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Form 990

Return of Organization Exempt From Income Tax

OMB No 1545-0047

2017

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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](#)

A For the 2017 calendar year, or tax year beginning 01-01-2017 , and ending 12-31-2017

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

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

MARSHA LADENBURGER RN

1000 Remington Boulevard Suite 100

Bolingbrook, IL 60440

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

I Tax-exempt status

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

J Website: ▶

www.presencehealth.org

K Form of organization

☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation

1997

M State of legal domicile

IL

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities

THE ORGANIZATION STRIVES TO MAINTAIN AND IMPROVE THE HEALTH OF THE COMMUNITIES IT SERVES BY PROVIDING SERVICES THAT AVOIDS ILLNESS USING PREVENTIVE CARE AND ADVANCED TECHNOLOGIES

2 Check this box ☐ 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)

5

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

4

5 Total number of individuals employed in calendar year 2017 (Part V, line 2a)

0

6 Total number of volunteers (estimate if necessary)

1,406

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

2,750,312

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

1,370,313

Revenue

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

2,039,004

Prior Year

Current Year

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

1,064,991,061

2,039,004

3,041,073

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

2,276,488

1,064,991,061

1,864,048

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

22,453,451

2,276,488

15,252,732

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

1,091,760,004

22,453,451

1,090,197,093

Expenses

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

139,479

139,479

125,633

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)

387,598,543

387,598,543

368,584,174

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)

646,341,406

646,341,406

685,644,063

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

1,034,079,428

1,034,079,428

1,054,353,870

19 Revenue less expenses Subtract line 18 from line 12

57,680,576

57,680,576

35,843,223

Net Assets or Fund Balances

20 Total assets (Part X, line 16)

752,067,620

Beginning of Current Year

End of Year

21 Total liabilities (Part X, line 26)

119,585,156

119,585,156

101,150,308

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

632,482,464

632,482,464

592,900,586

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

2018-11-15

Date

TONYA MERSHON TAX OFFICER

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

Check ☐ if self-employed

PTIN

P01564049

Firm's name ▶ ERNST & YOUNG US LLP

Firm's EIN ▶ 34-6565596

Firm's address ▶ 155 N WACKER DRIVE

Phone no (312) 879-2000

CHICAGO, IL 60606

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 (2017)

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:

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

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 \$ 922,230,217	including grants of \$ 125,633) (Revenue \$ 1,078,632,715)
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 \$)
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4e	Total program service expenses	922,230,217
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Part IV Checklist of Required Schedules

	Yes	No
1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A 	1 Yes	
2 Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)? 	2 Yes	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I	3	No
4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II	4	No
5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? If "Yes," complete Schedule C, Part III	5	No
6 Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes," complete Schedule D, Part I	6	No
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II	7	No
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III	8	No
9 Did the organization report an amount in Part X, line 21 for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? If "Yes," complete Schedule D, Part IV	9	No
10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? If "Yes," complete Schedule D, Part V 	10 Yes	
11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable		
a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI 	11a Yes	
b Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII	11b	No
c Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII	11c	No
d Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part IX 	11d Yes	
e Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X 	11e Yes	
f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part X 	11f Yes	
12a Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII	12a	No
b Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional 	12b Yes	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	13	No
14a Did the organization maintain an office, employees, or agents outside of the United States?	14a	No
b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV	14b	No
15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? If "Yes," complete Schedule F, Parts II and IV	15	No
16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? If "Yes," complete Schedule F, Parts III and IV	16	No
17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I (see instructions)	17	No
18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II	18	No
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III	19	No

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 Yes	
36 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i>	36	No
37 Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i>	37	No
38 Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? Note. All Form 990 filers are required to complete Schedule O	38 Yes	

Part V Statements Regarding Other IRS Filings and Tax ComplianceCheck 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.	1a	0
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable.	1b	0
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.	2a	0
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	Yes
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	5		
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			No
5 Did the organization become aware during the year of a significant diversion of the organization's assets?	5			No
6 Did the organization have members or stockholders?	6		Yes	
7a Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a		Yes	
b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b		Yes	
8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:				
a The governing body?	8a		Yes	
b Each committee with authority to act on behalf of the governing body?	8b		Yes	
9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O.	9			No

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

		Yes	No	
10a Did the organization have local chapters, branches, or affiliates?	10a		No	
b If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	10b			
11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a		No	
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. ►ROBERT R LAMONT 1000 REMINGTON BOULEVARD SUITE 100 BOLINGBROOK, IL 60440 (630) 914-2618	

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

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

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

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

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

[illegible]

[illegible]

1b Sub-Total			
c Total from continuation sheets to Part VII, Section A			
d Total (add lines 1b and 1c)	4,116,430	7,691,414	1,151,995

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 ▶ 312

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
US BANK CORPORATE TRUST PO BOX 70870 ST PAUL, MN 55170	CLINICAL AGENCY	3,866,373
CARDIAC SURGERY ASSOCIATES SC 2650 WARRENVILLE RD STE 280 DOWNERS GROVE, IL 60515	CARDIAC SERVICES	3,381,402
CHRISTIE CLINIC LLC 101 UNIVERSITY AVE CHAMPAIGN, IL 61820	HOSPITALIST SERVICES	2,791,256
CEP AMERICA 2100 POWELL ST STE 900 EMERYVILLE, CA 94608	EMERGENCY MEDICINE RESIDENCY TRAINING	1,476,432
SODEXO INC AND AFFILIATES 4880 PAYSHERE CIRCLE CHICAGO, IL 60674	FOOD SERVICES	1,308,076

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization ► 96

Part VIII Statement of RevenueCheck if Schedule O contains a response or note to any line in this Part VIII ☒

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514	
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns . . .	1a					
	b Membership dues . . .	1b					
	c Fundraising events . . .	1c					
	d Related organizations	1d	3,041,073				
	e Government grants (contributions)	1e					
	f All other contributions, gifts, grants, and similar amounts not included above	1f					
	g Noncash contributions included in lines 1a-1f \$ _____						
	h Total. Add lines 1a-1f ▶		3,041,073				
Program Service Revenue			Business Code				
	2a NET PATIENT REVENUE		622110	1,054,539,282	1,054,539,282		
	b RETAIL/CONTRACT PHARMACY		446110	2,035,689	1,146,235	889,454	
	c MEANINGFUL USE & BLUE CROSS BONUS		622110	8,813,020	8,813,020		
	d MEDICAL OFFICE BLDG RENT		561000	3,285,891	3,285,891		
	e JOINT VENTURE INCOME		900099	1,365,358		1,365,358	
	f All other program service revenue			0	0	0	
	g Total. Add lines 2a-2f ▶		1,070,039,240				
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts) ▶		1,318,768		835	1,317,933	
	4 Income from investment of tax-exempt bond proceeds ▶						
	5 Royalties ▶						
	6a Gross rents	(i) Real	(ii) Personal				
			128,956				
		b Less rental expenses	42,951				
		c Rental income or (loss)	86,005	0			
	d Net rental income or (loss) ▶		86,005		86,005		
	7a Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other				
			545,280	0			
		b Less cost or other basis and sales expenses					
		c Gain or (loss)	545,280	0			
	d Net gain or (loss) ▶		545,280			545,280	
	8a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18 a						
	b Less direct expenses b						
	c Net income or (loss) from fundraising events . . . ▶						
	9a Gross income from gaming activities See Part IV, line 19 a						
	b Less direct expenses b						
	c Net income or (loss) from gaming activities . . . ▶						
	10a Gross sales of inventory, less returns and allowances . . . a						
b Less cost of goods sold . . . b							
c Net income or (loss) from sales of inventory . . . ▶							
Miscellaneous Revenue		Business Code					
11a CAFETERIA SALES		722514	3,284,022		23,509	3,260,513	
b GIFT SHOP & AUXILIARY		453220	650,102			650,102	
c ADMINISTRATION		900099	5,302,384	5,302,384			
d All other revenue			5,930,219	5,545,068	385,151	0	
e Total. Add lines 11a-11d ▶			15,166,727				
12 Total revenue. See Instructions ▶			1,090,197,093	1,078,631,880	2,750,312	5,773,828	

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.	120,133	120,133		
2 Grants and other assistance to domestic individuals. See Part IV, line 22.	5,500	5,500		
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.				
4 Benefits paid to or for members.				
5 Compensation of current officers, directors, trustees, and key employees.	2,312,744	2,312,744		
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B).				
7 Other salaries and wages.	298,171,572	298,171,572		
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).	12,111,746	12,111,746		
9 Other employee benefits.	33,961,586	33,961,586		
10 Payroll taxes.	22,026,526	22,026,526		
11 Fees for services (non-employees):				
a Management.	131,789,433		131,789,433	
b Legal.	334,220		334,220	
c Accounting.				
d Lobbying.				
e Professional fundraising services. See Part IV, line 17.				
f Investment management fees.				
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	155,450,377	155,450,377	0	0
12 Advertising and promotion.	168,783	168,783		
13 Office expenses.	3,057,508	3,057,508		
14 Information technology.	391,849	391,849		
15 Royalties.				
16 Occupancy.	25,300,644	25,300,644		
17 Travel.	585,327	585,327		
18 Payments of travel or entertainment expenses for any federal, state, or local public officials.				
19 Conferences, conventions, and meetings.	79,915	79,915		
20 Interest.	16,510,200	16,510,200		
21 Payments to affiliates.				
22 Depreciation, depletion, and amortization.	47,385,811	47,385,811		
23 Insurance.	19,931,773	19,931,773		
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	181,744,610	181,744,610		
b TAXES AND ASSESSMENTS	62,387,918	62,387,918		
c REPAIRS AND MAINTENANCE	19,631,049	19,631,049		
d LEASE AND MINOR EQUIPMENT	8,927,959	8,927,959		
e All other expenses	11,966,687	11,966,687	0	0
25 Total functional expenses. Add lines 1 through 24e.	1,054,353,870	922,230,217	132,123,653	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).				

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			1	
	2	Savings and temporary cash investments		8,253,437	2	17,506,858
	3	Pledges and grants receivable, net			3	
	4	Accounts receivable, net		182,633,624	4	150,411,262
	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			6	0
	7	Notes and loans receivable, net			7	
	8	Inventories for sale or use		25,293,619	8	20,805,806
	9	Prepaid expenses and deferred charges		0	9	
	10a	Land, buildings, and equipment—cost or other basis. Complete Part VI of Schedule D	10a	888,210,356		
	b	Less: accumulated depreciation	10b	539,257,898		
				420,793,391	10c	348,952,458
	11	Investments—publicly traded securities		27,297,123	11	29,351,026
	12	Investments—other securities. See Part IV, line 11		0	12	
	13	Investments—program-related. See Part IV, line 11		1,743,746	13	1,541,951
	14	Intangible assets			14	
15	Other assets. See Part IV, line 11		86,052,680	15	125,481,533	
16	Total assets. Add lines 1 through 15 (must equal line 34)		752,067,620	16	694,050,894	
Liabilities	17	Accounts payable and accrued expenses		15,012,800	17	7,869,195
	18	Grants payable			18	
	19	Deferred revenue		306,938	19	54,385
	20	Tax-exempt bond liabilities			20	
	21	Escrow or custodial account liability. Complete Part IV of Schedule D			21	
	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			22	0
	23	Secured mortgages and notes payable to unrelated third parties		1,172,122	23	660,760
	24	Unsecured notes and loans payable to unrelated third parties			24	
	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		103,093,296	25	92,565,968
	26	Total liabilities. Add lines 17 through 25		119,585,156	26	101,150,308
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		632,482,464	27	592,900,586
	28	Temporarily restricted net assets		0	28	0
	29	Permanently restricted net assets		0	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		632,482,464	33	592,900,586
34	Total liabilities and net assets/fund balances		752,067,620	34	694,050,894	

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	1,090,197,093
2	Total expenses (must equal Part IX, column (A), line 25)	2	1,054,353,870
3	Revenue less expenses Subtract line 2 from line 1	3	35,843,223
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	632,482,464
5	Net unrealized gains (losses) on investments	5	1,458,602
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-76,883,703
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	592,900,586

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: 17005876
Software Version: 2017v2.2
EIN: 36-4195126
Name: Presence Central and Suburban Hospitals Network

Form 990 (2017)

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 PATIENT 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 ITS UNWAVERING COMMITMENT TO STAY IN WILL COUNTY AND GROW SO IT MAY CONTINUE TO PROVIDE THE BEST OF CARE TO RESIDENTS IN THE FUTURE FOR CALENDAR YEAR ENDED DECEMBER 2017 PRESENCE SAINT JOSEPH MEDICAL CENTER PROVIDED PATIENT CARE OF 99,098 PATIENT DAYS AND 21,052 DISCHARGES EMERGENCY ROOM VISITS TOTALED 57,432, SURGERIES TOTALED 10,799, AND OUTPATIENT REGISTRATIONS TOTALED 267,464 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 OTHER MINISTRIES IN KANKAKEE TO CONTINUE TO CARRY OUT OUR MISSION OF BRINGING HEALING AND HOPE TO THE COMMUNITY FOR CALENDAR YEAR ENDED DECEMBER 2017 PRESENCE SAINT MARY HOSPITAL PROVIDED PATIENT CARE OF 21,100 PATIENT DAYS AND 5,203 DISCHARGES EMERGENCY ROOM VISITS TOTALED 28,695, SURGERIES TOTALED 4,187, AND OUTPATIENT REGISTRATIONS TOTALED 52,944 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 IT SERVES FOR CALENDAR YEAR ENDED DECEMBER 2017 PRESENCE SAINT JOSEPH HOSPITAL ELGIN PROVIDED PATIENT CARE OF 38,660 PATIENT DAYS AND 7,027 DISCHARGES EMERGENCY ROOM VISITS TOTALED 24,740, SURGERIES TOTALED 4,288, AND OUTPATIENT REGISTRATIONS TOTALED 104,567 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 2017 PRESENCE MERCY MEDICAL CENTER PROVIDED PATIENT CARE OF 38,183 PATIENT DAYS AND 8,219 DISCHARGES EMERGENCY ROOM VISITS TOTALED 38,418, SURGERIES TOTALED 2,685, AND OUTPATIENT REGISTRATIONS TOTALED 129,714 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 2017 PRESENCE COVENANT MEDICAL CENTER PROVIDED PATIENT CARE OF 26,678 PATIENT DAYS AND 6,684 DISCHARGES EMERGENCY ROOM VISITS TOTALED 22,574, SURGERIES TOTALED 4,994, AND OUTPATIENT REGISTRATIONS TOTALED 121,534 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 VERMILLION COUNTY, ILLINOIS (NEARLY 82,000 RESIDENTS), COMMUNITIES IN RURAL SOUTHERN IROQUOIS AND NORTHERN EDGAR COUNTIES IN ILLINOIS, AND VERMILLION, FOUNTAIN AND WARREN COUNTIES IN INDIANA FOR CALENDAR YEAR ENDED DECEMBER 2017 PRESENCE UNITED SAMARITANS MEDICAL CENTER PROVIDED PATIENT CARE OF 17,138 PATIENT DAYS AND 5,052 DISCHARGES EMERGENCY ROOM VISITS TOTALED 37,371, SURGERIES TOTALED 2,587, AND OUTPATIENT REGISTRATIONS TOTALED 147,216

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			
MARSHA LADENBURGER RN	1 0									
DIRECTOR, CHAIR	..... 2 0	X		X				0	0	0
MARK HANSON	1 0									
DIRECTOR, VICE CHAIR (START 1/2017)	..... 2 0	X		X				0	0	0
SAM BAGCHI MD	1 0									
DIRECTOR (END 3/2017)	..... 41 0	X						0	383,149	20,121
DAVID J BORDO MD	1 0									
DIRECTOR	..... 40 0	X						0	400,401	40,834
PATRICIA FOLTZ	1 0									
DIRECTOR	..... 1 0	X						0	0	0
STEVE TALTY MD	1 0									
DIRECTOR	..... 0	X						0	0	0
PATRICIA EDDY	1 0									
ASSISTANT TREASURER, SYSTEM FINANCIAL OFFICER	..... 54 0			X				0	331,210	55,715
JEANNIE C FREY	1 0									
SECRETARY, SYSTEM CHIEF LEGAL OFFICER	..... 54 0			X				0	882,091	125,418
BETTINA JOHNSON	1 0									
ASSISTANT TREASURER, SYSTEM DIRECTOR (START 5/2017)	..... 54 0			X				0	270,133	29,642
JAMES KELLEY	1 0									
TREASURER, CHIEF FINANCIAL OFFICER	..... 54 0			X				0	930,214	185,845

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			
PATRICK QUINN	1 0 54 0			X				0	87,398	1,191
ASSISTANT TREASURER, SENIOR VICE PRESIDENT (END 2/2017)										
JULIE ROKNICH	1 0 54 0			X				0	235,311	31,048
ASSISTANT SECRETARY, SYS DIRECTOR SR ASSOCIATE GENERAL COUNSEL TRANSACTIONS										
JEFFREY ROONEY	1 0 54 0			X				0	452,460	109,175
ASSISTANT TREASURER, SVP FINANCIAL OPERATIONS (START 5/2017)										
ANN ERRICHETTI	1 0 42 0			X				0	1,307,360	22,555
PRESIDENT										
MICHAEL L BROWN	40 0 0 0				X			742,960	0	101,398
REGIONAL PRESIDENT & CEO - FXV										
ROBERT JAMES ERICKSON	40 0 0				X			419,906	0	75,255
PRESIDENT - PSJMC (START 3/2017)										
JARED C ROGERS	40 0 0				X			534,345	0	29,253
REGIONAL PRESIDENT & CEO - CES										
CHRISTOPHER SCOTT SHRIDE	40 0 0				X			346,504	0	63,122
PRESIDENT - PSMH										
ANIL B GOPINATH MD	40 0 0					X		382,750	0	37,099
REGIONAL CHIEF MEDICAL OFFICER										
VINCENT KUCICH	40 0 0					X		328,156	0	19,913
REGIONAL CHIEF MEDICAL OFFICER										

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			
GARY LIPINSKI MD REGIONAL CHIEF MEDICAL OFFICER	40 0 1 0					X		458,219	0	28,777
SHOBHANA RAVIKUMAR MD PHYSICIAN	40 0 0					X		331,775	0	33,467
DEBORAH A SCHIMEROWSKI REGIONAL FINANCE OFFICER - CES/SSB	40 0 0					X		292,194	0	25,663
BEEJAL Y AMIN MD FORMER HIGHEST COMPENSATED EMPLOYEE	0 0 40 0						X	0	941,664	36,192
SURENDRA M GULATI FORMER HIGHEST COMPENSATED EMPLOYEE	0 0 40 0						X	0	499,122	28,596
KAIZ ASIF FORMER HIGHEST COMPENSATED EMPLOYEE	0 0 40 0						X	0	540,702	32,976
LISA LAGGER FORMER KEY EMPLOYEE (END 12/2014)	0 0 40 0						X	0	208,849	4,131
CONNIE J NOLTEMEYER FORMER KEY EMPLOYEE (END 12/2014)	0 0 0						X	144,270	0	14,608
KATHLEEN RHINE FORMER KEY EMPLOYEE (END 9/2016)	0 0 0						X	135,351	0	0
ANTHONY FILER FORMER OFFICER (END 01/2016)	0 0 0 0						X	0	100,273	0

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

<p>(A) Name and Title</p>	<p>(B) Average hours per week (list any hours for related organizations below dotted line)</p>	<p>(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)</p>						<p>(D) Reportable compensation from the organization (W-2/1099-MISC)</p>	<p>(E) Reportable compensation from related organizations (W-2/1099-MISC)</p>	<p>(F) Estimated amount of other compensation from the organization and related organizations</p>
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
<p>AMY D STEVENS</p> <p>FORMER OFFICER (END 12/2015)</p>	<p>0 0</p> <p>.....</p> <p>0 0</p>						X	0	121,076	0

SCHEDULE A

(Form 990 or 990EZ)

Department of the Treasury

Internal Revenue Service

Public Charity Status and Public Support

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

OMB No 1545-0047

2017

Open to Public Inspection

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 **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), 170(b)(1)(A)(vi), and 170(b)(1)(A)(ix)

(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							
	Calendar year (or fiscal year beginning in) ►	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(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							
Calendar year (or fiscal year beginning in) ►		(a)2013	(b)2014	(c)2015	(d)2016	(e)2017	(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 2017 (line 6, column (f) divided by line 11, column (f))	14
15	Public support percentage for 2016 Schedule A, Part II, line 14	15
16a	33 1/3% support test—2017. 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—2016. 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—2017. 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—2016. 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) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(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) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(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 2017 (line 8, column (f) divided by line 13, column (f))	15	
16 Public support percentage from 2016 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2017 (line 10c, column (f) divided by line 13, column (f))	17	
18 Investment income percentage from 2016 Schedule A, Part III, line 17	18	

19a 33 1/3% support tests—2017. 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—2016. 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>		
	1	
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>		
	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?		
	1	
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>		
	2	
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>		
	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** ☐ The organization satisfied the Activities Test. Complete **line 2** below.
- b** ☐ The organization is the parent of each of its supported organizations. Complete **line 3** below.
- c** ☐ 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.

