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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/foi/m990](#)

OMB No 1545-0047

2015

Open to Public Inspection

A For the 2015 calendar year, or tax year beginning 01-01-2015, and ending 12-31-2015

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

C Name of organization
PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK
% JAMES H KELLEY
Doing business as

Number and street (or P O box if mail is not delivered to street address) Room/suite
1000 REMINGTON BOULEVARD SUITE 100

City or town, state or province, country, and ZIP or foreign postal code
BOLINGBROOK, IL 60440

F Name and address of principal officer
MICHAEL ENGLEHART
200 SOUTH WACKER DRIVE
CHICAGO, IL 60606

D Employer identification number

36-4195126

E Telephone number

(630) 914-2791

G Gross receipts \$ 1,146,924,059

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

J Website: ▶ WWW.PRESENCEHEALTH.ORG

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

L Year of formation 1997 **M** State of legal domicile IL

Part I Summary					
Activities & Governance	1 Briefly describe the organization's mission or most significant activities THE ORGANIZATION STRIVES TO MAINTAIN AND IMPROVE THE HEALTH OF THE COMMUNITIES IT SERVES BY PROVIDING SERVICES THAT AVOIDS ILLNESS USING PREVENTIVE CARE AND ADVANCED TECHNOLOGIES				
	2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets				
	3 Number of voting members of the governing body (Part VI, line 1a)	3	17		
	4 Number of independent voting members of the governing body (Part VI, line 1b)	4	17		
	5 Total number of individuals employed in calendar year 2015 (Part V, line 2a)	5	0		
Revenue	6 Total number of volunteers (estimate if necessary)	6	1,661		
	7a Total unrelated business revenue from Part VIII, column (C), line 12	7a	4,467,688		
	b Net unrelated business taxable income from Form 990-T, line 34	7b	2,348,779		
	8 Contributions and grants (Part VIII, line 1h) 9 Program service revenue (Part VIII, line 2g) 10 Investment income (Part VIII, column (A), lines 3, 4, and 7d) 11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) 12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	Prior Year		Current Year	
		4,593,403		2,244,326	
		1,049,160,317		1,125,420,820	
		3,097,577		3,114,452	
		14,639,842		14,322,191	
Expenses		1,071,491,139		1,145,101,789	
13 Grants and similar amounts paid (Part IX, column (A), lines 1–3)	148,930		174,927		
14 Benefits paid to or for members (Part IX, column (A), line 4)	0		0		
15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	412,539,891		405,214,427		
16a Professional fundraising fees (Part IX, column (A), line 11e)	25,231		0		
Net Assets or Fund Balances	b Total fundraising expenses (Part IX, column (D), line 25) ▶1,855,342				
	17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	622,033,586		792,310,967	
	18 Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	1,034,747,638		1,197,700,321	
	19 Revenue less expenses Subtract line 18 from line 12	36,743,501		-52,598,532	
	20 Total assets (Part X, line 16) 21 Total liabilities (Part X, line 26) 22 Net assets or fund balances Subtract line 21 from line 20	Beginning of Current Year		End of Year	
Paid Preparer Use Only		790,635,498		757,839,362	
		247,609,118		171,622,372	
		543,026,380		586,216,990	

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

JAMES H KELLEY TREASURER

Type or print name and title

2017-02-23

Date

Paid Preparer Use Only

Print/Type preparer's name
Jacob J Zehnder

Firm's name ▶ ERNST & YOUNG US LLP

Firm's address ▶ 155 N Wacker Drive
Chicago, IL 60606

Preparer's signature
Jacob J Zehnder

Firm's EIN ▶

Phone no (312) 879-2000

Date

PTIN
P01564049

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 Form990(2015)

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

See Schedule O

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 \$	822,613,339	including grants of \$	174,927)	(Revenue \$	1,133,728,248)
	<p>PRESENCE SAINT JOSEPH MEDICAL CENTER (PSJMC) IS A 480 BED REGIONAL LEADER OF HEALTH SERVICES, PROVIDING EXCELLENCE IN HEALTH CARE TO A 23-COMMUNITY POPULATION OF CLOSE TO 700,000 PSJMC HAS A MEDICAL STAFF OF MORE THAN 570 PHYSICIANS REPRESENTING OVER 50 MEDICAL SPECIALTIES AND EMPLOYS 2,600 PROFESSIONAL, TECHNICAL AND SUPPORT PERSONNEL, MAKING IT ONE OF THE LARGEST EMPLOYERS IN WILL COUNTY PSJMCS MISSION OF PROVIDING HEALING AND HOPE IS ENHANCED BY THE FACILITY'S STATE-OF-THE-ART TECHNOLOGY AND THE BED TOWERS CENTERED APPROACH TO CARE THE NEW FACILITY ALLOWS PSJMC TO PROVIDE THE HIGHEST LEVEL OF PATIENT CARE FOR THE BEST HEALTH OUTCOMES WITH PSJMCS NEW FACILITY, WILL COUNTY RESIDENTS CAN ACCESS THE BEST DOCTORS AND HIGHEST QUALITY HEALTHCARE WITHOUT HAVING TO TRAVEL TO CHICAGO PSJMC HAS BEEN PART OF THE JOLIET COMMUNITY FOR OVER 130 YEARS AND CONTINUES TO CARRY OUT THE MISSION OF ITS DEDICATED FOUNDING SISTERS, THE FRANCISCAN SISTERS OF THE SACRED HEART, AND SET THE HIGHEST STANDARDS OF MEDICAL CARE FOR THE COMMUNITY PSJMCS ROOTS IN THE COMMUNITY ARE MATCHED ONLY BY OUR UNWAVERING COMMITMENT TO STAY IN WILL COUNTY AND GROW SO WE MAY CONTINUE TO PROVIDE THE BEST OF CARE TO RESIDENTS HERE IN THE FUTURE FOR CALENDAR YEAR ENDED DECEMBER 2015 PRESENCE SAINT JOSEPH MEDICAL CENTER PROVIDED PATIENT CARE OF 102,027 PATIENT DAYS AND HAD 22,266 DISCHARGES EMERGENCY ROOM VISITS TOTALLED 65,181, SURGERIES TOTALLED 14,049, AND OUTPATIENT REGISTRATIONS TOTALLED 357,718 PRESENCE ST MARYS HOSPITAL (PSMH) HAS BEEN MEETING THE HEALTH NEEDS OF KANKAKEE COUNTY RESIDENTS FOR OVER 115 YEARS FOUNDED BY THE SERVANTS OF THE HOLY HEART OF MARY, PRESENCE ST MARYS HOSPITAL CONTINUES TO CARRY OUT ITS MISSION OF PROVIDING "COMPASSIONATE, HOLISTIC CARE WITH A SPIRIT OF HEALING AND HOPE IN THE COMMUNITIES" IT SERVES PSMH IS A 189 BED ACUTE CARE FACILITY EMPLOYING 920 PEOPLE, WITH A LEVEL II EMERGENCY/TRAUMA CENTER PSMH PROVIDES MANY HEALTHCARE SERVICES SUCH AS A REGIONAL CANCER CENTER, REHABILITATION SERVICES, FAMILY BIRTHING CENTER, PEDIATRIC UNIT, MENTAL HEALTH SERVICES, SLEEP DISORDER CENTER, RENAL DIALYSIS CENTER, WOUND CARE, INFUSION CENTER, OCCUPATIONAL HEALTH AND A TOTAL WELLNESS CENTER LOCATED IN KANKAKEE, ILLINOIS, PSMH SERVES THE KANKAKEE COMMUNITY AND PARTNERS WITH OUR MINISTRIES IN KANKAKEE TO CONTINUE TO CARRY OUT OUR MISSION OF BRINGING HEALING AND HOPE TO OUR COMMUNITY FOR CALENDAR YEAR ENDED DECEMBER 2015 PRESENCE SAINT MARY HOSPITAL PROVIDED PATIENT CARE OF 22,883 PATIENT DAYS AND HAD 5,461 DISCHARGES EMERGENCY ROOM VISITS TOTALLED 30,917, SURGERIES TOTALLED 5,167, AND OUTPATIENT REGISTRATIONS TOTALLED 67,291 PRESENCE SAINT JOSEPH HOSPITAL (PSJH) HAS BEEN MEETING THE HEALTH NEEDS OF KANE COUNTY RESIDENTS FOR OVER 110 YEARS FOUNDED BY THE FRANCISCAN SISTERS, PSJH CONTINUES TO CARRY OUT ITS MISSION OF PROVIDING "COMPASSIONATE, HOLISTIC CARE WITH A SPIRIT OF HEALING AND HOPE IN THE COMMUNITIES" IT SERVES PSJH IS A 178-BED FACILITY LOCATED IN ELGIN, ILLINOIS, A GROWING SUBURB 40 MILES NORTHWEST OF CHICAGO, ILLINOIS ON THE FOX RIVER CONSISTENT WITH THE MISSION AND VISION SET FORTH BY THE FOUNDING FRANCISCAN SISTERS, PSJH DILIGENTLY WORKS TO MEET THE NEEDS OF THE COMMUNITY THIS IS ACHIEVED THROUGH A COMMITMENT TO PROVIDE HIGH QUALITY, STATE-OF-THE-ART, COST-EFFECTIVE CARE, WITHIN A CATHOLIC, CULTURALLY-SENSITIVE ENVIRONMENT, TO ALL MEMBERS OF THE COMMUNITY REGARDLESS OF RELIGIOUS PREFERENCE WITH OVER 1,200 EMPLOYEES AND A MEDICAL STAFF OF OVER 340 PHYSICIANS ACROSS MULTIPLE SPECIALTIES, PSJH OFFERS A FULL RANGE OF INPATIENT AND OUTPATIENT MEDICAL SERVICES FOR THE GREATER ELGIN AREA IN CONCERT WITH OTHER PRESENCE MINISTRIES, PSJH STRIVES TO LIVE OUT ITS MISSION OF PROVIDING COMPASSIONATE, HOLISTIC CARE WITH A SPIRIT OF HEALING AND HOPE IN THE COMMUNITIES WE SERVE FOR CALENDAR YEAR ENDED DECEMBER 2015 PRESENCE SAINT JOSEPH HOSPITAL ELGIN PROVIDED PATIENT CARE OF 40,647 PATIENT DAYS AND HAD 7,231 DISCHARGES EMERGENCY ROOM VISITS TOTALLED 26,684, SURGERIES TOTALLED 4,518, AND OUTPATIENT REGISTRATIONS TOTALLED 107,432 PRESENCE MERCY MEDICAL CENTER (PMMC) HAS BEEN MEETING THE HEALTH NEEDS OF KANE COUNTY RESIDENTS FOR OVER 100 YEARS FOUNDED BY THE SISTERS OF MERCY, PMMC CONTINUES TO CARRY OUT ITS MISSION OF PROVIDING "COMPASSIONATE, HOLISTIC CARE WITH A SPIRIT OF HEALING AND HOPE IN THE COMMUNITIES" IT SERVES PMMC IS A 350-BED FACILITY LOCATED IN AURORA, ILLINOIS, A GROWING SUBURB 40 MILES WEST OF CHICAGO CONSISTENT WITH THE MISSION AND VISION SET FORTH BY THE FOUNDING SISTERS OF MERCY, PMMC DILIGENTLY WORKS TO MEET THE NEEDS OF THE COMMUNITY THIS IS ACHIEVED THROUGH A COMMITMENT TO PROVIDE HIGH QUALITY, STATE-OF-THE-ART, COST-EFFECTIVE CARE, WITHIN A CATHOLIC, CULTURALLY SENSITIVE ENVIRONMENT, TO ALL MEMBERS OF THE COMMUNITY REGARDLESS OF RELIGIOUS PREFERENCE WITH OVER 1,200 EMPLOYEES AND A MEDICAL STAFF OF OVER 340 PHYSICIANS ACROSS MULTIPLE SPECIALTIES, PMMC OFFERS A FULL RANGE OF INPATIENT AND OUTPATIENT MEDICAL SERVICES FOR THE GREATER AURORA AREA IN CONCERT WITH OTHER PRESENCE MINISTRIES, PMMC STRIVES TO LIVE OUT ITS MISSION OF PROVIDING COMPASSIONATE, HOLISTIC CARE WITH A SPIRIT OF HEALING AND HOPE IN THE COMMUNITIES IT SERVES FOR CALENDAR YEAR ENDED DECEMBER 2015 PRESENCE MERCY MEDICAL CENTER PROVIDED PATIENT CARE OF 40,245 PATIENT DAYS AND HAD 8,907 DISCHARGES EMERGENCY ROOM VISITS TOTALLED 36,778, SURGERIES TOTALLED 3,265, AND OUTPATIENT REGISTRATIONS TOTALLED 136,412 PRESENCE COVENANT MEDICAL CENTER (PCMC) HAS BEEN MEETING THE HEALTH NEEDS OF CHAMPAIGN COUNTY RESIDENTS FOR OVER 90 YEARS FOUNDED BY THE SERVANTS OF THE HOLY HEART OF MARY, OUR HOSPITAL CONTINUES TO CARRY OUT ITS MISSION OF PROVIDING "COMPASSIONATE, HOLISTIC CARE WITH A SPIRIT OF HEALING AND HOPE IN THE COMMUNITIES" IT SERVES PRESENCE COVENANT MEDICAL CENTER IS A 210-BED COMPREHENSIVE MEDICAL FACILITY WITH A RICH HISTORY IN THE CHAMPAIGN-URBANA COMMUNITY TODAY, PCMC IS ONE OF EAST CENTRAL ILLINOIS MOST ADVANCED MEDICAL FACILITIES, WITH A MEDICAL STAFF OF OVER 250 PHYSICIANS REPRESENTING VARIOUS AREAS OF SPECIALIZED CARE PCMC MAINTAINS THE AREAS LARGEST INPATIENT REHABILITATION CENTER, FEATURING FACILITIES FOR PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY PCMC ALSO HAS ORTHOPEDIC SERVICES, THE CENTER FOR HEALTHY LIVING, AND THE AREAS ONLY ADULT BEHAVIORAL HEALTH UNIT IN A HOSPITAL SETTING FOR CALENDAR YEAR ENDED DECEMBER 2015 PRESENCE COVENANT MEDICAL CENTER PROVIDED PATIENT CARE OF 29,939 PATIENT DAYS AND HAD 7,504 DISCHARGES EMERGENCY ROOM VISITS TOTALLED 25,527, SURGERIES TOTALLED 6,291, AND OUTPATIENT REGISTRATIONS TOTALLED 109,696 PRESENCE UNITED SAMARITANS MEDICAL CENTER (PUSMC) HAS BEEN MEETING THE HEALTH NEEDS OF DANVILLE AND THE SURROUNDING EAST CENTRAL ILLINOIS AND WESTERN INDIANA RESIDENTS SINCE 1882 FOUNDED BY THE FRANCISCAN SISTERS OF THE SACRED HEART, PUSMC CONTINUES TO CARRY OUT ITS MISSION OF PROVIDING "COMPASSIONATE, HOLISTIC CARE WITH A SPIRIT OF HEALING AND HOPE IN THE COMMUNITIES IT SERVES " PUSMC IS A CATHOLIC, NON-PROFIT 174-LICENSED ACUTE BED HOSPITAL PROVIDING QUALITY HEALTH CARE LOCATED IN DANVILLE, ILLINOIS PUSMCS PRIMARY SERVICE AREA CONSISTS OF VERMILLION COUNTY, ILLINOIS (NEARLY 82,000 RESIDENTS) COMMUNITIES IN RURAL SOUTHERN IROQUOIS AND NORTHERN EDGAR COUNTIES IN ILLINOIS AND VERMILLION, FOUNTAIN AND WARREN COUNTIES IN INDIANA COMPLETE THE 110,000 RESIDENT TOTAL SERVICE AREAS FOR CALENDAR YEAR ENDED DECEMBER 2015 PRESENCE UNITED SAMARITANS MEDICAL CENTER PROVIDED PATIENT CARE OF 19,209 PATIENT DAYS AND HAD 5,584 DISCHARGES EMERGENCY ROOM VISITS TOTALLED 39,329, SURGERIES TOTALLED 3,224, AND OUTPATIENT REGISTRATIONS TOTALLED 136,412</p>						

[illegible][illegible]

4d	Other program services (Describe in Schedule O) (Expenses \$ including grants of \$) (Revenue \$)
4e	Total program service expenses ▶ 822,613,339

Part IV Checklist of Required Schedules

	Yes	No
1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A	1 Yes	
2 Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?	2 Yes	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I	3	No
4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II	4	No
5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? If "Yes," complete Schedule C, Part III	5	No
6 Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes," complete Schedule D, Part I	6	No
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II	7	No
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III	8	No
9 Did the organization report an amount in Part X, line 21 for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? If "Yes," complete Schedule D, Part IV	9	No
10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? If "Yes," complete Schedule D, Part V	10 Yes	
11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable		
a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI	11a Yes	
b Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII	11b	No
c Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII	11c	No
d Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part IX	11d Yes	
e Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	11e Yes	
f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part X	11f Yes	
12a Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII	12a	No
b Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional	12b Yes	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	13	No
14a Did the organization maintain an office, employees, or agents outside of the United States?	14a	No
b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV	14b	No
15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? If "Yes," complete Schedule F, Parts II and IV	15	No
16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? If "Yes," complete Schedule F, Parts III and IV	16	No
17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I (see instructions)	17	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 Yes	
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III	19	No
20a Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H	20a Yes	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b Yes	

Part IV Checklist of Required Schedules (continued)

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

Part V

Statements Regarding Other IRS Filings and Tax Compliance

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

☒

		Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable.		
1b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable.		
1c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?		
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.		
2b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions).		
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?	Yes	
3b	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O.	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)?		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?		No
5b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		No
5c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?		
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?		No
6b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		
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?	Yes	
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	Yes	
7c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		No
7d	If "Yes," indicate the number of Forms 8282 filed during the year.		
7e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		No
7f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		No
7g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		
7h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		
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?		
9a	Did the sponsoring organization make any taxable distributions under section 4966?		
9b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?		
10	Section 501(c)(7) organizations. Enter		
a	Initiation fees and capital contributions included on Part VIII, line 12.	10a	
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities.	10b	
11	Section 501(c)(12) organizations. Enter		
a	Gross income from members or shareholders.	11a	
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them).	11b	
12a	Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?	12a	
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year.	12b	
13	Section 501(c)(29) qualified nonprofit health insurance issuers.		
a	Is the organization licensed to issue qualified health plans in more than one state? Note. See the instructions for additional information the organization must report on Schedule O.	13a	
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans.	13b	
c	Enter the amount of reserves on hand.	13c	
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a	No
b	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O.	14b	

