIC 740-10 ALSO PROVIDES GUIDANCE ON DERECOGNITION, CLASSIFICATION, INTEREST AND PENALTIES ON INCOME TAXES, AND ACCOUNTING IN INTERIM PERIODS AND REQUIRES INCREASED DISCLOSURES AS OF SEPTEMBER 30, 2015 AND 2014, OSF DOES NOT HAVE ANY UNCERTAIN TAX POSITIONS.

[illegible]

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  
OSF HEALTHCARE SYSTEM

Employer identification number  
37-0813229

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 type="checkbox"/> 200% <input checked="" type="checkbox"/> Other _____ 125 %  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		No
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care? . . . . .	5c		
6a	Did the organization prepare a community benefit report during the tax year? . . . . .	6a	Yes	
b	If "Yes," did the organization make it available to the public? . . . . .	6b	Yes	
	Complete the following table using the worksheets provided in the Schedule H instructions Do not submit these worksheets with the Schedule H			

7

Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1) . . . . .			28,481,889	0	28,481,889	1 500 %
b Medicaid (from Worksheet 3, column a) . . . . .			388,288,523	276,847,147	111,441,376	5 890 %
c Costs of other means-tested government programs (from Worksheet 3, column b) . . . . .						
d <b>Total</b> Financial Assistance and Means-Tested Government Programs . . . . .			416,770,412	276,847,147	139,923,265	7 390 %
<b>Other Benefits</b>						
e Community health improvement services and community benefit operations (from Worksheet 4) . . . . .			4,784,984	559,146	4,225,838	0 220 %
f Health professions education (from Worksheet 5) . . . . .			66,382,568	24,926,987	41,455,581	2 190 %
g Subsidized health services (from Worksheet 6) . . . . .			58,873,346	46,584,685	12,288,661	0 650 %
h Research (from Worksheet 7) . . . . .			1,443,885	1,051,771	392,114	0 020 %
i Cash and in-kind contributions for community benefit (from Worksheet 8) . . . . .			1,611,717	0	1,611,717	0 090 %
j <b>Total.</b> Other Benefits . . . . .			133,096,500	73,122,589	59,973,911	3 170 %
k <b>Total.</b> Add lines 7d and 7j . . . . .			549,866,912	349,969,736	199,897,176	10 560 %

Part II

Community Building Activities

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing					
2	Economic development					
3	Community support					
4	Environmental improvements					
5	Leadership development and training for community members					
6	Coalition building					
7	Community health improvement advocacy		63,516	0	63,516	
8	Workforce development					
9	Other					
10	Total		63,516	0	63,516	

Part III

Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

1

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

1

Yes

No

2

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

2

14,489,621

3

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

3

4

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

Section B. Medicare

5

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

5

479,931,323

6

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

6

563,329,295

7

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

7

-83,397,972

8

Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used.

☐

Cost accounting system

☒

Cost to charge ratio

☐

Other

Section C. Collection Practices

9a

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

9a

Yes

No

b

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

9b

Yes

No

Part IV

Management Companies and Joint Ventures

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

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1	NONE			
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

## Section A. Hospital Facilities

9

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 )

SAINT FRANCIS 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 13		
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) SEE PART V, SECTION C		
b <input type="checkbox"/> Other website (list url)		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 14		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	No
a If "Yes" (list url)		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	Yes
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

SAINT FRANCIS MEDICAL CENTER

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

Part V

Facility Information (continued)

SAINT FRANCIS MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

SAINT ANTHONY 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 13		
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	No
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) SEE PART V, SECTION C		
b <input type="checkbox"/> Other website (list url)		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 14		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	No
a If "Yes" (list url)		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	Yes
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

SAINT ANTHONY 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 type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input type="checkbox"/> Underinsurance discount		
g	<input type="checkbox"/> Residency		
h	<input checked="" 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 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>SEE PART V, SECTION C</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
c	<input type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>SEE PART V, SECTION C</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 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 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)

SAINT ANTHONY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

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):

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 13		
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	No
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) SEE PART V, SECTION C		
b <input type="checkbox"/> Other website (list url)		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 14		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	No
a If "Yes" (list url)		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	Yes
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

ST JOSEPH MEDICAL CENTER

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

Part V

Facility Information (continued)

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	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 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 checked="" 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 )

ST MARY 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):

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 <u>13</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>SEE PART V, SECTION C</u>		
b	<input type="checkbox"/> Other website (list url) _____		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 . . . . .	8	Yes
9	Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>14</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . .	10	No
a	If "Yes" (list url) _____		
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	10b	Yes
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

ST MARY MEDICAL CENTER

	Yes	No
<b>Financial Assistance Policy (FAP)</b>		
<b>13</b> 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	<b>13</b> Yes	
<b>a</b> <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>125</u> % and FPG family income limit for eligibility for discounted care of <u>300</u> %		
<b>b</b> <input type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b> <input type="checkbox"/> Asset level		
<b>d</b> <input checked="" type="checkbox"/> Medical indigency		
<b>e</b> <input checked="" type="checkbox"/> Insurance status		
<b>f</b> <input type="checkbox"/> Underinsurance discount		
<b>g</b> <input type="checkbox"/> Residency		
<b>h</b> <input checked="" type="checkbox"/> Other (describe in Section C)		
<b>14</b> Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b> Yes	
<b>15</b> Explained the method for applying for financial assistance? . . . . .	<b>15</b> 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)		
<b>a</b> <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</b> <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
<b>c</b> <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
<b>d</b> <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b> <input type="checkbox"/> Other (describe in Section C)		
<b>16</b> Included measures to publicize the policy within the community served by the hospital facility? . . . . .	<b>16</b> Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)		
<b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
<b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
<b>c</b> <input type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
<b>d</b> <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b> <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>f</b> <input type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>g</b> <input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
<b>h</b> <input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b> <input type="checkbox"/> Other (describe in Section C)		
<b>Billing and Collections</b>		
<b>17</b> Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment? . . . . .	<b>17</b> Yes	
<b>18</b> Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies)		
<b>b</b> <input type="checkbox"/> Selling an individual's debt to another party		
<b>c</b> <input type="checkbox"/> Actions that require a legal or judicial process		
<b>d</b> <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>e</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		

Part V

Facility Information (continued)

ST MARY 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 <b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>d</b> <input type="checkbox"/> Other similar actions (describe in Section C) <b>20</b> Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (check all that apply) <b>a</b> <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission <b>b</b> <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge <b>c</b> <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills <b>d</b> <input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy <b>e</b> <input type="checkbox"/> Other (describe in Section C) <b>f</b> <input type="checkbox"/> None of these efforts were made	19	No
<b>Policy Relating to Emergency Medical Care</b>			
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 <b>a</b> <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions <b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing <b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) <b>d</b> <input type="checkbox"/> Other (describe in Section C)	21	Yes
<b>Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)</b>			
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 <b>a</b> <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged <b>b</b> <input 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 <b>c</b> <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged <b>d</b> <input checked="" type="checkbox"/> Other (describe in Section C) <b>23</b> During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? . . . . . 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)

OSF SAINT ANTHONY'S HEALTH 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 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 13		
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) SEE PART V, SECTION C		
b <input type="checkbox"/> Other website (list url)		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 14		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	No
a If "Yes" (list url)		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	Yes
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

OSF SAINT ANTHONY'S HEALTH CENTER

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

Part V

Facility Information (continued)

OSF SAINT ANTHONY'S HEALTH 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 <b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>d</b> <input type="checkbox"/> Other similar actions (describe in Section C) <b>20</b> Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (check all that apply) <b>a</b> <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission <b>b</b> <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge <b>c</b> <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills <b>d</b> <input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy <b>e</b> <input type="checkbox"/> Other (describe in Section C) <b>f</b> <input type="checkbox"/> None of these efforts were made	19	No
<b>Policy Relating to Emergency Medical Care</b>			
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 <b>a</b> <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions <b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing <b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) <b>d</b> <input type="checkbox"/> Other (describe in Section C)	21	Yes
<b>Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)</b>			
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 <b>a</b> <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged <b>b</b> <input 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 <b>c</b> <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged <b>d</b> <input checked="" type="checkbox"/> Other (describe in Section C) <b>23</b> During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? . . . . . 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 )

ST FRANCIS 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):

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 <u>13</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	No
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>SEE PART V, SECTION C</u>		
b	<input type="checkbox"/> Other website (list url) _____		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 . . . . .	8	Yes
9	Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>14</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . .	10	No
a	If "Yes" (list url) _____		
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	10b	Yes
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

ST FRANCIS HOSPITAL

		Yes	No
<b>Financial Assistance Policy (FAP)</b>			
<b>13</b>	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	<b>13</b>	Yes
<b>a</b>	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>400</u> %		
<b>b</b>	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b>	<input type="checkbox"/> Asset level		
<b>d</b>	<input checked="" type="checkbox"/> Medical indigency		
<b>e</b>	<input checked="" type="checkbox"/> Insurance status		
<b>f</b>	<input type="checkbox"/> Underinsurance discount		
<b>g</b>	<input type="checkbox"/> Residency		
<b>h</b>	<input checked="" type="checkbox"/> Other (describe in Section C)		
<b>14</b>	Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b>	Yes
<b>15</b>	Explained the method for applying for financial assistance? . . . . .	<b>15</b>	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)		
<b>a</b>	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</b>	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
<b>c</b>	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
<b>d</b>	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>16</b>	Included measures to publicize the policy within the community served by the hospital facility? . . . . .	<b>16</b>	Yes
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)		
<b>a</b>	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
<b>b</b>	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
<b>c</b>	<input type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
<b>d</b>	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b>	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>f</b>	<input type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>g</b>	<input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
<b>h</b>	<input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>Billing and Collections</b>			
<b>17</b>	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment? . . . . .	<b>17</b>	Yes
<b>18</b>	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
<b>a</b>	<input type="checkbox"/> Reporting to credit agency(ies)		
<b>b</b>	<input type="checkbox"/> Selling an individual's debt to another party		
<b>c</b>	<input type="checkbox"/> Actions that require a legal or judicial process		
<b>d</b>	<input type="checkbox"/> Other similar actions (describe in Section C)		
<b>e</b>	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		

Part V

Facility Information (continued)

ST FRANCIS 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 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 checked="" 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 )

SAINT JAMES 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):

7

		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 13		
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		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	No
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) SEE PART V, SECTION C		
b	<input type="checkbox"/> Other website (list url)		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9	Indicate the tax year the hospital facility last adopted an implementation strategy 20 14		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?		
10		10	No
a	If "Yes" (list url)		
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		
10b		10b	Yes
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		12a	No
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
12b		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

SAINT JAMES HOSPITAL

		Yes	No
<b>Financial Assistance Policy (FAP)</b>			
<b>13</b>	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	<b>13</b>	Yes
<b>a</b>	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>125</u> % and FPG family income limit for eligibility for discounted care of <u>300</u> %		
<b>b</b>	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b>	<input type="checkbox"/> Asset level		
<b>d</b>	<input checked="" type="checkbox"/> Medical indigency		
<b>e</b>	<input checked="" type="checkbox"/> Insurance status		
<b>f</b>	<input type="checkbox"/> Underinsurance discount		
<b>g</b>	<input type="checkbox"/> Residency		
<b>h</b>	<input checked="" type="checkbox"/> Other (describe in Section C)		
<b>14</b>	Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b>	Yes
<b>15</b>	Explained the method for applying for financial assistance? . . . . .	<b>15</b>	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)		
<b>a</b>	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</b>	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
<b>c</b>	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
<b>d</b>	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>16</b>	Included measures to publicize the policy within the community served by the hospital facility? . . . . .	<b>16</b>	Yes
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)		
<b>a</b>	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
<b>b</b>	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
<b>c</b>	<input type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
<b>d</b>	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b>	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>f</b>	<input type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>g</b>	<input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
<b>h</b>	<input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>Billing and Collections</b>			
<b>17</b>	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment? . . . . .	<b>17</b>	Yes
<b>18</b>	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
<b>a</b>	<input type="checkbox"/> Reporting to credit agency(ies)		
<b>b</b>	<input type="checkbox"/> Selling an individual's debt to another party		
<b>c</b>	<input type="checkbox"/> Actions that require a legal or judicial process		
<b>d</b>	<input type="checkbox"/> Other similar actions (describe in Section C)		
<b>e</b>	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		

Part V

Facility Information (continued)

SAINT JAMES 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 <b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>d</b> <input type="checkbox"/> Other similar actions (describe in Section C) <b>20</b> Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (check all that apply) <b>a</b> <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission <b>b</b> <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge <b>c</b> <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills <b>d</b> <input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy <b>e</b> <input type="checkbox"/> Other (describe in Section C) <b>f</b> <input type="checkbox"/> None of these efforts were made	19	No
<b>Policy Relating to Emergency Medical Care</b>			
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 <b>a</b> <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions <b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing <b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) <b>d</b> <input type="checkbox"/> Other (describe in Section C)	21	Yes
<b>Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)</b>			
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 <b>a</b> <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged <b>b</b> <input 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 <b>c</b> <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged <b>d</b> <input checked="" type="checkbox"/> Other (describe in Section C) <b>23</b> During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? . . . . . If "Yes," explain in Section C <b>24</b> During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? . . . . . If "Yes," explain in Section C	23	No
		24	No

Part V

Facility Information (continued)

Section B. Facility Policies and Practices

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

OSF SAINT LUKE 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):

8

		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>13</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		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	No
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>SEE PART V, SECTION C</u>		
b	<input type="checkbox"/> Other website (list url) _____		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 . . . . .	8	Yes
9	Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>14</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . .	10	No
a	If "Yes" (list url) _____		
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	10b	Yes
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

OSF SAINT LUKE MEDICAL CENTER

		Yes	No
<b>Financial Assistance Policy (FAP)</b>			
<b>13</b>	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	<b>13</b>	Yes
<b>a</b>	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>125</u> % and FPG family income limit for eligibility for discounted care of <u>300</u> %		
<b>b</b>	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b>	<input type="checkbox"/> Asset level		
<b>d</b>	<input checked="" type="checkbox"/> Medical indigency		
<b>e</b>	<input checked="" type="checkbox"/> Insurance status		
<b>f</b>	<input type="checkbox"/> Underinsurance discount		
<b>g</b>	<input type="checkbox"/> Residency		
<b>h</b>	<input checked="" type="checkbox"/> Other (describe in Section C)		
<b>14</b>	Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b>	Yes
<b>15</b>	Explained the method for applying for financial assistance? . . . . .	<b>15</b>	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)		
<b>a</b>	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</b>	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
<b>c</b>	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
<b>d</b>	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>16</b>	Included measures to publicize the policy within the community served by the hospital facility? . . . . .	<b>16</b>	Yes
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)		
<b>a</b>	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
<b>b</b>	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
<b>c</b>	<input type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
<b>d</b>	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b>	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>f</b>	<input type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>g</b>	<input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
<b>h</b>	<input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>Billing and Collections</b>			
<b>17</b>	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment? . . . . .	<b>17</b>	Yes
<b>18</b>	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
<b>a</b>	<input type="checkbox"/> Reporting to credit agency(ies)		
<b>b</b>	<input type="checkbox"/> Selling an individual's debt to another party		
<b>c</b>	<input type="checkbox"/> Actions that require a legal or judicial process		
<b>d</b>	<input type="checkbox"/> Other similar actions (describe in Section C)		
<b>e</b>	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		

Part V Facility Information (continued)

OSF SAINT LUKE 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)	19	No
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 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 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 checked="" 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)

OSF HOLY FAMILY 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):

9

		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>13</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>SEE PART V, SECTION C</u>		
b	<input type="checkbox"/> Other website (list url) _____		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 . . . . .	8	Yes
9	Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>14</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . .	10	No
a	If "Yes" (list url) _____		
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	10b	Yes
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

OSF HOLY FAMILY MEDICAL CENTER

		Yes	No
<b>Financial Assistance Policy (FAP)</b>			
<b>13</b>	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	<b>13</b>	Yes
<b>a</b>	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>125</u> % and FPG family income limit for eligibility for discounted care of <u>300</u> %		
<b>b</b>	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b>	<input type="checkbox"/> Asset level		
<b>d</b>	<input checked="" type="checkbox"/> Medical indigency		
<b>e</b>	<input checked="" type="checkbox"/> Insurance status		
<b>f</b>	<input type="checkbox"/> Underinsurance discount		
<b>g</b>	<input type="checkbox"/> Residency		
<b>h</b>	<input checked="" type="checkbox"/> Other (describe in Section C)		
<b>14</b>	Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b>	Yes
<b>15</b>	Explained the method for applying for financial assistance? . . . . .	<b>15</b>	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)		
<b>a</b>	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</b>	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
<b>c</b>	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
<b>d</b>	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>16</b>	Included measures to publicize the policy within the community served by the hospital facility? . . . . .	<b>16</b>	Yes
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)		
<b>a</b>	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
<b>b</b>	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
<b>c</b>	<input type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
<b>d</b>	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b>	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>f</b>	<input type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>g</b>	<input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
<b>h</b>	<input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>Billing and Collections</b>			
<b>17</b>	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment? . . . . .	<b>17</b>	Yes
<b>18</b>	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
<b>a</b>	<input type="checkbox"/> Reporting to credit agency(ies)		
<b>b</b>	<input type="checkbox"/> Selling an individual's debt to another party		
<b>c</b>	<input type="checkbox"/> Actions that require a legal or judicial process		
<b>d</b>	<input type="checkbox"/> Other similar actions (describe in Section C)		
<b>e</b>	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		

Part V

Facility Information (continued)

OSF HOLY FAMILY 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 <b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>d</b> <input type="checkbox"/> Other similar actions (describe in Section C) <b>20</b> Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (check all that apply) <b>a</b> <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission <b>b</b> <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge <b>c</b> <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills <b>d</b> <input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy <b>e</b> <input type="checkbox"/> Other (describe in Section C) <b>f</b> <input type="checkbox"/> None of these efforts were made	19		No
<b>Policy Relating to Emergency Medical Care</b>				
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 <b>a</b> <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions <b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing <b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) <b>d</b> <input type="checkbox"/> Other (describe in Section C)	21	Yes	
<b>Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)</b>				
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 <b>a</b> <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged <b>b</b> <input 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 <b>c</b> <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged <b>d</b> <input checked="" type="checkbox"/> Other (describe in Section C) <b>23</b> During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? . . . . . If "Yes," explain in Section C <b>24</b> During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? . . . . . If "Yes," explain in Section C	23		No
		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? **41**

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

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, LINE 3C	THE CORPORATION PROVIDES - CATASTROPHIC CHARITY ASSISTANCE REGARDLESS OF INCOME OR ASSET LEVELS FOR MEDICALLY NECESSARY SERVICES WHICH EXCEED 25% OF ANNUAL FAMILY INCOME The amount due is adjusted to 25% of family income when OSF determines catastrophic charity is more generous - ALL PATIENTS RECEIVE THE GREATEST REQUESTED DISCOUNT AVAILABLE UNDER ANY OF the OSF PROGRAMS NO ASSET TESTS ARE USED - EXCEPT AS OTHERWISE NOTED, THESE POLICIES APPLY BOTH TO UNINSURED PATIENTS AND TO INSURED PATIENTS WITH RESPECT TO THE PATIENT RESPONSIBILITY AMOUNT

Form and Line Reference	Explanation
PART I, LINE 7	COSTS REPORTED ON LINES 7 A, B, AND C ARE CALCULATED USING THE RATIO OF PATIENT CARE COST-TO-CHARGES DERIVED FROM WORKSHEET 2 COSTS REPORTED ON LINES 7 E,F,G,H, AND I ARE COSTS DERIVED FROM GENERAL LEDGER ACCOUNTS AND HOSPITAL DEPARTMENT COST CENTER REPORTS WHICH INCLUDE BOTH DIRECT AND INDIRECT COSTS LESS REVENUE LINE 7G REPRESENTS ALL PAYERS EXCLUDING MEDICARE, MEDCAID AND SELF-PAY

Form and Line Reference	Explanation
PART I, LINE 7G	NET COSTS (TOTAL EXPENSE LESS REVENUE) OF THIRTEEN PHYSICIAN CLINICS ARE INCLUDED AS SUBSIDIZED HEALTH SERVICES ON PART I, LINE 7G SUCH NET COSTS TOTAL \$4,753,553

Form and Line Reference	Explanation
PART I, LINE 7, COLUMN F	BAD DEBT EXPENSE IN THE AMOUNT OF \$54,225,436 IS INCLUDED ON FORM 990, PART IX, LINE 24C, COLUMN (A), BUT WAS SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGES IN SCHEDULE H, PART I, LINE 7, COLUMN (F)

Form and Line Reference	Explanation
PART II	COMMUNITY BUILDING ACTIVITIES THE CORPORATION'S COMMUNITY BUILDING ACTIVITIES PROMOTE THE HEALTH OF THE COMMUNITIES SERVED IN THE FOLLOWING WAYS - CORPORATE EXECUTIVES VOLUNTEER TO SERVE ON BOARDS AND COMMITTEES OF COMMUNITY ORGANIZATIONS SUCH AS UNITED WAY AND OTHERS - TRANSPORTATION VOUCHERS ARE GIVEN TO INDIGENT PERSONS FOR THEIR PERSONAL TRANSPORTATION NEEDS (OTHER THAN TO OR FROM THE CORPORATION'S FACILITIES)

Form and Line Reference	Explanation
PART III, LINE 4	<p>IN GENERAL, AND IN ACCORDANCE WITH MEDICARE REGULATIONS, PATIENT ACCOUNT BALANCES ARE WRITTEN OFF TO BAD DEBT EXPENSE AFTER REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED AND THE ACCOUNT HAS BEEN SENT TO A COLLECTION AGENCY OR LAW FIRM. PATIENTS' ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS. IN EVALUATING THE COLLECTIBILITY OF PATIENTS' ACCOUNTS RECEIVABLE, OSF ANALYZES IT'S PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYOR SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS AND PROVISION FOR BAD DEBTS. MANAGEMENT REGULARLY REVIEWS DATA ABOUT THESE MAJOR PAYOR SOURCES OF REVENUE IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS. FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, OSF ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND A PROVISION FOR BAD DEBTS, 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 THE OSF FINANCIAL ASSISTANCE POLICY AND UNINSURED DISCOUNT POLICY. FOR ANY REMAINING PATIENT RESPONSIBILITY BALANCE, OSF RECORDS A PROVISION FOR BAD DEBTS 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 RATES (OR THE DISCOUNTED RATES IF NEGOTIATED) AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS CHARGED OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS. BAD DEBT EXPENSE OF \$54,225,436 ON FORM 990, PART IX, LINE 24C IS BASED UPON ACCRUAL ACCOUNTING REQUIRED BY GENERALLY ACCEPTED ACCOUNTING PRINCIPLES. THIS AMOUNT CONSEQUENTLY DIFFERS FROM THE BAD DEBT EXPENSE OF \$14,489,621 ON SCHEDULE H, PART III, LINE 2 WHICH REQUIRES THE ORGANIZATION TO REPORT AGGREGATE BAD DEBT AT COST. BAD DEBT EXPENSE REPORTED ON PART III, LINE 2 IS THEREFORE CALCULATED BY MULTIPLYING GROSS CHARGES WRITTEN OFF TO BAD DEBT EXPENSE TIMES THE RATIO OF PATIENT CARE COST-TO-CHARGES DERIVED FROM WORKSHEET 2. DISCOUNTS, INCLUDING ANY APPLICABLE THIRD PARTY PAYER CONTRACTUAL ALLOWANCES AND ANY CHARITY CARE DISCOUNTS (VALUED AT GROSS CHARGES), ARE APPLIED TO PATIENT ACCOUNT GROSS CHARGES TO DETERMINE THE ACCOUNT BALANCE BEFORE PATIENT PAYMENTS. THE AGGREGATE AMOUNT OF ALL PATIENT PAYMENTS IS THEN APPLIED TO THE ACCOUNT BALANCE. WHEN DETERMINATION IS MADE THAT NO FURTHER AMOUNTS CAN BE COLLECTED IN ACCORDANCE WITH THE CORPORATION'S BAD DEBT POLICY, THE REMAINING BALANCE IS WRITTEN OFF TO BAD DEBT EXPENSE. PRESUMPTIVE CHARITY CHARGES MAY BE ADJUSTED TO PROVIDE FOR A CHARITY DISCOUNT OF 100% OF BILLED CHARGES FOR MEDICALLY NECESSARY SERVICES PROVIDED TO AN UNINSURED PATIENT WHO ESTABLISHES FINANCIAL NEED AT TIME OF REGISTRATION BY SATISFYING ONE OF THE FOLLOWING CATEGORIES OF PRESUMPTIVE ELIGIBILITY CRITERIA: PRESUMPTIVE CHARITY CATEGORIES FOR ALL OSF HOSPITALS - HOMELESSNESS, - DECEASED WITH NO ESTATE, - MENTAL INCAPACITATION WITH NO ONE TO ACT ON PATIENT'S BEHALF, OR - CURRENT MEDICAID ELIGIBILITY, BUT NOT ON DATE OF SERVICE OR FOR NON-COVERED SERVICE. FOR OSF HOSPITAL'S THAT ARE NOT CRITICAL ACCESS HOSPITALS OR RURAL HOSPITALS, ENROLLMENT IN ANY OF THE FOLLOWING PROGRAMS WITH CRITERIA AT OR BELOW 200% OF THE FEDERAL POVERTY INCOME GUIDELINES SHALL ESTABLISH A PRESUMPTIVE CHARITY CATEGORY - WOMEN, INFANTS AND CHILDREN NUTRITION PROGRAM (WIC), - SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP), - ILLINOIS FREE LUNCH AND BREAKFAST PROGRAM, - LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP), - ENROLLMENT IN AN ORGANIZED COMMUNITY-BASED PROGRAM PROVIDING ACCESS TO MEDICAL CARE THAT ASSESSES AND DOCUMENTS LIMITED LOW-INCOME FINANCIAL STATUS AS CRITERION FOR MEMBERSHIP, OR - RECEIPT OF GRANT ASSISTANCE FOR MEDICAL SERVICES. THEREFORE, THE CORPORATION DOES NOT BELIEVE THAT BAD DEBT EXPENSE REPORTED ON PART III, LINE 3 INCLUDES ANY AMOUNTS THAT REASONABLY COULD BE ATTRIBUTABLE TO PATIENTS WHO WOULD LIKELY QUALIFY UNDER THE CORPORATION'S FINANCIAL ASSISTANCE POLICY.</p>

