

CHANGE IN ACCOUNTING PERIOD

Form **990**

OMB No 1545-0047

Return of Organization Exempt From Income Tax**2018****Open to Public Inspection**

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

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

▶ Go to www.irs.gov/Form990 for instructions and the latest information.Department of the Treasury
Internal Revenue Service

A For the 2017 calendar year, or tax year beginning 01/01, 2018, and ending 06/30, 2018

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) Room/suite
200 SOUTH WACKER DRIVE
 City or town, state or province, country, and ZIP or foreign postal code
CHICAGO, IL 60606

D Employer identification number
36-4195126

E Telephone number
(877) 737-4636

G Gross receipts \$ **590,682,267**

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)

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

1 Briefly describe the organization's mission or most significant activities: **TO IMPROVE THE HEALTH AND WELL-BEING OF ALL PEOPLE IN THE COMMUNITIES WE SERVE**

2 Check this box ☒ if the organization discontinued its operations or disposed of more than 25% of its net assets

Activities & Governance	3	6
3 Number of voting members of the governing body (Part VI, line 1a)		
4 Number of independent voting members of the governing body (Part VI, line 1b)		
5 Total number of individuals employed in calendar year 2017 (Part VII, line 2a)		
6 Total number of volunteers (estimate if necessary)		1,169
7a Total unrelated business revenue from Part VIII, column (C), line 12		627,039
7b Net unrelated business taxable income from Form 990-T, line 34		162,817

Revenue	Prior Year	Current Year
8 Contributions and grants (Part VIII, line 1h)	3,041,073	1,363,037
9 Program service revenue (Part VIII, line 2g)	1,070,039,240	430,668,254
10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	1,864,048	75,489,533
11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11a)	15,252,732	5,816,907
12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	1,090,197,093	513,337,731

Expenses	Prior Year	Current Year
13 Grants and similar amounts paid (Part IX, column (A), lines 1–3)	125,633	50,400
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)	368,584,174	149,220,667
16a Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b Total fundraising expenses (Part IX, column (D), line 25) ▶	0	
17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	685,644,063	291,539,487
18 Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	1,054,353,870	440,810,554
19 Revenue less expenses. Subtract line 18 from line 12	35,843,223	72,527,177

Net Assets or Fund Balances	Beginning of Current Year	End of Year
20 Total assets (Part X, line 16)	694,050,894	528,047,649
21 Total liabilities (Part X, line 26)	101,150,308	128,247,373
22 Net assets or fund balances. Subtract line 21 from line 20	592,900,586	399,800,276

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.

Signature of officer *Tonya Mershon* Date **05/15/19**

Type or print name and title **TONYA MERSHON, TAX OFFICER**

Print/Type preparer's name Preparer's signature Date Check ☐ if self-employed PTIN

Firm's name ▶ Firm's EIN ▶

Firm's address ▶ Phone no

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

- 1** Briefly describe the organization's mission.
OUR MISSION AS PART OF A CATHOLIC HEALTH CARE SYSTEM IS TO FURTHER THE HEALING MINISTRY OF JESUS BY CONTINUALLY IMPROVING THE HEALTH AND WELL-BEING OF ALL PEOPLE, ESPECIALLY THE POOR, IN THE COMMUNITIES WE SERVE
- 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 \$ 386,924,249 including grants of \$ 50,400) (Revenue \$ 434,327,634)
PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK OPERATED 6 ACUTE CARE HOSPITALS IN JANUARY 2018 ON FEBRUARY 1, 2018 PRESENCE UNITED SAMARITANS AND PRESENCE COVENANT MEDICAL CENTER WERE SOLD TO OSF HEALTHCARE THE INFORMATION PROVIDED IN THIS 990 INCLUDES ONLY 1 MONTH OF ACTIVITY FOR THE HOSPITALS THAT WERE SOLD