Part VI

Governance, Management, and Disclosure

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

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

Section A. Governing Body and Management

			Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a	17	
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O			
b	Enter the number of voting members included in line 1a, above, who are independent	1b	17	
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2		No
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?	3		No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4		No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5		No
6	Did the organization have members or stockholders?	6	Yes	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a	Yes	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b	Yes	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following			
a	The governing body?	8a	Yes	
b	Each committee with authority to act on behalf of the governing body?	8b	Yes	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O	9		No

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

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

Section C. Disclosure

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

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

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

Form **990** (2015)

Part VII

1b	Sub-Total			
c	Total from continuation sheets to Part VII, Section A			
d	Total (add lines 1b and 1c)	6,778,870	5,580,128	2,993,545

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 ► 294

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
OWENS AND MINOR DISTRIBUTION INC, 437 TOWER BLVD CAROL STREAM, IL 60188	CONSULTING SERVICE	6,018,850
AMERICAN ANESTHESIA ASSOCIATES OF I, 19627 S LA GRANGE RD MOKENA, IL 60448	ANESTHESIA SERVICES	6,310,206
REHABCARE GROUP MGMT SERVICES INC, 680 SOUTH FOURTH STREET LOUISVILLE, KY 402022412	REHABILITATION SVCS	3,612,132
US BANK CORPORATE TRUSTSHIFTWISE, PO BOX 70870 ST PAUL, MN 55170	CLINICAL STAFFING	3,269,772
CHRISTIE CLINIC LLC, 101 UNIVERSITY AVE CHAMPAIGN, IL 61820	HOSPITALIST SERVICES	2,521,228

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 ► 112

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	509,562					
	d	Related organizations . . .	1d						
	e	Government grants (contributions)	1e	122,796					
	f	All other contributions, gifts, grants, and similar amounts not included above	1f	1,611,968					
	g	Noncash contributions included in lines 1a-1f \$		62,624					
	h	Total. Add lines 1a-1f			2,244,326				
Program Service Revenue	2a	NET PATIENT REVENUE	Business Code 622110	1,059,947,321	1,059,947,321				
	b	RETAIL/CONTRACT PHARMACY	446110	3,985,521	2,305,746	1,679,775			
	c	MEANINGFUL USE	622110	5,733,935	5,733,935				
	d	MEDICAL OFFICE BLDG RENT	561000	2,190,071	2,190,071				
	e	PHP CAPITATION REVENUE	622110	53,563,972	53,563,972				
	f	All other program service revenue							
	g	Total. Add lines 2a-2f			1,125,420,820				
	Other Revenue	3	Investment income (including dividends, interest, and other similar amounts)		2,924,591		1,475,834	1,448,757	
4		Income from investment of tax-exempt bond proceeds . . .		0					
5		Royalties		0					
6a		(i) Real		(ii) Personal					
		Gross rents		178,246					
		Less rental expenses		130,966					
		Rental income or (loss)		47,280					0
d		Net rental income or (loss)		47,280		47,280			
7a		(i) Securities		(ii) Other					
		Gross amount from sales of assets other than inventory		1,324,809					
		Less cost or other basis and sales expenses		1,080,184					54,764
		Gain or (loss)		244,625					-54,764
d		Net gain or (loss)		189,861	189,861				
8a		Gross income from fundraising events (not including \$ 509,562 of contributions reported on line 1c) See Part IV, line 18			219,073			219,073	
		a	775,429						
		b	556,356						
c		Net income or (loss) from fundraising events . . .							
9a		Gross income from gaming activities See Part IV, line 19			0				
		a							
		b							
c		Net income or (loss) from gaming activities							
10a		Gross sales of inventory, less returns and allowances			0				
	a								
	b								
c	Net income or (loss) from sales of inventory . . .								
Miscellaneous Revenue		Business Code							
11a	CAFETERIA SALES	722514	3,972,231			3,972,231			
b	GIFT SHOP & AUXILIARY	453220	701,241			701,241			
c	ADMINISTRATION SERVICES		5,859,694	5,859,694					
d	All other revenue		3,522,672	2,257,873	1,264,799				
e	Total. Add lines 11a-11d			14,055,838					
12	Total revenue. See Instructions			1,145,101,789	1,132,048,473	4,467,688	6,341,302		

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	125,883	125,883		
2	Grants and other assistance to domestic individuals. See Part IV, line 22	49,044	49,044		
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	5,645,814		5,645,814	
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	323,893,521	306,370,335	16,367,075	1,156,111
8	Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	12,755,458	193,138	12,562,320	
9	Other employee benefits	38,407,364	581,550	37,825,814	
10	Payroll taxes	24,512,270	27,592	24,484,678	
11	Fees for services (non-employees)				
a	Management	108,471,264		108,471,264	
b	Legal	557,752		557,752	
c	Accounting	0			
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)	138,836,574	108,556,289	30,280,285	
12	Advertising and promotion	352,235	125,077	175,855	51,303
13	Office expenses	4,348,368	4,244,041	100,439	3,888
14	Information technology	104,369	93,095	11,156	118
15	Royalties	0			
16	Occupancy	31,199,427	12,035,791	19,158,879	4,757
17	Travel	692,962	344,855	327,112	20,995
18	Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19	Conferences, conventions, and meetings	211,926	172,748	29,099	10,079
20	Interest	24,597,917		24,597,917	
21	Payments to affiliates	0			
22	Depreciation, depletion, and amortization	52,275,679	2,748,157	49,527,368	154
23	Insurance	38,701,213	140,533	38,560,680	
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	MEDICAL SUPPLIES	182,821,599	182,821,599		
b	BAD DEBT EXPENSE	63,150,366	63,150,366		
c	IL MEDICAID TAX	53,523,211	53,523,211		
d	CAPITATION EXPENSE	51,841,132	51,841,132		
e	All other expenses	40,624,973	35,468,903	4,548,133	607,937
25	Total functional expenses. Add lines 1 through 24e	1,197,700,321	822,613,339	373,231,640	1,855,342
26	Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)				

Part X

Balance Sheet

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

				(A)		(B)	
				Beginning of year		End of year	
Assets	1	Cash—non-interest-bearing		0	1	0	
	2	Savings and temporary cash investments		37,736,241	2	35,929,304	
	3	Pledges and grants receivable, net		0	3	0	
	4	Accounts receivable, net		223,684,989	4	165,237,905	
	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		28,182,384	8	25,803,971	
	9	Prepaid expenses and deferred charges		3,449,564	9	1,985,458	
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a	1,081,223,824			
	b	Less: accumulated depreciation	10b	640,007,163	456,003,351	10c	441,216,661
	11	Investments—publicly traded securities		0	11	26,026,731	
	12	Investments—other securities. See Part IV, line 11		0	12	0	
	13	Investments—program-related. See Part IV, line 11		0	13	3,276,773	
	14	Intangible assets		0	14	0	
	15	Other assets. See Part IV, line 11		41,578,969	15	58,362,559	
16	Total assets. Add lines 1 through 15 (must equal line 34)		790,635,498	16	757,839,362		
Liabilities	17	Accounts payable and accrued expenses		80,724,559	17	48,110,201	
	18	Grants payable		0	18	0	
	19	Deferred revenue		0	19	241,698	
	20	Tax-exempt bond liabilities		0	20	0	
	21	Escrow or custodial account liability. Complete Part IV of Schedule D		0	21	0	
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		0	22	0	
	23	Secured mortgages and notes payable to unrelated third parties		0	23	3,205,609	
	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		166,884,559	25	120,064,864	
	26	Total liabilities. Add lines 17 through 25		247,609,118	26	171,622,372	
	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		530,928,782	27	571,625,531	
28		Temporarily restricted net assets		10,562,188	28	13,070,811	
29		Permanently restricted net assets		1,535,410	29	1,520,648	
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		543,026,380	33	586,216,990	
34		Total liabilities and net assets/fund balances		790,635,498	34	757,839,362	

Part XI **Reconciliation of Net Assets**

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	1,145,101,789
2	Total expenses (must equal Part IX, column (A), line 25)	2	1,197,700,321
3	Revenue less expenses Subtract line 2 from line 1	3	-52,598,532
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) . .	4	543,026,380
5	Net unrealized gains (losses) on investments	5	-1,161,565
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	96,950,707
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	586,216,990

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

Additional Data

Software ID:

Software Version:

EIN: 36-4195126

Name: PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
SANDRA BRUCE PRESIDENT/CEO/EX-OFFICIO-12/30	1 0 47 0	X		X				0	1,668,089	20,881
HAVEN COCKERHAM DIRECTOR	1 0 3 0	X						0	0	0
BRUCE HAMORY MD DIRECTOR	1 0 3 0	X						0	0	0
MARK HANSON DIRECTOR	1 0 3 0	X						0	0	0
THOMAS HUBERTY MD DIRECTOR	1 0 3 0	X						0	0	0
SISTER PATRICIA ANN KOSCHALKE CSFN DIRECTOR	1 0 3 0	X						0	0	0
SISTER CLARA FRANCES KUSEK CR DIRECTOR	1 0 3 0	X						0	0	0
MARSHA LADENBURGER DIRECTOR	1 0 3 0	X						0	0	0
LAURIE LAFONTAINE DIRECTOR	1 0 3 0	X						0	0	0
SISTER TERRY MALTBY RSM DIRECTOR	1 0 3 0	X						0	0	0

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
SUSAN MCDONOUGH DIRECTOR	1 0 3 0	X						0	0	0
VICTOR ORLER DIRECTOR	1 0 3 0	X						0	0	0
KENT RUSSELL DIRECTOR	1 0 3 0	X						0	0	0
JOSE SANTIAGO MD DIRECTOR (TERM 9/15)	1 0 3 0	X						0	0	0
THOMAS D SETTLES VICE CHAIR/DIRECTOR	1 0 4 0	X		X				0	0	0
SISTER MARY SHINNICK OSF DIRECTOR	1 0 3 0	X						0	0	0
SISTER EVELYN VARBONCOEUR-SSCM DIRECTOR	1 0 3 0	X						0	0	0
GUY WIEBKING CHAIR /DIRECTOR	1 0 3 0	X		X				0	0	0
JAMES WINIKATES DIRECTOR	1 0 3 0	X						0	0	0
MICHAEL ENGLEHART PRESIDENT/CEO	1 0 46 0			X				0	540,805	39,897

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JEANNIE C FREY SECRETARY	1 0 63 0			X				0	577,236	125,759
ANTHONY J FILER TREASURER	1 0 62 0			X				0	1,401,909	1,209,330
PATRICK QUINN ASSISTANT TREASURER	1 0 61 0			X				0	328,224	71,480
JULIE ROKNICH ASSISTANT SECRETARY	1 0 60 0			X				0	217,095	30,640
MICHAEL L BROWN REGIONAL PRESIDENT & CEO-FXV	40 0 0 0				X			580,180	0	98,167
JARED C ROGERS REGIONAL PRESIDENT & CEO-CES	40 0 0 0				X			489,968	0	76,357
DAVID R FRANZBLAU CONVERSION - Regional CMO	40 0 0 0				X			447,595	0	67,025
ANIL B GOPINATH REGIONAL CHIEF MEDICAL OFFFXV	40 0 0 0				X			354,770	0	59,395
JANICE M NEMRI RGN CHIEF AMB & ANCIL OFF-SSB	40 0 0 0				X			372,260	0	52,516
JACQUELINE J MEDLAND CHIEF NURSING OFFICER-SSB	40 0 0 0				X			414,367	0	79,992

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
DEBORAH A SCHIMEROWSKI REGIONAL FIN OFFICER- CES/SSB	40 0 0 0				X			317,216	0	21,636
KEVIN W LARKIN REGIONAL FINANCE OFFICER-FXV	40 0 0 0				X			312,752	0	38,027
CATHERINE EMANUEL REGN STRATEGY & GROWTH OFFCES	40 0 0 0				X			285,540	0	13,250
MOLLY A NICHOLSON REGIONAL CHIEF NURSING OFFICER	40 0 0 0				X			266,365	0	38,060
SYED SAEED P BOKHARI PSMH CHIEF MEDICAL OFFICER	40 0 0 0				X			259,792	0	9,036
GRACE L MCBRIDE REGIONAL CHIEF NURSING OFFICER	40 0 0 0				X			248,073	0	24,533
JENNIFER S CORD REGCHF AMB/ANC/SPT/MSN OFF-CES	40 0 0 0				X			223,771	0	32,206
ERIC M RHODES REG CHIEF AMB & ANC OFF-FXV	40 0 0 0				X			209,742	0	25,161
TIMOTHY J DAUGHERTY REGN STRATEGY & GROWTH OFFSSB	40 0 0 0				X			200,251	0	27,806
SURENDRA M GULATI PHYSICIAN	40 0 0 0					X		474,087	0	28,308

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
LESLIE A MASOOD PHYSICIAN	40 0 0 0					X		332,297	0	32,456
JOSEPH R DANNA MEDICAL DIRECTOR	40 0 0 0					X		294,806	0	27,483
MICHAEL PANUSKA MEDICAL DIRECTOR	40 0 0 0					X		290,561	0	29,671
SHOBHANA RAVIKUMAR PHYSICIAN	40 0 0 0					X		259,007	0	32,939
LISA M LAGGER FORMER REG CHIEF REL OFFICER	0 0 40 0						X	0	332,865	37,869
AMY D STEVENS FORMER COO	0 0 40 0						X	0	513,905	639,390
Connie J Noltemeyer FORMER REGIONAL QUALITY LEADER	0 0 0 0						X	145,470	0	4,275

SCHEDULE A
(Form 990 or 990EZ)

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

OMB No 1545-0047
2015
Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK	Employer identification number 36-4195126
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Part I

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

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

1

☐

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

2

☐

A school described in **section 170(b)(1)(A)(ii).**(Attach Schedule E (Form 990 or 990-EZ))

3

☒

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

4

☐

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

5

☐

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

6

☐

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

7

☐

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

8

☐

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

9

☐

An 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 (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)2011	(b)2012	(c)2013	(d)2014	(e)2015	(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)2011	(b)2012	(c)2013	(d)2014	(e)2015	(f)Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI)						
11 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc (see instructions)					12	
13 First five years.If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here ► <input type="checkbox"/>						

Section C. Computation of Public Support Percentage						
14 Public support percentage for 2015 (line 6, column (f) divided by line 11, column (f))		14				
15 Public support percentage for 2014 Schedule A, Part II, line 14		15				
16a 33 1/3% support test—2015.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 ► <input type="checkbox"/>						
b 33 1/3% support test—2014.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 ► <input type="checkbox"/>						
17a 10%-facts-and-circumstances test—2015.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 ► <input type="checkbox"/>						
b 10%-facts-and-circumstances test—2014.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 ► <input type="checkbox"/>						
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 ► <input type="checkbox"/>						

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

(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a)2011	(b)2012	(c)2013	(d)2014	(e)2015	(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)2011	(b)2012	(c)2013	(d)2014	(e)2015	(f)Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						
14 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here ► <input type="checkbox"/>						

Section C. Computation of Public Support Percentage

15 Public support percentage for 2015 (line 8, column (f) divided by line 13, column (f))	15	
16 Public support percentage from 2014 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2015 (line 10c, column (f) divided by line 13, column (f))	17	
18 Investment income percentage from 2014 Schedule A, Part III, line 17	18	

19a 33 1/3% support tests—2015. 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—2014. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ► ☐

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV

Supporting Organizations (continued)

Section B. Type I Supporting Organizations

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

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)? <i>If "No," describe in Part VI how control or management of the supporting organization was vested in the same persons that controlled or managed the supported organization(s).</i>		

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? <i>If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s).</i>		
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? <i>If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.</i>		

Section E. Type III Functionally-Integrated Supporting Organizations

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

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

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

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

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

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

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

Section D - Distributions	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI) See instructions	
7 Total annual distributions. Add lines 1 through 6	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI) See instructions	
9 Distributable amount for 2015 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-2015	(iii) Distributable Amount for 2015
1 Distributable amount for 2015 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2015 (reasonable cause required--see instructions)			
3 Excess distributions carryover, if any, to 2015			
a			
b			
c			
d From 2013.			
e From 2014.			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2015 distributable amount			
i Carryover from 2010 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2015 from Section D, line 7 \$			
a Applied to underdistributions of prior years			
b Applied to 2015 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2015, if any Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions)			
6 Remaining underdistributions for 2015 Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions)			
7 Excess distributions carryover to 2016. Add lines 3j and 4c			
8 Breakdown of line 7			
a			
b			
c Excess from 2013.			
d From 2014.			
e From 2015.			

Part VI Supplemental Information.

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

Facts And Circumstances Test

Return Reference

Explanation

SCHEDULE D

(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

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

OMB No 1545-0047

2015

Open to Public Inspection

Name of the organization PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK	Employer identification number 36-4195126
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Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.

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

	(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year	
2	Aggregate value of contributions to (during year)	
3	Aggregate value of grants from (during year)	
4	Aggregate value at end of year	
5	Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? <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" on Form 990, Part IV, line 7.