Form and Line Reference	Explanation
PART III, LINE 8	100% OF THE MEDICARE SHORTFALL SHOULD BE TREATED AS COMMUNITY BENEFIT OSF IS COMMITTED TO SERVING PATIENTS, REGARDLESS OF ABILITY TO PAY OR IF THE PAYMENTS TO BE RECEIVED WILL BE LESS THAN THE COST TO PROVIDE THE SERVICE, WHICH IS THE CASE FOR MEDICARE AND MEDICAID PATIENTS THE MEDICARE ALLOWABLE COSTS ON LINE 6 PART III HAVE BEEN CALCULATED BY MULTIPLYING MEDICARE CHARGES BY THE PATIENT CARE COST TO CHARGE RATIO DERIVED FROM WORKSHEET 2 THE AMOUNT IS COMPARED TO TOTAL MEDICARE PAYMENTS RECEIVED INCLUDING DSH AND IME PAYMENTS THIS SHORTFALL SHOULD BE TREATED AS A COMMUNITY BENEFIT SINCE IT REFLECTS UNREIMBURSED COSTS TO THE HEALTH SYSTEM FOR PROVIDING MEDICAL SERVICES TO THE MEDICARE RESIDENTS OF THE COMMUNITY

Form and Line Reference	Explanation
PART III, LINE 9B	<p>THE CORPORATION HAS A FAIR BILLING/COLLECTION POLICY WHICH APPLIES FOR ALL PATIENTS THE POLICY INCLUDES - REQUIRED INFORMATION PROVIDED IN BILLS TO PATIENTS (INCLUDING A REQUIREMENT THAT INFORMATION BE PROVIDED ON HOW THE PATIENT MAY APPLY FOR FINANCIAL ASSISTANCE) - PROCESS FOR PATIENTS TO INQUIRE ABOUT OR DISPUTE A BILL, INCLUDING TOLL-FREE TELEPHONE NUMBER, ADDRESS, CONTACT NAME, AND E-MAIL ADDRESS - REQUIREMENTS FOR TIMELY RESPONSE TO PATIENT INQUIRIES - CONDITIONS WHICH MUST BE SATISFIED AND VERIFIED BY AN AUTHORIZED HOSPITAL REPRESENTATIVE BEFORE THE ACCOUNT OF AN UNINSURED PATIENT MAY BE SENT TO A COLLECTION AGENCY OR ATTORNEY - LEGAL ACTION FOR NON-PAYMENT OF A PATIENT BILL MAY NOT BE INITIATED UNTIL AN AUTHORIZED HOSPITAL OFFICIAL HAS DETERMINED THAT ALL CONDITIONS IN THE CORPORATION'S POLICY (INCLUDING ALL OF THE FOREGOING POLICY PROVISIONS) HAVE BEEN SATISFIED FOR INITIATING LEGAL ACTION - LEGAL ACTION MAY NOT BE PURSUED AGAINST UNINSURED PATIENTS WHO HAVE clearly DEMONSTRATED THAT THEY HAVE NEITHER SUFFICIENT INCOME NOR ASSETS TO MEET THEIR FINANCIAL OBLIGATIONS - EVEN IF SUCH PATIENTS do not apply FOR FINANCIAL ASSISTANCE - THE CORPORATION SHALL NOT OBTAIN A BODY ATTACHMENT AGAINST ANY PATIENT OR GUARANTOR - THE CORPORATION SHALL NOT ENGAGE IN ANY EXTRAORDINARY COLLECTION ACTIONS, SUCH AS SUBMITTING REPORTS TO CREDIT AGENCIES BEFORE REASONABLE EFFORTS TO DETERMINE ELIGIBILITY FOR FINANCIAL ASSISTANCE HAVE BEEN COMPLETED</p>

Form and Line Reference	Explanation
SCHEDULE H - PART VI SUPPLEMENTAL INFORMATION - CHNA	<p>THE HEALTH SYSTEM COMMENCED WORK DURING ITS FISCAL YEAR 2012 ON CONDUCTING A COMMUNITY HEALTH NEEDS ASSESSMENT ("CHNA") FOR EACH OF ITS HOSPITALS, AS REQUIRED BY INTERNAL REVENUE CODE SECTION 501(R)(3). THE CHNA PROCESS CONTINUED INTO FISCAL YEAR 2013 AND CULMINATED IN A FINAL CHNA FOR EACH OF THE HEALTH SYSTEM'S HOSPITALS BEING APPROVED AND ADOPTED BY THE SYSTEM'S BOARD OF DIRECTORS ON JULY 29, 2013. SUBSEQUENT TO FISCAL YEAR 2013 AND IN RESPONSE TO THE SIGNIFICANT COMMUNITY HEALTH NEEDS IDENTIFIED IN EACH RESPECTIVE HOSPITAL'S CHNA, THE HOSPITALS COMPLETED AN IMPLEMENTATION STRATEGY TO ADDRESS THESE CRITICAL HEALTH NEEDS. THE NARRATIVE BELOW INCLUDES AN OUTLINE OF EACH RESPECTIVE HOSPITAL'S GOALS AND SUBSEQUENT ACCOMPLISHMENTS FOR FISCAL YEAR 2015 AS PART OF THE IMPLEMENTATION STRATEGY APPROVED AND ADOPTED BY THE BOARD OF DIRECTORS.</p> <p><b>SAINT FRANCIS MEDICAL CENTER - PEORIA, IL</b> THE CHNA THAT WAS APPROVED AND ADOPTED FOR SAINT FRANCIS MEDICAL CENTER IDENTIFIED THE FOLLOWING AS THE COMMUNITY'S MOST SIGNIFICANT HEALTH NEEDS:</p> <p><b>IDENTIFIED NEED: ACCESS TO HEALTHCARE</b> THIS NEED IS BASED ON RESULTS FROM SURVEY RESPONDENTS DEFINED AS LIVING IN DEEP POVERTY WHO INDICATED THAT ACCESS TO HEALTHCARE SERVICES IS LIMITED. THIS INCLUDES MEDICAL, PRESCRIPTION MEDICATIONS, DENTAL AND MENTAL HEALTHCARE.</p> <p><b>ACCESS TO MEDICAL CARE, DENTAL CARE, PRESCRIPTION MEDICATION AND COUNSELING IS LIMITED FOR THOSE LIVING IN DEEP POVERTY.</b> ONLY HALF OF PEOPLE LIVING IN DEEP POVERTY SEEK MEDICAL SERVICES AT A CLINIC OR DOCTOR'S OFFICE. FOR THIS SEGMENT OF THE POPULATION, IT IS VERY COMMON TO SEEK MEDICAL SERVICES FROM AN EMERGENCY DEPARTMENT, OR EVEN MORE CONCERNING IS THAT 13% OF THIS SEGMENT OF THE POPULATION WILL NOT SEEK ANY MEDICAL SERVICES AT ALL.</p> <p><b>FY2015 GOALS:</b> ACCESS TO HEALTHCARE *IMBDE HEALTHCARE EDUCATION AND SERVICES WITHIN THE INDIGENT POPULATION IN CONJUNCTION WITH EXISTING COMMUNITY RESOURCES.</p> <p><b>FY2015 ACCOMPLISHMENTS:</b> ACCESS TO HEALTHCARE *Partnering with additional agencies in underserved population areas. *Agreements signed by church leaders and agencies include Salvation Army, Peoria Rescue, Friendship house, St. Philomena, St. Vincent. *Participation in local health fairs throughout community.</p> <p><b>IDENTIFIED NEED: RISKY BEHAVIORS/SUBSTANCE ABUSE</b> THIS NEED IS BASED ON THE PREVALENCE OF ALCOHOL, TOBACCO AND MARIJUANA IN OUR COMMUNITY. IN THE TRI-COUNTY REGION, AMONG 8TH GRADERS, THE AVERAGE AGE AT FIRST USE OF ALCOHOL, TOBACCO AND MARIJUANA IS 13, 11.5 AND 12.4 YEARS RESPECTIVELY. THE SAME AVERAGE AGE FOR 12TH GRADERS IS 15.9, 14 AND 14.9 YEARS RESPECTIVELY. PEORIA COUNTY IS MUCH HIGHER FOR MARIJUANA USE COMPARED TO STATE AVERAGES, ESPECIALLY AMONG 12TH GRADERS (33% VS 21%).</p> <p><b>FY2015 GOALS:</b> RISKY BEHAVIORS/SUBSTANCE ABUSE *INCREASE AWARENESS AT THE JUNIOR HIGH AND HIGH SCHOOL LEVEL OF THE CONSEQUENCES OF USING ALCOHOL, TOBACCO AND MARIJUANA. *RAISE AWARENESS ON THE IMPORTANCE OF SUBSTANCE ABUSE AVOIDANCE.</p> <p><b>FY2015 ACCOMPLISHMENTS:</b> RISKY BEHAVIORS/SUBSTANCE ABUSE *Local doctor continues to see referrals from OSFMG.</p> <p><b>IDENTIFIED NEED: ASTHMA</b> THIS NEED IS BASED ON AN INCREASE IN INPATIENT ADMISSIONS FOR ASTHMA. INPATIENT ADMISSIONS TO THE PEORIA AREA HOSPITALS INCLUDING UNITYPOINT HEALTH - METHODIST, SAINT FRANCIS MEDICAL CENTER, PROCTOR, AND PEKIN, INCREASED BY 26.7%.</p> <p><b>FY2015 GOALS:</b> ASTHMA *INCREASE AWARENESS OF ASTHMA PREVENTION STRATEGIES. *INCREASE COMPLIANCE WITH ASTHMA ACTION PLANS. *REDUCE ASTHMA RELATED PROMPTCARE/EMERGENCY ROOM VISITS AND ADMISSIONS.</p> <p><b>FY2015 ACCOMPLISHMENTS:</b> ASTHMA *To date, 56% of adults and children with a diagnosis of asthma have a completed Home Asthma Action Plan. This is an improvement from October 2014, when the percentage was 16.5%.</p> <p><b>IDENTIFIED NEED: DIABETES</b> BY EVALUATING MAGNITUDE OF MORBIDITIES AND GROWTH RATES OF MORBIDITIES, THIS NEED IS BASED ON AN INCREASE IN INPATIENT ADMISSIONS FOR DIABETES AND AN INCREASE IN THE PREVALENCE OF DIABETES IN THE GENERAL POPULATION. TYPE I AND TYPE II DIABETES ARE INCREASING AND ALL THREE COUNTIES ARE HIGHER THAN STATE AVERAGES.</p> <p><b>FY2015 GOALS:</b> DIABETES *PROMOTE PREVENTION, SCREENING AND EARLY THERAPY FOR METABOLIC SYNDROME, HYPERGLYCEMIA AND DIABETES FOR THE TRI-COUNTY AREA.</p> <p><b>FY2015 ACCOMPLISHMENTS:</b> DIABETES *Diabetes education is being offered by Children's Hospital of Illinois. *Quality measures include 1) percentage of patients with HbA1c &gt;9% and 2) completed Eye Exam.</p> <p><b>*HEALTH SCREENING</b> provided at community events.</p> <p><b>IDENTIFIED NEED: HEALTHY BEHAVIORS</b> THIS NEED BASED ON RESULTS FROM SURVEY RESPONDENTS DEFINED AS LIVING IN DEEP POVERTY INDICATED THAT THERE ARE LIMITED EFFORTS AT PROACTIVELY MANAGING ONE'S OWN HEALTH. THIS INCLUDES LIMITED EXERCISE, POOR EATING HABITS AND INCREASED INCIDENCE OF SMOKING. ONLY 15% OF THE POPULATION ENGAGES IN EXERCISE AT LEAST 5 TIMES A WEEK. LESS THAN 5% OF THE POPULATION CONSUMES AT LEAST THE MINIMUM RECOMMENDED SERVINGS OF FRUITS/VEGETABLES IN A DAY. YET, IN TERMS OF SELF-PERCEPTIONS OF PHYSICAL AND MENTAL HEALTH, ALMOST 90% OF THE POPULATION I</p>

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SCHEDULE H - PART VI SUPPLEMENTAL INFORMATION - CHNA	<p>NDICATED THAT THEY WERE IN AVERAGE OR GOOD PHYSICAL HEALTH FY2015 GOALS HEALTHY BEHAVIOR S *INCREASE THE AWARENESS IN AND ENGAGEMENT OF POPULATION ON THE IMPORTANCE OF HEALTH BEHA VIORS *SLEEP HYGIENE, NUTRITION, EXERCISE, HEALTHY WEIGHT, SAFETY, SPIRITUALITY, AND AVOI DANCE OF SUBSTANCE ABUSE FY2015 ACCOMPLISHMENTS HEALTHY BEHAVIORS *Community Education o ffered via 30 minute and 60 minute TV presentations on WEEK and WMBD Topics include Cooki ng Demonstrations, Breast Cancer, Smoking and Nutrition In addition, very active with a B log Post on the Peoria Journal Star *SEVERAL CLASSES HELD IN DIFFERENT LOCATIONS PROMOTIN G HEALTH- RELATED BEHAVIORS *HEALTH FAIRS AND OTHER VARIOUS EVENTS IN COMMUNITY IDENTIFI ED NEED CANCER THIS NEED IS BASED ON AN INCREASE IN INPATIENT ADMISSIONS FOR ALL CANCER D IAGNOSES WHILE SOME TYPES OF CANCER HAVE EXPERIENCED DECREASED GROWTH RATES IN RECENT YEA RS, LUNG CANCER HAS BEEN STEADILY INCREASING FY2015 GOALS CANCER *PROMOTE PREVENTION, SC REENING AND EARLY THERAPY FOR THE MAJOR CANCERS OF THE TRI-COUNTY AREA LUNG, BREAST, COLO N, AND PROSTRATE FY2015 ACCOMPLISHMENTS CANCER *Recording measures for smoking, tobacco use, breast screening and colon cancer screening Data regarding cancer screening performa nce in Peoria Region Tracking measured to create outcomes IDENTIFIED NEED MENTAL HEALTH THIS NEED LOOKS AT THE PERCENT OF PATIENTS THAT REPORTED THEY HAD EXPERIENCED 1-7 DAYS WI TH POOR MENTAL HEALTH PER MONTH BETWEEN 2007 AND 2009 THIS INCLUDES MENTAL DISABILITIES, DEPRESSION AND SELF-PERCEPTIONS OF MENTAL HEALTH APPROXIMATELY 25% OF RESIDENTS IN THE TR I-COUNTY REGION REPORTED THEY HAD EXPERIENCED 1-7 DAYS WITH POOR MENTAL HEALTH PER MONTH B ETWEEN 2007 AND 2009 THESE PERCENTAGES ARE GREATER THAN THE STATE OF ILLINOIS AVERAGE FOR THE SAME TIME FRAME AND REPRESENT A MODEST INCREASE COMPARED TO 2006 FY2015 GOALS MENTA L HEALTH *INCREASE SCREENING AND INTERVENTION IN MENTAL HEALTH ISSUES INCLUDING DEPRESSION , ANXIETY, AND ABUSE FY2015 ACCOMPLISHMENTS MENTAL HEALTH *COLLABORATING WITH LOCAL MENT AL HEALTH PROVIDER TO HELP WITH ACCESS AND INFORMATION IDENTIFIED NEED OBESITY THIS NEED IS BASED ON AN INCREASE IN THE PREVALENCE OF OBESITY IN OUR COMMUNITY POPULATION RESEARC H STRONGLY SUGGESTS THAT OBESITY IS A SIGNIFICANT PROBLEM FACING YOUTH AND ADULTS NATIONAL LY, IN ILLINOIS, AND WITHIN THE TRI-COUNTY REGION IN TERMS OF OBESITY, THE TRI-COUNTY ARE A AS A WHOLE IS SIGNIFICANTLY HIGHER THAN THE STATE AVERAGE CONSIDERING THAT ILLINOIS IS THE 6TH WORSE STATE IN THE U S IN TERMS OF OBESITY, THIS IS AN IMPORTANT ISSUE FY2015 GO ALS OBESITY *PROMOTE OBESITY PREVENTION AND HEALTHY LIFESTYLES IN THE TRI-COUNTY REGION FY2015 ACCOMPLISHMENTS OBESITY *Continue to provide weight loss clinic at local health cl ub facility *Offer COOKING DEMONSTRATIONS and OTHER VARIOUS HEALTH RELATED CLASSES *NEED S NOT ADDRESSED THE CHNA CONDUCTED BY THE HOSPITAL IN 2013 ALSO INDENTIFIED "SEXUAL HEALTH ", AND "HEART DISEASE" AMONGST THE MANY IMPORTANT COMMUNITY HEALTH NEEDS A COLLABORATIVE TEAM RECOGNIZED THE IMPACT OF SEXUAL HEALTH, AND HEART DISEASE ON THE POPULATION OF PATIEN TS WE SERVE AS A HEALTH CARE ORGANIZATION WE CONTINUE TO FOCUS RESOURCES ON PATIENT EDUCA TION, EARLY DETECTION AND CARE, BUT WE UNDERSTAND THAT WE ALSO NEED TO HAVE A GREATER FOCU S IN OUR COMMUNITIES ON THOSE RISK FACTORS THAT CONTRIBUTE TO SEXUAL HEALTH, AND HEART DIS EASE WE ANTICIPATE THAT THE GREATEST OVERALL LONG TERM HEALTH IMPACT WILL COME FROM A BRO ADER PREVENTION STRATEGY FOCUSING ON OBESITY, HEALTHY BEHAVIORS, EXERCISE AND SMOKING, RAT HER THAN ON JUST SEXUAL HEALTH, AND HEART DISEASE THE NEEDS OF THOSE IN AREAS OF LOW INCO ME POPULATIONS ARE EXACERBATED BY POVERTY, WAITING TOO LONG FOR MEDICAL ATTENTION AND TRAN SPORTATION IT IS FOR THESE REASONS THAT WE ESTABLISHED AND CONTINUE TO SUPPORT CLINICS TH AT ARE CONVENIENT AND FINANCIALLY ACCESSIBLE THE NEEDS OF THOSE IN SPARSELY POPULATED RUR AL AREAS AND SMALL COMMUNITIES WITH FEW</p>

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SCHEDULE H - PART VI SUPPLEMENTAL INFORMATION - CHNA CONTINUED	<p>ST JOSEPH MEDICAL CENTER - BLOOMINGTON, IL THE CHNA THAT WAS APPROVED AND ADOPTED FOR ST JOSEPH MEDICAL CENTER IDENTIFIED THE FOLLOWING AS THE COMMUNITY'S MOST SIGNIFICANT HEALTH NEEDS IDENTIFIED NEED ACCESS TO HEALTHCARE THIS HEALTH NEED IS BASED ON RESULTS FROM SURVEY RESPONDENTS DEFINED AS LIVING IN DEEP POVERTY WHO INDICATED THAT ACCESS TO HEALTHCARE SERVICES IS LIMITED THIS INCLUDES MEDICAL, PRESCRIPTION MEDICATIONS, DENTAL AND MENTAL HEALTHCARE POVERTY IS A KEY FACTOR, AS 24% OF PEOPLE LIVING IN POVERTY IN MCLEAN COUNTY CONSIDER THE EMERGENCY DEPARTMENT THEIR PRIMARY SOURCE OF HEALTH CARE FURTHERMORE, 44% OF PEOPLE IN POVERTY WERE UNABLE TO OBTAIN MEDICAL CARE WHEN THEY NEEDED IT IN THE PAST YEAR RESULTS ALSO SUGGEST A STRONG CORRELATION BETWEEN ETHNICITY AND ONE'S ABILITY TO OBTAIN MEDICAL CARE AS SURVEY DATA SUGGEST INDIVIDUALS WHO IDENTIFY AS BLACK ARE MORE LIKELY TO USE THE EMERGENCY DEPARTMENT, AS WELL AS YOUNG MEN, LOW EDUCATION AND HOMELESSNESS WITH REGARD TO PRESCRIPTION DRUGS, 46% OF INDIVIDUALS LIVING IN POVERTY IN MCLEAN COUNTY WERE UNABLE TO FILL A PRESCRIPTION IN THE PAST YEAR BECAUSE THEY LACKED HEALTH CARE COVERAGE WITH REGARD TO DENTAL CARE, 44% OF INDIVIDUALS LIVING IN POVERTY IN MCLEAN COUNTY NEEDED DENTAL CARE AND WERE UNABLE TO OBTAIN IT LAST YEAR AND 25% OF INDIVIDUALS LIVING IN POVERTY IN MCLEAN COUNTY NEEDED COUNSELING AND WERE UNABLE TO OBTAIN IT IN THE LAST YEAR "AFFORDABILITY" WAS CITED AS THE LEADING IMPEDIMENT TO VARIOUS TYPES OF HEALTH CARE FY2015 GOALS ACCESS TO HEALTHCARE *EDUCATING COMMUNITY ABOUT ACCESSING APPROPRIATE CARE AT APPROPRIATE TIME, LINK COMMUNITY TO LOWER COST CARE RESOURCES FY2015 ACCOMPLISHMENTS ACCESS TO HEALTHCARE *MATERIALS DISTRIBUTED TO OSF SITES AS WELL AS SCHOOL NURSES, HEALTH FAIRS AND COMMUNITY EVENTS</p> <p>IDENTIFIED NEED RISKY BEHAVIORS/SUBSTANCE ABUSE THIS HEALTH NEED IS BASED ON THE PREVALENCE OF ALCOHOL, TOBACCO AND MARIJUANA IN OUR COMMUNITY RISKY BEHAVIORS ARE DEFINED AS ACTIVITIES THAT INCLUDE ADDICTION, CHEMICAL DEPENDENCY AND RISKY SEXUAL BEHAVIORS NOTE THAT YOUTH SUBSTANCE USAGE IN MCLEAN COUNTY EXCEEDS THE STATE OF ILLINOIS AVERAGES FOR 12TH GRADERS IN TERMS OF ALCOHOL USAGE FY2015 GOALS RISKY BEHAVIORS/SUBSTANCE ABUSE *DECREASE ALCOHOL USE AMONG YOUTH FY2015 ACCOMPLISHMENTS RISKY BEHAVIORS/SUBSTANCE ABUSE *VIDEO COMPLETE AND DISTRIBUTED TO THE BLOOMINGTON/NORMAL PARENTS GROUP IDENTIFIED NEED HEALTHY BEHAVIORS THIS HEALTH NEED BASED ON RESULTS FROM SURVEY RESPONDENTS DEFINED AS LIVING IN DEEP POVERTY, INDICATED THAT THERE ARE LIMITED EFFORTS AT PROACTIVELY MANAGING ONE'S OWN HEALTH THIS INCLUDES LIMITED EXERCISE, POOR EATING HABITS AND INCREASED INCIDENCE OF SMOKING ONLY 17% OF THE MCLEAN COUNTY POPULATION ENGAGES IN EXERCISE 5 OR MORE TIMES PER WEEK NOTE THAT RESIDENTS WITH HIGHER EDUCATION AND HIGHER INCOME ARE MORE LIKELY TO ENGAGE IN EXERCISE WITH REGARD TO HEALTHY EATING, ONLY 7% OF THE POPULATION CONSUMES THE MINIMUM RECOMMENDED SERVINGS OF FRUITS/VEGETABLES IN A DAY THOSE MORE LIKELY TO HAVE HEALTHY EATING HABITS INCLUDE WOMEN, OLDER PEOPLE, PEOPLE WITH HIGHER EDUCATION AND MORE INCOME HOMELESS PEOPLE ARE LESS LIKELY TO EXHIBIT HEALTHY EATING HABITS FINALLY, SMOKING IS ON THE DECLINE, HOWEVER, LESS EDUCATED PEOPLE, MEN, YOUNGER PEOPLE, NON-WHITE RESIDENTS, THOSE WITH LOWER INCOME AND HOMELESS PEOPLE ARE STILL MORE LIKELY TO SMOKE FY2015 GOALS HEALTHY BEHAVIORS *INCREASE USE OF EVIDENCE-BASED INTERVENTIONS FOR SMOKING CESSATION FY2015 ACCOMPLISHMENTS HEALTHY BEHAVIORS *MARKETING OUTREACH THAT HAS OCCURRED RADIO SPOT, HEALTHY CELLS, PANTAGRAPH AND SOCIAL MEDIA *Tracking education at Home Sweet Home Ministries and Community Health Care Clinic IDENTIFIED NEED MENTAL HEALTH THIS HEALTH NEED LOOKS AT THE PERCENT OF PATIENTS THAT REPORTED THEY HAD EXPERIENCED 1-7 DAYS WITH POOR MENTAL HEALTH PER MONTH BETWEEN 2007 AND 2009 THIS INCLUDES MENTAL DISABILITIES, DEPRESSION AND SELF-PERCEPTIONS OF MENTAL HEALTH APPROXIMATELY 23% OF RESIDENTS IN MCLEAN COUNTY REPORTED THEY HAD EXPERIENCED 1-7 DAYS WITH POOR MENTAL HEALTH PER MONTH BETWEEN 2007 AND 2009 APPROXIMATELY 11% OF RESIDENTS IN MCLEAN COUNTY REPORTED THEY HAD EXPERIENCED 8-30 DAYS WITH POOR MENTAL HEALTH PER MONTH BETWEEN 2007 AND 2009 FOR BOTH SEGMENTS OF RESIDENTS (THOSE EXPERIENCING 1-7 DAYS AND 8-30 DAYS WITH POOR MENTAL HEALTH PER MONTH), EACH WAS BELOW THE STATE AVERAGE FOR THE SAME TIME FRAME FY2015 GOALS MENTAL HEALTH *Link community to existing resources for mental health care FY2015 ACCOMPLISHMENTS MENTAL HEALTH *Completed radio program and stress less programs IDENTIFIED NEED OBESITY THIS HEALTH NEED IS BASED ON AN INCREASE IN THE PREVALENCE OF OBESITY IN OUR COMMUNITY POPULATION RESEARCH STRONGLY SUGGESTS THAT OBESITY IS A SIGNIFICANT PROBLEM FACING YOUTH AND ADULTS NATIONALLY, IN ILLINOIS, AND WITHIN THE MCLEAN COUNTY REGION IN TERMS OF OBESITY, THE MCLEAN COUNTY AREA AS A WHOLE IS HIGHER THAN THE STATE AVERAGE AND GROWING RAPIDLY</p>