	Yes	No
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>		
	2a	
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>		
	2b	
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>		
	3a	
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>		
	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 (explain in Part VI) **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 2017 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-2017	(iii) Distributable Amount for 2017
1 Distributable amount for 2017 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2017 (reasonable cause required-- explain in Part VI) See instructions			
3 Excess distributions carryover, if any, to 2017			
a			
b From 2013.			
c From 2014.			
d From 2015.			
e From 2016.			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2017 distributable amount			
i Carryover from 2012 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2017 from Section D, line 7 \$			
a Applied to underdistributions of prior years			
b Applied to 2017 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2017, if any Subtract lines 3g and 4a from line 2 If the amount is greater than zero, explain in Part VI See instructions			
6 Remaining underdistributions for 2017 Subtract lines 3h and 4b from line 1 If the amount is greater than zero, explain in Part VI See instructions			
7 Excess distributions carryover to 2018. Add lines 3j and 4c			
8 Breakdown of line 7			
a Excess from 2013.			
b Excess from 2014.			
c Excess from 2015.			
d Excess from 2016.			
e Excess from 2017.			

Additional Data

Software ID: 17005876
Software Version: 2017v2.2
EIN: 36-4195126
Name: Presence Central and Suburban Hospitals Network

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: 93493319173118	
<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>2017</div> <div>Open to Public Inspection</div>
Name of the organization Presence Central and Suburban Hospitals Network				Employer identification number 36-4195126	
Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" on Form 990, Part IV, line 6.					
		(a) Donor advised funds		(b) Funds and other accounts	
1		Total number at end of year			
2		Aggregate value of contributions to (during year)			
3		Aggregate value of grants from (during year)			
4		Aggregate value at end of year			
5		Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>			
6		Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>			
Part II Conservation Easements. Complete if the organization answered "Yes" on Form 990, Part IV, line 7.					
1 Purpose(s) of conservation easements held by the organization (check all that apply) <div><input type="checkbox"/> Preservation of land for public use (e g , recreation or education) <input type="checkbox"/> Preservation of an historically important land area <input type="checkbox"/> Protection of natural habitat <input type="checkbox"/> Preservation of a certified historic structure <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 <input type="checkbox"/> No</div>					
6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ►					
7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ► \$					
8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>					
9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements					
Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets. Complete if the organization answered "Yes" on Form 990, Part IV, line 8.					
1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items					
b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items <div><div>(i) Revenue included on Form 990, Part VIII, line 1 (ii) Assets included in Form 990, Part X</div><div>► \$ ► \$</div></div>					
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 <div><div>a Revenue included on Form 990, Part VIII, line 1 b Assets included in Form 990, Part X</div><div>► \$ ► \$</div></div>					
For Paperwork Reduction Act Notice, see the Instructions for Form 990.					
Cat No 52283D		Schedule D (Form 990) 2017			

Part III

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

3

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

a

☐

Public exhibition

b

☐

Scholarly research

c

☐

Preservation for future generations

d

☐

Loan or exchange programs

e

☐

Other

4

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

5

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

☐ Yes

☐ No

Part IV

Escrow and Custodial Arrangements.

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

1a

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

☐ Yes

☐ No

b

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

	Amount
1c	
1d	
1e	
1f	

c

Beginning balance

d

Additions during the year

e

Distributions during the year

f

Ending balance

2a

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

☐ Yes

☐ No

b

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

☐

Part V

Endowment Funds. Complete if the organization answered "Yes" 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	0	14,591,459	2,899,207	2,848,100	2,744,115
b	Contributions		16,897,832	2,872	4,756	
c	Net investment earnings, gains, and losses		89,083	-21,361	104,946	122,906
d	Grants or scholarships		45,525	29,359	55,109	21,530
e	Other expenditures for facilities and programs		14,635,017	5,154,860	1,602	2,147
f	Administrative expenses					
g	End of year balance	0	0	14,591,459	2,899,207	2,848,100

2

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

a

Board designated or quasi-endowment

0 %

b

Permanent endowment

0 %

c

Temporarily restricted endowment

0 %

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

3a(i)

Yes

No

(ii) related organizations

3a(ii)

Yes

b

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

3b

Yes

4

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

Part VI

Land, Buildings, and Equipment.

Complete if the organization answered "Yes" 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	14,056,461		14,056,461
b	Buildings	595,198,099	338,013,912	257,184,187
c	Leasehold improvements	8,156,511	1,677,765	6,478,746
d	Equipment	253,917,133	190,647,187	63,269,946
e	Other	16,882,152	8,919,034	7,963,118
Total.	Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c))			348,952,458

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	36,511,946
(2) THIRD PARTY RECEIVABLES	8,936,430
(3) MANUAL RECEIVABLES	4,501,497
(4) INCENTIVE RECEIVABLES	2,270,975
(5) DEFERRED COMPENSATION ASSET	173,308
(6) LONG TERM RECEIVABLES	89,987
(7) PHYSICIAN LOAN RECEIVABLE LT/ST	198,421
(8) MISCELLANEOUS BILLING AR	321,794
(9) ASSET HELD FOR SALE	72,477,175
Total. (Column (b) must equal Form 990, Part X, col (B) line 15) ▶	125,481,533

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	
DUE TO THIRD PARTY PAYORS	91,071,173
OTHER LONG TERM LIABILITIES	1,321,487
CAPITAL ACCUMULATION	173,308
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 25) ▶	92,565,968

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: 17005876
Software Version: 2017v2.2
EIN: 36-4195126
Name: Presence Central and Suburban Hospitals Network

Form 990, Schedule D, Part IX, - Other Assets

(a) Description	(b) Book value
DUE FROM AFFILIATES	36,511,946
THIRD PARTY RECEIVABLES	8,936,430
MANUAL RECEIVABLES	4,501,497
INCENTIVE RECEIVABLES	2,270,975
DEFERRED COMPENSATION ASSET	173,308
LONG TERM RECEIVABLES	89,987
PHYSICIAN LOAN RECEIVABLE LT/ST	198,421
MISCELLANEOUS BILLING AR	321,794
ASSET HELD FOR SALE	72,477,175

Supplemental Information	
Return Reference	Explanation
Schedule D, Part V, Line 4 Intended uses of endowment funds	THE ENDOWMENT FUNDS ARE USED TO SUPPORT CHARITABLE EFFORTS WITHIN THE PRESENCE HEALTH SYSTEM

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, 2017 AND 2016, PRESENCE HEALTH DOES NOT HAVE ANY LIABILITIES FOR UNRECOGNIZED TAX BENEFITS

SCHEDULE H (Form 990) Department of the Treasury Internal Revenue Service	<h2 style="margin:0;">Hospitals</h2> <p>► 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.</p>	OMB No 1545-0047 <h1 style="margin:0;">2017</h1> <p>Open to Public Inspection</p>
Name of the organization Presence Central and Suburban Hospitals Network		Employer identification number 36-4195126

Part I Financial Assistance and Certain Other Community Benefits at Cost

		Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	Yes	
b If "Yes," was it a written policy?	1b	Yes	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year			
<input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities			
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year			
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %	3a	Yes	
b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other _____ 60000 %	3b	Yes	
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care			
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	Yes	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	Yes	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	Yes	
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		No
6a Did the organization prepare a community benefit report during the tax year?	6a	Yes	
b If "Yes," did the organization make it available to the public?	6b	Yes	
Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.			

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)		0	23,844,407	0	23,844,407	2 26 %
b Medicaid (from Worksheet 3, column a)		106,346	232,215,431	184,640,839	47,574,592	4 51 %
c Costs of other means-tested government programs (from Worksheet 3, column b)	0	0	0	0	0	0 %
d Total Financial Assistance and Means-Tested Government Programs	0	106,346	256,059,838	184,640,839	71,418,999	6 76 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	94	66,062	1,574,182	180,012	1,394,170	0 13 %
f Health professions education (from Worksheet 5)	15	3,035	5,310,583	566,428	4,744,155	0 45 %
g Subsidized health services (from Worksheet 6)	5	534	5,816,568	3,724,067	2,092,501	0 20 %
h Research (from Worksheet 7)	2	100	558,886	0	558,886	0 05 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)	34	8,754	357,792	928	356,864	0 03 %
j Total. Other Benefits	150	78,485	13,618,011	4,471,435	9,146,576	0 87 %
k Total. Add lines 7d and 7j	150	184,831	269,677,849	189,112,274	80,565,575	7 63 %

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	0	0	0	0	0	0 %
2 Economic development	0	0	0	0	0	0 %
3 Community support	5	6,625	383,309	36,475	346,834	0 03 %
4 Environmental improvements	0	0	0	0	0	0 %
5 Leadership development and training for community members	0	0	0	0	0	0 %
6 Coalition building	2	0	1,753	0	1,753	0 %
7 Community health improvement advocacy	0	0	0	0	0	0 %
8 Workforce development	1	4	472	0	472	0 %
9 Other	0	0	0	0	0	0 %
10 Total	8	6,629	385,534	36,475	349,059	0 03 %

Part III

Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

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

1

Yes

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

-1,614,513

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

377,263,753

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

6

459,262,163

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

7

-81,998,410

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

☐ Cost accounting system ☒ Cost to charge ratio ☐ Other

Section C. Collection Practices

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

9a

Yes

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

(a) Name of entity (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)	(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 DIALYSIS CENTER	DIALYSIS CENTER	50 %		50 %
2 DRYER MERCY AMBULATORY SURGERY CENTER	AMBULATORY SURGERY CENTER	40 %		60 %
3 CENTER FOR DIGESTIVE DISEASE	DIGESTIVE HEALTH SERVICES	10 %		90 %
4 PRESENCE SAINT JOSEPH HOSPITAL ORTHOPEDIC CLINICAL CO-MANAGEMENT COMPANY LLC	MANAGEMENT OF ORTHOPEDIC SERVICE LINE	20 %		80 %
5				
6				
7				
8				
9				
10				
11				
12				
13				

Schedule H (Form 990) 2017

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 UNITED SAMARITANS 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): _____

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 checked="" 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 17</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>https://www.osfhealthcare.org/about/community-health/</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 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) <u>http://www.presencehealth.org/community-health</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 UNITED SAMARITANS 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 <u>200.0</u> % and FPG family income limit for eligibility for discounted care of <u>600.0</u> %			
b <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input 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) <u>http://presencehealth.org/financial-assistance</u>			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>http://presencehealth.org/financial-assistance</u>			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>http://presencehealth.org/financial-assistance</u>			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g <input checked="" type="checkbox"/> 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 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 nonpayment?	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 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
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 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 checked="" 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>17</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 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-HEALTH</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>15</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10 Yes	
a If "Yes" (list url) <u>HTTP //PRESENCEHEALTH ORG/COMMUNITY-HEALTH</u>		
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 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 <u>200.0</u> % and FPG family income limit for eligibility for discounted care of <u>600.0</u> %			
b <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input 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) <u>HTTP //PRESENCEHEALTH.ORG/FINANCIAL-ASSISTANCE</u>			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>HTTP //PRESENCEHEALTH.ORG/FINANCIAL-ASSISTANCE</u>			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>HTTP //PRESENCEHEALTH.ORG/FINANCIAL-ASSISTANCE</u>			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g <input checked="" type="checkbox"/> 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 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 nonpayment?	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 checked="" 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 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-HEALTH</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 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10 Yes	
a If "Yes" (list url) <u>HTTP //PRESENCEHEALTH ORG/COMMUNITY-HEALTH</u>		
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 MERCY 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 <u>200.0</u> % and FPG family income limit for eligibility for discounted care of <u>600.0</u> %			
b <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input 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) <u>http://presencehealth.org/financial-assistance</u>			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>http://presencehealth.org/financial-assistance</u>			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>http://presencehealth.org/financial-assistance</u>			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g <input checked="" type="checkbox"/> 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 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 nonpayment?	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 checked="" 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-HEALTH</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 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10 Yes	
a If "Yes" (list url) <u>HTTP //PRESENCEHEALTH ORG/COMMUNITY-HEALTH</u>		
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 <u>200.0</u> % and FPG family income limit for eligibility for discounted care of <u>600.0</u> %			
b <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input 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) <u>http://presencehealth.org/financial-assistance</u>			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>http://presencehealth.org/financial-assistance</u>			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>http://presencehealth.org/financial-assistance</u>			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g <input checked="" type="checkbox"/> 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 nonpayment?	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 checked="" 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-HEALTH</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>15</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10 Yes	
a If "Yes" (list url) <u>HTTP //PRESENCEHEALTH ORG/COMMUNITY-HEALTH</u>		
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 MARY'S 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 <u>200.0</u> % and FPG family income limit for eligibility for discounted care of <u>600.0</u> %			
b <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input 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?	15	Yes	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)			
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e <input type="checkbox"/> Other (describe in Section C)			
16 Was widely publicized within the community served by the hospital facility?	16	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>http://presencehealth.org/financial-assistance</u>			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>http://presencehealth.org/financial-assistance</u>			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>http://presencehealth.org/financial-assistance</u>			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g <input checked="" type="checkbox"/> 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 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 nonpayment?	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
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 checked="" 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>17</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>https://www.osfhealthcare.org/about/community-health/</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>16</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10 Yes	
a If "Yes" (list url) <u>http://www.presencehealth.org/community-health</u>		
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 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 <u>200.0</u> % and FPG family income limit for eligibility for discounted care of <u>600.0</u> %			
b <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input 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) <u>http://presencehealth.org/financial-assistance</u>			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>http://presencehealth.org/financial-assistance</u>			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>http://presencehealth.org/financial-assistance</u>			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g <input checked="" type="checkbox"/> 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 nonpayment?	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

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
Schedule H, Part I, Line 3c 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 (I.E. 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 PATIENT'S FAMILY IS ENROLLED IN ILLINOIS HOUSING DEVELOPMENT AUTHORITY'S RENTAL HOUSING SUPPORT PROGRAM</p> <p>N PATIENT OR PATIENT'S 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 PATIENT'S FAMILY'S INABILITY TO PAY ANY PORTION OF PATIENT-LIABILITY AMOUNT HAS BEEN VERIFIED BY AN INDEPENDENT THIRD-PARTY AGENCY 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 PATIENT'S FAMILY'S ANNUAL GROSS INCOME, EVEN AFTER PAYMENT BY THIRD-PARTY PAYERS</p> <p>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</p> <p>1 THERE IS NO APPLICATION PROCESS FOR THE PATIENT TO RECEIVE THE UNINSURED SELF-PAY DISCOUNT THE DISCOUNT IS APPLIED BASED ON THE ACCOUNT'S 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 PATIENT'S OUT OF POCKET (OOP) LIABILITY REDUCED BY 100% OF THE HOSPITAL'S MEDICARE COST-TO-CHARGE RATIO OR THE AMOUNT THE PATIENT WOULD HAVE BEEN RESPONSIBLE FOR HAD THEY BEEN UNINSURED THE AMOUNT</p>

Form and Line Reference	Explanation
Schedule H, Part I, Line 3c PART I, LINE 3C	OF FINANCIAL ASSISTANCE WILL BE DETERMINED ONCE ALL THIRD-PARTY PAYMENT AMOUNTS HAVE BEEN IDENTIFIED IN ADDITION, INSURED PATIENTS WITH HIGH HOSPITAL BILLS MAY RECEIVE A CATASTROP HIC 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
Schedule H, Part I, Line 6a PART I, LINE 6A	PRESENCE HEALTH NETWORK, THE PARENT OF PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK, PUBLISHED A COMMUNITY BENEFIT REPORT WITH 2017 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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part I, Line 6b PART I, LINE 6B	THE 2017 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 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 2017 COMMUNITY BENEFIT REPORT 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 * AN INTERACTIVE TOOL FOR EXPLORING THE COMMUNITY BENEFIT PROVIDED BY EACH MINISTRY WAS MADE AVAILABLE AT PRESENCEHEALTH.GITHUB.IO/COMMUNITYTOUCH, WITH A LINK PROVIDED ON EACH HOSPITAL'S WEBSITE

990 Schedule H, Supplemental Information	
Form and Line Reference	Explanation
Schedule H, Part I, Line 7f PART I, LINE 7, COLUMN F	PER 2017 INSTRUCTIONS FOR SCHEDULE H (FORM 990), THE REVERSAL OF BAD DEBT EXPENSE OF (\$1,614,515) HAS BEEN ADDED BACK TO THE DENOMINATOR IN CALCULATING THE PERCENTAGE OF TOTAL EXPENSE IN LINE 7

Form and Line Reference	Explanation
<p>Schedule H, Part VI, Line 5 PROMOTION OF COMMUNITY HEALTH</p>	<p>Presence Mercy Medical Center (PMMC), Aurora, IL I'M REDUCING OBESITY IN CHILDREN (IROC) N UTRITION PROGRAM Identified need Obesity and Chronic Disease I'm Reducing Obesity in Children (IROC) Nutrition program is designed to provide a series of eight 1 0 hour workshops that will emphasize proper nutrition education for parents and children including goal setting and motivation related to healthy behavior issues. The workshops will also provide families with information and resources relevant to the topics covered. Each 8- week session involves parents attending an education workshop presented by a registered dietitian as children concurrently participate in a cooking demonstration activity led by a registered nurse. Children will create and eat some healthy snacks in this hands-on class that introduces little cooks to the kitchen with easy recipes, simple measurements and kitchen safety. A1C ACHIEVER DIABETES MANAGEMENT PROGRAM Identified need Chronic Disease "Life with Diabetes" is a 2-3 month program that combines diabetes self-management education and medical nutrition therapy concurrently. Patients are referred by their primary healthcare provider to meet with a diabetes educator for an individual initial assessment to determine the plan of care. Patients attend six 1 5 hour sessions and two individual medical nutrition therapy sessions. Healthy behavior goals are selected by the patient and diabetes educator to be re- evaluated midway through the program and upon program completion or as needed. All patients that achieve an A1C of less than 7% become part of the "A1C Achiever" program which is a patient recognition program that rewards patients for achieving glycemic control. A-LIST ACHIEVING GOOD HEALTH DIABETES PREVENTION PROGRAM Identified need Chronic disease A-List is a diabetes screening and education program that focuses to prevent the onset of type 2 diabetes. Established in 2011, the A-List Achieving Good Health Diabetes Prevention program is an 8-week program that combines diabetes prevention education strategies and medical nutrition therapy concurrently. Participants must have at least one risk factor for type 2 diabetes but must not be diagnosed upon program entry. Participants meet with a diabetes educator for an individual initial assessment to determine the plan of care. Participants will then attend eight 1 5 hour workshops and two individual medical nutrition therapy sessions. Healthy behavior goals are selected by participants and a diabetes educator at the beginning of the program and then to be re-evaluated midway through the program and upon program completion or as needed. All participants that can demonstrate optimal glycemic levels or improved glycemic levels are invited to attend a recognition celebration that rewards them for achieving improved health status. COMMUNITY WELLNESS PROGRAM Identified need Obesity and Chronic disease The Community Wellness Program provides community education and screening programs on a variety of health and wellness topics both in the community and main hospital location. Components of the program include blood pressure, blood glucose, blood lipid, body fat and body mass index (BMI) screenings. Health education topics on chronic disease include hypertension, stroke, diabetes, obesity and heart disease. LIVE WELL, BE WELL CHRONIC DISEASE SELF-MANAGEMENT PROGRAM Identified need Obesity and Chronic Disease The Live Well, Be Well Chronic Disease Self-Management Program is a 6-week program with participants education workshop that is evidence based Chronic Disease Self-Management Program developed by Stanford School of Medicine Patient Education Research Center. The program provides information and teaches practical skills on managing chronic health problems. Live Well, Be Well program gives people the confidence and motivation they need to manage the challenges of living with chronic disease including communication with physicians, symptom management, action planning & strategies for disease prevention. Caregivers are encouraged to attend. FREEDOM FROM SMOKING PROGRAM Identified need Chronic Disease Although smoking cessation was not one of the six major threats identified in the CHNA it was listed as a priority for Kane County. Smoking cessation is included in the Community Health Implementation Strategy Plan because of the impact that smoking has on the health of an individual when addressing chronic disease management and prevention. Smoking cessation initiatives was identified as a priority to address. Freedom from Smoking is a 7-week, small group, program for adults trying to quit smoking and covers topics on what triggers the need to continue smoking, how to cope with changes in quitting and how to find the necessary support. The program teaches participants how to understand their habit, increase their motivation, help them develop an individualized plan for quitting, and teach them skills to maintain a healthy lifestyle. FAITH COMMUN</p>

