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Form 990

Return of Organization Exempt From Income Tax

OMB No 1545-0047

2016

Open to Public Inspection

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

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

Information about Form 990 and its instructions is at [www.irs.gov/form990](#)

Department of the Treasury
Internal Revenue Service

A For the 2016 calendar year, or tax year beginning 01-01-2016 , and ending 12-31-2016

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

SEE SCHEDULE O

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

1000 REMINGTON BOULEVARD SUITE 100

Room/suite

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

H(a) Is this a group return for subordinates?

☐ Yes ☒ No

H(b) Are all subordinates included?

☐ Yes ☐ No

If "No," attach a list (see instructions)

H(c) Group exemption number

0928

D Employer identification number

36-4195126

E Telephone number

(630) 914-2791

G Gross receipts \$

1,091,858,288

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

SEE SCHEDULE O

2 Check this box ▶ ☐ 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)

6

4 Number of independent voting members of the governing body (Part VI, line 1b)

4

5 Total number of individuals employed in calendar year 2016 (Part V, line 2a)

0

6 Total number of volunteers (estimate if necessary)

1,775

7a Total unrelated business revenue from Part VIII, column (C), line 12

3,826,438

7b Net unrelated business taxable income from Form 990-T, line 34

1,706,076

Revenue

8 Contributions and grants (Part VIII, line 1h)

2,244,326

9 Program service revenue (Part VIII, line 2g)

1,125,420,820

10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)

3,114,452

11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)

14,322,191

12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)

1,145,101,789

Expenses

13 Grants and similar amounts paid (Part IX, column (A), lines 1–3)

174,927

14 Benefits paid to or for members (Part IX, column (A), line 4)

0

15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)

405,214,427

16a Professional fundraising fees (Part IX, column (A), line 11e)

0

b Total fundraising expenses (Part IX, column (D), line 25) ▶0

17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)

792,310,967

18 Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)

1,197,700,321

19 Revenue less expenses Subtract line 18 from line 12

-52,598,532

Net Assets or Fund Balances

20 Total assets (Part X, line 16)

757,839,362

21 Total liabilities (Part X, line 26)

171,622,372

22 Net assets or fund balances Subtract line 21 from line 20

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

2017-11-13

Date

JAMES H KELLEY TREASURER

Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name

Jacob J Zehnder

Preparer's signature

Jacob J Zehnder

Date

Firm's name ▶ ERNST & YOUNG US LLP

Firm's EIN ▶

Firm's address ▶ 155 N Wacker Drive

Chicago, IL 60606

Phone no (312) 879-2000

Check ☐ if self-employed

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

Form 990 (2016)

Part III Statement of Program Service AccomplishmentsCheck 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 \$ 913,533,257	including grants of \$ 134,479	(Revenue \$ 1,082,321,764)
See Additional Data				

4b	(Code)	(Expenses \$	including grants of \$	(Revenue \$)
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4c	(Code)	(Expenses \$	including grants of \$	(Revenue \$)
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4d	Other program services (Describe in Schedule O)			
	(Expenses \$	including grants of \$	(Revenue \$)

4e	Total program service expenses ▶	913,533,257
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Part IV Checklist of Required Schedules

	Yes	No
1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? <i>If "Yes," complete Schedule A</i>	1 Yes	
2 Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> (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? <i>If "Yes," complete Schedule C, Part I</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? <i>If "Yes," complete Schedule C, Part II</i>	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? <i>If "Yes," complete Schedule C, Part III</i>	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? <i>If "Yes," complete Schedule D, Part I</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? <i>If "Yes," complete Schedule D, Part II</i>	7	No
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III</i>	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? <i>If "Yes," complete Schedule D, Part IV</i>	9	No
10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? <i>If "Yes," complete Schedule D, Part V</i>	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? <i>If "Yes," complete Schedule D, Part VI</i>	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? <i>If "Yes," complete Schedule D, Part VII</i>	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? <i>If "Yes," complete Schedule D, Part VIII</i>	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? <i>If "Yes," complete Schedule D, Part IX</i>	11d Yes	
e Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i>	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)? <i>If "Yes," complete Schedule D, Part X</i>	11f Yes	
12a Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI and XII</i>	12a	No
b Was the organization included in consolidated, independent audited financial statements for the tax year? <i>If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional</i>	12b Yes	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i>	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? <i>If "Yes," complete Schedule F, Parts I and IV</i>	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? <i>If "Yes," complete Schedule F, Parts II and IV</i>	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? <i>If "Yes," complete Schedule F, Parts III and IV</i>	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? <i>If "Yes," complete Schedule G, Part I</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? <i>If "Yes," complete Schedule G, Part II</i>	18	No
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III</i>	19	No

Part IV Checklist of Required Schedules (continued)

	Yes	No
20a Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	20a Yes	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b Yes	
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	No
30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i>	30	No
31 Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i>	31	No
32 Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i>	32	No
33 Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I</i>	33 Yes	
34 Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i>	34 Yes	
35a Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a Yes	
b If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i>	35b	No
36 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i>	36	No
37 Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i>	37	No
38 Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 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	1a0		
b	Enter the number of Forms W-2G included in line 1a Enter -0- if not applicable	1b0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a0		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note.If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	2b		
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?	3a	Yes	
b	If "Yes," has it filed a Form 990-T for this year?If "No" to line 3b, provide an explanation in Schedule O	3b	Yes	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a		No
b	If "Yes," enter the name of the foreign country See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)			
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a		No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b		No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	5c		
6a	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	6a		No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b		
7	Organizations that may receive deductible contributions under section 170(c).			
a	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?	7a		No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c		No
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d		
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e		No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f		No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h		
8	Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	8		
9a	Did the sponsoring organization make any taxable distributions under section 4966?	9a		
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	9b		
10	Section 501(c)(7) organizations. Enter			
a	Initiation fees and capital contributions included on Part VIII, line 12	10a		
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b		
11	Section 501(c)(12) organizations. Enter			
a	Gross income from members or shareholders	11a		
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)	11b		
12a	Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?	12a		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b		
13	Section 501(c)(29) qualified nonprofit health insurance issuers.			
a	Is the organization licensed to issue qualified health plans in more than one state?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	6		
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	4		
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		Yes	
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		Yes	
b Other officers or key employees of the organization	15b		Yes	
If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).				
16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a		Yes	
b If "Yes," 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 SOUTH 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

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[illegible]

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 ▶ 274

Section B. Independent Contractors

(A) Name and business address	(B) Description of services	(C) Compensation
US BANK CORPORATE TRUST, PO BOX 70870 ST PAUL, MN 55170	CLINICAL AGENCY	3,359,091
CARDIAC SURGERY ASSOCIATES SC, 2650 Warrenville Rd STE 280 DOWNERS GROVE, IL 60515	CARDIAC SERVICES	3,100,136
CHRISTIE CLINIC LLC, 101 UNIVERSITY AVE CHAMPAIGN, IL 61820	HOSPITALIST SERVICES	2,932,427
STANDARD TEXTILE CO INC, PO BOX 630302 CINCINNATI, OH 45263	LAUNDRY SERVICES	1,775,686
DANVILLE POLYCLINIC LTD, 707 N LOGAN AVE DANVILLE, IL 61832	CARDIOLOGY SERVICES	1,414,416

Form 990 (2016)

Part VIII

Statement of Revenue

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

Contributions, Gifts, Grants
and Other Similar Amounts

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
1a	Federated campaigns	1a			
b	Membership dues	1b			
c	Fundraising events	1c			
d	Related organizations	1d	1,368,521		
e	Government grants (contributions)	1e	122,671		
f	All other contributions, gifts, grants, and similar amounts not included above	1f	547,812		
g	Noncash contributions included in lines 1a-1f \$		0		
h	Total. Add lines 1a-1f		2,039,004		

Program Service Revenue

	Business Code				
2a	NET PATIENT REVENUE	622110	1,056,698,030	1,056,698,030	0
b	RETAIL/CONTRACT PHARMACY	446110	2,071,644	500,714	1,570,930
c	MEDICARE MEANINGFUL USE	622110	2,317,814	2,317,814	0
d	MEDICAL OFFICE BLDG RENT	561000	2,319,068	2,319,068	0
e	JOINT VENTURE INCOME	900099	1,584,505	0	1,584,505
f	All other program service revenue				
g	Total. Add lines 2a-2f		1,064,991,061		

Other Revenue

3	Investment income (including dividends, interest, and other similar amounts)		1,292,628			1,292,628
4	Income from investment of tax-exempt bond proceeds		0			
5	Royalties		0			
6a	Gross rents	(i) Real	(ii) Personal			
		172,871				
b	Less rental expenses	98,284				
c	Rental income or (loss)	74,587	0			
d	Net rental income or (loss)		74,587		74,587	
7a	Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other			
		608,486	375,374			
b	Less cost or other basis and sales expenses					
c	Gain or (loss)	608,486	375,374			
d	Net gain or (loss)		983,860			983,860
8a	Gross income from fundraising events (not including \$ of contributions reported on line 1c) See Part IV, line 18	a	0			
b	Less direct expenses	b	0			
c	Net income or (loss) from fundraising events		0			
9a	Gross income from gaming activities See Part IV, line 19	a	0			
b	Less direct expenses	b	0			
c	Net income or (loss) from gaming activities		0			
10a	Gross sales of inventory, less returns and allowances	a	0			
b	Less cost of goods sold	b	0			
c	Net income or (loss) from sales of inventory		0			
	Miscellaneous Revenue	Business Code				
11a	ADMINISTRATION SERVICES	900099	13,407,897	13,407,897	0	0
b	CAFETERIA SALES	722514	3,720,629	0	47,022	3,673,607
c	GIFT SHOP & AUXILLARY	453220	778,138	0	0	778,138
d	All other revenue		4,472,200	3,922,806	549,394	
e	Total. Add lines 11a-11d		22,378,864			
12	Total revenue. See Instructions		1,091,760,004	1,079,166,329	3,826,438	6,728,233

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.	134,479	134,479		
2 Grants and other assistance to domestic individuals. See Part IV, line 22.	5,000	5,000		
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.	0	0		
4 Benefits paid to or for members.	0	0		
5 Compensation of current officers, directors, trustees, and key employees.	2,020,331	2,020,331	0	0
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B).	0	0	0	0
7 Other salaries and wages.	311,122,088	311,122,088	0	0
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).	13,530,670	13,530,670	0	0
9 Other employee benefits.	37,525,400	37,525,400	0	0
10 Payroll taxes.	23,400,054	23,400,054	0	0
11 Fees for services (non-employees):				
a Management.	119,973,523	0	119,973,523	0
b Legal.	572,648	0	572,648	0
c Accounting.	0	0	0	0
d Lobbying.	0	0	0	0
e Professional fundraising services. See Part IV, line 17.	0			0
f Investment management fees.	0	0	0	0
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	150,824,734	150,824,734		
12 Advertising and promotion.	285,595	285,595	0	0
13 Office expenses.	3,890,814	3,890,814	0	0
14 Information technology.	484,532	484,532	0	0
15 Royalties.	0	0	0	0
16 Occupancy.	23,391,739	23,391,739	0	0
17 Travel.	552,616	552,616	0	0
18 Payments of travel or entertainment expenses for any federal, state, or local public officials.	0	0	0	0
19 Conferences, conventions, and meetings.	98,845	98,845	0	0
20 Interest.	17,246,398	17,246,398	0	0
21 Payments to affiliates.	0	0	0	0
22 Depreciation, depletion, and amortization.	50,985,101	50,985,101	0	0
23 Insurance.	18,179,040	18,179,040	0	0
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 & PHARMACY	180,311,551	180,311,551	0	0
b TAXES AND ASSESSMENTS	56,189,990	56,189,990	0	0
c REPAIRS AND MAINTENANCE	18,924,226	18,924,226	0	0
d LEASE AND MINOR EQUIPMENT	9,815,192	9,815,192	0	0
e All other expenses	-5,385,138	-5,385,138		
25 Total functional expenses. Add lines 1 through 24e.	1,034,079,428	913,533,257	120,546,171	0
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).	0			

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

				(A) Beginning of year		(B) End of year
Assets	1	Cash—non-interest-bearing		0	1	0
	2	Savings and temporary cash investments		35,929,304	2	8,253,437
	3	Pledges and grants receivable, net		0	3	0
	4	Accounts receivable, net		165,237,905	4	182,633,624
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L.		0	5	0
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L.		0	6	0
	7	Notes and loans receivable, net		0	7	0
	8	Inventories for sale or use		25,803,971	8	25,293,619
	9	Prepaid expenses and deferred charges		1,985,458	9	0
	10a	Land, buildings, and equipment—cost or other basis. Complete Part VI of Schedule D.	10a 1,092,442,830			
	b	Less: accumulated depreciation	10b 671,649,439	441,216,661	10c	420,793,391
	11	Investments—publicly traded securities		26,026,731	11	27,297,123
	12	Investments—other securities. See Part IV, line 11		0	12	0
	13	Investments—program-related. See Part IV, line 11		3,276,773	13	1,743,746
	14	Intangible assets		0	14	0
	15	Other assets. See Part IV, line 11		58,362,559	15	86,052,680
16	Total assets. Add lines 1 through 15 (must equal line 34)		757,839,362	16	752,067,620	
Liabilities	17	Accounts payable and accrued expenses		48,110,201	17	15,012,800
	18	Grants payable		0	18	0
	19	Deferred revenue		241,698	19	306,938
	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		3,205,609	23	1,172,122
	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.		120,064,864	25	103,093,296
	26	Total liabilities. Add lines 17 through 25		171,622,372	26	119,585,156
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		571,625,531	27	632,482,464
	28	Temporarily restricted net assets		13,070,811	28	0
	29	Permanently restricted net assets		1,520,648	29	0
	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		586,216,990	33	632,482,464
34	Total liabilities and net assets/fund balances		757,839,362	34	752,067,620	

Part XI Reconciliation of Net AssetsCheck 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	1,091,760,004
2	Total expenses (must equal Part IX, column (A), line 25)	2	1,034,079,428
3	Revenue less expenses Subtract line 2 from line 1	3	57,680,576
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	586,216,990
5	Net unrealized gains (losses) on investments	5	549,438
6	Donated services and use of facilities	6	0
7	Investment expenses	7	0
8	Prior period adjustments	8	0
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-11,964,540
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	632,482,464

Part XII Financial Statements and ReportingCheck 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 (2016)

Form 990, Part III, Line 4a:

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 PSJMC'S MISSION OF PROVIDING HEALING AND HOPE IS ENHANCED BY THE FACILITY'S STATE-OF-THE-ART TECHNOLOGY AND THE BED TOWER'S CENTERED APPROACH TO CARE THE NEW FACILITY ALLOWS PSJMC TO PROVIDE THE HIGHEST LEVEL OF PATIENT CARE FOR THE BEST HEALTH OUTCOMES WITH PSJMC'S 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 PSJMC'S 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 2016 PRESENCE SAINT JOSEPH MEDICAL CENTER PROVIDED PATIENT CARE OF 101,697 PATIENT DAYS AND HAD 21,949 DISCHARGES EMERGENCY ROOM VISITS TOTALED 62,911, SURGERIES TOTALED 11,283, AND OUTPATIENT REGISTRATIONS TOTALED 291,630 PRESENCE ST MARY'S 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 MARY'S 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 2016 PRESENCE SAINT MARY HOSPITAL PROVIDED PATIENT CARE OF 22,475 PATIENT DAYS AND HAD 5,511 DISCHARGES EMERGENCY ROOM VISITS TOTALED 30,137, SURGERIES TOTALED 4,093, AND OUTPATIENT REGISTRATIONS TOTALED 54,591 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 2016 PRESENCE SAINT JOSEPH HOSPITAL ELGIN PROVIDED PATIENT CARE OF 39,654 PATIENT DAYS AND HAD 6,966 DISCHARGES EMERGENCY ROOM VISITS TOTALED 26,684, SURGERIES TOTALED 4,363, AND OUTPATIENT REGISTRATIONS TOTALED 106,108 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 2016 PRESENCE MERCY MEDICAL CENTER PROVIDED PATIENT CARE OF 37,460 PATIENT DAYS AND HAD 8,145 DISCHARGES EMERGENCY ROOM VISITS TOTALED 36,700, SURGERIES TOTALED 4,214, AND OUTPATIENT REGISTRATIONS TOTALED 130,353 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 AREA'S LARGEST INPATIENT REHABILITATION CENTER, FEATURING FACILITIES FOR PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY PCMC ALSO HAS ORTHOPEDIC SERVICES, THE CENTER FOR HEALTHY LIVING, AND THE AREA'S ONLY ADULT BEHAVIORAL HEALTH UNIT IN A HOSPITAL SETTING FOR CALENDAR YEAR ENDED DECEMBER 2016 PRESENCE COVENANT MEDICAL CENTER PROVIDED PATIENT CARE OF 28,940 PATIENT DAYS AND HAD 7,038 DISCHARGES EMERGENCY ROOM VISITS TOTALED 24,738, SURGERIES TOTALED 5,490, AND OUTPATIENT REGISTRATIONS TOTALED 133,435 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 PUSMC'S PRIMARY SERVICE AREA CONSISTS OF VERMILION COUNTY, ILLINOIS (NEARLY 82,000 RESIDENTS) COMMUNITIES IN RURAL SOUTHERN IROQUOIS AND NORTHERN EDGAR COUNTIES IN ILLINOIS AND VERMILION, FOUNTAIN AND WARREN COUNTIES IN INDIANA COMPLETE THE 110,000 RESIDENT TOTAL SERVICE AREAS FOR CALENDAR YEAR ENDED DECEMBER 2016 PRESENCE UNITED SAMARITANS MEDICAL CENTER PROVIDED PATIENT CARE OF 16,558 PATIENT DAYS AND HAD 5,055 DISCHARGES EMERGENCY ROOM VISITS TOTALED 39,292, SURGERIES TOTALED 3,399, AND OUTPATIENT REGISTRATIONS TOTALED 178,802

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										(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
(A) Name and Title	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)										
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former					
DAVID BORDO MD DIRECTOR, CMO	1 0 40 0	X							0	398,873	41,577	
SAM BAGCHI MD DIR SYS CH MEDICAL & QUAL OFFC	1 0 41 0	X							0	650,989	150,847	
CAROL CAIRNS DIRECTOR	1 0 1 0	X							0	0	0	
MARSHA LADENBURGER RN DIRECTOR, CHAIR	1 0 2 0	X		X					0	0	0	
PATRICIA FOLTZ DIRECTOR	1 0 0 0	X							0	0	0	
STEVE TALTY MD DIRECTOR	1 0 0 0	X							0	0	0	
ANTHONY FILER TREASURER (TERM 1/2016), CFO	1 0 55 0			X					0	804,167	7,726	
JAMES H KELLEY TREASURER, CFO	1 0 55 0			X					0	439,434	93,832	
JEANNIE C FREY SECRETARY SYS CH LEGL OFFC	1 0 55 0			X					0	573,469	126,323	
JULIE ROKNICH ASST SECRETARY, SYS DIR SR AGC	1 0 54 0			X					0	189,987	29,914	

(A) Name and Title	(B) Average hours per week (list any hours spent on the organization)	(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 (list all sources)	(E) Reportable compensation from other organizations (list all sources)
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(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			
PATRICIA EDDY ASST TREASURER, SYS FIN OFFC	1 0 54 0			X				0	164,402	29,313
PATRICK QUINN ASST TREASURER (TERM 2/17) SVP	1 0 54 0			X				0	270,559	55,888
PAULA J CAMPBELL ASST TREAS (TERM 8/16) SYS FO	1 0 54 0			X				0	293,454	5,179
STEPHEN WALTER TREASURER (TERM 5/2016)	1 0 54 0			X				0	85,675	0
ANN ERRICHETTI PRESIDENT	1 0 42 0			X				0	631,440	27,105
KATHLEEN RHINE REGIONAL PRESIDENT & CEO-SSB	40 0 1 0				X			854,170	0	65,220
JARED C ROGERS REGIONAL PRESIDENT & CEO-CES	40 0 0 0				X			492,286	0	29,040
MICHAEL L BROWN REGIONAL PRESIDENT & CEO-FXV	40 0 0 0				X			483,435	0	96,182
GARY LIPINSKI MD REGIONAL CHIEF MEDICAL OFFSSB	40 0 1 0					X		408,840	0	22,206
SURENDRA M GULATI PHYSICIAN	40 0 0 0					X		553,920	0	28,652

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			
BEEJAL Y AMIN PHYSICIAN	40 0 0 0					X		503,232	0	16,147
KAIZ ASIF PHYSICIAN	40 0 0 0					X		465,324	0	31,805
BHAVIN C SHAH PHYSICIAN	40 0 0 0					X		341,357	0	34,469
AMY D STEVENS FORMER COO	0 0 0 0						X	0	486,782	261
LISA M LAGGER REG CHIEF REL OFFICER	0 0 40 0						X	0	209,925	26,759
SANDRA BRUCE FMR PRES/CEO/EX-OFFC-TRM 12/15	0 0 0 0						X	0	289,815	5,300
CONNIE J NOLTEMAYER Former Regional Quality Leader	0 0 0 0						X	0	142,950	13,971