1	Purpose(s) of conservation easements held by the organization (check all that apply) <div><input type="checkbox"/> Preservation of land for public use (e g , recreation or education)<div><input type="checkbox"/> Protection of natural habitat <input type="checkbox"/> Preservation of open space</div><input type="checkbox"/> Preservation of an historically important land area <input type="checkbox"/> Preservation of a certified historic structure</div>	
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	
a	Total number of conservation easements	Held at the End of the Year
b	Total acreage restricted by conservation easements	2a
c	Number of conservation easements on a certified historic structure included in (a)	2b
d	Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2c
3	Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ►	2d
4	Number of states where property subject to conservation easement is located ►	
5	Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>	
6	Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ►	
7	Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ► \$	
8	Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>	
9	In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements	

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

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

1a	If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items	
b	If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items	
(i)	Revenue included on Form 990, Part VIII, line 1	► \$
(ii)	Assets included in Form 990, Part X	► \$
2	If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items	
a	Revenue included on Form 990, Part VIII, line 1	► \$
b	Assets included in Form 990, Part X	► \$

Part III

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

(continued)

3

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

a

☐

Public exhibition

b

☐

Scholarly research

c

☐

Preservation for future generations

d

☐

Loan or exchange programs

e

☐

Other

4

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

5

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

☐

Yes

☐

No

Part IV

Escrow and Custodial Arrangements.

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

1a

Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?

☐

Yes

☐

No

2

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

1c

Beginning balance

1d

Additions during the year

1e

Distributions during the year

1f

Ending balance

Amount

2a

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

☐

Yes

☐

No

2

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

☐

Part V

Endowment Funds.

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

	(a)Current year	(b)Prior year	b (c)Two years back	(d)Three years back	(e)Four years back
1a Beginning of year balance	2,899,207	2,848,100	2,744,115	1,885,241	1,823,675
b Contributions	16,897,832	2,872	4,756	765,424	61,758
c Net investment earnings, gains, and losses	-21,361	104,946	122,906	108,794	43,217
d Grants or scholarships	29,359	55,109	21,530	13,844	26,673
e Other expenditures for facilities and programs	5,154,860	1,602	2,147	1,500	16,425
f Administrative expenses					311
g End of year balance	14,591,459	2,899,207	2,848,100	2,744,115	1,885,241

2

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

a

Board designated or quasi-endowment ▶

b

Permanent endowment ▶ 10 000 %

c

Temporarily restricted endowment ▶ 90 000 %

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

3a

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

(i) unrelated organizations

(ii) related organizations

3a(i)

Yes

3a(ii)

Yes

b

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

3b

Yes

4

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

Part VI

Land, Buildings, and Equipment.

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

Description of property	(a)Cost or other basis (investment)	(b)Cost or other basis (other)	Accumulated (c)depreciation	(d)Book value
1a Land		22,201,396		22,201,396
b Buildings		696,401,085	367,125,645	329,275,440
c Leasehold improvements		4,854,931	852,184	4,002,747
d Equipment		337,105,630	258,144,261	78,961,369
e Other		20,660,782	13,885,073	6,775,709
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c)) ▶				441,216,661

Part XI

Reconciliation of Revenue per Audited Financial Statements With Revenue per Return

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

1	Total revenue, gains, and other support per audited financial statements		1	
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' on 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 1B	CONTRIBUTIONS INCLUDES A \$9,198,390 ADJUSTMENT FOR ENDOWMENT FUNDS THAT WERE NOT INCLUDED IN PRIOR YEARS. PRIOR YEAR BALANCE AND ACTIVITY INADVERTENTLY DID NOT INCLUDE ALL THE ENDOWMENT FUNDS. SCHEDULE D, PART V, LINE 4 ENDOWMENT FUND USES THE INTENDED USES OF THE ENDOWMENT FUND INCLUDE THE FOLLOWING: SUPPLEMENTAL HOSPITAL INCOME, EDUCATION, TECHNOLOGY, HEALTH AND HUMAN SERVICES FOR THE POOR, SCHOLARSHIPS, AND DIABETES WELLNESS CENTER.

Part XIII **Supplemental Information** *(continued)*

Return Reference	Explanation

SCHEDULE G
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information Regarding
Fundraising or Gaming Activities

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

Attach to Form 990 or Form 990-EZ

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

OMB No 1545-0047

2015

Open to Public Inspection

Name of the organization
PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK

Employer identification number
36-4195126

Part I Fundraising Activities

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

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

e ☐ Solicitation of non-government grants

b ☐ Internet and email solicitations

f ☐ Solicitation of government grants

c ☐ Phone solicitations

g ☐ Special fundraising events

d ☐ In-person solicitations
- 2a Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services? ☐ Yes ☐ No
- b If "Yes," list the ten highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least \$5,000 by the organization.

(i) Name and address of individual or entity (fundraiser)	(ii) Activity	(iii) Did fundraiser have custody or control of contributions?		(iv) Gross receipts from activity	(v) Amount paid to (or retained by) fundraiser listed in col (i)	(vi) Amount paid to (or retained by) organization
		Yes	No			
1 CENTRAL IL BOOKS	BOOK FAIR	Yes				
2 MASQUERADE FUNDRAISING	\$5 SALE	Yes				
3 GOLD COAST	JEWELRY	Yes				
4 DANVILLE GARDENS	FLOWER SALE		No			
5						
6						
7						
8						
9						
10						
Total						

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

Part II Fundraising Events.

Complete if the organization answered "Yes" on Form 990, Part IV, line 18, or reported more than \$15,000 of fundraising event contributions and gross income on Form 990-EZ, lines 1 and 6b. List events with gross receipts greater than \$5,000.

		(a)Event #1	(b)Event #2	(c)Other events	(d)
		GALA (event type)	FEST. OF TREES (event type)	10 (total number)	Total events (add col (a) through col (c))
Revenue	1 Gross receipts	263,727	254,386	766,878	1,284,991
	2 Less Contributions	83,532	77,750	348,280	509,562
	3 Gross income (line 1 minus line 2)	180,195	176,636	418,598	775,429
Direct Expenses	4 Cash prizes				
	5 Noncash prizes				
	6 Rent/facility costs			20,693	20,693
	7 Food and beverages				
	8 Entertainment				
	9 Other direct expenses	112,949	153,046	269,668	535,663
	10 Direct expense summary Add lines 4 through 9 in column (d) ▶				556,356
	11 Net income summary Subtract line 10 from line 3, column (d) ▶				219,073

Part III Gaming.

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

		(a)Bingo	(b)Pull tabs/Instant bingo/progressive bingo	(c)Other gaming	(d)
					Total gaming (add col (a) through col (c))
Revenue	1 Gross revenue				
Direct Expenses	2 Cash prizes				
	3 Noncash prizes				
	4 Rent/facility costs				
	5 Other direct expenses				
	6 Volunteer labor	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	
	7 Direct expense summary Add lines 2 through 5 in column (d) ▶				
	8 Net gaming income summary Subtract line 7 from line 1, column (d). ▶				

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

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

b If "No," explain _____

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

b If "Yes," explain _____

11

Does the organization conduct gaming activities with nonmembers?

☐ Yes ☐ No

12

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

☐ Yes ☐ No

13

Indicate the percentage of gaming activity conducted in

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

14

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

Name ▶

Address ▶

1400 W PARK
URBANA,IL 61801

15a

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

☐ Yes ☐ No

b

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

c

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

Name ▶

Address ▶

16

Gaming manager information

Name ▶

Gaming manager compensation ▶ \$ _____

Description of services provided ▶

☐ Director/officer ☐ Employee ☐ Independent contractor

17

Mandatory distributions

a

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

☐ Yes ☐ No

b

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

Part IV

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

Return Reference	Explanation
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SCHEDULE H
(Form 990)

Department of the
Treasury
Internal Revenue
Service

Hospitals

► Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
► Attach to Form 990.

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

OMB No 1545-0047

2015

Open to Public Inspection

Name of the organization PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK	Employer identification number 36-4195126
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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 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 type="checkbox"/> Other _____ %	3a	Yes	
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 type="checkbox"/> Other _____ 600 %	3b	Yes	
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	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)		29,341	26,140,884		26,140,884	3 920 %
b Medicaid (from Worksheet 3, column a)		122,408	232,561,177	183,084,930	49,476,247	7 420 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs		151,749	258,702,061	183,084,930	75,617,131	11 340 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	110	56,554	2,416,651	153,336	2,263,315	0 340 %
f Health professions education (from Worksheet 5)	15	3,077	5,819,073	631,731	5,187,342	0 780 %
g Subsidized health services (from Worksheet 6)	5	1,463	4,794,497	4,252,847	541,650	0 080 %
h Research (from Worksheet 7)	5		347,215		347,215	0 050 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)	24	8,131	605,489	153,754	451,735	0 070 %
j Total. Other Benefits	159	69,225	13,982,925	5,191,668	8,791,257	1 320 %
k Total. Add lines 7d and 7j	159	220,974	272,684,986	188,276,598	84,408,388	12 660 %

Part IICommunity Building Activities

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1Physical improvements and housing						
2Economic development						
3Community support	3	6,292	176,488		176,488	
4Environmental improvements						
5Leadership development and training for community members						
6Coalition building	1		951		951	
7Community health improvement advocacy						
8Workforce development						
9Other						
10Total	4	6,292	177,439		177,439	

Part IIIBad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense				Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	Yes		
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	2	63,150,366		
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	435,898,545		
6	Enter Medicare allowable costs of care relating to payments on line 5	6	484,278,435		
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-48,379,890		
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used. <input type="checkbox"/> Cost accounting system <input type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other				
Section C. Collection Practices					
9a	Did the organization have a written debt collection policy during the tax year?		9a	Yes	
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI		9b	Yes	

Part IVManagement Companies and Joint Ventures

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

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1Alliance PHO	Physician Hospital Org	50 %		50 %
2KANKAKEE VALLEY DLY	Dialysis Center	50 %		50 %
3Kendail PT Surgery	Surgery Center	15 %		50 %
4Dreyer Provena Amb	Ambulatory Care Center	40 %		60 %
5Ctr Digestive Dis	Digestive Health Center	10 %		80 %
6PSJH ORTHO CLINICAL	MGMT OF ORTHOPEDIC SERV LINE	20 %		80 %
7				
8				
9				
10				
11				
12				
13				

Part V Facility Information

Section A. Hospital Facilities

(list in order of size from largest to smallest—see instructions)
How many hospital facilities did the organization operate during the tax year?
6

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

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

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

PRESENCE ST JOSEPH MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

	Yes	No
Community Health Needs Assessment		
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	Yes
If "Yes," indicate what the CHNA report describes (check all that apply)		
a <input type="checkbox"/> A definition of the community served by the hospital facility		
b <input type="checkbox"/> Demographics of the community		
c <input type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input type="checkbox"/> How data was obtained		
e <input type="checkbox"/> The significant health needs of the community		
f <input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess 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>14</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	Yes
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a <input type="checkbox"/> Hospital facility's website (list url) <u>www.presencehealth.org/community-reports</u>		
b <input type="checkbox"/> Other website (list url)		
c <input 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	Yes
a If "Yes" (list url) <u>www.presencehealth.org/community-reports</u>		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	No
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V

Facility Information (continued)

Financial Assistance Policy (FAP)

PRESENCE ST JOSEPH MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

		Yes	No	
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 a <input 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 type="checkbox"/> Medical indigency e <input type="checkbox"/> Insurance status f <input type="checkbox"/> Underinsurance discount g <input type="checkbox"/> Residency h <input type="checkbox"/> Other (describe in Section C)	13	Yes	
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply) a <input type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application b <input type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application c <input 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)	15	Yes	
16	Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply) a <input type="checkbox"/> The FAP was widely available on a website (list url) <u>presencehealth.org</u> b <input type="checkbox"/> The FAP application form was widely available on a website (list url) <u>presencehealth.org</u> c <input type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>presencehealth.org</u> d <input type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) e <input 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 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)	16	Yes	

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 type="checkbox"/> None of these actions or other similar actions were permitted			

Part V

Facility Information (continued)

PRESENCE ST JOSEPH MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

		Yes	No
19	Did the hospital facility or other authorized 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 19 (check all that apply)		
a	<input type="checkbox"/> Notified individuals of the financial assistance policy on admission		
b	<input type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge		
c	<input type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills		
d	<input 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 type="checkbox"/> Other (describe in Section C)		
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C	23	No
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C	24	No

Part V

Facility Information (continued)

Section B. Facility Policies and Practices

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

PRESENCE MERCY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

2

	Yes	No
Community Health Needs Assessment		
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	Yes
If "Yes," indicate what the CHNA report describes (check all that apply)		
a <input type="checkbox"/> A definition of the community served by the hospital facility		
b <input type="checkbox"/> Demographics of the community		
c <input type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input type="checkbox"/> How data was obtained		
e <input type="checkbox"/> The significant health needs of the community		
f <input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess 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>15</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	Yes
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a <input type="checkbox"/> Hospital facility's website (list url) <u>www.presencehealth.org/community-reports</u>		
b <input type="checkbox"/> Other website (list url)		
c <input 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>15</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes
a If "Yes" (list url) <u>www.presencehealth.org/community-reports</u>		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	No
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V

Facility Information (continued)

Financial Assistance Policy (FAP)

PRESENCE MERCY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

		Yes	No
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 type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 % and FPG family income limit for eligibility for discounted care of 600 %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input type="checkbox"/> Medical indigency		
e	<input type="checkbox"/> Insurance status		
f	<input type="checkbox"/> Underinsurance discount		
g	<input type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	14	Yes
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	15	Yes
a	<input type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input 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? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	16	Yes
a	<input type="checkbox"/> The FAP was widely available on a website (list url) presencehealth.org		
b	<input type="checkbox"/> The FAP application form was widely available on a website (list url) presencehealth.org		
c	<input type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) presencehealth.org		
d	<input type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input 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 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 type="checkbox"/> None of these actions or other similar actions were permitted		

Part V

Facility Information *(continued)*

PRESENCE MERCY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group			Yes	No
19	Did the hospital facility or other authorized 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 19 (check all that apply)			
a	<input type="checkbox"/> Notified individuals of the financial assistance policy on admission			
b	<input type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge			
c	<input type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills			
d	<input 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 type="checkbox"/> Other (describe in Section C)			
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C	23		No
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C	24		No

Part V

Facility Information (continued)

Section B. Facility Policies and Practices

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

PRESENCE ST JOSEPH HOSPITAL

Name of hospital facility or letter of facility reporting group

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

3

	Yes	No
Community Health Needs Assessment		
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	Yes
If "Yes," indicate what the CHNA report describes (check all that apply)		
a <input type="checkbox"/> A definition of the community served by the hospital facility		
b <input type="checkbox"/> Demographics of the community		
c <input type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input type="checkbox"/> How data was obtained		
e <input type="checkbox"/> The significant health needs of the community		
f <input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess 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>15</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	Yes
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a <input type="checkbox"/> Hospital facility's website (list url) <u>www.presencehealth.org/community-reports</u>		
b <input type="checkbox"/> Other website (list url)		
c <input 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>15</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes
a If "Yes" (list url) <u>www.presencehealth.org/community-reports</u>		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	No
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V

Facility Information (continued)

Financial Assistance Policy (FAP)

PRESENCE ST JOSEPH HOSPITAL			
Name of hospital facility or letter of facility reporting group			
		Yes	No
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 type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 % and FPG family income limit for eligibility for discounted care of 600 %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input type="checkbox"/> Medical indigency		
e	<input type="checkbox"/> Insurance status		
f	<input type="checkbox"/> Underinsurance discount		
g	<input type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	14	Yes
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	15	Yes
a	<input type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input 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? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	16	Yes
a	<input type="checkbox"/> The FAP was widely available on a website (list url) presencehealth.org		
b	<input type="checkbox"/> The FAP application form was widely available on a website (list url) presencehealth.org		
c	<input type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) presencehealth.org		
d	<input type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input 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 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 type="checkbox"/> None of these actions or other similar actions were permitted		

Part V

Facility Information (continued)

PRESENCE ST JOSEPH HOSPITAL

Name of hospital facility or letter of facility reporting group			Yes	No
19	Did the hospital facility or other authorized 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 19 (check all that apply)			
a	<input type="checkbox"/> Notified individuals of the financial assistance policy on admission			
b	<input type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge			
c	<input type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills			
d	<input 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 type="checkbox"/> Other (describe in Section C)			
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C	23		No
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C	24		No

Part V

Facility Information (continued)

Section B. Facility Policies and Practices

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

PRESENCE ST MARY'S HOSPITAL

Name of hospital facility or letter of facility reporting group

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

4

	Yes	No
Community Health Needs Assessment		
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	Yes
If "Yes," indicate what the CHNA report describes (check all that apply)		
a <input type="checkbox"/> A definition of the community served by the hospital facility		
b <input type="checkbox"/> Demographics of the community		
c <input type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input type="checkbox"/> How data was obtained		
e <input type="checkbox"/> The significant health needs of the community		
f <input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess 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>15</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	Yes
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a <input type="checkbox"/> Hospital facility's website (list url) <u>www.presencehealth.org/community-reports</u>		
b <input type="checkbox"/> Other website (list url)		
c <input 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>15</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes
a If "Yes" (list url) <u>www.presencehealth.org/community-reports</u>		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	No
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V

Facility Information (continued)

Financial Assistance Policy (FAP)

		PRESENCE ST MARY'S HOSPITAL	
Name of hospital facility or letter of facility reporting group			
		Yes	No
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 type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 % and FPG family income limit for eligibility for discounted care of 600 %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input type="checkbox"/> Medical indigency		
e	<input type="checkbox"/> Insurance status		
f	<input type="checkbox"/> Underinsurance discount		
g	<input type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	14	Yes
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	15	Yes
a	<input type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input 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? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	16	Yes
a	<input type="checkbox"/> The FAP was widely available on a website (list url) presencehealth.org		
b	<input type="checkbox"/> The FAP application form was widely available on a website (list url) presencehealth.org		
c	<input type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) presencehealth.org		
d	<input type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input 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 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 type="checkbox"/> None of these actions or other similar actions were permitted		

Part V

Facility Information (continued)

PRESENCE ST MARY'S HOSPITAL

Name of hospital facility or letter of facility reporting group			Yes	No
19	Did the hospital facility or other authorized 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 19 (check all that apply)			
a	<input type="checkbox"/> Notified individuals of the financial assistance policy on admission			
b	<input type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge			
c	<input type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills			
d	<input 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 type="checkbox"/> Other (describe in Section C)			
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C	23		No
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C	24		No

Part V

Facility Information (continued)