Form and Line Reference	Explanation
Schedule H, Part VI, Line 5 PROMOTION OF COMMUNITY HEALTH	<p>ITY NURSING PROGRAM Identified need Access to Care The Faith Community Nursing (FCN) program at PMMC integrates faith and health in order to serve the health care needs of members of faith congregations and the community. The FCN role is a specialty of nursing focused on the integration of the spiritual dimension into the health system through visits involving advocacy, referral, wellness education and navigation of the health system.</p> <p>LANGUAGE ACCESS TO HEALTHCARE (LAH) INTERPRETING SERVICES Identified Need Access to Care Language Access to Healthcare is a community-based interpreting and translating services program. In an effort to provide equal access to health care, LAH was designed to help break the language barriers for limited English proficient and non-English speaking individuals. Interpreting and translating services are available to individuals and organizations within the hospital's primary and secondary service area. Although language barriers were not a specific need in the CHNA, this program is included in the Community Health Implementation Strategy Plan because of the impact that language barriers has on the health of an individual.</p> <p>Mental Health First Aid Identified need Poor Social and Emotional Wellness 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 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 hospital system 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 2016-2017 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 Enroll America.</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part VI, Line 5 PROMOTION OF COMMUNITY HEALTH	<p>Presence Saint Joseph Hospital (PSJH), Elgin, IL LIVE WELL, BE WELL CHRONIC DISEASE SELF-MANAGEMENT PROGRAM Identified Need Obesity and Chronic Disease The Live Well, Be Well Chronic Disease Self-Management Program is a 6-week program with participants education workshop that is evidence based Chronic Disease Self-Management Program developed by Stanford School of Medicine Patient Education Research Center The program provides information and teaches practical skills on managing chronic health problems Live Well, Be Well program gives people the confidence and motivation they need to manage the challenges of living with chronic disease including communication with physicians, symptom management, action planning & strategies for disease prevention Caregivers are encouraged to attend FREEDOM FROM SMOKING PROGRAM Identified Need Chronic Disease Although smoking cessation was not one of the six major threats identified in the CHNA it was listed as a priority for Kane County Smoking cessation is included in the Community Health Implementation Strategy Plan because of the impact that smoking has on the health of an individual when addressing chronic disease management and prevention Smoking cessation initiatives was identified as a priority to address Freedom from Smoking is a 7-week, small group, program for adults trying to quit smoking and covers topics on what triggers the need to continue smoking, how to cope with changes in quitting and how to find the necessary support The program teaches participants how to understand their habit, increase their motivation, help them develop an individualized plan for quitting, and teach them skills to maintain a healthy lifestyle Mental Health First Aid Identified need Poor social and emotional wellness 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 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 Enrollment Strategy Overall hospital system 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 2016-2017 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 Enroll America</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part VI, Line 5 PROMOTION OF COMMUNITY HEALTH	<p>Presence St Mary's Hospital (PSMH), Kankakee, IL FIT "N" HEALTHY & WE FIT! PROGRAMS Identified need Chronic disease Fit "N" Healthy (FNH) is a free program offered in the DUHN community of Kankakee County to provide education and exercise to those suffering from obesity and obesity related health problems FNH participants meet with a certified fitness trainer twice a week for 10 weeks Each session participants exercise for 40 minutes followed by a 10 minute cool down period FNH offers four 10 week sessions per year with pre- and post-screenings which include blood pressure, BMI (body mass index), glucose, HDL, triglycerides and body measurements Along with the screenings, PNH offers bi-weekly education regarding nutrition, cardiac education, sleep disorders, behavior health and respiratory conditions linked to obesity The FNH program also offers a spiritual component in which participants glean support from each other through prayer and scriptural meditation Based on the popularity of Fit "N" Healthy for adults, We Fit! program was developed for the DUHN community of Kankakee County and provides free education and exercise to children and their parents Our participants meet with a certified fitness trainer twice a week for 6 weeks This program includes topics to promote healthy eating habits and physical activity for children Each session has a 10 minutes education then 40 minutes of exercise Pre and post-tests assess knowledge of physical activity, dietary behavior, recreational screen time behaviors and sugary beverage consumptions DR AROCHA'S CAMP AIRE Identified need Chronic disease A two day Asthma camp that will teach children with asthma how to manage their Asthma and what trigger to avoid to assist in controlling their asthma Activities will be planned, baseball, swimming, hiking, crafts and others Along with activities we will also provide "camp" crafts Classes on nutrition and health maintenance will be provided Return demonstration will allow us to see how successful the child has been in controlling their asthma PARTNERSHIP FOR A HEALTHY COMMUNITY Identified need Chronic Disease In 2012, PSMH partnered with the Kankakee Health Department as well as Riverside Medical Center and other community organizations to for the Partnership for a Healthy Community Through this partnership the initial CHNA was completed and now updated in 2015 PARTNERSHIP FOR A HEALTHY COMMUNITY Identified need Mental Health & Substance Abuse In 2012, PSMH partnered with the Kankakee Health Department as well as Riverside Medical Center and other community organizations to for the Partnership for a Healthy Community Through this partnership the initial CHNA was completed and now updated in 2015 PARTNERSHIP FOR A HEALTHY COMMUNITY Identified need Access to Care In 2012, PSMH partnered with the Kankakee Health Department as well as Riverside Medical Center and other community organizations to for the Partnership for a Healthy Community Through this partnership the initial CHNA was completed and now updated in 2015 Mental Health First Aid & Substance Abuse 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 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 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 2016-2017 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 Enroll America</p>

Form and Line Reference	Explanation
<p>Schedule H, Part VI, Line 5 PROMOTION OF COMMUNITY HEALTH</p>	<p>Presence Covenant Medical Center (PCMC), Champaign, IL Identified Need Reducing Obesity and Promoting Healthy Lifestyles Community Resource Center Presence Covenant Community Resource Center was developed to address unmet medical and social needs of those patients that were frequently utilizing the Emergency Room. It has recently expanded its services to serve any community member that seeks assistance. The center primarily provides community referral services to clients and helps them connect with an array of social service agencies based on a holistic approach to medical problems. The PCMC Community Resource Center is staffed by three PCMC Health Navigators and one PCMC social worker. In addition to the hospital staff, the center is made up of community partners that provide services at the center. These partners include Catholic Charities, Champaign County Christian Health Clinic, Champaign County Health Care Consumers, Patient Innovation Center, and Promise Health. Smile Healthy SmileHealthy is a collection of dental programs that work to improve the oral health of the community through providing preventive care, treatment, and education. Mobile Dental Program - The mobile program sets up inside dozens of locations and provides exam, preventive services, and treatments such as fillings and extractions. Pediatric Restorative Outpatient Surgery (PROPS) - Once a month, a SmileHealthy dentist provides comprehensive treatment under general anesthesia in hospital setting. The program cares for three low-income children each month who have extensive treatment plans often needing 10-20 treatments at once. Dental Emergency Referral - SmileHealthy offers an education and referral program for patients that present to the Emergency Department with dental pain. The program provides oral health and nutrition education, counseling and case management to facilitate patients getting treatment from a dentist and works to reduce repeat visits to the Emergency Department for the same dental health issues. The program targets low-income uninsured adults who have difficulty finding dental care. Faith in Action Faith in Action is a volunteer care giving ministry in Champaign-Urbana and the surrounding areas. The program uses faith and community volunteers to provide assistance to the senior population 55+ years. We provide transportation to medical appointments, banking, shopping and other necessary errands. Other services include home and phone visits, chores, and respite care. Center for Healthy Living The Center for Healthy Living (CHL) provides health and wellness programs that promote healthy living, reduce the risk of disease, and preserve independence. CHL offers a variety of educational programs, screenings, special events, and other services for adults that address the physical, social, mental, and spiritual dimensions of health. Most programs offered by CHL are free of charge. Faith-Squared The purpose of FAITH2 "Funds to Accelerate Innovation towards Healing and Hope", is to serve as a catalyst for innovation and acceleration of community partnership and programs to improve the health of the communities we serve consistent with the Mission, Vision, and Values of our Ministry. Promise Healthcare is dedicated to improving the health of the community through treatment, prevention and education, which aligns with our mission. In 2015, Presence Covenant Medical Center's Foundation funded Promise Healthcare through its FAITH2 program the amount of \$103,824 a second year for their project. Promise Healthcare at the Community Resource Center (CRC), to move their startup nurse practitioner satellite at the CRC to an established clinic, to work on possible expansion and improvements, to begin to address population health, and to potentially create a pilot structure for care coordination through Medicaid managed care. Enrollment Strategy In response to a demonstrated community need of improving affordable access to health care, Presence Health and its community partners engaged in the development of a community-wide enrollment strategy so as to decrease the percentage of Illinois residents without health insurance. An over-arching strategy was created in partnership with community stakeholders to guide the 2016-2017 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 Enroll America. Diabetes Coalition * The Community Diabetes Coalition was established in March 2011 to focus on the widespread problem of diabetes. The purpose of the coalition is to develop diabetes prevention and management activities through unified community effort of hospitals, clinics, social service agencies, and other interested community partners. The coalition is co-led by Presence Center for Healthy Living (PCHL) and the Champaign-Urbana Public Health District. Presence Home Care</p>

Form and Line Reference	Explanation
<p>Schedule H, Part VI, Line 5 PROMOTION OF COMMUNITY HEALTH</p>	<p>is an active member of this coalition. Identified Need: Violence Crisis Nursery. Crisis Nursery is located on the grounds of PCMC and creates an "Island of Safety" dedicated to the prevention of child abuse and neglect by providing 24-hour emergency care for children and support to strengthen families in crisis. Crisis Nursery is the only emergency-based child care facility open 24 hours, 365 days a year for the entire community to access with no fees or income eligibility. Besides safe shelter for children, age's birth through six, Crisis Nursery also provides family support and education to strengthen parent skills and confidence. The Nursery believes that "asking for help is a sign of strength." In fiscal year 2015, Crisis Nursery served 549 families, comprised of 886 children and 852 caregivers (unduplicated count) and provided nearly 29,000 hours of crisis care. Of our admissions, 43% were due to parental stress, 17% were for medical or mental health related reasons, and 2 % were for substance abuse or domestic violence related reasons. Crisis Nursery programming consists of two components: Safe Children and Strong Families. The Safe Children program is available for families who are experiencing a crisis/emergency, need child care, and have no other resources available to help. If needed, basic care items such as diapers, wipes, formula, and clothing may be available. The Strong Families program provides additional support to families, including crisis counseling, home visits, parent-child interaction groups, support groups, parent education, and referrals for resources and follow-ups. Identified Need: Behavioral Health Mental Health First Aid. 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 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>

Form and Line Reference	Explanation
<p>Schedule H, Part VI, Line 5 PROMOTION OF COMMUNITY HEALTH</p>	<p>Presence United Samaritans Medical Center (PUSMC), Danville, IL Mental Health First Aid Id entified need Mental Health In response to a demonstrated system and state-wide need of a ddressing barriers to accessing and utilizing mental health services, Presence Health and its community partners implemented an evidence-based program, Mental Health First Aid (MHF A), to reduce the stigma associated with mental illness and improve the coordination of me ntal health care throughout a six county service area A system-wide action team was creat ed to oversee the process, with administrative, local and behavioral health representative s that earned support from applicable Senior and Executive leadership teams Community sta keholders partnered in the development of the strategy and its implementation throughout t he process, recruiting trainees, identifying resources, and disseminating findings Progra m participants increased recognition of mental health disorders, increased understanding o f appropriate treatments, improved confidence in providing help to others during crisis si tuations, and decreased stigmatizing attitudes Having demonstrated its effectiveness, the program continues to expand and add both participants and partners Community Resource Ce nter Identified need Access to Care Presence United Samaritans Community Resource Center was developed to address unmet medical and social needs of those patients that were freque ntly utilizing the Emergency Room The center primarily provides community referral servic es to clients and helps them connect with an array of social service agencies based on a h olistic approach to medical problems The PUSMC Community Resource Center is staffed by 2 5 Health Navigators The CRC is in working towards mirroring the success that has been see n at the PCMC CRC and are looking toward bringing on community partners in the future Fai th in Action Identified need Access to Care Faith in Action is a volunteer care giving mi nistry in the Danville area The program uses faith and community volunteers to provide as sistance to the senior adult population 60+ years We provide transportation to medical ap pointments, banking, shopping and other necessary errands Other services include home and phone visits, chores, and respite care We have limited donated funds available for home repairs (paid contractors) and emergency needs such as RX, utilities assistance, medical e quipment and supplies, and wheelchair ramp construction (volunteers or paid contractors) Faith in Action South Identified need Access to Care Faith in Action South is a volunteer care giving ministry (South County) The program uses faith and community volunteers to pr ovide assistance to the senior adult population 60+ years We provide transportation to me dical appointments, banking, shopping and other necessary errands Other services include home and phone visits, chores, and respite care We have limited donated funds available f or home repairs (paid contractors) and emergency needs such as RX, utilities assistance, m edical equipment and supplies, and wheelchair ramp construction (volunteers or paid contra ctors) HALO Identified need Childhood Obesity The mission of the HALO Project is to focu s on building a community culture that supports healthy life choices and a high quality of life HALO Project serves as a catalyst to mobilize individuals, organizations, local gov ernment, neighborhood groups, social service agencies and healthcare providers to become p artners in reclaiming responsibility for individual and community health HALO Project has many committees and coalitions manned by community volunteers, community partners, and co mmunity stakeholders who come together to plan, develop, and implement programs and events HALO Project's target population is all areas, ages, and members of the broader communit y in Vermilion County with an emphasis on the disproportionate unmet health needs (DUHN) p opulations I Sing the Body Electric (ISBE) Identified need Access to Care I Sing the Bod y Electric is a three-phase health education and prevention program by and for youth in Ve rmilion County (VC) This program challenges high school students to develop creative, th ight-provoking art projects to help our youth build the strength and confidence necessary to make healthy life choices and to communicate the importance of those choices to their p eers, younger students, and the community in general The end result is the promotion of a culture of health Young Men Aware Identified need Abstinence education Young Men Aware is a leadership development program serving Danville High School, North Ridge Middle Schoo l, and South View Middle School The program focuses on Education, Health Awareness, and L eadership with three objectives, which include high school completion, college attainment, and early fatherhood prevention with a focus on abstinence Young Women Aware Identified need Teen pregnancy Young Women Aware is a leader</p>

Form and Line Reference	Explanation
<p>Schedule H, Part VI, Line 5</p> <p>PROMOTION OF COMMUNITY HEALTH</p>	<p>ship program serving Danville High School, North Ridge Middle School, and South View Middle School</p> <p>The program focuses on Education, Health Awareness, and Leadership with three objectives, which include high school completion, college attainment, and pregnancy prevention with a focus on abstinence</p> <p>The program goal is to increase young girl's knowledge and awareness of the consequences and ramifications of engaging in risky behaviors such as teenage sex, which will have emotional and physical consequences and ramifications</p> <p>Enrollment Strategy In response to a demonstrated community need of improving affordable access to health care, Presence Health and its community partners engaged in the development of a community-wide enrollment strategy so as to decrease the percentage of Illinois residents without health insurance</p> <p>An over-arching strategy was created in partnership with community stakeholders to guide the 2016-2017 Open Enrollment period</p> <p>The model boasts a four-pronged approach</p> <p>1 Certified Application Counselors, 2 In-Person Counselor Partnerships, 3 Directional Support and Navigation, and 4 Public Outreach and Education through Enrollment America</p>

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Form and Line Reference	Explanation
Schedule H, Part I, Line 6a Community benefit report prepared by related organization	PRESENCE HEALTH NETWORK

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Form and Line Reference	Explanation
Schedule H, Part I, Line 7g Subsidized Health Services	COSTS FROM PHYSICIAN CLINICS ARE NOT INCLUDED IN SUBSIDIZED SERVICE TOTALS

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Form and Line Reference	Explanation
Schedule H, Part I, Line 7 Bad Debt Expense excluded from financial assistance calculation	-1614515

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Form and Line Reference	Explanation
Schedule H, Part I, Line 7 Costing Methodology used to calculate financial assistance	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

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Form and Line Reference	Explanation
Schedule H, Part II Community Building Activities	<p>COMMUNITY BUILDING ACTIVITIES INCLUDE PROGRAMS THAT IMPROVE THE COMMUNITY'S HEALTH AND SAFETY BY ADDRESSING THE ROOT CAUSES OF HEALTH PROBLEMS, SUCH AS POVERTY, HOMELESSNESS AND ENVIRONMENTAL HAZARDS PARTICIPATION IN COLLABORATIVE COMMUNITY EFFORTS TO PROMOTE PUBLIC HEALTH INITIATIVES IS ALSO INCLUDED, SUCH AS ENGAGEMENT IN COALITIONS AND ADVOCACY FOR HEALTH IMPROVEMENT THESE ACTIVITIES STRENGTHEN THE COMMUNITY'S CAPACITY TO PROMOTE THE HEALTH AND WELL-BEING OF ITS RESIDENTS BY OFFERING THE EXPERTISE AND RESOURCES OF THE HEALTH CARE ORGANIZATION PRESENCE HEALTH HOSPITAL MINISTRIES ENGAGE IN A VARIETY OF COMMUNITY-BUILDING ACTIVITIES WHICH ULTIMATELY IMPROVE THE HEALTH AND WELL-BEING OF THE COMMUNITIES WE ARE PRIVILEGED TO SERVE, EVEN THOUGH THEY ARE NOT SPECIFIC HEALTH ACTIVITIES EXAMPLES OF COMMUNITY BUILDING ACTIVITIES INCLUDE</p> <ul style="list-style-type: none">*THE WORK OF ALL OF OUR HOSPITALS IN SUPPORT OF DISASTER READINESS AND EMERGENCY PREPAREDNESS THIS WORK GOES ABOVE AND BEYOND ANY LICENSURE REQUIREMENTS TO PROACTIVELY ENSURE THAT OUR COMMUNITIES ARE SAFE AND PREPARED IF A DISASTER SHOULD PRESENT ITSELF*COMMUNITY SUPPORT DONATIONS FROM OUR MINISTRIES TO ORGANIZATIONS ADDRESSING THE ROOT CAUSES OF HEALTH PROBLEMS*COALITION BUILDING PRESENCE SAINT JOSEPH MEDICAL CENTER LEADS A COMMUNITY COALITION, JOLIET PARTNERS FOR HEALTHY FAMILIES (JPHF), WITH THE GOAL OF MAKING WILL COUNTY A HEALTHIER PLACE TO LIVE JPHF IS WORKING WITH LOCAL LEGISLATORS ON POLICY, SYSTEMS AND ENVIRONMENTAL CHANGES*WORKFORCE DEVELOPMENT PRESENCE ST MARY'S HOSPITAL PARTNERS WITH THE KANKAKEE REGIONAL VOLUNTEER SERVICES COALITION THIS COALITION ALLOWS LOCAL TEEN PARTICIPANTS THE OPPORTUNITY TO USE THEIR TIME AND TALENTS FOR THOSE IN NEED, WHILE PROVIDING THEMSELVES WITH EXCELLENT EXPOSURE TO MANY HEALTH-RELATED CAREERS, AS WELL AS BUSINESS COMMUNICATIONS AND EARLY CHILDHOOD TEACHING