PRESENCE UNITED SAMARITANS IS A 174-BED HOSPITAL CAMPUS PROVIDING SERVICES WITHOUT REGARD TO PATIENT RACE, CREED, NATIONAL ORIGIN, ECONOMIC STATUS, OR ABILITY TO PAY DURING JANUARY 1, 2018, PRESENCE UNITED SAMARITANS TREATED 673 ADULTS AND CHILDREN FOR A TOTAL OF 1,952 PATIENT DAYS OF SERVICE THE HOSPITAL ALSO PROVIDED SERVICES FOR 12,948 OUTPATIENT VISITS, WHICH INCLUDED 131 OUTPATIENT SURGERIES AND 3,499 EMERGENCY ROOM VISITS

(CONTINUED ON SCHEDULE O)

4b (Code:) (Expenses \$ including grants of \$) (Revenue \$)

4c (Code:) (Expenses \$ including grants of \$) (Revenue \$)

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

4e Total program service expenses ▶ 386,924,249

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	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2 Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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	<input checked="" type="checkbox"/>	<input type="checkbox"/>
e Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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	<input checked="" type="checkbox"/>	<input type="checkbox"/>
12 a Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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	<input checked="" type="checkbox"/>	<input type="checkbox"/>
13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	<input type="checkbox"/>	<input checked="" type="checkbox"/>
14 a Did the organization maintain an office, employees, or agents outside of the United States?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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	<input type="checkbox"/>	<input checked="" type="checkbox"/>

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Part IV Checklist of Required Schedules (continued)

	Yes	No
20a Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H	<input checked="" type="checkbox"/>	<input type="checkbox"/>
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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? If "Yes," complete Schedule I, Parts I and II	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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? If "Yes," complete Schedule I, Parts I and III	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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? If "Yes," complete Schedule J	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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? If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	<input type="checkbox"/>	<input type="checkbox"/>
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? If "Yes," complete Schedule L, Part I	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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? If "Yes," complete Schedule L, Part I	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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? If "Yes," complete Schedule L, Part II	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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? If "Yes," complete Schedule L, Part III	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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):	<input type="checkbox"/>	<input type="checkbox"/>
a A current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b A family member of a current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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? If "Yes," complete Schedule L, Part IV	<input type="checkbox"/>	<input checked="" type="checkbox"/>
29 Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M	<input type="checkbox"/>	<input checked="" type="checkbox"/>
30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? If "Yes," complete Schedule M	<input type="checkbox"/>	<input checked="" type="checkbox"/>
31 Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, Part I	<input type="checkbox"/>	<input checked="" type="checkbox"/>
32 Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? If "Yes," complete Schedule N, Part II	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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? If "Yes," complete Schedule R, Part I	<input checked="" type="checkbox"/>	<input type="checkbox"/>
34 Was the organization related to any tax-exempt or taxable entity? If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1	<input checked="" type="checkbox"/>	<input type="checkbox"/>
35a Did the organization have a controlled entity within the meaning of section 512(b)(13)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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)? If "Yes," complete Schedule R, Part V, line 2	<input checked="" type="checkbox"/>	<input type="checkbox"/>
36 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? If "Yes," complete Schedule R, Part V, line 2	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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? If "Yes," complete Schedule R, Part VI	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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.	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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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 ✓	
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 ✓	
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	✓
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	✓
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b	✓
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	✓
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b	
7	Organizations that may receive deductible contributions under section 170(c).		
a	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?	7a	✓
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c	✓
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	✓
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f	✓
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	
9	Sponsoring organizations maintaining donor advised funds.		
a	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	✓
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 line 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 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	1a 6	
b Enter the number of voting members included in line 1a, above, who are independent	1b 5	
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	<input checked="" type="checkbox"/>
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	<input checked="" type="checkbox"/>
4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4	<input checked="" type="checkbox"/>
5 Did the organization become aware during the year of a significant diversion of the organization's assets?	5	<input checked="" type="checkbox"/>
6 Did the organization have members or stockholders?	6	<input checked="" type="checkbox"/>
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	<input checked="" type="checkbox"/>
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	<input checked="" type="checkbox"/>
8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:		
a The governing body?	8a	<input checked="" type="checkbox"/>
b Each committee with authority to act on behalf of the governing body?	8b	<input checked="" type="checkbox"/>
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	<input checked="" type="checkbox"/>