Section B. Facility Policies and Practices

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

PRESENCE COVENANT MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

5

	Yes	No
Community Health Needs Assessment		
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply) a <input type="checkbox"/> A definition of the community served by the hospital facility b <input type="checkbox"/> Demographics of the community c <input type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community d <input type="checkbox"/> How data was obtained e <input type="checkbox"/> The significant health needs of the community f <input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups g <input type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs h <input type="checkbox"/> The process for consulting with persons representing the community's interests i <input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess 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>15</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	3 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	5 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	6a Yes	
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply) a <input type="checkbox"/> Hospital facility's website (list url) <u>www.presencehealth.org/community-reports</u> b <input type="checkbox"/> Other website (list url) _____ c <input 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	6b Yes	
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u> 10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	7 Yes	
a If "Yes" (list url) <u>www.presencehealth.org/community-reports</u> b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	8 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)?	10 Yes	
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	10b	No
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____	12a	No
	12b	

Part V

Facility Information (continued)

Financial Assistance Policy (FAP)

PRESENCE COVENANT MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

		Yes	No	
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 a <input 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 type="checkbox"/> Medical indigency e <input type="checkbox"/> Insurance status f <input type="checkbox"/> Underinsurance discount g <input type="checkbox"/> Residency h <input type="checkbox"/> Other (describe in Section C)	13	Yes	
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply) a <input type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application b <input type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application c <input 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)	15	Yes	
16	Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply) a <input type="checkbox"/> The FAP was widely available on a website (list url) <u>presencehealth.org</u> b <input type="checkbox"/> The FAP application form was widely available on a website (list url) <u>presencehealth.org</u> c <input type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>presencehealth.org</u> d <input type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) e <input 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 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)	16	Yes	

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 type="checkbox"/> None of these actions or other similar actions were permitted			

Part V

Facility Information (continued)

PRESENCE COVENANT MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

		Yes	No
19	Did the hospital facility or other authorized 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 19 (check all that apply)		
a	<input type="checkbox"/> Notified individuals of the financial assistance policy on admission		
b	<input type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge		
c	<input type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills		
d	<input 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 type="checkbox"/> Other (describe in Section C)		
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C	23	No
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C	24	No

Part V

Facility Information (continued)

Section B. Facility Policies and Practices

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

PRESENCE UNITED SAMARITANS MED CNTR

Name of hospital facility or letter of facility reporting group

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

6

	Yes	No
Community Health Needs Assessment		
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply) a <input type="checkbox"/> A definition of the community served by the hospital facility b <input type="checkbox"/> Demographics of the community c <input type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community d <input type="checkbox"/> How data was obtained e <input type="checkbox"/> The significant health needs of the community f <input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups g <input type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs h <input type="checkbox"/> The process for consulting with persons representing the community's interests i <input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess 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>15</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	3 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	5 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	6a Yes	
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply) a <input type="checkbox"/> Hospital facility's website (list url) <u>www.presencehealth.org/community-reports</u> b <input type="checkbox"/> Other website (list url) _____ c <input 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	6b Yes	
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u> 10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	7 Yes	
a If "Yes" (list url) <u>www.presencehealth.org/community-reports</u> b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	8 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)?	10 Yes	
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	10b	No
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____	12a	No
	12b	

Part V

Facility Information (continued)

Financial Assistance Policy (FAP)

PRESENCE UNITED SAMARITANS MED CNTR

Name of hospital facility or letter of facility reporting group

		Yes	No	
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 a <input 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 type="checkbox"/> Medical indigency e <input type="checkbox"/> Insurance status f <input type="checkbox"/> Underinsurance discount g <input type="checkbox"/> Residency h <input type="checkbox"/> Other (describe in Section C)	13	Yes	
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply) a <input type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application b <input type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application c <input 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)	15	Yes	
16	Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply) a <input type="checkbox"/> The FAP was widely available on a website (list url) <u>presencehealth.org</u> b <input type="checkbox"/> The FAP application form was widely available on a website (list url) <u>presencehealth.org</u> c <input type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>presencehealth.org</u> d <input type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) e <input 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 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)	16	Yes	

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 type="checkbox"/> None of these actions or other similar actions were permitted			

Part V

Facility Information (continued)

PRESENCE UNITED SAMARITANS MED CNTR

Name of hospital facility or letter of facility reporting group			Yes	No
19	Did the hospital facility or other authorized 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 19 (check all that apply)			
a	<input type="checkbox"/> Notified individuals of the financial assistance policy on admission			
b	<input type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge			
c	<input type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills			
d	<input 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 type="checkbox"/> Other (describe in Section C)			
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C	23		No
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C	24		No

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

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

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

Form and Line Reference	Explanation

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? **28**

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

Part VI Supplemental Information

Provide the following information

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

Form and Line Reference	Explanation
PART I, LINE 3C	THIS QUESTION IS NOT APPLICABLE BECAUSE PRESENCE HEALTH USES THE FEDERAL POVERTY GUIDELINES

Form and Line Reference	Explanation
PART I, LINE 6A	<p>Presence Health, the parent of Presence Central and Suburban Hospitals Network, published a Community Benefit Report with 2015 data, which details the combined charitable impact our ministries have within the communities we serve. Each ministry creates ministry-specific Implementation Strategies which outline the goals and objectives they have established to address the prioritized needs of their communities.</p>

Form and Line Reference	Explanation
PART I, LINE 6B	<p>The 2015 Presence Health Community Benefit Report was made publicly available through a variety of ways to share the information with the community at large</p> <ul style="list-style-type: none"> *Print version of report The report will be mailed from the system office to community partners, elected officials, and local leaders *Website A robust community section has been developed and can be found online at www.presencehealth.org/community This section includes an online, downloadable file of the 2015 Community Benefit Report Each ministry has its own link on this page Through this link, Community Health Needs Assessment (CHNA) documents specific to the hospital can be downloaded, including a community-friendly CHNA flipbook, the source documents of all data reviewed, an overall CHNA Report, and an Implementation Strategy *PowerPoint presentation A standard PowerPoint of the entire 2015 Community Benefit Report has been made available A customized version of this presentation has also been created for each ministry to share with the community, which shows the local community benefit contributions, persons served, and the 2015 prioritized community needs

Form and Line Reference	Explanation
PART I, LINE 7, COLUMN G	Costs from physician clinics are not included in subsidized service totals PART I, LINE 7, COLUMN F Per 2015 Instructions for Schedule H (Form 990), the Bad Debt Expense of \$63,150,366 has been removed from the denominator in calculating the percentage of total expense in Line 7

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

Form and Line Reference	Explanation
PART II, COMMUNITY BUILDING ACTIVITIES	<p>Community building activities include programs that improve the community's health and safety by addressing the root causes of health problems, such as poverty, homelessness and environmental hazards. Participation in collaborative community efforts to promote public health initiatives is also included, such as engagement in coalitions and advocacy for health improvement. These activities strengthen the community's capacity to promote the health and well-being of its residents by offering the expertise and resources of the health care organization. Presence Health hospital ministries engage in a variety of community-building activities which ultimately improve the health and well-being of the communities we are privileged to serve, even though they are not specific health activities. Examples of community building activities include:</p> <ul style="list-style-type: none"> *The work of all of our hospitals in support of disaster readiness and emergency preparedness. This work goes above and beyond any licensure requirements to proactively ensure that our communities are safe and prepared if a disaster should present itself. *Community Support: Donations from our ministries to organizations addressing the root causes of health problems. *Coalition Building: Presence Saint Joseph Medical Center leads a community coalition, Joliet Partners for Healthy Families (JPHF), with the goal of making Will County a healthier place to live. JPHF is working with local legislators on policy, systems and environmental changes. *Workforce Development: Presence St. Mary's Hospital partners with the Kankakee Regional Volunteer Services coalition. This coalition allows local teen participants the opportunity to use their time and talents for those in need, while providing themselves with excellent exposure to many health-related careers, as well as business communications and early childhood teaching.

Form and Line Reference	Explanation
PART III, BAD DEBT, MEDICARE, & COLLECTION PRACTICES	PART III, SECTION A, LINE 2 The bad debt reported on Part III, line 2 agrees to the financial statements account. This account reduces the revenue recognized related to the account that is deemed uncollectible to zero.

Form and Line Reference	Explanation
PART III, SECTION A, LINE 3	The Provision for Financial Assistance Policy allows for accounts in bad debt to be approved for Financial Assistance if the patient meets the criteria. There are possible financial assistance accounts in bad debt, although the exact percentage is unknown as we do not have the appropriate tools to determine this percentage accurately.

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

Form and Line Reference	Explanation
PART III, SECTION B, LINE 8	<p>Presence Health computes the Medicare shortfall based on a ratio of cost to charges. Presence Health believes it is important for the community and the IRS to be made aware of government shortfalls, specifically Medicare. However, we acknowledge that Medicare shortfalls may be experienced by other than non-profit healthcare organizations. As such, Presence Health does not believe that Medicare shortfall should be considered community benefit.</p>

Form and Line Reference	Explanation
PART III, SECTION C, LINE 9B	<p>Collection policies are the same for all Presence Health entities. Patients are notified of the financial assistance policy at the time of registration via posted notifications and on every account statement that is sent to them. This information is available in a number of languages. Patients may apply for financial assistance at any time during the revenue cycle. Per the Provision for Financial Assistance Policy, the collection process is as follows:</p> <ol style="list-style-type: none"> 1. Pre-Litigation Review: Prior to an account being authorized for the filing of suit for non-payment of a patient bill, a final review of the account will be conducted and approved by the Financial Counseling Representative (or designee) to make sure that no application of financial assistance was ever received and that there exists objective evidence that the patient does have sufficient financial means to pay all or part of his/her bill. Prior to a collections suit being filed, the Self-pay Collections Director must review and approve. 2. Residential Liens: No hospital will place a lien on the primary residence of a patient who has been determined to be eligible for Financial Assistance/Charity Care, for payment of the patient's undiscounted balance due. Further, in no case will any hospital execute a lien by forcing the sale or foreclosure of the primary residence of any patient to pay for any outstanding medical bill. 3. No Use of Body Attachments: No hospital will use body attachment to require any person, whether receiving Financial Assistance/Charity Care discounts or not, to appear in court. 4. Collection Agency Referrals: Each hospital Finance accounting will ensure that all collection agencies used to collect patient bills promptly refer any patient who indicates financial need, or otherwise appears to qualify for Financial Assistance/Charity Care discounts, to a financial counselor to determine if the patient is eligible for such a charitable discount. For more information about Presence Health's Financial Assistance Program, visit http://presencehealth.org/patients-and-visitors/financial-assistance.

Form and Line Reference	Explanation
PART VI, LINE 2 NEEDS ASSESSMENT	<p>Presence Health ministries join forces with local community organizations to assess the health needs of the community. Community health needs assessments (CHNAs) are completed for the individual counties we serve with community partners every 3 years as required. To supplement the CHNA, Presence hospitals also review and analyze Inpatient and Emergency Department utilization on an annual basis to uncover any new community health trends. In addition to assessing the health needs, Presence hospital ministries also complete medical staff development plans. The plans are conducted by external consultants, who provide an independent assessment of the need for physicians by specialty within the hospitals primary service area as defined by Stark regulations. Identifying community needs is just one step in the CHNA process. The most critical step is prioritizing and aligning expertise to make an impact on the identified needs. To facilitate this process, the Board of Directors of each hospital ministry has appointed a Community Leadership Board that is ultimately responsible for the oversight and direction of the community benefit initiatives. On a triennial basis this advisory board, which is made up of community members, approves the hospitals Implementation Strategy pursuant to authority delegated by the hospital ministrys board of directors. This plan identifies the priorities and actions that will take place to transform community health.</p> <p>Identifying community needs is just one step in the CHNA process. The most critical step is prioritizing and aligning expertise to make an impact on the identified needs. To facilitate this process, the Board of Directors of each hospital ministry has appointed a Community Leadership Board that is ultimately responsible for the oversight and direction of the community benefit initiatives. On a triennial basis this advisory board, which is made up of community members, approves the hospitals Implementation Strategy pursuant to authority delegated by the hospital ministrys board of directors. This plan identifies the priorities and actions that will take place to transform community health.</p>

Form and Line Reference	Explanation
PART VI, LINE 3 PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE	<p>Presence Health hospital ministries proactively communicate the availability of our financial assistance/charity care programs by using multiple types of appropriate media and in multiple appropriate languages. The mechanisms used by Presence Health hospitals to communicate the availability of Financial Assistance/Charity Care include, but are not limited to the following:</p> <ol style="list-style-type: none"> 1 Signage: Signs are posted prominently throughout high traffic areas of our ministries, as well as within our inpatient and outpatient registration/patient admitting areas and emergency departments. Signs state that patients may be eligible for Financial Assistance/Charity Care discounts, and describe how to obtain more information, including identification of appropriate hospital representatives by title. Signs are in multiple languages. 2 Provision of Financial Assistance Materials to Uninsured Patients: Presence Health hospitals provide a summary of its Financial Assistance Programs and a Financial Assistance application to all persons receiving hospital care that it identifies as uninsured patients at the time of in-person registration, admission, or such later time that the patient is first identified as an uninsured patient. For patients presenting in the Emergency Department, all Presence Health hospitals provide such Financial Assistance materials at such time and in such manner as is consistent with their obligations under EMTALA to access and stabilize the patient before making inquiry of the patient's ability to pay. 3 Brochures: Brochures, information sheets and similar forms of written communication regarding the hospital's Financial Assistance/Charity Care policy are maintained in appropriate areas of the hospital (e.g. Emergency Department, organized registration areas, the Business Office). These communications state in multiple languages that the hospital offers Financial Assistance/Charity Care discounts and describes how to obtain more information. 4 Website: Comprehensive information about our financial assistance programs including eligibility criteria, application details, and contact information is also available on our consumer Web site (http://presencehealth.org/patients-and-visitors/financial-assistance). 5 Billing Notices: Each Presence Health hospital includes a note on or with the hospital bill and/or statement regarding the hospital's Financial Assistance/Charity Care program and how the patient may apply for consideration under this program. 6 Financial Counselors: Each Presence Health hospital has one or more financial counselors whose contact information is listed or provided with other information concerning the Financial Assistance/Charity Care discount program. These counselors are available to discuss eligibility and other questions concerning the program, and provide assistance with applications. They are also available to meet with patients during their stay if they have questions about their ability to pay for services and our financial assistance programs. 7 Notification of Determination: When a Presence Health hospital makes a determination that a patient's bill is discounted or adjusted based on a determination of financial need, the hospital notifies the patient of such eligibility determination and that there is no further collection action taken on the discounted portion of the patient's bill.

Form and Line Reference	Explanation
PART VI, LINE 4 COMMUNITY INFORMATION	<p>Presence Hospital ministries provide services at 150 sites, including eleven acute care hospitals with a total of 3,188 staffed beds and over 90 primary and specialty care clinics. These ministries offer a broad range of services from highly specialized tertiary services to an extended network of primary and ambulatory care. Presence Health hospital ministries have identified a separate service area for each of its acute care hospitals utilizing a consistent methodology and reflecting a combination of geographic location and market share criteria. The total service area of each ministry represents approximately 80% to 90% of the total inpatient discharges from that facility. The primary service area (the "Primary Service Area") of each facility represents approximately 65 to 75% of such discharges and the secondary service area (the "Secondary Service Area") of each facility represents approximately 15 to 25% of such discharges. The Primary Service Areas and Secondary Service Areas have been determined by utilizing a patient origin analysis to identify those zip codes that represent inpatient discharges. These zip codes are then mapped to identify geographic coverage of the Primary Service Areas and Secondary Service Areas. Many of the Presence Health hospital ministries facilities are located in population growth areas. Based upon population estimates and projections obtained from Claritas, Inc., the population of the four hospitals combined service area is expected to grow at a rate of 1.9% annually between 2012 and 2017, compared with a growth rate of 1.3% and 1.6% per year in the Chicago MSA and in Illinois, respectively. Of Presence's total service area population, 10.7% is over the age of 65, compared to 11.1% and 12.3% in the Chicago MSA and in Illinois, respectively. Presence Covenant Medical Center, Champaign, IL (PCMC). Champaign County is the tenth largest county in the state of Illinois with a 2013 population of 203,276. In the primary service area, 11% of the population is over the age 65 and the median household income is \$46,708. The primary demographic make-up of Champaign County is as follows: 74.1% white, 12.2% black or African American, 9.1% Asian, 5.1% Hispanic/Latino. Just under 22% of families in Champaign County live below the poverty level. The PCMC service area is defined by zip codes below. Service Area Primary Market Zip Code City 61821 Champaign 61801 Urbana 61820 Champaign 61866 Rantoul 61802 Urbana 61953 Tuscola 61880 Tolono 61873 Saint Joseph 61956 Villa Grove 61874 Savoy 61849 Horner 61878 Thomasboro 61822 Champaign 61847 Gifford 61877 Sidney 61943 Oakland 61851 Ivesdale 61884 White Heath 61839 De Land 61931 Humboldt 61844 Fithian 61862 Penfield 61882 Weldon 61773 Sibley 61930 Hindsboro 61812 Armstrong 60933 Elliott 61932 Hume 61871 Royal 60926 Claytonville 61845 Foosland 61941 Murdock Service Area Secondary Market Zip Code City 60948 Loda 60957 Paxton 61856 Monticello 61853 Mahomet 61938 Mattoon 61910 Arcola 60936 Gibson City 61920 Charleston 61942 Newman 61813 Bement Presence United Samaritans Medical Center (PUSMC), Danville, IL. PUSMCs primary and secondary service areas have an estimated population of 81,625 residents. In the primary service area, 16.7% of the population is over the age 65 and the average household income is \$40,463. The primary demographic make-up of Vermillion County is as follows: 83.6% white, 13.3% black or African American, 4.5% Hispanic/Latino. 18.8% of families in Vermillion County live below the poverty level. The PUSMC service area is defined by zip codes below. Service Area Primary Market Zip Code City 61832 Danville 61834 Danville 61846 Georgetown 61883 Westville 61833 Tilton Service Area Secondary Market Zip Code City 47932 Covington, IN 60942 Hoopeston 61817 Catlin 61858 Oakwood 61870 Ridge Farm 61924 Chrisman 60963 Rossville 47987 Veedersburg, IN 61841 Fairmont 47974 Perrysville, IN 47993 Williamsport, IN 61814 Bismark 61865 Potomac 47928 Cayuga, IN 47952 Kingman, IN 61876 Sidell 61811 Alvin 61844 Fithian 61850 Indianapolis 47991 West Lebanon, IN 61848 Henning 47982 State Line, IN 60960 Rankin 47918 Attica, IN 61812 Armstrong 60973 Wellington 61940 Metcalf 61831 Collision Presence Saint Joseph Medical Center (PSJMC), Joliet, IL. PSJMCs primary service has an estimated population of 677,560 according to the 2010 census. In the primary service area, 9.3% of the population is over the age 65 and the median household income is \$75,906. Approximately, 7.1% of the population in Joliet lives below the poverty level. The racial makeup of the city is 76.0% White, 11.2% African American, 4.6% Asian, and 7.9% Multi-racial/Other. The 2014 population also estimates that 22.5% are Hispanic or Latino. The Presence Saint Joseph Medical Center service area is defined by zip codes below. Service Area Primary Market Zip Code City 60435 Joliet 60436 Joliet 60544 Plainfield 60433 Joliet 60431 Joliet 60432 Joliet 60434 Joliet 60585 Plainfield 60586 Plainfield 60</p>