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Form and Line Reference	Explanation
Schedule H, Part III, Line 2 Bad debt expense - methodology used to estimate amount	THE BAD DEBT REPORTED ON PART III, LINE 2 AGREES WITH THE AMOUNT REPORTED IN THE AUDITED FINANCIAL STATEMENTS BAD DEBT REDUCES THE REVENUE RECOGNIZED RELATED TO THE ACCOUNT THAT IS DEEMED UNCOLLECTIBLE TO ZERO

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Form and Line Reference	Explanation
Schedule H, Part III, Line 3 Bad Debt Expense Methodology	THE PROVISION FOR FINANCIAL ASSISTANCE POLICY ALLOWS FOR ACCOUNTS IN BAD DEBT TO BE APPROVED FOR FINANCIAL ASSISTANCE IF THE PATIENT MEETS THE CRITERIA IT 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 PERCENTAGE ACCURATELY

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

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Form and Line Reference	Explanation
Schedule H, Part III, Line 8 Community benefit & methodology for determining medicare costs	PRESENCE HEALTH COMPUTES THE MEDICARE SHORTFALL BASED ON A RATIO OF COST TO CHARGES PRESENCE HEALTH BELIEVES IT IS IMPORTANT FOR THE COMMUNITY AND THE IRS TO BE MADE AWARE OF GOVERNMENT SHORTFALLS, SPECIFICALLY MEDICARE HOWEVER, WE ACKNOWLEDGE THAT MEDICARE SHORTFALLS MAY BE EXPERIENCED BY OTHER THAN NON-PROFIT HEALTHCARE ORGANIZATIONS AS SUCH, PRESENCE HEALTH DOES NOT BELIEVE THAT MEDICARE SHORTFALL SHOULD BE CONSIDERED COMMUNITY BENEFIT

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Form and Line Reference	Explanation
Schedule H, Part III, Line 9b Collection practices for patients eligible for financial assistance	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 HOUSEHOLDS 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 THE REVENUE CYCLE PER THE PROVISION FOR FINANCIAL ASSISTANCE POLICY, THE COLLECTION PROCESS IS AS FOLLOWS 1 PRE-LITIGATION REVIEW PRIOR TO AN ACCOUNT BEING AUTHORIZED FOR THE FILING OF SUIT FOR NON-PAYMENT OF A PATIENT BILL, A FINAL REVIEW OF THE ACCOUNT WILL BE CONDUCTED AND APPROVED BY THE FINANCIAL COUNSELING REPRESENTATIVE (OR DESIGNEE) TO MAKE SURE THAT NO APPLICATION OF FINANCIAL ASSISTANCE WAS EVER RECEIVED AND THAT THERE EXISTS OBJECTIVE EVIDENCE THAT THE PATIENT DOES HAVE SUFFICIENT FINANCIAL MEANS TO PAY ALL OR PART OF HIS/HER BILL PRIOR TO A COLLECTIONS SUIT BEING FILED, THE SELF-PAY COLLECTIONS DIRECTOR MUST REVIEW AND APPROVE 2 RESIDENTIAL LIENS NO HOSPITAL WILL PLACE A LIEN ON THE PRIMARY RESIDENCE OF A PATIENT WHO HAS BEEN DETERMINED TO BE ELIGIBLE FOR FINANCIAL ASSISTANCE/CHARITY CARE, FOR PAYMENT OF THE PATIENT'S UNDISCOUNTED BALANCE DUE FURTHER, IN NO CASE WILL ANY HOSPITAL EXECUTE A LIEN BY FORCING THE SALE OR FORECLOSURE OF THE PRIMARY RESIDENCE OF ANY PATIENT TO PAY FOR ANY OUTSTANDING MEDICAL BILL 3 NO USE OF BODY ATTACHMENTS NO HOSPITAL WILL USE BODY ATTACHMENT TO REQUIRE ANY PERSON, WHETHER RECEIVING FINANCIAL ASSISTANCE/CHARITY CARE DISCOUNTS OR NOT, TO APPEAR IN COURT 4 COLLECTION AGENCY REFERRALS EACH HOSPITAL FINANCE ACCOUNTING WILL ENSURE THAT ALL COLLECTION AGENCIES USED TO COLLECT PATIENT BILLS PROMPTLY REFER ANY PATIENT WHO INDICATES FINANCIAL NEED, OR OTHERWISE APPEARS TO QUALIFY FOR FINANCIAL ASSISTANCE/CHARITY CARE DISCOUNTS, TO A FINANCIAL COUNSELOR TO DETERMINE IF THE PATIENT IS ELIGIBLE FOR SUCH A CHARITABLE DISCOUNT IN CASES WHERE A PATIENT HAS BEEN BILLED BUT IS LATER DETERMINED TO QUALIFY 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 HEALTH'S FINANCIAL ASSISTANCE PROGRAM, VISIT HTTP //PRESENCEHEALTH ORG/FINANCIAL-ASSISTANCE

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Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 16a FAP website	- PRESENCE ST JOSEPH MEDICAL CENTER Line 16a URL HTTP //PRESENCEHEALTH ORG/FINANCIAL-ASSISTANCE, - PRESENCE MERCY MEDICAL CENTER Line 16a URL http //presencehealth org/financial-assistance, - PRESENCE ST JOSEPH HOSPITAL Line 16a URL http //presencehealth org/financial-assistance, - PRESENCE ST MARY'S HOSPITAL Line 16a URL http //presencehealth org/financial-assistance, - PRESENCE COVENANT MEDICAL CENTER Line 16a URL http //presencehealth org/financial-assistance, - PRESENCE UNITED SAMARITANS MEDICAL CENTER Line 16a URL http //presencehealth org/financial-assistance,

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Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 16b FAP Application website	- PRESENCE ST JOSEPH MEDICAL CENTER Line 16b URL HTTP //PRESENCEHEALTH ORG/FINANCIAL-ASSISTANCE, - PRESENCE MERCY MEDICAL CENTER Line 16b URL http //presencehealth org/financial-assistance, - PRESENCE ST JOSEPH HOSPITAL Line 16b URL http //presencehealth org/financial-assistance, - PRESENCE ST MARY'S HOSPITAL Line 16b URL http //presencehealth org/financial-assistance, - PRESENCE COVENANT MEDICAL CENTER Line 16b URL http //presencehealth org/financial-assistance, - PRESENCE UNITED SAMARITANS MEDICAL CENTER Line 16b URL http //presencehealth org/financial-assistance,

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Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 16c FAP plain language summary website	- PRESENCE ST JOSEPH MEDICAL CENTER Line 16c URL HTTP //PRESENCEHEALTH.ORG/FINANCIAL-ASSISTANCE , - PRESENCE MERCY MEDICAL CENTER Line 16c URL http //presencehealth.org/financial-assistance , - PRESENCE ST JOSEPH HOSPITAL Line 16c URL http //presencehealth.org/financial-assistance , - PRESENCE ST MARY'S HOSPITAL Line 16c URL http //presencehealth.org/financial-assistance , - PRESENCE COVENANT MEDICAL CENTER Line 16c URL http //presencehealth.org/financial-assistance , - PRESENCE UNITED SAMARITANS MEDICAL CENTER Line 16c URL http //presencehealth.org/financial-assistance ,

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Form and Line Reference	Explanation
Schedule H, 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 HOSPITAL'S PRIMARY SERVICE AREA AS DEFINED BY STARK REGULATIONS IDENTIFYING COMMUNITY NEEDS IS JUST ONE STEP IN THE CHNA PROCESS THE MOST CRITICAL STEP IS PRIORITIZING AND ALIGNING EXPERTISE TO MAKE AN IMPACT ON THE IDENTIFIED NEEDS TO FACILITATE THIS PROCESS, 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 HOSPITAL'S 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>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part VI, Line 3 Patient education of eligibility for assistance	<p>PRESENCE HEALTH HOSPITAL MINISTRIES PROACTIVELY COMMUNICATE THE AVAILABILITY OF OUR FINANCIAL ASSISTANCE/CHARITY CARE PROGRAMS BY USING MULTIPLE TYPES OF APPROPRIATE MEDIA AND IN MULTIPLE APPROPRIATE LANGUAGES THE MECHANISMS USED BY PRESENCE HEALTH HOSPITALS TO COMMUNICATE THE AVAILABILITY OF FINANCIAL ASSISTANCE/CHARITY CARE INCLUDE, BUT ARE NOT LIMITED TO THE FOLLOWING</p> <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 PATIENT'S ABILITY TO PAY</p> <p>3 FLIERS FLIERS, INFORMATION SHEETS AND SIMILAR FORMS OF WRITTEN COMMUNICATION REGARDING THE HOSPITAL'S FINANCIAL ASSISTANCE/CHARITY CARE POLICY ARE MAINTAINED IN APPROPRIATE AREAS OF THE HOSPITAL (E G EMERGENCY DEPARTMENT, ORGANIZED REGISTRATION AREAS, THE BUSINESS OFFICE) THESE COMMUNICATIONS STATE IN MULTIPLE LANGUAGES THAT THE HOSPITAL OFFERS FINANCIAL ASSISTANCE/CHARITY CARE DISCOUNTS AND DESCRIBES HOW TO OBTAIN MORE INFORMATION</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 HOSPITAL'S 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 PATIENT'S BILL IS DISCOUNTED OR ADJUSTED BASED ON A DETERMINATION OF FINANCIAL NEED, THE HOSPITAL NOTIFIES THE PATIENT OF SUCH ELIGIBILITY DETERMINATION AND THAT THERE IS NO FURTHER COLLECTION ACTION TAKEN ON THE DISCOUNTED PORTION OF THE PATIENT'S BILL</p>

Form and Line Reference	Explanation
Schedule H, Part VI, Line 4 Community Information	<p>PRESENCE HEALTH HOSPITAL MINISTRIES HAVE IDENTIFIED A SEPARATE SERVICE AREA FOR EACH OF IT S ACUTE CARE HOSPITALS UTILIZING A CONSISTENT METHODOLOGY AND REFLECTING A COMBINATION OF GEOGRAPHIC LOCATION AND MARKET SHARE CRITERIA THE TOTAL SERVICE AREA OF EACH MINISTRY REP RESENTS APPROXIMATELY 80% TO 90% OF THE TOTAL INPATIENT DISCHARGES FROM THAT FACILITY THE PRIMARY SERVICE AREA OF EACH FACILITY REPRESENTS APPROXIMATELY 65 TO 75% OF SUCH DISCHARG ES AND THE SECONDARY SERVICE AREA OF EACH FACILITY REPRESENTS APPROXIMATELY 15 TO 25% OF S UCH DISCHARGES THE PRIMARY SERVICE AREAS AND SECONDARY SERVICE AREAS HAVE BEEN DETERMINED BY UTILIZING A PATIENT ORIGIN ANALYSIS TO IDENTIFY THOSE ZIP CODES THAT REPRESENT INPATIE NT DISCHARGES THESE ZIP CODES ARE THEN MAPPED TO IDENTIFY GEOGRAPHIC COVERAGE OF THE PRIM ARY SERVICE AREAS AND SECONDARY SERVICE AREAS MANY OF THE PRESENCE HEALTH HOSPITAL MINIST RIES FACILITIES ARE LOCATED IN POPULATION GROWTH AREAS BASED UPON POPULATION ESTIMATES AN D PROJECTIONS OBTAINED FROM CLARITAS, INC , THE POPULATION OF THE OUR HOSPITALS' COMBINED SERVICE AREA IS EXPECTED TO GROW AT A RATE OF 1 9% ANNUALLY BETWEEN 2012 AND 2017, COMPARE D WITH A GROWTH RATE OF 1 3% AND 1 6% PER YEAR IN THE CHICAGO MSA AND IN ILLINOIS, RESPECT IVELY OF PRESENCE'S TOTAL SERVICE AREA POPULATION, 10 7% IS OVER THE AGE OF 65, COMPARED TO 11 1% AND 12 3% IN THE CHICAGO MSA AND IN ILLINOIS, RESPECTIVELY PSJMC'S PRIMARY SERVI CE HAS AN ESTIMATED POPULATION OF 677,560 ACCORDING TO THE 2010 CENSUS IN THE PRIMARY SER VICE AREA, 9 3% OF THE POPULATION IS OVER THE AGE 65 AND THE MEDIAN HOUSEHOLD INCOME IS \$7 5,906 APPROXIMATELY, 7 1% OF THE POPULATION IN JOLIET LIVES BELOW THE POVERTY LEVEL THE RACIAL MAKEUP OF THE CITY IS 76 0% WHITE, 11 2% AFRICAN AMERICAN, 4 6% ASIAN, AND 7 9% MUL TI-RACIAL/OTHER THE 2014 POPULATION ALSO ESTIMATES THAT 22 5% ARE HISPANIC OR LATINO THE PRESENCE SAINT JOSEPH MEDICAL CENTER SERVICE AREA IS DEFINED BY ZIP CODES BELOW SERVICE AREA PRIMARY MARKET - ZIP CODE CITY 60435 JOLIET 60436 JOLIET 60544 PLAINFIELD 60433 JOLI ET 60431 JOLIET 60432 JOLIET 60434 JOLIET 60585 PLAINFIELD 60586 PLAINFIELD 60403 CREST HI LL 60404 SHOREWOOD SERVICE AREA SECONDARY MARKET - ZIP CODE CITY 60451 NEW LENOX 60481 WI LMINGTON 60450 MORRIS 60410 CHANNAHON 60446 ROMEOVILLE 60447 MINOOKA 60416 COAL CITY 60408 BRAIDWOOD 60421 ELWOOD 60441 LOCKPORT 60448 MOKENA 60442 MANHATTAN 60423 FRANKFORT 60440 BOLINGBROOK 60424 GARDNER 60439 LEMONT 60407 BRACEVILLE 60474 SOUTH WILMINGTON 60491 HOMER GLEN AURORA, WHERE PMMC RESIDES, IS THE SECOND LARGEST CITY IN ILLINOIS AND ACCOUNTS FOR MOST OF THE HOSPITAL'S PRIMARY SERVICE AREA KANE COUNTY'S POPULATION ACCORDING TO THE 201 0 CENSUS IS 515,269 IN THE PRIMARY SERVICE AREA, 10 7% OF THE POPULATION IS OVER THE AGE 65 AND THE AVERAGE HOUSEHOLD INCOME IS \$69,496 WITHIN THE PRIMARY SERVICE AREA (AURORA), APPROXIMATELY 35,000 INDIVIDUALS (21 3%) RESIDE IN MEDICALLY UNDERSERVED AREAS (MUAS) OF THAT POPULATION, ABOUT 30% FALL 200% BELOW THE FEDERAL POVERTY LEVEL WITHIN THE MUA, 68% OF THE POPULATION IS HISPANIC AND 11% IS AFRICAN AMERICAN FIFTY-THREE PER CENT ARE UNDERI NSURED AND 47% ARE MEDICAID RECIPIENTS 10 1% OF RESIDENTS IN KANE COUNTY LIVE BELOW THE P OVERTY LEVEL PMMC'S SERVICE AREA IS DEFINED BY ZIP CODES BELOW SERVICE AREA PRIMARY MAR KET - ZIP CODE CITY 60506 AURORA 60505 AURORA 60542 NORTH AURORA 60538 MONTGOMERY 60504 AU RORA 60507 AURORA 60502 AURORA SERVICE AREA SECONDARY MARKET - ZIP CODE CITY 60510 BATAVI A 60543 OSWEGO 60560 YORKVILLE 60548 SANDWICH 60545 PLANO 60174 SAINT CHARLES 60554 SUGAR GROVE 60134 GENEVA 60552 SOMONAUK 60503 AURORA 60511 BIG ROCK 60520 HINCKLEY 60119 ELBURN 60115 DEKALB 60541 NEWARK 60512 BRISTOL 60531 LELAND 60556 WATERMAN 60539 MOOSEHEART KANE COUNTY'S POPULATION ACCORDING TO THE 2010 CENSUS IS 515,269 IN THE PRIMARY SERVICE AREA, 8 6% OF THE POPULATION IS OVER THE AGE 65 AND THE AVERAGE HOUSEHOLD INCOME IS \$59,032 12 3% OF FAMILIES IN ELGIN LIVE BELOW THE POVERTY LEVEL THE RACIAL MAKEUP OF THE CITY IS 65 9% WHITE, 7 4% AFRICAN AMERICAN, 5 4% ASIAN, AND 3 6% FROM TWO OR MORE RACES 43 6% OF THE POPULATION ARE HISPANIC OR LATINO OF ANY RACE THE PSJH'S SERVICE AREA IS DEFINED BY ZIP CODE BELOW SERVICE AREA PRIMARY MARKET - ZIP CODE CITY 60123 ELGIN 60120 ELGIN 60124 ELG IN 60121 ELGIN 60110 CARPENTERSVILLE 60177 SOUTH ELGIN 60140 HAMPSHIRE 60118 DUNDEE SERVIC E AREA SECONDARY MARKET - ZIP CODE CITY 60102 ALGONQUIN 60103 BARTLETT 60174 SAINT CHARLE S 60014 CRYSTAL LAKE 60107 STREAMWOOD 60142 HUNTLEY 60098 WOODSTOCK 60050 MCHENRY 60051 MC HENRY 60156 LAKE IN THE HILLS 60175 SAINT CHARLES 60136 GILBERTS 60134 GENEVA 60013 CARY 6 0152 MARENGO 60135 GENOA 60109 BURLINGTON 60012 CRYSTAL LAKE 60180 UNION PSMH'S PRIMARY SE RVICE 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 LIVE</p>