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SCHEDULE H - PART VI SUPPLEMENTAL INFORMATION - CHNA CONTINUED	<p>THERE WAS A 13% INCREASE IN THE GROWTH OF MCLEAN COUNTY RESIDENTS REPORTING THEY WERE OV ERWEIGHT BETWEEN 2006 (35 0%) AND 2009 (39 5%) CONSIDERING THAT ILLINOIS HAS THE 6TH HIGH EST OBESITY RATE IN THE U S , THIS IS AN IMPORTANT ISSUE FY2015 GOALS OBESITY *Access to affordable nutrition/physical activity education FY2015 ACCOMPLISHMENTS OBESITY *Offered education events at employers and community sites, e g St Mary's Church, schools, Weste rn Avenue, Home Sweet Home Ministry, Parish Nurses *Harvested several hundred pounds of pr oduce and donated to Home Sweet Homes IDENTIFIED NEED DENTAL THIS HEALTH NEED IS BASED ON A PERSON'S PERCEPTION OF THE ABILITY TO OBTAIN DENTAL CARE IN THEIR COMMUNITY WHILE SIG NIFICANT RESEARCH EXISTS LINKING DENTAL CARE TO NUMEROUS DISEASES, INCLUDING HEART DISEASE , ONLY 51% OF THE AGGREGATE MCCLEAN COUNTY POPULATION HAD A CHECKUP IN THE LAST YEAR SPEC IFICALLY MEN, YOUNGER RESPONDENTS, NON-WHITE ETHNICITIES, LESS EDUCATED PEOPLE, LOWER HOUS Ehold INCOME AND THE HOMELESS WERE LESS LIKELY TO VISIT A DENTIST FY2015 GOALS DENTAL *I MPROVEMENT OF DENTAL HEALTH IN MCLEAN COUNTY FY2015 ACCOMPLISHMENTS DENTAL *Distributed p ediatric toothbrushes or dental kits *NEEDS NOT ADDRESSED THE CHNA CONDUCTED BY THE HOSPIT AL IN 2013 ALSO INDENTIFIED "CANCER", "HEART DISEASE","RESPIRATORY ISSUES", "DIABETES", "C OMMUNITY MISPERCEPTIONS", AND "WOMAN'S HEALTH" AMONGST THE MANY IMPORTANT COMMUNITY HEALTH NEEDS A COLLABORATIVE TEAM RECOGNIZED THE IMPACT OF CANCER, HEART DISEASE, RESPIRATORY I SSUES, DIABETES, COMMUNITY MISPERCEPTIONS, AND WOMAN'S HEALTH ON THE POPULATION OF PATIENT S WE SERVE AS A HEALTH CARE ORGANIZATION WE CONTINUE TO FOCUS RESOURCES ON PATIENT EDUCAT ION, EARLY DETECTION AND CARE, BUT WE UNDERSTAND THAT WE ALSO NEED TO HAVE A GREATER FOCUS IN OUR COMMUNITIES ON THOSE RISK FACTORS THAT CONTRIBUTE TO CANCER, HEART DISEASE, RESPIR ATORY ISSUES, DIABETES, COMMUNITY MISPERCEPTIONS, AND WOMAN'S HEALTH WE ANTICIPATE THAT T HE GREATEST OVERALL LONG TERM HEALTH IMPACT WILL COME FROM A BROADER PREVENTION STRATEGY F OCUSING ON OBESITY, HEALTHY BEHAVIORS, EXERCISE AND SMOKING, RATHER THAN ON JUST CANCER, H EART DISEASE, RESPIRATORY ISSUES, DIABETES, COMMUNITY MISPERCEPTIONS, AND WOMAN'S HEALTH ST MARY MEDICAL CENTER - GALESBURG, IL THE CHNA THAT WAS APPROVED AND ADOPTED FOR ST MARY MEDICAL CENTER IDENTIFIED THE FOLLOWING AS THE COMMUNITY'S MOST SIGNIFICANT HEALTH NEEDS IDENTIFIED NEED ACCESS TO HEALTH CARE SERVICES THIS HEALTH NEED BASED ON RESULTS FROM S URVEY RESPONDENTS DEFINED AS LIVING IN DEEP POVERTY INDICATED THAT ACCESS TO HEALTHCARE SE RVICES IS LIMITED THIS INCLUDES MEDICAL, PRESCRIPTION MEDICATIONS, DENTAL AND MENTAL HEAL THCARE POVERTY IS A KEY FACTOR, AS 13% OF PEOPLE LIVING IN POVERTY IN KNOX AND WARREN COU NTIES CONSIDER THE EMERGENCY DEPARTMENT THEIR PRIMARY SOURCE OF HEALTH CARE FURTHERMORE, 23% OF PEOPLE IN POVERTY WERE UNABLE TO OBTAIN MEDICAL CARE WHEN THEY NEEDED IT RESULTS A LSO SUGGEST A STRONG CORRELATION BETWEEN ETHNICITY AND SOCIOECONOMIC STATUS AND ONE'S ABIL ITY TO OBTAIN MEDICAL CARE SURVEY DATA SUGGEST INDIVIDUALS WHO IDENTIFY AS BLACK, POSSESS ING LESS EDUCATION, AND OF LOWER INCOME ARE MORE LIKELY TO USE THE EMERGENCY DEPARTMENT F URTHERMORE, RESIDENTS RESIDING IN KNOX COUNTY ARE MORE LIKELY TO USE THE EMERGENCY DEPARTM ENT WITH REGARD TO PRESCRIPTION DRUGS, 28% OF INDIVIDUALS LIVING IN POVERTY IN KNOX AND WARREN COUNTIES WERE UNABLE TO FILL A PRESCRIPTION BECAUSE THEY LACKED HEALTH CARE COVERAGE WITH REGARD TO DENTAL CARE, 35% OF INDIVIDUALS LIVING IN POVERTY IN KNOX AND WARREN COUN TIES NEEDED DENTAL CARE AND WERE UNABLE TO OBTAIN IT AND 15% OF INDIVIDUALS LIVING IN POVE RTY IN KNOX AND WARREN COUNTIES NEEDED COUNSELING AND WERE UNABLE TO OBTAIN IT "AFFORDABI LITY" WAS CITED AS THE LEADING IMPEDIMENT TO VARIOUS TYPES OF HEALTH CARE NEEDS FY2015 GO ALS ACCESS TO HEALTHCARE *IMPROVE ACCESS TO COMPREHENSIVE QUALITY HEALTH CARE SERVICES FY 2015 ACCOMPLISHMENTS ACCESS TO HEALTHCA</p>

Form and Line Reference	Explanation
SCHEDULE H - PART VI SUPPLEMENTAL INFORMATION - CHNA CONTINUED	<p>ST FRANCIS HOSPITAL - ESCANABA, MI THE CHNA THAT WAS APPROVED AND ADOPTED FOR ST FRANCIS HOSPITAL IDENTIFIED THE FOLLOWING AS THE COMMUNITIES MOST SIGNIFICANT HEALTH NEEDS IDENT IFIED NEED RISKY BEHAVIORS - SUBSTANCE ABUSE THIS HEALTH NEED IS BASED ON THE PREVALENCE OF ALCOHOL, TOBACCO AND MARIJUANA IN OUR COMMUNITY IN DELTA COUNTY, 25% OF RESPONDENTS EN GAGE IN BINGE DRINKING VERSUS 18% IN THE STATE OF MICHIGAN BOTH FIGURES EXCEED THE US NAT IONAL 90TH PERCENTILE BENCHMARK OF 8% THERE HAS ALSO BEEN A 4 5% INCREASE FOR THOSE IDENT IFYING THEMSELVES AS SMOKERS IN DELTA COUNTY BETWEEN 2005-2007 AND 2008-2010 IN CONTRAST, THERE WAS A DECREASE FOR THOSE IDENTIFYING THEMSELVES AS SMOKERS FOR THE STATE OF MICHIGA N DURING SAME TIME FRAME THUS, DELTA COUNTY IS CURRENTLY 8 5% HIGHER THAN STATE OF MICHIG AN AVERAGES ADDITIONALLY, ACCORDING TO SURVEY RESPONDENTS, FOR BOTH DELTA COUNTY'S AGGREG ATE POPULATION AND THOSE LIVING IN POVERTY, DRUG AND ALCOHOL ABUSE WERE PERCEIVED AS THE T WO MOST IMPORTANT UNHEALTHY BEHAVIORS IN THE COMMUNITY FY2015 GOALS RISKY BEHAVIORS - SU BSTANCE ABUSE *DECREASE INSTANCES OF RISKY BEHAVIOR AND SUBSTANCE ABUSE IN DELTA COUNTY FY 2015 ACCOMPLISHMENTS RISKY BEHAVIORS/SUBSTANCE ABUSE *REACHING OUT TO MEMBERS OF COMMUNIT Y DRUG COALITION *CLINIC COORDINATORS TRACKING SPREADSHEET ON ALL FACTORS (DRUG CONTRACT, DRUG SCREEN, MAPS, PILL COUNT, ETC ) *SPONSORED LIFE RIDES PROVIDED TAXI CAB VOUCHERS FOR NEW YEARS DON'T DRINK AND DRIVE PROGRAM *EDUCATION ON DANGERS OF RISKY BEHAVIORS OFFERED IDENTIFIED NEED DIABETES THIS HEALTH NEED IS BASED ON AN INCREASE IN INPATIENT ADMISSIONS FOR DIABETES AND AN INCREASE IN THE PREVALENCE OF DIABETES IN THE GENERAL POPULATION IT IS ESTIMATED THAT 90-95% OF INDIVIDUALS WITH DIABETES HAVE TYPE II DIABETES (PREVIOUSLY KN OWN AS ADULT-ONSET DIABETES) DIABETES IS THE LEADING CAUSE OF KIDNEY FAILURE, ADULT BLIND NESS AND AMPUTATIONS AND IS A LEADING CONTRIBUTOR TO STROKES AND HEART ATTACKS DATA FROM THE MICHIGAN BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM INDICATE THAT NEARLY 10% OF DELTA COUNTY REGION RESIDENTS HAVE DIABETES COMPARED TO DATA FROM THE STATE OF MICHIGAN (9 5%), THE PREVALENCE OF DIABETES NOW EXCEEDS THE STATE AVERAGE FY2015 GOALS DIABETES *ENCOURA GE HEALTHY BEHAVIORS AMONG RESIDENTS OF DELTA COUNTY TO BETTER MANAGE AND PREVENT THE ONSE T OF DIABETES FY2015 ACCOMPLISHMENTS DIABETES *GRADUATED 1ST CLASS IN PERSONAL ACTION TOWARDS HEALTH PROGRAM THIS PROGRAM HELPS PEOPLE WITH KNOWLEDGE TO HANDLE CHRONIC DISEASES *PROVIDED ON-GOING EDUCATION AND TRAINING FOR MANAGEMENT/PREVENTION OF DIABETES *PERFORME D FREE BLOOD SUGAR SCREENINGS AT COMMUNITY EVENTS *OFFER FREE DIABETIC SUPPORT GROUP MEET INGS NEED IDENTIFIED COMMUNITY MISPERCEPTIONS THIS HEALTH NEED IS BASED ON RESULTS FROM THE SURVEY WHERE RESPONDENTS INCORRECTLY PERCEIVED CERTAIN BEHAVIORS AS BEING RELATIVELY U NIMPORTANT HEALTH CONCERNS IN THE COMMUNITY THIS HEALTH NEED OBSERVES THE GAP BETWEEN PAT IENT PERCEPTIONS OF COMMUNITY NEEDS AND THE ACTUAL TOP CAUSES OF MORTALITY IN THEIR COMMUN ITY WHILE THE RESPONSE OF THOSE LIVING IN DEEP POVERTY MISINTERPRETS SOME OF THE MOST CRI TICAL NEEDS OF THE COMMUNITY BASED ON ACTUAL MORTALITY DATA, THERE IS MUCH TO BE LEARNED F ROM THEIR RESPONSES THESE PERSONS PERCEPTIONS ARE THEIR REALITY AND FORCES TO ACKNOWLEDGE THAT WE MUST NEVER LOSE FOCUS ON THE INDIVIDUAL AS WE IMPROVE THE HEALTH OF THE COMMUNITY OSF HEALTHCARE SYSTEM HAS DEVELOPED A CARE MANAGEMENT PROGRAM TO PROVIDE THOSE IN NEED WITH THE HELP THEY NEED TO IMPROVE THEIR INDIVIDUAL HEALTH AND OVERCOME BARRIERS TO HEALTH BASED ON RESULTS FROM THE SURVEY, RESPONDENTS INCORRECTLY PERCEIVED, "DIABETES", "HEART D ISEASE", AND "DENTAL" AS BEING RELATIVELY LESS IMPORTANT HEALTH CONCERNS TO THE COMMUNITY THESE RESULTS CONFLICT WITH MORTALITY DATA THAT SUGGESTS DIABETES RATES IN DELTA COUNTY A RE HIGHER THAN RATES ACROSS THE STATE OF MICHIGAN MORTALITY DATA INDICATES HEART DISEASE IS THE LEADING CAUSE OF DEATH IN DELTA COUNTY, AND DENTAL DATA ILLUSTRATES DELTA COUNTY RE SIDENTS HAVE UNDERGONE ANNUAL DENTAL CHECKUPS AT A LOWER RATE (62 8%) THAN RATES FOR THE S TATE OF MICHIGAN (73 8%) AND HAVE HIGHER RATES OF LOST TEETH DUE TO TOOTH DECAY OR GUM DIS EASE (19 9%) VERSUS RATES FOR THE STATE OF MICHIGAN (13 8%) MOREOVER, FOR THOSE RESPONDEN TS LIVING IN POVERTY, MISPERCEPTIONS OF PROGRAMS SUCH AS MEDICAID AND FINANCIAL ASSISTANCE PROGRAMS IS EVIDENT GIVEN THAT RESPONDENTS DO NOT SEEK NECESSARY MEDICAL CARE BECAUSE THE Y BELIEVE THEY CANNOT AFFORD TO PAY FINALLY, THERE ARE MISPERCEPTIONS WITH RESPONDENTS' S ELF PERCEPTIONS OF THEIR OWN HEALTH, AS 94% FELT THAT THEY ARE EITHER AVERAGE OR ABOVE AVE RAGE OVERALL FY2015 GOALS COMMUNITY MISPERCEPTIONS *ENCOURAGE HEALTHY BEHAVIORS AMONG RE SIDENTS OF DELTA COUNTY, PARTICULARLY WITHIN THE AT-RISK POPULATION FY2015 ACCOMPLISHMENTS COMMUNITY MISPERCETPTIONS *PROVIDED MONTHLY MEDIA ANNOUNCEMENTS *ESTABLISHED A COMMITTEE WITH REPRESENTATIVES FROM OSF AND OTHER SERVICE O</p>

Form and Line Reference	Explanation
SCHEDULE H - PART VI SUPPLEMENTAL INFORMATION - CHNA CONTINUED	<p>RGANIZATIONS IDENTIFIED NEED MENTAL HEALTH THIS HEALTH NEED LOOKS AT THE PERCENT OF PATI ENTS THAT REPORTED THEY HAD EXPERIENCED 1-7 DAYS WITH POOR MENTAL HEALTH PER MONTH BETWEEN 2007 AND 2009 THIS INCLUDES MENTAL DISABILITIES, DEPRESSION AND SELF-PERCEPTIONS OF MENT AL HEALTH WHILE THERE WAS A SLIGHT DECREASE IN AVERAGE NUMBER OF MENTALLY UNHEALTHY DAYS INDICATED BY DELTA COUNTY RESIDENTS BETWEEN 2010 AND 2012 FROM 4 TO 3 5 DAYS IN THE LAST M ONTH, IT IS 30% HIGHER WHEN COMPARED TO THE U S 90TH PERCENTILE MOREOVER, AMONG PEOPLE LIVING IN POVERTY, MENTAL HEALTH WAS RATED AS THE MOST IMPORTANT HEALTH CONCERN FY2015 GOA LS MENTAL HEALTH *ENSURE ACCESS TO MENTAL HEALTH SERVICES IN DELTA COUNTY FY2015 ACCOMPLI SHMENTS MENTAL HEALTH *END OF 2014, SIGNED A CONTRACT WITH PATHWAYS TO SUBSIDIZE COSTS ON EXPANDING SERVICES PATHWAYS HAD PREVIOUSLY SEEN ONLY MEDICAID AND SELF PATIENTS WILL NO W SEE ALL PATIENTS UPON A REFERRAL FROM OSF *PROVIDED FINANCIAL SUPPORT TO A KEY PROVIDER OF MENTAL HEALTH</p> <p>IDENTIFIED NEED OBESITY THIS HEALTH NEED IS BASED ON AN INCREASE IN TH E PREVALENCE OF OBESITY IN OUR COMMUNITY POPULATION RESEARCH STRONGLY SUGGESTS THAT OBESI TY IS A SIGNIFICANT PROBLEM FACING YOUTH AND ADULTS NATIONALLY, AS IT HAS BEEN LINKED TO N UMEROUS MORBIDITIES (E G , TYPE II DIABETES, HYPERTENSION, CARDIOVASCULAR DISEASE, CANCER, ETC ) IN DELTA COUNTY, THE RATE OF OBESITY HAS INCREASED FROM 26 1% TO 29 6% IN A THREE- YEAR PERIOD DURING THE SAME TIME FRAME, THE PERCENTAGE OF THE POPULATION THAT IS DEFINED AS OVERWEIGHT HAS RISEN FROM 38 6% TO 41% NOTE THAT THIS IS ALMOST 6% HIGHER THAN STATE O F MICHIGAN AVERAGES FY2015 GOALS OBESITY *ENCOURAGE HEALTHY BEHAVIORS AMONG THE CITIZENS OF DELTA COUNTY TO MANAGE AND PREVENT THE ONSET OF OBESITY FY2015 ACCOMPLISHMENTS OBESIT Y *INVOLVEMENT IN "FUEL UP TO PLAY 60" *PROVIDE MEDICAL NUTRITION EDUCATION AND TRAINING ON MANAGEMENT AND PREVENTION OF OBESITY *ON-GOING SUPPORT OF CHAMBER "CENTURY" BIKE RIDE AND COMMUNITY RUN/WALKS *NEEDS NOT ADDRESSED THE CHNA CONDUCTED BY THE HOSPITAL IN 2013 A LSO INDENTIFIED "CANCER", "HEART DISEASE", "RESPIRATORY ISSUES", "POVERTY - HEALTHY BEHAVI ORS", "ACCESS TO HEALTH" AND "DENTAL" AMONGST THE MANY IMPORTANT COMMUNITY HEALTH NEEDS A COLLABORATIVE TEAM RECOGNIZED THE IMPACT OF CANCER, HEART DISEASE, RESPIRATORY ISSUES, PO VERTY - HEALTHY BEHAVIORS, ACCESS TO HEALTH AND DENTAL ON THE POPULATION OF PATIENTS WE SE RVE AS A HEALTH CARE ORGANIZATION WE CONTINUE TO FOCUS RESOURCES ON PATIENT EDUCATION, EA RLY DETECTION AND CARE, BUT WE UNDERSTAND THAT WE ALSO NEED TO HAVE A GREATER FOCUS IN OUR COMMUNITIES ON THOSE RISK FACTORS THAT CONTRIBUTE TO CANCER, HEART DISEASE, RESPIRATORY I SSUES, POVERTY - HEALTHY BEHAVIORS, ACCESS TO HEALTH AND DENTAL WE ANTICIPATE THAT THE GR EATEST OVERALL LONG TERM HEALTH IMPACT WILL COME FROM A BROADER PREVENTION STRATEGY FOCUSI NG ON OBESITY, EXERCISE AND SMOKING, RATHER THAN ON JUST CANCER, HEART DISEASE, RESPIRATOR Y ISSUES, POVERTY - HEALTHY BEHAVIORS, ACCESS TO HEALTH AND DENTAL SAINT JAMES HOSPITAL - PONTIAC, IL THE CHNA THAT WAS APPROVED AND ADOPTED FOR SAINT JAMES HOSPITAL IDENTIFIED TH E FOLLOWING AS THE COMMUNITY'S MOST SIGNIFICANT HEALTH NEEDS IDENTIFIED NEED COMMUNITY M ISPERCEPTIONS THIS NEED IS BASED ON RESULTS FROM THE SURVEY WHERE RESPONDENTS INCORRECTLY PERCEIVED CERTAIN BEHAVIORS AS BEING RELATIVELY UNIMPORTANT HEALTH CONCERNS IN THE COMMUNI TY THIS NEED OBESERVES THE GAP BETWEEN PATIENT PERCEPTIONS OF COMMUNITY NEEDS AND THE ACT UAL TOP CAUSES OF MORTALITY IN THEIR COMMUNITY WHILE THE RESPONSE OF THOSE LIVING IN DEEP POVERTY MISINTERPRETS SOME OF THE MOST CRITICAL NEEDS OF THE COMMUNITY BASED ON ACTUAL MO RTALITY DATA, THERE IS MUCH TO BE LEARNED FROM THEIR RESPONSES THESE PEOPLE'S PERCEPTIONS ARE THEIR REALITY AND FORCES TO ACKNOWLEDGE THAT WE MUST NEVER LOSE FOCUS ON THE INDIVIDU AL AS WE IMPROVE THE HEALTH OF THE COMMUNITY OSF HEALTHCARE SYSTEM HAS DEVELOPED A CARE M ANAGEMENT PROGRAM TO PROVIDE THOSE IN NE</p>

Form and Line Reference	Explanation
SCHEDULE H - PART VI SUPPLEMENTAL INFORMATION - CHNA CONTINUED	SUMMARY WE BELIEVE THE OBJECTIVES LISTED ABOVE WILL HELP US FOCUS ON OUR COMMUNITIES' MOST PRESSING HEALTH CARE NEEDS NOT ONLY FOR OUR FY 2015 BUT BEYOND AS WELL OSF HEALTHCARE EXISTS TO CARE FOR OTHERS, IN PARTICULAR THEIR HEALTH AND MEDICAL RELATED NEEDS AT ALL LEVELS OF OSF THERE IS A VERY STRONG COMMITMENT TO OUR MISSION ("TO SERVE PERSONS WITH THE GREATEST CARE AND LOVE") AND IN CARRYING OUT OUR MISSION IN THE CONTEXT OF OUR VALUES CITED EARLIER, OUR FIRST VALUE, "JUSTICE PERSONAL WORTH AND DIGNITY OF EVERY PERSON WE SERVE REGARDLESS OF RACE, COLOR, RELIGION AND ABILITY TO PAY " SPECIFICALLY ADDRESSES THOSE WHO ARE UNINSURED OR UNDER-INSURED THE SISTERS OF THE THIRD ORDER OF ST FRANCIS STARTED THEIR HEALING MINISTRY IN 1877 AND HAVE BEEN ACTIVELY GROWING THAT MINISTRY IN EACH OF THE LAST THREE CENTURIES BECAUSE OF THE HEALTHCARE NEEDS OF ALL THOSE IN OUR ELEVEN SERVICE AREAS ADDITIONALLY, OUR LEADERSHIP THROUGHOUT OSF IS COMMITTED TO CONTINUING TO ADDRESS UNMET HEALTH CARE NEEDS IN OUR SERVICE AREAS BY WORKING WITH THEIR RESPECTIVE COUNTY HEALTH DEPARTMENTS AND LOCAL SOCIAL/COMMUNITY SERVICE ORGANIZATIONS LIKE THEIR UNITED WAY ORGANIZATIONS THERE IS MUCH TO BE DONE, BUT THROUGH COLLABORATION "MANY HANDS WILL MAKE LIGHT WORK "