Form and Line Reference	Explanation
PART VI, LINE 4 COMMUNITY INFORMATION	<p>403 Crest Hill 60404 Shorewood Service Area Secondary Market Zip Code City 60451 New Leno x 60481 Wilmington 60450 Morris 60410 Channahon 60446 Romeoville 60447 Minooka 60416 Coal City 60408 Braidwood 60421 Elwood 60441 Lockport 60448 Mokena 60442 Manhattan 60423 Frankfort 60440 Bolingbrook 60424 Gardner 60439 Lemont 60407 Braceville 60474 South Wilmington 6 0491 Homer Glen Presence St Marys Hospital (PSMH), Kankakee, IL PSMHs primary service has an estimated population of 113,449, according to the 2010 census In the primary service area 14 1% of the population is over the age 65 and the average household income is \$49,266 15% of the population in Kankakee lives below the poverty level The racial makeup of the city is 81 3% White, 15 5% African American, 9 3% Hispanic The PSMH service area is defined by zip codes below Service Area Primary Market Zip Code City 60901 Kankakee 60914 Bourbonnais 60915 Bradley 60954 Momence 60950 Manteno Service Area Secondary Market Zip Code City 60964 Saint Anne 60927 Clifton 60922 Chebanse 60940 Grant Park 60970 Watseka 609 41 Herscher 60913 Bonfield 60938 Gilman 60911 Ashkum 60955 Onarga 60944 Hopkins Park 60951 Martinton 60930 Danforth 60910 Aroma Park 60912 Beaverville 60919 Cabery 60961 Reddick 60 917 Buckingham 60935 Essex 60928 Crescent City 60481 Wilmington 60468 Peotone 60420 Dwight 60958 Pembroke Township Presence Mercy Medical Center (PMMC), Aurora, IL Aurora, where P MMC resides, is the second largest city in Illinois and accounts for most of the hospitals primary service area Kane Countys population according to the 2010 census is 515,269 In the primary service area, 10 7% of the population is over the age 65 and the average household income is \$69,496 Within the primary service area (Aurora), approximately 35,000 individuals (21 3%) reside in medically underserved areas (MUAs) Of that population, about 30% fall 200% below the federal poverty level Within the MUA, 68% of the population is Hispanic and 11% is African American Fifty-three per cent are underinsured and 47% are Medicaid recipients 10 1% of residents in Kane County live below the poverty level PMMCs service area is defined by zip codes below Service Area Primary Market Zip Code City 60506 Aurora 60505 Aurora 60542 North Aurora 60538 Montgomery 60504 Aurora 60507 Aurora 60502 Aurora Service Area Secondary Market Zip Code City 60510 Batavia 60543 Oswego 60560 Yorkville 60548 Sandwich 60545 Plano 60174 Saint Charles 60554 Sugar Grove 60134 Geneva 60552 Somonauk 60503 Aurora 60511 Big Rock 60520 Hinckley 60119 Elburn 60115 DeKalb 60541 Newark 60 512 Bristol 60531 Leland 60556 Waterman 60539 Mooseheart Presence Saint Joseph Hospital (P SJH), Elgin, IL Kane Countys population according to the 2010 census is 515,269 In the primary service area, 8 6% of the population is over the age 65 and the average household income is \$59,032 12 3% of families in Elgin live below the poverty level The racial makeup of the city is 65 9% White, 7 4% African American, 5 4% Asian, and 3 6% from two or more races 43 6% of the population are Hispanic or Latino of any race The PSJHs service area is defined by zip code below Service Area Primary Market Zip Code City 60123 Elgin 601 20 Elgin 60124 Elgin 60121 Elgin 60110 Carpentersville 60177 South Elgin 60140 Hampshire 6 0118 Dundee Service Area Secondary Market Zip Code City 60102 Algonquin 60103 Bartlett 60 174 Saint Charles 60014 Crystal Lake 60107 Streamwood 60142 Huntley 60098 Woodstock 60050 McHenry 60051 McHenry 60156 Lake in the Hills 60175 Saint Charles 60136 Gilberts 60134 Geneva 60013 Cary 60152 Marengo 60135 Genoa 60109 Burlington 60012 Crystal Lake 60180 Union</p>

Form and Line Reference	Explanation
PART VI, LINE 5 PROMOTION OF COMMUNITY HEALTH	<p>Presence Health hospitals are faith-based ministries that provide services based upon the ethical and religious directives of the Catholic Church. Presence Health hospitals enhance the public health of our communities by:</p> <ol style="list-style-type: none"> 1. Ensuring our medical staff is open to all qualified physician. 2. All of our hospitals are accredited and in good standing with the Joint Commission Accreditation of Healthcare Organizations. 3. Ensuring our board of directors is diverse and able to provide expertise, and made up of independent members of the communities we serve. Our board members must follow a conflict of interest policy. 4. Reinvesting surplus funds into the organization to improve patient care through new programs and technology. 5. Providing financial assistance, sliding scale discounts and has collection practices that are in compliance with state and federal guidelines. In addition, we follow the financial assistance and charity guidelines of the Catholic Health Association. 6. Participating in all government sponsored health care programs, Medicare, Medicaid, CHAMPUS, Tricare, SCHIP and others. 7. Providing emergency room services in all of our communities and providing training to local fire departments and ambulances. Our emergency room participates with local police and fire departments in disaster drills. 8. Staffing Board Certified Emergency Room Physicians in our emergency room and urgent care services. We treat patients according to EMTALA guidelines and serve all patients regardless of ability to pay. In addition, we are committed to determining the needs of our communities and creating ways to meet those needs. The obligation to reach out to those in need and improve health flows directly from our Catholic identity and the heritage of our founding congregations. In each of the communities we serve, we work with others including charitable organizations, community health providers, elected officials, business leaders, schools, churches, and residents to look at the overall health of the community and identify the greatest needs. We then make a plan and develop strategies together with our communities to address the highest priority health needs. The highest priority needs and the programs we've developed to meet these needs are identified below for each hospital. <p>Presence Covenant Medical Center, Champaign, IL (PCMC) Community Resource Center Identified Need: Access to Care. Presence Covenant Community Resource Center was developed to address unmet medical and social needs of those patients that were frequently utilizing the Emergency Room. It has recently expanded its services to serve any community member that seeks assistance. The center primarily provides community referral services to clients and helps them connect with an array of social service agencies based on a holistic approach to medical problems. The PCMC Community Resource Center is staffed by three PCMC Health Navigators and one PCMC social worker. In addition to the hospital staff, the center is made up of community partners that provide services at the center. These partners include Catholic Charities, Champaign County Christian Health Clinic, Champaign County Health Care Consumers, Patient Innovation Center, and Promise Health.</p> <p>2015 Objectives:</p> <ul style="list-style-type: none"> *Solidify process of case coordination for patients identified for our program. *Develop a client registry and charting system. *Expand services from solely working with Emergency Department patients to also working with any community member that seeks assistance. *Develop standards and procedures for working with our target population. *Increase outreach to community services to increase community partners and better serve our clients. <p>2015 Measurable Outcomes:</p> <ul style="list-style-type: none"> *In 2015, the navigators held a case load of approximately 160-200 SuperUsers at any time. *As of 12/15/15, we have over 3,500 people entered into our database. *The navigators averaged 30-40 contacts per week in a designated time in 2015. *Standards and Procedures manual modified throughout 2015. *We now have over 150 different referral sources. <p>Smile Healthy SmileHealthy is a collection of dental programs that work to improve the oral health of the community through providing preventive care, treatment, and education.</p> <p>Mobile Dental Program - The mobile program sets up inside dozens of locations and provides exam, preventive services, and treatments such as fillings and extractions.</p> <p>Pediatric Restorative Outpatient Surgery (PROPS) - Once a month, a SmileHealthy dentist provides comprehensive treatment under general anesthesia in hospital setting. The program cares for three low-income children each month who have extensive treatment plans often needing 10-20 treatments at once.</p> <p>Dental Emergency Referral - SmileHealthy offers an education and referral program for patients that present to the Emergency Department with dental pain. The program provides oral health and nutrition education, counseling and case management to facilitate patients' goals.</p>

Form and Line Reference	Explanation
PART VI, LINE 5 PROMOTION OF COMMUNITY HEALTH	<p>etting treatment from a dentist and works to reduce repeat visits to the Emergency Department for the same dental health issues. The program targets low-income uninsured adults who have difficulty finding dental care. 2015 Objectives *Provide 200 People with 600 dental treatments to reduce repeat Emergency Department visits for dental conditions *Provide care for 36 children with approximately 12 treatments per child *Increase the number of patients who receive dental education through the Dental Emergency Referral Program (DEERP) 2015 Measurable Outcomes *These results are from January-November 2015. Provided 714 treatments to 152 unduplicated patients. There were total of 244 patient visits in 14 mobile clinics. We anticipate an additional 20 visits and 40 treatments for the upcoming December mobile clinic. *Provided 253 treatments to 17 children. We expect additional 5 children and 50 treatments for two December PROPS days. *30 people were seen at DEERP. Faith in Action (FIA) Faith in Action is a volunteer care giving ministry in Champaign-Urbana and the surrounding areas. The program uses faith and community volunteers to provide assistance to the senior population 55+ years. We provide transportation to medical appointments, banking, shopping and other necessary errands. Other services include home and phone visits, chores, and respite care. 2015 Objectives *Seniors are directly assisted by the FIA ministry to remain safely in their home. *Work with families to fill in gaps with what family is able to do. *Increase the number of Faith in Action volunteers. *Annual Survey of Volunteer Care Givers and Care Receivers. *Conduct follow-up calls for Care Receivers after Chore Day. 2015 Measurable Outcomes *Seniors are directly assisted by the FIA ministry to remain safely in their home, with access to care. *Promote health and wellness with seniors. *Increase the number of Faith in Action volunteers. Center for Healthy Living The Center for Healthy Living (CHL) provides health and wellness programs that promote healthy living, reduce the risk of disease, and preserve independence. CHL offers a variety of educational programs, screenings, special events, and other services for adults that address the physical, social, mental, and spiritual dimensions of health. Most programs offered by CHL are free of charge. 2015 Objectives *Promote healthy living, reduce the risk of disease, and preserve independence. 2015 Measurable Outcomes *The Center for Healthy Living was not included in the previous Implementation Strategy, so there are no previous baselines or outcomes. Faith2 The purpose of FAITH2 "Funds to Accelerate Innovation towards healing and hope", is to serve as a catalyst for innovation and acceleration of community partnership and programs to improve the health of the communities we serve consistent with the Mission, Vision, and Values of our Ministry. Promise Healthcare is dedicated to improving the health of the community through treatment, prevention and education, which aligns with our mission. In 2015, Presence Covenant Medical Centers Foundation funded Promise Healthcare through its FAITH2 program the amount of \$103,824 a second year for their project. Promise Healthcare at the Community Resource Center (CRC), to move their startup nurse practitioner satellite at the CRC to an established clinic, to work on possible expansion and improvements, to begin to address population health, and to potentially create a pilot structure for care coordination through Medicaid managed care. Enrollment Strategy In response to a demonstrated community need of improving affordable access to health care, Presence Health and its community partners engaged in the development of a community-wide enrollment strategy so as to decrease the percentage of Illinois residents without health insurance. An over-arching strategy was created in partnership with community stakeholders to guide the 2014-2015 Open Enrollment period. The model boasts a four-</p>

Form and Line Reference	Explanation
PART VI, LINE 6 AFFILIATED HEALTH CARE SYSTEM	<p>The Provena Health and Resurrection Health Care Systems combined on November 1, 2011 to form a new health system, Presence Health, creating a comprehensive family of not-for-profit health care services and the single largest Catholic health system based in Illinois. Presence Health embodies the act of being present in every moment we share with those we serve and is the cornerstone of a patient, resident and family-centered care environment. Presence Health embodies the way we choose to be present in our communities, as well as with one another and those we serve. Presence Health is sponsored by five congregations of Catholic religious women: the Franciscan Sisters of the Sacred Heart, the Servants of the Holy Heart of Mary, the Sisters of the Holy Family of Nazareth, Sisters of Mercy of the Americas and the Sisters of the Resurrection. As was the case from our very beginnings, Presence Health is called to be much more than just a provider of health services. Presence Health has instilled within all of its ministries that are committed to responding to the needs of those we are privileged to serve, delivering high quality care that is accessible to all. It is this culture of caring and giving that drives our diligent efforts to ensure we return the optimal value of our charitable assets to our local communities. As a not-for-profit health system, Presence Health invests a significant portion of its operating capital into the community through programs to serve vulnerable populations, such as the poor and uninsured, manage chronic conditions, and promote health education and promotion outreach and initiatives. In Fiscal Year 2015, this included \$206 million in community benefit activities. Presence Health thus takes a systems approach to its community benefit efforts, and therefore ensures its member hospitals and other entities and affiliates are helping to promote and address the health needs of the communities they serve. For more information on Presence Health, visit www.presencehealth.org.</p>

Form and Line Reference	Explanation
PART VI, LINE 7 STATE FILING OF COMMUNITY BENEFIT REPORT	Presence Health files its annual community benefit report in Illinois

Schedule H (Form 990) 2015

Additional Data

Software ID:

Software Version:

EIN: 36-4195126

Name: PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK

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

Section A. Hospital Facilities

(list in order of size from largest to smallest—see instructions)
How many hospital facilities did the organization operate during the tax year?
6

Name, address, primary website address, and state license number

		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER—24 hours	ER—other	Other (Describe)	Facility reporting group
1	PRESENCE ST JOSEPH MEDICAL CENTER 333 N MADISON STREET JOILET,IL 60435 www.presencehealth.org 0004838	X	X					X			
2	PRESENCE MERCY MEDICAL CENTER 1325 NORTH HIGHLAND AVENUE AURORA,IL 60506 www.presencehealth.org 0004903	X	X					X			
3	PRESENCE ST JOSEPH HOSPITAL 77 NORTH AIRLITE AVENUE ELGIN,IL 60123 WWW.PRESENCEHEALTH.ORG 0004887	X	X					X			
4	PRESENCE ST MARY'S HOSPITAL 500 WEST COURT STREET KANKAKEE,IL 60901 WWW.PRESENCEHEALTH.ORG 0004879	X	X					X			
5	PRESENCE COVENANT MEDICAL CENTER 1400 WEST PARK STREET URBANA,IL 61801 WWW.PRESENCEHEALTH.ORG 0004861	X	X					X			
6	PRESENCE UNITED SAMARITANS MED CNTR 812 NORTH LOGAN AVENUE DANVILLE,IL 61832 WWW.PRESENCEHEALTH.ORG 0004853	X	X					X			

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

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

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

Name and address	Type of Facility (describe)
1 PRESENCE PHYSICAL THERAPY 3000 W JEFFERSON ST JOLIET, IL 60435	PHYSICAL THERAPY
1 PRESENCE PHYSICAL THERAPY SERVICES 600 SOUTH WEBER ROAD ROMEOVILLE, IL 60446	PHYSICAL THERAPY
2 PRESENCE CENTER FOR WOUND CARE 301 NORTH MADISON ST JOLIET, IL 60435	WOUND CARE CENTER
3 PRESENCE PHYSICAL THERAPY INDUSTRIAL REH 852 SHARP AVENUE SHOREWOOD, IL 60404	PHYSICAL THERAPY
4 MERCY PROFESSIONAL BUILDING PHARMACY 1315 N HIGHLAND Suite 201 AURORA, IL 60506	OUTPATIENT PHARMACY
5 PRESENCE PHYSICAL REHAB & SPORT INJURY 2132 JEFFERSON STREET JOLIET, IL 60435	PHYSICAL THERAPY
6 PRESENCE PHYSICAL THERAPY SERVICES 1812 LINCOLN HIGHWAY NEW LENOX, IL 60451	PHYSICAL THERAPY
7 PRESENCE PHYSICAL THERAPY SERVICES 15120 WALLIN DRIVE PLAINFIELD, IL 60544	PHYSICAL THERAPY
8 PRESENCE SLEEP DISORDER CENTER 2132 JEFFERSON STREET JOLIET, IL 60435	SLEEP DISORDER CENTER
9 PRESENCE SLEEP LAB 412 SHERIDAN DANVILLE, IL 61832	SLEEP DISORDER CENTER
10 PRESENCE UNITED SAMARITANS ONCOLOGY CTR 806 NORTH LOGAN AVENUE DANVILLE, IL 61832	ONCOLOGY CENTER
11 PRESENCE MANTENO MEDCENTRE 501 S LOCUST STREET MANTENO, IL 60950	MEDICAL OFFICE BUILDING
12 PRESENCE MEDCENTRE EAST 455 WEST COURT STREET KANKAKEE, IL 60901	MEDICAL OFFICE BUILDING
13 PRESENCE MEDCENTRE WEST 555 WEST COURT STREET KANKAKEE, IL 60901	MEDICAL OFFICE BUILDING
14 PRESENCE MOMENCE MEDCENTRE 739 NORTH DIXIE HIGHWAY MOMENCE, IL 60954	MEDICAL OFFICE BUILDING