Form and Line Reference	Explanation
Schedule H, Part VI, Line 4 Community Information	<p>S 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 A PRIMARY MARKET - ZIP CODE CITY 60901 KANKAKEE 60914 BOURBONNAIS 60915 BRADLEY 60954 MOM ENCE 60950 MANTENO SERVICE AREA SECONDARY MARKET - ZIP CODE CITY 60964 SAINT ANNE 60927 C LIFTON 60922 CHEBANSE 60940 GRANT PARK 60970 WATSEKA 60941 HERSCHER 60913 BONFIELD 60938 G ILMAN 60911 ASHKUM 60955 ONARGA 60944 HOPKINS PARK 60951 MARTINTON 60930 DANFORTH 60910 AR OMA PARK 60912 BEAVERVILLE 60919 CABERY 60961 REDDICK 60917 BUCKINGHAM 60935 ESSEX 60928 C RESCENT CITY 60481 WILMINGTON 60468 PEOTONE 60420 DWIGHT 60958 PEMBROKE TOWNSHIP CHAMPAIGN COUNTY IS THE TENTH LARGEST COUNTY IN THE STATE OF ILLINOIS WITH A 2013 POPULATION OF 203 ,276 IN THE PRIMARY SERVICE AREA, 11% OF THE POPULATION IS OVER THE AGE 65 AND THE MEDIAN HOUSEHOLD INCOME IS \$46,708 THE PRIMARY DEMOGRAPHIC MAKE-UP OF CHAMPAIGN COUNTY IS AS FOLLOWS 74 1% WHITE, 12 2% BLACK OR AFRICAN AMERICAN, 9 1% ASIAN, 5 1% HISPANIC/LATINO JUST UNDER 22% OF FAMILIES IN CHAMPAIGN COUNTY LIVE BELOW THE POVERTY LEVEL THE PCMC SERVICE AREA IS DEFINED BY ZIP CODES BELOW SERVICE AREA PRIMARY MARKET - ZIP CODE CITY 61821 CHAMPAIGN 61801 URBANA 61820 CHAMPAIGN 61866 RANTOUL 61802 URBANA 61953 TUSCOLA 61880 TOLONO 61873 SAINT JOSEPH 61956 VILLA GROVE 61874 SAVOY 61849 HORNER 61878 THOMASBORO 61822 CHAMPAIGN 61847 GIFFORD 61877 SIDNEY 61943 OAKLAND 61851 IVESDALE 61884 WHITE HEATH 61839 DE L AND 61931 HUMBOLDT 61844 FITHIAN 61862 PENFIELD 61882 WELDON 61773 SIBLEY 61930 HINDSBORO 61812 ARMSTRONG 60933 ELLIOTT 61932 HUME 61871 ROYAL 60926 CLAYTONVILLE 61845 FOOSLAND 619 41 MURDOCK SERVICE AREA SECONDARY MARKET - ZIP CODE CITY 60948 LODA 60957 PAXTON 61856 MONTICELLO 61853 MAHOMET 61938 MATTOON 61910 ARCOLA 60936 GIBSON CITY 61920 CHARLESTON 61942 NEWMAN 61813 BEMENT PUSMC'S PRIMARY AND SECONDARY SERVICE AREAS HAVE AN ESTIMATED POPULATION OF 81,625 RESIDENTS IN THE PRIMARY SERVICE AREA, 16 7% OF THE POPULATION IS OVER THE AGE 65 AND THE AVERAGE HOUSEHOLD INCOME IS \$40,463 THE PRIMARY DEMOGRAPHIC MAKE-UP OF VERMILLION COUNTY IS AS FOLLOWS 83 6% WHITE, 13 3% BLACK OR AFRICAN AMERICAN, 4 5% HISPANIC/ LATINO 18 8% OF FAMILIES IN VERMILLION COUNTY LIVE BELOW THE POVERTY LEVEL THE PUSMC SERVICE AREA IS DEFINED BY ZIP CODES BELOW SERVICE AREA PRIMARY MARKET - ZIP CODE CITY 6183 2 DANVILLE 61834 DANVILLE 61846 GEORGETOWN 61883 WESTVILLE 61833 TILTON SERVICE AREA SECONDARY MARKET - ZIP CODE CITY 47932 COVINGTON, IN 60942 HOOPESTON 61817 CATLIN 61858 OAKWOOD 61870 RIDGE FARM 61924 CHRISMAN 60963 ROSSVILLE 47987 VEEDERSBURG, IN 61841 FAIRMONT 479 74 PERRYSVILLE, IN 47993 WILLIAMSPORT, IN 61814 BISMARCK 61865 POTOMAC 47928 CAYUGA, IN 479 52 KINGMAN, IN 61876 SIDELL 61811 ALVIN 61844 FITHIAN 61850 INDIANOLA 47991 WEST LEBANON, IN 61848 HENNING 47982 STATE LINE, IN 60960 RANKIN 47918 ATTICA, IN 61812 ARMSTRONG 60973 WELLINGTON 61940 METCALF 61831 COLLISION</p>

Form and Line Reference	Explanation
Schedule H, Part VI, Line 5 Promotion of community health	<p>PRESENCE HEALTH HOSPITALS ARE FAITH-BASED MINISTRIES THAT PROVIDE SERVICES BASED UPON THE ETHICAL AND RELIGIOUS DIRECTIVES OF THE CATHOLIC CHURCH PRESENCE HEALTH HOSPITALS ENHANCE THE PUBLIC HEALTH OF OUR COMMUNITIES BY 1 ENSURING OUR MEDICAL STAFF IS OPEN TO ALL QUALIFIED PHYSICIANS 2 ALL OF OUR HOSPITALS ARE ACCREDITED AND IN GOOD STANDING WITH THE JOINT COMMISSION ACCREDITATION OF HEALTHCARE ORGANIZATIONS 3 ENSURING OUR BOARD OF DIRECTORS IS DIVERSE AND ABLE TO PROVIDE EXPERTISE, AND MADE UP OF INDEPENDENT MEMBERS OF THE COMMUNITIES WE SERVE OUR BOARD MEMBERS MUST FOLLOW A CONFLICT OF INTEREST POLICY 4 REINVESTING SURPLUS FUNDS INTO THE ORGANIZATION TO IMPROVE PATIENT CARE THROUGH NEW PROGRAMS AND TECHNOLOGY 5 PROVIDING FINANCIAL ASSISTANCE, SLIDING SCALE DISCOUNTS AND HAS COLLECTION PRACTICES THAT ARE IN COMPLIANCE WITH STATE AND FEDERAL GUIDELINES IN ADDITION, WE FOLLOW THE FINANCIAL ASSISTANCE AND CHARITY GUIDELINES OF THE CATHOLIC HEALTH ASSOCIATION 6 PARTICIPATING IN ALL GOVERNMENT SPONSORED HEALTH CARE PROGRAMS, MEDICARE, MEDICAID, CHAMPUS, TRICARE, SCHIP AND OTHERS 7 PROVIDING EMERGENCY ROOM SERVICES IN ALL OF OUR COMMUNITIES AND PROVIDING TRAINING TO LOCAL FIRE DEPARTMENTS AND AMBULANCES OUR EMERGENCY ROOM PARTICIPATES WITH LOCAL POLICE AND FIRE DEPARTMENTS IN DISASTER DRILLS 8 STAFFING BOARD CERTIFIED EMERGENCY ROOM PHYSICIANS IN OUR EMERGENCY ROOM AND URGENT CARE SERVICES WE TREAT PATIENTS ACCORDING TO EMTALA GUIDELINES AND SERVE ALL PATIENTS REGARDLESS OF ABILITY TO PAY IN ADDITION, WE ARE COMMITTED TO DETERMINING THE NEEDS OF OUR COMMUNITIES AND CREATING WAYS TO MEET THOSE NEEDS THE OBLIGATION TO REACH OUT TO THOSE IN NEED AND IMPROVE HEALTH FLOWS DIRECTLY FROM OUR CATHOLIC IDENTITY AND THE HERITAGE OF OUR FOUNDING CONGREGATIONS IN EACH OF THE COMMUNITIES WE SERVE, WE WORK WITH OTHERS - INCLUDING CHARITABLE ORGANIZATIONS, COMMUNITY HEALTH PROVIDERS, ELECTED OFFICIALS, BUSINESS LEADERS, SCHOOLS, CHURCHES, AND RESIDENTS - TO LOOK AT THE OVERALL HEALTH OF THE COMMUNITY AND IDENTIFY THE GREATEST NEEDS WE THEN MAKE A PLAN AND DEVELOP STRATEGIES TOGETHER WITH OUR COMMUNITIES TO ADDRESS THE HIGHEST PRIORITY HEALTH NEEDS THE HIGHEST PRIORITY NEEDS AND THE PROGRAMS WE'VE DEVELOPED TO MEET THESE NEEDS ARE IDENTIFIED BELOW FOR EACH HOSPITAL Presence Saint Joseph Medical Center (PSJMC), Joliet, IL PARTNERSHIP WITH THE WILL-GRUNDY MEDICAL CLINIC (WGMC) & AUNT MARTHA'S YOUTH SERVICES CENTER/ KNOW WHERE TO GO CAMPAIGN IDENTIFIED NEED ACCESS TO DENTAL AND PRIMARY CARE PSJMC 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 WGMC'S 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 MARTHA'S 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 2017, WE ARE PARTNERING WITH THESE TWO ORGANIZATIONS AS WELL AS OTHERS SERVING ON THE MAPP COLLABORATIVE PRIMARY HEALTH CARE 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 FOR 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 PHY</p>

Form and Line Reference	Explanation
Schedule H, Part VI, Line 5 Promotion of community health	<p>SICAL 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 AT A GREATER JOLIET YMCA LOCATION. STUDENTS WHO EXCEED THE RECOMMENDED 60 MINUTES OF DAILY PHYSICAL ACTIVITY WERE ENTERED TO WIN RAFFLE PRIZES. WE WILL WORK HEALTHY AWARD IDENTIFIED NEED: CHRONIC DISEASE. THE WE WILL 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 WORKSITE WELLNESS: 1. HEALTH PROMOTION/EDUCATION 2. PHYSICAL ACTIVITY 3. MENTAL HEALTH 4. ENVIRONMENTAL HEALTH 5. NUTRITION 6. SAFETY. RETHINK YOUR DRINK CAMPAIGN IDENTIFIED NEED: CHRONIC DISEASE. THE MAPP COLLABORATIVE CHRONIC CARE ACTION TEAM PARTNERED WITH THE ILLINOIS ALLIANCE TO PREVENT OBESITY (IAPO) 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. MENTAL HEALTH FIRST AID IDENTIFIED NEED: BEHAVIORAL 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 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. ENROLLMENT STRATEGY IDENTIFIED NEED: ACCESS TO DENTAL AND PRIMARY 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 2016-2017 OPEN ENROLLMENT PERIOD. THE MODEL BOASTS A FOUR-PRONGED APPROACH: 1. CERTIFIED APPLICATION COUNSELORS, 2. IN-PERSON COUNSELOR PARTNERSHIPS, 3. DIRECT IONAL SUPPORT AND NAVIGATION, AND 4. PUBLIC OUTREACH AND EDUCATION THROUGH ENROLL AMERICA.</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, 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 2017, THIS INCLUDED \$213 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
Schedule H, Part VI, Line 7 State filing of community benefit report	IL

Schedule H (Form 990) 2017

Additional Data

Software ID: 17005876

Software Version: 2017v2.2

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											
6	PRESENCE UNITED SAMARITANS MEDICAL CENTER 812 NORTH LOGAN AVENUE DANVILLE, IL 61832 WWW.PRESENCEHEALTH.ORG 0004853	X	X					X			
1	PRESENCE ST JOSEPH MEDICAL CENTER 333 N MADISON STREET JOLIET, 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			

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		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
5	PRESENCE COVENANT MEDICAL CENTER 1400 WEST PARK STREET URBANA, IL 61801 WWW.PRESENCEHEALTH.ORG 0004861	X	X					X			

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 3E	THE SIGNIFICANT HEALTH NEEDS ARE A PRIORITIZED DESCRIPTION OF THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY AS IDENTIFIED THROUGH THE CHNA

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	Facility , 1 - PRESENCE UNITED SAMARITANS MEDICAL CENTER The 2017-2022 Vermilion County C ommunity Health Plan (IPLAN) was accomplished with direct contribution from the Vermilion County Health Department, the Executive Committee, the Regional Community Health Plan Coor dinator and over 50 individuals representing a variety of agencies and organizations (see list of Executive Committee Members and Community Advisory Committee Members) from across the county In addition, we received direct input from over 1500 county residents via a co mmunity survey Development of this plan was truly a collaborative effort working with our community partners, our local schools of nursing, our local and state government represen tatives, and input from our county residents In 2015, the Vermilion County Board of Healt h asked the Vermilion County Health Department to develop a 5-year strategic plan (IPLAN) to identify the challenges facing the health department and to capitalize on its strengths and opportunities The Board of Health seeks to ensure ongoing viability and sustainabili ty for the health department as the health department continues to serve the critical need s of the residents of Vermilion County The overall 5-year strategic plan was approved by the Board of Health on November 10th, 2015 and the plan itself was completed in late 2017 One of the outcomes of the IPLAN was the Presence United Samaritans Medical Center CHNA, approved in December 2017 The community phase of the process began during the summer of 2 016, as staff worked to compile relevant data for the Executive Committee and the Communit y Advisory Committee to review during its assessment of needs The Vermilion County Health Department and the Regional Community Health Plan Coordinator worked collaboratively with a Presence Intern in researching and compiling much of the data used An array of represe ntative community leaders were identified and invited to join in the IPLAN process The co mmunity partner phase of the IPLAN began in January 2017 The community advisory committee invested a great deal of thought and effort into identifying the priority areas In the p ast we have only addressed three priority areas The community advisory committee demonst rated a genuine concern to weigh and balance all the information provided including the dat a presented, their own beliefs, experiences and perceptions as community stakeholders, as well as the information obtained from our county residents The committee expressed consid erable concern about how we, as a community, can address many of the health issues as the state fiscal crisis continues and funding sources diminish There was extended dialogue ab out how much our challenges are interrelated with many of the contributing factors being t he same for all priority areas including education, abuse, and a lack of hope and dreams o f a future The community advisory committee discussed strategies about being proactive in our approaches and ensuring a

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	ction and a way to measure those actions After discussion from the first meeting, the gro up consensus was reached that we were not finished with the current priorities and still h ad a lot of work to accomplish them, so group decided to maintain the current priorities, but wanted to add a fourth priority, mental health As the planning process moved forward, we addressed each priority by setting attainable goals with measurable outcomes throughou t the 2017-2022 Plan

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 6a Facility , 1	Facility , 1 - PRESENCE UNITED SAMARITANS MEDICAL CENTER PUSMC PARTNERED WITH HOOPESTON HOSPITAL TO COMPLETE THEIR CHNA

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 6b Facility , 1	Facility , 1 - PRESENCE UNITED SAMARITANS MEDICAL CENTER SEE 990 SCHEDULE H PART V LINE 5 EXPLANATION

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 7 Facility , 1	Facility , 1 - PRESENCE UNITED SAMARITANS MEDICAL CENTER 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 INDIVIDUALS ON THEIR MAILING LISTS AND RESPECTIVE CONSTITUENTS

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	Facility , 1 - PRESENCE UNITED SAMARITANS MEDICAL CENTER THE TOP FOUR COMMUNITY HEALTH PRIORITIES TO BE ADDRESSED IN THE 2014-2017 PLAN ARE *TEEN PREGNANCY, *ALCOHOL/SUBSTANCE ABUSE, *OBESITY, AND *MENTAL HEALTH PLEASE SEE PART VI, LINE 5 FOR THE DESCRIPTION OF PROGRAMS IN PLACE TO ADDRESS THESE IDENTIFIED NEEDS ALONG WITH 2017 OBJECTIVES AND 2017 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

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - PRESENCE UNITED SAMARITANS MEDICAL CENTER 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 600% OF THE FPL

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 3E	THE SIGNIFICANT HEALTH NEEDS ARE A PRIORITIZED DESCRIPTION OF THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY AS IDENTIFIED THROUGH THE CHNA

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	Facility , 1 - PRESENCE SAINT JOSEPH MEDICAL CENTER IN 2016, THE WILL COUNTY MAPP COLLABORATIVE CONVENED TO CONDUCT THE THIRD ITERATION OF THE MAPP PROCESS MAPP IS A COMMUNITY-DRIVEN, STRATEGIC PLANNING FRAMEWORK THAT ASSISTS COMMUNITIES IN DEVELOPING AND IMPLEMENTING EFFORTS AROUND THE PRIORITIZATION OF PUBLIC HEALTH ISSUES AND THE IDENTIFICATION OF RESOURCES TO ADDRESS THEM, AS DEFINED BY THE 10 ESSENTIAL PUBLIC HEALTH SERVICES THE MAPP PROCESS HAS SIX PHASES WHICH INCLUDE FOUR ASSESSMENTS COMMUNITY HEALTH STATUS ASSESSMENT THE COMMUNITY HEALTH STATUS ASSESSMENT (CHSA) IS ONE OF FOUR ASSESSMENTS CONDUCTED AS A PART OF THE MAPP PROCESS DURING THIS ASSESSMENT, INFORMATION REGARDING DEMOGRAPHICS, HEALTH STATUS, HEALTH BEHAVIORS, AND SOCIAL DETERMINANTS IN THE COMMUNITY IS GATHERED AND ANALYZED DATA IS COLLECTED FROM A VARIETY OF RESOURCES AND ANALYZED COMPARING LOCAL, STATE, AND NATIONAL BENCHMARKS WHEN AVAILABLE THE CHSA WAS CONDUCTED MAY - NOVEMBER 2016 COMMUNITY THEMES AND STRENGTHS ASSESSMENT THE COMMUNITY THEMES AND STRENGTHS ASSESSMENT (CTSA) AIMS TO GATHER COMMUNITY MEMBERS' PERCEPTIONS, THOUGHTS, OPINIONS, AND CONCERNS REGARDING QUALITY OF LIFE IN WILL COUNTY THIS INPUT PROVIDES VALUABLE INSIGHT INTO THE ISSUES OF IMPORTANCE TO THE COMMUNITY THE CTSA WAS CONDUCTED DECEMBER 2016 - MARCH 2017 FORCES OF CHANGE ASSESSMENT THE FORCES OF CHANGE ASSESSMENT (FOCA) AIMS TO IDENTIFY ALL THE FORCES AND ASSOCIATED OPPORTUNITIES AND THREATS THAT CAN AFFECT, EITHER NOW OR IN THE FUTURE, THE LOCAL PUBLIC HEALTH SYSTEM FORCES MAY BE SOCIAL, ECONOMIC, POLITICAL, TECHNOLOGICAL, ENVIRONMENTAL, SCIENTIFIC, LEGAL, AND/OR ETHICAL IN NATURE FORCES CAN BE TRENDS, FACTORS, OR EVENTS THE FOCA WAS CONDUCTED SEPTEMBER - DECEMBER 2016 LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT THE LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT (LPHSA) WAS CONDUCTED ON DECEMBER 1, 2016 THE LPHSA IS USED TO UNDERSTAND THE OVERALL STRENGTHS AND WEAKNESSES OF THE PUBLIC HEALTH SYSTEM BASED ON THE 10 ESSENTIAL PUBLIC HEALTH SERVICES THE WILL COUNTY MAPP COLLABORATIVE WAS FORMED FOLLOWING THE COMPLETION OF THE MAPP PROJECT IN 2011 THE SECOND ITERATION OF THE MAPP PROCESS BEGAN IN SEPTEMBER 2012 AND WAS COMPLETED IN MAY 2014 THE THIRD ROUND OF THE MAPP PROCESS BEGAN IN JANUARY 2016 THE MAPP EXECUTIVE COMMITTEE MEETS BI-MONTHLY TO PROVIDE OVERSIGHT TO THE ONGOING MAPP PROCESS AND MAKE RECOMMENDATIONS TO THE OVERALL OPERATIONS OF THE MAPP COLLABORATIVE A PROGRAM COORDINATOR WAS APPOINTED IN MARCH 2013 THE COORDINATOR IS A FULL-TIME STAFF MEMBER OF THE WILL COUNTY HEALTH DEPARTMENT, WITH PARTIAL FUNDING BY THE WILL COUNTY MAPP COLLABORATIVE ACTION TEAMS WERE ESTABLISHED AROUND THE IDENTIFIED PRIORITIES AND HAVE BEEN IMPLEMENTING ACTION PLANS AND STRATEGIES TO ADDRESS THOSE NEEDS THE ACTION TEAMS ARE LED BY CHAIRS AND CO-CHAIRS FROM PARTNER ORGANIZATIONS MOST OF THE TEAMS MEET MONTHLY OR BI-MONTHLY AS NEEDED ORGANIZATIONS INVOLVED IN THE MAPP EXECUTIVE COMMITTEE ARE LISTED BELOW * A