Form and Line Reference	Explanation
<p>SCHEDULE H - PART VI - 3 - PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE</p>	<p>THE CORPORATION INFORMS AND EDUCATES PATIENTS AND PERSONS WHO ARE BILLED FOR PATIENT CARE ABOUT THEIR ELIGIBILITY FOR ASSISTANCE UNDER GOVERNMENT PROGRAMS AND THE CORPORATION'S CHARITY ASSISTANCE POLICY IN THE FOLLOWING WAYS - SIGNS ARE POSTED IN PATIENT REGISTRATION AREAS (INCLUDING EMERGENCY DEPARTMENT REGISTRATION) INFORMING PATIENTS OF THE AVAILABILITY OF CHARITY ASSISTANCE AND THE AVAILABILITY OF FINANCIAL ASSISTANCE REPRESENTATIVES - PRINTED BROCHURES ARE DISTRIBUTED TO PATIENTS AT REGISTRATION INFORMING THEM OF THE AVAILABILITY OF CHARITY ASSISTANCE AND UNINSURED PATIENTS DISCOUNTS (FOR BOTH INSURED AND UNINSURED PATIENTS), AND FINANCIAL ASSISTANCE REPRESENTATIVES (INCLUDING CONTACT INFORMATION) - A NOTICE OF AVAILABILITY OF THE CORPORATION'S CHARITY CARE AND UNINSURED PATIENT DISCOUNT POLICIES IS PROMINENTLY AVAILABLE ON THE CORPORATION'S WEB SITE (AND SEPARATE WEB SITES OF ITS HOSPITAL FACILITIES) THE APPLICATION FORM WITH INSTRUCTIONS IS AVAILABLE FOR DOWNLOAD - A NOTE REGARDING THE AVAILABILITY OF CHARITY AND FINANCIAL ASSISTANCE (TOGETHER WITH CONTACT PHONE NUMBERS) APPEARS ON EVERY PATIENT BILL AND STATEMENT - FINANCIAL ASSISTANCE COUNSELORS ARE AVAILABLE IN PERSON AND BY PHONE TO ASSIST PATIENTS IN COMPLETING CHARITY AND FINANCIAL ASSISTANCE APPLICATIONS AND IN DETERMINING ELIGIBILITY AND APPLYING FOR GOVERNMENT PROGRAM BENEFITS, INCLUDING MEDICAID - THE CORPORATION'S CHARITY CARE POLICY IS FILED WITH THE ILLINOIS ATTORNEY GENERAL AND IS AVAILABLE TO THE PUBLIC</p>

Form and Line Reference	Explanation
SCHEDULE H - PART VI - 4 COMMUNITY INFORMATION - AS NOTED IN CHNA	<p>SAINT FRANCIS MEDICAL CENTER IS LOCATED IN PEORIA COUNTY IN ILLINOIS AND SERVES THOSE IN THE COUNTIES OF PEORIA, TAZEWELL, AND WOODFORD PEORIA COUNTY IS A METROPOLITAN STATISTICAL AREA AND ITS POPULATION IN 2010 WAS 186,494 FOR PEORIA COUNTY, THE MEDIAN HOUSEHOLD INCOME IN 2010 WAS \$49,819 AND THE PERCENT OF PERSONS BELOW POVERTY LEVEL WAS 15 4% TAZEWELL COUNTY IS A METROPOLITAN STATISTICAL AREA AND ITS POPULATION IN 2010 WAS 135,394 FOR TAZEWELL COUNTY, THE MEDIAN HOUSEHOLD INCOME IN 2010 FOR WAS \$54,078 AND THE PERCENT OF PERSONS BELOW POVERTY LEVEL WAS 8 5% WOODFORD COUNTY IS A METROPOLITAN STATISTICAL AREA AND ITS POPULATION IN 2010 WAS 38,664 FOR WOODFORD COUNTY, THE MEDIAN HOUSEHOLD INCOME IN 2010 WAS \$65,342 AND THE PERCENT OF PERSONS BELOW POVERTY LEVEL WAS 7 2% SAINT ANTHONY MEDICAL CENTER IS LOCATED IN WINNEBAGO COUNTY WINNEBAGO COUNTY IS A METROPOLITAN STATISTICAL AREA AND ITS POPULATION IN 2010 WAS 295,266 FOR WINNEBAGO COUNTY, THE MEDIAN HOUSEHOLD INCOME IN 2010 WAS \$45,611 AND THE PERCENT OF PERSONS BELOW POVERTY LEVEL WAS 12 7% ST JOSEPH MEDICAL CENTER IS LOCATED IN MCLEAN COUNTY IN ILLINOIS MCLEAN COUNTY IS A METROPOLITAN STATISTICAL AREA AND ITS POPULATION IN 2010 WAS 169,572 FOR MCLEAN COUNTY, THE MEDIAN HOUSEHOLD INCOME IN 2010 WAS \$58,365 AND THE PERCENT OF PERSONS BELOW POVERTY LEVEL WAS 11% SAINT JAMES HOSPITAL IS LOCATED IN LIVINGSTON COUNTY IN ILLINOIS LIVINGSTON COUNTY IS A METROPOLITAN STATISTICAL AREA AND ITS POPULATION IN 2010 WAS 38,950 FOR LIVINGSTON COUNTY, THE MEDIAN HOUSEHOLD INCOME IN 2010 WAS \$53,745 AND THE PERCENT OF PERSONS BELOW POVERTY LEVEL WAS 11 0% ST MARY MEDICAL CENTER IS LOCATED IN KNOX COUNTY IN ILLINOIS KNOX COUNTY IS A METROPOLITAN STATISTICAL AREA AND ITS POPULATION IN 2010 WAS 52,919 FOR KNOX COUNTY, THE MEDIAN HOUSEHOLD INCOME IN 2010 WAS \$38,535 AND THE PERCENT OF PERSONS BELOW POVERTY LEVEL WAS 15 5% OSF HOLY FAMILY MEDICAL CENTER IS LOCATED IN WARREN COUNTY IN ILLINOIS WARREN COUNTY IS A METROPOLITAN STATISTICAL AREA AND ITS POPULATION IN 2010 WAS 17,707 FOR WARREN COUNTY, THE MEDIAN HOUSEHOLD INCOME IN 2010 WAS \$42,773 AND THE PERCENT OF PERSONS BELOW POVERTY LEVEL WAS 13 4% ST FRANCIS HOSPITAL IS LOCATED IN DELTA COUNTY IN MICHIGAN DELTA COUNTY IS A METROPOLITAN STATISTICAL AREA AND ITS POPULATION IN 2010 WAS 37,069 FOR DELTA COUNTY, THE MEDIAN HOUSEHOLD INCOME IN 2010 WAS \$40,496 AND THE PERCENT OF PERSONS BELOW POVERTY LEVEL WAS 12 7% OSF SAINT LUKE MEDICAL CENTER IS LOCATED IN HENRY COUNTY IT'S POPULATION IN 2010 WAS 50,486 FOR HENRY COUNTY, THE MEDIAN HOUSEHOLD INCOME FROM 2009-2013 WAS \$52,940 AND THE PERCENT OF PERSONS BELOW POVERTY LEVEL WAS 10 5% OSF SAINT ANTHONY'S HEALTH CENTER IS LOCATED IN MADISON COUNTY IN ILLINOIS MADISON COUNTY IS A PART OF THE METRO-EAST REGION OF THE ST LOUIS METRO AREA AND ITS POPULATION IN 2010 WAS 269,328 FOR MADISON COUNTY, THE MEDIAN HOUSEHOLD INCOME IN 2010 WAS \$53,912 AND THE PERCENT OF PERSONS BELOW POVERTY LEVEL WAS 13 1%</p>

Form and Line Reference	Explanation
SCHEDULE H - PART VI - 5 - PROMOTION OF COMMUNITY HEALTH	<p>THE CORPORATION'S SPONSORING ORGANIZATION IS A RELIGIOUS CONGREGATION OF THE ROMAN CATHOLIC CHURCH KNOWN AS THE SISTERS OF THE THIRD ORDER OF ST FRANCIS IN ACCORDANCE WITH CANON LAW OF THE ROMAN CATHOLIC CHURCH AND FEDERAL TAX LAW APPLICABLE TO SUPPORTING ORGANIZATIONS, A MAJORITY OF THE MEMBERS OF THE BOARD OF DIRECTORS OF THE CORPORATION ARE PROFESSED MEMBERS OF THE SPONSORING RELIGIOUS CONGREGATION EACH HOSPITAL OPERATED BY THE CORPORATION HAS A COMMUNITY ADVISORY BOARD CONSISTING OF MEMBERS OF THE COMMUNITY WHO ARE NOT DIRECTORS, OFFICERS, OR CONTRACTORS OF THE CORPORATION EXCEPT FOR HOSPITAL DEPARTMENTS WHICH HAVE BEEN CLOSED, OR IN WHICH CLINICAL PRIVILEGES HAVE BEEN RESTRICTED, FOR CLINICAL OR QUALITY OF CARE REASONS BY ACTIONS OF THE HOSPITAL'S MEDICAL STAFF AND THE BOARD OF DIRECTORS, THE CORPORATION EXTENDS MEDICAL STAFF PRIVILEGES TO ALL QUALIFIED PHYSICIANS IN ITS COMMUNITIES THE CORPORATION'S SURPLUS FUNDS WERE USED DURING ITS FISCAL YEAR ENDED SEPTEMBER 30, 2015 FOR IMPROVEMENTS IN PATIENT CARE, MEDICAL EDUCATION, AND RESEARCH IN THE FOLLOWING WAYS - CAPITAL EXPENDITURES OF APPROXIMATELY \$72,287,000 WERE MADE DURING THE FISCAL YEAR FOR CONSTRUCTION AND RENOVATION OF PATIENT CARE FACILITIES AND ACQUISITION OF MEDICAL EQUIPMENT AND OTHER EQUIPMENT USED IN PATIENT CARE AND RELATED SUPPORT SERVICES - THE CORPORATION INCURRED NET COSTS (EXPENSES MINUS REVENUES) OF APPROXIMATELY \$32,523,931 DURING THE FISCAL YEAR FOR ACCREDITED PHYSICIAN RESIDENCY PROGRAMS AND NET COSTS OF APPROXIMATELY \$8,931,650 FOR UNDERGRADUATE AND GRADUATE NURSING EDUCATION PROGRAMS AND OTHER MEDICAL EDUCATION PROGRAMS SEE SCHEDULE O, FORM 990, PART III, LINE 4D FOR A DESCRIPTION OF SUCH PROGRAMS - THE CORPORATION INCURRED NET COSTS (EXPENSES MINUS REVENUES) OF APPROXIMATELY \$392,114 DURING THE FISCAL YEAR FOR CLINICAL RESEARCH PROGRAMS AND ACTIVITIES ALL OF THE CORPORATION'S HOSPITALS MEET THE REQUIREMENTS OF REVENUE RULING 69-545 BY - OPERATING EMERGENCY DEPARTMENTS WHICH ARE STAFFED 24 HOURS PER DAY BY QUALIFIED PHYSICIANS AND OTHER MEDICAL PERSONNEL AND WHICH ARE OPEN TO ALL PERSONS WITHOUT REGARD TO ABILITY TO PAY - HAVING MEDICAL STAFFS WHICH ARE OPEN TO ALL QUALIFIED PHYSICIANS, MID-LEVEL PROVIDERS, PODIATRISTS, AND DENTISTS IN THE COMMUNITY (EXCEPT WHERE RESTRICTED IN RARE CASES FOR CLINICAL QUALITY REASONS BY ACTION OF THE MEDICAL STAFF AND THE BOARD OF DIRECTORS) - ACCEPTING MEDICARE, MEDICAID AND OTHER GOVERNMENT PROGRAM PATIENTS - ACCEPTING ALL PATIENTS, INCLUDING UNINSURED PATIENTS, WITHOUT REGARD TO THEIR ABILITY TO PAY - USING SURPLUS FUNDS TO IMPROVE THEIR FACILITIES, EQUIPMENT, PATIENT CARE, MEDICAL TRAINING, EDUCATION, AND RESEARCH AS DESCRIBED ABOVE THE FOLLOWING PROVIDES A SUMMARY OF SERVICES FOR EACH OSF HOSPITAL SAINT FRANCIS MEDICAL CENTER ("SAINT FRANCIS MEDICAL CENTER") IS A 609 LICENSED BED TERTIARY ACUTE CARE TEACHING HOSPITAL LOCATED NEAR DOWNTOWN PEORIA, ILLINOIS SAINT FRANCIS MEDICAL CENTER OPERATES SEVERAL HOSPITAL-BASED OUTPATIENT FACILITIES IN AND AROUND PEORIA, ILLINOIS IN ADDITION TO ITS REGULAR HOSPITAL ACCREDITATION, SAINT FRANCIS MEDICAL CENTER HAS RECEIVED DISEASE SPECIFIC CERTIFICATION FROM THE JOINT COMMISSION FOR ITS PRIMARY STROKE NETWORK AND ITS MYOCARDIAL INFARCTION AND ACUTE CORONARY SYNDROME PROGRAMS THE UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE AT PEORIA, FOUNDED IN 1970, MAINTAINS ITS PRIMARY TEACHING AFFILIATION WITH SAINT FRANCIS MEDICAL CENTER AND HAS ESTABLISHED 15 FULLY ACCREDITED RESIDENCY AND FELLOWSHIP PROGRAMS AT SAINT FRANCIS MEDICAL CENTER CURRENTLY, 231 RESIDENTS AND FELLOWS ARE IN TRAINING AT SAINT FRANCIS MEDICAL CENTER IN ADDITION TO PROVIDING THE FULL RANGE OF PRIMARY, SECONDARY AND TERTIARY SERVICES, SAINT FRANCIS MEDICAL CENTER PROVIDES CERTAIN SPECIALIZED SERVICES, INCLUDING LEVEL I (HIGHEST LEVEL) TRAUMA SERVICES, LIFE FLIGHT HELICOPTER TRANSPORT SERVICES (USING THE HELICOPTERS OWNED BY OSF AVIATION), ADULT AND PEDIATRIC OPEN HEART SURGERY, PANCREAS AND KIDNEY TRANSPLANTATION SERVICES, NEUROSURGERY AND NEUROLOGY, LEVEL III (HIGHEST LEVEL) PERINATAL SERVICES, RADIATION ONCOLOGY (INCLUDING GAMMA KNIFE AND THE VARIAN TRILOGY UNIT), AND SPECIALIZED SERVICES OF THE CHILDREN'S HOSPITAL OF ILLINOIS (WHICH IS OPERATED AS A PART OF SAINT FRANCIS MEDICAL CENTER) SAINT ANTHONY MEDICAL CENTER ("SAINT ANTHONY") IS A 254 LICENSED BED ACUTE CARE HOSPITAL LOCATED ON THE EAST SIDE OF ROCKFORD, ILLINOIS SAINT ANTHONY PROVIDES PRIMARY, SECONDARY AND TERTIARY CARE SAINT ANTHONY PROVIDES CERTAIN SPECIALIZED SERVICES, INCLUDING LEVEL 1 (HIGHEST LEVEL) TRAUMA SERVICES, HELICOPTER SERVICES (USING HELICOPTERS OWNED BY OSF AVIATION), ADULT OPEN HEART SURGERY, A REGIONAL BURN UNIT, NEUROSURGERY, AND NEUROLOGY, AND RADIATION ONCOLOGY (INCLUDING VARIAN TRUE BEAM AND STEREOTACTIC RADIO-SURGERY) ST JOSEPH MEDICAL CENTER ("ST JOSEPH") IN BLOOMINGTON, ILLINOIS, AND OSF SAINT JAMES-JOHN W ALBRECHT MEDICAL CENTER ("SAINT JAMES") IN PONTIAC, ILLINOIS ARE LOCATED APPR</p>

Form and Line Reference	Explanation
SCHEDULE H - PART VI - 5 - PROMOTION OF COMMUNITY HEALTH	<p>OXIMATELY 35 MILES APART AND SERVE PARTIALLY OVERLAPPING MARKETS ST JOSEPH IS A 137 LICE NSED ACUTE CARE BED AND 12 BED SKILLED NURSING CARE HOSPITAL LOCATED ON THE EAST SIDE OF B LOOMINGTON, ILLINOIS ST JOSEPH PROVIDES PRIMARY, SECONDARY AND TERTIARY CARE, INCLUDING OPEN HEART SURGERY SAINT JAMES HAS 42 LICENSED ACUTE CARE BEDS WHICH ARE ALSO MEDICARE SWING BED APPROVED THIS HOSPITAL FACILITY IS LOCATED ON THE WEST SIDE OF PONTIAC, ILLINOIS, NEAR INTERSTATE 55 SAINT JAMES IS THE ONLY ACUTE CARE HOSPITAL LOCATED IN LIVINGSTON COU NTY, ILLINOIS ST MARY MEDICAL CENTER ("ST MARY") IN GALESBURG, ILLINOIS, AND OSF HOLY FAMILY MEDICAL CENTER ("HOLY FAMILY") IN MONMOUTH, ILLINOIS ARE LOCATED APPROXIMATELY 19 MI LES APART AND SERVE PARTIALLY OVERLAPPING MARKETS RESIDENTS OF MONMOUTH AND ITS SURROUNDI NG AREAS FREQUENTLY TRAVEL TO GALESBURG TO RECEIVE HEALTH CARE SERVICES ST MARY IS A 81 LICENSED BED ACUTE CARE HOSPITAL LOCATED ON THE NORTHEAST SIDE OF GALESBURG, ILLINOIS IN ADDITION TO PRIMARY AND SECONDARY CARE, INCLUDING DIAGNOSTIC CARDIAC CATHETERIZATION SERVI CES, ST MARY HAS DESIGNATIONS FROM THE STATE OF ILLINOIS AS A LEVEL II TRAUMA CENTER, A T RAUMA NETWORK RESOURCE HOSPITAL, A LEVEL II PERINATAL CENTER AND A HEMOPHILIA EMERGENCY TR EATMENT CENTER HOLY FAMILY IS A 23 bed LICENSED Critical ACCESS HOSPITAL FACILITY LOCATED IN MONMOUTH, ILLINOIS ALL OF ITS ACUTE BEDS ARE ALSO MEDICARE APPROVED SWING BEDS ST F RANCIS HOSPITAL ("ST FRANCIS HOSPITAL") IS A 25 LICENSED BED CRITICAL ACCESS HOSPITAL LOC ATED ON THE WEST SIDE OF ESCANABA, MICHIGAN AS THE ONLY HOSPITAL IN DELTA COUNTY, MICHIGA N, ST FRANCIS HOSPITAL PROVIDES A RANGE OF INPATIENT AND OUTPATIENT HOSPITAL, DIAGNOSTIC, THERAPEUTIC AND ANCILLARY SERVICES OSF SAINT LUKE MEDICAL CENTER IS A 25 BED CRITICAL AC CESS HOSPITAL LOCATED IN KEWANEE, IL OSF SAINT LUKE MEDICAL CENTER MERGED INTO OSF PURSUA NT TO A STATUTORY MERGER ON APRIL 1, 2014 AND HAS BEEN SERVING THE COMMUNITY SINCE 1919 O SF SAINT ANTHONY'S HEALTH CENTER IS A 173 BED HOSPITAL and 30 bed skilled nursing care hos pital LOCATED IN ALTON, IL OSF SAINT ANTHONY'S HEALTH CENTER JOINED THE OSF HEALTHCARE SY STEM IN NOVEMBER, 2014, AND HAS BEEN SERVING THE COMMUNITY SINCE 1925</p>

Form and Line Reference	Explanation
PART VI, LINE 6	<p>           AFFILIATED HEALTH CARE SYSTEM ROLES THE CORPORATION IS PART OF AN AFFILIATED HEALTH CARE SYSTEM (THE "OSF SYSTEM") WHICH PROVIDES INTEGRATED HEALTH CARE SERVICES THROUGHOUT CENTRAL ILLINOIS, PARTS OF NORTHERN ILLINOIS, AND PARTS OF THE UPPER PENNINSULA OF MICHIGAN THE OSF SYSTEM INCLUDES THE OTHER CORPORATIONS LISTED BELOW, ALL OF WHICH ARE CONTROLLED, DIRECTLY OR INDIRECTLY, BY THE SISTERS OF THE THIRD ORDER OF ST FRANCIS (THE "CONGREGATION") ALL AFFILIATED CORPORATIONS (WHETHER TAXABLE OR EXEMPT) APPLY AND FOLLOW THE CHARITY CARE POLICY OF THE CORPORATION AND ARE OPERATED IN FURTHERANCE OF THE MISSION OF THE CONGREGATION TO PROVIDE COMPREHENSIVE, INTEGRATED, QUALITY CARE, INCLUDING PREVENTIVE, PRIMARY, ACUTE, CONTINUOUS AND REHABILITATIVE HEALTH SERVICES TO THE COMMUNITIES SERVED BY THE CORPORATION AND THE OSF SYSTEM SPECIAL EMPHASIS IS PLACED ON MEETING THE PHYSICAL, SPIRITUAL, EMOTIONAL, AND SOCIAL NEEDS OF EVERYONE WHO IS CARED FOR IN THE OSF SYSTEM REGARDLESS OF RACE, COLOR, RELIGION AND ABILITY TO PAY THE AFFILIATED CORPORATIONS ARE - THE SISTERS OF THE THIRD ORDER OF ST FRANCIS, WHICH HOLDS THE ASSETS OF THE RELIGIOUS CONGREGATION AND DIRECTS ALL OTHER CORPORATIONS IN THE AFFILIATED HEALTH CARE SYSTEM THROUGH BOARD REPRESENTATION AND THE EXERCISE OF RESERVED POWERS - OSF SAINT FRANCIS, INC , WHICH PROVIDES HOME INFUSION AND DURABLE MEDICAL EQUIPMENT SERVICES, MOBILE MEDICAL IMAGING SERVICES, MEDICAL EQUIPMENT MAINTENANCE AND REPAIR SERVICES, MEDICAL STAFFING SERVICES, BILLING SERVICES, AND OTHER SERVICES IN SUPPORT OF THE AFFILIATED HEALTH CARE SYSTEM - OSF AVIATION, LLC, WHICH IS AN FAA PART 135 CERTIFIED CARRIER PROVIDING EMS HELICOPTER SERVICES THROUGHOUT CENTRAL ILLINOIS AND PARTS OF NORTHERN ILLINOIS - OSF LIFELINE AMBULANCE, LLC, WHICH PROVIDES GROUND AMBULANCE TRANSPORTATION SERVICES IN PARTS OF NORTHERN ILLINOIS - OSF MULTISPECIALTY GROUP - PEORIA, LLC, WHICH PROVIDES PEDIATRIC CARDIOLOGY PHYSICIAN SERVICES IN CENTRAL ILLINOIS - ILLINOIS NEUROLOGICAL INSTITUTE - PHYSICIANS, LLC, WHICH PROVIDES PHYSICIAN NEUROSURGERY SERVICES IN CENTRAL ILLINOIS - HEARTCARE MIDWEST, LTD , WHICH PROVIDES CARDIOLOGY AND CARDIOVASCULAR SURGERY PHYSICIAN SERVICES IN CENTRAL ILLINOIS - CARDIOVASCULAR INSTITUTE AT OSF, LLC, WHICH PROVIDES CARDIOLOGY AND CARDIOVASCULAR SURGERY PHYSICIAN SERVICES IN PARTS OF NORTHERN ILLINOIS - OSF MULTISPECIALTY GROUP - EASTERN REGION, LLC, WHICH PROVIDES PRIMARY AND SPECIALTY PHYSICIAN SERVICES IN PARTS OF CENTRAL ILLINOIS - ILLINOIS PATHOLOGIST SERVICES, LLC, WHICH PROVIDES PROFESSIONAL PATHOLOGY SERVICES IN PARTS OF NORTHERN ILLINOIS - ILLINOIS SPECIALTY PHYSICIAN SERVICES AT OSF, LLC, WHICH PROVIDES PULMONOLOGY AND CRITICAL CARE PHYSICIAN SERVICES IN CENTRAL ILLINOIS - OSF PERINATAL ASSOCIATES, LLC, WHICH PROVIDES MATERNAL FETAL MEDICINE PHYSICIAN SERVICES IN CENTRAL ILLINOIS - OSF MULTISPECIALTY GROUP - WESTERN REGION, LLC, WHICH PROVIDES PRIMARY AND SPECIALTY PHYSICIAN SERVICES IN WESTERN ILLINOIS - OSF CHILDREN'S MEDICAL GROUP- CONGENITAL HEART CENTER, LLC WHICH PROVIDES PEDIATRIC CARE FOR CARDIOVASCULAR ILLNESSES IN NORTHERN ILLINOIS - PREFERRED EMERGENCY PHYSICIANS OF ILLINOIS, LLC WHICH PROVIDES PHYSICIAN COVERAGE FOR EMERGENCY DEPARTMENTS - Saint Anthony Physician Group which provides a variety of general and specialty physicians services in Alton, Illinois         </p>

Form and Line Reference	Explanation
PART VI, LINE 7	ALL STATES WHICH ORGANIZATION FILES A COMMUNITY BENEFIT REPORT IL, MI