SCHEDULE A (Form 990 or 990-EZ)	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 2016 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

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 12, 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 agricultural research organization described in **section 170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture See instructions Enter the name, city, and state of the college or university _____
- 10 ☐ 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)
- 11 ☐ An organization organized and operated exclusively to test for public safety See **section 509(a)(4)**.
- 12 ☐ 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 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g
- 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- 10 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, 8, or 9 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						
<div>Calendar year (or fiscal year beginning in) ▶</div>	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant.")						
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						
<div>Calendar year (or fiscal year beginning in) ▶</div>	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(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 2016 (line 6, column (f) divided by line 11, column (f))					14	
15 Public support percentage for 2015 Schedule A, Part II, line 14					15	
16a 33 1/3% support test—2016. 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—2015. 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—2016. 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—2015. 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 10 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

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

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

Section C. Computation of Public Support Percentage

15 Public support percentage for 2016 (line 8, column (f) divided by line 13, column (f))	15	
16 Public support percentage from 2015 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2016 (line 10c, column (f) divided by line 13, column (f))	17	
18 Investment income percentage from 2015 Schedule A, Part III, line 17	18	

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

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

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

	Yes	No
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?		
b A family member of a person described in (a) above?		
c A 35% controlled entity of a person described in (a) or (b) above? <i>If "Yes" to a, b, or c, provide detail in Part VI</i>		
11a		
11b		
11c		

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>		
1		
2		

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>		
1		

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, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?		
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>		
1		
2		
3		

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>		
2a		
2b		
3a		
3b		

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

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

Section A - Adjusted Net Income

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

Section B - Minimum Asset Amount

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

Section C - Distributable Amount

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

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

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

efile GRAPHIC print - DO NOT PROCESS		As Filed Data -		DLN: 93493319176127	
<div>SCHEDULE D (Form 990)</div> <div>Department of the Treasury Internal Revenue Service</div>		<div>Supplemental Financial Statements</div> <div>► 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.</div> <div>Information about Schedule D (Form 990) and its instructions is at www.irs.gov/form990.</div>			<div>OMB No 1545-0047</div> <div>2016</div> <div>Open to Public Inspection</div>
<div>Name of the organization</div> <div>PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK</div>				<div>Employer identification number</div> <div>36-4195126</div>	
<div>Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.</div> <div>Complete if the organization answered "Yes" on Form 990, Part IV, line 6.</div>					
		(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</div> <div><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</div> <div><input type="checkbox"/> No</div>					
<div>Part II Conservation Easements.</div> <div>Complete if the organization answered "Yes" on Form 990, Part IV, line 7.</div>					
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> <div><input type="checkbox"/> Preservation of an historically important land area</div> <div><input type="checkbox"/> Protection of natural habitat</div> <div><input type="checkbox"/> Preservation of a certified historic structure</div> <div><input type="checkbox"/> Preservation of open space</div>					
2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year					
				Held at the End of the Year	
a Total number of conservation easements				2a	
b Total acreage restricted by conservation easements				2b	
c Number of conservation easements on a certified historic structure included in (a)				2c	
d Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register				2d	
3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ►					
4 Number of states where property subject to conservation easement is located ►					
5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?					
<div><input type="checkbox"/> Yes</div> <div><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</div> <div><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					
<div>Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.</div> <div>Complete if the organization answered "Yes" on Form 990, Part IV, line 8.</div>					
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 ► \$					
For Paperwork Reduction Act Notice, see the Instructions for Form 990.					
		Cat No 52283D		Schedule D (Form 990) 2016	

Part III

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

3

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

a

☐ Public exhibition

d

☐ Loan or exchange programs

b

☐ Scholarly research

e

☐ Other

c

☐ Preservation for future generations

4

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

5

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

☐ Yes

☐ No

Part IV

Escrow and Custodial Arrangements.

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

1a

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

☐ Yes

☐ No

b

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

c

Beginning balance

d

Additions during the year

e

Distributions during the year

f

Ending balance

	Amount
1c	
1d	
1e	
1f	

2a

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

☐ Yes

☐ No

b

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

☐

Part V

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

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

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

c Temporarily restricted endowment

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

b

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

	Yes	No
3a(i)	Yes	
3a(ii)	Yes	
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' on Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		22,154,369		22,154,369
b Buildings		683,074,927	380,683,809	302,391,118
c Leasehold improvements		7,817,781	1,210,751	6,607,030
d Equipment		356,381,793	274,763,063	81,618,730
e Other		23,013,960	14,991,816	8,022,144
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c))				420,793,391

Part VII

Investments—Other Securities. Complete if the organization answered 'Yes' on Form 990, Part IV, line 11b.
See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other _____		
(A)		
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Column (b) must equal Form 990, Part X, col (B) line 12) ▶		

Part VIII

Investments—Program Related. Complete if the organization answered 'Yes' on Form 990, Part IV, line 11c.
See Form 990, Part X, line 13.

(a) Description of investment	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. (Column (b) must equal Form 990, Part X, col (B) line 13) ▶		

Part IX

Other Assets. Complete if the organization answered 'Yes' on Form 990, Part IV, line 11d See Form 990, Part X, line 15

(a) Description	(b) Book value
(1) DUE FROM AFFILIATES	67,661,582
(2) THIRD PARTY RECEIVABLES	9,428,056
(3) MANUAL RECEIVABLES	6,331,158
(4) INCENTIVE RECEIVABLES	2,205,735
(5) DEFERRED COMPENSATION ASSET	263,100
(6) LONG TERM RECEIVABLES	117,121
(7) PHYSICIAN LOAN RECEIVABLE LT	45,928
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 15) ▶	86,052,680

Part X

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	0
DUE TO THIRD PARTY PAYORS	101,783,079
OTHER LONG TERM LIABILITIES	1,047,117
CAPITAL ACCUMULATION	263,100
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 25) ▶	103,093,296

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

☒

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

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

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
See Additional Data Table	

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

Additional Data

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

Supplemental Information

Return Reference	Explanation
SCHEDULE D, PART V, LINE 4	intended use of endowment funds TEMPORARILY RESTRICTED FUNDS WERE TRANSFERRED TO PRESENCE HEALTH FOUNDATION BOARD OF TRUSTEES TO BE ADMINISTERED AT THE CORPORATE LEVEL FOR THE FOLL OWING USES SUPPLEMENTAL HOSPITAL INCOME, EDUCATION, TECHNOLOGY, HEALTH AND HUMAN SERVICES FOR THE POOR, SCHOLARSHIPS, AND DIABETES WELLNESS CENTER

Supplemental Information	
Return Reference	Explanation
SCHEDULE D, PART X, LINE 2	FIN 48 (ASC 740) Footnote PRESENCE HEALTH RECOGNIZES THE TAX BENEFIT FROM AN UNCERTAIN TAX POSITION ONLY IF IT IS MORE LIKELY THAN NOT THAT THE TAX POSITION WILL BE SUSTAINED ON EXAMINATION BY THE TAXING AUTHORITIES, BASED ON THE TECHNICAL MERITS OF THE POSITION AS OF DECEMBER 31, 2016 AND 2015, PRESENCE HEALTH DOES NOT HAVE ANY LIABILITIES FOR UNRECOGNIZED TAX BENEFITS

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SCHEDULE H
(Form 990)

Hospitals

OMB No 1545-0047

2016

Open to Public Inspection

Department of the Treasury

Internal Revenue Service

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

Name of the organization

Employer identification number

PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK

36-4195126

Part I

Financial Assistance and Certain Other Community Benefits at Cost

1a

Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a

1a

Yes

1b

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

☒ Applied uniformly to all hospital facilities

☐ Applied uniformly to most hospital facilities

☐ 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 free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care

3a

Yes

☐ 100% ☐ 150% ☒ 200% ☐ Other %

b

Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care

3b

Yes

☐ 200% ☐ 250% ☐ 300% ☐ 350% ☐ 400% ☒ Other 600 %

c

If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care

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

5b

If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?

5b

Yes

5c

If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?

5c

No

6a

Did the organization prepare a community benefit report during the tax year?

6a

Yes

6b

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)			23,544,470		23,544,470	2 240 %
b Medicaid (from Worksheet 3, column a)		109,622	216,145,015	192,267,490	23,877,525	2 270 %
c Costs of other means-tested government programs (from Worksheet 3, column b)			0		0	
d Total Financial Assistance and Means-Tested Government Programs		109,622	239,689,485	192,267,490	47,421,995	4 510 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	84	58,891	2,355,853	186,064	2,169,789	0 210 %
f Health professions education (from Worksheet 5)	16	2,675	6,331,054	645,077	5,685,977	0 540 %
g Subsidized health services (from Worksheet 6)	4	293	3,768,916	2,691,727	1,077,189	0 100 %
h Research (from Worksheet 7)	4	95	696,142		696,142	0 070 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)	28	6,539	362,349	25,239	337,110	0 030 %
j Total. Other Benefits	136	68,493	13,514,314	3,548,107	9,966,207	0 950 %
k Total. Add lines 7d and 7j	136	178,115	253,203,799	195,815,597	57,388,202	5 460 %

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

Cat No 50192T

Schedule H (Form 990) 2016

Part II

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing	1		326,344		326,344	0 %
2 Economic development						
3 Community support	5	6,998	331,939	68,220	263,719	0 010 %
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building	4		1,543	78	1,465	0 %
7 Community health improvement advocacy						
8 Workforce development						
9 Other						
10 Total	10	6,998	659,826	68,298	591,528	0 010 %

Part III

Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

		Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	Yes	
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	2	-18,729,757	
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	403,196,739
6 Enter Medicare allowable costs of care relating to payments on line 5.	6	434,920,944
7 Subtract line 6 from line 5. This is the surplus (or shortfall).	7	-31,724,205
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 checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other		

Section C. Collection Practices

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

Management Companies and Joint Ventures

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

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1 Kankakee Valley DLY	dialysis center	50 %		50 %
2 Dryer Mercy AMB	Ambulatory surgery center	40 %		60 %
3 Ctr Digestive Dis	DIGESTIVE HEALTH SERVICES	10 %		80 %
4 PSJH Ortho Clinical	MGMT of Orthopedic Serv Line	20 %		80 %
5				
6				
7				
8				
9				
10				
11				
12				
13				

Part V Facility Information**Section A. Hospital Facilities**

(list in order of size from largest to smallest—see instructions)

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

6

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

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

Part V Facility Information (continued)**Section B. Facility Policies and Practices**(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)
PRESENCE ST JOSEPH MEDICAL CENTER**Name of hospital facility or letter of facility reporting group** _____**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** _____

1

Community Health Needs Assessment

	Yes	No
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3	Yes
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA 20 <u>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
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	Yes
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>http //presencehealth org/community</u>		
b <input type="checkbox"/> Other website (list url) _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>17</u>	10	Yes
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) <u>http //presencehealth org/community</u>	10b	
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																																																																																								
	<table><tr><td></td><td>Yes</td><td>No</td></tr><tr><td>Did the hospital facility have in place during the tax year a written financial assistance policy that</td><td></td><td></td></tr><tr><td>13 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</td><td>13 Yes</td><td></td></tr><tr><td>a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 % and FPG family income limit for eligibility for discounted care of 600 %</td><td></td><td></td></tr><tr><td>b <input type="checkbox"/> Income level other than FPG (describe in Section C)</td><td></td><td></td></tr><tr><td>c <input type="checkbox"/> Asset level</td><td></td><td></td></tr><tr><td>d <input checked="" type="checkbox"/> Medical indigency</td><td></td><td></td></tr><tr><td>e <input checked="" type="checkbox"/> Insurance status</td><td></td><td></td></tr><tr><td>f <input checked="" type="checkbox"/> Underinsurance discount</td><td></td><td></td></tr><tr><td>g <input checked="" type="checkbox"/> Residency</td><td></td><td></td></tr><tr><td>h <input checked="" type="checkbox"/> Other (describe in Section C)</td><td></td><td></td></tr><tr><td>14 Explained the basis for calculating amounts charged to patients?</td><td>14 Yes</td><td></td></tr><tr><td>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)</td><td>15 Yes</td><td></td></tr><tr><td>a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application</td><td></td><td></td></tr><tr><td>b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application</td><td></td><td></td></tr><tr><td>c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process</td><td></td><td></td></tr><tr><td>d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications</td><td></td><td></td></tr><tr><td>e <input type="checkbox"/> Other (describe in Section C)</td><td></td><td></td></tr><tr><td>16 Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)</td><td>16 Yes</td><td></td></tr><tr><td>a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) See Part V, Section C</td><td></td><td></td></tr><tr><td>b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) See Part V, Section C</td><td></td><td></td></tr><tr><td>c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) See Part V, Section C</td><td></td><td></td></tr><tr><td>d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)</td><td></td><td></td></tr><tr><td>e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)</td><td></td><td></td></tr><tr><td>f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)</td><td></td><td></td></tr><tr><td>g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention</td><td></td><td></td></tr><tr><td>h <input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP</td><td></td><td></td></tr><tr><td>i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations</td><td></td><td></td></tr><tr><td>j <input type="checkbox"/> Other (describe in Section C)</td><td></td><td></td></tr></table>		Yes	No	Did the hospital facility have in place during the tax year a written financial assistance policy that			13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13 Yes		a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 % and FPG family income limit for eligibility for discounted care of 600 %			b <input type="checkbox"/> Income level other than FPG (describe in Section C)			c <input type="checkbox"/> Asset level			d <input checked="" type="checkbox"/> Medical indigency			e <input checked="" type="checkbox"/> Insurance status			f <input checked="" type="checkbox"/> Underinsurance discount			g <input checked="" type="checkbox"/> Residency			h <input checked="" type="checkbox"/> Other (describe in Section C)			14 Explained the basis for calculating amounts charged to patients?	14 Yes		15 Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	15 Yes		a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			d <input 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 Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	16 Yes		a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) See Part V, Section C			b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) See Part V, Section C			c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) See Part V, Section C			d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			h <input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			j <input type="checkbox"/> Other (describe in Section C)		
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j <input type="checkbox"/> Other (describe in Section C)																																																																																								

Part V Facility Information (continued)**Billing and Collections**

PRESENCE ST JOSEPH MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

		Yes	No
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"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C) f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted			
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?	19		No
If "Yes," check all actions in which the hospital facility or a third party engaged			
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <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 checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs b <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications d <input checked="" type="checkbox"/> Made presumptive eligibility determinations 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?	21	Yes	
If "No," indicate why			
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions b <input type="checkbox"/> The hospital facility's policy was not in writing c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) d <input type="checkbox"/> Other (describe in Section C)			

Part V Facility Information *(continued)*

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

PRESENCE ST JOSEPH MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

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** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** ☒ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- c** ☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- d** ☐ The hospital facility used a prospective Medicare or Medicaid method

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

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

	Yes	No
22		
23		No
24		No

Part V Facility Information (continued)**Section B. Facility Policies and Practices**(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)
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****Community Health Needs Assessment**

	Yes	No
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3	Yes
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA <u>20 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
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	Yes
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>http //presencehealth org/community</u>		
b <input type="checkbox"/> Other website (list url) _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 17</u>	10	Yes
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) <u>http //presencehealth org/community</u>	10b	
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
<p>Did the hospital facility have in place during the tax year a written financial assistance policy that</p> <p>13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?</p> <p>If "Yes," indicate the eligibility criteria explained in the FAP</p> <p>a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 % and FPG family income limit for eligibility for discounted care of 600 %</p> <p>b <input type="checkbox"/> Income level other than FPG (describe in Section C)</p> <p>c <input type="checkbox"/> Asset level</p> <p>d <input checked="" type="checkbox"/> Medical indigency</p> <p>e <input checked="" type="checkbox"/> Insurance status</p> <p>f <input checked="" type="checkbox"/> Underinsurance discount</p> <p>g <input checked="" type="checkbox"/> Residency</p> <p>h <input checked="" type="checkbox"/> Other (describe in Section C)</p>	13 Yes	
<p>14 Explained the basis for calculating amounts charged to patients?</p> <p>15 Explained the method for applying for financial assistance?</p> <p>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)</p> <p>a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application</p> <p>b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application</p> <p>c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process</p> <p>d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications</p> <p>e <input type="checkbox"/> Other (describe in Section C)</p>	14 Yes	
<p>16 Was widely publicized within the community served by the hospital facility?</p> <p>If "Yes," indicate how the hospital facility publicized the policy (check all that apply)</p> <p>a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) See Part V, Section C</p> <p>b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) See Part V, Section C</p> <p>c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) See Part V, Section C</p> <p>d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)</p> <p>e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)</p> <p>f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)</p> <p>g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention</p> <p>h <input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP</p> <p>i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations</p> <p>j <input type="checkbox"/> Other (describe in Section C)</p>	15 Yes	
	16 Yes	

Part V Facility Information (continued)**Billing and Collections**

PRESENCE MERCY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

		Yes	No
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"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C) f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted			
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?	19		No
If "Yes," check all actions in which the hospital facility or a third party engaged			
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <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 checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs b <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications d <input checked="" type="checkbox"/> Made presumptive eligibility determinations 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?	21	Yes	
If "No," indicate why			
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions b <input type="checkbox"/> The hospital facility's policy was not in writing c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) d <input type="checkbox"/> Other (describe in Section C)			

Part V Facility Information *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

PRESENCE MERCY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____**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** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** ☒ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- c** ☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- d** ☐ The hospital facility used a prospective Medicare or Medicaid method

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

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

	Yes	No
22		
23		No
24		No

Part V Facility Information (continued)**Section B. Facility Policies and Practices**

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

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****Community Health Needs Assessment**

	Yes	No
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3	Yes
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA <u>20 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
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	Yes
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>http //presencehealth org/community</u>		
b <input type="checkbox"/> Other website (list url) _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 17</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) <u>http //presencehealth org/community</u>	10	Yes
a		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	
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
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13 Yes	
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 % and FPG family income limit for eligibility for discounted care of 600 %			
b <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input checked="" type="checkbox"/> Underinsurance discount			
g <input checked="" type="checkbox"/> Residency			
h <input checked="" type="checkbox"/> Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14 Yes	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	15 Yes	
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d <input 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	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	16 Yes	
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) See Part V, Section C			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) See Part V, Section C			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) See Part V, Section C			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h <input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j <input type="checkbox"/> Other (describe in Section C)			

Part V Facility Information (continued)**Billing and Collections**

PRESENCE ST JOSEPH HOSPITAL

Name of hospital facility or letter of facility reporting group

		Yes	No
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"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C) f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted			
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?	19		No
If "Yes," check all actions in which the hospital facility or a third party engaged			
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <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 checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs b <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications d <input checked="" type="checkbox"/> Made presumptive eligibility determinations 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?	21	Yes	
If "No," indicate why			
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions b <input type="checkbox"/> The hospital facility's policy was not in writing c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) d <input type="checkbox"/> Other (describe in Section C)			

Part V Facility Information *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

PRESENCE ST JOSEPH HOSPITAL

Name of hospital facility or letter of facility reporting group _____**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** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** ☒ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- c** ☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- d** ☐ The hospital facility used a prospective Medicare or Medicaid method

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

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

	Yes	No
22		
23		No
24		No

Part V Facility Information (continued)**Section B. Facility Policies and Practices**(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)
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

Community Health Needs Assessment

	Yes	No
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3	Yes
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA <u>20 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
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	Yes
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>http //presencehealth org/community</u>		
b <input type="checkbox"/> Other website (list url) _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 16</u>	10	Yes
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) <u>http //presencehealth org/community</u>	10b	
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																																																																																								
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If "Yes," indicate the eligibility criteria explained in the FAP</td><td>13 Yes</td><td></td></tr><tr><td>a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 % and FPG family income limit for eligibility for discounted care of 600 %</td><td></td><td></td></tr><tr><td>b <input type="checkbox"/> Income level other than FPG (describe in Section C)</td><td></td><td></td></tr><tr><td>c <input type="checkbox"/> Asset level</td><td></td><td></td></tr><tr><td>d <input checked="" type="checkbox"/> Medical indigency</td><td></td><td></td></tr><tr><td>e <input checked="" type="checkbox"/> Insurance status</td><td></td><td></td></tr><tr><td>f <input checked="" type="checkbox"/> Underinsurance discount</td><td></td><td></td></tr><tr><td>g <input checked="" type="checkbox"/> Residency</td><td></td><td></td></tr><tr><td>h <input checked="" type="checkbox"/> Other (describe in Section C)</td><td></td><td></td></tr><tr><td>14 Explained the basis for calculating amounts charged to patients?</td><td>14 Yes</td><td></td></tr><tr><td>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)</td><td>15 Yes</td><td></td></tr><tr><td>a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application</td><td></td><td></td></tr><tr><td>b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application</td><td></td><td></td></tr><tr><td>c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process</td><td></td><td></td></tr><tr><td>d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications</td><td></td><td></td></tr><tr><td>e <input type="checkbox"/> Other (describe in Section C)</td><td></td><td></td></tr><tr><td>16 Was widely publicized within the community served by the hospital facility? 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If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	15 Yes		a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			d <input 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 Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	16 Yes		a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) See Part V, Section C			b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) See Part V, Section C			c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) See Part V, Section C			d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			h <input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			j <input type="checkbox"/> Other (describe in Section C)		
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Part V Facility Information (continued)**Billing and Collections**