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	<input checked="" type="checkbox"/>
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	<input checked="" type="checkbox"/>
11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a	<input checked="" type="checkbox"/>
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	<input checked="" type="checkbox"/>
b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	<input checked="" type="checkbox"/>
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	<input checked="" type="checkbox"/>
13 Did the organization have a written whistleblower policy?	13	<input checked="" type="checkbox"/>
14 Did the organization have a written document retention and destruction policy?	14	<input checked="" type="checkbox"/>
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	<input checked="" type="checkbox"/>
b Other officers or key employees of the organization	15b	<input checked="" type="checkbox"/>
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	<input checked="" type="checkbox"/>
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	<input checked="" type="checkbox"/>

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed ► NONE

18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
☐ Own website ☐ Another's website ☒ Upon request ☐ 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: ►
 JEANNIE JUSTIE, 2601 NAVISTAR DR BLD 4, FL 2 FINANCE, LISLE, IL 60532, (224) 273-0515

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent ContractorsCheck if Schedule O contains a response or note to any line in this Part VII ☒**Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees****1a** Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) MARSHA LADENBURGER*, RN DIRECTOR, CHAIR	1 0 2 0	✓		✓				0	0	0
(2) THOMAS HUBERTY*, MD DIRECTOR, VICE CHAIR	1 0 2 0	✓		✓				0	0	0
(3) DAVID J BORDO, MD DIRECTOR	1 0 49 0	✓						0	0	0
(4) MARK HANSON* DIRECTOR	1 0 1 0	✓						0	0	0
(5) PATRICIA FOLTZ* DIRECTOR	1 0 1 0	✓						0	0	0
(6) STEVEN TALTY*, MD DIRECTOR	1 0 0 0	✓						0	0	0
(7) BETTINA JOHNSON ASSISTANT TREASURER	1 0 49 0			✓				0	0	0
(8) JAMES KELLEY TREASURER (END 3/2018)	1 0 49 0			✓				0	0	0
(9) JEANNIE C FREY SECRETARY (END 3/2018)	1 0 49 0			✓				0	0	0
(10) JEFFREY ROONEY ASSISTANT TREASURER (END 3/2018)	1 0 49 0			✓				0	0	0
(11) JULIE ROKNICH ASSISTANT SECRETARY	1 0 49 0			✓				0	0	0
(12) PATRICIA EDDY ASSISTANT TREASURER	1 0 49 0			✓				0	0	0
(13) ANN ERRICHETTI* PRESIDENT (END 3/2018)	1 0 1 0			✓				0	0	0
(14)										

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(15)										
(16)										
(17)										
(18)										
(19)										
(20)										
(21)										
(22)										
(23)										
(24)										
(25)										
1b Sub-total								0	0	0
c Total from continuation sheets to Part VII, Section A								0	0	0
d Total (add lines 1b and 1c)								0	0	0

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

- 3** Did the organization list any **former** officer, director, or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual
- 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? If "Yes," complete Schedule J for such individual
- 5** Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? If "Yes," complete Schedule J for such person

	Yes	No
3		✓
4		✓
5		✓

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
NONE		

- 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

0

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	1,356,853			
	e Government grants (contributions)	1e	6,184			
	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		1,363,037			
Program Service Revenue		Business Code				
	2a NET PATIENT REVENUE	622110	422,554,939	422,554,939		
	b RETAIL/CONTRACT PHARMACY	446110	724,354	308,615	415,739	
	c MEANINGFUL USE & BLUE CROSS BONUS	622110	4,015,637	4,015,637		
	d MEDICAL OFFICE BLDG RENT	561000	1,273,331	1,273,331		
	e JOINT VENTURE INCOME	900099	2,099,993	2,099,993		
	f All other program service revenue		0	0	0	0
	g Total. Add lines 2a-2f		430,668,254			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		305,016			305,016
	4 Income from investment of tax-exempt bond proceeds					
	5 Royalties					
		(i) Real	(ii) Personal			
	6a Gross rents	63,570				
	b Less: rental expenses	18,931				
	c Rental income or (loss)	44,639	0			
	d Net rental income or (loss)		44,639		44,639	
	7a Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other			
		3,517	152,506,605			
	b Less: cost or other basis and sales expenses		77,325,605			
	c Gain or (loss)	3,517	75,181,000			
	d Net gain or (loss)		75,184,517			75,184,517
	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	187,929				
b Less: cost of goods sold	b					
c Net income or (loss) from sales of inventory		187,929			187,929	
	Miscellaneous Revenue	Business Code				
11a CAFETERIA SALES	722514	1,354,719		12,160	1,342,559	
b						
c						
d All other revenue		4,229,620	4,075,119	154,501	0	
e Total. Add lines 11a-11d		5,584,339				
12 Total revenue. See instructions.		513,337,731	434,327,634	627,039	77,020,021	