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	MITA HEALTH ADVENTIST MEDICAL CENTER BOLINGBROOK * AUNT MARTHA'S YOUTH SERVICES * CATHOLIC CHARITIES * CHESTNUT HEALTH SYSTEMS * EASTERSEALS JOLIET REGION, INC * EDWARD HOSPITAL * GOVERNORS STATE UNIVERSITY * NEW LIFE CHURCH * PRESENCE SAINT JOSEPH MEDICAL CENTER * SEN IOR SERVICES OF WILL COUNTY * SILVER CROSS HOSPITAL * STEPPING STONES, INC * UNITED WAY O F WILL COUNTY * WILL COUNTY COMMUNITY HEALTH CENTER * WILL COUNTY EXECUTIVE'S OFFICE * WIL L COUNTY HEALTH DEPARTMENT * WILL-GRUNDY MEDICAL CLINIC PRIORITIZATION OF STRATEGIC ISSUES ON APRIL 7, 2017, FORTY-ONE WILL COUNTY PUBLIC HEALTH STAKEHOLDERS PARTICIPATED IN A PLAN NING SESSION AT PRESENCE SAINT JOSEPH MEDICAL CENTER TO REVIEW KEY FINDINGS FROM THE FOUR MAPP ASSESSMENTS, IDENTIFY CROSS-CUTTING THEMES AND POTENTIAL STRATEGIC ISSUES, AND PRIORI TIZE A SET OF STRATEGIC ISSUES THE MEETING WAS FACILITATED BY THE ILLINOIS PUBLIC HEALTH INSTITUTE ATTENDEES IDENTIFIED FIVE POTENTIAL STRATEGIC ISSUES BUT COULD NOT COME TO CONS ENSUS IN MAY OF 2017, MAPP EXECUTIVE COMMITTEE MEMBERS WERE ASKED TO USE A PRIORITIZATION CRITERIA AND PLANNING WORKSHEET DURING THE DISCUSSION OF THE PREVIOUSLY IDENTIFIED STRATE GIC ISSUES ALL ATTENDEES AGREED THAT TRANSPORTATION IS A CONCERN, BUT THAT IT COULD BE NE STED UNDER ALL STRATEGIC ISSUES AND BECOME A GOAL OF THE MAPP EXECUTIVE COMMITTEE ACCESS TO HEALTHY LIFESTYLE CHOICES WOULD ALSO BE NESTED IN ALL ISSUES AS A STRATEGY MAPP EXECUT IVE COMMITTEE MEMBERS DECIDED THAT BEHAVIORAL HEALTH, ACCESS TO DENTAL AND PRIMARY CARE, A ND CHRONIC DISEASE WOULD BE THE TOP THREE STRATEGIC ISSUES FOR THE NEXT THREE YEARS

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 6a Facility , 1	Facility , 1 - PRESENCE SAINT JOSEPH MEDICAL CENTER PSJMC PARTNERED WITH SILVER CROSS HOSPITAL, ADVENTIST BOLINGBROOK HOSPITAL AND EDWARD HOSPITAL TO COMPLETE THEIR CHNA

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 6b Facility , 1	Facility , 1 - PRESENCE SAINT JOSEPH MEDICAL CENTER SEE 990 SCHEDULE H PART V LINE 5 EXPLANATION

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 7 Facility , 1	Facility , 1 - PRESENCE SAINT JOSEPH MEDICAL CENTER 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 INDIVIDUALS ON THEIR MAILING LISTS AND RESPECTIVE CONSTITUENTS

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	Facility , 1 - PRESENCE SAINT JOSEPH MEDICAL CENTER AFTER CONSOLIDATING OVERLAPPING ISSUES IDENTIFIED IN THE MAPP CHNA, THE TOP IDENTIFIED NEEDS IN WILL COUNTY ARE *BEHAVIORAL HEALTH *ACCESS TO DENTAL AND PRIMARY CARE * CHRONIC DISEASE 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 2017 OBJECTIVES AND 2017 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

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - PRESENCE SAINT JOSEPH MEDICAL CENTER 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

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 3E	THE SIGNIFICANT HEALTH NEEDS ARE A PRIORITIZED DESCRIPTION OF THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY AS IDENTIFIED THROUGH THE CHNA

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	<p>Facility , 1 - PRESENCE MERCY MEDICAL CENTER THE CHNA PROCESS WAS INITIATED BY PRESENCE M ERGY MEDICAL CENTER (PMMC) AND PRESENCE SAINT JOSEPH HOSPITAL (PSJH) IN COLLABORATION WITH THE COMMUNITIES THEY SERVE, THE KANE COUNTY HEALTH DEPARTMENT, DELNOR HOSPITAL, RUSH-COPL EY MEDICAL CENTER, SHERMAN HOSPITAL, FOX VALLEY UNITED WAY AND THE UNITED WAY OF ELGIN EN GAGEMENT OF PUBLIC HEALTH EXPERTISE THE KANE COUNTY HEALTH DEPARTMENT FACILITATED THE CHNA PROCESS BY USING THE MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP) TOOL PMMC SERVED AS ONE OF EIGHT PARTNERS THAT PARTICIPATED IN THE KANE COUNTY COMMUNITY HEALTH H NEEDS ASSESSMENT THIS PROVIDED THE OPPORTUNITY FOR PMMC TO ACTIVELY PROVIDE EXPERTISE, INPUT, AND FINANCIAL SUPPORT PARTNERS ALSO INVOLVED IN THIS PROCESS INCLUDED THE FOUR OTH ER HOSPITALS IN KANE COUNTY INCLUDING DELNOR HOSPITAL, PRESENCE SAINT JOSEPH HOSPITAL, RUS H-COPLEY MEDICAL CENTER, SHERMAN HOSPITAL, AS WELL AS FOX VALLEY UNITED WAY AND THE UNITED WAY OF ELGIN COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) COMMITTEE TO PROVIDE COMMUNITY LEV EL OVERSIGHT FOR THE PROCESS, A DIVERSE GROUP OF COMMUNITY STAKEHOLDERS AND PMMC REPRESENT ATIVES WERE INVITED TO PARTICIPATE ON THE CHIP STEERING COMMITTEE TO ENSURE REPRESENTATIV E ENGAGEMENT, PERSONAL INVITATIONS WERE SENT TO ORGANIZATIONS REPRESENTING CULTURAL, LINGU ISTIC, RACIAL, ETHNIC, AND OTHER MINORITY GROUPS IN ADDITION, INDIVIDUALS WITH SPECIALIZE D QUALIFICATIONS IN DEALING WITH SPECIAL POPULATIONS OR CLINICAL GROUPS WERE SOLICITED FOR THEIR PARTICIPATION FINALLY, EFFORTS WERE MADE TO INCLUDE INDIVIDUALS ON THE CHIP STEERI NG COMMITTEE WITH PUBLIC HEALTH EXPERTISE THOSE WHO COMMITTED TO THE ASSESSMENT AND PLANN ING PROCESS BECAME THE EIGHT MEMBERS OF THE CHNA STEERING COMMITTEE, WHICH CONTINUES TO ME ET 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 D EPARTMENT *UNITED WAY OF ELGIN *PRESENCE MERCY MEDICAL CENTER *PRESENCE SAINT JOSEPH HOSPI TAL *SHERMAN HOSPITAL *FOX VALLEY UNITED WAY *INC BOARD *CADENCE HEALTH *RUSH-COPLEY MEDIC AL CENTER To establish priorities for the identified needs, Presence Mercy Medical Center engaged in a joint prioritization exercise with other Kane County partner organizations On May 10th, 2018, the Kane County Health Department and the collaborating hospital partner s convened a group of community stakeholders (representing a cross-section of community-ba sed agencies and organizations) to evaluate, discuss and prioritize health issues for comm unity, based on findings of this Community Health Needs Assessment (CHNA) Professional Re search Consultants, Inc (PRC) began the meeting with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research (see Are as of Opportunity above) Following the data review, PRC answered any questions and facili tated a group dialogue, allowi</p>

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	<p>ng participants to advocate for any of the health issues discussed. Afterward, participant s were provided an overview of the prioritization exercise that followed. To solicit input from key informants, those individuals who have a broad interest in the health of the com munity, an Online Key Informant Survey also was implemented as part of this process. A lis t of recommended participants was provided by Kane County Health Department and collaborat ing partner organizations, this list included names and contact information for physicians , public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as o f the community overall. Key informants were contacted by email, introducing the purpose o f the survey and providing a link to take the survey online, reminder emails were sent as needed to increase participation. In all, 157 community stakeholders took part in the Onli ne Key Informant Survey. Presence Mercy Medical Center will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the sig nificant health needs in the community. While the hospital will likely not implement strat egies for all of the health issues listed above, the results of this prioritization exerci se will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.</p>

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 6a Facility , 1	Facility , 1 - PRESENCE MERCY MEDICAL CENTER PMMC PARTNERED WITH SHERMAN HOSPITAL, CADENCE HEALTH, PRESENCE SAINT JOSEPH HOSPITAL AND RUSH-COPLEY MEDICAL CENTER TO COMPLETE THEIR CHNA

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 6b Facility , 1	Facility , 1 - PRESENCE MERCY MEDICAL CENTER SEE 990 SCHEDULE H PART V LINE 5 EXPLANATION

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 7 Facility , 1	Facility , 1 - PRESENCE MERCY MEDICAL CENTER 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 INDIVIDUALS ON THEIR MAILING LISTS AND RESPECTIVE CONSTITUENTS

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	Facility , 1 - PRESENCE MERCY MEDICAL CENTER BASED ON THE CHNA FINDINGS, INTERNAL RESOURCES, AND INTERNAL EXPERTISE THE AREAS OF FOCUS FOR THE 2018 IMPLEMENTATION STRATEGY PLAN THAT PMMC WILL HELP ADDRESS INCLUDE *OBESITY *CHRONIC DISEASE *POOR SOCIAL AND EMOTIONAL WELLNESS PLEASE SEE PART VI, LINE 5 FOR THE DESCRIPTION OF PROGRAMS IN PLACE TO ADDRESS THESE IDENTIFIED NEEDS ALONG WITH 2015-2017 OBJECTIVES AND 2015-2017 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

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - PRESENCE MERCY MEDICAL CENTER 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 600 % OF THE FPL

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 3E	THE SIGNIFICANT HEALTH NEEDS ARE A PRIORITIZED DESCRIPTION OF THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY AS IDENTIFIED THROUGH THE CHNA

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	Facility , 1 - PRESENCE ST JOSEPH HOSPITAL THE CHNA PROCESS WAS INITIATED BY PRESENCE SA INT JOSEPH HOSPITAL (PSJH) AND PRESENCE MERCY MEDICAL CENTER (PMMC) IN COLLABORATION WITH THE COMMUNITIES THEY SERVE, THE KANE COUNTY HEALTH DEPARTMENT, DELNOR HOSPITAL, RUSH-COPLEY MEDICAL CENTER, SHERMAN HOSPITAL, FOX VALLEY UNITED WAY AND THE UNITED WAY OF ELGIN ENGAGEMENT OF PUBLIC HEALTH EXPERTISE THE KANE COUNTY HEALTH DEPARTMENT FACILITATED THE CHNA PROCESS BY USING THE MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP) TOOL PSJH SERVED AS ONE OF EIGHT PARTNERS THAT PARTICIPATED IN THE KANE COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT THIS PROVIDED THE OPPORTUNITY FOR PSJH TO ACTIVELY PROVIDE EXPERTISE, INPUT, AND FINANCIAL SUPPORT PARTNERS ALSO INVOLVED IN THIS PROCESS INCLUDED THE FOUR OTHER HOSPITALS IN KANE COUNTY INCLUDING DELNOR HOSPITAL, PRESENCE MERCY MEDICAL CENTER, RUSH- COPLEY MEDICAL CENTER, SHERMAN HOSPITAL, AS WELL AS FOX VALLEY UNITED WAY AND THE UNITED WAY OF ELGIN COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) COMMITTEE TO PROVIDE COMMUNITY LEVEL OVERSIGHT FOR THE PROCESS, A DIVERSE GROUP OF COMMUNITY STAKEHOLDERS AND PSJH REPRESENTATIVES WERE INVITED TO PARTICIPATE ON THE CHIP STEERING COMMITTEE TO ENSURE REPRESENTATIVE ENGAGEMENT, PERSONAL INVITATIONS WERE SENT TO ORGANIZATIONS REPRESENTING CULTURAL, LINGUISTIC, RACIAL, ETHNIC, AND OTHER MINORITY GROUPS IN ADDITION, INDIVIDUALS WITH SPECIALIZED QUALIFICATIONS IN DEALING WITH SPECIAL POPULATIONS OR CLINICAL GROUPS WERE SOLICITED FOR THEIR PARTICIPATION FINALLY, EFFORTS WERE MADE TO INCLUDE INDIVIDUALS ON THE CHIP STEERING COMMITTEE WITH PUBLIC HEALTH EXPERTISE THOSE WHO COMMITTED TO THE ASSESSMENT AND PLANNING PROCESS BECAME THE EIGHT MEMBERS OF THE CHNA STEERING COMMITTEE, WHICH CONTINUES TO MEET REGULARLY TO PROVIDE FEEDBACK AND OVERSIGHT, ASSESS PROGRESS, AND MODIFY PLANS AS NEEDED THE KANE COUNTY CHIP STEERING COMMITTEE MEMBERS ARE LISTED BELOW KANE COUNTY HEALTH DEPARTMENT UNITED WAY OF ELGIN PRESENCE MERCY MEDICAL CENTER PRESENCE SAINT JOSEPH HOSPITAL SHERMAN HOSPITAL FOX VALLEY UNITED WAY INC BOARD CADENCE HEALTH RUSH-COPLEY MEDICAL CENTER To establish priorities for the identified needs, Presence Saint Joseph Hospital engaged in a joint prioritization exercise with other Kane County partner organizations On May 10th, 2018, the Kane County Health Department and the collaborating hospital partners convened a group of community stakeholders (representing a cross-section of community-based agencies and organizations) to evaluate, discuss and prioritize health issues for community, based on findings of this Community Health Needs Assessment (CHNA) Professional Research Consultants, Inc (PRC) began the meeting with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research Following the data review, PRC answered any questions and facilitated a group dialogue, allowing participants to advocate for any of the

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	<p>health issues discussed. Afterward, participants were provided an overview of the prioritization exercise that followed. To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented as part of this process. A list of recommended participants was provided by Kane County Health Department and collaborating partner organizations, this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall. Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online, reminder emails were sent as needed to increase participation. In all, 157 community stakeholders took part in the Online Key Informant Survey. Presence Saint Joseph Hospital will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.</p>

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 6a Facility , 1	Facility , 1 - PRESENCE ST JOSEPH HOSPITAL PSJH PARTNERED WITH SHERMAN HOSPITAL, PRESENCE MERCY MEDICAL CENTER, CADENCE HEALTH AND RUSH-COPLEY MEDICAL CENTER TO COMPLETE THEIR CHNA

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 6b Facility , 1	Facility , 1 - PRESENCE ST JOSEPH HOSPITAL SEE 990 SCHEDULE H PART V LINE 5 EXPLANATION

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 7 Facility , 1	Facility , 1 - PRESENCE ST JOSEPH HOSPITAL 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 INDIVIDUALS ON THEIR MAILING LISTS AND RESPECTIVE CONSTITUENTS

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	Facility , 1 - PRESENCE ST JOSEPH HOSPITAL BASED ON THE CHNA FINDINGS, INTERNAL RESOURCES, AND INTERNAL EXPERTISE THE AREAS OF FOCUS FOR THE 2018 IMPLEMENTATION STRATEGY PLAN THAT PSJH WILL HELP ADDRESS INCLUDE *OBESITY *CHRONIC DISEASE *POOR SOCIAL AND EMOTIONAL WELLNESS PLEASE SEE PART VI, LINE 5 FOR THE DESCRIPTION OF PROGRAMS IN PLACE TO ADDRESS THESE IDENTIFIED NEEDS ALONG WITH 2015-2017 OBJECTIVES AND 2015-2017 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

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - PRESENCE ST JOSEPH HOSPITAL 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 600% OF THE FPL

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 3E	THE SIGNIFICANT HEALTH NEEDS ARE A PRIORITIZED DESCRIPTION OF THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY AS IDENTIFIED THROUGH THE CHNA

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	Facility , 1 - PRESENCE ST MARY'S HOSPITAL DURING 2015, A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) WAS FACILITATED BY PRESENCE ST MARY'S HOSPITAL (PSMH), RIVERSIDE MEDICAL CENTER AND KANKAKEE COUNTY HEALTH DEPARTMENT. THIS REPORT SUMMARIZES THE HEALTH PROFILE AND COMMUNITY INPUT FINDINGS OF THE CHNA CONDUCTED FOR THE POPULATION SERVED BY PSMH AND IDENTIFIES THE TOP PRIORITY HEALTH ISSUES FOR THE COMMUNITY TO FOCUS ON IN DEVELOPING ITS IMPLEMENTATION STRATEGIES. ENGAGEMENT OF PUBLIC HEALTH EXPERTISE THE KANKAKEE COUNTY HEALTH DEPARTMENT AND PSMH CO-FACILITATED THE CHNA PROCESS BY USING THE MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP) TOOL. THE PARTNERSHIP FOR A HEALTHY COMMUNITY FORMALLY ENGAGED THE ILLINOIS PUBLIC HEALTH INSTITUTE (IPHI) FOR ASSISTANCE IN PLANNING AND EXECUTING THE CHNA PROCESS. IPHI SERVED AS AN EXPERT PUBLIC HEALTH CONSULTANT THROUGHOUT THE CHNA. THE CHNA STEERING COMMITTEE TO PROVIDE COMMUNITY LEVEL OVERSIGHT FOR THE PROCESS, A DIVERSE GROUP OF COMMUNITY STAKEHOLDERS AND PSMH REPRESENTATIVES WERE INVITED TO PARTICIPATE ON THE CHNA STEERING COMMITTEE. TO ENSURE REPRESENTATIVE ENGAGEMENT, PERSONAL INVITATIONS WERE SENT TO ORGANIZATIONS REPRESENTING CULTURAL, LINGUISTIC, RACIAL, ETHNIC, AND OTHER MINORITY GROUPS. IN ADDITION, INDIVIDUALS WITH SPECIALIZED QUALIFICATIONS IN DEALING WITH SPECIAL POPULATIONS OR CLINICAL GROUPS WERE SOLICITED FOR THEIR PARTICIPATION. FINALLY, EFFORTS WERE MADE TO INCLUDE INDIVIDUALS ON THE CHNA STEERING COMMITTEE WITH PUBLIC HEALTH EXPERTISE. THOSE WHO COMMITTED TO THE ASSESSMENT AND PLANNING PROCESS BECAME THE 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 LISTED BELOW: KANKAKEE COMMUNITY COLLEGE, UNITED WAY OF KANKAKEE COUNTY, PRESENCE ST MARY'S HOSPITAL, ILLINOIS REGIONAL OFFICE OF EDUCATION & NAACP, RIVERSIDE MEDICAL CENTER, NEW LIFE PENTECOSTAL CHURCH & HISPANIC PARTNERSHIP, PRESENCE HOME HEALTH CARE, THE HELEN WHEELER CENTER FOR COMMUNITY MENTAL HEALTH, RIVERSIDE MEDICAL CENTER, KANKAKEE COUNTY HEALTH DEPARTMENT. PROCESS USED TO IDENTIFY COMMUNITY NEEDS EVERY FIVE YEARS, LOCAL HEALTH DEPARTMENTS IN ILLINOIS MUST COMPLETE A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) AND HEALTH PLAN AS A REQUIREMENT FOR RECERTIFICATION WITH THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH (IDPH). THIS PROCESS IS KNOWN AS ILLINOIS PROJECT FOR LOCAL 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 FACILITATE 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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	AT PROVIDES A COMPREHENSIVE FRAMEWORK FOR ASSESSING COMMUNITY NEEDS, AND DEVELOPING AND AD DRESSING STRATEGIC ISSUES THE PURPOSE OF THE KANKAKEE COUNTY MAPP PROCESS IS TO PROVIDE A COMMUNITY PLAN THAT IS DEVELOPED BY AND FOR THE COMMUNITY THE BENEFITS OF KANKAKEE COUNT Y ENGAGING IN THIS PROCESS INCLUDE *A HEALTHIER COMMUNITY THAT IMPROVES THE QUALITY OF LI FE FOR THE PEOPLE WHO LIVE AND WORK IN IT *INCREASED VISIBILITY OF PUBLIC HEALTH IN THE C OMMUNITY *INCREASED AWARENESS AND KNOWLEDGE ABOUT PUBLIC HEALTH ISSUES *PREPARATION OF O UR LOCAL PUBLIC HEALTH SYSTEM TO BETTER ANTICIPATE, MANAGE AND RESPOND TO CHANGES IN THE C OUNTY *GREATER COLLABORATION AND SHARING OF RESOURCES AMONG PARTNERS *REFLECTION OF PRIO RITIES IN HOSPITAL IMPLEMENTATION STRATEGIES MAPP HAS SIX PHASES THE FIRST FIVE PHASES W ERE COMPLETED OVER TWENTY-TWO MONTHS PHASE SIX, THE ACTION CYCLE, IS AN ONGOING PROCESS O F PLANNING, IMPLEMENTING AND EVALUATING KANKAKEE COUNTY IS CURRENTLY IN PHASE SIX OF THE PROCESS