PRESENCE ST MARY'S HOSPITAL

Name of hospital facility or letter of facility reporting group

		Yes	No
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"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C) f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted			
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?	19		No
If "Yes," check all actions in which the hospital facility or a third party engaged			
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <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 checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs b <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications d <input checked="" type="checkbox"/> Made presumptive eligibility determinations 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?	21	Yes	
If "No," indicate why			
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions b <input type="checkbox"/> The hospital facility's policy was not in writing c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) d <input type="checkbox"/> Other (describe in Section C)			

Part V Facility Information *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

PRESENCE ST MARY'S HOSPITAL

Name of hospital facility or letter of facility reporting group _____**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** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** ☒ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- c** ☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- d** ☐ The hospital facility used a prospective Medicare or Medicaid method

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

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

	Yes	No
22		
23		No
24		No

Part V Facility Information (continued)**Section B. Facility Policies and Practices**(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)
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

Community Health Needs Assessment

	Yes	No
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3	Yes
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA <u>20 16</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	Yes
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>http //presencehealth org/community</u>		
b <input type="checkbox"/> Other website (list url) _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 17</u>	10	Yes
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) <u>http //presencehealth org/community</u>	10b	
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 COVENANT MEDICAL CENTER			
Name of hospital facility or letter of facility reporting group			
		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13	Yes
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 % and FPG family income limit for eligibility for discounted care of 600 %			
b <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input checked="" type="checkbox"/> Underinsurance discount			
g <input checked="" type="checkbox"/> Residency			
h <input checked="" type="checkbox"/> Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	15	Yes
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d <input 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	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	16	Yes
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) See Part V, Section C			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) See Part V, Section C			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) See Part V, Section C			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h <input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j <input type="checkbox"/> Other (describe in Section C)			

Part V Facility Information (continued)**Billing and Collections**

PRESENCE COVENANT MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

		Yes	No
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"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C) f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted			
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?	19		No
If "Yes," check all actions in which the hospital facility or a third party engaged			
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <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 checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs b <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications d <input checked="" type="checkbox"/> Made presumptive eligibility determinations 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?	21	Yes	
If "No," indicate why			
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions b <input type="checkbox"/> The hospital facility's policy was not in writing c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) d <input type="checkbox"/> Other (describe in Section C)			

Part V Facility Information *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

PRESENCE COVENANT MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____**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** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** ☒ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- c** ☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- d** ☐ The hospital facility used a prospective Medicare or Medicaid method

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

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

	Yes	No
22		
23		No
24		No

Part V Facility Information (continued)**Section B. Facility Policies and Practices**

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

Community Health Needs Assessment

	Yes	No
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3	Yes
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA <u>20 16</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	Yes
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>http //presencehealth org/community</u>		
b <input type="checkbox"/> Other website (list url) _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 17</u>	10	Yes
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) <u>http //presencehealth org/community</u>		
a		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	
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 UNITED SAMARITANS MED CNTR

Name of hospital facility or letter of facility reporting group _____

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

Part V Facility Information (continued)**Billing and Collections**

PRESENCE UNITED SAMARITANS MED CNTR

Name of hospital facility or letter of facility reporting group

	Yes	No
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"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C) f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
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?	19	No
If "Yes," check all actions in which the hospital facility or a third party engaged		
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <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 checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs b <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications d <input checked="" type="checkbox"/> Made presumptive eligibility determinations 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?	21 Yes	
If "No," indicate why		
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions b <input type="checkbox"/> The hospital facility's policy was not in writing c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) d <input type="checkbox"/> Other (describe in Section C)		

Part V Facility Information *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

PRESENCE UNITED SAMARITANS MED CNTR

Name of hospital facility or letter of facility reporting group _____**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** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** ☒ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- c** ☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- d** ☐ The hospital facility used a prospective Medicare or Medicaid method

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

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

	Yes	No
23		No
24		No

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

[illegible]

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	<p>IN ADDITION TO THE FEDERAL POVERTY GUIDELINES (FPG), WITH FPG FAMILY INCOME LIMIT FOR ELIGIBILITY OF FREE CARE OF 200% AND FPG FAMILY INCOME LIMIT FOR ELIGIBILITY FOR DISCOUNTED CARE OF 600% THE FOLLOWING ELIGIBILITY CRITERIA ARE EXPLAINED IN THE FINANCIAL ASSISTANCE POLICY PRESUMPTIVE ELIGIBILITY CRITERIA ANY PATIENT MEETING ANY OF THE CRITERIA SET FORTH BELOW WILL BE CONSIDERED PRESUMPTIVELY ELIGIBLE FOR FINANCIAL ASSISTANCE WITHOUT FURTHER DOCUMENTATION REQUIREMENTS IN SUCH SITUATIONS, THE PATIENT IS DEEMED TO HAVE A FAMILY INCOME OF 200% OR LESS OF THE FEDERAL POVERTY LEVEL, AND THEREFORE ELIGIBLE FOR A 100% REDUCTION FROM MEDICALLY NECESSARY HOSPITAL CHARGES (IE FULL CHARITY WRITE OFF)</p> <p>PATIENTS WILL RECEIVE A MINIMUM OF ONE (1) STATEMENT TO PROVIDE A SUMMARY OF SERVICES AND ACCOUNT INFORMATION PRESUMPTIVE ELIGIBILITY FOR 100% FINANCIAL ASSISTANCE WILL BE MADE FOR PATIENTS MEETING ANY OF THE FOLLOWING CRITERIA</p> <p>A PATIENT IS HOMELESS (WITH SUCH STATUS VERIFIED AFTER REVIEW OF AVAILABLE FACTS)</p> <p>B PATIENT IS DECEASED WITH NO ESTATE</p> <p>C PATIENT IS MENTALLY OR PHYSICALLY INCAPACITATED AND HAS NO ONE TO ACT ON HIS/HER BEHALF</p> <p>D PATIENT IS CURRENTLY ELIGIBLE FOR MEDICAID, BUT WAS NOT ON A PRIOR DATE OF SERVICE OR FOR NON-COVERED SERVICES</p> <p>E PATIENT IS ENROLLED OR COVERED BY THE WOMEN, INFANTS AND CHILDREN NUTRITION PROGRAM (WIC)</p> <p>F PATIENT IS ENROLLED OR COVERED BY THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) OR FOOD STAMP ELIGIBILITY (LINK)</p> <p>G PATIENT IS ENROLLED OR COVERED BY THE ILLINOIS FREE LUNCH AND BREAKFAST PROGRAM (ELIGIBLE FOR FREE AND REDUCED PRICE SCHOOL MEALS)</p> <p>H PATIENT IS ENROLLED OR COVERED BY THE LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)</p> <p>I PATIENT OR FAMILY IS A QUALIFIED PARTICIPANT IN AN ORGANIZED COMMUNITY-BASED PROGRAM FOR PROVIDING ACCESS TO MEDICAL CARE THAT ACCESSES AND DOCUMENTS LIMITED LOW-INCOME FINANCIAL STATUS CRITERIA</p> <p>J PATIENT RECEIVES OR QUALIFIES FOR FREE CARE FROM A COMMUNITY CLINIC AFFILIATED WITH THE HOSPITAL OR KNOWN TO HAVE ELIGIBILITY STANDARDS SUBSTANTIALLY EQUIVALENT TO THAT OF THE HOSPITAL UNDER THIS POLICY, AND THE COMMUNITY CLINIC REFERS THE PATIENT TO THE HOSPITAL FOR TREATMENT OR FOR A PROCEDURE</p> <p>K PATIENT IS A RECIPIENT OF GRANT ASSISTANCE FOR MEDICAL SERVICES</p> <p>L PATIENT PARTICIPATES IN STATE-FUNDED PRESCRIPTION PROGRAMS</p> <p>M PATIENT OR PATIENTS FAMILY IS ENROLLED IN ILLINOIS HOUSING DEVELOPMENT AUTHORITYS RENTAL HOUSING SUPPORT PROGRAM</p> <p>N PATIENT OR PATIENTS FAMILY HAS BEEN DETERMINED BY AN INDEPENDENT THIRD-PARTY REPORTING AGENCY TO HAVE FAMILY INCOME OF 200% OR LESS THAN THE FEDERAL POVERTY LEVEL</p> <p>O PATIENT OR PATIENTS FAMILYS INABILITY TO PAY ANY PORTION OF PATIENT-LIABILITY AMOUNT HAS BEEN VERIFIED BY AN INDEPENDENT THIRD-PARTY AGENCY</p> <p>APPLICATION OF CATASTROPHIC DISCOUNT THE CATASTROPHIC DISCOUNT WILL BE AVAILABLE TO PATIENTS WHO HAVE MEDICAL EXPENSES OVER A 12-MONTH PERIOD FOR MEDICALLY NECESSARY SERVICES FROM A PRESENCE HEALTH HOSPITAL THAT EXCEED 15% OF THE PATIENTS FAMILYS ANNUAL GROSS INCOME, EVEN AFTER PAYMENT BY THIRD-PARTY PAYERS ANY PATIENT RESPONSIBILITY IN EXCESS OF 15% WILL BE WRITTEN OFF TO CHARITY SERVICES THAT ARE NOT MEDICALLY NECESSARY WILL NOT BE ELIGIBLE FOR THIS DISCOUNT</p> <p>UNINSURED SELF-PAY DISCOUNT 1 THERE IS NO APPLICATION PROCESS FOR THE PATIENT TO RECEIVE THE UNINSURED SELF-PAY DISCOUNT THE DISCOUNT IS APPLIED BASED ON THE ACCOUNTS SELF-PAY/UNINSURED STATUS</p> <p>2 PATIENTS RECEIVING PRE-NEGOTIATED DISCOUNTS (PACKAGE PRICING) FOR HOSPITAL SERVICES WILL NOT BE ELIGIBLE FOR THE UNINSURED SELF-PAY DISCOUNT</p> <p>3 IF A PATIENT IS SUBSEQUENTLY APPROVED FOR FINANCIAL ASSISTANCE, THE UNINSURED SELF-PAY DISCOUNT WILL BE REVERSED SO THAT THE FULL AMOUNT CAN BE RECOGNIZED AS A CHARITY DISCOUNT</p> <p>FINANCIAL ASSISTANCE FOR CERTAIN CRIME VICTIMS INDIVIDUALS WHO ARE DEEMED ELIGIBLE BY THE STATE OF ILLINOIS TO RECEIVE ASSISTANCE UNDER THE VIOLENT CRIME VICTIMS COMPENSATION ACT OR THE SEXUAL ASSAULT VICTIMS COMPENSATION ACT SHALL FIRST BE EVALUATED FOR ELIGIBILITY FOR FINANCIAL ASSISTANCE BASED ON THE FINANCIAL ASSISTANCE GUIDELINES AND THE ELIGIBILITY CRITERIA APPLICATIONS FOR REIMBURSEMENT UNDER SUCH CRIME VICTIMS FUNDS WILL BE MADE ONLY TO THE EXTENT OF ANY REMAINING PATIENT LIABILITY AFTER THE FINANCIAL ASSISTANCE ELIGIBILITY DETERMINATION IS MADE</p> <p>FINANCIAL ASSISTANCE FOR INSURED PATIENTS FINANCIAL ASSISTANCE IN THE FORM OF 100% DISCOUNTS (FREE CARE) ARE AVAILABLE FOR PATIENT-LIABILITY AMOUNTS REMAINING AFTER INSURANCE PAYMENTS, FOR INSURED PATIENTS WHO ARE ILLINOIS RESIDENTS WITH FAMILY GROSS INCOME LESS THAN OR UP TO 200% OF THE FEDERAL POVERTY GUIDELINES FOR INSURED PATIENTS WITH FAMILY GROSS INCOME BETWEEN 200% AND 400% OF THE FEDERAL POVERTY GUIDELINES, THE EXPECTED PATIENT PAYMENT WILL BE THE LESSER OF PATIENTS OUT OF POCKET (OOP) LIABILITY REDUCED BY 100% OF THE HOSPITALS MEDICARE COST-TO-CHARGE RATIO OR THE AMOUNT THE PATIENT WOULD HAVE BEEN RESPONSIBLE FOR HAD THEY BEEN UNINSURED THE AMOUNT OF FINANCIAL</p>

Form and Line Reference	Explanation
PART I, LINE 3C	AL ASSISTANCE WILL BE DETERMINED ONCE ALL THIRD-PARTY PAYMENT AMOUNTS HAVE BEEN IDENTIFIED IN ADDITION, INSURED PATIENTS WITH HIGH HOSPITAL BILLS MAY RECEIVE A CATASTROPHIC DISCOUNT FINANCIAL ASSISTANCE FOR STUDENTS FINANCIAL ASSISTANCE FOR VERIFIED FULL-TIME ENROLLED STUDENTS WITH INCOME OF 200% OR LESS OF THE FEDERAL POVERTY LEVEL WILL BE ELIGIBLE FOR A 100% REDUCTION FROM CHARGES (I E , FULL CHARITY WRITE-OFF)

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 6A	PRESENCE HEALTH NETWORK (EIN 36-1649520), THE PARENT OF PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK, PUBLISHED A COMMUNITY BENEFIT REPORT WITH 2016 DATA, WHICH DETAILS THE COMBINED CHARITABLE IMPACT OUR MINISTRIES HAVE WITHIN THE COMMUNITIES WE SERVE AS WELL AS THE IMPACT OF EACH INDIVIDUAL MINISTRY. EACH MINISTRY CREATES MINISTRY-SPECIFIC IMPLEMENTATION STRATEGIES FOLLOWING THEIR COMMUNITY HEALTH NEEDS ASSESSMENTS WHICH OUTLINE THE GOALS AND OBJECTIVES THEY HAVE ESTABLISHED TO ADDRESS THE PRIORITIZED NEEDS OF THEIR COMMUNITIES.

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Form and Line Reference	Explanation
PART I, LINE 6B	<p>The 2016 Presence Health Community Benefit Report was made publicly available through a variety of ways to share the information with the community at large - Print version of report The report was mailed from the system office and each hospital 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 2016 Community Benefit Report as well as an interactive tool for exploring the community benefit provided by each ministry Through this link, Community Health Needs Assessment (CHNA) documents specific to the hospital can be downloaded, including a community-friendly CHNA document, the source documents of all data reviewed, an overall CHNA Report, and an Implementation Strategy - PowerPoint presentation A standard PowerPoint of the entire 2016 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 2016 prioritized community needs</p>

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Form and Line Reference	Explanation
PART I, LINE 7, COLUMN F	PER 2016 INSTRUCTIONS FOR SCHEDULE H (FORM 990), THE reversal of BAD DEBT EXPENSE OF \$18,729,757 HAS BEEN added back to THE DENOMINATOR IN CALCULATING THE PERCENTAGE OF TOTAL EXPENSE IN LINE 7 Part I, Line 7g costs from physician clinics are not included in subsidized service totals

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Form and Line Reference	Explanation
PART I LINE 7 EXPLANATION OF COSTING METHODOLOGY	<p>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</p> <p>Part I Provider List attached to the FAP During calendar year 2017 certain Presence Health hospitals were audited for Section 501(r) compliance The IRS determined that based on its interpretation of Treasury Regulations Section 1.501(r)-4(b)(1)(iii)(F), the provider list attached to the hospitals FAP should include all providers of medically necessary hospital services, indicating whether or not such providers are not covered by the FAP Presence is making this change to comply with the IRS interpretation</p>

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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.

Form and Line Reference	Explanation
PART III, Section A, Line 2	<p>The bad debt reported on Part III, line 2 agrees with the financial statements account PA RT III, SECTION A, LINE 3 The Provision for Financial Assistance Policy allows for account s in bad debt to be approved for Financial Assistance if the patient meets the criteria I t is possible that there are financial assistance accounts in bad debt, although the exact percentage is unknown as we do not have the appropriate tools to determine this percentag e accurately PART III, SECTION A, LINE 4 FOR TAX RETURN PURPOSES THE BAD DEBT EXPENSE IS SHOWN ON PART IX, STATEMENT OF FUNCTIONAL EXPENSE FOR AUDIT PURPOSES THE ORGANIZATION FOL LOWS ASU 2011-07 PRESENTATION PATIENTS ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FO R UNCOLLECTIBLE ACCOUNTS IN EVALUATING THE COLLECTABILITY OF PATIENTS ACCOUNTS RECEIVABLE , PRESENCE HEALTH ANALYZES ITS PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PA YOR SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS AN D PROVISION FOR UNCOLLECTIBLE ACCOUNTS RECEIVABLE MANAGEMENT REGULARLY REVIEWS DATA ABOUT THESE MAJOR PAYOR SOURCES OF REVENUE IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR U NCOLLECTIBLE ACCOUNTS FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO H AVE THIRD-PARTY COVERAGE, PRESENCE HEALTH ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS AND A PROVISION FOR UNCOLLECTIBLE ACCOUNTS RECEIVA BLE, IF NECESSARY FOR RECEIVABLES ASSOCIATED WITH PATIENT RESPONSIBILITY (WHICH INCLUDES BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND COPAYMENT BALANCES DUE FO R WHICH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL), THE PATIENTS ARE SCREENED AGAIN ST PRESENCE HEALTH CHARITY CARE POLICY AND UNINSURED DISCOUNT POLICY FOR ANY REMAINING PA TIENT RESPONSIBILITY BALANCE, PRESENCE HEALTH RECORDS A PROVISION FOR UNCOLLECTIBLE ACCOUN TS RECEIVABLE IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATE S THAT MANY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH TH EY ARE FINANCIALLY RESPONSIBLE THE DIFFERENCE BETWEEN THE STANDARD RATE (OR DISCOUNTED RA TES IF NEGOTIATED) AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFO RTS HAVE BEEN EXHAUSTED IS CHARGED OFF AGAINST THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS P ART III, SECTION B, LINE 8 PRESENCE HEALTH COMPUTES THE MEDICARE SHORTFALL BASED ON A RATI O OF COST TO CHARGES PRESENCE HEALTH BELIEVES IT IS IMPORTANT FOR THE COMMUNITY AND THE I RS TO BE MADE AWARE OF GOVERNMENT SHORTFALLS, SPECIFICALLY MEDICARE HOWEVER, WE ACKNOWLED GE THAT MEDICARE SHORTFALLS MAY BE EXPERIENCED BY OTHER THAN NON-PROFIT HEALTHCARE ORGANIZ ATIONS AS SUCH, PRESENCE HEALTH DOES NOT BELIEVE THAT MEDICARE SHORTFALL SHOULD BE CONSID ERED COMMUNITY BENEFIT PART III, SECTION C, LINE 9B COLLECTION POLICIES ARE THE SAME FOR ALL PRESENCE HEALTH HOSPITALS 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 ALL LANGUAGES SPOKEN BY AT LEAST 1,000 HOUS Eholds OF LIMITED ENGLISH PROFICIENCY IN THE AREA SERVED BY THE HOSPITAL ENTITY, PER FINAL RULE 501(R) GUIDELINES PATIENTS MAY APPLY FOR FINANCIAL ASSISTANCE AT ANY TIME DURING TH E REVENUE CYCLE PER THE PROVISION FOR FINANCIAL ASSISTANCE POLICY, THE COLLECTION PROCESS IS AS FOLLOWS 1 PRE-LITIGATION REVIEW PRIOR TO AN ACCOUNT BEING AUTHORIZED FOR THE FIL ING OF SUIT FOR NON-PAYMENT OF A PATIENT BILL, A FINAL REVIEW OF THE ACCOUNT WILL BE CONDU CTED AND APPROVED BY THE FINANCIAL COUNSELING REPRESENTATIVE (OR DESIGNEE) TO MAKE SURE TH AT NO APPLICATION OF FINANCIAL ASSISTANCE WAS EVER RECEIVED AND THAT THERE EXISTS OBJECTIV E 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 RE SIDENCE OF A PATIENT WHO HAS BEEN DETERMINED TO BE ELIGIBLE FOR FINANCIAL ASSISTANCE/CHARI TY CARE, FOR PAYMENT OF THE PATIENT'S UNDISCOUNTED BALANCE DUE FURTHER, IN NO CASE WILL A NY 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 HOS PITAL WILL USE BODY ATTACHMENT TO REQUIRE ANY PERSON, WHETHER RECEIVING FINANCIAL ASSISTAN CE/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 PATI ENT 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 DETE RMINE IF THE PATIENT IS ELIGIBLE FOR SUCH A CHARITABLE DISCOUNT IN CASES WHERE A PATIENT HAS BEEN BILLED BUT IS LATER DETERMINED TO QUALIFY</p>