Additional Data

Software ID:  
Software Version:  
EIN: 37-0813229  
Name: OSF HEALTHCARE SYSTEM

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

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

Form and Line Reference	Explanation
PART V SECTION B NUMBER 5 - ALL FACILITIES	OSF HOSPITALS TOOK INTO ACCOUNT THE INPUT OF THE COMMUNITY MEMBERS BY HAVING THESE INDIVIDUALS HELP PRIORITIZE THE IDENTIFIED NEEDS WITHIN EACH COMMUNITY IN ADDITION, EACH FACILITY OBTAINED AND USED RESOURCES FROM OR RESOURCES PROVIDED BY THESE COMMUNITY MEMBERS

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

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

Form and Line Reference	Explanation
PART V SECTION B NUMBER 6A	SAINT FRANCIS MEDICAL CENTER - PEORIA, IL THE TRI-COUNTY COMMUNITY HEALTH-NEEDS ASSESSMENT IS A COLLABORATIVE UNDERTAKING BY UNITYPOINT HEALTH - METHODIST, OSF SAINT FRANCIS MEDICAL CENTER AND PROCTOR HOSPITAL ST MARY MEDICAL CENTER - GALESBURG, IL THE KNOX AND WARREN COUNTIES COMMUNITY HEALTH-NEEDS ASSESSMENT IS A COLLABORATIVE UNDERTAKING BY ST MARY MEDICAL CENTER AND OSF HOLY FAMILY MEDICAL CENTER OSF HOLY FAMILY MEDICAL CENTER THE KNOX AND WARREN COUNTIES COMMUNITY HEALTH-NEEDS ASSESSMENT IS A COLLABORATIVE UNDERTAKING BY ST MARY MEDICAL CENTER AND OSF HOLY FAMILY MEDICAL CENTER SAINT ANTHONY'S HEALTH CENTER, ALTON, IL THE MADISON COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT WAS CONDUCTED BY SAINT ANTHONY'S HEALTH CENTER, SAINT CLARE'S HOSPITAL AND ALTON MEMORIAL HOSPITAL PART V, LINE 11 SEE PART VI, LINE 2, "NEEDS ASSESSMENT" SUPPLEMENTAL INFO - CHNA - FOR DETAILED DESCRIPTION ON HOW SIGNIFICANT NEEDS ARE BEING ADDRESSED FOR EACH HOSPITAL ALONG WITH THE NEEDS NOT ADDRESSED PART V, SECTION B, LINE 7A <a href="https://www.osfhealthcare.org">HTTPS //WWW.OSFHEALTHCARE.ORG</a> PART V, SECTION B, LINE 16A AND 16B <a href="https://www.osfhealthcare.org">HTTPS //WWW.OSFHEALTHCARE.ORG</a>

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

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

Form and Line Reference	Explanation
PART V - LINE 13B AND 13H	SAINT FRANCIS MEDICAL CENTER, ST ANTHONY MEDICAL CENTER, ST JOSEPH MEDICAL CENTER, ST MARY MEDICAL CENTER, SAINT JAMES HOSPITAL, OSF HOLY FAMILY MEDICAL CENTER, ST FRANCIS HOSPITAL, SAINT LUKE MEDICAL CENTER, OSF SAINT ANTHONY HEALTH CENTER PLEASE REFER TO THE RESPONSE TO SCHEDULE H, PART I, LINE 3C FOR A DESCRIPTION OF HOW THE ABOVE MENTIONED FACILITIES EXPLAINED THE BASIS FOR CALCULATING AMOUNTS CHARGED TO PATIENTS

**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
AMOUNTS BILLED TO Financial Assistance Policy Eligible individuals for	<p>emergency or other medically necessary care PART V, LINE 22D SAINT FRANCIS MEDICAL CENTER , ST ANTHONY MEDICAL CENTER, ST JOSEPH MEDICAL CENTER, OSF SAINT ANTHONY HEALTH CENTER THE HOSPITAL DETERMINED THE AMOUNTS BILLED TO INDIVIDUALS WHO DID NOT HAVE INSURANCE COVER ING EMERGENCY OR OTHER MEDICALLY NECESSARY CARE IN THE FOLLOWING WAYS THE AMOUNT BILLED T O THE INDIVIDUAL WAS THE LOWEST AMOUNT DETERMINED UNDER ANY OF THE FOLLOWING METHODS WHICH APPLY TO THE INDIVIDUAL - For Illinois residents who incur gross charges in excess of \$3 00 for any one inpatient admission or outpatient encounter, who apply for financial assist ance, and whose family income is 200% or less of the federal poverty guideline for family size, the amount billed is \$0 00 If family income is between 201% and 600% of the federal poverty guideline for their family size, the amount billed is calculated by multiplying g ross charges times the hospital's cost to charge ratio determined from its most recently f iled Medicare Cost Report and then multiplying that product times 135% The amount billed to patients regardless of residency whose family income in not more than 200% of federal p overty guideline for their family size is \$0 00 Discounted financial assistance is availa ble on a sliding scale to patients regardless of residency whose family income is between 201% and 600% of federal poverty guidelines for their family size Catastrophic financial assistance is available when charges exceed 25% of annual family income The amount billed is adjusted to 25% of family income when OSF determines this is the most generous assista nce - THE MAXIMUM AMOUNT THAT CAN BE COLLECTED IN A 12 MONTH PERIOD FOR EMERGENCY OR OTHE R MEDICALLY NECESSARY CARE TO ANY PATIENT WHO APPLIES FOR FINANCIAL ASSISTANCE DOES NOT EX CEED 25% OF FAMILY INCOME - The amount billed to Financial Assistance Policy eligible indivi duals is never more than the amount generally billed to individuals who have insurance covering such care This maximum charge billed to financial assistance policy eligible ind ividuals is determined by multiplying the gross charges for all emergency and other medica lly necessary care by a percentage calculated annually and equal to (i) the aggregate dol lar amount of claims allowed for all medical services during the 12-month period ended on the preceding September 30 by private insurers, together with any associated portions of t hese claims the insured individuals are responsible for paying in the form of co-payments, co-insurance, or deductibles, divided by (ii) the sum of the associated gross charges for those claims The amount billed to a patient eligible for financial assistance is less th an the amount of the gross charges No insurance company contract which includes provision s for interim payments subject to later reconciliation shall be included in the calculatio n of the maximum charge The amount billed to a patient eligible for financial assistance under this policy will be less than the amount of the gross charges ST FRANCIS HOSPITAL THE HOSPITAL DETERMINED THE AMOUNTS BILLED TO financial assistance policy eligible indivi duals for EMERGENCY OR OTHER MEDICALLY NECESSARY CARE IN THE FOLLOWING WAYS THE AMOUNT BI LLED TO THE INDIVIDUAL WAS THE LOWEST AMOUNT DETERMINED UNDER ANY OF THE FOLLOWING METHODS WHICH APPLY TO THE INDIVIDUAL - THE MAXIMUM AMOUNT THAT CAN BE COLLECTED IN A 12 MONTH P ERIOD FOR EMERGENCY OR OTHER MEDICALLY NECESSARY CARE TO ANY PATIENT WHO applies for finan cial assistance does not exceed 25% of family income - Uninsured patients with family inc ome below 250% of the federal poverty guideline qualify for a Healthy Michigan Law discoun t equal to the Medicare reimbursement rate plus 15% Patients do not need to apply for the discount The discount is applied to all patients determined to have no insurance If a s ervice is not covered under a patient's plan, they do not qualify for the uninsured discou nt The program is available only to patients who are not enrolled in an insurance plan T he amount billed to patients regardless of enrollment in an insurance plan, when family in come in not more than 200% of federal poverty guideline for their family size, is \$0 00 D iscounted financial assistance is available on a sliding scale to patients regardless of e nrollment in an insurance plan when family income is between 201% and 600% of federal pove rty guidelines for their family size Catastrophic financial assistance is available when charges exceed 25% of annual family income The amount billed is adjusted to 25% of family income when OSF determines this is the most generous assistance ST MARY MEDICAL CENTER, SAINT JAMES HOSPITAL, OSF HOLY FAMILY MEDICAL CENTER, SAINT LUKE MEDICAL CENTER THE HOSP ITAL DETERMINED THE AMOUNTS BILLED TO financial assistance policy eligible individuals FOR EMERGENCY OR OTHER MEDICALLY NECESSARY CARE IN THE FOLLOWING WAYS THE AMOUNT BILLED TO T HE INDIVIDUAL WAS THE LOWEST AMOUNT DETERMINED UND</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
AMOUNTS BILLED TO Financial Assistance Policy Eligible individuals for	ER ANY OF THE FOLLOWING METHODS WHICH APPLY TO THE INDIVIDUAL - For Illinois residents wh o incur gross charges in excess of \$300 for any one inpatient admission or outpatient enco unter, who apply for financial assistance, and whose family income is 125% or less of the federal poverty guideline for family size, the amount billed is \$0 00 If family income is between 126% and 300% of the federal poverty guideline for their family size, the amount billed is calculated by multiplying gross charges times the hospital's cost to charge rati o determined from its most recently filed Medicare Cost Report and then multiplying that p roduct times 135% The amount billed to patients regardless of residency whose family inco me in not more than 200% of federal poverty guideline for their family size is \$0 00 Disc ounted financial assistance is available on a sliding scale to patients regardless of resi dency whose family income is between 201% and 600% of federal poverty guidelines for their family size Catastrophic financial assistance is available when charges exceed 25% of an nual family income The amount billed is adjusted to 25% of family income when OSF determi nes this is the most generous assistance - THE MAXIMUM AMOUNT THAT CAN BE COLLECTED IN A 12 MONTH PERIOD FOR EMERGENCY OR OTHER MEDICALLY NECESSARY CARE TO ANY PATIENT WHO APPLIES FOR FINANCIAL ASSISTANCE DOES NOT EXCEED 25% OF FAMILY INCOME - The amount billed to fin anical assistance policy eligible individuals is never more than the amount generally bill ed to individuals who have insurance covering such care This maximum charge billed to ind ividuals eligible under the financial assistance policy is determined by multiplying the g ross charges for all emergency and other medically necessary care by a percentage calculat ed annually and equal to ( i) the aggregate dollar amount of claims allowed for all medica l services during the 12-month period ended on the preceding September 30 by private insur ers, together with any associated portions of these claims the insured individuals are res ponsible for paying in the form of co-payments, co-insurance, or deductibles, divided by ( ii) the sum of the associated gross charges for those claims The amount billed to a patie nt eligible for financial assistance is less than the amount of the gross charges NO INSU RANCE COMPANY CONTRACT WHICH INCLUDES PROVISIONS FOR INTERIM PAYMENTS SUBJECT TO LATER REC ONCILIATION SHALL BE INCLUDED IN THE CALCULATION OF THE MAXIMUM CHARGE THE AMOUNT BILLED TO A PATIENT ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER THIS POLICY WILL BE LESS THAN THE AMO UNT OF THE GROSS CHARGES

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

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

Form and Line Reference	Explanation
PATIENTS CHARGED AMOUNT EQUAL TO THE GROSS CHARGE FOR SERVICES PROVIDED	PART V, LINE 24 SAINT FRANCIS MEDICAL CENTER, ST ANTHONY MEDICAL CENTER, ST JOSEPH MEDICAL CENTER, ST MARY MEDICAL CENTER, SAINT JAMES HOSPITAL, OSF HOLY FAMILY MEDICAL CENTER, SAINT LUKE MEDICAL CENTER , OSF Saint Anthony Health Center NONE OF THE HOSPITALS CHARGED ANY PATIENT WHO WAS ELIGIBLE FOR FINANCIAL ASSISTANCE AN AMOUNT EQUAL TO THE GROSS CHARGES ASSOCIATED WITH EMERGENCY OR OTHER MEDICALLY NECESSARY CARE IN THE FOLLOWING LIMITED INSTANCES, HOWEVER THE HOSPITAL CHARGED PATIENTS AN AMOUNT EQUAL TO GROSS CHARGES - PATIENTS RECEIVING ELECTIVE MEDICAL SERVICES OTHER THAN EMERGENCY OR OTHER MEDICALLY NECESSARY CARE, SUCH AS ELECTIVE COSMETIC SURGERY PERFORMED TO IMPROVE ONE'S APPEARANCE AND NOT RELATED TO A TRAUMA OR DISFIGURATION - PATIENTS WHOSE MEDICAL BILLS ARE THE RESPONSIBILITY OF A THIRD PARTY PURSUANT TO A CLAIM BROUGHT BY THE PATIENT AGAINST THE THIRD PARTY -Patients whose medical bills are covered by an automobile insurance medical payment or underinsured policy benefit ST FRANCIS HOSPITAL THE HOSPITAL CHARGED ITS PATIENTS AN AMOUNT EQUAL TO GROSS CHARGES IN THE FOLLOWING CIRCUMSTANCES - PATIENTS RCEIVING ELECTIVE MEDICAL SERVICES OTHER THAN EMERGENCY OR OTHER MEDICALLY NECESSARY CARE, SUCH AS ELECTIVE COSMETIC SURGERY PERFORMED TO IMPROVE ONE'S APPEARANCE AND NOT RELATED TO A TRAUMA OR DISFIGURATION - PATIENTS WHOSE MEDICAL BILLS ARE THE RESPONSIBILITY OF A THIRD PARTY PURSUANT TO A CLAIM BROUGHT BY THE PATIENT AGAINST THE THIRD PARTY -Patients whose medical bills are covered by an automobile insurance medical payment or undersinsured policy benefit

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)
CENTER FOR OCCUPATIONAL HEALTH RANDOLPH BLDG SUITE 100 NE RANDOL PEORIA,IL 61606	REHAB, PHYSICAL THERAPY, OCCUPATIONAL THERAPY
CENTER FOR INDUSTRIAL REHAB 506 HIGH POINT LANE EAST PEORIA,IL 61611	REHAB, PHYSICAL THERAPY, OCCUPATIONAL THERAPY
PEKIN CANCER TREATMENT CENTER 603 THIRTEENTH STREET PEKIN,IL 61554	REHAB, PHYSICAL THERAPY, OCCUPATIONAL THERAPY
SAINT CLARE FAMILY HEALTH CENTER 10 SAINT CLARE COURT WASHINGTON,IL 61571	REHAB, PHYSICAL THERAPY, OCCUPATIONAL THERAPY
OSF CENTER FOR HEALTH 8600-8800 RT 91 NORTH NORTH PEORIA,IL 61615	REHAB, PHYSICAL THERAPY, OCCUPATIONAL THERAPY
OSF SAINT FRANCIS RIVERPLEX 600 NE WATER STREET PEORIA,IL 61602	REHAB, PHYSICAL THERAPY, OCCUPATIONAL THERAPY
OSF SAINT FRANCIS HEART HOSPITAL 5405 N KNOXVILLE AVENUE PEORIA,IL 61614	REHAB, PHYSICAL THERAPY, OCCUPATIONAL THERAPY
OSF HEART HOSPITAL DIAGNOSTIC CENTER 610 PARK AVENUE PEKIN,IL 615544650	REHAB, PHYSICAL THERAPY, OCCUPATIONAL THERAPY
OSF SF RADIATION ONCOLOGY 8948 N WOOD SAGE ROAD PEORIA,IL 61615	REHAB, PHYSICAL THERAPY, OCCUPATIONAL THERAPY
OSF SAINT FRANCIS MORTON HEALTH CENTER 435 MAXINE DR MORTON,IL 61550	REHAB, PHYSICAL THERAPY, OCCUPATIONAL THERAPY
SAINT FRANCIS MEDICAL INI REHABILITATION FIVE POINTS WASHINGTON 360 WILMOR R WASHINGTON,IL 615711252	REHAB, PHYSICAL THERAPY, OCCUPATIONAL THERAPY
OSF SAINT FRANCIS CENTER FOR HEALTH GLEN 5114 GLEN PARK PLACE PEORIA,IL 616144686	REHAB, PHYSICAL THERAPY, OCCUPATIONAL THERAPY
ROCKFORD CARDIOVASCULAR ASSOCIATES 444 ROXBURY ROAD ROCKFORD,IL 61107	REHAB, PHYSICAL THERAPY, OCCUPATIONAL THERAPY
OSF CENTER FOR HEALTH-ROCK CUT CROSSING 9951 ROCK CUT CROSSING LOVES PARK,IL 611111999	REHAB, PHYSICAL THERAPY, OCCUPATIONAL THERAPY
OSF ST FRANCIS HOSPITAL AND MEDICAL GRP N 15995 MAIN ST POWERS,MI 49870	REHAB, PHYSICAL THERAPY, OCCUPATIONAL THERAPY

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)
OSF ST FRANCIS HOSPITAL MEDICAL GROUP 128 MICHIGAN GLADSTONE,MI 49837	REHAB, PHYSICIAL THERAPY, OCCUPATIONAL THERAPY
OSF ST FRANCIS HOSPITAL MEDICAL GROUP 3409 LUDINGTON ST ESCANABA,MI 49829	REHAB, PHYSICIAL THERAPY, OCCUPATIONAL THERAPY
ST FRANCIS HOSPITAL- REHAB SERVICES 704 SUPERIOR AVENUE GLADSTONE,MI 49837	REHAB, PHYSICIAL THERAPY, OCCUPATIONAL THERAPY
OSF SAINT JAMES REHABILITATION 106 SOUTH FIRST STREET FAIRBURY,IL 61739	REHAB, PHYSICIAL THERAPY, OCCUPATIONAL THERAPY
OSF SAINT JAMES REHABILITATION 105 JOHN STREET DWIGHT,IL 60420	REHAB, PHYSICIAL THERAPY, OCCUPATIONAL THERAPY
CENTER FOR HEALTH AT FT JESSE 2200 FT JESSE ROAD NORMAL,IL 61761	REHAB, PHYSICIAL THERAPY, OCCUPATIONAL THERAPY
OSF ST JOSEPH MEDICAL CENTER-COLLEGE AV 1701 EAST COLLEGE AVENUE BLOOMINGTON,IL 61704	REHAB, PHYSICIAL THERAPY, OCCUPATIONAL THERAPY
OSF HOLY FAMILY CLINIC 1000 WEST HARLEM AVE MONMOUTH,IL 61462	REHAB, PHYSICIAL THERAPY, OCCUPATIONAL THERAPY
OSF SAINT CLARE'S HOSPITAL 915 EAST FIFTH STREET ALTON,IL 620020340	REHAB, PHYSICIAL THERAPY, OCCUPATIONAL THERAPY
OSF SAINT ANTHONY'S CANCER CENTER 815 EAST FIFTH STREET SUITE 303 ALTON,IL 62002	REHAB, PHYSICIAL THERAPY, OCCUPATIONAL THERAPY
OSF SAINT ANTHONY MEDICAL CTR- BELVIDERE 1954 GATEWAY CENTER DR BELVIDERE,IL 610089303	REHAB, PHYSICIAL THERAPY, OCCUPATIONAL THERAPY
OSF SAINT ANTHONY MED CT-BELVIDERE REHAB 1916 GATEWAY CENTER DR BELVIDERE,IL 610089303	REHAB, PHYSICIAL THERAPY, OCCUPATIONAL THERAPY
OSF SAINT ANTHONY MED CT- CTR FOR HEALTH 5666 E STATE STREET ROCKFORD,IL 611082425	REHAB, PHYSICIAL THERAPY, OCCUPATIONAL THERAPY
OSF SAINT ELIZABETH MED CTR SLEEP CTR 1601 MERCURY CIRCLE SUITE 200 OTTAWA,IL 61350	REHAB, PHYSICIAL THERAPY, OCCUPATIONAL THERAPY
OTTAWA MEDICAL CENTER RADIOLOGY SERVICES 1614 EAST NORRIS DRIVE OTTAWA,IL 61350	REHAB, PHYSICIAL THERAPY, OCCUPATIONAL THERAPY

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)
OSF HEALTHCARE OTTAWA SOUTH 1640 FIRST AVENUE OTTAWA,IL 61350	REHAB, PHYSICIAL THERAPY, OCCUPATIONAL THERAPY
OSF CENTER FOR HEALTH - STREATOR 111 SPRING STREET STREATOR,IL 613643399	REHAB, PHYSICIAL THERAPY, OCCUPATIONAL THERAPY
OSF SAINT FRANCIS MED CTR OUTPATIENT REH 610 WVINE ST CHILICOTHE,IL 615231500	REHAB, PHYSICIAL THERAPY, OCCUPATIONAL THERAPY
OSF SAINT FRANCIS MEDICAL CENTER 3300 NORTH MAIN STREET EAST PEORIA,IL 61611	REHAB, PHYSICIAL THERAPY, OCCUPATIONAL THERAPY
GLEN AVENUE DIAGNOSTIC CENTER 4911 EXECUTIVE DRIVE MAIN LEVEL S PEORIA,IL 61614	REHAB, PHYSICIAL THERAPY, OCCUPATIONAL THERAPY
ILLINOIS NEUOLOGICAL INSTITUTE (INI) RANDELPH BLDG STE100 NE RANDOLP PEORIA,IL 61606	REHAB, PHYSICIAL THERAPY, OCCUPATIONAL THERAPY
WOMEN'S HEALTH CENTER 7800 N SOMMER STE 508 PEORIA,IL 61615	REHAB, PHYSICIAL THERAPY, OCCUPATIONAL THERAPY
OSF SAINT JAMES REHABILITATION 608 NORTH LADD STREET PONTIAC,IL 61764	REHAB, PHYSICIAL THERAPY, OCCUPATIONAL THERAPY
OSF SAINT JAMES SLEEP LABORATORY 702 RITTENHOUSE DRIVE PONTIAC,IL 61764	REHAB, PHYSICIAL THERAPY, OCCUPATIONAL THERAPY
OSF ST JOSEPH MEDICAL CTR SLEEP LAB 2200 E WASHINGTON ST BLOOMINGTON,IL 617014323	REHAB, PHYSICIAL THERAPY, OCCUPATIONAL THERAPY
OSF SAINT FRANCIS MEDICAL CENTER 1001 MAIN ST SUITE 201 PEORIA,IL 61603	REHAB, PHYSICIAL THERAPY, OCCUPATIONAL THERAPY

Schedule I  
(Form 990)

Department of the Treasury  
Internal Revenue Service

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

Complete if the organization answered "Yes," 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](http://www.irs.gov/form990).