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)
16 PRESENCE PEOTONE MEDCENTRE 117 SOUTH HARLEM AVENUE PEOTONE,IL 60468	MEDICAL OFFICE BUILDING
1 PRESENCE ST MARY'S REGIONAL CANCER CTR 100 PROVENA WAY BOURBONNAIS,IL 60914	REGIONAL ONCOLOGY CENTER
2 PRESENCE ST MARY'S IMAGING CENTER 100 PROVENA WAY BOURBONNAIS,IL 60914	IMAGING CENTER
3 PRESENCE CENTER FOR HEALTHY AGING 401 EAST UNIVERSITY SUITE 102 CHAMPAIGN,IL 61820	SENIOR HEALTH CENTER
4 PRESENCE REGIONAL EMS 408 S NEIL STREET CHAMPAIGN,IL 61820	EMS PARAMEDIC SERVICES
5 PRO AMBULANCE SERVICES 408 S NEIL STREET CHAMPAIGN,IL 61820	AMBULANCE SERVICES
6 PUSMC RETAIL Pharmacy 800 N LOGAN AVENUE DANVILLE,IL 61832	RETAIL PHARMACY
7 PRESENCE SLEEP DISORDER 656 N CONVENT STREET BOURBONNAIS,IL 60914	SLEEP DISORDER CENTER
8 PRESENCE ADVANCED IMAGING 410 EAST LINCOLN HIGHWAY NEW LENOX,IL 60451	IMAGING CENTER
9 PRESENCE HEALING ARTS PAVILION 410 EAST LINCOLN HIGHWAY NEW LENOX,IL 60451	MEDICAL OFFICE BUILDING
10 PRESENCE ADVANCED IMAGING 2000 GLENWOOD AVENUE JOLIET,IL 60435	IMAGING CENTER
11 PRESENCE HEALING ARTS PAVILION 16615 SOUTH ROUTE 59 PLAINFIELD,IL 60586	MEDICAL OFFICE BUILDING
12 PCMC MOB 1405 WEST PARK STREET URBANA,IL 61801	MEDICAL OFFICE BUILDING

2015

36-4195126

Schedule I (Form 990) 2015

Part III

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

(a)Type of grant or assistance	(b)Number of recipients	(c)Amount of cash grant	(d)Amount of non-cash assistance	(e)Method of valuation (book, FMV, appraisal, other)	(f)Description of non-cash assistance
(1) SCHOLARSHIPS	50	49,044			

Part IV

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

Return Reference	Explanation
Form Schedule I, Part I, Line 2	ALL SCHOLARSHIPS ARE MONITORED BY THE APPROPRIATE GRANT ADMINISTRATORS TO ENSURE THAT ALL FUNDS ARE USED FOR QUALIFIED EDUCATION EXPENSES, AND THAT EDUCATION IS PURSUED AND COURSES ARE COMPLETED. ALL ORGANIZATIONS WHICH ARE RECIPIENTS OF GRANT FUNDS ARE TAX-EXEMPT ORGANIZATIONS DESCRIBED IN 501(C)(3) AND THEREFORE THE CORPORATION DOES NOT MONITOR THE USE OF THOSE FUNDS.

Additional Data

Software ID:
Software Version:
EIN: 36-4195126
Name: PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
Champaign County Healthcare Consumers 44 E Main St Suite 208 Champaign,IL 618203649	37-1073411	501(c)(3)	80,883				COMMUNITY ACCESS AND RESOURCES
UNITED WAY OF WILL COUNTY 54 N OTTAWA STREET SUITE 300 JOLIET,IL 60432	36-2515625	501(c)(3)	10,000				COMMUNITY HEALTH NEEDS
WILL-GRUNDY MEDICAL CLINIC 213 EAST CASS STREET JOLIET,IL 60432	36-3492306	501(C)(3)	35,000				FREE HEALTH CLINIC

Schedule J
(Form 990)

Compensation Information

OMB No 1545-0047

2015

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees
▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23.
▶ Attach to Form 990.
▶ Information about Schedule J (Form 990) and its instructions is at www.irs.gov/form990.

Name of the organization PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK	Employer identification number 36-4195126
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Part I Questions Regarding Compensation

	Yes	No
1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items. <div><input type="checkbox"/> First-class or charter travel</div> <div><input type="checkbox"/> Travel for companions</div> <div><input type="checkbox"/> Tax indemnification 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 type="checkbox"/> Health or social club dues or initiation fees</div> <div><input type="checkbox"/> Personal services (e g , maid, chauffeur, chef)</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	
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	
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><input type="checkbox"/> Compensation committee</div> <div><input type="checkbox"/> Independent compensation consultant</div> <div><input type="checkbox"/> Form 990 of other organizations</div> <div><input type="checkbox"/> Written employment contract</div> <div><input type="checkbox"/> Compensation survey or study</div> <div><input type="checkbox"/> Approval by the board or compensation committee</div>		
4 During the year, did any person listed on Form 990, Part VII, Section A, line 1a with respect to the filing organization or a related organization: a Receive a severance payment or change-of-control payment?	4a	Yes
b Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b	Yes
c Participate in, or receive payment from, an equity-based compensation arrangement? If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.	4c	No
Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.		
5 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of: a The organization?	5a	No
b Any related organization? If "Yes," on line 5a or 5b, describe in Part III	5b	No
6 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of: a The organization?	6a	No
b Any related organization? If "Yes," on line 6a or 6b, describe in Part III	6b	No
7 For persons listed on 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	
8 Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	8	
9 If "Yes" on 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 on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that are not listed on Form 990, Part VII.

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

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

Part III Supplemental Information

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

Return Reference	Explanation
DETERMINATION OF COMPENSATION OF ORGANIZATION'S CEO/EXECUTIVE DIRECTOR	SCHEDULE J, PART I, LINE 3 COMPENSATION FOR THE CORPORATION'S CEO AND OTHER OFFICERS OR KEY EMPLOYEES IS DETERMINED IN ACCORDANCE WITH WRITTEN POLICIES AND PROCEDURES ADOPTED BY THE BOARD OF DIRECTORS OF THE CORPORATION AND THE CORPORATIONS ULTIMATE PARENT, PRESENCE HEALTH NETWORK. SUCH POLICIES AND PROCEDURES ARE APPLIED BY THE HUMAN RESOURCES COMMITTEE OF PRESENCE HEALTH NETWORK, WHICH CONSISTS WHOLLY OF INDEPENDENT DIRECTORS. PRESENCE HEALTH NETWORK USES MARKET DATA COMPILED BY AN INDEPENDENT COMPENSATION CONSULTANT TO ESTABLISH BASE SALARIES AND TOTAL CASH COMPENSATION OPPORTUNITIES. THE HUMAN RESOURCES COMMITTEE MONITORS EXECUTIVE TOTAL COMPENSATION, ANNUALLY REVIEWING AND APPROVING COMPENSATION CHANGES FOR EACH EXECUTIVE, AND REGULARLY REPORTING ITS ACTIVITIES TO THE BOARD.
SEVERANCE PAYMENTS	SCHEDULE J, PART I, LINE 4A PRESENCE HAS THREE SEVERANCE PLANS DEPENDING UPON LEVEL. THESE PLANS ALLOW INDIVIDUALS WHOSE JOBS HAVE BEEN ELIMINATED AND WHO HAVE NOT BEEN ABLE TO FIND A SIMILAR POSITION WITHIN THE SYSTEM TIME TO TRANSITION. THE NUMBER OF WEEKS OF WAGE CONTINUATION ARE BASED UPON LENGTH OF SERVICE. THE PLANS ARE NOT FUNDED. THE FOLLOWING INDIVIDUALS RECEIVED SEVERANCE PAYMENTS IN CALENDAR YEAR 2015: ANTHONY J. FILER \$ 1,169,835; DAVID R. FRANZBLAU \$ 152,132; SYED SAEED P. BOKHARI \$ 28,846. THE CORPORATION ALSO ACCRUED DEFERRED SEVERANCE FOR THE FOLLOWING INDIVIDUALS, WHICH WILL VEST IN A LATER YEAR: DAVID R. FRANZBLAU \$ 58,183; AMY D. STEVENS \$ 593,357.
PAYMENTS FROM A SUPPLEMENTAL NON QUALIFIED RETIREMENT PLAN	SCHEDULE J, PART I, QUESTION 4B IN ORDER TO ENHANCE THE ABILITY OF PRESENCE HEALTH TO ATTRACT AND RETAIN QUALIFIED MANAGEMENT PERSONNEL BY PROVIDING ELIGIBLE EXECUTIVES WITH ADDITIONAL RETIREMENT BENEFITS ON A DEFERRED BASIS, PRESENCE HEALTH NETWORK MAINTAINS AN UNFUNDED SUPPLEMENTAL RETIREMENT PLAN (THE "PLAN") FOR A SELECT GROUP OF MANAGEMENT, WHICH IS INTENDED TO COMPLY WITH SECTION 457(F), AND SECTION 409A OF THE INTERNAL REVENUE CODE. THE PLAN, PRESENCE HEALTH NETWORK CREDITS TO SUCH ELIGIBLE EXECUTIVE'S RETIREMENT ACCOUNT AN AMOUNT BASED ON A PERCENTAGE OF SALARY EARNINGS AND/OR LOSSES ON INVESTMENTS ARE CREDITED AT A RATE EQUAL TO THE RATE OF RETURN OVER THE SAME PERIOD ON INVESTMENT OPTIONS SELECTED BY THE ELIGIBLE EXECUTIVE. ELIGIBLE EXECUTIVES ARE ENTITLED TO RECEIVE BENEFITS ON THE EARLIEST OF (I) JANUARY 1 OF THE THIRD CALENDAR YEAR BEGINNING AFTER THE YEAR IN WHICH SUCH CONTRIBUTION IS CREDITED, (II) ATTAINING AGE 62, OR (III) ATTAINING THE AGE OF 60 IF THE ELIGIBLE EXECUTIVE HAS COMPLETED TEN (10) YEARS OF SERVICE. THE FOLLOWING LISTED INDIVIDUALS BECAME VESTED IN SUPPLEMENTAL RETIREMENT BENEFITS UNDER THE SERP, AND THEREFORE HAD BENEFITS INCLUDED IN THEIR TAXABLE INCOME: SANDRA BRUCE \$ 265,646; ANTHONY J. FILER \$ 558,075; PATRICK QUINN \$ 21,921; MICHAEL L. BROWN \$ 59,255; JARED C. ROGERS \$ 26,971; JANICE M. NEMRI \$ 18,941; DEBORAH A. SCHIMEROWSKI \$ 20,596; KEVIN W. LARKIN \$ 17,036; MOLLY A. NICHOLSON \$ 14,662; JENNIFER S. CORD \$ 14,481; ERIC M. RHODES \$ 11,373; LISA M. LAGGER \$ 36,590. ALSO IN RESPONSE TO QUESTION 4B, THE FOLLOWING LISTED INDIVIDUALS PARTICIPATED IN THE ORGANIZATION'S SECTION 457(F) PLAN AND EARNED UNVESTED BENEFITS DURING 2015 WHICH ARE REPORTED IN COLUMN (C): MICHAEL ENGLEHART \$ 36,673; JEANNIE FREY \$ 86,489; PATRICK QUINN \$ 24,076; MICHAEL L. BROWN \$ 69,580; JARED C. ROGERS \$ 46,776; AMY D. STEVENS \$ 43,469.

Additional Data

Software ID:

Software Version:

EIN: 36-4195126

Name: PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1SANDRA BRUCE PRESIDENT/CEO/EX-OFFICIO-12/30	(i)	0	0	0	0	0	0	0
	(ii)	1,055,767	329,629	282,693	5,300	15,581	1,688,970	0
1MICHAEL ENGLEHART PRESIDENT/CEO	(i)	0	0	0	0	0	0	0
	(ii)	284,074	250,000	6,731	36,674	3,223	580,702	0
2JEANNIE C FREYSECRETARY	(i)	0	0	0	0	0	0	0
	(ii)	446,640	105,384	25,212	102,389	23,370	702,995	0
3ANTHONY J FILER TREASURER	(i)	0	0	0	0	0	0	0
	(ii)	658,477	161,537	581,895	1,185,735	23,595	2,611,239	377,532
4PATRICK QUINN ASSISTANT TREASURER	(i)	0	0	0	0	0	0	0
	(ii)	234,711	62,409	31,104	49,265	22,215	399,704	18,512
5JULIE ROKNICH ASSISTANT SECRETARY	(i)	0	0	0	0	0	0	0
	(ii)	189,526	27,407	162	9,850	20,790	247,735	0
6MICHAEL L BROWN REGIONAL PRESIDENT & CEO-FXV	(i)	404,868	99,498	75,814	84,382	13,785	678,347	43,575
	(ii)	0	0	0	0	0	0	0
7JARED C ROGERS REGIONAL PRESIDENT & CEO-CES	(i)	371,917	87,115	30,936	60,026	16,331	566,325	20,800
	(ii)	0	0	0	0	-0	0	0
8DAVID R FRANZBLAU CONVERSION - Regional CMO	(i)	217,845	43,995	185,755	58,183	8,842	514,620	0
	(ii)	0	0	0	0	-0	0	0
9ANIL B GOPINATH REGIONAL CHIEF MEDICAL OFFFXV	(i)	310,246	25,728	18,796	13,250	46,145	414,165	0
	(ii)	0	0	0	0	-0	0	0
10JANICE M NEMRI RGN CHIEF AMB & ANCIL OFF-SSB	(i)	233,395	71,436	67,429	38,882	13,634	424,776	18,001
	(ii)	0	0	0	0	-0	0	0
11JACQUELINE J MEDLAND CHIEF NURSING OFFICER-SSB	(i)	199,945	74,498	139,924	13,250	66,742	494,359	0
	(ii)	0	0	0	0	-0	0	0
12DEBORAH A SCHIMEROWSKI REGIONAL FIN OFFICER-CES/SSB	(i)	230,431	65,245	21,540	13,250	8,386	338,852	16,046
	(ii)	0	0	0	0	-0	0	0
13KEVIN W LARKIN REGIONAL FINANCE OFFICER-FXV	(i)	217,797	77,077	17,878	16,253	21,774	350,779	12,895
	(ii)	0	0	0	0	-0	0	0
14CATHERINE EMANUEL REGN STRATEGY & GROWTH OFFCES	(i)	223,416	53,396	8,728	13,250	0	298,790	0
	(ii)	0	0	0	0	-0	0	0
15MOLLY A NICHOLSON REGIONAL CHIEF NURSING OFFICER	(i)	194,930	56,357	15,078	17,948	20,112	304,425	12,001
	(ii)	0	0	0	0	-0	0	0
16SYED SAEED P BOKHARI PSMH CHIEF MEDICAL OFFICER	(i)	218,244	8,313	33,235	0	9,036	268,828	0
	(ii)	0	0	0	0	-0	0	0
17GRACE L MCBRIDE REGIONAL CHIEF NURSING OFFICER	(i)	223,148	23,485	1,440	10,969	13,564	272,606	0
	(ii)	0	0	0	0	-0	0	0
18JENNIFER S CORD REGCHF AMB/ANC/SPT/MSN OFF-CES	(i)	157,789	50,945	15,037	9,787	22,419	255,977	10,833
	(ii)	0	0	0	0	-0	0	0
19ERIC M RHODES REG CHIEF AMB & ANC OFF-FXV	(i)	159,232	38,794	11,716	5,697	19,464	234,903	8,801
	(ii)	0	0	0	0	-0	0	0

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1TIMOTHY J DAUGHERTY REGN STRATEGY & GROWTH OFFSSB	(i)	185,042	14,427	782	6,192	21,614	228,057	0
	(ii)	0	0	0	0	0	0	0
1SURENDRA M GULATI PHYSICIAN	(i)	468,623	0	5,464	13,250	15,058	502,395	0
	(ii)	0	0	0	0	0	0	0
2LESLIE A MASOOD PHYSICIAN	(i)	331,983	0	314	10,404	22,052	364,753	0
	(ii)	0	0	0	0	0	0	0
3JOSEPH R DANNA MEDICAL DIRECTOR	(i)	292,848	0	1,958	7,515	19,968	322,289	0
	(ii)	0	0	0	0	0	0	0
4MICHAEL PANUSKA MEDICAL DIRECTOR	(i)	262,882	0	27,679	18,550	11,121	320,232	0
	(ii)	0	0	0	0	0	0	0
5SHOBHANA RAVIKUMAR PHYSICIAN	(i)	246,145	12,500	362	13,201	19,738	291,946	0
	(ii)	0	0	0	0	0	0	0
6LISA M LAGGER FORMER REG CHIEF REL OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	198,932	71,009	62,924	23,268	14,601	370,734	16,046
7AMY D STEVENS FORMER COO	(i)	0	0	0	0	0	0	0
	(ii)	323,777	130,862	59,266	636,826	2,564	1,153,295	0
8Connie J Noltemeyer FORMER REGIONAL QUALITY LEADER	(i)	143,121	1,087	1,262	0	4,275	149,745	0
	(ii)	0	0	0	0	0	0	0

SCHEDULE M

(Form 990)

Noncash Contributions

OMB No 1545-0047

2015

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

Name of the organization PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK	Employer identification number 36-4195126
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Part I

Types of Property

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art—Works of art	X	1	1,000	cost
2 Art—Historical treasures				
3 Art—Fractional interests				
4 Books and publications				
5 Clothing and household goods				
6 Cars and other vehicles				
7 Boats and planes				
8 Intellectual property				
9 Securities—Publicly traded				
10 Securities—Closely held stock				
11 Securities—Partnership, LLC, or trust interests				
12 Securities—Miscellaneous				
13 Qualified conservation contribution—Historic structures				
14 Qualified conservation contribution—Other				
15 Real estate—Residential				
16 Real estate—Commercial				
17 Real estate—Other				
18 Collectibles				
19 Food inventory				
20 Drugs and medical supplies				
21 Taxidermy				
22 Historical artifacts				
23 Scientific specimens				
24 Archeological artifacts				
25 Other ▶ (TRAILER)	X	1	10,400	COST
26 Other ▶ (SPORTING EVENT TICKETS)	X	24	10,162	COST
27 Other ▶ (DINNERS/LUNCHES)	X	10	5,945	COST
28 Other ▶ (GALA RAFFLE/MISC)	X	142	35,117	COST

29	Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement	29	
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30a	During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 28, that it must hold for at least three years from the date of the initial contribution, and which is not required to be used for exempt purposes for the entire holding period?	Yes	No
b	If "Yes," describe the arrangement in Part II		
31	Does the organization have a gift acceptance policy that requires the review of any non-standard contributions?	Yes	
32a	Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions?		No
b	If "Yes," describe in Part II		
33	If the organization did not report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II		

Part II

Supplemental Information.