Form and Line Reference	Explanation
PART III, Section A, Line 2	UNDER THE FINANCIAL ASSISTANCE POLICY WITHIN THE APPLICATION PERIOD, THE CHARGE IS REVERSED AND THE APPROPRIATE AMOUNT APPLIED TO CHARITY, AND THE PATIENT IS PROVIDED A REFUND IF THE FINAL PATIENT RESPONSIBILITY IS LESS THAN THE PATIENT ALREADY PAID FOR MORE INFORMATION ABOUT PRESENCE HEALTHS FINANCIAL ASSISTANCE PROGRAM, VISIT HTTP //PRESENCEHEALTH ORG/FI NANCIAL-ASSISTANCE

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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 MINISTRY'S BOARD OF DIRECTORS. THIS PLAN IDENTIFIES THE PRIORITIES AND ACTIONS THAT WILL TAKE PLACE TO TRANSFORM COMMUNITY HEALTH.</p>

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Form and Line Reference	Explanation
PART VI, 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> <p>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 AT EVERY HOSPITAL ARE IN ALL LANGUAGES SPOKEN BY AT LEAST 1,000 HOUSEHOLDS OF LIMITED ENGLISH PROFICIENCY IN ANY PRESENCE HEALTH HOSPITAL SERVICE AREA (18 LANGUAGES)</p> <p>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 PATIENTS ABILITY TO PAY</p> <p>3 FLIERS FLIERS, INFORMATION SHEETS AND SIMILAR FORMS OF WRITTEN COMMUNICATION REGARDING THE HOSPITALS 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</p> <p>4 WEBSITE COMPREHENSIVE INFORMATION ABOUT OUR FINANCIAL ASSISTANCE PROGRAMS INCLUDING ELIGIBILITY CRITERIA, APPLICATION DETAILS, AND CONTACT INFORMATION IS ALSO AVAILABLE ON OUR WEBSITE (HTTP //PRESENCEHEALTH.ORG/FINANCIAL-ASSISTANCE)</p> <p>5 BILLING NOTICES EACH PRESENCE HEALTH HOSPITAL INCLUDES A NOTE ON OR WITH THE HOSPITAL BILL AND/OR STATEMENT REGARDING THE HOSPITALS FINANCIAL ASSISTANCE/CHARITY CARE PROGRAM AND HOW THE PATIENT MAY APPLY FOR CONSIDERATION UNDER THIS PROGRAM</p> <p>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</p> <p>7 NOTIFICATION OF DETERMINATION WHEN A PRESENCE HEALTH HOSPITAL MAKES A DETERMINATION THAT A PATIENTS 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 PATIENTS BILL</p>

Form and Line Reference	Explanation
PART VI, 4 COMMUNITY INFORMATION	<p>PRESENCE HOSPITAL MINISTRIES PROVIDE SERVICES AT 150 SITES, INCLUDING ELEVEN ACUTE CARE HO SPITALS 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 SERVICE S TO AN EXTENDED NETWORK OF PRIMARY AND AMBULATORY CARE PRESENCE HEALTH HOSPITAL MINISTRI ES 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 SH ARE 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 "PRIMA RY SERVICE AREA") OF EACH FACILITY REPRESENTS APPROXIMATELY 65 TO 75% OF SUCH DISCHARGES A ND THE SECONDARY SERVICE AREA (THE "SECONDARY SERVICE AREA") OF EACH FACILITY REPRESENTS A PPROXIMATELY 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 C ODES THAT REPRESENT INPATIENT DISCHARGES THESE ZIP CODES ARE THEN MAPPED TO IDENTIFY GEOG RAPHC COVERAGE OF THE PRIMARY SERVICE AREAS AND SECONDARY SERVICE AREAS MANY OF THE PRES ENCE HEALTH HOSPITAL MINISTRIES FACILITIES ARE LOCATED IN POPULATION GROWTH AREAS BASED U PON POPULATION ESTIMATES AND PROJECTIONS OBTAINED FROM CLARITAS, INC , THE POPULATION OF T HE OUR HOSPITALS COMBINED SERVICE AREA IS EXPECTED TO GROW AT A RATE OF 1 9% ANNUALLY BETW EEN 2012 AND 2017, COMPARED WITH A GROWTH RATE OF 1 3% AND 1 6% PER YEAR IN THE CHICAGO MS A AND IN ILLINOIS, RESPECTIVELY OF PRESENCES 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, RESPECTIVE LY Presence Saint Joseph Medical Center (1) PSJMCs primary service has an estimated popu lation of 677,560 according to the 2010 census In the primary service area, 9 3% of the p opulation 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 cit y is 76 0% White, 11 2% African American, 4 6% Asian, and 7 9% Multi-racial/Other The 201 4 population also estimates that 22 5% are Hispanic or Latino The Presence Saint Joseph M edical 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 Joli et 60434 Joliet 60585 Plainfield 60586 Plainfield 60403 Crest Hill 60404 Shorewood Service Area Secondary Market Zip Code City 60451 New Lenox 60481 Wilmington 60450 Morris 60410 Channahon 60446 Romeoville 60447 Minooka 60416 Coal City 60408 Braidwood 60421 Elwood 6044 1 Lockport 60448 Mokena 60442 Manhattan 60423 Frankfort 60440 Bolingbrook 60424 Gardner 60 439 Lemont 60407 Braceville 60474 South Wilmington 60491 Homer Glen Presence Mercy Medical Center (2) PSMHs primary service has an estimated population of 113,449, according to th e 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, and 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 Momeno 60950 Ma nteno Service Area Secondary Market Zip Code City 60964 Saint Anne 60927 Clifton 60922 Ch ebanse 60940 Grant Park 60970 Watseka 60941 Herscher 60913 Bonfield 60938 Gilman 60911 Ash kum 60955 Onarga 60944 Hopkins Park 60951 Martinton 60930 Danforth 60910 Aroma Park 60912 Beaverville 60919 Cabery 60961 Reddick 60917 Buckingham 60935 Essex 60928 Crescent City 60 481 Wilmington 60468 Peotone 60420 Dwight 60958 Pembroke Township Presence Saint Joseph Ho spital (3) Kane Countys population according to the 2010 census is 515,269 In the primar y 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 rac es 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 60120 El gin 60124 Elgin 60121 Elgin 60110 Carpentersville 60177 South Elgin 60140 Hampshire 60118 Dundee Service Area Secondary Market Zip Code City 60102 Algonquin 60103 Bartlett 60174 S aint Charles 60014 Crystal Lake 60107 Streamwood 60142 Huntley 60098 Woodstock 60050 McHen ry 60051 McHenry 60156 Lake in the Hills 60175 Saint Charles 60136 Gilberts 60134 Geneva 6 0013 Cary 60152 Marengo 60135 Genoa 60109 Burlington 60012 Crystal Lake 60180 Union Presen ce St Mary's Hospital (4) PSMHs primary service</p>

Form and Line Reference	Explanation
PART VI, 4 COMMUNITY INFORMATION	<p>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, and 9.3% Hispanic. The PSMH service area is defined by zip codes below:</p> <p>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 60941 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 60917 Buckingham 60935 Essex 60928 Crescent City 60481 Wilmington 60468 Peotone 60420 Dwight 60958 Pembroke Township Presence Covenant Medical Center (5) 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:</p> <p>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 Be ment Presence United Samaritans Medical Center (6) 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:</p> <p>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 Hoopes 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</p>

Form and Line Reference	Explanation
PART VI, 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 1 ENSURING OUR MEDICAL STAFF IS OPEN TO ALL QUALIFIED PHYSICIANS 2 ALL OF OUR HOSPITALS ARE ACCREDITED AND IN GOOD STANDING WITH THE JOINT COMMISSION ACCREDITATION OF HEALTHCARE ORGANIZATIONS 3 ENSURING OUR BOARD OF DIRECTORS IS DIVERSE AND ABLE TO PROVIDE EXPERTISE, AND MADE UP OF INDEPENDENT MEMBERS OF THE COMMUNITIES WE SERVE OUR BOARD MEMBERS MUST FOLLOW A CONFLICT OF INTEREST POLICY 4 REINVESTING SURPLUS FUNDS INTO THE ORGANIZATION TO IMPROVE PATIENT CARE THROUGH NEW PROGRAMS AND TECHNOLOGY 5 PROVIDING FINANCIAL ASSISTANCE, SLIDING SCALE DISCOUNTS AND HAS COLLECTION PRACTICES THAT ARE IN COMPLIANCE WITH STATE AND FEDERAL GUIDELINES IN ADDITION, WE FOLLOW THE FINANCIAL ASSISTANCE AND CHARITY GUIDELINES OF THE CATHOLIC HEALTH ASSOCIATION 6 PARTICIPATING IN ALL GOVERNMENT SPONSORED HEALTH CARE PROGRAMS, MEDICARE, MEDICAID, CHAMPUS, TRICARE, SCHIP AND OTHERS 7 PROVIDING EMERGENCY ROOM SERVICES IN ALL OF OUR COMMUNITIES AND PROVIDING TRAINING TO LOCAL FIRE DEPARTMENTS AND AMBULANCES OUR EMERGENCY ROOM PARTICIPATES WITH LOCAL POLICE AND FIRE DEPARTMENTS IN DISASTER DRILLS 8 STAFFING BOARD CERTIFIED EMERGENCY ROOM PHYSICIANS IN OUR EMERGENCY ROOM AND URGENT CARE SERVICES WE TREAT PATIENTS ACCORDING TO EMTALA GUIDELINES AND SERVE ALL PATIENTS REGARDLESS OF ABILITY TO PAY IN ADDITION, WE ARE COMMITTED TO DETERMINING THE NEEDS OF OUR COMMUNITIES AND CREATING WAYS TO MEET THOSE NEEDS THE OBLIGATION TO REACH OUT TO THOSE IN NEED AND IMPROVE HEALTH FLOWS DIRECTLY FROM OUR CATHOLIC IDENTITY AND THE HERITAGE OF OUR FOUNDING CONGREGATIONS IN EACH OF THE COMMUNITIES WE SERVE, WE WORK WITH OTHERS INCLUDING CHARITABLE ORGANIZATIONS, COMMUNITY HEALTH PROVIDERS, ELECTED OFFICIALS, BUSINESS LEADERS, SCHOOLS, CHURCHES, AND RESIDENTS TO LOOK AT THE OVERALL HEALTH OF THE COMMUNITY AND IDENTIFY THE GREATEST NEEDS WE THEN MAKE A PLAN AND DEVELOP STRATEGIES TOGETHER WITH OUR COMMUNITIES TO ADDRESS THE HIGHEST PRIORITY HEALTH NEEDS THE HIGHEST PRIORITY NEEDS AND THE PROGRAMS WEVE DEVELOPED TO MEET THESE NEEDS ARE IDENTIFIED BELOW FOR EACH HOSPITAL Additionally, at each of our ministries, we invest in community building activities, or activities to increase community capacity and foster community through physical improvements and leadership All of our ministries have a Community Leadership Board composed of business, faith, healthcare, and nonprofit leaders from the community which is charged with overseeing community health strategy for the ministry Presence Saint Joseph Medical Center (1) PARTNERSHIP WITH THE WILL-GRUNDY MEDICAL CLINIC (WGMC) & AUNT MARTHAS YOUTH SERVICES CENTER/ KNOW WHERE TO GO CAMPAIGN Identified need Primary Health Care PSJMC has budgeted \$35,000 to donate to the Will-Grundy Medical Clinic in 2016 In addition to this donation, PSJMC will continue to provide clinical staff volunteers, and will contribute free services and leadership through service on WGMCs board of directors PSJMC will also continue to accept patients from Will-Grundy Medical Clinic for surgical procedures and related services to provide better access to care, particularly specialty care In December 2012, an Aunt Marthas Federally Qualified Healthcare Center (FQHC) was opened adjacent to our Emergency Department Since its opening, PSJMC has provided rental space to the FQHC for \$1 per year In 2016, we are partnering with these two organizations as well as others serving on the MAPP Collaborative Primary Healthcare action team to develop an educational media campaign called Know Where to Go This county-wide campaign will educate consumers on when to visit the Emergency Department and when to see their primary health care provider It will also re-educate the community on the availability of FQHCs within our county as well as the WGMC Will COUNTY PARTNERS FOR HEALTHY FAMILIES (WCPHF) Identified need Chronic Disease In 2007, PSJMC created the Joliet Partners for Healthy Families coalition to help combat childhood obesity in Will County In 2015, the partnership completed a strategic planning session in which the name was changed to the Will County Partners for Healthy Families (WCPHF) The mission of WCPHF is to enhance the quality of life by improving the health and wellness of the community The vision is healthy kids, healthy families, healthy community through programs, policies and environmental changes in Will County The partner list includes the Greater Joliet Area YMCA, Harvey Brooks Foundation, Joliet Park District, University of Illinois Extension, University of Saint Francis, Will County Health Department and the Will County Regional Office of Education WCPHF has been innovative in its collaboration and approaches to childhood obesity by creating the two community based grants f</p>

Form and Line Reference	Explanation
PART VI, 5 PROMOTION OF COMMUNITY HEALTH	<p>or CATCH Kids Club of Will County and Junior Master Gardener Community Gardens of Will County. These initiatives focus on educating students and families about the importance of balanced nutrition and regular physical activity while incorporating programs and policies to help sustain greater health for future youth. In addition, in 2013 the partnership started a month-long physical activity contest with the purpose of encouraging Will County students to incorporate more physical activity into their daily lives. Similar to reading contests within the schools, the Commit to Be Fit Contest was offered to all Will County students. Students committed to the program by signing up and tracking their daily physical activity. They did this manually on forms distributed by their teachers or online on the Will County Regional Office of Education's website. All participants in the program received a free daily pass to be used at either the Joliet Park District Splash Station Water Park and/or at a Greater Joliet YMCA location. Students who exceeded the recommended 60 minutes of daily physical activity were entered to win raffle prizes.</p> <p>WEWILL WORK HEALTHY AWARD Identified need: Chronic Disease. The WEWILL Work Healthy award program was created by the MAPP Chronic Care Action Team to recognize Will County workplaces that are committed to improving employee health and well-being through six main areas of workplace wellness: 1. Health Promotion/Education, 2. Physical Activity, 3. Mental Health, 4. Environmental Health, 5. Nutrition, 6. Safety.</p> <p>RETHINK YOUR DRINK CAMPAIGN Identified need: Chronic Disease. The MAPP Collaborative Chronic Care action team partnered with the Illinois Alliance to Prevent Obesity (IAP/O) to bring the Rethink Your Drink education and communication campaign to Will County to educate stakeholder organizations and community residents about the harms of sugar-sweetened beverage (SSB) consumption.</p> <p>Mental Health First Aid Identified need: Mental Health. In response to a demonstrated system and state-wide need of addressing barriers to accessing and utilizing mental health services, Presence Health and its community partners implemented an evidence-based program, Mental Health First Aid (MHFA), to reduce the stigma associated with mental illness and improve the coordination of mental health care throughout a six-county service area. A system-wide action team was created to oversee the process, with a administrative, local and behavioral health representatives that earned support from applicable Senior and Executive leadership teams. Community stakeholders partnered in the development of the strategy and its implementation throughout the process, recruiting trainees, identifying resources, and disseminating findings. Program participants increased recognition of mental health disorders, increased understanding of appropriate treatments, improved confidence in providing help to others during crisis situations, and decreased stigmatizing attitudes. Having demonstrated its effectiveness, the program continues to expand and add both participants and partners.</p> <p>Enrollment Strategy Identified need: Access to Care. 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 2015-2016 Open Enrollment period. The model boasts a four-pronged approach: 1. Certified Application Counselors, 2. In-Person Counselor Partnerships, 3. Directional Support and Navigation, and 4. Public Outreach and Education through Enrollment America.</p> <p>Presence Mercy Medical Center (2) A1C Achiever Diabetes Management Program Identified Need: Chronic Disease. A 2-3 month education program that combines diabetes self-management training and medical nutrition therapy concurrent</p>

990 Schedule H, Supplemental Information

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 PRESENCE HEALTH MINISTRIES, A PUBLIC JURIDIC PERSON COMPRISED INITIALLY OF 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 2016, THIS INCLUDED \$161 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>

990 Schedule H, Supplemental Information	
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

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		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
(list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? 6											
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 C. Supplemental Information for Part V, Section B.Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

Form and Line Reference	Explanation
PRESENCE SAINT JOSEPH MEDICAL CENTER (1)	<p>Part V, Section B, Line 3I The hospital CHNAs do not discuss the impact of actions taken t o address significant health needs identified in prior CHNAs Instead, each hospital produ ced an implementation strategy annually over the three-year CHNA cycle discussing actions taken in the prior year and their impact in terms of outputs and outcomes (where possible to determine) These implementation strategies each include a plan for addressing health n eeds based on the success of programs in the prior year, and allow us to adapt strategies during the 3-year cycle and report progress regularly to the community These implementati on strategies are available on our website at www.presencehealth.org/community PART V, SEC TION B, LINE 5 PRESENCE SAINT JOSEPH MEDICAL CENTER (PSJMC) USED THE MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP) PROCESS TO CONDUCT ITS CHNA THIS PROCESS IS A T HOROUGH, COLLABORATIVE PROCESS WHICH INCLUDES FOUR SEPARATE ASSESSMENTS THAT ENGAGE REPRESENTATIVES FROM ALL COMMUNITY SECTORS TO OBTAIN INPUT AND FEEDBACK ON WHAT THE IDENTIFIED N EEDS ARE IN THE COMMUNITY THE ASSESSMENTS ARE LISTED BELOW, INCLUDING THE AGENCIES WHO PR OVIDED INPUT COMMUNITY HEALTH STATUS ASSESSMENT (CHSA) THE CHSA COMMITTEE WAS COMPRISED OF MAPP EXECUTIVE COMMITTEE MEMBERS, DATA AND PLANNING STAFF FROM THE THREE LOCAL HOSPITAL S AND THE HEALTH DEPARTMENTS EPIDEMIOLOGIST THIS TEAM REVIEWED KEY HEALTH INDICATORS AND THE HEALTH DEPARTMENTS EPIDEMIOLOGIST ANALYZED THE DATA GATHERED TO PROVIDE INSIGHT INTO T HE TRENDS AND TOP ISSUES LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT (LPHSA) OVER 100 PUBLIC H EALTH SYSTEM PARTNERS WERE INVITED TO PARTICIPATE IN THE WILL COUNTY PUBLIC HEALTH SYSTEM FORUM HELD IN DECEMBER 2013 AT NEW LIFE CHURCH IN NEW LENOX APPROXIMATELY 70 PARTNERS PAR TICIPATED IN ASSESSING HOW WELL THE WILL COUNTY PUBLIC HEALTH SYSTEM PROVIDES THE TEN ESSENTIAL PUBLIC HEALTH SERVICES (EPHS) IN WILL COUNTY COMMUNITY THEMES AND STRENGTHS ASSESSMENT (CTSA) THREE SEPARATE METHODS OF DATA COLLECTION WERE USED IN CONDUCTING THE CTSA RA NDOM AND TARGETED COMMUNITY SURVEYS AND PHOTOVOICE *RANDOM SURVEY IN A COUNTY-WIDE RANDO M SAMPLE, 5,000 RESIDENTS WERE MAILED A COMMUNITY SURVEY BETWEEN SEPTEMBER AND NOVEMBER 20 13 THE SURVEY WAS 10 PAGES IN LENGTH AND TOOK ABOUT 20 MINUTES TO COMPLETE IT ASKED QUES TIONS ABOUT RESIDENTS PERCEPTIONS ON THE QUALITY OF LIFE IN WILL COUNTY THERE WERE 496 RE SPONDENTS *TARGETED SURVEY AFTER SURVEY RESULTS WERE COLLECTED, THE MAPP EXECUTIVE COMMITTEE REALIZED THAT THE SURVEY RESPONDENTS DID NOT REFLECT THE DEMOGRAPHICS OF WILL COUNTY IN ORDER TO OBTAIN THE PERSPECTIVE OF RESIDENTS UNDERREPRESENTED IN THE RANDOM SURVEY, TA RGETED SURVEYS WERE DISTRIBUTED IN JANUARY 2014 TO GATHER ADDITIONAL INFORMATION FROM VULNERABLE POPULATIONS EIGHTY-THREE PARTICIPANTS GAVE THEIR INPUT ON STRENGTHS AND ASSETS OF THEIR COMMUNITY AND THEIR PERCEPTION ABOUT THE QUALITY OF LIFE IN WILL COUNTY THROUGH THES E TARGETED SURVEYS *PHOTOVOICE</p>