OMB No 1545-0047

2014

Open to Public  
Inspection

Name of the organization  
OSF HEALTHCARE SYSTEM

Employer identification number  
37-0813229

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
See Additional Data Table							

2

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

12

3

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

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	153	253,679			

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
SUPPLEMENTAL INFORMATION	PROCEDURES FOR MONITORING GRANTS PART I, LINE 2 THE CORPORATION MONITORS THE USE OF GRANT FUNDS IN THE UNITED STATES IN A VARIETY OF WAYS FOR EDUCATIONAL SCHOLARSHIPS, THE CORPORATION TRACKS AND REVIEWS THE STUDENT'S GRADES AND SUCCESSFUL COURSE COMPLETION EACH SEMESTER IN SOME CASES, THE CORPORATION'S CHIEF FINANCIAL OFFICER OR OTHER REPRESENTATIVE OF THE CORPORATION SERVES ON THE BOARD OF DIRECTORS OR ON THE FINANCE COMMITTEE OF THE GRANTEE ORGANIZATION AND RECEIVES DIRECT INFORMATION REGARDING USE OF GRANT FUNDS IN SUCH CAPACITY IN OTHER CASES, THE CORPORATION RECEIVES WRITTEN REPORTS AND/OR FINANCIAL STATEMENTS FROM THE GRANTEE ORGANIZATION WHICH INCLUDE INFORMATION REGARDING USE OF GRANT FUNDS REQUIREMENTS FOR SAINT FRANCIS MEDICAL CENTER SCHOLARSHIP ALL SCHOLARSHIPS ARE APPROVED BY THE SCHOLARSHIP COMMITTEE NURSING MINIMUM REQUIREMENTS - GPA 2 5/4 0 SCALE - TWO FAVORABLE ACADEMIC REFERENCES FROM CLINICAL INSTRUCTORS - TWO FAVORABLE EMPLOYER REFERENCES - COMPLETED SCHOLARSHIP APPLICATION FORM - ACCEPTANCE OF THE SCHOLARSHIP REQUIRES THE STUDENT TO SECURE AND START IN AN OSF SAINT FRANCIS MEDICAL CENTER RN STAFF POSITION WITHIN 60 DAYS OF GRADUATION AND REMAIN EMPLOYED IN A 72-80 HOURS/PAY FOR TWO YEARS FOLLOWING COMPLETION OF THE 90 DAY UNIT NURSING ORIENTATION RADIOLOGY, RADIATION THERAPIST & SONOGRAPHY MINIMUM REQUIREMENTS - GPA 2 5/4 0 SCALE - TWO FAVORABLE ACADEMIC REFERENCES FROM CLINICAL INSTRUCTORS - TWO FAVORABLE EMPLOYER REFERENCES - COMPLETED SCHOLARSHIP APPLICATION FORM - ACCEPTANCE OF THE SCHOLARSHIP REQUIRES THE STUDENT TO SECURE AND START IN AN OSF SAINT FRANCIS MEDICAL CENTER DIAGNOSTIC RADIOLOGY TECHNOLOGIST STAFF POSITION WITHIN 30 DAYS OF GRADUATION AND REMAIN EMPLOYED FOR TWO YEARS FOLLOWING COMPLETION OF THE DEPARTMENT ORIENTATION PHARMACY MINIMUM REQUIREMENTS - INTERVIEW - GPA 2 5/4 0 OR 3 125/5 0 SCALE - TWO FAVORABLE ACADEMIC REFERENCES FROM CLINICAL INSTRUCTORS - TWO FAVORABLE EMPLOYER REFERENCES - COMPLETED SCHOLARSHIP APPLICATION FORM - ACCEPTANCE OF THE SCHOLARSHIP REQUIRES THE STUDENT TO SECURE AND START IN AN OSF SAINT FRANCIS MEDICAL CENTER R PH POSITION WITHIN 30 DAYS OF GRADUATION AND REMAIN EMPLOYED FOR TWO YEARS OR THREE YEARS, DEPENDING ON THE MONIES RECEIVED, FOLLOWING COMPLETION OF THE PHARMACY ORIENTATION RESPIRATORY THERAPY MINIMUM REQUIREMENTS FOR EXTERNAL CANDIDATES - MEET ALL ILLINOIS CENTRAL COLLEGE'S (ICC) MINIMUM REQUIREMENTS FOR ADMISSION - GPA 3 0/4 0 SCALE - PASS A WONDERLIC TEST SCORE OF A 3 ON THE VERBAL SECTION AND A 2 ON THE MATH PORTION - TWO FAVORABLE ACADEMIC REFERENCES FROM CLINICAL INSTRUCTORS - TWO FAVORABLE EMPLOYER REFERENCES - A BRIEF 1-2 PAGE TYPED ESSAY EXPLAINING INTEREST AND DESIRE TO ENROLL THE SCHOLARSHIP PROGRAM - INTERVIEW FOR OSF SAINT FRANCIS MEDICAL CENTER EMPLOYEES - MEET ALL ILLINOIS CENTRAL COLLEGE'S (ICC) MINIMUM REQUIREMENTS FOR ADMISSION - GPA 3 0/4 0 SCALE - PASS A WONDERLIC TEST SCORE OF A 3 ON THE VERBAL SECTION AND A 2 ON THE MATH PORTION - MUST NOT BE ON ANY CURRENT FORMAL LEVELS OF DISCIPLINE - TWO FAVORABLE SUPERVISOR/MANAGER OR DIRECTOR REFERENCES - A BRIEF 1-2 PAGE TYPED ESSAY EXPLAINING INTEREST AND DESIRE TO ENROLL THE SCHOLARSHIP PROGRAM - INTERVIEW MERIT SCHOLARSHIP REQUIREMENT - GPA 3 4/4 0 SCALE - DEAN'S LIST IN THE SEMESTER PREVIOUS TO POSTING ON STUDENTS ACCOUNT INSTITUTIONAL SCHOLARSHIP REQUIREMENT - COLLEGE OF NURSING STUDENT IN GOOD ACADEMIC STANDING AND IN FINANCIAL NEED PRESIDENT'S SCHOLARSHIP REQUIREMENT - GPA 3 55/4 0 SCALE REQUIREMENTS FOR SAINT ANTHONY MEDICAL CENTER SCHOLARSHIPS SCHOLARSHIPS ARE AWARDED BASED ON 50% ACADEMICS, 30% FINANCIAL NEED, AND 20% COMMUNITY SERVICE THE AWARDS ARE APPROVED BY THE SAINT ANTHONY COLLEGE OF NURSING FINANCIAL AID COMMITTEE THE ALUMNI MEMORIAL SCHOLARSHIP ARE AWARDED BASED ON 60% ACADEMICS, 30% FINANCIAL NEED, AND 10% COMMUNITY SERVICE MINIMUM REQUIREMENTS FOR ALL SCHOLARSHIPS - GPA 2 5/4 0 SCALE - RESUME - TWO FAVORABLE LETTERS OF RECOMMENDATION, AT LEAST ONE FROM A CLINICAL INSTRUCTOR - A BRIEF TYPED ESSAY EXPLAINING INTEREST AND DESIRE TO ENROLL THE SCHOLARSHIP PROGRAM REQUIREMENTS FOR HOLY FAMILY MEDICAL CENTER SCHOLARSHIPS - APPLICATION FOR ASSISTANCE FROM OSF HOLY FAMILY MEDICAL CENTER SIGNIFIES A DESIRE TO WORK AT OSF HFMC AT THE COMPLETION OF THE EDUCATIONAL COURSE WORK - MEETING DEADLINES IS THE RESPONSIBILITY OF THE APPLICANT ALL APPLICATION MATERIALS MUST REACH OSF HFMC BY APRIL 1 AWARDS WILL BE MADE BY MAY 31 - FUNDS MAY ONLY BE USED FOR HEALTH CARE-RELATED COURSEWORK AT THE BACHELOR'S DEGREE LEVEL OR BELOW - RECIPIENTS MUST RESIDE IN WARREN OR HENDERSON COUNTY, ILLINOIS, BE EMPLOYEES OF OSF HOLY FAMILY MEDICAL CENTER, OR RELATED TO EMPLOYEES OF OSF HFMC - THE MAXIMUM AVAILABLE AMOUNT OF EDUCATIONAL ASSISTANCE IS \$3,500 ANNUALLY THIS AMOUNT WILL BE DISTRIBUTED FOR TUITION, BOOKS, AND LAB FEES FUNDS MAY NOT BE USED FOR LIVING EXPENSES OR TRANSPORTATION - EACH DISBURSEMENT OF FUNDS REQUIRES THE RECIPIENT SIGN A "STUDENT LOAN PROMISSORY NOTE" WHICH IS FORGIVEN WHEN THE STUDENT BORROWER BECOMES EMPLOYED AT OSF HFMC AT COMPLETION OF THE EDUCATIONAL PROGRAM WITHIN SPECIFIED TIME CONSTRAINTS THIS MEANS EACH REQUEST FOR FUNDS REQUIRES A PERSONAL APPEARANCE BY THE STUDENT (ACCORDING TO TAX LAW, DISBURSEMENTS ARE TAXABLE INCOME ) - WHEN FUNDS HAVE BEEN DISTRIBUTED FOR A GIVEN SEMESTER, ADDITIONAL FUNDS WILL NOT BE PAID UNTIL OSF HFMC HAS BEEN FURNISHED WITH A COPY OF PRIOR SEMESTER GRADES, GIVING PROOF OF SUCCESSFUL COMPLETION OF COURSE WORK A CUMULATIVE 3 0 GRADE POINT AVERAGE OR HIGHER IS REQUIRED - RECIPIENTS MUST REAPPLY ANNUALLY IF THEY DESIRE FUNDS FOR SUBSEQUENT YEARS WHILE FUNDS FOR SUBSEQUENT YEARS ARE NOT GUARANTEED, SERIOUS CONSIDERATION WILL BE GIVEN TO THOSE STUDENTS WHO HAVE EXCELLED ACADEMICALLY - RECEIPT OF EDUCATIONAL ASSISTANCE DOES NOT GUARANTEE THE RECIPIENT WILL BE OFFERED EMPLOYMENT AT THE COMPLETION OF THE EDUCATIONAL PROGRAM AN APPROPRIATE POSITION MAY NOT BE AVAILABLE AT THAT TIME IF AN APPROPRIATE POSITION IS AVAILABLE, THE RECIPIENT MUST ACCEPT THE POSITION OR BE PREPARED TO REPAY ANY FUNDS RECEIVED - WITH MUTUAL AGREEMENT, THE REQUIREMENT TO ACCEPT A POSITION AT OSF HFMC MAY BE MET BY ACCEPTING EMPLOYMENT AT OTHER OSF FACILITIES

Additional Data

Software ID:  
Software Version:  
EIN: 37-0813229  
Name: OSF HEALTHCARE SYSTEM

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

(a) Name and address of organization or government	(b) EIN	(c) IRC Code section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
UNIVERSITY OF ILL COLLEGE OF MED1 ILLINI DR PEORIA,IL 61605	37-6000511	501(C)3	558,366				SUPPORT OF CLINIC OPERATION
HEARTLAND COMMUNITY HEALTH1701 W GARDEN STREET PEORIA,IL 61605	37-1270794	501(C)3	500,000				SUPPORT OF CLINIC OPERATION
HEART OF ILLINOIS UNITED WAY509 WHIGH ST PEORIA,IL 61606	37-0661504	501(C)3	60,000				SUPPORT OF ORG OPERATIONS

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

(a) Name and address of organization or government	(b) EIN	(c) IRC Code section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
FRIENDS OF WILDLIFE PRAIRIE PARK3826 N TAYLOR RD HANNA CITY,IL 61536	20-8064678	501(C)3	50,000				SUPPORT OF ORG OPERATIONS
PROJECT FIT AMERICAPO BOX 308 BOYES HOT SPRINGS,CA 95416	36-3730823	501(C)3	35,600				SUPPORT OF ORG OPERATIONS
FRIENDS OF THE CHILDREN OF HAITIPO BOX 780 PEORIA,IL 61652	37-1274477	501(C)3	25,000				SUPPORT OF ORG OPERATIONS

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

(a) Name and address of organization or government	(b) EIN	(c) IRC Code section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MORTON COMMUNITY FOUNDATION105 E JEFFERSON ST MORTON,IL 61550	37-1397503	501(C)3	25,000				SUPPORT OF ORG OPERATIONS
ECONOMIC DEVELOPMENT COUNCIL100 SW WATER ST PEORIA,IL 61602	37-1104504	501(C)3	25,000				SUPPORT OF ORG OPERATIONS
JUNIOR ACHIEVEMENT 4450 N PROSPECT PEORIA HEIGHTS,IL 61616	37-0657600	501(C)3	15,000				SUPPORT OF ORG OPERATIONS

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

(a) Name and address of organization or government	(b) EIN	(c) IRC Code section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV , appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
ST JUDE262 DANNY THOMAS PLACE MEMPHIS,TN 38105	62-0646012	501(C)3	11,593				SUPPORT OF ORG OPERATIONS
BRADLEY UNIVERSITY 1501 W BRADLEY AVE PEORIA,IL 61625	32-7607873	501(C)3	11,233				SUPPORT OF ORG OPERATIONS
CYSTIC FIBROSIS FOUNDATION4507 N STERLING AVE 210 PEORIA,IL 61615	13-1930701	501(C)3	10,000				SUPPORT OF ORG OPERTIONS

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](http://www.irs.gov/form990).

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization  
OSF HEALTHCARE SYSTEM

Employer identification number  
37-0813229

Part I

Questions Regarding Compensation

		Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items. <div><div><input type="checkbox"/> First-class or charter travel</div><div><input type="checkbox"/> Travel for companions</div><div><input type="checkbox"/> Tax idemnification and gross-up payments</div><div><input type="checkbox"/> Discretionary spending account</div><div><input type="checkbox"/> Housing allowance or residence for personal use</div><div><input type="checkbox"/> Payments for business use of personal residence</div><div><input checked="" type="checkbox"/> Health or social club dues or initiation fees</div><div><input type="checkbox"/> Personal services (e g , maid, chauffeur, chef)</div></div>		
b	If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	1b Yes	
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?	2 Yes	
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III. <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><input checked="" 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>		
4	During the year, did any person listed in Form 990, Part VII, Section A, line 1a with respect to the filing organization or a related organization: <div><div>a Receive a severance payment or change-of-control payment?</div><div>b Participate in, or receive payment from, a supplemental nonqualified retirement plan?</div><div>c Participate in, or receive payment from, an equity-based compensation arrangement?</div></div> If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.	4a 4b 4c	No Yes No
Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.			
5	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of: <div><div>a The organization?</div><div>b Any related organization?</div></div> If "Yes," to line 5a or 5b, describe in Part III.	5a 5b	No No
6	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of: <div><div>a The organization?</div><div>b Any related organization?</div></div> If "Yes," to line 6a or 6b, describe in Part III.	6a 6b	No No
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III.	7	No
8	Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III.	8	No
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9	

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

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

**Note.** The sum of columns (B)(i)-(iii) 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				
1 GERALD J MCSHANE MD, BOARD MEMBER	(i)	524,291	93,017	38,358	35,950	12,594	704,210	0
	(ii)	0	0	0	0	0	0	0
2 JAMES W GIRARDY MD, BOARD MEMBER	(i)	165,750	0	0	0	0	165,750	0
	(ii)	0	0	0	0	0	0	0
3 KEVIN D SCHOEPLIN, VICE CHAIRPERSON, CEO	(i)	981,508	197,963	80,954	35,950	16,370	1,312,745	0
	(ii)	0	0	0	0	0	0	0
4 DANIEL E BAKER, SENIOR VP, CFO	(i)	489,524	62,651	27,707	35,950	14,111	629,943	0
	(ii)	0	0	0	0	0	0	0
5 DANIEL R FASSETT MD, PHYSICIAN, NEUROSURGERY	(i)	471,265	1,539,222	18,788	18,100	65	2,047,440	0
	(ii)	0	0	0	0	0	0	0
6 JEFFREY D KLOPPENSTEIN MD, PHYSICIAN, NEUROSURGERY	(i)	483,994	649,070	1,282	18,100	15,935	1,168,381	0
	(ii)	0	0	0	0	0	0	0
7 ANDREW J TSUNG MD, PHYSICIAN, NEUROSURGERY	(i)	686,762	431,070	46	18,100	11,278	1,147,256	0
	(ii)	0	0	0	0	0	0	0
8 BRIAN D SIPE MD, PHYSICIAN, ORTHOPEDICS	(i)	1,038,516	0	28,013	18,100	15,935	1,100,564	0
	(ii)	0	0	0	0	0	0	0
9 JAMES L MCGEE, PHYSICIAN, ONCOLOGY	(i)	873,823	50,000	20,187	29,873	12,286	986,169	0
	(ii)	0	0	0	0	0	0	0

Part IIISupplemental 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
SCHEDULE J, PART I, LINE 1A	THE CORPORATION REIMBURSES CERTAIN EXECUTIVES FOR SOCIAL CLUB DUES PAID BY SUCH EXECUTIVES ELIGIBILITY FOR CLUB DUES REIMBURSEMENT IS DETERMINED BY THE HUMAN RESOURCES COMMITTEE OF THE BOARD OF DIRECTORS AND IS TAKEN INTO CONSIDERATION BY THE COMMITTEE IN DETERMINING FAIR MARKET COMPENSATION SEE FORM 990 - SCHEDULE O - PART VI - LINES 15A AND 15B FOR AN EXPLANATION OF THE ROLE OF THE HUMAN RESOURCES COMMITTEE AND THE MANNER IN WHICH FAIR MARKET COMPENSATION IS DETERMINED CLUB DUES ARE NOT ELIGIBLE FOR REIMBURSEMENT IF THE CLUB IN QUESTION DISCRIMINATES ON THE BASIS OF RACE, RELIGION, SEX, NATIONAL ORIGIN, OR OTHER PROHIBITED FACTORS DUES REIMBURSEMENT IS TREATED AND REPORTED AS TAXABLE COMPENSATION SCHEDULE J, PART I, LINE 3 SEE EXPLANATION IN SCHEDULE O, PART VI, LINE 15A FOR DETAILS REGARDING THE PROCESS TO ESTABLISH THE COMPENSATION OF THE ORGANIZATION'S CEO SCHEDULE J, PART I, LINE 4B OSF HEALTHCARE SYSTEM HAS A DEFERRED COMPENSATION PLAN FOR SELECT KEY EXECUTIVES THIS PLAN WAS DEVELOPED TO ASSIST WITH ATTRACTING AND RETAINING CERTAIN KEY EXECUTIVES IN THE CORPORATION THE PLAN IS DESIGNED TO ENCOURAGE THE PARTICIPANTS TO STAY UNTIL A CERTAIN RETIREMENT DATE IF THE PARTICIPANTS TERMINATE PRIOR TO THEIR TARGET RETIREMENT DATE, THEY FORFEIT WHAT IS IN THE PLAN THE CORPORATION DETERMINES THE REQUIRED DEPOSITS FOR THE PLAN AT A CONSOLIDATED LEVEL DURING FY15 NO DEPOSITS WERE MADE TO THE PLAN AND NO DISTRIBUTIONS WERE MADE TO THE PLAN

Additional Data

Software ID:  
Software Version:  
EIN: 37-0813229  
Name: OSF HEALTHCARE SYSTEM

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred in prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
GERALD J MCSHANE MD, BOARD MEMBER	(i) (ii)	524,291 0	93,017 0	38,358 0	35,950 0	12,594 0	704,210 0	0 0
JAMES W GIRARDY MD, BOARD MEMBER	(i) (ii)	165,750 0	0 0	0 0	0 0	0 0	165,750 0	0 0
KEVIN D SCHOEPLEIN, VICE CHAIRPERSON, CEO	(i) (ii)	981,508 0	197,963 0	80,954 0	35,950 0	16,370 0	1,312,745 0	0 0
DANIEL E BAKER, SENIOR VP, CFO	(i) (ii)	489,524 0	62,651 0	27,707 0	35,950 0	14,111 0	629,943 0	0 0
DANIEL R FASSETT MD, PHYSICIAN, NEUROSURGERY	(i) (ii)	471,265 0	1,539,222 0	18,788 0	18,100 0	65 0	2,047,440 0	0 0
JEFFREY D KLOPPENSTEIN MD, PHYSICIAN, NEUROSURGERY	(i) (ii)	483,994 0	649,070 0	1,282 0	18,100 0	15,935 0	1,168,381 0	0 0
ANDREW J TSUNG MD, PHYSICIAN, NEUROSURGERY	(i) (ii)	686,762 0	431,070 0	46 0	18,100 0	11,278 0	1,147,256 0	0 0
BRIAN D SIPE MD, PHYSICIAN, ORTHOPEDICS	(i) (ii)	1,038,516 0	0 0	28,013 0	18,100 0	15,935 0	1,100,564 0	0 0
JAMES L MCGEE, PHYSICIAN, ONCOLOGY	(i) (ii)	873,823 0	50,000 0	20,187 0	29,873 0	12,286 0	986,169 0	0 0

Schedule K  
(Form 990)

Department of the Treasury  
Internal Revenue Service

Supplemental Information on Tax Exempt Bonds

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

OMB No 1545-0047

2014

Open to Public  
Inspection

Name of the organization  
OSF HEALTHCARE SYSTEM

Employer identification number  
37-0813229

Part I

Bond Issues

(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pool financing	
						Yes	No	Yes	No	Yes	No
A ILLINOIS FINANCE AUTHORITY	86-1091967	45203HVM1	08-29-2007	461,801,780	SEE PART VI	X			X		X
B ILLINOIS FINANCE AUTHORITY	86-1091967	45200FWG0	03-31-2009	249,074,230	SEE PART VI	X			X		X
C ILLINOIS FINANCE AUTHORITY	86-1091967		08-18-2009	70,000,000	SEE PART VI	X			X		X
D ILLINOIS FINANCE AUTHORITY	86-1091967	45200F3R8	06-29-2010	158,535,888	SEE PART VI		X		X		X

Part II

Proceeds

		A		B		C		D	
1	Amount of bonds retired	222,095,000		2,395,000		53,000,000		6,025,000	
2	Amount of bonds legally defeased	112,905,000		122,595,000		0		0	
3	Total proceeds of issue	461,801,780		249,074,230		70,000,000		158,535,888	
4	Gross proceeds in reserve funds	2,556		2,977		11,362		2,575	
5	Capitalized interest from proceeds	0		0		0		0	
6	Proceeds in refunding escrows	0		0		0		0	
7	Issuance costs from proceeds	3,319,397		3,114,169		0		2,080,292	
8	Credit enhancement from proceeds	8,846,375		126,677		0		0	
9	Working capital expenditures from proceeds	0		0		0		0	
10	Capital expenditures from proceeds	285,706,088		0		70,000,000		28,000,000	
11	Other spent proceeds	0		0		0		0	
12	Other unspent proceeds	0		0		0		0	
13	Year of substantial completion	2010		2010				2010	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue?	X		X			X	X	
15	Were the bonds issued as part of an advance refunding issue?		X		X		X		X
16	Has the final allocation of proceeds been made?	X		X		X		X	
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X		X	

Part III

Private Business Use

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

Part III

Private Business Use (Continued)

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
3a	Are there any management or service contracts that may result in private business use of bond-financed property?		X		X		X		X
b	If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
c	Are there any research agreements that may result in private business use of bond-financed property?		X		X		X		X
d	If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4	Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government	0 %		0 %		0 %		0 %	
5	Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government								
6	Total of lines 4 and 5								
7	Does the bond issue meet the private security or payment test?		X		X		X		X
8a	Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?		X		X		X		X
b	If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of								
c	If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?		X		X		X		X
9	Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?		X		X		X		X

Part IV

Arbitrage

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X		X		X		X
2	If "No" to line 1, did the following apply?								
a	Rebate not due yet?								
b	Exception to rebate?								
c	No rebate due?	X		X		X		X	
	If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3	Is the bond issue a variable rate issue?	X		X		X			X
4a	Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?	X			X		X		X
b	Name of provider	MERRILL LYNCH		0		0			
c	Term of hedge								
d	Was the hedge superintegrated?		X						
e	Was the hedge terminated?	X							

Part IV

Arbitrage (Continued)

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
5a	Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X		X		X
b	Name of provider	0		0		0		0	
c	Term of GIC								
d	Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6	Were any gross proceeds invested beyond an available temporary period?	X			X		X		X
7	Has the organization established written procedures to monitor the requirements of section 148?		X		X		X		X

Part V

Procedures To Undertake Corrective Action

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

Part VI

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

Schedule K  
(Form 990)

Department of the Treasury  
Internal Revenue Service

Supplemental Information on Tax Exempt Bonds

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

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization  
OSF HEALTHCARE SYSTEM

Employer identification number  
37-0813229

Part I Bond Issues											
(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pool financing	
						Yes	No	Yes	No	Yes	No
A ILLINOIS FINANCE AUTHORITY	86-1091967	45203HLH3	09-26-2012	191,360,304	SEE PART VI		X		X		X
B ILLINOIS FINANCE AUTHORITY	86-1091967	45203H5F5	09-29-2015	392,744,128	SEE PART VI		X		X		X

Part II Proceeds											
				A		B		C		D	
1	Amount of bonds retired			5,000,000		0					
2	Amount of bonds legally defeased			0		0					
3	Total proceeds of issue			191,360,304		392,744,128					
4	Gross proceeds in reserve funds			2,575		131,635,953					
5	Capitalized interest from proceeds			0		0					
6	Proceeds in refunding escrows			0		183,785,112					
7	Issuance costs from proceeds			2,402,586		4,151,388					
8	Credit enhancement from proceeds			0		0					
9	Working capital expenditures from proceeds			0		0					
10	Capital expenditures from proceeds			15,813,583		22,765,077					
11	Other spent proceeds			0		54,185,845					
12	Other unspent proceeds			0		0					
13	Year of substantial completion			2012							
				Yes	No						
14	Were the bonds issued as part of a current refunding issue?			X		X					
15	Were the bonds issued as part of an advance refunding issue?			X		X					
16	Has the final allocation of proceeds been made?			X			X				
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?			X		X					

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

Part III

Private Business Use (Continued)

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
3a	Are there any management or service contracts that may result in private business use of bond-financed property?		X		X				
b	If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
c	Are there any research agreements that may result in private business use of bond-financed property?		X		X				
d	If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4	Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government	0 %		0 %					
5	Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government								
6	Total of lines 4 and 5								
7	Does the bond issue meet the private security or payment test?		X		X				
8a	Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?		X		X				
b	If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of								
c	If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?		X		X				
9	Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?		X		X				

Part IV

Arbitrage

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X		X				
2	If "No" to line 1, did the following apply?								
a	Rebate not due yet?	X		X					
b	Exception to rebate?								
c	No rebate due?								
	If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3	Is the bond issue a variable rate issue?		X		X				
4a	Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X	X					
b	Name of provider	0		BARCLAY'S					
c	Term of hedge								
d	Was the hedge superintegrated?				X				
e	Was the hedge terminated?			X					

Part IV

Arbitrage (Continued)

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
5a	Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X				
b	Name of provider	0		0					
c	Term of GIC								
d	Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6	Were any gross proceeds invested beyond an available temporary period?		X		X				
7	Has the organization established written procedures to monitor the requirements of section 148?		X		X				