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 6a Facility , 1	Facility , 1 - PRESENCE ST MARY'S HOSPITAL PSMH PARTNERED WITH RIVERSIDE MEDICAL CENTER TO COMPLETE THEIR CHNA

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 6b Facility , 1	Facility , 1 - PRESENCE ST MARY'S HOSPITAL SEE 990 SCHEDULE H PART V LINE 5 EXPLANATION

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 7 Facility , 1	Facility , 1 - PRESENCE ST MARY'S HOSPITAL 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 INDIVIDUALS ON THEIR MAILING LISTS AND RESPECTIVE CONSTITUENTS

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	Facility , 1 - PRESENCE ST MARY'S HOSPITAL AFTER CONSOLIDATING OVERLAPPING ISSUES IDENTIFIED IN THE MAPP CHNA, THE TOP IDENTIFIED NEEDS IN KANKAKEE COUNTY ARE *TEEN PREGNANCY & INFANT MORTALITY *ACCESS TO CARE *CHRONIC DISEASE *MENTAL HEALTH & SUBSTANCE ABUSE *VIOLENCE & SAFETY *EDUCATION To ensure that we can have a measurable impact on our identified needs, and based on the capacities of the hospital, we decided to focus on addressing the following three needs *CHRONIC DISEASE *ACCESS TO CARE *MENTAL HEALTH & SUBSTANCE ABUSE PLEASE SEE PART VI, LINE 5 FOR THE DESCRIPTION OF PROGRAMS IN PLACE TO ADDRESS THESE IDENTIFIED NEEDS ALONG WITH 2017 OBJECTIVES AND 2017 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

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - PRESENCE ST MARY'S HOSPITAL 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 600% OF THE FPL

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 3E	THE SIGNIFICANT HEALTH NEEDS ARE A PRIORITIZED DESCRIPTION OF THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY AS IDENTIFIED THROUGH THE CHNA

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	Facility , 1 - PRESENCE COVENANT MEDICAL CENTER THE 2017 CHAMPAIGN COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN (IPLAN) WAS ACCOMPLISHED WITH DIRECT CONTRIBUTION FROM OVER 90 INDIVIDUALS REPRESENTING DOZENS OF DIFFERENT AGENCIES FROM ACROSS THE COUNTY PRESENCE COVENANT MEDICAL CENTER (PCMC) ALSO INCORPORATED THE VOICE OF MORE THAN 1,000 COMMUNITY RESIDENTS THROUGH SURVEYS, FOCUS GROUPS AND COMMUNITY MEETINGS INTO PCMC'S CHNA ENGAGEMENT OF PUBLIC HEALTH EXPERTISE PCMC WAS A PARTICIPANT AND HELPED FACILITATE SOME ASPECTS OF THE 2014-2016 CHAMPAIGN COUNTY IPLAN THE CHAMPAIGN URBANA PUBLIC HEALTH DEPARTMENT (CUPHD) CHOSE TO UTILIZE THE MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIP (MAPP) MODEL TO HELP ACQUIRE INPUT FROM COMMUNITY PARTNERS, PLANNERS, ELECTED OFFICIALS AND RESIDENTS OF THE COMMUNITY THIS MAPP PROCESS ASSESSED THE CURRENT HEALTH STATUS 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 OF RESIDENTS IN CHAMPAIGN COUNTY WE USED AGGREGATED DATA ACCESSED FROM COUNTYHEALTHRANKINGS ORG AND CITY AND COUNTY AGENCIES INCLUDING THE CHAMPAIGN AND URBANA POLICE DEPARTMENTS *COMMUNITY THEMES AND STRENGTHS ASSESSMENT (CTSA) WE SURVEYED 748 COMMUNITY RESIDENTS REPRESENTING DIFFERENT COMMUNITY GROUPS TO GET AN IN-DEPTH PICTURE OF STRENGTHS AND WEAKNESSES *LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT (LPHSA) INCLUDED 84 COMMUNITY LEADERS FROM OVER 50 DIFFERENT AGENCIES, INCLUDING LOCAL GOVERNMENT, COMMUNITY PLANNERS, PUBLIC HEALTH PROFESSIONALS, CLINICIANS, 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 IMPACTING MANY SECTORS, MEETING THE NEEDS OF INCREASING POPULATIONS OF UNDOCUMENTED IMMIGRANTS, ADDRESSING WIDENING HEALTH DISPARITIES AND THE LACK OF ECONOMIC OPPORTUNITIES, AND THE INCREASED USE OF TECHNOLOGY IN HEALTHCARE (E G TELEMEDICINE AND ELECTRONIC MEDICAL RECORDS) AND USING SOCIAL MEDIA AND TECHNOLOGY TO PROMOTE GENERAL HEALTH WERE IDENTIFIED AS MAJOR FORCES OF CHANGE

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 6a Facility , 1	Facility , 1 - PRESENCE CONVENANT MEDICAL CENTER PCMC PARTNERED WITH CARLE FOUNDATION HOSPITAL TO COMPLETE THEIR CHNA

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 6b Facility , 1	Facility , 1 - PRESENCE CONVENANT MEDICAL CENTER SEE 990 SCHEDULE H PART V LINE 5 EXPLANATION

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 7 Facility , 1	Facility , 1 - PRESENCE COVENANT MEDICAL CENTER 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 INDIVIDUALS ON THEIR MAILING LISTS AND RESPECTIVE CONSTITUENTS

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	Facility , 1 - PRESENCE COVENANT MEDICAL CENTER RESULTS OF THE 2017 COMMUNITY HEALTH NEEDS ASSESSMENT Over the course of several meetings with the input of 89 individuals representing more than 55 different agencies, the following three health priorities were determined These community leaders were presented with the findings from the four MAPP assessment components After these presentations, the leaders were asked to list their top health priorities, justify their reasoning and what would be the implication for not addressing these priorities in the short and long term After an extended discussion the following three were selected as the health priorities to be addressed in the current 3-year community health plan These are not ranked in order or preference All significant needs identified in the most recently conducted CHNA are being addressed * Behavioral Health - Access, prevention, substance abuse, and resources * Reducing Obesity and Promoting Healthy Lifestyles - Nutrition, environment, and physical activity *Violence - Gun Violence, domestic violence, child abuse and neglect PCMC'S REVIEW OF CURRENT COMMUNITY BENEFIT PROGRAMS FOUND THAT THE HOSPITAL IS MEETING EXISTING COMMUNITY NEEDS THROUGH THE FOLLOWING PROGRAMS THE SMILEHEALTHY PARTNERSHIP, FAITH IN ACTION, CRISIS NURSERY, DIABETES COALITION, FAITH-SQUARED AND TRANSITIONS PLEASE SEE PART VI, LINE 5 FOR THE DESCRIPTION OF PROGRAMS IN PLACE TO ADDRESS THESE IDENTIFIED NEEDS ALONG WITH 2017 OBJECTIVES AND 2017 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

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - PRESENCE COVENANT MEDICAL CENTER 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 600% OF THE FPL

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 AVENU DANVILLE, IL 61832	ONCOLOGY CENTER
11 PRESENCE MANTENO MEDCENTRE 501 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 BOURONNAIS, IL 60914	REGIONAL ONCOLOGY CENTER
2 PRESENCE ST MARY'S IMAGING CENTER 100 PROVENA WAY BOURONNAIS, 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 BOURONNAIS, IL 60914	SLEEP DISORDER CENTER
8 PRESENCE ADVANCED IMAGING 410 EAST LINCOLN HIGHWAY NEW LENOX, IL 60451	IMAGING CENTER
9 PRESENCE HEALTING 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

Name of the organization
Presence Central and Suburban Hospitals Network

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

2017

Open to Public
Inspection

Employer identification number
36-4195126

Part I

General Information on Grants and Assistance

- 1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance?

☒ Yes ☐ No
- 2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States

Part II

Grants and Other Assistance to 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 noncash assistance	(h) Purpose of grant or assistance
(1) See Additional Data							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table 7

3 Enter total number of other organizations listed in the line 1 table 2

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 noncash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of noncash assistance
(1) SCHOLARSHIPS	11	5,500			
(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 Procedures for monitoring use of grant funds	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) OR GOVERNMENTAL ENTITIES AND THEREFORE THE CORPORATION DOES NOT MONITOR THE USE OF THOSE FUNDS

Additional Data

Software ID: 17005876
Software Version: 2017v2.2
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
ALIGNMENT COLLABORATIVE FOR EDUCATION 1750 GRANDSTAND PLACE 5 ELGIN, IL 60123	47-4377813	501(C)(3)	16,000				GENERAL SUPPORT
FOX VALLEY HANDS OF HOPE 200 WHITFIELD DRIVE GENEVA, IL 60134	36-3111451	501(C)(3)	11,953				GRIEF PROGRAM

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 W BROOKMONT BLVD KANKAKEE, IL 60901	36-2317629	501(c)(3)	6,000				SPONSORSHIP
KANKAKEE COUNTY CHAMBER OF COMMERCE 200 EAST COURT STREET 710 KANKAKEE, IL 60901	26-1497369	501(c)(6)	5,650				GENERAL SUPPORT

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 KANKAKEE & IROQUOIS COUNTIES PO BOX 1286 KANKAKEE, IL 60901	36-2188452	501(C)(3)	5,380				COMMUNITY PROGRAMS
WILL-GRUNDY MEDICAL CLINIC 213 E CASS STREET JOLIET, IL 60432	36-3492306	501(C)(3)	37,250				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
SENIOR SERVICES CENTER OF WILL CO 251 NORTH CENTER STREET JOLIET, IL 60435	36-2615835	501(C)(3)	5,000				MOBILE PANTRY FUNDING
GRANT PARK FIRE PROTECTION DISTRICT 12624 E STATE RTE 1 17 GRANT PARK, IL 60940	36-2800846		10,400				FOR FIRST AID SERVICES

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)	22,500				DENTAL WORK FOR THE POOR

Schedule J (Form 990)	<div>Compensation Information</div> <div>For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees</div> <div>▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23. ▶ Attach to Form 990.</div> <div>▶ Information about Schedule J (Form 990) and its instructions is at www.irs.gov/form990.</div>	OMB No 1545-0047
		2017
		Open to Public Inspection

Department of the Treasury Internal Revenue Service	Name of the organization Presence Central and Suburban Hospitals Network	Employer identification number 36-4195126
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Part I 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.			
<input type="checkbox"/> First-class or charter travel	<input type="checkbox"/> Housing allowance or residence for personal use		
<input type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence		
<input type="checkbox"/> Tax indemnification and gross-up payments	<input type="checkbox"/> Health or social club dues or initiation fees		
<input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)		
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.			
<input type="checkbox"/> Compensation committee	<input type="checkbox"/> Written employment contract		
<input type="checkbox"/> Independent compensation consultant	<input type="checkbox"/> Compensation survey or study		
<input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Approval by the board or compensation committee		
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?		4c	No
If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
Only 501(c)(3), 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?		5b	No
If "Yes," on line 5a or 5b, describe in Part III.			
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?		6b	No
If "Yes," on line 6a or 6b, describe in Part III.			
7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed 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	

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.

See Additional Data Table

Schedule J (Form 990) 2017

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
Schedule J, Part I, Line 3 Arrangement used to establish the top management official's compensation	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 CORPORATION'S 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.
Schedule J, Part I, Line 4a Severance or change-of-control payment	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 2017: AMY D STEVENS \$121,076; ANTHONY FILER \$100,273; KATHLEEN RHINE \$49,562.
Schedule J, Part I, Line 4b Supplemental nonqualified retirement plan	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: ANN ERRICHETTI \$171,002; JARED C ROGERS \$59,100; JEANNIE C FREY \$93,573; LISA LAGGER \$34,396; MICHAEL L BROWN \$68,756; PATRICK QUINN \$25,013. THE FOLLOWING LISTED INDIVIDUALS PARTICIPATED IN THE ORGANIZATION'S SECTION 457(F) PLAN AND EARNED UNVESTED BENEFITS DURING 2017 WHICH ARE REPORTED IN COLUMN (C): CHRISTOPHER SCOTT SHRIDE \$28,499; JAMES H KELLEY \$147,003; JEANNIE C FREY \$87,579; JEFFREY ROONEY \$83,914; MICHAEL L BROWN \$74,581; PATRICIA EDDY \$25,002; ROBERT JAMES ERICKSON \$52,071; SAM BAGCHI, MD \$13,750.

Additional Data

Software ID: 17005876
Software Version: 2017v2.2
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				
1SAM BAGCHI MD DIRECTOR (END 3/2017)	(i)	0	0	0	0	0	0	0
	(ii)	192,101	150,000	41,047	13,750	6,371	403,270	0
1DAVID J BORDO MD DIRECTOR	(i)	0	0	0	0	0	0	0
	(ii)	344,548	36,673	19,180	18,900	21,934	441,235	0
2ANTHONY FILER FORMER OFFICER (END 01/2016)	(i)	0	0	0	0	0	0	0
	(ii)	0	0	100,273	0	0	100,273	100,273
3AMY D STEVENS FORMER OFFICER (END 12/2015)	(i)	0	0	0	0	0	0	0
	(ii)	0	0	121,076	0	0	121,076	121,076
4PATRICIA EDDY ASSISTANT TREASURER, SYSTEM FINANCIAL OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	253,320	70,781	7,109	34,287	21,428	386,925	0
5JEANNIE C FREY SECRETARY, SYSTEM CHIEF LEGAL OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	454,279	304,240	123,571	103,779	21,639	1,007,509	88,489
6BETTINA JOHNSON ASSISTANT TREASURER, SYSTEM DIRECTOR (START 5/2017)	(i)	0	0	0	0	0	0	0
	(ii)	194,870	68,137	7,126	13,500	16,142	299,775	0
7JAMES KELLEY TREASURER, CHIEF FINANCIAL OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	665,673	252,994	11,547	160,503	25,342	1,116,059	0
8JULIE ROKNICH ASSISTANT SECRETARY, SYS DIRECTOR SR ASSOCIATE GENERAL COUNSEL TRANSACTIONS	(i)	0	0	0	0	0	0	0
	(ii)	206,786	28,324	202	11,060	19,988	266,359	0
9JEFFREY ROONEY ASSISTANT TREASURER, SVP FINANCIAL OPERATIONS (START 5/2017)	(i)	0	0	0	0	0	0	0
	(ii)	426,943	0	25,517	92,014	17,161	561,634	0
10ANN ERRICHETTI PRESIDENT	(i)	0	0	0	0	0	0	0
	(ii)	774,686	347,804	184,871	13,500	9,055	1,329,915	0
11LISA LAGGER FORMER KEY EMPLOYEE (END 12/2014)	(i)	0	0	0	0	0	0	0
	(ii)	122,058	29,468	57,323	0	4,131	212,980	0
12CONNIE J NOLTEMEYER FORMER KEY EMPLOYEE (END 12/2014)	(i)	140,237	2,750	1,282	4,420	10,188	158,878	0
	(ii)	0	0	0	0	0	0	0
13KATHLEEN RHINE FORMER KEY EMPLOYEE (END 9/2016)	(i)	0	85,789	49,562	0	0	135,351	49,562
	(ii)	0	0	0	0	0	0	0
14MICHAEL L BROWN REGIONAL PRESIDENT & CEO - FXV	(i)	431,122	229,719	82,120	88,013	13,385	844,358	68,714
	(ii)	0	0	0	0	0	0	0
15ROBERT JAMES ERICKSON PRESIDENT - PSJMC (START 3/2017)	(i)	341,223	50,000	28,683	60,171	15,084	495,161	0
	(ii)	0	0	0	0	0	0	0
16JARED C ROGERS REGIONAL PRESIDENT & CEO - CES	(i)	376,688	85,636	72,022	13,500	15,753	563,598	0
	(ii)	0	0	0	0	0	0	0
17CHRISTOPHER SCOTT SHRIDE PRESIDENT - PSMH	(i)	279,464	50,100	16,939	37,860	25,263	409,626	0
	(ii)	0	0	0	0	0	0	0
18BEEJAL Y AMIN MD FORMER HIGHEST COMPENSATED EMPLOYEE	(i)	0	0	0	0	0	0	0
	(ii)	856,624	20,000	65,040	13,500	22,692	977,856	0
19SURENDRA M GULATI FORMER HIGHEST COMPENSATED EMPLOYEE	(i)	0	0	0	0	0	0	0
	(ii)	474,251	0	24,871	13,500	15,096	527,718	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				
21KAIZ ASIF	(i)	0	0	0	0	0	0	0
FORMER HIGHEST COMPENSATED EMPLOYEE	(ii)	514,677	25,000	1,025	13,500	19,476	573,678	0
1ANIL B GOPINATH MD	(i)	318,369	46,620	17,761	13,500	23,599	419,849	0
REGIONAL CHIEF MEDICAL OFFICER	(ii)	0	0	0	0	0	0	0
2VINCENT KUCICH	(i)	287,267	38,979	1,911	10,352	9,561	348,069	0
REGIONAL CHIEF MEDICAL OFFICER	(ii)	0	0	0	0	0	0	0
3GARY LIPINSKI MD	(i)	381,686	55,086	21,446	13,500	15,277	486,996	0
REGIONAL CHIEF MEDICAL OFFICER	(ii)	0	0	0	0	0	0	0
4SHOBHANA RAVIKUMAR MD	(i)	270,841	0	60,934	13,500	19,967	365,242	0
PHYSICIAN	(ii)	0	0	0	0	0	0	0
5DEBORAH A SCHIMEROWSKI	(i)	238,584	34,713	18,897	16,200	9,463	317,857	0
REGIONAL FINANCE OFFICER - CES/SSB	(ii)	0	0	0	0	0	0	0

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Name of the organization

Presence Central and Suburban Hospitals Network

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

2017

**Open to Public
Inspection**

Employer identification number

36-4195126

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part I, Line 1 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 NEW YOU CENTER