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

Form and Line Reference	Explanation
PRESENCE SAINT JOSEPH MEDICAL CENTER (1)	E THE THIRD METHOD USED FOR DATA COLLECTION PHOTOVOICE IS A TECHNIQUE THAT ENABLES COMMUNITY RESIDENTS OF ALL AGES AND LANGUAGES TO SHARE INFORMATION ABOUT THEIR COMMUNITIES THROUGH PICTURES TWENTY-EIGHT PHOTOS WERE RECEIVED FROM A NUMBER OF RESIDENTS IN WILL COUNTY FORCES OF CHANGE ASSESSMENT (FOCA) THE FOCA WAS COMPLETED IN SEPTEMBER 2013 WITH 41 PARTICIPANTS, CONSISTING OF MAPP EXECUTIVE COMMITTEE MEMBERS AND OTHER COMMUNITY LEADERS FACTORS AND TRENDS MOST IMPACTING WILL COUNTY INCLUDES THE CURRENT ECONOMY WITH RISING UNEMPLOYMENT, LOSS OF SERVICES AND PROGRAMS, AND INCREASED NEED FOR MENTAL HEALTH SERVICES PSJMC ENGAGED THE FOLLOWING AGENCIES AS PART OF ITS CHNA PROCESS ADVENTIST BOLINGBROOK HOSPITAL AMERICAN CANCER SOCIETY AUNT MARTHAS YOUTH SERVICE/CENTER BRIDGES TO A NEW DAY, NFP CATHOLIC CHARITIES CASA OF WILL COUNTY CENTER FOR ECONOMIC DEVELOPMENT (THREE RIVERS EDUCATIONAL PARTNERSHIP TREP) CHESTNUT HEALTH SYSTEMS CHILD CARE RESOURCE AND REFERRAL AGENCY COMMUNITY SERVICE COUNCIL OF WILL COUNTY, INC CRETE MONEE SCHOOL DISTRICT 201 CRISIS LINE OF WILL AND GRUNDY COUNTY EASTER SEALS OF JOLIET REGION, INC EDWARD HOSPITAL GREATER JOLIET AREA YMCA GOVERNORS STATE UNIVERSITY GUARDIAN ANGEL COMMUNITY SERVICES HARVEY BROOKS FOUNDATION HOUSING AUTHORITY OF JOLIET JOLIET JUNIOR COLLEGE JOLIET TOWNSHIP JOLIET TOWNSHIP HIGH SCHOOL/YESS (YOUTH EXPERIENCING SUCCESS IN SCHOOL) LEWIS UNIVERSITY LINDEN OAKS AT EDWARDS HOSPITAL LUTHERAN SOCIAL SERVICES OF ILLINOIS MARIAN VILLAGE MOUNT ZION BAPTIST CHURCH MORNINGSTAR MISSION NATIONAL ASSOCIATION OF MENTAL ILLNESS (NAMI) WILL COUNTY NATIONAL HOOK-UP OF BLACK WOMEN, INC NEW LIFE CHURCH PROVENA HOME CARE PRESENCE HEALTH SYSTEM PRESENCE SAINT JOSEPH MEDICAL CENTER PRESENCE VILLA FRANCISCAN PRESENCE LIFE CONNECTIONS SENIORS SERVICES CENTER OF WILL COUNTY SERVICE INC , CHILD AND FAMILY CONNECTIONS #15 SILVER CROSS HOSPITAL STEPPING STONES, INC THREE RIVERS MANUFACTURES ASSOCIATION TRINITY SERVICES, INC UOFI EXTENSION KANKAKEE, WILL GRUNDY CO UNITED WAY OF WILL COUNTY UNIVERSITY OF ST FRANCIS WARREN-SHARPE COMMUNITY CENTER WILL COUNTY COMMUNITY CONCERNS WILL COUNTY COMMUNITY FOUNDATION WILL COUNTY COMMUNITY HEALTH CENTER WILL COUNTY EMA WILL COUNTY EXECUTIVES OFFICE WILL COUNTY FOREST PRESERVE DISTRICT WILL COUNTY HEALTH DEPARTMENT WILL COUNTY LOCAL AREA NETWORK (LAN) WILL COUNTY LAND USE COMMUNITY DEVELOPMENT WILL COUNTY REGIONAL OFFICE OF EDUCATION WILL COUNTY RESIDENTS WILL GRUNDY CENTER FOR INDEPENDENT LIVING WILL-GRUNDY MEDICAL CLINIC When requested, all input was received from community partners and stakeholders Part V, Section B, Line 6 PSJMC PARTNERED WITH SILVER CROSS HOSPITAL, ADVENTIST BOLINGBROOK HOSPITAL AND EDWARD HOSPITAL TO COMPLETE THEIR CHNA Part V, Section B, Line 7d COPIES OF THE CHNA REPORT WERE MAILED AND/OR E-MAILED TO COMMUNITY PARTNERS WHO PARTICIPATED IN THE CHNA PROCESS PARTNERS WERE ALSO PROVIDED LINKS TO THE WEBSITE FOR DISSEMINATION TO THEIR MAILING LISTS AND RESPEC

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

Form and Line Reference	Explanation
<p>PRESENCE SAINT JOSEPH MEDICAL CENTER (1)</p>	<p>TIVE CONSTITUENTS Part V, Section B, Line 11 AFTER CONSOLIDATING OVERLAPPING ISSUES IDENTIFIED IN THE MAPP CHNA, THE TOP IDENTIFIED NEEDS IN WILL COUNTY ARE *BEHAVIORAL HEALTH *CHRONIC CARE *PRIMARY HEALTH CARE PSJMC WILL CONTINUE TO SERVE ON THE MAPP EXECUTIVE COMMITTEE AND MAPP ACTION TEAMS TO ADDRESS THE IDENTIFIED NEEDS IN WILL COUNTY WITHIN THE NEXT THREE TO FIVE YEARS PLEASE SEE PART VI, LINE 5 FOR THE DESCRIPTION OF PROGRAMS IN PLACE TO ADDRESS THESE IDENTIFIED NEEDS ALONG WITH 2016 OBJECTIVES AND 2016 MEASURABLE OUTCOMES PART VI, LINE 5 ALSO INCLUDES THE SYSTEM-WIDE MENTAL HEALTH AND ENROLLMENT STRATEGIES THAT ARE BEING USED BY EACH HOSPITAL IN THE SYSTEM All significant needs identified in the most recently conducted CHNA are being addressed Part V, Section B, Line 13h PATIENTS WITH INSURANCE WHO FACE OUT-OF-POCKET EXPENSES ARE PRESUMPTIVELY ELIGIBLE FOR FULL WRITE-OFF OF OUT-OF-POCKET EXPENSES WITH AN INCOME UP TO 200% OF THE FPL AND DISCOUNTS ON THEIR OUT-OF-POCKET EXPENSES WITH AN INCOME UP TO 400% OF THE FPL Part V, Section B, Line 14 Federal Poverty Guidelines are also used in determining the basis of calculating amounts charged to patients Part V, Section B, Lines 16a-16c http://presencehealth.org/financial-assistance</p>

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

Form and Line Reference	Explanation
PRESENCE MERCY MEDICAL CENTER (2)	<p>Part V, Section B, Line 3I The hospital CHNAs do not discuss the impact of actions taken t o address significant health needs identified in prior CHNAs. Instead, each hospital produ ced an implementation strategy annually over the three-year CHNA cycle discussing actions taken in the prior year and their impact in terms of outputs and outcomes (where possible to determine). These implementation strategies each include a plan for addressing health n eeds based on the success of programs in the prior year, and allow us to adapt strategies during the 3-year cycle and report progress regularly to the community. These implementati on strategies are available on our website at www.presencehealth.org/community Part V, Sec tion B, Line 5 THE CHNA PROCESS WAS INITIATED BY PRESENCE MERCY MEDICAL CENTER (PMMC) AND PRESENCE SAINT JOSEPH HOSPITAL (PSJH) IN COLLABORATION WITH THE COMMUNITY THEY SERVE, THE KANE COUNTY HEALTH DEPARTMENT, DELNOR HOSPITAL, RUSH-COPLEY MEDICAL CENTER, SHERMAN HOSPIT AL, FOX VALLEY UNITED WAY AND THE UNITED WAY OF ELGIN. ENGAGEMENT OF PUBLIC HEALTH EXPERTI SE THE KANE COUNTY HEALTH DEPARTMENT FACILITATED THE CHNA PROCESS BY USING THE MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP) TOOL. PMMC SERVED AS ONE OF EIGHT PART NERS THAT PARTICIPATED IN THE KANE COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT. THIS PROVIDED THE OPPORTUNITY FOR PMMC TO ACTIVELY PROVIDE EXPERTISE, INPUT, AND FINANCIAL SUPPORT. PAR TNERS ALSO INVOLVED IN THIS PROCESS INCLUDED THE FOUR OTHER HOSPITALS IN KANE COUNTY INCLU DING DELNOR HOSPITAL, PRESENCE SAINT JOSEPH HOSPITAL, RUSH-COPLEY MEDICAL CENTER, SHERMAN HOSPITAL, AS WELL AS FOX VALLEY UNITED WAY AND THE UNITED WAY OF ELGIN. COMMUNITY HEALTH I MPROVEMENT PLAN (CHIP) COMMITTEE TO PROVIDE COMMUNITY LEVEL OVERSIGHT FOR THE PROCESS, A D IVERSE GROUP OF COMMUNITY STAKEHOLDERS AND PMMC REPRESENTATIVES WERE INVITED TO PARTICIPAT E ON THE CHIP STEERING COMMITTEE. TO ENSURE REPRESENTATIVE ENGAGEMENT, PERSONAL INVITATION S WERE SENT TO ORGANIZATIONS REPRESENTING CULTURAL, LINGUISTIC, RACIAL, ETHNIC, AND OTHER MINORITY GROUPS. IN ADDITION, INDIVIDUALS WITH SPECIALIZED QUALIFICATIONS IN DEALING WITH SPECIAL POPULATIONS OR CLINICAL GROUPS WERE SOLICITED FOR THEIR PARTICIPATION. FINALLY, EF FORTS WERE MADE TO INCLUDE INDIVIDUALS ON THE CHIP STEERING COMMITTEE WITH PUBLIC HEALTH E XPERTISE. THOSE WHO COMMITTED TO THE ASSESSMENT AND PLANNING PROCESS BECAME THE EIGHT MEMB ERS OF THE CHNA STEERING COMMITTEE, WHICH CONTINUES TO MEET REGULARLY TO PROVIDE FEEDBACK AND OVERSIGHT, ASSESS PROGRESS, AND MODIFY PLANS AS NEEDED. THE KANE COUNTY CHIP STEERING COMMITTEE MEMBERS ARE LISTED BELOW: *KANE COUNTY HEALTH DEPARTMENT *UNITED WAY OF ELGIN *P RESENCE MERCY MEDICAL CENTER *PRESENCE SAINT JOSEPH HOSPITAL *SHERMAN HOSPITAL *FOX VALLEY UNITED WAY *INC BOARD *CADENCE HEALTH *RUSH-COPLEY MEDICAL CENTER. APPROACH: As part of th e Community Health Needs Assessment, a series of three focus groups was held throughout Ka ne County on November 4 and 5,</p>

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

Form and Line Reference	Explanation
PRESENCE MERCY MEDICAL CENTER (2)	<p>2014, one group each was held in the communities of Aurora, Geneva, and Elgin The focus group participants included a total of 26 key informants, including physicians, other health professionals, social service providers, and other business and community leaders A list of recommended participants for the focus groups was provided by the study sponsors Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as the community overall Participants included several individuals who work with low-income, minority, or other medically underserved populations Focus group candidates were first contacted by letter to request their participation Follow-up phone calls were then made to ascertain whether they would be able to attend Confirmation calls were placed the day before the group was scheduled in order to ensure a reasonable turnout When requested, all of these stakeholders provided input METHODOLOGY To ensure the best representation of the population surveyed, a telephone interview methodology - one that incorporates both landline and cell phone interviews - was employed The primary advantages of telephone interviewing are timeliness, efficiency and random-selection capabilities The sample design used for this effort consisted of a stratified random sample of individuals age 18 and older, this sample yielded 1,084 respondents in Kane County, including 393 in North Kane County, 342 in Central Kane County, and 349 in South Kane County Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent Kane County as a whole All administration of the surveys, data collection, and data analysis was conducted by Professional Research Consultants, Inc (PRC) PART V, SECTION B, LINE 6 PMMC PARTNERED WITH SHERMAN HOSPITAL, CADENCE HEALTH, PRESENCE SAINT JOSEPH HOSPITAL AND RUSH-COPLEY MEDICAL CENTER TO COMPLETE THEIR CHNA We also worked with Kane County Health Department, Fox Valley United Way, and United Way of Elgin Part V, Section B, Line 7d COPIES OF THE CHNA REPORT WERE MAILED AND/OR E-MAILED TO COMMUNITY PARTNERS WHO PARTICIPATED IN THE CHNA PROCESS PARTNERS WERE ALSO PROVIDED LINKS TO THE WEBSITE FOR DISSEMINATION TO THEIR MAILING LISTS AND RESPECTIVE CONSTITUENTS Part V, Section B, Line 11 BASED ON THE CHNA FINDINGS, INTERNAL RESOURCES, AND INTERNAL EXPERTISE THE AREAS OF FOCUS FOR THE 2017 IMPLEMENTATION STRATEGY PLAN THAT PSJH WILL HELP ADDRESS INCLUDE *CHRONIC DISEASE *MENTAL HEALTH *INCOME AND EDUCATION PLEASE SEE PART VI, LINE 5 FOR THE DESCRIPTION OF PROGRAMS IN PLACE TO ADDRESS THESE IDENTIFIED NEEDS PART VI, LINE 5 ALSO INCLUDES THE SYSTEM-WIDE MENTAL HEALTH AND ENROLLMENT STRATEGIES THAT ARE BEING USED BY EACH HOSPITAL IN THE SYSTEM All significant needs identified in the most recently conducted CHNA are being addressed Part V, Section B, Line 13h PATIENTS WITH INSURAN</p>

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

Form and Line Reference	Explanation
PRESENCE MERCY MEDICAL CENTER (2)	CE WHO FACE OUT-OF-POCKET EXPENSES ARE PRESUMPTIVELY ELIGIBLE FOR FULL WRITE-OFF OF OUT-OF-POCKET EXPENSES WITH AN INCOME UP TO 200% OF THE FPL AND DISCOUNTS ON THEIR OUT-OF-POCKET EXPENSES WITH AN INCOME UP TO 400% OF THE FPL Part V, Section B, Line 14 Federal Poverty Guidelines are also used in determining the basis of calculating amounts charged to patie nts Part V, Section B, Lines 16a-16c http //presencehealth org/financial-assistance

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

Form and Line Reference	Explanation
PRESENCE SAINT JOSEPH HOSPITAL (3)	<p>Part V, Section B, Line 3I The hospital CHNAs do not discuss the impact of actions taken t o address significant health needs identified in prior CHNAs Instead, each hospital produ ced an implementation strategy annually over the three-year CHNA cycle discussing actions taken in the prior year and their impact in terms of outputs and outcomes (where possible to determine) These implementation strategies each include a plan for addressing health n eeds based on the success of programs in the prior year, and allow us to adapt strategies during the 3-year cycle and report progress regularly to the community These implementati on strategies are available on our website at www.presencehealth.org/community Part V, Sec tion B, Line 5 THE CHNA PROCESS WAS INITIATED BY PRESENCE SAINT JOSEPH HOSPITAL (PSJH) AND PRESENCE MERCY MEDICAL CENTER (PMMC) IN COLLABORATION WITH THE COMMUNITY THEY SERVE, THE KANE COUNTY HEALTH DEPARTMENT, DELNOR HOSPITAL, RUSH-COPLEY MEDICAL CENTER, SHERMAN HOSPIT AL, FOX VALLEY UNITED WAY AND THE UNITED WAY OF ELGIN ENGAGEMENT OF PUBLIC HEALTH EXPERTI SE THE KANE COUNTY HEALTH DEPARTMENT FACILITATED THE CHNA PROCESS BY USING THE MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP) TOOL PSJH SERVED AS ONE OF EIGHT PART NERS THAT PARTICIPATED IN THE KANE COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT THIS PROVIDED THE OPPORTUNITY FOR PSJH TO ACTIVELY PROVIDE EXPERTISE, INPUT, AND FINANCIAL SUPPORT PAR TNERS ALSO INVOLVED IN THIS PROCESS INCLUDED THE FOUR OTHER HOSPITALS IN KANE COUNTY INCLU DING DELNOR HOSPITAL, PRESENCE MERCY MEDICAL CENTER, RUSH-COPLEY MEDICAL CENTER, SHERMAN H OSPITAL, AS WELL AS FOX VALLEY UNITED WAY AND THE UNITED WAY OF ELGIN COMMUNITY HEALTH IM PROVEMENT PLAN (CHIP) COMMITTEE TO PROVIDE COMMUNITY LEVEL OVERSIGHT FOR THE PROCESS, A D IVERSE GROUP OF COMMUNITY STAKEHOLDERS AND PSJH REPRESENTATIVES WERE INVITED TO PARTICIPAT E ON THE CHIP STEERING COMMITTEE TO ENSURE REPRESENTATIVE ENGAGEMENT, PERSONAL INVITATION S WERE SENT TO ORGANIZATIONS REPRESENTING CULTURAL, LINGUISTIC, RACIAL, ETHNIC, AND OTHER MINORITY GROUPS IN ADDITION, INDIVIDUALS WITH SPECIALIZED QUALIFICATIONS IN DEALING WITH SPECIAL POPULATIONS OR CLINICAL GROUPS WERE SOLICITED FOR THEIR PARTICIPATION FINALLY, EF FORTS WERE MADE TO INCLUDE INDIVIDUALS ON THE CHIP STEERING COMMITTEE WITH PUBLIC HEALTH E XPERTISE THOSE WHO COMMITTED TO THE ASSESSMENT AND PLANNING PROCESS BECAME THE EIGHT MEMB ERS OF THE CHNA STEERING COMMITTEE, WHICH CONTINUES TO MEET REGULARLY TO PROVIDE FEEDBACK AND OVERSIGHT, ASSESS PROGRESS, AND MODIFY PLANS AS NEEDED THE KANE COUNTY CHIP STEERING COMMITTEE MEMBERS ARE LISTED BELOW KANE COUNTY HEALTH DEPARTMENT UNITED WAY OF ELGIN PRES ENCE MERCY MEDICAL CENTER PRESENCE SAINT JOSEPH HOSPITAL SHERMAN HOSPITAL FOX VALLEY UNITE D WAY INC BOARD CADENCE HEALTH RUSH-COPLEY MEDICAL CENTER APPROACH As part of the Communi ty Health Needs Assessment, a series of three focus groups was held throughout Kane County on November 4 and 5, 2014, on</p>

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

Form and Line Reference	Explanation
PRESENCE SAINT JOSEPH HOSPITAL (3)	<p>e group each was held in the communities of Aurora, Geneva, and Elgin The focus group par ticipants included a total of 26 key informants, including physicians, other health profes sionals, social service providers, and other business and community leaders A list of rec ommended participants for the focus groups was provided by the study sponsors Potential p articipants were chosen because of their ability to identify primary concerns of the popul ations with whom they work, as well as the community overall Participants included severa l individuals who work with low-income, minority, or other medically underserved populatio ns Focus group candidates were first contacted by letter to request their participation Follow-up phone calls were then made to ascertain whether they would be able to attend Co nfirmation calls were placed the day before the group was scheduled in order to ensure a r easonable turnout When requested, all of these stakeholders provided input</p> <p>METHODOLOGY To ensure the best representation of the population surveyed, a telephone interview method ology - one that incorporates both landline and cell phone interviews - was employed The primary advantages of telephone interviewing are timeliness, efficiency and random-selecti on capabilities The sample design used for this effort consisted of a stratified random s ample of individuals age 18 and older, this sample yielded 1,084 respondents in Kane Count y, including 393 in North Kane County, 342 in Central Kane County, and 349 in South Kane C ounty Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent Kane County as a whole All admi nistration of the surveys, data collection, and data analysis was conducted by Professiona l Research Consultants, Inc (PRC) Part V, Section B, Line 6 PSJH PARTNERED WITH SHERMAN HOSPITAL, PRESENCE MERCY MEDICAL CENTER, CADENCE HEALTH AND RUSH-COPLEY MEDICAL CENTER TO COMPLETE THEIR CHNA We also worked with Kane County Health Department, Fox Valley United Way, and United Way of Elgin Part V, Section B, Line 7d COPIES OF THE CHNA REPORT WERE MA ILED AND/OR E-MAILED TO COMMUNITY PARTNERS WHO PARTICIPATED IN THE CHNA PROCESS PARTNERS WERE ALSO PROVIDED LINKS TO THE WEBSITE FOR DISSEMINATION TO THEIR MAILING LISTS AND RESPE CTIVE CONSTITUENTS Part V, Section B, Line 11 BASED ON THE CHNA FINDINGS, INTERNAL RESOUR CES, AND INTERNAL EXPERTISE THE AREAS OF FOCUS FOR THE 2015 IMPLEMENTATION STRATEGY PLAN T HAT PSJH WILL HELP ADDRESS INCLUDE *CHRONIC DISEASE *Mental Health *INCOME AND EDUCATION PLEASE SEE PART VI, LINE 5 FOR THE DESCRIPTION OF PROGRAMS IN PLACE TO ADDRESS THESE IDENT IFIED NEEDS PART VI, LINE 5 ALSO INCLUDES THE SYSTEM-WIDE MENTAL HEALTH AND ENROLLMENT ST RATEGIES THAT ARE BEING USED BY EACH HOSPITAL IN THE SYSTEM All significant needs identif ied in the most recently conducted CHNA are being addressed Part V, Section B, Line 13h P ATIENTS WITH INSURANCE WHO FAC</p>