Part V

Procedures To Undertake Corrective Action

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

Part VI

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

Return Reference	Explanation
SUPPLEMENTAL INFORMATION 1	SCHEDULE K - PART I - BOND ISSUES ILLINOIS FINANCE AUTHORITY - 08/29/2007 CUSIP# 45203HVM1, 45203HVN9 THE CORPORATION USED THE PROCEEDS OF THE SERIES 2007 BONDS WHICH INCLUDED FIXED RATE BONDS, AUCTION BONDS AND VARIABLE RATE BONDS, TOGETHER WITH CERTAIN OTHER AVAILABLE FUNDS TO (I) FINANCE OR REFINANCE THE COST OF THE ACQUISITION, CONSTRUCTION AND EQUIPPING OF A 441,000 SQ FT NEW PATIENT TOWER, (II) PAY CAPITALIZED INTEREST WITH RESPECT TO A PORTION OF THE SYSTEMWIDE BONDS, (III) FUND DEBT SERVICE RESERVE FUNDS FOR CERTAIN OF THE SYSTEMWIDE BONDS, (IV) REFINANCE THE PRIOR INDEBTDEDNESS DESCRIBED BELOW AND (V) PAY CERTAIN EXPENSES INCURRED IN CONNECTION WITH THE ISSUANCE OF THE SYSTEMWIDE BONDS AND THE REFINANCING ILLINOIS FINANCE AUTHORITY - 03/31/2009 CUSIP# 45200FWG0, 45200FWE5, 45200FWF2 THE CORPORATION USED THE PROCEEDS OF THE SYSTEMWIDE BONDS, TOGETHER WITH CERTAIN OTHER AVAILABLE FUNDS, TO (I) REFINANCE AND REDEEM THE PRIOR BONDS DESCRIBED BELOW, (II) FUND A DEBT SERVICE RESERVE FUND FOR THE SERIES 2009 BONDS, AND (III) PAY CERTAIN EXPENSES INCURRED IN CONNECTION WITH THE ISSUANCE OF THE SYSTEMWIDE BONDS AND THE REFINANCING ILLINOIS FINANCE AUTHORITY - 08/18/2009 NO CUSIP# (PRIVATE PLACEMENTS) THE CORPORATION USED THE PROCEEDS OF THE SERIES 2009EFG TO PAY OR REIMBURSE THE CORPORATION FOR THE PROJECTS ILLINOIS FINANCE AUTHORITY - 06/29/2010 CUSIP# 45200F3R8 THE CORPORATION USED THE PROCEEDS OF THE SERIES 2010A BONDS, TOGETHER WITH CERTAIN OTHER AVAILABLE FUNDS, TO (i) REFINANCE AND REDEEM, THE ILLINOIS HEALTH FACILITY AUTHORITY VARIABLE DEMAND REVENUE BONDS, SERIES 1985B (REVOLVING FUND POOLED FINANCING PROGRAM)IN THE AMOUNT OF \$75,000,000, ILLINOIS FINANCE AUTHORITY VARIABLE RATE REVENUE BONDS, SERIES 2001 IN THE AMOUNT OF \$46,050,000, AND THE ILLINOIS FINANCE AUTHORITY REVENUE BONDS, SERIES 2007D IN THE AMOUNT OF \$20,050,000, (II) REIMBURSE THE CORPORATION FOR A PORTION OF THE COST OF CONSTRUCTING AND EQUIPPING THE DATA CENTER, A KEY ELEMENT IN THE IMPLEMENTATION OF THE CORPORATION'S INFORMATION MANAGEMENT STRATEGIC PLAN THAT PLAN INCLUDES, IN ADDITION TO THE DATA CENTER, REPLACEMENT OF EXISTING INFORMATION SYSTEMS WITH NEWER SYSTEMS PROVIDING FULL ELECTRONIC MEDICAL RECORD AND INTEGRATED BILLING FUNCTIONS FOR BOTH HOSPITAL AND AMBULATORY SERVICES, (III) FUND A DEBT SERVICE RESERVE FUND FOR THE SERIES 2010A BONDS, AND PAY CERTAIN EXPENSES INCURRED IN CONNECTION WITH THE ISSUANCE OF THE SERIES 2010A BONDS AND THE REFINANCING OF THE SERIES 1985B BONDS, THE SERIES 2001 BONDS AND THE SERIES 2007D BONDS ILLINOIS FINANCE AUTHORITY - 09/26/2012 CUSIP #45203HLH3, 45203HLG5 THE CORPORATION USED THE PROCEEDS OF THE SERIES 2012 BONDS TO (I) PAY OR REIMBURSE THE CORPORATION OR OTTAWA REGIONAL HOSPITAL & HEALTHCARE CENTER FOR THE COSTS OF ACQUIRING, CONSTRUCTING, RENOVATING, REMODELING AND EQUIPPING HEALTHCARE FACILITIES, (II) ADVANCE REFUND ALL OF THE ILLINOIS FINANCE AUTHORITY REVENUE BONDS, SERIES 2004, (III) CURRENT REFUND A PORTION OF THE ILLINOIS FINANCE AUTHORITY INSURED VARIABLE RATE DEMAND REVENUE BONDS, SERIES 2007F, (IV) CURRENTLY REFUND ALL OF THE ILLINOIS FINANCE AUTHORITY VARIABLE RATE DEMAND REVENUE BONDS, SERIES 2007G, (V) ADVANCE REFUND A PORTION OF THE ILLINOIS FINANCE AUTHORITY REVENUE BONDS, SERIES 2009A, (VI) CURRENTLY REFUND ALL OF THE ILLINOIS FINANCE AUTHORITY REVENUE BONDS, SERIES 2009F, (VII) REFINANCE THE PNC BANK LOAN, AND (VIII) PAY CERTAIN EXPENSES INCURRED IN CONNECTION WITH THE ISSUANCE OF THE BONDS AND THE REFUNDING OF THE PRIOR BONDS AND PNC BANK LOAN ILLINOIS FINANCE AUTHORITY - 09/29/2015 CUSIP# 45203H5F5 THE CORPORATION USED THE PROCEEDS OF THE SERIES 2015A BONDS, TOGETHER WITH CERTAIN OTHER AVAILABLE FUNDS, (I) ADVANCE REFUND ALL OF THE ILLINOIS FINANCE AUTHORITY REVENUE BONDS, SERIES 2007A (OSF HEALTHCARE SYSTEM OUTSTANDING), (II) ADVANCE REFUND ALL OF THE ILLINOIS FINANCE AUTHORITY REVENUE BONDS, SERIES 2009A OUTSTANDING, (III) CURRENTLY REFUND ALL OF THE ILLINOIS FINANCE AUTHORITY REVENUE BONDS, SERIES 2009E CURRENTLY OUTSTANDING, (IV) PAY OR REIMBURSE THE CORPORATION FOR THE COST OF ACQUIRING, CONSTRUCTING, RENOVATING, REMODELING AND EQUIPPING,CONSTRUCTION OF AN APPROXIMATELY 150,000 SQUARE-FOOT, FOUR STORY BED PAVILION (THE "ROCKFORD BED PAVILION") AND THE RENOVATION AND EXPANSION OF THE COMPREHENSIVE CANCER CENTER, EACH AT OSF SAINT ANTHONY MEDICAL CENTER IN ROCKFORD, ILLINOIS THE RENOVATION OF THE FORMER NEONATAL INTENSIVE CARE UNIT AND THE OUTPATIENT NEUROSCIENCES CENTER, EACH PROJECT TO BECOME PRIVATE INPATIENT ROOMS AT OSF SAINT FRANCIS MEDICAL CENTER IN PEORIA, ILLINOIS THE CONSTRUCTION OF A NEW PEDIATRIC OPERATING ROOM SUITE AT OSF SAINT FRANCIS MEDICAL CENTER AND THE CONSTRUCTION OF SURGICAL SUITES AT OSF ST JOSEPH MEDICAL CENTER IN BLOOMINGTON, ILLINOIS (V) PAY CERTAIN CAPITALIZED INTEREST ON THE SERIES 2015A BONDS DURING CONSTRUCTION, (VI) PAY CERTAIN SWAP TERMINATION COSTS RELATED TO THE SERIES 2015A BONDS, AND (VII) PAY CERTAIN EXPENSES INCURRED IN CONNECTION WITH THE ISSUANCE OF THE SERIES 2015A BONDS AND THE REFINANCE OF THE PRIOR BONDS AND THE PRIOR DEBT

Return Reference	Explanation
SUPPLEMENTAL INFORMATION 2	SCHEDULE K - PART II - LINE 7 BOND ISSUANCE COSTS BOND ISSUANCE COST CREDIT ENHANCEMENT TOTAL A \$3,319,397 \$8,846,375 \$12,165,772 B \$3,114,169 \$126,677 \$3,240,846 C \$0 \$0 \$0 D \$2,080,292 \$0 \$2,080,292 E \$2,402,586 \$0 \$2,402,586 F \$4,151,388 \$0 \$4,151,388

Return Reference	Explanation
SUPPLEMENTAL INFORMATION 3	SCHEDULE K - PART IV - LINE 2C DATE THE REBATE COMPUTATION WAS PERFORMED A NOVEMBER 28, 2011 B MAY 30, 2014 C JUNE 3, 2014 D JULY 9, 2015

Return Reference	Explanation
SUPPLEMENTAL INFORMATION 4	SCHEDULE K - PART III - LINE 9, PART IV - LINE 7 AND PART V ALTHOUGH FORMAL WRITTEN PROCEDURES WERE NOT FINALIZED BY YEAR-END, THEY ARE IN PROCESS AND SHOULD BE FINALIZED BY 9/30/16

Schedule L  
(Form 990 or 990-EZ)

Department of the Treasury  
Internal Revenue Service

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

OMB No 1545-0047  
**2014**  
Open to Public Inspection

Name of the organization OSF HEALTHCARE SYSTEM	Employer identification number 37-0813229
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Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 501(c)(29) organizations only) Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b				
1	(a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected?
				YesNo

2	Enter the amount of tax incurred by organization managers or disqualified persons during the year under section 4958 . . . . .	▶ \$	
3	Enter the amount of tax, if any, on line 2, above, reimbursed by the organization . . . . .	▶ \$	

Part II

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

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

Total	▶ \$			
-------	------	--	--	--

Part III Grants or Assistance Benefiting Interested Persons. Complete if the organization answered "Yes" on Form 990, Part IV, line 27.				
(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance

**Part IV Business Transactions Involving Interested Persons.**

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) DR JAMES W GIRARDY	BOARD MEMBER	245,070	SEE PART V INFORMATION		No

**Part V Supplemental Information**

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

Return Reference	Explanation
SCHEDULE L, PART IV - DESCRIPTION OF TRANSACTION	DR JAMES W GIRARDY, A BOARD MEMBER OF THE ORGANIZATION IS THE 100% STOCKHOLDER OF GOODFELLOW MEDICAL CONSULTING, LLC WHICH PROVIDED SERVICES AND RECEIVED FEES FOR A RELATED ORGANIZATION, OSF SAINT ANTHONY'S MEDICAL CENTER IN ROCKFORD ILLINOIS, FOR WHICH HE RECEIVED A 1099 IN THE AMOUNT OF \$245,070 DURING 2014

**SCHEDULE O**  
(Form 990 or 990-EZ)Department of the Treasury  
Internal Revenue Service**Supplemental Information to Form 990 or 990-EZ****Complete to provide information for responses to specific questions on  
Form 990 or 990-EZ or to provide any additional information.****▶ Attach to Form 990 or 990-EZ.****▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at  
[www.irs.gov/form990](http://www.irs.gov/form990).**

OMB No 1545-0047

**2014****Open to Public  
Inspection**Name of the organization  
OSF HEALTHCARE SYSTEM

Employer identification number

37-0813229

**Return  
Reference****Explanation**Form 990 -  
Part I - Line  
1

OSF is a Catholic Intergrated Health Care Delivery System. During FY 15 OSF Operated 11 Hospitals (9 included in this return and 2 that file separate returns), 5 Home Health Agencies, 4 Hospices and employed approximately 690 physicians. FORM 990 - PART III - LINE 4A INPATIENT SERVICES OSF HEALTHCARE SYSTEM OWNS AND OPERATES ACUTE CARE HOSPITALS IN ESCANABA, MICHIGAN, ROCKFORD, ILLINOIS, PONTIAC, ILLINOIS, BLOOMINGTON, ILLINOIS, PEORIA, ILLINOIS, GALESBURG, ILLINOIS, MONMOUTH, ILLINOIS, AND ALTON, ILLINOIS. AS OF THE CLOSE OF THE REPORTING PERIOD ON SEPTEMBER 30, 2015, THESE NINE FACILITIES HAD A COMBINED TOTAL OF 1,420 LICENSED INPATIENT AND RESIDENT BEDS AND OPERATED A COMBINED TOTAL OF 1,401 STAFFED INPATIENT AND RESIDENT BEDS. THEY HAD COMBINED TOTALS OF 60,106 INPATIENT AND RESIDENT DISCHARGES AND 289,271 INPATIENT AND RESIDENT DAYS, INCLUDING 14,421 NEWBORN INPATIENT DAYS. THE NINE ACUTE CARE HOSPITALS COLLECTIVELY SERVED 53 COUNTIES. THEY HAD A COMBINED TOTAL OF APPROXIMATELY 2,948 PHYSICIANS ON THEIR MEDICAL STAFFS, INCLUDING APPROXIMATELY 1,380 PHYSICIANS ON THEIR ACTIVE OR ASSOCIATE MEDICAL STAFFS. ONE OF THE HOSPITALS IS A SOLE COMMUNITY HOSPITAL AND TWO ARE CRITICAL ACCESS HOSPITALS. THE CORPORATION'S HOSPITALS OFFER A BROAD RANGE OF INPATIENT SERVICES. THREE OF THE HOSPITALS PROVIDE OPEN HEART SURGERY SERVICES, TWO OFFER LEVEL II NEONATAL SERVICES, ONE OFFERS LEVEL III NEONATAL SERVICES (HIGHEST LEVEL), AND ONE OFFERS KIDNEY AND PANCREAS ORGAN TRANSPLANT SERVICES. THE CORPORATION HAS ORGANIZED AND OPERATES COMPREHENSIVE CARDIAC AND STROKE CARE NETWORKS IN CENTRAL AND NORTHERN ILLINOIS AND OPERATES THE ONLY COMPREHENSIVE CHILDREN'S HOSPITAL IN CENTRAL ILLINOIS.

Return Reference	Explanation
FORM 990 - PART III - LINE 4B	OUTPATIENT SERVICES THE NINE ACUTE CARE HOSPITALS OWNED AND OPERATED BY OSF HEALTHCARE SYSTEM COLLECTIVELY PROVIDED 1,097,378 OUTPATIENT VISITS DURING THE REPORTING PERIOD ENDED SEPTEMBER 30, 2015, INCLUDING 51,798 OUTPATIENT SURGERY VISITS BUT EXCLUDING EMERGENCY DEPARTMENT VISITS THE CORPORATION'S HOSPITALS OFFER A BROAD RANGE OF OUTPATIENT THERAPEUTIC AND DIAGNOSTIC SERVICES, INCLUDING OUTPATIENT SURGERY AND ADVANCED MEDICAL IMAGING

Return Reference	Explanation
FORM 990 - PART III - LINE 4C	PHY S I C I A N S E R V I C E S   P H Y S I C I A N S E M P L O Y E D B Y   O S F H E A L T H C A R E S Y S T E M P R O V I D E D 1,172,253 O F F I C E V I S I T S ( N O T I N C L U D I N G S E R V I C E S P R O V I D E D T O H O S P I T A L I N P A T I E N T S A N D O U T P A T I E N T S ) A T O F F I C E S I N 68 S E P A R A T E L O C A T I O N S T H R O U G H O U T C E N T R A L A N D N O R T H E R N I L L I N O I S A N D T H E U P P E R P E N I N S U L A O F M I C H I G A N

Return Reference	Explanation
FORM 990 - PART III - LINE 4D	OTHER PROGRAM SERVICES (EXPENSES \$245,261,458 INCLUDING GRANTS OF \$253,679) (REVENUE \$197,079,460) BEYOND INPATIENT, OUTPATIENT AND PHYSICIAN SERVICES OSF HEALTHCARE SYSTEM ALSO PROVIDES CARE FOR THE FOLLOWING SERVICES HOME HEALTH SERVICES - FIVE AGENCIES LOCATED IN ILLINOIS AND MICHIGAN HOSPICE SERVICES - FOUR PROGRAMS LOCATED IN ILLINOIS AND MICHIGAN EMERGENCY DEPARTMENT SERVICES - ALL ACUTE CARE HOSPITALS PROVIDE 24 HOUR EMERGENCY CARE RESIDENCY PROGRAMS - OSF HEALTHCARE SYSTEM IS AFFILIATED WITH THE UNIVERSITY OF ILLINOIS AND PROVIDES SUPPORT FOR TEACHING OF RESIDENTS AND FELLOWSHIP PROGRAMS COLLEGE OF NURSING PROGRAMS - TWO OF THE CORPORATIONS HOSPITALS OPERATE ACCREDITED COLLEGES OF NURSING THAT OFFER ACCREDITED BACCALAUREATE, MASTERS, AND DOCTORAL DEGREES TRAUMA SERVICES (LEVEL 1) - TWO HOSPITALS IN THE SYSTEM ARE DESIGNATED AS LEVEL I TRAUMA (HIGHEST LEVEL) TRAUMA CENTERS AND TWO HAVE BEEN DESIGNATED AS LEVEL II TRAUMA CENTERS EMS FLIGHT & GROUND TRANSPORT SERVICES - THE CORPORATION PROVIDES HELICOPTER AND GROUND TRANSPORTS TO PATIENTS IN NORTHERN AND CENTRAL ILLINOIS COMMUNITY CLINIC, OUTREACH AND OTHER EDUCATIONAL PROGRAMS THE CORPORATION OFFERS TWO UNINSURED AND UNDERINSURED COMMUNITY CLINICS IN BLOOMINGTON AND PEORIA THE CORPORATION ALSO PROVIDES OUTREACH PROGRAMS TO THE COMMUNITY WITH PARISH NURSING, PERINATAL OUTREACH, AND A COMMUNITY TRAINING CENTER ALL OF THESE PROGRAMS REACH AT RISK POPULATIONS TO HELP THEM WITH SPECIFIC AND EVERYDAY HEALTHCARE NEEDS THE CORPORATION ALSO PROVIDES PARAMEDIC EDUCATION, EMT EDUCATION, MEDICAL TECH EDUCATION, RADIOLOGY TECH EDUCATION AND DIETETIC EDUCATION PROGRAMS

Return Reference	Explanation
FORM 990 - PART VI - LINE 1A	BY ADOPTING CERTAIN PROVISIONS OF THE CORPORATE BYLAWS, THE BOARD OF DIRECTORS HAS DELEGATED BROAD AUTHORITY TO THE EXECUTIVE COMMITTEE OF THE BOARD. THE BYLAWS PROVIDE THAT THE EXECUTIVE COMMITTEE SHALL BE AUTHORIZED TO TAKE SUCH ACTION AS MAY BE NECESSARY ON BEHALF OF THE CORPORATION DURING PERIODS WHEN THE BOARD OF DIRECTORS IS NOT IN SESSION.

Return Reference	Explanation
FORM 990 - PART VI - LINE 6 & 7A	OSF HEALTHCARE SYSTEM HAS NO CORPORATE STOCK OR STOCKHOLDERS. ITS SOLE MEMBER IS THE SISTERS OF THE THIRD ORDER OF ST. FRANCIS, AN ILLINOIS NOT FOR PROFIT CORPORATION, WHICH IS CONTROLLED BY MEMBERS OF A RELIGIOUS CONGREGATION OF THE CATHOLIC CHURCH ALSO KNOWN AS THE SISTERS OF THE THIRD ORDER OF ST. FRANCIS. THE GOVERNING BOARD OF THE SISTERS OF THE THIRD ORDER OF ST. FRANCIS, AN ILLINOIS NOT FOR PROFIT CORPORATION AND THE SOLE MEMBER OF OSF HEALTHCARE SYSTEM, HOLDS RESERVED POWERS TO ELECT AND REMOVE ALL OF THE MEMBERS OF THE BOARD OF DIRECTORS OF OSF HEALTHCARE SYSTEM.

Return Reference	Explanation
FORM 990 - PART VI - LINE 7B	<p>AS GOVERNED BY CANONICAL AND CIVIL GUIDELINES PERTAINING TO ROMAN CATHOLIC CHURCH PROPERTIES AND AS PROVIDED IN THE BYLAWS, CERTAIN TRANSACTIONS OF OSF HEALTHCARE SYSTEM MAY BE AUTHORIZED ONLY BY VOTE OF THE GOVERNING BOARD OF THE SISTERS OF THE THIRD ORDER OF ST FRANCIS, WHICH VOTE IS TO BE TAKEN ONLY AFTER CONSIDERING THE ADVICE OF THE BOARD OF DIRECTORS OF OSF HEALTHCARE SYSTEM THESE TRANSACTIONS ARE AS FOLLOWS - TO ESTABLISH THE PHILOSOPHY AND MISSION ACCORDING TO WHICH THE CORPORATION OPERATES - TO AMEND THE CORPORATION'S ARTICLES OF INCORPORATION AND BYLAWS - TO ELECT AND REMOVE WITH OR WITHOUT CAUSE THE DIRECTORS OF THE CORPORATION - TO MERGE OR DISSOLVE THE CORPORATION - TO LEASE, SELL, ENCUMBER OR OTHERWISE ALIENATE REAL PROPERTY OF THE CORPORATION - TO APPROVE ANY TRANSFER, LEASE, SALE OR ENCUMBRANCE OF PERSONAL PROPERTY OF THE CORPORATION EXCEPT IN THE ORDINARY COURSE OF BUSINESS - TO APPROVE ANY BORROWING OR DEBT FINANCING IN EXCESS OF A SPECIFIED LIMIT (CURRENTLY \$1,000,000) ESTABLISHED BY RESOLUTION OF THE MEMBER - TO APPOINT (OR APPROVE THE APPOINTMENT OF) OR REMOVE THE CORPORATION'S CHAIRPERSON, CHIEF EXECUTIVE OFFICER, PRESIDENT, REGIONAL PRESIDENT/CHIEF EXECUTIVE OFFICERS, AND THE LOCAL PRESIDENT/CHIEF EXECUTIVE OFFICER OF EACH HEALTH CARE FACILITY AND OPERATING DIVISION OWNED, OPERATED OR CONTROLLED BY THE CORPORATION - TO APPROVE STRATEGIC PLANS, MANAGEMENT OBJECTIVES AND CAPITAL AND OPERATING BUDGETS OF THE CORPORATION - TO APPROVE ANY PURCHASE OR OTHER ACQUISITION IN EXCESS OF A SPECIFIED LIMIT (CURRENTLY \$1,000,000) ESTABLISHED BY RESOLUTION OF THE MEMBER - TO REQUIRE A CERTIFIED AUDIT OF THE CORPORATION'S FINANCES AND TO APPOINT THE CERTIFIED PUBLIC ACCOUNTANT TO PERFORM THE AUDIT - TO APPROVE THE ENGAGEMENT OF ANY OUTSIDE LEGAL COUNSEL TO REPRESENT THE CORPORATION ON A REGULAR BASIS AND THE DISMISSAL OF ANY CURRENT LEGAL COUNSEL REPRESENTING THE CORPORATION ON A REGULAR BASIS - TO GIVE PRELIMINARY APPROVAL PRIOR TO THE DEVELOPMENT OF, AND TO GIVE FINAL APPROVAL PRIOR TO THE EXECUTION OF, ALL DOCUMENTS TO WHICH THE CORPORATION IS OR WILL BE A PARTY AND WHICH RELATE TO THE CREATION, FORMATION, ORGANIZATION, OR TERMINATION OF ANY OTHER LEGAL ENTITY (WHETHER A CORPORATION, LIMITED LIABILITY COMPANY, PARTNERSHIP, OR ANY OTHER ENTITY) IN WHICH THE CORPORATION WILL HAVE ANY OWNERSHIP INTEREST, MEMBERSHIP INTEREST, POWER TO ELECT OR APPOINT BOARD MEMBERS OR OFFICERS, OR ANY OTHER FORMAL PARTICIPATION ARRANGEMENT, WHETHER ACTING ALONE OR IN CONJUNCTION WITH ANY OTHER PERSON OR ENTITY</p>

Return Reference	Explanation
FORM 990 - PART VI - LINE 9	JAMES W GIRARDY, M D 5666 EAST STATE STREET ROCKFORD, IL 61108

Return Reference	Explanation
FORM 990 - PART VI - LINE 11B	<p>THE INITIAL DRAFT FORM 990 AND ALL REQUIRED SCHEDULES ARE PREPARED USING A MULTI-DISCIPLINARY PROCESS WHICH INCLUDES CORPORATE FINANCE AND ACCOUNTING, CORPORATE LEGAL, CORPORATE COMPLIANCE, AND CORPORATE MARKETING AND COMMUNICATIONS PERSONNEL WHO FOCUS INITIALLY ON SPECIFIC PORTIONS OF THE RETURN. THE COMPLETED DRAFT FORM 990 AND ALL SCHEDULES ARE THEN REVIEWED BY THIS SAME MULTI-DISCIPLINARY TEAM TO ENSURE ACCURACY AND INTEGRATION OF THE INDIVIDUAL PARTS AND SCHEDULES. IN ADDITION, THE INFORMATION AND SCHEDULES OF THE RETURN ARE SENT TO THE CORPORATION'S OUTSIDE AUDITORS, KPMG LLP FOR REVIEW AND COMMENT. KPMG REVIEWS THE INFORMATION AND SCHEDULES AND PREPARES AND SIGNS THE FINAL RETURN. COMMENTS FROM THE MULTI-DISCIPLINARY TEAM AND FROM THE AUDITORS ARE INCORPORATED INTO A PROPOSED FINAL VERSION OF FORM 990 AND ALL SCHEDULES. THIS PROPOSED FINAL VERSION IS THEN SENT VIA E-MAIL TO ALL OFFICERS AND MEMBERS OF THE BOARD OF DIRECTORS FOR THEIR REVIEW PRIOR TO FILING. ANY APPROPRIATE CHANGES REQUESTED BY THE OFFICERS AND DIRECTORS ARE THEN INCORPORATED INTO THE FINAL FORM 990 AND ALL SCHEDULES FOR FILING.</p>

Return Reference	Explanation
FORM 990 - PART VI - LINE 12C	DISCLOSURES BY OFFICERS, DIRECTORS AND TRUSTEES, AS WELL AS KEY EMPLOYEES AND EMPLOYEES CHARGED WITH PURCHASING, PROCUREMENT AND CONTRACTING DECISION-MAKING ARE MADE THROUGH AN ELECTRONIC REPORTING SYSTEM. DISCLOSURES ARE RECEIVED AND REVIEWED BY THE CORPORATE COMPLIANCE DIVISION. IF A POTENTIAL CONFLICT OF INTEREST IS IDENTIFIED, THEN THE DISCLOSING EMPLOYEE IS NOTIFIED OF THE POTENTIAL CONFLICT AND MAY BE ASKED FOR ADDITIONAL INFORMATION ABOUT THE INTEREST. THE CORPORATE COMPLIANCE DIVISION DETERMINES WHETHER A PLAN TO MANAGE A POSSIBLE OR ACTUAL CONFLICT OF INTEREST IS NEEDED, DISCUSSES THE MANAGEMENT PLAN WITH THE EMPLOYEE AND MONITORS THE EMPLOYEE'S COMPLIANCE WITH THE PLAN. PLANS TO MANAGE CONFLICTS ARE TRACKED THROUGH THE ELECTRONIC DISCLOSURE SYSTEM.