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	50,400	50,400		
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees				
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	122,196,029	122,196,029		
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	3,340,641	3,340,641		
9 Other employee benefits	14,459,958	14,459,958		
10 Payroll taxes	9,224,039	9,224,039		
11 Fees for services (non-employees)				
a Management				
b Legal	90,898		90,898	
c Accounting				
d Lobbying	5,296		5,296	
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.)	57,768,965	57,768,965	0	0
12 Advertising and promotion	90,916	90,916		
13 Office expenses	1,209,533	1,209,533		
14 Information technology	33,775	33,775		
15 Royalties				
16 Occupancy	10,132,774	10,132,774		
17 Travel	160,172	160,172		
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	35,483	35,483		
20 Interest	6,866,548	6,866,548		
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	18,348,190	18,348,190		
23 Insurance	6,972,953	6,972,953		
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 & PHARMACEUTICALS	75,905,856	75,905,856		
b MANAGEMENT ALLOCATION	53,790,111		53,790,111	
c TAXES & ASSESSMENTS	27,209,044	27,209,044		
d BAD DEBT EXPENSE	16,229,716	16,229,716		
e All other expenses	16,689,257	16,689,257	0	0
25 Total functional expenses. Add lines 1 through 24e	440,810,554	386,924,249	53,886,305	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 X ☐

		(A) Beginning of year		(B) End of year
Assets	1 Cash—non-interest-bearing		1	14,484,837
	2 Savings and temporary cash investments	17,506,858	2	1,116,611
	3 Pledges and grants receivable, net		3	
	4 Accounts receivable, net	150,411,262	4	128,539,665
	5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L	0	5	0
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L	0	6	0
	7 Notes and loans receivable, net	198,421	7	311,704
	8 Inventories for sale or use	20,805,806	8	23,076,848
	9 Prepaid expenses and deferred charges	0	9	0
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 309,071,886		
	b Less: accumulated depreciation	10b 11,219,560	10c	297,852,326
	11 Investments—publicly traded securities		11	
	12 Investments—other securities. See Part IV, line 11	0	12	0
	13 Investments—program-related. See Part IV, line 11	30,892,977	13	30,448,483
	14 Intangible assets		14	
	15 Other assets. See Part IV, line 11	125,283,112	15	32,217,175
16 Total assets. Add lines 1 through 15 (must equal line 34)	694,050,894	16	528,047,649	
Liabilities	17 Accounts payable and accrued expenses	7,869,195	17	11,285,202
	18 Grants payable	0	18	0
	19 Deferred revenue	54,385	19	13,193
	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	660,760	23	525,887
	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	92,565,968	25	116,423,091
	26 Total liabilities. Add lines 17 through 25	101,150,308	26	128,247,373
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	592,900,586	27	399,800,276
	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.	592,900,586	33	399,800,276
34 Total liabilities and net assets/fund balances.	694,050,894	34	528,047,649	

Form **990** (2017)

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	513,337,731
2	Total expenses (must equal Part IX, column (A), line 25)	2	440,810,554
3	Revenue less expenses. Subtract line 2 from line 1	3	72,527,177
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	592,900,586
5	Net unrealized gains (losses) on investments	5	(42,603)
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	(265,584,884)
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	399,800,276

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 checked="" type="checkbox"/>
<input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		
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 checked="" type="checkbox"/>	
<input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		
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	<input checked="" type="checkbox"/>	
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? . . .		<input checked="" type="checkbox"/>
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		

Form **990** (2017)

SCHEDULE A
(Form 990 or 990-EZ)