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

Form and Line Reference	Explanation
PRESENCE SAINT JOSEPH HOSPITAL (3)	E OUT-OF-POCKET EXPENSES ARE PRESUMPTIVELY ELIGIBLE FOR FULL WRITE-OFF OF OUT-OF-POCKET EXPENSES WITH AN INCOME UP TO 200% OF THE FPL AND DISCOUNTS ON THEIR OUT-OF-POCKET EXPENSES WITH AN INCOME UP TO 400% OF THE FPL Part V, Section B, Line 14 Federal Poverty Guidelines are also used in determining the basis of calculating amounts charged to patients Part V, Section B, Lines 16a-16c http //presencehealth org/financial-assistance

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

Form and Line Reference	Explanation
PRESENCE ST MARY'S HOSPITAL (4)	<p>Part V, Section B, Line 3I The hospital CHNAs do not discuss the impact of actions taken t o address significant health needs identified in prior CHNAs Instead, each hospital produ ced an implementation strategy annually over the three-year CHNA cycle discussing actions taken in the prior year and their impact in terms of outputs and outcomes (where possible to determine) These implementation strategies each include a plan for addressing health n eeds based on the success of programs in the prior year, and allow us to adapt strategies during the 3-year cycle and report progress regularly to the community These implementati on strategies are available on our website at www.presencehealth.org/community Part V, Sec tion B, Line 5 DURING 2015, A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) WAS FACILITATED BY PRESENCE ST MARYS HOSPITAL (PSMH), RIVERSIDE MEDICAL CENTER AND KANKAKEE COUNTY HEALTH DE PARTMENT THIS REPORT SUMMARIZES THE HEALTH PROFILE AND COMMUNITY INPUT FINDINGS OF THE CH NA CONDUCTED FOR THE POPULATION SERVED BY PSMH AND IDENTIFIES THE TOP PRIORITY HEALTH ISSU ES FOR THE COMMUNITY TO FOCUS ON IN DEVELOPING ITS IMPLEMENTATION STRATEGIES ENGAGEMENT O F PUBLIC HEALTH EXPERTISE THE KANKAKEE COUNTY HEALTH DEPARTMENT AND PSMH CO-FACILITATED TH E CHNA PROCESS BY USING THE MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP) TOOL THE PARTNERSHIP FOR A HEALTHY COMMUNITY FORMALLY ENGAGED THE ILLINOIS PUBLIC HEALTH INSTITUTE (IPHI) FOR ASSISTANCE IN PLANNING AND EXECUTING THE CHNA PROCESS IPHI SERVED A S AN EXPERT PUBLIC HEALTH CONSULTANT THROUGHOUT THE CHNA TIMELINE CHNA STEERING COMMITTEE TO PROVIDE COMMUNITY LEVEL OVERSIGHT FOR THE PROCESS, A DIVERSE GROUP OF COMMUNITY STAKEH OLDERS AND PSMH REPRESENTATIVES WERE INVITED TO PARTICIPATE ON THE CHNA STEERING COMMITTEE TO ENSURE REPRESENTATIVE ENGAGEMENT, PERSONAL INVITATIONS WERE SENT TO ORGANIZATIONS REP RESENTING CULTURAL, LINGUISTIC, RACIAL, ETHNIC, AND OTHER MINORITY GROUPS IN ADDITION, IN DIVIDUALS WITH SPECIALIZED QUALIFICATIONS IN DEALING WITH SPECIAL POPULATIONS OR CLINICAL GROUPS WERE SOLICITED FOR THEIR PARTICIPATION FINALLY, EFFORTS WERE MADE TO INCLUDE INDIV IDUALS ON THE CHNA STEERING COMMITTEE WITH PUBLIC HEALTH EXPERTISE THOSE WHO COMMITTED TO THE ASSESSMENT AND PLANNING PROCESS BECAME THE 11 MEMBERS OF THE CHNA STEERING COMMITTEE, WHICH CONTINUES TO MEET REGULARLY TO PROVIDE FEEDBACK AND OVERSIGHT, ASSESS PROGRESS, AND MODIFY PLANS AS NEEDED THE AGENCIES REPRESENTED ON THE CHNA STEERING COMMITTEE ARE LISTE D BELOW KANKAKEE COMMUNITY COLLEGE UNITED WAY OF KANKAKEE COUNTY PRESENCE ST MARYS HOSPI TAL I KAN REGIONAL OFFICE OF EDUCATION & NAACP RIVERSIDE MEDICAL CENTER NEW LIFE PENTECOST AL CHURCH & HISPANIC PARTNERSHIP PRESENCE HOME HEALTH CARE THE HELEN WHEELER CENTER FOR CO MMUNITY MENTAL HEALTH RIVERSIDE MEDICAL CENTER KANKAKEE COUNTY HEALTH DEPARTMENT PROCESS U SED TO IDENTIFY COMMUNITY NEEDS EVERY FIVE YEARS, LOCAL HEALTH DEPARTMENTS IN ILLINOIS MUS T COMPLETE A COMMUNITY HEALTH</p>

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

Form and Line Reference	Explanation
PRESENCE ST MARY'S HOSPITAL (4)	<p>NEEDS ASSESSMENT (CHNA) AND HEALTH PLAN AS A REQUIREMENT FOR RECERTIFICATION WITH THE ILLI NOIS DEPARTMENT OF PUBLIC HEALTH (IDPH) THIS PROCESS IS KNOWN AS ILLINOIS PROJECT FOR LOC AL ASSESSMENT OF NEED, (IPLAN) HOSPITALS ARE REQUIRED BY THE IRS TO COMPLETE A CHNA EVERY THREE YEARS FOR THE 2015 ASSESSMENT AND PLANNING PROCESS, THE PARTNERSHIP FOR A HEALTHY COMMUNITY USED THE MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP) PROCESS AS AN EQUIVALENT FOR IPLAN THE KANKAKEE COUNTY HEALTH DEPARTMENT AND PSMH PARTNERED TO FA CILITATE THE MAPP PROCESS IN 2012 AND AGAIN IN 2015 FROM JUNE 2014 THROUGH JULY 2015 FOUR SEPARATE ASSESSMENTS WERE CONDUCTED MAPP IS A PROCESS THAT PROVIDES A COMPREHENSIVE FRAM EWORK FOR ASSESSING COMMUNITY NEEDS, AND DEVELOPING AND ADDRESSING STRATEGIC ISSUES THE P URPOSE OF THE KANKAKEE COUNTY MAPP PROCESS IS TO PROVIDE A COMMUNITY PLAN THAT IS DEVELOPE D BY AND FOR THE COMMUNITY THE BENEFITS OF KANKAKEE COUNTY ENGAGING IN THIS PROCESS INCLU DE</p> <ul style="list-style-type: none"> *A HEALTHIER COMMUNITY THAT IMPROVES THE QUALITY OF LIFE FOR THE PEOPLE WHO LIVE AND W ORK IN IT *INCREASED VISIBILITY OF PUBLIC HEALTH IN THE COMMUNITY *INCREASED AWARENESS A ND KNOWLEDGE ABOUT PUBLIC HEALTH ISSUES *PREPARATION OF OUR LOCAL PUBLIC HEALTH SYSTEM TO BETTER ANTICIPATE, MANAGE AND RESPOND TO CHANGES IN THE COUNTY *GREATER COLLABORATION AN D SHARING OF RESOURCES AMONG PARTNERS *REFLECTION OF PRIORITIES IN HOSPITAL IMPLEMENTATIO N STRATEGIES <p>MAPP HAS SIX PHASES THE FIRST FIVE PHASES WERE COMPLETED OVER TWENTY-TWO MO NTHS PHASE SIX, THE ACTION CYCLE, IS AN ONGOING PROCESS OF PLANNING, IMPLEMENTING AND EVA LUATING KANKAKEE COUNTY IS CURRENTLY IN PHASE SIX OF THE PROCESS When requested, all Inp ut was received from community partners and stakeholders Part V, Section B, Line 6 PSMH P ARTNERED WITH RIVERSIDE MEDICAL CENTER TO COMPLETE THEIR CHNA We also worked with the Kan kakee County Health Department Part V, Section B, Line 7d COPIES OF THE CHNA REPORT WERE MAILED AND/OR E-MAILED TO COMMUNITY PARTNERS WHO PARTICIPATED IN THE CHNA PROCESS PARTNER S WERE ALSO PROVIDED LINKS TO THE WEBSITE FOR DISSEMINATION TO THEIR MAILING LISTS AND RES PECTIVE CONSTITUENTS Part V, Section B, Line 11 AFTER CONSOLIDATING OVERLAPPING ISSUES ID ENTIFIED IN THE MAPP CHNA, THE TOP IDENTIFIED NEEDS IN KANKAKEE COUNTY ARE</p> <ul style="list-style-type: none"> *TEEN PREGNANC Y & INFANT MORTALITY *ACCESS TO CARE *CHRONIC DISEASE *MENTAL HEALTH & SUBSTANCE ABUSE *VI OLENCE & SAFETY *EDUCATION PLEASE SEE PART VI, LINE 5 FOR THE DESCRIPTION OF PROGRAMS IN P LACE TO ADDRESS THESE IDENTIFIED NEEDS ALONG WITH 2016 OBJECTIVES AND 2016 MEASURABLE OUTC OMES <p>PART VI, LINE 5 ALSO INCLUDES THE SYSTEM-WIDE MENTAL HEALTH AND ENROLLMENT STRATEGIE S THAT ARE BEING USED BY EACH HOSPITAL IN THE SYSTEM To be able to direct sufficient reso urces to address the prioritized needs, our overall focus was on</p> <ul style="list-style-type: none"> *ACCESS TO CARE *CHRONIC DISEASE *MENTAL HEALTH & SUBSTANCE ABUSE <p>We are working in partnership with others on the MAPP Executive Committee and</p>

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

Form and Line Reference	Explanation
PRESENCE ST MARY'S HOSPITAL (4)	<p>MAPP Action Teams to address the prioritized needs that are not part of our focus in the P SMH Service Area This decision was made due to shortages in manpower and resources and a concern for concentrating sufficiently on the most important needs in our community Part V, Section B, Line 13h</p> <p>PATIENTS WITH INSURANCE WHO FACE OUT-OF-POCKET EXPENSES ARE PRESUMPTIVELY ELIGIBLE FOR FULL WRITE-OFF OF OUT-OF-POCKET EXPENSES WITH AN INCOME UP TO 200% OF THE FPL AND DISCOUNTS ON THEIR OUT-OF-POCKET EXPENSES WITH AN INCOME UP TO 400% OF THE FPL Part V, Section B, Line 14 Federal Poverty Guidelines are also used in determining the basis of calculating amounts charged to patients Part V, Section B, Lines 16a-16c http //p resencehealth org/financial-assistance</p>

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

Form and Line Reference	Explanation
<p>PRESENCE COVENANT MEDICAL CENTER (5)</p>	<p>Part V, Section B, Line 3I The hospital CHNAs do not discuss the impact of actions taken t o address significant health needs identified in prior CHNAs Instead, each hospital produ ced an implementation strategy annually over the three-year CHNA cycle discussing actions taken in the prior year and their impact in terms of outputs and outcomes (where possible to determine) These implementation strategies each include a plan for addressing health n eeds based on the success of programs in the prior year, and allow us to adapt strategies during the 3-year cycle and report progress regularly to the community These implementati on strategies are available on our website at www.presencehealth.org/community Part V, Sec tion B, Line 5 THE 2014-2016 CHAMPAIGN COUNTY ILLINOIS PLANNING FOR LOCAL ASSESSMENT OF NE EDS (IPLAN) WAS ACCOMPLISHED WITH DIRECT CONTRIBUTION FROM OVER 60 INDIVIDUALS REPRESENTIN G MORE THAN 30 DIFFERENT AGENCIES FROM ACROSS THE COUNTY When requested, all input was re ceived from community stakeholders It ALSO INCORPORATED THE VOICE OF MORE THAN 1,000 COMM UNITY RESIDENTS THROUGH SURVEYS, FOCUS GROUPS AND COMMUNITY MEETINGS throughout fall 2013 - spring 2014 ENGAGEMENT OF PUBLIC HEALTH EXPERTISE PCMC WAS A PARTICIPANT AND HELPED FAC ILITATE SOME ASPECTS OF THE 2014-2016 CHAMPAIGN COUNTY IPLAN THE CHAMPAIGN URBANA PUBLIC HEALTH DEPARTMENT (CUPHD) CHOSE TO UTILIZE THE MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIP (MAPP) MODEL TO HELP ACQUIRE INPUT FROM COMMUNITY PARTNERS, PLANNERS, ELECTED OFFICIALS AND RESIDENTS OF THE COMMUNITY THIS MAPP PROCESS ASSESSED THE CURRENT HEALTH ST ATUS OF THE COMMUNITY, IDENTIFIED THE NEEDS, AND CREATED A COMPREHENSIVE PLAN TO MAKE THE COMMUNITY HEALTHIER FOUR ASSESSMENTS WERE CONDUCTED AS DETAILED BELOW *COMMUNITY HEALTH STATUS ASSESSMENT (CHSA) EVALUATED THE BASIC DEMOGRAPHICS AND HEALTH-RELATED STATISTICS O F RESIDENTS IN CHAMPAIGN COUNTY WE USED AGGREGATED DATA ACCESSED FROM COUNTYHEALTHRANKING S ORG AND CITY AND COUNTY AGENCIES INCLUDING THE CHAMPAIGN AND URBANA POLICE DEPARTMENTS *COMMUNITY THEMES AND STRENGTHS ASSESSMENT (CTSA) WE SURVEYED 975 COMMUNITY RESIDENTS AND HELD FOCUS GROUPS WITH 32 RESIDENTS REPRESENTING DIFFERENT COMMUNITY GROUPS (UNDERGRADUAT E AND GRADUATE STUDENTS, INTERNATIONAL STUDENT FAMILY HOUSING RESIDENTS, AND HOMELESS RESI DENTS) TO GET A MORE IN-DEPTH PICTURE OF STRENGTHS AND WEAKNESSES *LOCAL PUBLIC HEALTH SY STEM ASSESSMENT (LPHSA) INCLUDED ALMOST 60 COMMUNITY LEADERS FROM OVER 30 DIFFERENT AGENC IES, INCLUDING LOCAL GOVERNMENT, COMMUNITY PLANNERS, PUBLIC HEALTH PROFESSIONALS, CLINICIA NS, POLICE AND FIRE, EMERGENCY PREPAREDNESS, AND THE UNIVERSITY OF ILLINOIS THIS MEASURED HOW THE LOCAL PUBLIC HEALTH SYSTEM IS ADDRESSING THE 10 ESSENTIAL PUBLIC HEALTH SERVICES *FORCES OF CHANGE ASSESSMENT IDENTIFIED THE AFFORDABLE CARE ACT (ACA) AS A FORCE IMPACTI NG MANY SECTORS, MEETING THE NEEDS OF INCREASING POPULATIONS OF UNDOCUMENTED IMMIGRANTS, A DDRESSING WIDENING HEALTH DISP</p>

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

Form and Line Reference	Explanation
PRESENCE COVENANT MEDICAL CENTER (5)	ARITIES AND THE LACK OF ECONOMIC OPPORTUNITIES, AND THE INCREASED USE OF TECHNOLOGY IN HEA LTHCARE (E G TELEMEDICINE AND ELECTRONIC MEDICAL RECORDS) AND USING SOCIAL MEDIA AND TECH NOLOGY TO PROMOTE GENERAL HEALTH WERE IDENTIFIED AS MAJOR FORCES OF CHANGE IPLAN COMMUNIT Y ADVISORY COMMITTEE TO PROVIDE COMMUNITY LEVEL OVERSIGHT FOR THE PROCESS, A DIVERSE GROUP OF COMMUNITY STAKEHOLDERS AND PCMC REPRESENTATIVES WERE INVITED TO PARTICIPATE ON THE IPL AN COMMUNITY ADVISORY COMMITTEE TO ENSURE REPRESENTATIVE ENGAGEMENT, PERSONAL INVITATIONS WERE SENT TO ORGANIZATIONS REPRESENTING CULTURAL, LINGUISTIC, RACIAL, ETHNIC, AND OTHER M INORITY GROUPS IN ADDITION, INDIVIDUALS WITH SPECIALIZED QUALIFICATIONS IN DEALING WITH S PECIAL POPULATIONS OR CLINICAL GROUPS WERE SOLICITED FOR THEIR PARTICIPATION FINALLY, EFF ORTS WERE MADE TO INCLUDE INDIVIDUALS ON THE IPLAN COMMUNITY ADVISORY COMMITTEE WITH PUBLI C HEALTH EXPERTISE THOSE WHO COMMITTED TO THE ASSESSMENT AND PLANNING PROCESS BECAME THE 65 MEMBERS TO INCLUDE THE CUPHD STAFF OF THE IPLAN COMMUNITY ADVISORY COMMITTEE AGENCIES REPRESENTED ON THIS COMMITTEE ARE LISTED BELOW AVICENNA COMMUNITY HEALTH CENTER CARLE FOU NDTION HOSPITAL CHAMPAIGN COUNTY ADMINISTRATOR CHAMPAIGN COUNTY BOARD CHAIR CHAMPAIGN COU NTY CHAMBER OF COMMERCE CHAMPAIGN COUNTY CORONER CHAMPAIGN COUNTY HEALTHCARE CONSUMERS CHA MPAIGN COUNTY REGIONAL PLANNING COMMISSION CHAMPAIGN FIRE DEPARTMENT CHAMPAIGN PARK DISTRI CT CHAMPAIGN POLICE DEPARTMENT CHAMPAIGN UNIT 4 SCHOOL DISTRICT CHAMPAIGN URBANA PUBLIC HE ALTH DISTRICT CHRISTIE CLINIC CITY OF CHAMPAIGN FIRE DEPARTMENT CITY OF URBANA COMMUNITY D EVELOPMENT SERVICES CITY OR URBANA COMMUNITY ELEMENTS CU MASS TRANSIT DISTRICT CUPHD-INFEC TIOUS DISEASE HOUSING AUTHORITY OF CHAMPAIGN COUNTY LAND OF LINCOLN MCKINLEY HEALTH CENTER NATIONAL ALLIANCE ON MENTAL ILLNESS PARKLAND COLLEGE PRESENCE COVENANT CENTER FOR HEALTHY LIVING PRESENCE COVENANT MEDICAL CENTER PROMISE HEALTHCARE PROSPERITY GARDENS INC SOIL A ND WATER CONSERVATION DISTRICT UNITED WAY OF CHAMPAIGN COUNTY UNIVERSITY OF ILLINOIS UNIVE RSITY OF ILLINOIS NCSA UNIVERSITY OF ILLINOIS POLICE UNIVERSITY OF ILLINOIS-CPRD URBANA MA RKET AT THE SQUARE URBANA PARK DISTRICT URBANA SCHOOL DISTRICT 116 Part V, Section B, Line 6 PCMC PARTNERED WITH CARLE FOUNDATION HOSPITAL TO COMPLETE THEIR CHNA We also worked wi th Champaign-Urbana Public Health District, United Way of Champaign County, and the Champa ign County Regional Planning Commission Part V, Section B, Line 7d COPIES OF THE CHNA REP ORT WERE MAILED AND/OR E-MAILED TO COMMUNITY PARTNERS WHO PARTICIPATED IN THE CHNA PROCESS PARTNERS WERE ALSO PROVIDED LINKS TO THE WEBSITE FOR DISSEMINATION TO THEIR MAILING LIST S AND RESPECTIVE CONSTITUENTS Part V, Section B, Line 11 RESULTS OF THE 2014-2017 COMMUNI TY HEALTH NEEDS ASSESSMENT BASED ON THE FOUR MAPP ASSESSMENTS, COMMUNITY LEADERS CONVENED TO IDENTIFY PRIORITIES AFTER IDENTIFYING OVER 30 HEALTH CONCERNS, PARTICIPANTS VOTED TO N ARROW DOWN THE LIST TO FOUR PR