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

Return Reference	Explanation
Schedule M, Part II, Column B	The amounts reported in column (b) are the number of contributors

SCHEDULE O
(Form 990 or
990-EZ)Department of the
Treasury
Internal Revenue
Service**Supplemental Information to Form 990 or 990-EZ**Complete to provide information for responses to specific questions on
Form 990 or 990-EZ or to provide any additional information.

▶ Attach to Form 990 or 990-EZ.

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

OMB No 1545-0047

2015**Open to Public
Inspection**Name of the organization
PRESENCE CENTRAL AND SUBURBAN HOSPITALS
NETWORK**Employer identification number**

36-4195126

Return Reference	Explanation
FORM 990, BOX C	DOING BUSINESS AS/ASSUMED NAMES PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK ALSO OPERATES UNDER THE FOLLOWING ASSUMED NAMES - PRESENCE COVENANT MEDICAL CENTER - PRESENCE MERCY MEDICAL CENTER - PRESENCE SAINT JOSEPH HOSPITAL ELGIN - PRESENCE SAINT JOSEPH MEDICAL CENTER - PRESENCE ST MARYS HOSPITAL - PRESENCE UNITED SAMARITANS MEDICAL CENTER - COVENANT OUTPATIENT PHARMACY - HIGHLAND ANSWERING SERVICE - MERCY PROFESSIONAL BUILDING PHARMACY - PRESENCE IMAGING PLAINFIELD - PRESENCE IMMEDIATE CARE PLAINFIELD - PRESENCE SURGERY CENTER JOLIET - THE APOTHECARY DANVILLE - PRESENCE COVENANT MEDICAL CENTER FOUNDATION - PRESENCE MERCY MEDICAL CENTER FOUNDATION - PRESENCE SAINT JOSEPH HOSPITAL ELGIN FOUNDATION - PRESENCE SAINT JOSEPH MEDICAL CENTER FOUNDATION - PRESENCE ST MARYS HOSPITAL FOUNDATION - PRESENCE UNITED SAMARITANS MEDICAL CENTER FOUNDATION

Return Reference	Explanation
FORM 990, PART III, QUESTION 1	MISSION STATEMENT THE CORPORATION IS PART OF THE PRESENCE HEALTH SYSTEM AND ACTS IN ACCORDANCE WITH THE PRESENCE HEALTH MISSION, WHICH IS AS FOLLOWS INSPIRED BY THE HEALING MINISTRY OF JESUS CHRIST AND AS PART OF PRESENCE HEALTH, A CATHOLIC HEALTH SYSTEM, PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK PROVIDES HEALTHCARE SERVICES IN A COMPASSIONATE, HOLISTIC MANNER IN THE SPIRIT OF HEALING AND HOPE

Return Reference	Explanation
FORM 990, PART I, QUESTION 5, AND PART V, QUESTION 2	COMPENSATION AND FORM W-3 TRANSMITTAL OF WAGES AND TAX STATEMENT PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK (THE "CORPORATION") REPORTS 0 EMPLOYEES ON FORM 990, PART I, QUESTION 5 AND FORM 990, PART V, QUESTION 2A AS IT IS NOT REQUIRED TO FILE FORM W-3, TRANSMITTAL OF WAGES AND TAX STATEMENT THE CORPORATIONS COMPENSATION IS PAID BY PRESENCE CARE TRANSFORMATION CORPORATION ("PCTC"), WHICH ISSUES THE FORMS W-2 AND W-3, AND THE EXPENSE IS TRANSFERRED TO THE CORPORATION THE COMPENSATION AMOUNTS REPORTED IN THIS 990 REFLECT THE AMOUNT TRANSFERRED TO THE CORPORATION FROM PCTC

Return Reference	Explanation
FORM 990, PART V, QUESTION 1A	FORM 1096 TRANSMITTAL OF U S INFORMATION RETURNS PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK (THE "CORPORATION") REPORTS 0 ON FORM 990, PART V, QUESTION 1A AS IT IS NOT REQUIRED TO FILE FORM 1096, TRANSMITTAL OF U S INFORMATION RETURNS ALL OF THE CORPORATIONS ACCOUNTS PAYABLE REPORTABLE ON FORM 1096 ARE PAID BY PRESENCE CARE TRANSFORMATION CORPORATION ("PCTC"), WHICH ISSUES ALL FORMS 1099, AND THE EXPENSE IS TRANSFERRED TO THE CORPORATION THE COMPENSATION AMOUNTS REPORTED IN THIS 990 REFLECT THE AMOUNT TRANSFERRED TO THE CORPORATION FROM PCTC

Return Reference	Explanation
FORM 990, PART VI, QUESTION 6	MEMBERS OR SHAREHOLDERS PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK HAS ONE MEMBER, PRESENCE CARE TRANSFORMATION CORPORATION

Return Reference	Explanation
FORM 990, PART VI, QUESTION 7A	PERSONS WITH AUTHORITY TO ELECT MEMBERS OF THE GOVERNING BODY THE CORPORATIONS SOLE MEMBER, PRESENCE CARE TRANSFORMATION CORPORATION, HAS THE POWER TO APPOINT MEMBERS OF THE GOVERNING BODY, OTHER THAN EX-OFFICIO DIRECTORS

Return Reference	Explanation
FORM 990, PART VI, QUESTION 7B	<p>DECISIONS OF GOVERNING BODY APPROVAL BY MEMBERS OR SHAREHOLDERS PRESENCE CARE TRANSFORMATION CORPORATION (THE "MEMBER"), THROUGH ITS BOARD OF DIRECTORS, HAS CERTAIN GENERAL AND RESERVED POWERS WITH RESPECT TO THE FOLLOWING GENERAL POWERS THE MEMBER SHALL PROVIDE OVERSIGHT AND SUPPORT FOR THE ACTIVITIES OF THE CORPORATION, FOR THE PURPOSE OF ASSURING THAT ALL ACTIONS OF THE CORPORATION ARE CONSISTENT WITH THE MISSION AND VALUES OF THE SYSTEM, THE PURPOSES OF THE CORPORATION, THE ETHICAL AND RELIGIOUS DIRECTIVES, THE PRESENCE HEALTH SYSTEM STRATEGIC PLAN, AND BEST PRACTICES EXCLUSIVE POWERS IN FURTHERANCE OF THE EXERCISE OF ITS GENERAL POWERS AND RESPONSIBILITIES, THE MEMBER SHALL HAVE THE SOLE POWER TO TAKE THE ACTIONS SPECIFIED BELOW WITH RESPECT TO THE FOLLOWING MATTERS A) AMEND OR REPEAL THE BYLAWS OF THE CORPORATION B) APPOINT AND REMOVE ALL OFFICERS OF THE CORPORATION AND ALL DIRECTORS OF THE CORPORATION, OTHER THAN ANY EX-OFFICIO DIRECTORS C) APPROVAL CAPITAL AND OPERATING BUDGETS, AND LONG-TERM CAPITAL EQUIPMENT PLANS FOR THE CORPORATION D) APPROVE UNBUDGETED EXPENDITURES IN EXCESS OF THE LIMIT ESTABLISHED BY THE MEMBER FROM TIME TO TIME E) APPROVE ANY BORROWING OR SIGNIFICANT INCURRENCE OF DEBT BY THE CORPORATION IN EXCESS OF THE LIMIT ESTABLISHED BY THE MEMBER FROM TIME TO TIME, OR ANY SALE, PURCHASE, ALIENATION, EXCHANGE, SIGNIFICANT LEASES (OTHER THAN IN THE ORDINARY COURSE) OR ENCUMBRANCES OF THE CORPORATIONS REAL PROPERTY, EXCEPT THOSE MADE PURSUANT TO APPROVED BUDGETS F) APPROVE EXECUTION OF ANY DEEDS, MORTGAGES, BONDS, OR MAJOR EQUIPMENT LEASES, EXCEPT THOSE MADE PURSUANT TO APPROVED BUDGETS G) APPROVE ANY OTHER SIGNIFICANT AND UNBUDGETED SALE, PURCHASE, EXCHANGE, LEASE (OTHER THAN IN THE ORDINARY COURSE) TRANSFER, LITIGATION OR LEGAL SETTLEMENT, BENEFITS PACKAGES, ENCUMBRANCE OR OTHER DISPOSITION OR OTHER SIGNIFICANT TRANSACTION INVOLVING THE NON-REAL-ESTATE ASSETS OF THE CORPORATION IN EXCESS OF THE LIMIT ESTABLISHED BY THE MEMBER FROM TIME TO TIME H) APPROVE MATERIAL CHANGES IN THE KIND OF SERVICES RENDERED, SUCH AS THE ADDITION OR DISCONTINUATION OF ANY MAJOR SERVICE LINE (E.G., OBSTETRICS) OR CHANGE IN THE FUNDAMENTAL NATURE OF SERVICES PROVIDED BY THE CORPORATION (E.G., A CHANGE REQUIRING A DIFFERENT KIND OF LICENSE) I) APPROVE STRATEGIC PLANS FOR THE CORPORATION CONSISTENT WITH AN IN FURTHERANCE OF SYSTEM MISSION AND VALUES, AND RESPONSIVE TO THE NEEDS OF THE COMMUNITIES SERVED BY THE CORPORATION AND SUPPORT THE ABILITY OF THE CORPORATION AND ITS AFFILIATES TO PROVIDE HIGH-QUALITY CARE AND SERVICES J) APPROVE ANY CONTRACT FOR THE MANAGEMENT OF ALL OR SUBSTANTIALLY ALL OF THE CORPORATION OR ANY HEALTH CARE FACILITIES OWNED BY THE CORPORATION K) APPROVE ANY SELECTION OR MODIFICATION OF THE BUSINESS NAME OR LOGO OF THE CORPORATION OR ANY PROGRAM OR DIVISION OF THE CORPORATION, OR THE USE OF ANY CORPORATE OR BUSINESS NAME OF THE CORPORATION BY AN ENTITY OTHER THAN THE MEMBER OR AN AFFILIATE L) PROVIDE OR ASSURE THE PROVISION OF APPROPRIATE INSURANCE COVERAGE, STANDARDIZED EMPLOYEE BENEFITS, INFORMATION SYSTEMS AND TECHNOLOGY, FINANCIAL MANAGEMENT SERVICES, LEGAL, MARKETING, RISK MANAGEMENT AND OTHER ADMINISTRATIVE SERVICES NECESSARY TO SUPPORT THE CORPORATIONS OPERATIONS M) APPROVE THE ESTABLISHMENT, TERMINATION, OR SALE OF ANY SIGNIFICANT JOINT VENTURE RELATIONSHIP BY THE CORPORATION N) APPROVE THE ACQUISITION OR DEVELOPMENT OF ANY BUSINESS OR ACTIVITY UNRELATED TO THE PROVISION OF HEALTH CARE SERVICES O) APPROVE THE CREATION OF ANY NEW AFFILIATE TO BE OWNED OR CONTROLLED BY THE CORPORATION P) DIRECT AND APPROVE ANY CONTRIBUTIONS, DONATIONS OR OTHER ASSET TRANSFERS WITHOUT CONSIDERATION TO THE MEMBER OR ANY AFFILIATE, IN FURTHERANCE OF THE MISSION AND VALUES Q) APPROVE ACCEPTANCE OF A CONTRIBUTION THAT IMPOSES A MATERIAL OBLIGATION ON THE CORPORATION, IF APPROVED BY THE CORPORATIONS APPLICABLE FOUNDATION OR FUNDRAISING AFFILIATE AS CONSISTENT WITH THE CORPORATIONS AND SYSTEMS MISSION AND GOALS R) DEFINE THE CRITERIA FOR THE SELECTION OF BANKS AND OTHER FINANCIAL DEPOSITORIES TO BE USED BY THE CORPORATION, AND AUTHORIZE THE PROCESS BY WHICH SIGNATORIES ON ALL BANK AND SIMILAR ACCOUNTS OF THE CORPORATION ARE APPROVED S) SELECT INDEPENDENT AUDITORS FOR THE CORPORATION, IN CONNECTION WITH THE CONSOLIDATED AUDIT OF ALL SYSTEM ENTITIES T) APPROVE OR CHANGE THE CORPORATIONS REGISTERED AGENT OR REGISTERED OFFICE, AS APPROPRIATE FROM TIME TO TIME U) APPROVE ANY VOLUNTARY CHANGE TO THE CORPORATIONS STATUS OF AN ORGANIZATION EXEMPT FROM TAXATION UNDER SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE, AS AMENDED FROM TIME TO TIME APPROVAL AND RECOMMENDATION POWERS TO BE EFFECTIVE, THE ACTIONS SET FORTH BELOW MUST BE APPROVED BY BOTH THE CORPORATIONS BOARD OF DIRECTORS AND THE MEMBER SUCH ACTIONS MAY BE INITIATED EITHER BY THE MEMBER OR THE CORPORATIONS BOARD A) ADOPTION, AMENDMENT OR REPEAL OF THE ARTICLES OF INCORPORATION OF THE CORPORATION B) ADOPTION OF ANY PLAN OF MERGER, CONSOLIDATION, OR DISSOLUTION OF THE CORPORATION</p>

Return Reference	Explanation
FORM 990, PART VI, QUESTION 11B	FORM 990 REVIEW PROCESS THE CORPORATION PROVIDES A COMPLETE COPY OF ITS FORM 990 TO ALL MEMBERS OF THE GOVERNING BODY OF ITS ULTIMATE PARENT CORPORATION, PRESENCE HEALTH NETWORK, FOR REVIEW PRIOR TO FILING WITH THE IRS THE BOARD OF DIRECTORS OF THE CORPORATION AND OTHER SUBSIDIARY ORGANIZATIONS WITHIN THE PRESENCE HEALTH SYSTEM ARE INTERNAL LIMITED FIDUCIARY BOARDS WHICH DO NOT RECEIVE A COMPLETED COPY OF THE FORM 990 PRIOR TO FILING AS A RESULT, THE CORPORATION ANSWERS "NO", TO FORM 990, PART VI, LINE 11A

Return Reference	Explanation
FORM 990, PART VI, LINE 12C	<p>PROCEDURES FOR ADDRESSING CONFLICTS OF INTEREST THE PURPOSE OF THE CONFLICT OF INTEREST POLICY IS TO PROTECT THE INTERESTS OF PRESENCE HEALTH NETWORK AND ALL OF ITS AFFILIATED MINISTRIES (COLLECTIVELY "PRESENCE HEALTH") WHEN IT IS CONTEMPLATING ENTERING INTO A TRANSACTION OR ARRANGEMENT THAT MIGHT BENEFIT THE PRIVATE INTEREST OF ANY DIRECTOR, TRUSTEE, OFFICER, CORPORATE MEMBER APPOINTEE, MEMBER OF A COMMITTEE WITH BOARD-DELEGATED POWERS, SENIOR LEADERS, AND OTHERS IN A RECENT POSITION TO EXERCISE SUBSTANTIAL INFLUENCE OVER PRESENCE HEALTH ("INTERESTED PERSONS"), AND CLARIFY THE STANDARDS OF CONDUCT, DUTIES AND OBLIGATIONS OF INTERESTED PERSONS IN THE CONTEXT OF POTENTIAL CONFLICTS OF INTEREST BY PROVIDING A METHOD FOR DISCLOSING AND RESOLVING SUCH POTENTIAL CONFLICTS NO PRESENCE HEALTH ENTITY WILL ENGAGE IN ANY CONTRACT, TRANSACTION OR ARRANGEMENT INVOLVING A CONFLICT OF INTEREST UNLESS DISINTERESTED MEMBERS OF THE APPLICABLE BOARD OF DIRECTORS OR OTHER GOVERNING BODY DETERMINE BY A MAJORITY VOTE THAT APPROPRIATE SAFEGUARDS TO PROTECT THE CHARITABLE MISSION OF PRESENCE HEALTH HAVE BEEN IMPLEMENTED TO FACILITATE THIS POLICY, ALL INTERESTED PERSONS HAVE A CONTINUING OBLIGATION TO PROMPTLY DISCLOSE THE EXISTENCE AND NATURE OF ANY ACTUAL, APPARENT, OR POTENTIAL CONFLICTS OF INTEREST HE/SHE MAY HAVE ALL DISCLOSURES MUST BE PROVIDED TO THE SYSTEM COMPLIANCE OFFICER AND GENERAL COUNSEL IN A WRITTEN DESCRIPTION OF THE MATERIAL FACTS DISCLOSURE SHALL BE ON A CONFLICTS OF INTEREST QUESTIONNAIRE OR SIMILAR FORMAT AS DESCRIBED IN THE CONFLICTS OF INTEREST POLICY ALL INTERESTED PERSONS SHALL ALSO COMPLETE A QUESTIONNAIRE BASED ON THE ASSUMPTION OF THE BOARD (OR OTHER RELEVANT) POSITION, AND THEREAFTER ON AT LEAST AN ANNUAL BASIS OR WHEN AN ACTUAL, APPARENT, OR POTENTIAL CONFLICT ARISES AT ANY TIME THAT AN ACTUAL, APPARENT OR A POTENTIAL CONFLICT OF INTEREST IS IDENTIFIED TO THE CORPORATIONS BOARD OF DIRECTORS, WHETHER THROUGH THE VOLUNTARY SUBMISSION OF A DISCLOSURE STATEMENT BY AN INTERESTED PERSON, OR BY A DISCLOSURE BY A PERSON OTHER THAN THE SUBJECT INTERESTED PERSON, THE CORPORATIONS BOARD OR APPLICABLE COMMITTEE SHALL REVIEW THE MATTER AND DETERMINE WHETHER A CONFLICT OF INTEREST EXISTS ONCE ALL NECESSARY INFORMATION HAS BEEN OBTAINED, ONLY DISINTERESTED DIRECTORS/COMMITTEE MEMBERS VOTE TO DETERMINE WHETHER A CONFLICT OF INTEREST EXISTS IF A CONFLICT IS FOUND TO EXIST THE INTERESTED PERSON WILL GENERALLY BE REQUIRED TO RECUSE HIM OR HERSELF DURING ANY MEETING IN WHICH THE BOARD OF DIRECTORS OR APPLICABLE COMMITTEE CONDUCTS THE EVALUATION OF THE SUBJECT TRANSACTION, EXCEPT TO ANSWER QUESTIONS AS MAY BE NECESSARY TO ENSURE THAT THE PRESENCE HEALTH OPERATES IN A MANNER CONSISTENT WITH ITS CHARITABLE PURPOSES AND THAT IT DOES NOT ENGAGE IN ACTIVITIES THAT COULD JEOPARDIZE ITS EXEMPT STATUS, TRANSACTIONS INVOLVING INTERESTED PERSONS ARE ONLY APPROVED IF, AFTER EXERCISING REASONABLE DUE DILIGENCE, THE BOARD DETERMINES THEY ARE FAIR AND REASONABLE, TAKING INTO ACCOUNT FACTORS SUCH AS WHETHER PRESENCE HEALTH COULD OBTAIN A MORE ADVANTAGEOUS CONTRACT, TRANSACTION OR ARRANGEMENT HOWEVER, LENDING MONEY OR GUARANTYING AN OBLIGATION OF A DIRECTOR, OFFICER, OR EMPLOYEE OF PRESENCE HEALTH (EXCLUSIVE OF CUSTOMARY INSURANCE COVERAGE FOR ACTS DONE IN CONNECTION WITH SUCH INDIVIDUALS SERVICE TO OR EMPLOYMENT BY PRESENCE HEALTH) IS STRICTLY PROHIBITED</p>