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.**

▶ **Go to www.irs.gov/Form990 for instructions and the latest information.**

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 **section 170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land-grant college of agriculture (see instructions). Enter the name, city, and state of the college or university: _____
- 10 ☐ An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)
- 11 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**
- 12 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.
- a ☐ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**
- b ☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**
- c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**
- d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**
- e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.
- f Enter the number of supported organizations _____
- g Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1–10 above (see instructions))	(iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
(A)						
(B)						
(C)						
(D)						
(E)						
Total						

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

Cat No 11285F

Schedule A (Form 990 or 990-EZ) 2017

Part II Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)

(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 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 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 from 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 ► <input type="checkbox"/>						

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 in line 12 on 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? 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.		
2 Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).		
3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? If "Yes," answer (b) and (c) below.		
b Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? If "Yes," describe in Part VI when and how the organization made the determination.		
c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? If "Yes," explain in Part VI what controls the organization put in place to ensure such use		
4a Was any supported organization not organized in the United States ("foreign supported organization")? If "Yes," and if you checked 12a or 12b in Part I, answer (b) and (c) below.		
b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.		
c Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.		
5a Did the organization add, substitute, or remove any supported organizations during the tax year? If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in Part VI , including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).		
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?		
c Substitutions only. Was the substitution the result of an event beyond the organization's control?		
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? If "Yes," provide detail in Part VI .		
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? If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).		
8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).		
9a Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? If "Yes," provide detail in Part VI .		
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? If "Yes," provide detail in Part VI .		
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? If "Yes," provide detail in Part VI .		
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)? If "Yes," answer 10b below.		
b Did the organization have any excess business holdings in the tax year? (Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)		

Schedule A (Form 990 or 990-EZ) 2017

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? If "Yes" to a, b, or c, provide detail in Part VI .		
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? 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.		
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? 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.		
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)? 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)		
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? If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s).		
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? If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.		
3		

Section E. Type III Functionally Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions).		
a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below		
b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions)		
2 Activities Test. Answer (a) and (b) below.		
a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? 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.		
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? 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.		
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? Provide details in Part VI .		
3a		
b Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? If "Yes," describe in Part VI the role played by the organization in this regard.		
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):			
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).			

Schedule A (Form 990 or 990-EZ) 2017

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. For result greater than zero, explain in Part VI . See instructions.			
6 Remaining underdistributions for 2017. Subtract lines 3h and 4b from line 1. For result 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			

Schedule A (Form 990 or 990-EZ) 2017

SCHEDULE C
(Form 990 or 990-EZ)

Political Campaign and Lobbying Activities

OMB No 1545-0047

2017

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

- ▶ **Complete if the organization is described below.** ▶ **Attach to Form 990 or Form 990-EZ.**
▶ **Go to www.irs.gov/Form990 for instructions and the latest information.**

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

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

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

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

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

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

Name of organization PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK	Employer identification number 36-4195126
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Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

- 1 Provide a description of the organization's direct and indirect political campaign activities in Part IV. (see instructions for definition of "political campaign activities")
- 2 Political campaign activity expenditures (see instructions) ▶ \$
- 3 Volunteer hours for political campaign activities (see instructions) ▶

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

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

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

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

(a) Name	(b) Address	(c) EIN	(d) Amount paid from filing organization's funds If none, enter -0-	(e) Amount of political contributions received and promptly and directly delivered to a separate political organization If none, enter -0-
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				

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

Cat No 50084S

Schedule C (Form 990 or 990-EZ) 2017

Part II-A Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).**A** Check ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).**B** Check ☐ if the filing organization checked box A and "limited control" provisions apply.

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

4-Year Averaging Period Under section 501(h)

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

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column (e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

Schedule C (Form 990 or 990-EZ) 2017

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

For each "Yes," response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.