Return Reference	Explanation
FORM 990 - PART VI - LINE 15A	<p>THE BOARD OF DIRECTORS HAS ESTABLISHED A BOARD COMMITTEE KNOWN AS THE HUMAN RESOURCES COMMITTEE WHOSE MEMBERS ARE ALL PROFESSED MEMBERS OF THE RELIGIOUS CONGREGATION KNOWN AS THE SISTERS OF THE THIRD ORDER OF ST FRANCIS WHO HAVE TAKEN A VOW OF POVERTY HENCE, THEY DO NOT PERSONALLY BENEFIT FROM DECISIONS OF THE COMMITTEE. THE CHIEF EXECUTIVE OFFICER ("CEO") IS NOT A MEMBER OF THE COMMITTEE. THE PERFORMANCE OF THE CEO AND HIS ACHIEVEMENT OF ANNUAL GOALS IS EVALUATED EACH YEAR BY THE FULL BOARD OF DIRECTORS, AND THIS PERFORMANCE REVIEW IS PROVIDED TO THE COMMITTEE. THE COMMITTEE ALSO OBTAINS COMPENSATION SURVEY DATA AND RECOMMENDATIONS FROM A NATIONALLY RECOGNIZED INDEPENDENT COMPENSATION CONSULTANT. BASED ON ALL OF THESE FACTORS, THE COMMITTEE SETS THE BASE SALARY AND BENEFITS OF THE CEO AND APPROVES THE EXECUTIVE COMPENSATION PLAN APPLICABLE TO THE CEO. PRIOR TO PAYMENT OF ANY BONUS OR INCENTIVE COMPENSATION, THE TOTAL COMPENSATION FOR THE CEO, INCLUDING BASE SALARY, BENEFITS, AND PROPOSED BONUS OR INCENTIVE COMPENSATION, IS AGAIN REVIEWED BY A NATIONALLY RECOGNIZED COMPENSATION CONSULTANT TO ENSURE THAT NO "EXCESS BENEFIT" AMOUNT IS PAID OR FURNISHED.</p>

Return Reference	Explanation
FORM 990 - PART VI - LINE 15B	<p>THE BOARD OF DIRECTORS HAS ESTABLISHED A BOARD COMMITTEE KNOWN AS THE HUMAN RESOURCES COMMITTEE WHOSE MEMBERS ARE ALL PROFESSED MEMBERS OF THE RELIGIOUS CONGREGATION KNOWN AS THE SISTERS OF THE THIRD ORDER OF ST FRANCIS WHO HAVE TAKEN A VOW OF POVERTY. HENCE, THEY DO NOT PERSONALLY BENEFIT FROM DECISIONS OF THE COMMITTEE. THE COMMITTEE DETERMINES WHICH OFFICERS, KEY EMPLOYEES AND OTHER EMPLOYEES ARE ELIGIBLE TO PARTICIPATE IN THE EXECUTIVE COMPENSATION PLAN BASED ON PERFORMANCE REVIEWS BY THE SUPERVISORS OF SUCH PERSONS AND COMPENSATION SURVEY DATA AND RECOMMENDATIONS FROM A NATIONALLY KNOWN INDEPENDENT COMPENSATION CONSULTANT, THE COMMITTEE APPROVES ANY EXECUTIVE COMPENSATION PLAN APPLICABLE TO KEY EMPLOYEES AND ESTABLISHES THE BASE SALARY AND BENEFITS FOR PLAN PARTICIPANTS. PRIOR TO PAYMENT OF ANY BONUS OR INCENTIVE COMPENSATION, THE TOTAL COMPENSATION FOR EACH KEY EMPLOYEE, INCLUDING BASE SALARY, BENEFITS, AND PROPOSED BONUS OR INCENTIVE COMPENSATION, IS AGAIN REVIEWED BY A NATIONALLY RECOGNIZED COMPENSATION CONSULTANT TO ENSURE THAT NO "EXCESS BENEFIT" AMOUNT IS PAID OR FURNISHED. PHYSICIANS GENERALLY ARE NOT PARTICIPANTS IN THE EXECUTIVE COMPENSATION PLAN, AND THEIR COMPENSATION, INCLUDING BASE SALARY, BENEFITS, AND ANY APPLICABLE BONUS OR INCENTIVE COMPENSATION, IS ESTABLISHED IN ACCORDANCE WITH NATIONALLY RECOGNIZED PHYSICIAN COMPENSATION SURVEYS AND IS SET FORTH IN WRITTEN EMPLOYMENT AGREEMENTS WHICH ARE APPROVED BY THE BOARD OF DIRECTORS OR ITS EXECUTIVE COMMITTEE.</p>

Return Reference	Explanation
FORM 990 - PART VI - LINE 18	OSF HEALTHCARE SYSTEM MAKES ITS FORM 990, ITS FORM 990-T, AND DOCUMENTATION OF ITS EXEMPT STATUS UNDER SECTION 501(C)(3) OF THE CODE AVAILABLE FOR PUBLIC INSPECTION AND COPYING UPON REQUEST IN ACCORDANCE WITH SECTION 6104 OF THE INTERNAL REVENUE CODE. NAMES AND ADDRESSES OF CONTRIBUTORS ARE NOT DISCLOSED. REQUESTS MAY BE MADE IN PERSON, IN WRITING, OR BY TELEPHONE. REQUESTS MADE IN PERSON ARE ACCEPTED AT THE CORPORATE OFFICE AND AT EACH HOSPITAL FACILITY OF THE CORPORATION. REQUESTS MADE IN WRITING OR BY TELEPHONE TO ANY FACILITY OR LOCATION OF THE CORPORATION ARE FORWARDED TO THE CORPORATE FINANCE AND ACCOUNTING DIVISION, WHICH THEN PROVIDES COPIES OF THE REQUESTED DOCUMENTS IN THE MANNER REQUESTED (IF SUCH DELIVERY METHOD IS AVAILABLE TO THE CORPORATION).

Return Reference	Explanation
FORM 990 - PART VI - LINE 19	THE CORPORATION MAKES ITS ARTICLES OF INCORPORATION, CORPORATE BY LAWS, AND CONFLICT OF INTEREST POLICY AVAILABLE TO THE PUBLIC UPON REQUEST. ALL REQUESTS ARE FORWARDED TO THE CORPORATE LEGAL DIVISION, WHICH THEN PROVIDES COPIES OF THE REQUESTED DOCUMENTS IN THE MANNER REQUESTED (IF SUCH DELIVERY METHOD IS AVAILABLE TO THE CORPORATION). IN ADDITION, THE CORPORATION'S ARTICLES OF INCORPORATION ARE PUBLICLY AVAILABLE FROM THE OFFICE OF THE ILLINOIS SECRETARY OF STATE OR FROM THE RECORDER OF DEEDS IN WOODFORD COUNTY, ILLINOIS, SITE OF THE CORPORATION'S REGISTERED OFFICE. FINANCIAL STATEMENTS OF THE CORPORATION ARE PUBLICLY AVAILABLE ON THE ELECTRONIC MUNICIPAL MARKET ACCESS (EMMA) WEBSITE OF THE MUNICIPAL SECURITIES RULEMAKING BOARD (MSRB) AND FROM THE ILLINOIS ATTORNEY GENERAL AS PART OF THE CORPORATION'S COMMUNITY BENEFIT REPORT.

Return Reference	Explanation
FORM 990 - PART VII - SECTION A	REPORTABLE COMPENSATION IN PART VII WAS DETERMINED FROM A REVIEW OF PAYROLL QUERIES FROM THE ORGANIZATION'S AND RELATED ORGANIZATION'S PAYROLL AND GENERAL LEDGER MODULES, YEARLY PAYROLL REPORTS, AND W-2 FILINGS

Return Reference	Explanation
FORM 990 - PART XI - LINE 9	OTHER CHANGES IN FUND BALANCE INCLUDE: CHANGE IN UNREALIZED MARKET VALUE OF SWAPS (13,646,171) NET ASSETS RELEASED FROM RESTRICTION (5,147,705) INCREASE IN PERMANENTLY RESTRICTED ASSETS 14,711,117 REVERSAL OF MINIMUM PENSION LIABILITY 22,970,539 SFI & SUBSIDIARY INCOME 3,655,574 MINORITY INTEREST (5,098,754) INVESTMENT IN HEALTHCARE MIDWEST (20,528,837) EQUITY TRANSFERS (55,058,032) EARLY EXTINGUISHMENT OF DEBT (28,879,836) TRANSFER TO PARENT (150,000) NET SETTLEMENT OF DERIVATIVE INSTRUMENT (9,888,864) ----- TOTAL CHANGES IN NET ASSETS OR FUND BALANCE (110,042,353)

SCHEDULE R  
(Form 990)

Department of the Treasury  
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization  
OSF HEALTHCARE SYSTEM

Employer identification number  
37-0813229

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) OSF LIFELINE AMBULANCE LLC 318 ROXBURY ROAD ROCKFORD, IL 61107 20-0080542	AMBULANCE SVS	IL	-1,282,552	-29,456	OSF
(2) POINTCORE LLC 9600 N FRANCISCAN DR PEORIA, IL 61615 46-5126926	IT SERVICES	IL	6,176,524	9,792,506	OSF
(3) SAINT ANTHONY'S LLC 915 EAST 5TH STREET ALTON, IL 62002 37-1407745	LOW INC HOUSI	IL	0	0	OSF

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	
See Additional Data Table												

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 Yes

1b Yes

1c

1d Yes

1e

1f

1g

1h

1i

1j

1k Yes

1l Yes

1m Yes

1n

1o

1p Yes

1q

1r

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
See Additional Data Table			

Schedule R (Form 990) 2014

**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
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Additional Data

Software ID:

Software Version:

EIN: 37-0813229

Name: OSF HEALTHCARE SYSTEM

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
(1) SISTERS OF THE THIRD ORDER OF STFRANCIS  800 NE GLEN OAK AVE PEORIA, IL 61603 37-1259286	PARENT/SU ORG	IL	501(c)(3)	LN11 TYPEII	NA		No
(1) OSF HEALTHCARE FOUNDATION  800 NE GLEN OAK AVE PEORIA, IL 61603 37-1259284	SUPPORT ORG	IL	501(c)(3)	LN11 TYPEII	NA		No
(2) ST FRANCIS COMMUNITY CLINIC  530 NE GLEN OAK AVE PEORIA, IL 61637 37-0661235	FREE CLINIC	IL	501(c)(3)	LN7	SIS 3RD OSF		No
(3) OTTAWA REGIONAL HOSP & HEALTHCARE CTR  1100 EAST NORRIS DRIVE OTTAWA, IL 61350 36-2604009	HOSPITAL	IL	501(c)(3)	LN3	OSF	Yes	
(4) OTTAWA REGIONAL HOSPITAL FOUNDATION  1100 EAST NORRIS DRIVE OTTAWA, IL 61350 36-4007569	SUPPORT ORG	IL	501(c)(3)	LN11A TYPEI	ORHHC	Yes	
(5) OTTAWA REGIONAL HOSPITAL AUXILIARY  1100 EAST NORRIS DRIVE OTTAWA, IL 61350 36-3854788	SUPPORT ORG	IL	501(c)(3)	LN11C TYIII	NA		No
(6) OTTAWA REG HOSP & HEALTHCARE CTR LIAB  1100 EAST NORRIS DRIVE OTTAWA, IL 61350 36-3612653	SUPPORT ORG	IL	501(c)(3)	LN11A TYPEI	ORHHC	Yes	
(7) OSF MULTI-SPECIALTY GROUP  800 NE GLEN OAK AVE PEORIA, IL 61603 38-3852646	HLTHCARE SVCS	IL	501(c)(3)	LN11A TYPEI	OSF	Yes	
(8) OSF HEART & VASCULAR INSTITUTE  800 NE GLEN OAK AVE PEORIA, IL 61603 35-2422385	HLTHCARE SVCS	IL	501(c)(3)	LN11A TYPEI	OSF	Yes	
(9) CHILDREN'S HOSPITAL OF ILLINOIS MED GRP  800 NE GLEN OAK AVE PEORIA, IL 61603 32-0353954	HLTHCARE SVCS	IL	501(c)(3)	LN11A TYPEI	OSF	Yes	
(10) ILLINOIS NEUROSCIENCE INSTITUTE  800 NE GLEN OAK AVE PEORIA, IL 61603 36-4709999	HLTHCARE SVCS	IL	501(c)(3)	LN11A TYPEI	OSF	Yes	
(11) MENDOTA COMMUNITY HOSPITAL  1201 E 12TH STREET MENDOTA, IL 61342 36-2167785	HOSPITAL	IL	501(c)(3)	LN3	OSF	Yes	
(12) SAINT ANTHONY'S PHYSICIAN GROUP  PO BOX 340 ALTON, IL 62002 37-1365059	HLTHCARE SVCS	IL	501(c)(3)	LN9	OSF	Yes	
(13) SISTERS OF ST FRANCIS MARTYR ST GEORGE  PO BOX 9020 ALTON, IL 62002 37-6034163	RELIGIOUS	IL	501(c)(3)	LN1	OSF	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) Dispropportionate 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	
CTR FOR HEALTH AMB SURGERY CTR  8800 RTE 91 N PEORIA, IL 61615 20-5557171	SURGICAL CENTER	IL	OSF	RELATED	3,165,979	2,118,400		No			No	55 500 %
STATE & ROXBURY LLC  1725 HUNTWOOD DR CHERRY VALLEY, IL 61016 26-1728983	REAL ESTATE MGMT	IL	OSF	RELATED	52,045	1,641,883		No			No	51 000 %
EASTLAND MED PLZ SURGICENTER LLC  1505 EASTLAND DR BLOOMINGTON, IL 61701 37-1400643	SURGICAL CENTER	IL	OSF	RELATED	2,757,812	6,380,947		No			No	52 720 %
FORT JESSE IMAGING CENTER LLC  2200 FT JESSE RD NORMAL, IL 61761 46-0515604	MEDICAL IMAGING	IL	OSF	RELATED	788,235	246,779		No			No	50 100 %
SLEEP CTR OF CENTRAL ILL LLC  2204 EASTLAND DR BLOOMINGTON, IL 61704 81-0581886	SLEEP CENTER	IL	OSF	RELATED	36,295	0		No			No	16 650 %
RADIATION ONCOLOGY OF NORTHERN ILLINOIS  1200 STARFIRE DR OTTAWA, IL 61350 75-3247165	RADIATION ONCOLG	IL	ORHHC	RELATED	-199,278	443,158		No			No	57 000 %
POINT CORE NETWORK SEVCS LLC  222 3RD AVE SE STE 500 CEDAR RAPIDS, IA 52401 46-5393141	IT SERVICES	IA	POINTCORELLC	RELATED	54,086	201,623		No			No	50 000 %
STCLARE'S VILLA LP  915 E 5TH ST ALTON, IL 62002 37-1397289	LOW INC HOUSING	IL	OSF	UNRELATED	-25	2,800,067		No		Yes		0 010 %

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								
OSF SAINT FRANCIS INC 800 NE GLEN OAK AVE PEORIA, IL 61603 36-3484677	HLTHCARE SVCS	IL	OSF	C Corp	2,383,845	177,067,173	100 000 %	Yes	
HEARTCARE MIDWEST LTD 5405 N KNOXVILLE AVENUE PEORIA, IL 61614 37-0996868	CARDIOVASCULAR	IL	OSF	C Corp	-20,528,837	8,670,232	100 000 %	Yes	
CARDIOVASCULAR INSTITUTE AT OSF LLC 444 ROXBURY ROAD ROCKFORD, IL 61107 26-4225726	CARDIOVASCULAR	IL	OSF	C Corp	-7,929,389	2,240,067	100 000 %	Yes	
ILLINOIS PATHOLOGIST SERVICES LLC 5666 EAST STATE STREET ROCKFORD, IL 61108 80-0439081	PATHOLOGY SVCS	IL	OSF	C Corp	273,522	1,348,977	100 000 %	Yes	
OSF MULTISPECIALTY GRP-EASTERN REG LLC 1701 E COLLEGE AVE BLOOMINGTON, IL 61704 30-0561892	MULTISPEC CLINIC	IL	OSF	C Corp	-13,958,185	5,233,232	100 000 %	Yes	
OSF MULTISPECIALTY GRP-PEORIA LLC 530 NE GLEN OAK AVENUE PEORIA, IL 61637 26-2800379	PEDIATRIC CARDIOV	IL	OSF	C Corp	-4,930,290	656,196	100 000 %	Yes	
ILLINOIS NEUROLOGICAL INSTITUTE-PHY LLC 719 N WILLIAM KUMPF BLVD PEORIA, IL 61605 26-3109118	PEDIATRIC NEUROLO	IL	OSF	C Corp	-5,541,639	1,481,992	100 000 %	Yes	
ILLINOIS SPEC PHY SVCS AT OSF LLC 1001 MAIN STREET SUITE 200 PEORIA, IL 61606 80-0462209	PULMONOLOGY	IL	OSF	C Corp	-5,411,424	350,832	100 000 %	Yes	
OSF PERINATAL ASSOCIATES LLC 4911 EXECUTIVE DRIVE SUITE 200 PEORIA, IL 61614 80-0498373	MATERNAL FET MED	IL	OSF	C Corp	-931,603	72,475	100 000 %	Yes	
OSF MULTISPECIALTY GR-WESTERN REG LLC 3315 NORTH SEMINARY STREET GALESBURG, IL 61401 80-0608541	MULTISPEC CLINIC	IL	OSF	C Corp	-7,463,453	1,669,516	100 000 %	Yes	
OSF CHILDREN'S MEDICAL GROUP-CONGENITAL 5701 STRATHMOOR DRIVE SUITE 1 ROCKFORD, IL 61107 90-0714643	PEDIATRIC CARDIOV	IL	OSF	C Corp	-937,797	1,107,485	100 000 %	Yes	
PREFERRED EMERGENCY PHY OF ILLINOIS LLC 800 NE GLEN OAK AVENUE PEORIA, IL 61603 90-0749855	EMERGENCY ROOM	IL	OSF	C Corp	-125,024	-319,668	100 000 %	Yes	
OTTAWA REG HEALTHCARE AFFILIATES INC 1100 EAST NORRIS DRIVE OTTAWA, IL 61350 26-3937519	HOLDING COMPANY	IL	ORHHC	C Corp	-5,394,452	5,076,668	100 000 %	Yes	
OTTAWA REGIONAL MEDICAL CENTER INC 1614 EAST NORRIS DRIVE OTTAWA, IL 61350 27-1036071	OUTPATIENT DIAG	IL	ORHHC	C Corp	-5,394,452	5,076,668	100 000 %	Yes	

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

(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
OTTAWA REGIONAL HOSPITAL & HEALTHCARE CENTER	A(I)	80	
CENTER FOR HEALTH AMBULATORY SURGERY CENTER	A(IV)	985,960	
EASTLAND MEDICAL PLAZA SURGICENTER LLC	A(IV)	572,715	
HEARTCARE MIDWEST LTD	A(IV)	367,082	
OSF MULTISPECIALTY GROUP - PEORIA LLC	A(IV)	277,215	
OSF PERINATAL ASSOCIATES LLC	A(IV)	6,485	
ILLINOIS NEUROLOGICAL INSTITUTE-PHYSICIANS	A(IV)	18,501	
CARDIOVASCUAL INSTITUTE AT OSF LLC	A(IV)	445	
SAINT ANTHONY PHYSICIAN GROUP	A(IV)	264,554	
OSF SAINT FRANCIS INC	A(IV)	513,986	
OSF MULTISPECIALTY GROUP-EASTERN REGION LLC	A(IV)	178,026	
OSF MULTISPECIALTY GROUP-WESTERN REGION LLC	A(IV)	20,812	
OSF CHILDREN'S MEDICAL GROUP-CONGENITAL HEART	A(IV)	34,850	
OSF MULTISPECIALTY GROUP - PEORIA LLC	B	5,100,000	
ILLINOIS NEUROLOGICAL INSTITUTE-PHYSICIANS	B	5,500,000	
CARDIOVASCULAR INSTITUTE AT OSF LLC	B	9,600,000	
OSF MULTISPECIALTY GROUP-EASTERN REGION LLC	B	16,500,000	
ILLINOIS SPECIALTY PHYSICIAN SERVICES AT OSF	B	4,900,000	
OSF MULTISPECIALTY GROUP-WESTERN REGION LLC	B	7,000,000	
OSF PERINATAL ASSOCIATES LLC	B	900,000	
OSF CHILDREN'S MEDICAL GROUP-CONGENITAL HEART	B	1,500,000	
HEARTCARE MIDWEST LTD	B	20,000,000	
STATE AND ROXBURY LLC	D	500,000	
OSF SAINT FRANCIS INC	K	6,068,667	
CARDIOVASCULAR INSTITUTE AT OSF LLC	K	564,138	

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

(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
STATE AND ROXBURY LLC	K	560,880	
HEARTCARE MIDWEST LTD	K	727,986	
OSF SAINT FRANCIS INC	L	19,078,735	
HEARTCARE MIDWEST LTD	L	68,132	
OSF MULTISPECIALTY GROUP-EASTERN REGION LLC	L	14,351,351	
CARDIOVASCULAR INSTITUTE AT OSF LLC	L	9,046,236	
ILLINOIS PATHOLOGIST SERVICES LLC	L	1,132,353	
ILLINOIS SPECIALTY PHYSICIAN SERVICES AT OSF	L	7,283,654	
OSF PERINATAL ASSOCIATES LLC	L	2,092,576	
OSF MULTISPECIALTY GROUP - PEORIA LLC	L	5,948,874	
ILLINOIS NEUROLOGICAL INSTITUTE-PHYSICIANS	L	8,038,866	
OSF MULTISPECIALTY GROUP-WESTERN REGION LLC	L	9,591,814	
OSF CHILDREN'S MEDICAL GROUP-CONGENITAL HEART	L	565,186	
PREFERRED EMERGENCY PHYSICIANS OF ILLINOIS	L	2,036,375	
OTTAWA REGIONAL HOSPITAL & HEALTHCARE CENTER	L	5,903,508	
OSF SAINT FRANCIS INC	M	100,823,753	
OSF SAINT FRANCIS INC	P	19,730,424	
HEARTCARE MIDWEST LTD	P	855,585	
OSF MULTISPECIALTY GROUP-EASTERN REGION LLC	P	30,152,210	
CARDIOVASCULAR INSTITUTE AT OSF LLC	P	11,251,771	
ILLINOIS PATHOLOGIST SERVICES LLC	P	1,546,019	
ILLINOIS SPECIALTY PHYSICIAN SERVICES AT OSF	P	2,969,866	
OSF PERINATAL ASSOCIATES LLC	P	531,970	
OSF MULTISPECIALTY GROUP - PEORIA LLC	P	4,629,553	
ILLINOIS NEUROLOGICAL INSTITUTE-PHYSICIANS	P	4,889,255	

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

(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
OSF MULTISPECIALTY GROUP-WESTERN REGION LLC	P	13,413,321	
OSF CHILDREN'S MEDICAL GROUP-CONGENITAL HEART	P	1,143,042	
PREFERRED EMERGENCY PHYSICIANS OF ILLINOIS	P	-206,253	
OTTAWA REGIONAL HOSPITAL & HEALTHCARE CENTER	P	3,315,907	
EASTLAND MEDICAL PLAZA SURGICENTER LLC	S	2,490,016	
FORT JESSE IMAGING CENTER LLC	S	398,706	
CENTER FOR HEALTH AMBULATORY SURGERY CENTER	S	2,969,250	
OSF MULTISPECIALTY GROUP-EASTERN REGION LLC	S	632,000	
CARDIOVASCULAR INSTITUTE AT OSF LLC	S	1,020,000	
ILLINOIS PATHOLOGIST SERVICES LLC	S	2,234,000	
ILLINOIS SPECIALTY PHYSICIAN SERVICES AT OSF	S	168,000	
OSF PERINATAL ASSOCIATES LLC	S	23,000	
OSF MULTISPECIALTY GROUP - PEORIA LLC	S	92,000	
ILLINOIS NEUROLOGICAL INSTITUTE-PHYSICIANS	S	102,000	
OSF CHILDREN'S MEDICAL GROUP-CONGENITAL HEART	S	1,033,000	
PREFERRED EMERGENCY PHYSICIANS OF ILLINOIS	S	2,455,000	
OSF SAINT FRANCIS INC	S	134,809,943	