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

Form and Line Reference	Explanation
PRESENCE COVENANT MEDICAL CENTER (5)	<p> IORITIES TO ADDRESS IN 2014-2017 BASED ON THE CDCS MODEL, SMART OBJECTIVES WERE USED TO I DENTIFY GOALS AND OBJECTIVES WITHIN EACH PRIORITY THAT WERE FEASIBLE, ACTIONABLE, AND COUL D BE IMPLEMENTED IN THE UPCOMING YEARS WORKGROUPS THEN FORMED AND MET SEPARATELY TO ADDRE SS EACH OF THE FOUR PRIORITIES, AND FORMULATE GOALS AND ACTION PLANS TO ADDRESS THEM All significant needs identified in the most recently conducted CHNA are being addressed *ACC ESS TO CARE (MEDICAL, MENTAL AND DENTAL HEALTH) RESOURCE MAPPING AND FORMING A COMMUNITY RESOURCE CENTER, INCREASING MEDICAID ENROLLMENT FOR ELIGIBLE PATIENTS, INCREASING CAPACITY , AND INCREASING COMMUNICATION AND COLLABORATION GOAL CHAMPAIGN COUNTY WILL DEVELOP OPPO RTUNITIES TO IMPROVE ACCESS TO AND AFFORDABILITY OF MEDICAL, BEHAVIORAL HEALTH (MENTAL HEA LTH AND/OR SUBSTANCE USE), AND DENTAL SERVICES FOR THOSE LIVING BELOW 200% OF THE FEDERAL POVERTY LEVEL *BEHAVIORAL HEALTH RESOURCE CENTER, PROMOTING EDUCATION AND TRAINING ON ME NTAL AND BEHAVIORAL HEALTH FOR TEACHERS AND OFFICERS GOAL CHAMPAIGN COUNTY WILL IMPROVE BEHAVIORAL HEALTH AND WELLNESS BY INCREASING CAPACITY AND ACCESS TO CARE, PROVIDING EDUCAT IONAL OPPORTUNITIES, INCREASING PREVENTION ACTIVITIES AND ADVOCATING THAT TREATMENT WORKS AND RECOVERY IS POSSIBLE *VIOLENCE (DOMESTIC VIOLENCE, RELATIONSHIP BETWEEN DRUG & ALCOHO L ABUSE AND VIOLENCE) IMPROVING MENTAL HEALTH SERVICES, LINKING PAROLEES AND THOSE INCARC ERATED TO RESOURCES INCLUDING HOUSING, JOBS, HEALTHCARE, COUNSELING, AND TAKING MEDICATION , DEVELOPING AND MAINTAINING SPECIALTY COURTS GOAL PREVENT VIOLENCE IN CHAMPAIGN COUNTY BY PROVIDING LINKAGES TO SERVICES AND ACCESS TO RESOURCES FOR INDIVIDUALS WITH BEHAVIORAL HEALTH NEEDS, AND INCREASING OPTIONS FOR YOUTH TO PARTICIPATE IN HEALTHY AFTERSCHOOL AND S UMMER ACTIVITIES *OBESITY (NUTRITION, DIET AND EXERCISE, RISK FACTORS & COMPLICATIONS) I MPROVING NUTRITION AND INCREASING PHYSICAL ACTIVITY BY INCREASING STREET LIGHTING AND SAFE TY GOAL INCREASE THE PROPORTION OF ADULTS WHO REPORT BEING AT A HEALTHY WEIGHT BY 5% PC MCS REVIEW OF CURRENT COMMUNITY BENEFIT PROGRAMS FOUND THAT THE HOSPITAL IS MEETING EXISTI NG COMMUNITY NEEDS THROUGH THE FOLLOWING PROGRAMS THE SMILEHEALTHY PARTNERSHIP, FAITH IN ACTION, CRISIS NURSERY, DIABETES COALITION, FAITH2 AND TRANSITIONS PLEASE SEE PART VI, LI NE 5 FOR THE DESCRIPTION OF PROGRAMS IN PLACE TO ADDRESS THESE IDENTIFIED NEEDS ALONG WITH 2016 OBJECTIVES AND 2016 MEASURABLE OUTCOMES PART VI, LINE 5 ALSO INCLUDES THE SYSTEM-WI DE MENTAL HEALTH AND ENROLLMENT STRATEGIES THAT ARE BEING USED BY EACH HOSPITAL IN THE SYS TEM Part V, Section B, Line 13h PATIENTS WITH INSURANCE WHO FACE OUT-OF-POCKET EXPENSES A RE PRESUMPTIVELY ELIGIBLE FOR FULL WRITE-OFF OF OUT-OF-POCKET EXPENSES WITH AN INCOME UP T O 200% OF THE FPL AND DISCOUNTS ON THEIR OUT-OF-POCKET EXPENSES WITH AN INCOME UP TO 400% OF THE FPL Part V, Section B, Line 14 Federal Poverty Guidelines are also used in determi ning the basis of calculating </p>

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

Form and Line Reference	Explanation
PRESENCE UNITED SAMARITANS MEDICAL CENTER (6)	<p>Part V, Section B, Line 3I The hospital CHNAs do not discuss the impact of actions taken t o address significant health needs identified in prior CHNAs. Instead, each hospital produ ced an implementation strategy annually over the three-year CHNA cycle discussing actions taken in the prior year and their impact in terms of outputs and outcomes (where possible to determine). These implementation strategies each include a plan for addressing health n eeds based on the success of programs in the prior year, and allow us to adapt strategies during the 3-year cycle and report progress regularly to the community. These implementati on strategies are available on our website at www.presencehealth.org/community Part V, Sec tion B, Line 5 A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) IS A SYSTEMATIC PROCESS INVOLVIN G THE COMMUNITY TO IDENTIFY AND ANALYZE COMMUNITY HEALTH NEEDS AND ASSETS IN ORDER TO PRIO RITIZE THESE NEEDS, AND TO PLAN AND ACT UPON SIGNIFICANT UNMET COMMUNITY HEALTH NEEDS. THI S CHNA IS CONDUCTED TO MEET THE HOSPITAL PARTNERS IRS REQUIREMENT EVERY THREE YEARS AND TH E HEALTH DEPARTMENTS ILLINOIS DEPARTMENT OF PUBLIC HEALTH IPLAN (ILLINOIS PLAN FOR LOCAL A SSESSMENT OF NEEDS) REQUIREMENT EVERY FIVE YEARS. THE INITIAL PLANNING MEETING FOR THE RE- ASSESSMENT PROCESS BEGAN ON MARCH 12, 2014. AT THIS MEETING JENNY TRIMMELL, VCHD HEALTH AD MINISTRATOR, DR. KRISTA JONES WITH THE UNIVERSITY OF ILLINOIS, SHERI ERVIN, REGIONAL DIREC TOR COMMUNITY HEALTH INTEGRATION, AND JENNIFER CORD, REGIONAL MISSION & ANCILLARY OFFICER DISCUSSED THE ASSESSMENT PROCESS AS WELL AS FORMING THE VERMILION COUNTY EXECUTIVE ASSESSM ENT COMMITTEE. ENGAGEMENT OF PUBLIC HEALTH EXPERTISE THE VERMILION COUNTY HEALTH DEPARTMEN T, AS A CERTIFIED LOCAL HEALTH DEPARTMENT FOR VERMILION COUNTY, ILLINOIS IS CHARGED TO ASS ESS THE HEALTH AND WELL-BEING OF THE COMMUNITY BY RETRIEVING AND PRESENTING RELEVANT DATA, SEEKING COMMUNITY INPUT, GENERATING DIALOGUE, AND IDENTIFYING EXISTING AND NEEDED RESOURC ES THAT LEAD TO THE DEVELOPMENT OF STRATEGIES WITH MEASURABLE OUTCOMES TO ADDRESS THE IDEN TIFIED PRIORITIES. THE VERMILION COUNTY HEALTH DEPARTMENT HAS A LONG STANDING RELATIONSHIP WITH AREA COLLEGES OF NURSING. DANVILLE AREA COMMUNITY COLLEGE, LAKEVIEW COLLEGE OF NURSI NG AND THE UNIVERSITY OF ILLINOIS HAVE COLLABORATED WITH THE HEALTH DEPARTMENT TO PROVIDE SEVERAL PREVENTION EDUCATION AND TARGETED KNOWLEDGE AWARENESS WORKSHOPS TO MEMBERS OF THE COMMUNITY. IN 2014, A REASSESSMENT WAS CONDUCTED IN ORDER TO REVIEW INFORMATION FOR UPDATE D AND NEW DATA. COMMUNITY AND STAKEHOLDER SURVEYS WERE COLLABORATIVELY DISTRIBUTED BY THE UNIVERSITY OF ILLINOIS COLLEGE OF NURSING, DANVILLE AREA COMMUNITY COLLEGE OF NURSING, AND LAKEVIEW COLLEGE OF NURSING. SURVEY INFORMATION WAS COLLECTED FROM SEPTEMBER 2014 THROUGH NOVEMBER 2014. AGE RANGE OF THOSE SURVEYED WAS FROM 23-67 YEARS OF AGE. THE TOP COMMUNITY HEALTH CONCERNS IDENTIFIED IN THE 2012 IPLAN WERE ALCOHOL/DRUG USE, TEEN PREGNANCY, AND O BESITY. THE REASSESSMENT IN 20</p>

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

Form and Line Reference	Explanation
PRESENCE UNITED SAMARITANS MEDICAL CENTER (6)	<p>14 AGAIN IDENTIFIED THE SAME TOP THREE HEALTH ISSUES IN THE SUMMER OF 2014, STUDENT INTER NS FROM DEPAUL UNIVERSITY AND THE UNIVERSITY OF ILLINOIS AT CHICAGO COLLECTED AND SUMMARIZ ED DATA IN THE ABOVE CATEGORIES THIS DATA WAS COMPILED INTO A PRELIMINARY REPORT AND SHAR ED WITH THE VERMILION COUNTY PARTNERS SEVERAL MEETINGS WERE HELD WITH THE CHNA TEAM TO RE VIEW THE DATA IN DETAIL, IDENTIFY GAPS OR OTHER DATA SOURCES NEEDED AND FINALIZE THE REPOR T THIS REPORT SUMMARIZES THE COMMUNITY HEALTH PROFILE FINDINGS CONDUCTED FOR THE POPULATI ON SERVED BY VERMILION COUNTY THE REPORT SUMMARIZES THE KEY FINDINGS FOR THE COMMUNITY TO FOCUS ON IN DEVELOPING ITS COMMUNITY HEALTH IMPROVEMENT PLAN AND IMPLEMENTATION STRATEGIE S IPLAN COMMUNITY ADVISORY COMMITTEE PRESENCE UNITED SAMARITANS MEDICAL CENTERS (PUSMC) I MPLEMENTATION STRATEGY WAS DEVELOPED BASED ON THE FINDINGS AND PRIORITIES ESTABLISHED BY T HE VERMILION COUNTY CHNA AND A REVIEW OF THE HOSPITALS EXISTING COMMUNITY BENEFIT ACTIVITI ES When requested, all input was received from community partners and stakeholders PUSMC WAS ONE OF OVER 40 STAKEHOLDER GROUPS REPRESENTING A VARIETY OF AGENCIES AND ORGANIZATION S FROM ACROSS THE COUNTY THE MEMBERS REPRESENTED ON THE IPLAN COMMUNITY ADVISORY COMMITTEE E ARE LISTED BELOW 708 MENTAL HEALTH BOARD AUNT MARTHAS HEALTH CENTER (FQHC) BIG BROTHERS /BIG SISTERS BOARD OF HEALTH CARLE CLINIC DANVILLE CARLE HOOPESTON REGIONAL HEALTH CENTER CENTER FOR CHILDREN SERVICES CENTRAL CHRISTIAN CHURCH CHANNEL 3 NEWS CROSSPOINT/YRFC DANVI LLE AREA COMMUNITY COLLEGE DANVILLE AREA COMMUNITY COLLEGE, SCHOOL OF NURSING DANVILLE FAM ILY YMCA DANVILLE MASS TRANSIT DANVILLE SCHOOL DISTRICT 118 FAITH IN ACTION FITHIAN (VILLA GE OF) HOOPESTON (CITY OF) - VOLUNTEER HOOPESTON MULTI-AGENCY I SING THE BODY ELECTRIC (PU SMC FOUNDATION) ILLINOIS HOUSE OF REPRESENTATIVES - CHAD HAYS LAKEVIEW COLLEGE OF NURSING NEW LIFE CHURCH OF FAITH OAKWOOD (VILLAGE OF) - MAYOR PRESENCE REGIONAL EMS PROJECT SUCCE S/CAPIT PUSMC - COMMUNITY BENEFIT COORDINATOR PUSMC FOUNDATION, HALO SALVATION ARMY UNITED WAY UNIVERSITY OF ILLINOIS UNIVERSITY OF ILLINOIS - CHICAGO COLLEGE OF NURSING VA ILLIANA HEALTHCARE VERMILION COUNTY REGIONAL OFFICE OF EDUCATION VERMILLION ADVANTAGE VERMILLION COUNTY BOARD VERMILLION COUNTY BOARD OF HEALTH - PRESIDENT AND MEMBERS VERMILLION COUNTY H EALTH DEPARTMENT - ADMINISTRATION VERMILLION COUNTY HEALTH DEPARTMENT - COMMUNITY HEALTH S ERVICES VERMILLION COUNTY HEALTH DEPARTMENT - EMERGENCY PREPAREDNESS Part V, Section B, Li ne 6 PUSMC PARTNERED WITH HOOPESTON HOSPITAL TO COMPLETE THEIR CHNA We also worked with the Vermilion County Health Department Part V, Section B, Line 7d COPIES OF THE CHNA REPOR T WERE MAILED AND/OR E-MAILED TO COMMUNITY PARTNERS WHO PARTICIPATED IN THE CHNA PROCESS PARTNERS WERE ALSO PROVIDED LINKS TO THE WEBSITE FOR DISSEMINATION TO THEIR MAILING LISTS AND RESPECTIVE CONSTITUENTS Part V, Section B, Line 11 THE TOP THREE COMMUNITY HEALTH PRI ORITIES TO BE ADDRESSED IN THE</p>

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

Form and Line Reference	Explanation
<p>PRESENCE UNITED SAMARITANS MEDICAL CENTER (6)</p>	<p>2014-2017 PLAN ARE *TEEN PREGNANCY, *ALCOHOL/SUBSTANCE ABUSE, AND *OBESITY PLEASE SEE P ART VI, LINE 5 FOR THE DESCRIPTION OF PROGRAMS IN PLACE TO ADDRESS THESE IDENTIFIED NEEDS ALONG WITH 2016 OBJECTIVES AND 2016 MEASURABLE OUTCOMES PART VI, LINE 5 ALSO INCLUDES THE SYSTEM-WIDE MENTAL HEALTH AND ENROLLMENT STRATEGIES THAT ARE BEING USED BY EACH HOSPITAL IN THE SYSTEM All significant needs identified in the most recently conducted CHNA are be ing addressed Part V, Section B, Line 13h PATIENTS WITH INSURANCE WHO FACE OUT-OF-POCKET EXPENSES ARE PRESUMPTIVELY ELIGIBLE FOR FULL WRITE-OFF OF OUT-OF-POCKET EXPENSES WITH AN I NCOME UP TO 200% OF THE FPL AND DISCOUNTS ON THEIR OUT-OF-POCKET EXPENSES WITH AN INCOME U P TO 400% OF THE FPL Part V, Section B, Line 14 Federal Poverty Guidelines are also used in determining the basis of calculating amounts charged to patients Part V, Section B, Li nes 16a-16c http //presencehealth org/financial-assistance</p>

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 THERAPYINDUSTRIAL 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

Schedule I
(Form 990)

Department of the Treasury
Internal Revenue Service

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

Complete if the organization answered "Yes," on Form 990, Part IV, line 21 or 22.
▶ Attach to Form 990.
▶ Information about Schedule I (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK

Employer identification number
36-4195126

Part I

General Information on Grants and Assistance

- 1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? ☒ Yes ☐ No
- 2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States

Part II

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

(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
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2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table 8

3 Enter total number of other organizations listed in the line 1 table 0

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	10	5,000			
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					

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
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
SMILEHEALTHY - HOPE CENTER 819 Bloomington Rd CHAMPAIGN, IL 61820	14-1880824	501(c)(3)	16,500				DENTAL WORK FOR THE POOR
JOLIET TOWNSHIP HIGH SCHOOL 300 CATERPILLAR DRIVE JOLIET, IL 60436	36-6005690	501(c)(3)	6,500	0			NSP SCHOLARSHIP AWARD Healthcare

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
UNITED WAY OF WILL COUNTY 54 N OTTAWA ST JOLIET, IL 604324345	36-2515624	501(c)(3)	16,000	0			Community Programs
WILL-GRUNDY MEDICAL CLINIC 213 EAST CASS STREET JOLIET, IL 60432	36-3492306	501(c)(3)	35,000	0			Medical Services and Supplies

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
BISHOP MCNAMARA CATHOLIC HIGH SCHOOL 550 WEST BROOKMONT BLVD KANKAKEE, IL 60901	36-2317629	501(c)(3)	7,750	0			Sponsorship
UNITED WAY OF KANKAKEE & IROQUOIS COUNTIES PO BOX 1286 KANKAKEE, IL 60901	36-2188452	501(c)(3)	5,780	0			Community Programs

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
FOX VALLEY HANDS OF HOPE 200 WHITFIELD DRIVE GENEVA, IL 60134	36-3111451	501(c)(3)	10,000	0			Grief Program
CRISIS NURSERY 1309 WEST HILL ST URBANA, IL 61801	37-1151152	501(c)(3)		36,949	Cost	Linens & meals	General support

Schedule J
(Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

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

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><div><input type="checkbox"/> First-class or charter travel</div><div><input type="checkbox"/> Travel for companions</div><div><input type="checkbox"/> Tax idemnification and gross-up payments</div><div><input type="checkbox"/> Discretionary spending account</div><div><input type="checkbox"/> Housing allowance or residence for personal use</div><div><input type="checkbox"/> Payments for business use of personal residence</div><div><input type="checkbox"/> Health or social club dues or initiation fees</div><div><input type="checkbox"/> Personal services (e g , maid, chauffeur, chef)</div></div>		
b If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	1b	
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><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></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 2016: Amy D Stevens \$296,774 ANTHONY FILER \$527,027 Kathleen Rhine \$114,374. THE CORPORATION ALSO ACCRUED DEFERRED SEVERANCE FOR THE FOLLOWING INDIVIDUALS, WHICH WILL VEST IN A LATER YEAR: Kathleen Rhine \$57,864.
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. 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: Amy D Stevens \$183,612 Ann Errichetti \$92,263 Anthony Filer \$5,874 Jared C Rogers \$110,176 Jeannie C Frey \$94,713 Kathleen Rhine \$314,362 Michael L Brown \$61,909 Patrick Quinn \$25,318. ALSO IN RESPONSE TO QUESTION 4B, THE FOLLOWING LISTED INDIVIDUALS PARTICIPATED IN THE ORGANIZATION'S SECTION 457(F) PLAN AND EARNED UNVESTED BENEFITS DURING 2016 WHICH ARE REPORTED IN COLUMN (C): JAMES H KELLEY \$80,634 JEANNIE C FREY \$88,579 Michael L Brown \$69,580 PATRICIA EDDY \$16,622 PATRICK QUINN \$24,559 Sam Bagchi, MD \$111,998.