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part V, Line 2a 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 CORPORATION'S 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, Line 1a FORM 1096 TRANSMITTAL OF US 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, ANNUAL SUMMARY AND TRANSMITTAL OF U S INFORMATION RETURNS ALL OF THE CORPORATION'S 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, Line 6 Classes of members or stockholders	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, Line 7a Members or stockholders electing members of governing body	THE CORPORATION'S 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, Line 7b Decisions requiring approval by members or stockholders	<p>PRESENCE CARE TRANSFORMATION CORPORATION (THE "MEMBER"), THROUGH ITS BOARD OF DIRECTORS, HAS CERTAIN GENERAL AND RESERVED POWERS WITH RESPECT TO THE FOLLOWING GENERAL POWERS. THE MEMBER SHALL PROVIDE OVERSIGHT AND SUPPORT FOR THE ACTIVITIES OF THE CORPORATION, FOR THE PURPOSE OF ASSURING THAT ALL ACTIONS OF THE CORPORATION ARE CONSISTENT WITH THE MISSION AND VALUES OF THE SYSTEM, THE PURPOSES OF THE CORPORATION, THE ETHICAL AND RELIGIOUS DIRECTIVES, THE PRESENCE HEALTH SYSTEM STRATEGIC PLAN, AND BEST PRACTICES. RESERVED POWERS IN FURTHERANCE OF THE EXERCISE OF ITS GENERAL POWERS AND RESPONSIBILITIES, THE MEMBER SHALL HAVE THE SOLE POWER TO TAKE THE ACTIONS SPECIFIED BELOW WITH RESPECT TO THE FOLLOWING MATTERS, SUBJECT TO ANY NOTICES OR FURTHER APPROVALS REQUIRED BY APPLICABLE CIVIL OR CANON LAW, OR THE MEMBER'S BYLAWS:</p> <p>A) BYLAWS - AMEND OR REPEAL THE BYLAWS OF THE CORPORATION. B) OFFICERS AND DIRECTORS - APPOINT AND REMOVE ALL OFFICERS OF THE CORPORATION AND ALL DIRECTORS OF THE CORPORATION, OTHER THAN ANY EX OFFICIO DIRECTORS. C) BUDGETS - APPROVE CAPITAL AND OPERATING BUDGETS, AND LONG-TERM CAPITAL EQUIPMENT PLANS FOR THE CORPORATION. D) UNBUDGETED EXPENDITURES - APPROVE UNBUDGETED 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 SIGNIFICANT INCURRENCE OF DEBT BY THE CORPORATION IN EXCESS OF THE LIMIT ESTABLISHED BY THE MEMBER FROM TIME TO TIME, OR ANY SALE, PURCHASE, ALIENATION, EXCHANGE, SIGNIFICANT LEASES (OTHER THAN IN THE ORDINARY COURSE) OR ENCUMBRANCES OF THE CORPORATION'S REAL PROPERTY, EXCEPT THOSE MADE PURSUANT TO APPROVED BUDGETS. F) REAL ESTATE DOCUMENT, 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 OTHER SIGNIFICANT AND UNBUDGETED SALE, PURCHASE, EXCHANGE, LEASE (OTHER THAN IN THE ORDINARY COURSE) TRANSFER, LITIGATION OR LEGAL SETTLEMENT, BENEFITS PACKAGES, ENCUMBRANCE OR OTHER DISPOSITION OR OTHER SIGNIFICANT TRANSACTION INVOLVING THE NON-REAL-ESTATE ASSETS OF THE CORPORATION IN EXCESS OF THE LIMIT ESTABLISHED BY THE MEMBER FROM TIME TO TIME. H) MATERIAL CHANGES IN SERVICES - APPROVE MATERIAL CHANGES IN THE KIND OF SERVICES RENDERED, SUCH AS THE ADDITION OR DISCONTINUATION OF ANY MAJOR SERVICE LINE (E.G., OBSTETRICS) OR CHANGE IN THE FUNDAMENTAL NATURE OF SERVICES PROVIDED BY THE CORPORATION (E.G., A CHANGE REQUIRING A DIFFERENT KIND OF LICENSE). I) STRATEGIC PLAN - APPROVE STRATEGIC PLANS FOR THE CORPORATION CONSISTENT WITH AND IN FURTHERANCE OF SYSTEM MISSION AND VALUES, AND RESPONSIVE TO THE NEEDS OF THE COMMUNITIES SERVED BY THE CORPORATION AND SUPPORT THE ABILITY OF THE CORPORATION AND ITS AFFILIATES TO PROVIDE HIGH-QUALITY CARE AND SERVICES. J) MANAGEMENT CONTRACTS - APPROVE ANY CONTRACT FOR THE MANAGEMENT OF ALL OR SUBSTANTIALLY ALL OF THE CORPORATION.</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 7b Decisions requiring approval by members or stockholders	<p>R ANY HEALTH CARE FACILITIES OWNED BY THE CORPORATION K) BUSINESS NAME, LOGO - APPROVE ANY SELECTION OR MODIFICATION OF THE BUSINESS NAME OR LOGO OF THE CORPORATION OR ANY PROGRAM OR DIVISION OF THE CORPORATION, OR THE USE OF ANY CORPORATE OR BUSINESS NAME OF THE CORPORATION BY AN ENTITY OTHER THAN THE MEMBER OR AN AFFILIATE L) ADMINISTRATIVE SERVICES - PROVIDE OR ASSURE THE PROVISION OF APPROPRIATE INSURANCE COVERAGE, STANDARDIZED EMPLOYEE BENEFITS, INFORMATION SYSTEMS AND TECHNOLOGY, FINANCIAL MANAGEMENT SERVICES, LEGAL, MARKETING, RISK MANAGEMENT AND OTHER ADMINISTRATIVE SERVICES NECESSARY TO SUPPORT THE CORPORATION'S OPERATIONS M) SIGNIFICANT JOINT VENTURES - APPROVE THE ESTABLISHMENT, TERMINATION, OR SALE OF ANY SIGNIFICANT JOINT VENTURE RELATIONSHIP BY THE CORPORATION N) UNRELATED BUSINESS 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 - DIRECT AND APPROVE ANY CONTRIBUTIONS, DONATIONS OR OTHER ASSET TRANSFERS WITHOUT CONSIDERATION TO THE MEMBER OR ANY AFFILIATE, IN FURTHERANCE OF THE MISSION AND VALUES Q) CONTRIBUTION ACCEPTANCE - APPROVE ACCEPTANCE OF A CONTRIBUTION THAT IMPOSES A MATERIAL OBLIGATION ON THE CORPORATION, IF APPROVED BY THE CORPORATION'S APPLICABLE FOUNDATION OR FUNDRAISING AFFILIATE AS CONSISTENT WITH THE CORPORATION'S AND SYSTEM'S MISSION AND GOALS R) BANKING - DEFINE THE CRITERIA FOR THE SELECTION OF BANKS AND OTHER FINANCIAL DEPOSITORIES TO BE USED BY THE CORPORATION, AND AUTHORIZE THE PROCESS BY WHICH SIGNATORIES ON ALL BANK AND SIMILAR ACCOUNTS OF THE CORPORATION ARE APPROVED S) AUDITORS - SELECT INDEPENDENT AUDITORS FOR THE CORPORATION, IN CONNECTION WITH THE CONSOLIDATED AUDIT OF ALL SYSTEM ENTITIES T) REGISTERED AGENT - APPROVE OR CHANGE THE CORPORATION'S REGISTERED AGENT OR REGISTERED OFFICE, AS APPROPRIATE FROM TIME TO TIME U) TAX EXEMPTION - APPROVE ANY VOLUNTARY CHANGE TO THE CORPORATION'S STATUS OF AN ORGANIZATION EXEMPT FROM TAXATION UNDER SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE, AS AMENDED FROM TIME TO TIME</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 11b Review of form 990 by governing body	DURING THE RETURN PREPARATION PROCESS, THE TAX DEPARTMENT WORKS WITH OTHER FUNCTIONAL AREAS INCLUDING FINANCE, ACCOUNTING, TREASURY, LEGAL, HUMAN RESOURCES, AND CORPORATE COMPLIANCE FOR ADVICE, INFORMATION AND ASSISTANCE IN ORDER TO PREPARE A COMPLETE AND ACCURATE RETURN UPON COMPLETION, THE FORM 990 IS REVIEWED BY THE ORGANIZATION'S INTERNAL TAX DEPARTMENT WHICH CONSISTS OF ATTORNEYS AND CPAS A COMPLETE FINAL COPY OF THE RETURN IS PROVIDED TO THE ORGANIZATION'S PRESIDENT, FINANCIAL OFFICER, AND/OR OTHER KEY OFFICERS IN LIEU OF THE FULL BOARD

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 12c Conflict of interest policy	<p>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 CORPORATION'S BOARD OF DIRECTORS, WHETHER THROUGH THE VOLUNTARY SUBMISSION OF A DISCLOSURE STATEMENT BY AN INTERESTED PERSON, OR BY A DISCLOSURE BY A PERSON OTHER THAN THE SUBJECT INTERESTED PERSON, THE CORPORATION'S BOARD OR APPLICABLE COMMITTEE SHALL REVIEW THE MATTER AND DETERMINE WHETHER A CONFLICT OF INTEREST EXISTS. 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 PRESENCE HEALTH OPERATES IN A MANNER CONSISTENT WITH ITS CHARITABLE PURPOSES AND THAT IT DOES NOT ENGAGE IN ACTIVITIES THAT COULD JEOPARDIZE ITS EXEMPT STATUS. TRANSACTIONS INVOLVING INTERESTED PERSONS ARE ONLY APPROVED IF, AFTER EXERCISING REASONABLE DUE DILIGENCE, THE BOARD DETERMINES THEY ARE FAIR AND REASONABLE, TAKING INTO ACCOUNT FACTORS SUCH AS WHETHER PRESENCE HEALTH COULD OBTAIN A MORE ADVANTAGEOUS CONTRACT, TRANSACTION OR ARRANGEMENT. HOWEVER, LENDING MONEY OR GUARANTYING AN OBLIGATION OF A DIRECTOR, OFFICER,</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 12c Conflict of interest policy	OR EMPLOYEE OF PRESENCE HEALTH (EXCLUSIVE OF CUSTOMARY INSURANCE COVERAGE FOR ACTS DONE IN CONNECTION WITH SUCH INDIVIDUALS SERVICE TO OR EMPLOYMENT BY PRESENCE HEALTH) IS STRICTLY PROHIBITED

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 15a Process to establish compensation of top management official	COMPENSATION FOR THE CORPORATION'S CEO IS DETERMINED IN ACCORDANCE WITH WRITTEN POLICIES AND PROCEDURES ADOPTED BY THE BOARD OF DIRECTORS OF THE SYSTEM'S 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 AS PHN'S BOARD OF DIRECTORS HAS ULTIMATE CONTROL OVER ALL SUBSIDIARY ORGANIZATIONS

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 15b Process to establish compensation of other employees	COMPENSATION FOR THE CORPORATION'S OTHER OFFICERS OR KEY EMPLOYEES IS DETERMINED IN ACCORDANCE WITH WRITTEN POLICIES AND PROCEDURES ADOPTED BY THE BOARD OF DIRECTORS OF THE SYSTEM'S 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 15B AS PHN'S BOARD OF DIRECTORS HAS ULTIMATE CONTROL OVER ALL SUBSIDIARY ORGANIZATIONS.

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 19 Required documents available to the public	THE CORPORATION'S 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 SYSTEM'S BOND DOCUMENTS CONFLICT 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 CORPORATION'S FORM 990

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VII, Section A 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

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VIII, Line 11d Other Miscellaneous Revenue	- Total Revenue 5930219, Related or Exempt Function Revenue 5545068, Unrelated Business Revenue 385151, Revenue Excluded from Tax Under Sections 512, 513, or 514 ,

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part IX, Line 11g Other Fees	PURCHASED SERVICES - Total Expense 60057008, Program Service Expense 60057008, Management and General Expenses , Fundraising Expenses , PHYSICIAN FEES - Total Expense 48579517, Program Service Expense 48579517, Management and General Expenses , Fundraising Expenses , LAB SERVICES - Total Expense 35709755, Program Service Expense 35709755, Management and General Expenses , Fundraising Expenses , AGENCY LABOR - Total Expense 4481686, Program Service Expense 4481686, Management and General Expenses , Fundraising Expenses , TRANSCRIPTION SERVICES - Total Expense 104048, Program Service Expense 104048, Management and General Expenses , Fundraising Expenses , FOOD MANAGEMENT SERVICES - Total Expense 4514804, Program Service Expense 4514804, Management and General Expenses , Fundraising Expenses , LAUNDRY SERVICES - Total Expense 2003559, Program Service Expense 2003559, Management and General Expenses , Fundraising Expenses ,

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part XI, Line 9 Other changes in net assets or fund balances	NET ASSET TRANSFER TO AFFILIATES - -76883703,

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part XII, Line 2b AUDITED FINANCIAL STATEMENT	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

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part XII, Line 3a PART XII, LINES 3A AND 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

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

2017

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	-199,348	5,581,237	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	NA	N/A								
(2) RH SLEEP CTR - NW 665 WEST NORTH AVE 500 LOMBARD, IL 60148 26-1519627	MEDICAL SERVICE	IL	NA	N/A								
(3) RH SLEEP CTR - EVAN 665 WEST NORTH AVE 500 LOMBARD, IL 60148 26-1519556	MEDICAL SERVICE	IL	NA	N/A								
(4) RH SLEEP CTR - LP 665 WEST NORTH AVE 500 LOMBARD, IL 60148 26-1519667	MEDICAL SERVICE	IL	NA	N/A								
(5) ALVERNO CLINIC LAB 2434 INTERSTATE PLAZA DRIVE HAMMOND, IN 46324 20-3240648	MEDICAL SERVICE	IN	NA	N/A								
(6) PROF CLINIC LAB LLC 113 E 4TH ST MICHIGAN CITY, IN 46360 30-0711211	MEDICAL SERVICE	IN	NA	N/A								

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of- year assets	(h) Percentage ownership	(i) Section 512(b) (13) controlled entity?	
								Yes	No
(1) L GILBRAITH INSURANCE SPC LTD 68 W BAY ROAD PO BOX 1109 GRAND CAYMAN CJ	INSURANCE	CJ	PRESENCE HEALTH NETWORK	C Corporation					No
(2) PROVENA HEALTH ASSURANCE SPC 23 LIME TREE BAY AVE PO BOX 1051 GRAND CAYMAN CJ 98-0420054	INSURANCE	CJ	PRESENCE CARE TRANSFORMATION CORPORATION	C Corporation				Yes	
(3) PRESENCE PROPERTIES INC 100 NORTH RIVER ROAD DES PLAINES, IL 60016 36-3520630	MEDICAL	IL	PV	C Corporation				Yes	
(4) PRESENCE SERVICE CORPORATION 2380 E DEMPSTER ROAD DES PLAINES, IL 60016 36-4314354	MEDICAL	IL	PRESENCE CARE TRANSFORMATION CORPORATION	C Corporation				Yes	
(5) PRESENCE VENTURES INC 100 NORTH RIVER ROAD DES PLAINES, IL 60016 37-1168085	MEDICAL	IL	PRESENCE CARE TRANSFORMATION CORPORATION	C Corporation				Yes	
(6) RESURRECTION MEDICAL CENTER AUXILIARY 7435 WEST TALCOTT AVENUE CHICAGO, IL 60631 36-6109825	FUNDRAISING	IL	PRESENCE CHICAGO HOSPITALS NETWORK	C Corporation				Yes	
(7) RESURRECTION MINISTRIES OF NEW YORK 90 NORTH MAIN STREET CASTLETON, NY 12033 14-1720818	PARENT CORP	NY	PRESENCE CHICAGO HOSPITALS NETWORK	C Corporation				Yes	

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)		No
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	3,041,073	CASH
(2) PRESENCE CARE TRANSFORMATION CORPORATION	M	131,789,433	COST ALLOCATION
(3) PRESENCE CARE TRANSFORMATION CORPORATION	P	910,332,007	COST

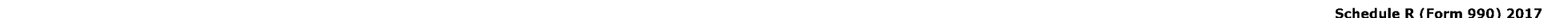
Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization. See instructions regarding exclusion for certain investment partnerships.

[illegible]

Part VII **Supplemental Information**

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

Return Reference	Explanation
Schedule R, Part V REIMBURSEMENTS FOR SHARED SERVICES	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.



Additional Data

Software ID: 17005876
Software Version: 2017v2.2
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
200 SOUTH WACKER DRIVE CHICAGO, IL 60606 36-1649520	PARENT CORP	IL	501(c)(3)	Type III-FI	NA		No
100 NORTH RIVER ROAD DES PLAINES, IL 60016 36-3495969	HEALTH CARE	IL	501(c)(3)	10	PRESENCE HEALTH PARTNERS SERVICES	Yes	
302 SWART HILL ROAD AMSTERDAM, NY 12010 14-1363014	HEALTH CARE	NY	501(c)(3)	3	RM NEW YORK	Yes	
2380 E DEMPSTER AVE STE 236 DES PLAINES, IL 60016 36-2644178	HEALTH CARE	IL	501(c)(3)	Type II	PRESENCE HEALTH NETWORK		No
18927 HICKORY CREEK DR 300 MOKENA, IL 60448 46-0483587	HEALTH CARE	IL	501(c)(3)	10	PRESENCE LIFE CONNECTIONS	Yes	
1000 REMINGTON BLVD STE 100 BOLINGBROOK, IL 60440 36-3366652	MGMT SUPPORT	IL	501(c)(3)	Type III-FI	PRESENCE HEALTH NETWORK		No
18927 HICKORY CREEK DR 300 MOKENA, IL 60448 46-0483581	HEALTH CARE	IL	501(c)(3)	10	PRESENCE LIFE CONNECTIONS	Yes	
18927 HICKORY CREEK DR 300 MOKENA, IL 60448 36-3438977	SENIOR LIVING	IL	501(c)(3)	10	PRESENCE LIFE CONNECTIONS	Yes	
18927 HICKORY CREEK DR 300 MOKENA, IL 60448 37-1127787	HEALTH CARE	IL	501(c)(3)	10	PRESENCE CARE TRANSFORMATION CORPORATION	Yes	
1820 SOUTH 25TH AVENUE BROADVIEW, IL 60155 36-2709982	HEALTH CARE	IL	501(c)(3)	3	PRESENCE CARE TRANSFORMATION CORPORATION	Yes	
100 NORTH RIVER ROAD DES PLAINES, IL 60016 36-4286236	HEALTH CARE	IL	501(c)(3)	10	PRESENCE CARE TRANSFORMATION CORPORATION	Yes	
200 SOUTH WACKER DRIVE CHICAGO, IL 60606 36-3330929	FUNDRAISING	IL	501(c)(3)	7	PRESENCE HEALTH NETWORK		No
200 SOUTH WACKER DRIVE CHICAGO, IL 60606 36-2235165	HEALTH CARE	IL	501(c)(3)	3	PRESENCE CARE TRANSFORMATION CORPORATION	Yes	
90 NORTH MAIN STREET CASTLETON, NY 12033 14-1348691	HEALTH CARE	NY	501(c)(3)	3	RM NEW YORK	Yes	
100 NORTH RIVER ROAD DES PLAINES, IL 60016 23-7061646	HEALTH CARE	IL	501(c)(3)	10	PRESENCE CARE TRANSFORMATION CORPORATION	Yes	
100 NORTH RIVER ROAD DES PLAINES, IL 60016 36-3330928	HEALTH CARE	IL	501(c)(3)	10	PRESENCE CARE TRANSFORMATION CORPORATION	Yes	
1190 E 2900 N ROAD CLIFTON, IL 60927 36-2841358	HEALTH CARE	IL	501(c)(3)	10	PRESENCE LIFE CONNECTIONS	Yes	
1550 BISHOP COURT MOUNT PROSPECT, IL 60056 36-3296367	HEALTH CARE	IL	501(c)(3)	10	PRESENCE LIFE CONNECTIONS	Yes	
1431 N CLAREMONT CHICAGO, IL 60622 36-2182170	EDUCATION	IL	501(c)(3)	2	PRESENCE HEALTH NETWORK		No

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of- year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity?	
								Yes	No
L GILBRAITH INSURANCE SPC LTD 68 W BAY ROAD PO BOX 1109 GRAND CAYMAN CJ	INSURANCE	CJ	PRESENCE HEALTH NETWORK	C Corporation					No
PROVENA HEALTH ASSURANCE SPC 23 LIME TREE BAY AVE PO BOX 1051 GRAND CAYMAN CJ 98-0420054	INSURANCE	CJ	PRESENCE CARE TRANSFORMATION CORPORATION	C Corporation				Yes	
PRESENCE PROPERTIES INC 100 NORTH RIVER ROAD DES PLAINES, IL 60016 36-3520630	MEDICAL	IL	PV	C Corporation				Yes	
PRESENCE SERVICE CORPORATION 2380 E DEMPSTER ROAD DES PLAINES, IL 60016 36-4314354	MEDICAL	IL	PRESENCE CARE TRANSFORMATION CORPORATION	C Corporation				Yes	
PRESENCE VENTURES INC 100 NORTH RIVER ROAD DES PLAINES, IL 60016 37-1168085	MEDICAL	IL	PRESENCE CARE TRANSFORMATION CORPORATION	C Corporation				Yes	
RESURRECTION MEDICAL CENTER AUXILIARY 7435 WEST TALCOTT AVENUE CHICAGO, IL 60631 36-6109825	FUNDRAISING	IL	PRESENCE CHICAGO HOSPITALS NETWORK	C Corporation				Yes	
RESURRECTION MINISTRIES OF NEW YORK 90 NORTH MAIN STREET CASTLETON, NY 12033 14-1720818	PARENT CORP	NY	PRESENCE CHICAGO HOSPITALS NETWORK	C Corporation				Yes	