Return Reference	Explanation
FORM 990 PART VI, QUESTIONS 15A AND 15B, AND PART V, QUESTION 2A	<p>COMPENSATION AND APPROVAL PROCESS FOR OFFICERS AND KEY EMPLOYEES COMPENSATION FOR THE CORPORATIONS CEO AND OTHER OFFICERS AND KEY EMPLOYEES IS DETERMINED IN ACCORDANCE WITH WRITTEN POLICIES AND PROCEDURES ADOPTED BY THE BOARD OF DIRECTORS OF PRESENCE HEALTH NETWORK, THE SYSTEM PARENT CORPORATION WHICH SHARES A MIRROR BOARD WITH PRESENCE CARE TRANSFORMATION CORPORATION (PCTC) AND PRESENCE CHICAGO HOSPITALS NETWORK (PCHN) SUCH POLICIES AND PROCEDURES ARE APPLIED BY THE HUMAN RESOURCES COMMITTEE OF THE SYSTEM PARENT CORPORATION, WHICH CONSISTS WHOLLY OF INDEPENDENT DIRECTORS THE SYSTEM PARENT CORPORATION USES MARKET DATA COMPILED BY AN INDEPENDENT COMPENSATION CONSULTANT TO ESTABLISH BASE SALARIES AND TOTAL CASH COMPENSATION OPPORTUNITIES THE SYSTEM PARENTS HUMAN RESOURCES COMMITTEE MONITORS EXECUTIVE TOTAL COMPENSATION AND APPROVES ALL COMPONENTS OF EXECUTIVE TOTAL COMPENSATION, ANNUALLY REVIEWING AND APPROVING COMPENSATION CHANGES FOR EACH EXECUTIVE, AND REGULARLY REPORTING ITS ACTIVITIES TO THE SYSTEM PARENTS BOARD THE CORPORATION ANSWERS "NO" TO FORM 990, PART VI, QUESTION 15A AND 15B PER THE FORM 990 INSTRUCTIONS AS ALL COMPENSATION IS PAID BY A RELATED ORGANIZATION, PRESENCE CARE TRANSFORMATION CORPORATION, THE SYSTEMS STATUTORY EMPLOYER</p>

Return Reference	Explanation
FORM 990, PART VI, LINE 19	DOCUMENT AVAILABILITY THE CORPORATIONS ARTICLES OF INCORPORATION ARE ON FILE WITH THE STATE OF ILLINOIS THE CONSOLIDATED AUDITED FINANCIAL STATEMENTS OF THE CORPORATION, TOGETHER WITH ITS AFFILIATES, ARE AVAILABLE FROM THE NATIONAL DISSEMINATION AGENT AS REQUIRED BY PRESENCE HEALTH SYSTEMS BOND DOCUMENTS CONFLICTS OF INTEREST POLICIES ARE NOT MADE AVAILABLE TO THE PUBLIC, HOWEVER A SUMMARY OF THE CURRENT POLICY IS ANNUALLY INCLUDED IN SCHEDULE O OF THE CORPORATIONS FORM 990

Return Reference	Explanation
FORM 990, PART VII, SECTIONS A & B	STATUTORY EMPLOYER PRESENCE CARE TRANSFORMATION CORPORATION ("PCTC") (FEIN 36-3366652) ACTS AS THE AGENT FOR THE CORPORATION CASH IS SWEEPED FROM THE CORPORATION ON A DAILY BASIS TO PCTC AND PCTC ISSUES ALL PAYROLL AND ACCOUNTS PAYABLE CHECKS ON BEHALF OF AND AS AGENT FOR THE CORPORATION AND THE APPROPRIATE ACCOUNTING ENTRIES ARE RECORDED FORM 990, PART XI, LINE 9 OTHER CHANGES IN NET ASSETS OR FUND BALANCES INTERCOMPANY TRANSFER FROM AFFILIATES \$ 96,037,579 NET ASSETS RELEASED FOR CAPITAL \$ 1,532,906 PRESENCE HEALTH PARTNERS \$ (3,113,640) RESTRICTED FUND ACTIVITY \$ 2,493,862 _____ TOTAL \$96,950,707

Return Reference	Explanation
FORM 990, PART XII, LINE 2B	AUDITED FINANCIAL STATEMENTS AN INDEPENDENT ACCOUNTANT ANNUALLY AUDITS THE CONSOLIDATED FINANCIAL STATEMENTS OF PRESENCE HEALTH NETWORK AND ITS AFFILIATES THE AUDIT OPINION IS ISSUED ON THE CONSOLIDATED FINANCIAL STATEMENTS AND EACH AFFILIATE IS NOT SEPARATELY AUDITED

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION PHYSICIAN FEES TOTAL FEES 47424452

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION AGENCY FEES TOTAL FEES 7923445

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION LAB SERVICES TOTAL FEES 11690131

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION ANESTHESIOLOGY SERVICES TOTAL FEES 4489895

Return Reference	Explanation
FORM 990 PART IX LINE 11 G	DESCRIPTION OTHER TOTAL FEES 67308651

SCHEDULE R
(Form 990)

Related Organizations and Unrelated Partnerships

OMB No 1545-0047

2015

Open to Public
Inspection

▶ 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.

Department of the Treasury
Internal Revenue Service

Name of the organization
PRESENCE CENTRAL AND SUBURBAN HOSPITALS
NETWORK

Employer identification number

36-4195126

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) Presence Health Partners LLC 18927 HICKORY CREEK DRIVE Mokena, IL 60448 46-3111349	MGD CARE CONT	IL	53,563,972	7,758,101	PCSHN
(2) Vermilion County Surgery Center LLC 26 W Newell Danville, IL 61834 80-0811427	MEDICAL SRVC	IL	-1,580,882	4,473,859	PCSHN

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 IIIPart 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) Disproporionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K- 1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) Bel Harlem Surg Ctr 3101 North Harlem Chicago, IL 60634 41-2237162	Medical Service	IL	N/A									
(2) RH Sleep Ctr - NW 665 West North Ave 500 Lombard, IL 60148 26-1519627	Medical Service	IL	N/A									
(3) RH Sleep Ctr - Evan 665 West North Ave 500 Lombard, IL 60148 26-1519556	Medical Service	IL	N/A									
(4) RH Sleep Ctr - LP 665 West North Ave 500 Lombard, IL 60148 26-1519667	Medical Service	IL	N/A									
(5) RH Sleep Ctr - RF 665 West North Ave 500 Lombard, IL 60148 26-2189763	Medical Service	IL	N/A									
(6) Alvemo Clinic Lab 2434 Interstate Plaza Drive Hammond, IN 46324 20-3240648	Medical Service	IN	N/A									
(7) Prof Clinic Lab LLC 113 E 4th St Michigan City, IN 46360 30-0711211	Medical Service	IN	N/A									

Part IVPart 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

1a

No

b

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

1b

No

c

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

1c

No

d

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

1d

No

e

Loans or loan guarantees by related organization(s)

1e

No

f

Dividends from related organization(s)

1f

No

g

Sale of assets to related organization(s)

1g

No

h

Purchase of assets from related organization(s)

1h

No

i

Exchange of assets with related organization(s)

1i

No

j

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

1j

No

k

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

1k

Yes

l

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

1l

No

m

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

1m

No

n

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

1n

No

o

Sharing of paid employees with related organization(s)

1o

Yes

p

Reimbursement paid to related organization(s) for expenses

1p

Yes

q

Reimbursement paid by related organization(s) for expenses

1q

Yes

r

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

1r

No

s

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

1s

No

2

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) PRESENCE CARE TRANSFORMATION CORPORATION	P	134,426,035	COST
(2) PRESENCE LIFE CONNECTIONS	P	89,863	COST
(3) PRESENCE SERVICE CORPORATION	P	2,898,115	COST
(4) PRESENCE CHICAGO HOSPITALS NETWORK	P	11,692,544	COST
(5) PRESENCE HOME CARE	Q	253,803	COST
(6) PRESENCE LIFE CONNECTIONS	Q	100,847	COST

Schedule R (Form 990) 2015

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

[illegible]

Part VII **Supplemental Information**

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

Return Reference	Explanation
REIMBURSEMENTS FOR SHARED SERVICES	PRESENCE CARE TRANSFORMATION CORPORATION (FKA PRESENCE PRV HEALTH) (FEIN 36-3366652) PAYS ALL OF THE COMPENSATION AND ACCOUNTS PAYABLE FOR ALL ENTITIES UNDER THE PRESENCE HEALTH SYSTEM AS THE DESIGNATED PAYMENT AGENT FOR SUCH ENTITIES CASH IS DEPOSITED INTO AN ACCOUNT BY PRESENCE HEALTH ENTITIES AND SWEEPED ON A MONTHLY BASIS TO REIMBURSE PRESENCE CARE TRANSFORMATION CORPORATION FOR THESE EXPENSES AT COST THE AMOUNTS REPORTED ON PART V OF SCHEDULE R REFLECT THE TOTAL CASH TRANSFERS TO/FROM PRESENCE CARE TRANSFORMATION CORPORATION

Additional Data

Software ID:

Software Version:

EIN: 36-4195126

Name: PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK

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
Presence Health Network 200 South Wacker Drive Chicago, IL 60606 36-1649520	Parent Corp	IL	501(C)(3)	11c III FI	na		No
Medicare Value Partners 100 North River Road Des Plaines, IL 60016 36-3495969	Health Care	IL	501(C)(3)	3	PCHN	Yes	
Presence Holy Family Medical Center 100 North River Road Des Plaines, IL 60016 36-2439318	Health Care	IL	501(C)(3)	3	PCHN	Yes	
Mount Loretto Nursing Home Inc 302 Swart Hill Road Amsterdam, NY 12010 14-1363014	Health Care	NY	501(C)(3)	3	RM New York	Yes	
Presence Health Partners Services 2380 E Dempster Ave Ste 236 Des Plaines, IL 60016 36-2644178	Health Care	IL	501(C)(3)	3	PCHN	Yes	
Presence Care Home 18927 Hickory Creek Drive 300 Mokena, IL 60448 46-0483587	Health Care	IL	501(C)(3)	9	PLC	Yes	
Presence Care Transformation Corp 1000 Remington Blvd Ste 100 Bolingbrook, IL 60440 36-3366652	Mgmt Support	IL	501(C)(3)	11c III FI	PHN		No
Presence Home Care 18927 Hickory Creek Drive 300 Mokena, IL 60448 46-0483581	Health Care	IL	501(C)(3)	9	PLC	Yes	
Laverna Terrace Housing Corporation 18927 Hickory Creek Drive 300 Mokena, IL 60448 36-3438977	Senior Living	IL	501(C)(3)	9	PCTC	Yes	
Provena Self-Insurance Trust 1000 Remington Blvd Suite 100 Bolingbrook, IL 60440 36-2987310	Insurance	IL	501(C)(3)	11c III FI	na		No
Presence Life Connections 18927 Hickory Creek Drive 300 Mokena, IL 60448 37-1127787	Health Care	IL	501(C)(3)	9	PCTC	Yes	
Presence Behavioral Health 1820 South 25th Avenue Broadview, IL 60155 36-2709982	Health Care	IL	501(C)(3)	3	PHS	Yes	
Presence Ambulatory Services 100 North River Road Des Plaines, IL 60016 36-4286236	Health Care	IL	501(C)(3)	9	PCHN	Yes	
Presence Health Fdn Board of Trustees 200 South Wacker Drive Chicago, IL 60606 36-3330929	Fundraising	IL	501(C)(3)	7	PCHN	Yes	
Presence Chicago Hospitals Network 200 South Wacker Drive Chicago, IL 60606 36-2235165	Mgmt Support	IL	501(C)(3)	11c III FI	PHN		No
Presence Home Care Services 5747 West Dempster Morton Grove, IL 60053 36-2893936	Home Care	IL	501(C)(3)	3	PCHN	Yes	
Presence Resurrection Medical Center 7435 West Talcott Avenue Chicago, IL 60631 36-3330926	Health Care	IL	501(C)(3)	3	PCHN	Yes	
Resurrection Nursing Home Inc 90 North Main Street Castleton, NY 12033 14-1348691	Health Care	NY	501(C)(3)	3	RM New York	Yes	
Presence Senior Srvcs - Chicagoland 100 North River Road Des Plaines, IL 60016 23-7061646	Health Care	IL	501(C)(3)	3	PCHN	Yes	
Presence Healthcare Services 100 North River Road Des Plaines, IL 60016 36-3330928	Health Care	IL	501(C)(3)	3	PCHN	Yes	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
Presence Saint Francis Hospital 355 Ridge Avenue Evanston, IL 60202 36-2167800	Health Care	IL	501(C)(3)	3	PCHN	Yes	
Presence St Mary and Elizabeth Med Cntr 2233 West Division Street Chicago, IL 60622 36-2171079	Health Care	IL	501(C)(3)	3	PCHN	Yes	
Presence Saint Joseph Hospital Chicago 2900 North Lake Shore Drive Chicago, IL 60657 36-3200170	Health Care	IL	501(C)(3)	3	PCHN	Yes	
Presence Nazarethville 300 North River Road Des Plaines, IL 60016 36-2801392	Health Care	IL	501(C)(3)	9	PSSC	Yes	
Arthur Merkle - Clara Knipprath Nursing 1190 E 2900 N Road Clifton, IL 60927 36-2841358	Health Care	IL	501(C)(3)	9	PLC	Yes	
Rainbow Hospice and Palliative Care 1550 Bishop Court Mount Prospect, IL 60056 36-3296367	Health Care	IL	501(C)(3)	9	PHCS	Yes	
Resurrection University 1431 N Claremont Chicago, IL 60622 36-2182170	Education	IL	501(C)(3)	2	PCHN	Yes	

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

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
(1) L Gilbraith Insurance SPC LTD 68 W Bay Road PO Box 1109 Grand Cayman CJ 000000000	Insurance	CJ	PCHN	Foreign Company				Yes	
(1) Provena Health Assurance SPC 23 Lime Tree Bay Ave PO Box 1051 Grand Cayman CJ 98-0420054	Insurance	CJ	PCTC	Foreign Company				Yes	
(2) Presence Properties Inc 100 North River Road Des Plaines, IL 60016 36-3520630	Medical	IL	PV	C Corp				Yes	
(3) Presence Service Corporation 2380 E Dempster Street Des Plaines, IL 60016 36-4314354	Medical	IL	PCSHN	C Corp	31,999,042	22,782,493	100 000 %	Yes	
(4) Presence Ventures Inc 100 North River Road Des Plaines, IL 60016 37-1168085	Medical	IL	PCTC	C Corp				Yes	
(5) Resurrection Medical Center Auxiliary 7435 West Talcott Avenue Chicago, IL 60631 36-6109825	Fundraising	IL	PRMC	C Corp				Yes	
(6) Resurrection Ministries of New York 90 North Main Street Castleton, NY 12033 14-1720818	Parent Corp	NY	PCHN	C Corp				Yes	
(7) Presence Health Care Preferred 100 North River Road Des Plaines, IL 60016 36-3974620	MGD Care Contract	IL	PCHN	C Corp				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
(1)	PRESENCE CARE TRANSFORMATION CORPORATION	P	134,426,035	COST
(1)	PRESENCE LIFE CONNECTIONS	P	89,863	COST
(2)	PRESENCE SERVICE CORPORATION	P	2,898,115	COST
(3)	PRESENCE CHICAGO HOSPITALS NETWORK	P	11,692,544	COST
(4)	PRESENCE HOME CARE	Q	253,803	COST
(5)	PRESENCE LIFE CONNECTIONS	Q	100,847	COST