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				
1ANTHONY FILER TREASURER (TERM 1/2016), CFO	(i)	0	0	0	0	0	0	0
	(ii)	63,489	0	740,678	5,841	-	-	527,027
						1,885	811,893	
1DAVID BORDO MD DIRECTOR, CMO	(i)	0	0	0	0	0	0	0
	(ii)	378,195	1,707	18,971	18,550	-	-	0
						23,027	440,450	
2JAMES H KELLEY TREASURER, CFO	(i)	0	0	0	0	0	0	0
	(ii)	432,039	0	7,395	80,634	-	-	0
						13,198	533,266	
3JEANNIE C FREY SECRETARY SYS CH LEGL OFFC	(i)	0	0	0	0	0	0	0
	(ii)	448,798	0	124,671	104,479	-	-	86,745
						21,844	699,792	
4JULIE ROKNICH ASST SECRETARY, SYS DIR SR AGC	(i)	0	0	0	0	0	0	0
	(ii)	189,804	0	183	9,052	-	-	0
						20,862	219,901	
5PATRICIA EDDY ASST TREASURER, SYS FIN OFFC	(i)	0	0	0	0	0	0	0
	(ii)	159,817	0	4,585	18,641	-	-	0
						10,672	193,715	
6PATRICK QUINN ASST TREASURER (TERM 2/17) SVP	(i)	0	0	0	0	0	0	0
	(ii)	237,924	0	32,635	39,294	-	-	23,604
						16,594	326,447	
7PAULA J CAMPBELL ASST TREAS (TERM 8/16) SYS FO	(i)	0	0	0	0	0	0	0
	(ii)	284,718	0	8,736	0	-	-	0
						5,179	298,633	
8SAM BAGCHI MD DIR SYS CH MEDICAL & QUAL OFFC	(i)	0	0	0	0	0	0	0
	(ii)	550,586	40,000	60,403	124,792	-	-	0
						26,055	801,836	
9AMY D STEVENS FORMER COO	(i)	0	0	0	0	0	0	0
	(ii)	6,396	0	480,386	131	-	-	473,689
						130	487,043	
10LISA M LAGGER REG CHIEF REL OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	208,690	260	975	12,733	-	-	0
						14,026	236,684	
11SANDRA BRUCE FMR PRES/CEO/EX-OFFC- TRM 12/15	(i)	0	0	0	0	0	0	0
	(ii)	16,341	0	273,474	5,300	-	-	0
						0	295,115	
12KATHLEEN RHINE REGIONAL PRESIDENT & CEO-SSB	(i)	401,614	78	452,478	57,864	7,356	919,390	249,784
	(ii)	0	0	0	0	-	-	0
						0	0	
13JARED C ROGERS REGIONAL PRESIDENT & CEO-CES	(i)	371,125	260	120,901	13,250	15,790	521,326	0
	(ii)	0	0	0	0	-	-	0
						0	0	
14MICHAEL L BROWN REGIONAL PRESIDENT & CEO-FXV	(i)	409,340	0	74,095	82,369	13,813	579,617	60,116
	(ii)	0	0	0	0	-	-	0
						0	0	
15GARY LIPINSKI MD REGIONAL CHIEF MEDICAL OFFSSB	(i)	368,541	20,000	20,299	7,950	14,256	431,046	0
	(ii)	0	0	0	0	-	-	0
						0	0	
16SURENDRA M GULATI PHYSICIAN	(i)	549,982	0	3,938	13,250	15,402	582,572	0
	(ii)	0	0	0	0	-	-	0
						0	0	
17BEEJAL Y AMINPHYSICIAN	(i)	503,026	0	206	4,789	11,358	519,379	0
	(ii)	0	0	0	0	-	-	0
						0	0	
18KAIZ ASIFPHYSICIAN	(i)	439,945	25,000	379	12,210	19,595	497,129	0
	(ii)	0	0	0	0	-	-	0
						0	0	
19BHAVIN C SHAHPHYSICIAN	(i)	322,996	0	18,361	11,450	23,019	375,826	0
	(ii)	0	0	0	0	-	-	0
						0	0	

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

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
	(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
21ANN ERRICHETTI PRESIDENT	(i)	0	0	0	0	0	0
		- - - - -	- - - - -	- - - - -	- - - - -	- - - - -	- - - - -
	(ii)	474,597	50,000	106,843	7,789	-	0
					19,316	658,545	
1CONNIE J NOLTEMEYER Former Regional Quality Leader	(i)	0	0	0	0	0	0
		- - - - -	- - - - -	- - - - -	- - - - -	- - - - -	- - - - -
	(ii)	138,577	3,111	1,262	4,362	-	0
					9,609	156,921	

SCHEDULE O (Form 990 or 990-EZ)	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 2016 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

990 Schedule O, Supplemental Information

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 - PRO AMBULANCE - PRESENCE N E W YOU CENTER

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART I, LINE 1	MISSION STATEMENT/SIGNIFICANT ACTIVITY 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

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, QUESTION 4	<p>CHANGES TO ORGANIZATIONAL DOCUMENTS THE CORPORATION'S ARTICLES OF INCORPORATION WERE AMENDED EFFECTIVE JANUARY 1, 2016 TO CHANGE THE CORPORATION'S NAME TO "PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK TO UPDATE THE ORGANIZATION'S PURPOSE TO SPECIFICALLY REFERENCE THAT IT MAINTAINS AND OPERATES HOSPITALS AND OTHER HEALTH CARE FACILITIES THE CORPORATION'S BYLAWS WERE AMENDED JANUARY 1, 2016 TO REFLECT THE NAME CHANGE TO "PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK " THE BYLAWS WERE ALSO AMENDED TO REFLECT THE CORPORATION'S CHARITABLE PURPOSES AS STATED IN ITS ARTICLES OF INCORPORATION BY INCLUDING THE CORPORATION'S PURPOSE STATEMENT, AS WELL AS A PROVISION CLARIFYING THAT THE CORPORATION IS NOT PERMITTED TO USE CONTRIBUTIONS TO CARRY ON ACTIVITIES THAT ARE NOT CHARITABLE, RELIGIOUS, SCIENTIFIC, OR EDUCATIONAL UNDER SECTION 170(C)(2) THE REVISED BYLAWS STATE A MINIMUM AND MAXIMUM AMOUNT OF DIRECTORS THAT WILL COMPRISE THE BOARD AT ANY GIVEN TIME</p>

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, QUESTION 7B	<p>DECISIONS OF GOVERNING BODY APPROVAL BY MEMBERS OR SHAREHOLDERS PRESENCE CARE TRANSFORMATI ON CORPORATION (THE "MEMBER"), THROUGH ITS BOARD OF DIRECTORS, HAS CERTAIN GENERAL AND RES ERVED POWERS WITH RESPECT TO THE FOLLOWING GENERAL POWERS THE MEMBER SHALL PROVIDE OVERS IGH T AND SUPPORT FOR THE ACTIVITIES OF THE CORPORATION, FOR THE PURPOSE OF ASSURING THAT A LL ACTIONS OF THE CORPORATION ARE CONSISTENT WITH THE MISSION AND VALUES OF THE SYSTEM, TH E PURPOSES OF THE CORPORATION, THE ETHICAL AND RELIGIOUS DIRECTIVES, THE PRESENCE HEALTH S YSTEM STRATEGIC PLAN, AND BEST PRACTICES RESERVED POWERS IN FURTHERANCE OF THE EXERCISE OF ITS GENERAL POWERS AND RESPONSIBILITIES, THE MEMBER SHALL HAVE THE SOLE POWER TO TAKE T HE ACTIONS SPECIFIED BELOW WITH RESPECT TO THE FOLLOWING MATTERS PERTAINING TO THE CORPORA TION AND EACH HOSPITAL MINISTRY, SUBJECT TO ANY NOTICES OR FURTHER APPROVALS REQUIRED BY A PPLICABLE CIVIL OR CANON LAW, OR THE MEMBER'S BYLAWS A BYLAWS AMEND OR REPEAL THE BYLAW S OF THE CORPORATION B OFFICERS AND DIRECTORS APPOINT AND REMOVE ALL OFFICERS OF THE CO RPORATION AND ALL DIRECTORS OF THE CORPORATION, OTHER THAN ANY EX-OFFICIO DIRECTORS C BU DGETS APPROVE CAPITAL AND OPERATING BUDGETS, AND LONG-TERM CAPITAL EQUIPMENT PLANS FOR TH E CORPORATION, INCLUDING EACH HOSPITAL MINISTRY D UNBUDGETED EXPENDITURES APPROVE UNBUD GETED EXPENDITURES IN EXCESS OF THE LIMIT ESTABLISHED BY THE MEMBER FROM TIME TO TIME E DEBT, SALE, LEASE AND OTHER REAL PROPERTY TRANSACTIONS APPROVE ANY BORROWING OR SIGNIFICA NT 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 CORPORATION'S REAL PROPERTY, EXCEPT TH OSE MADE PURSUANT TO APPROVED BUDGETS F REAL ESTATE DOCUMENTS, EQUIPMENT LEASES APPROVE EXECUTION OF ANY DEEDS, MORTGAGES, BONDS, OR MAJOR EQUIPMENT LEASES, EXCEPT THOSE ENTERED INTO PURSUANT TO APPROVED BUDGETS G SIGNIFICANT UNBUDGETED TRANSACTIONS APPROVE ANY OT HER 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 MATERIA L CHANGES IN SERVICES APPROVE MATERIAL CHANGES IN THE KIND OF SERVICES RENDERED AT ANY HO SPITAL MINISTRY, 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 TH ROUGH ANY HOSPITAL MINISTRY (E G , A CHANGE REQUIRING A DIFFERENT KIND OF LICENSE) I STR ATEGIC PLAN APPROVE STRATEGIC PLANS FOR THE CORPORATION AND EACH HOSPITAL MINISTRY, CONSI STENT WITH AND IN FURTHERANCE OF SYSTEM MISSION AND VALUES, AND RESPONSIVE TO THE NEEDS OF THE COMMUNITIES SERVED BY THE</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, QUESTION 7B	<p>CORPORATION AND SUPPORT THE ABILITY OF THE CORPORATION AND ITS AFFILIATES TO PROVIDE HIGH -QUALITY CARE AND SERVICES J MANAGEMENT CONTRACTS APPROVE ANY CONTRACT FOR THE MANAGEME NT OF ALL OR SUBSTANTIALLY ALL OF THE CORPORATION OR ANY INDIVIDUAL HOSPITAL MINISTRY OWNE D BY THE CORPORATION K BUSINESS NAME, LOGO APPROVE ANY SELECTION OR MODIFICATION OF THE BUSINESS NAME OR LOGO OF THE CORPORATION OR ANY HOSPITAL MINISTRY OR ANY PROGRAM OR DIVIS ION, OR THE USE OF ANY CORPORATE OR BUSINESS NAME OF THE CORPORATION OR ANY HOSPITAL MINIS TRY BY AN ENTITY OTHER THAN THE MEMBER OR AN AFFILIATE L ADMINISTRATIVE SERVICES PROVID E OR ASSURE THE PROVISION OF APPROPRIATE INSURANCE COVERAGE, STANDARDIZED EMPLOYEE BENEFIT S, INFORMATION SYSTEMS AND TECHNOLOGY, FINANCIAL MANAGEMENT SERVICES, LEGAL, MARKETING, RI SK MANAGEMENT AND OTHER ADMINISTRATIVE SERVICES NECESSARY TO SUPPORT THE CORPORATION'S OPE RATIONS M SIGNIFICANT JOINT VENTURES APPROVE THE ESTABLISHMENT, TERMINATION, OR SALE OF ANY SIGNIFICANT JOINT VENTURE RELATIONSHIP BY THE CORPORATION GENERALLY OR WITH RESPECT T O ONE OR MORE HOSPITAL OR OTHER MINISTRIES OPERATED BY THE CORPORATION N UNRELATED BUSIN ESS ACTIVITY APPROVE THE ACQUISITION OR DEVELOPMENT OF ANY BUSINESS OR ACTIVITY UNRELATED TO THE PROVISION OF HEALTH CARE SERVICES O NEW AFFILIATES APPROVE THE CREATION OF ANY NEW AFFILIATE TO BE OWNED OR CONTROLLED BY THE CORPORATION P CONTRIBUTIONS TO MEMBER DI RECT AND APPROVE ANY CONTRIBUTIONS, DONATIONS OR OTHER ASSET TRANSFERS WITHOUT CONSIDERATI ON TO THE MEMBER OR ANY AFFILIATE, IN FURTHERANCE OF THE MISSION AND VALUES Q CONTRIBUTI ON ACCEPTANCE APPROVE ACCEPTANCE OF A CONTRIBUTION THAT IMPOSES A MATERIAL OBLIGATION ON THE CORPORATION, IF APPROVED BY THE CORPORATION'S APPLICABLE FOUNDATION OR FUNDRAISING AFF ILIATE AS CONSISTENT WITH THE CORPORATION'S AND SYSTEM'S MISSION AND GOALS R BANKING DE FINE THE CRITERIA FOR THE SELECTION OF BANKS AND OTHER FINANCIAL DEPOSITORYIES TO BE USED B Y THE CORPORATION, AND AUTHORIZE THE PROCESS BY WHICH SIGNATORIES ON ALL BANK AND SIMILAR ACCOUNTS OF THE CORPORATION ARE APPROVED S AUDITORS SELECT INDEPENDENT AUDITORS FOR THE CORPORATION, IN CONNECTION WITH THE CONSOLIDATED AUDIT OF ALL SYSTEM ENTITIES T REGISTE RED AGENT APPROVE OR CHANGE THE CORPORATION'S REGISTERED AGENT OR REGISTERED OFFICE, AS A PPROPRIATE FROM TIME TO TIME U TAX-EXEMPTION APPROVE ANY VOLUNTARY CHANGE TO THE CORPOR ATION'S STATUS OF AN ORGANIZATION EXEMPT FROM TAXATION UNDER SECTION 501(C)(3) OF THE INTE RNAL REVENUE CODE, AS AMENDED FROM TIME TO TIME</p>

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

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, TA</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, LINE 12C	KING 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 PRE SENCE HEALTH) IS STRICTLY PROHIBITED

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990 PART VI, QUESTIONS 15A AND 15B, AND PART V, QUESTION 2A	COMPENSATION AND APPROVAL PROCESS FOR OFFICERS AND KEY EMPLOYEES COMPENSATION FOR THE CORPORATIONS CEO AND OTHER OFFICERS OR KEY EMPLOYEES IS DETERMINED IN ACCORDANCE WITH WRITTEN POLICIES AND PROCEDURES ADOPTED BY THE BOARD OF DIRECTORS OF THE SYSTEMS PARENT, PRESENCE HEALTH NETWORK ("PHN"), AND APPLIED BY THE HUMAN RESOURCES COMMITTEE OF THE BOARD OF DIRECTORS THE BOARD OF DIRECTORS 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 BY APPROVING ALL COMPONENTS OF EXECUTIVE TOTAL COMPENSATION, AND ANNUALLY REVIEWING AND APPROVING COMPENSATION CHANGES FOR EACH EXECUTIVE THE CORPORATION ANSWERS "YES" TO FORM 990, PART VI, QUESTION 15A AND 15B AS PHNS BOARD OF DIRECTORS HAS ULTIMATE CONTROL OVER ALL SUBSIDIARY ORGANIZATIONS

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

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 TRANSFER RESTRICTED FUNDS TO PHFBOT (13,048,213) NET RESTRICTED FUND ACTIVITY PRIOR TO TRANSFER TO PHFBOT (1,543,246) PRESENCE HEALTH PARTNERS LLC 12 31 2015 NET ASSETS 1,390,800 NET ASSETS RELEASED FROM RESTRICTION FOR CAPITAL 1,229,119 TRANSFER FROM AFFILIATES 7,000 ----- TOTAL (11,964,540)

990 Schedule O, Supplemental Information

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 FORM 990, PART XII, LINES 3A & 3B PRESENCE HEALTH NETWORK COMPLETES A CONSOLIDATED A-133 AUDIT WHICH INCLUDES ALL ENTITIES FOR WHICH IT IS A PARENT ORGANIZATION WHETHER THEY EXPENDED FEDERAL FUNDS DURING THE YEAR OR NOT

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION OTHER PURCHASED SERVICES TOTAL FEES 52921773

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION PHYSICIAN FEES TOTAL FEES 43302204

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION LAB SERVICES TOTAL FEES 35364674

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION AGENCY LABOR TOTAL FEES 8214694

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION TRANSCRIPTION SERVICES TOTAL FEES 4468223

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION FOOD MANAGEMENT SERVICES TOTAL FEES 4419251

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION LAUNDRY SERVICES TOTAL FEES 2133915

SCHEDULE R
(Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

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

OMB No 1545-0047

2016

Open to Public Inspection

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) Vermilion County Surgery Center LLC 26 W Newell Danville, IL 61834 80-0811427	MEDICAL SRVC	IL	-1,222,652	2,943,612	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.

See Additional Data Table

(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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512- 514)	(f) Share of total income	(g) Share of end-of- year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) Bel Harlem Surg Ctr 3101 North Harlem Chicago, IL 60634 41-2237162	Medical Service	IL										
(2) RH Sleep Ctr - NW 665 West North Ave 500 Lombard, IL 60148 26-1519627	Medical Service	IL										
(3) RH Sleep Ctr - Evan 665 West North Ave 500 Lombard, IL 60148 26-1519556	Medical Service	IL										
(4) RH Sleep Ctr - LP 665 West North Ave 500 Lombard, IL 60148 26-1519667	Medical Service	IL										
(5) RH Sleep Ctr - RF 665 West North Ave 500 Lombard, IL 60148 26-2189763	Medical Service	IL										
(6) Alverno Clinic Lab 2434 Interstate Plaza Drive Hammond, IN 46324 20-3240648	Medical Service	IN										
(7) Prof Clinic Lab LLC 113 E 4th St Michigan City, IN 46360 30-0711211	Medical Service	IN										

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

See Additional Data Table

(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

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?

	Yes	No
a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity		No
b Gift, grant, or capital contribution to related organization(s)		No
c Gift, grant, or capital contribution from related organization(s)	Yes	
d Loans or loan guarantees to or for related organization(s)		No
e Loans or loan guarantees by related organization(s)		No
f Dividends from related organization(s)		No
g Sale of assets to related organization(s)		No
h Purchase of assets from related organization(s)		No
i Exchange of assets with related organization(s)		No
j Lease of facilities, equipment, or other assets to related organization(s)		No
k Lease of facilities, equipment, or other assets from related organization(s)		No
l Performance of services or membership or fundraising solicitations for related organization(s)		No
m Performance of services or membership or fundraising solicitations by related organization(s)	Yes	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)		No
o Sharing of paid employees with related organization(s)	Yes	
p Reimbursement paid to related organization(s) for expenses	Yes	
q Reimbursement paid by related organization(s) for expenses		No
r Other transfer of cash or property to related organization(s)	Yes	
s Other transfer of cash or property from related organization(s)		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 HEALTH FOUNDATION BOARD OF TRUSTEES	c	1,368,521	CASH
(2) PRESENCE CARE TRANSFORMATION CORPORATION	m	119,893,329	COST ALLOCATION
(3) PRESENCE CARE TRANSFORMATION CORPORATION	p	928,959,350	COST
(4) PRESENCE HEALTH FOUNDATION BOARD OF TRUSTEES	r	13,048,213	BOOK VALUE

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	Form 990, Schedule R, Part V PRESENCE CARE TRANSFORMATION CORPORATION (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
(1) 200 South Wacker Drive Chicago, IL 60606 36-1649520	Parent Corp	IL	501(C)(3)	12c III FI	na		No
(1) 100 North River Road Des Plaines, IL 60016 36-3495969	Health Care	IL	501(C)(3)	10	PHPS	Yes	
(2) 302 Swart Hill Road Amsterdam, NY 12010 14-1363014	Health Care	NY	501(C)(3)	3	RM New York	Yes	
(3) 2380 E Dempster Ave STE 236 Des Plaines, IL 60016 36-2644178	Health Care	IL	501(C)(3)	12b	PHN		No
(4) 18927 Hickory Creek Drive 300 Mokena, IL 60448 46-0483587	Health Care	IL	501(C)(3)	10	PLC	Yes	
(5) 1000 Remington BLVD STE 100 Bolingbrook, IL 60440 36-3366652	Mgmt Support	IL	501(C)(3)	12c III FI	PHN		No
(6) 18927 Hickory Creek Drive 300 Mokena, IL 60448 46-0483581	Health Care	IL	501(C)(3)	10	PLC	Yes	
(7) 18927 Hickory Creek Drive 300 Mokena, IL 60448 36-3438977	Senior Living	IL	501(C)(3)	10	PLC	Yes	
(8) 18927 Hickory Creek DR 300 Mokena, IL 60448 37-1127787	Health Care	IL	501(C)(3)	10	PCTC	Yes	
(9) 1820 South 25th Avenue Broadview, IL 60155 36-2709982	Health Care	IL	501(C)(3)	3	PCTC	Yes	
(10) 100 North River Road Des Plaines, IL 60016 36-4286236	Health Care	IL	501(C)(3)	10	PCTC	Yes	
(11) 200 South Wacker Drive Chicago, IL 60606 36-3330929	Fundraising	IL	501(C)(3)	7	PHN		No
(12) 200 South Wacker Drive Chicago, IL 60606 36-2235165	Health Care	IL	501(C)(3)	3	PCTC	Yes	
(13) 90 North Main Street Castleton, NY 12033 14-1348691	Health Care	NY	501(C)(3)	3	RM New York	Yes	
(14) 100 North River Road Des Plaines, IL 60016 23-7061646	Health Care	IL	501(C)(3)	10	PCTC	Yes	
(15) 100 North River Road Des Plaines, IL 60016 36-3330928	Health Care	IL	501(C)(3)	10	PCTC	Yes	
(16) 1190 E 2900 N Road Clifton, IL 60927 36-2841358	Health Care	IL	501(C)(3)	10	PLC	Yes	
(17) 1550 Bishop Court Mount Prospect, IL 60056 36-3296367	Health Care	IL	501(C)(3)	10	PLC	Yes	
(18) 1431 N Claremont Chicago, IL 60622 36-2182170	Education	IL	501(C)(3)	2	PHN		No

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of- year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity?	
								Yes	No
(1) L Gilbraith Insurance SPC LTD 68 W Bay Road PO Box 1109 Grand Cayman CJ 000000000	Insurance	CJ	PHN	Foreign Company					No
(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	PCTC	C Corp				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	PCHN	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	