	(a)		(b)
	Yes	No	Amount
1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		✓	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		✓	
c Media advertisements?		✓	
d Mailings to members, legislators, or the public?		✓	
e Publications, or published or broadcast statements?		✓	
f Grants to other organizations for lobbying purposes?		✓	
g Direct contact with legislators, their staffs, government officials, or a legislative body?		✓	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		✓	
i Other activities?	✓		5,296
j Total Add lines 1c through 1i			5,296
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		✓	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

Part IV Supplemental Information

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

SEE NEXT PAGE

Part IV

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

Return Reference - Identifier	Explanation
SCHEDULE C, PART II-B, LINE 1 - DETAILED DESCRIPTION OF THE LOBBYING ACTIVITY	LOBBYING EXPENSES REPRESENT THE PORTION OF DUES PAID TO NATIONAL AND STATE HOSPITAL ASSOCIATIONS THAT ARE SPECIFICALLY ALLOCABLE TO LOBBYING PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK DOES NOT PARTICIPATE IN OR INTERVENE IN (INCLUDING THE PUBLISHING OR DISTRIBUTING OR STATEMENTS) ANY POLITICAL CAMPAIGN ON BEHALF OF (OR IN OPPOSITION TO) ANY CANDIDATE FOR PUBLIC OFFICE

**SCHEDULE D
(Form 990)**

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

▶ Go to www.irs.gov/Form990 for instructions and the latest information.

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 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No
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?		<input type="checkbox"/> Yes <input type="checkbox"/> No

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). <input type="checkbox"/> Preservation of land for public use (e.g., recreation or education) <input type="checkbox"/> Preservation of a 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	
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 Tax 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 7/25/06, 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.	

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

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

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

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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 **d** ☐ Loan or exchange programs
- b** ☐ Scholarly research **e** ☐ Other _____
- c** ☐ Preservation for future generations
- 4** Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.
- 5** During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? ☐ Yes ☐ No

Part IV Escrow and Custodial Arrangements.

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

- 1a** Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? ☐ Yes ☐ No
- b** If "Yes," explain the arrangement in Part XIII and complete the following table:
- | | Amount |
|--|-----------|
| c Beginning balance | 1c |
| d Additions during the year | 1d |
| e Distributions during the year | 1e |
| f Ending balance | 1f |
- 2a** Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? ☐ Yes ☐ No
- b** If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided on 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	0	14,591,459	2,899,207	2,848,100
b Contributions		0		16,897,832	2,872
c Net investment earnings, gains, and losses			89,083	(21,361)	104,946
d Grants or scholarships			45,525	29,359	55,109
e Other expenditures for facilities and programs			14,635,017	5,154,860	1,602
f Administrative expenses					
g End of year balance	0	0	0	14,591,459	2,899,207

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

- a** Board designated or quasi-endowment 0 00 %
- b** Permanent endowment 0 00 %
- c** Temporarily restricted endowment 100 00 %

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

- 3a** Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

- (i) unrelated organizations
- (ii) related organizations

	Yes	No
3a(i)		✓
3a(ii)	✓	
3b	✓	

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

- 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		23,750,000		23,750,000
b Buildings		204,954,777	2,604,620	202,350,157
c Leasehold improvements		3,290,393	92,662	3,197,731
d Equipment		66,615,214	8,182,116	58,433,098
e Other		10,461,502	340,162	10,121,340
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				297,852,326

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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) JOINT VENTURE INVESTMENT	1,059,176	
(2) BOARD DESIGNATED INVESTMENTS	29,389,307	
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 13.) ▶		30,448,483

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) THIRD PARTY RECEIVABLES	2,877,774
(2) MANUAL RECEIVABLES	1,220,761
(3) INCENTIVE RECEIVABLES	4,126,028
(4) LONG TERM RECEIVABLES	77,716
(5) MISCELLANEOUS BILLING AR	45,771
(6) MANAGED CARE SETTLEMENTS	17,501,214
(7) MEDICARE SETTLEMENTS	6,367,911
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15)	32,217,175

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.

Part X	
(a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) OTHER LONG TERM LIABILITIES	1,350,939
(3) DUE TO AFFILIATES	7,066,887
(4) MEDICAID SETTLEMENTS	493,072
(5) BLUE CROSS SETTLEMENTS	107,512,193
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	116,423,091

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.

SEE STATEMENT

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 - Identifier	Explanation
SCHEDULE D, PART X, LINE 2 - FIN 48 (ASC 740) FOOTNOTE	THE SYSTEM ACCOUNTS FOR UNCERTAINTY IN INCOME TAX POSITIONS BY APPLYING A RECOGNITION THRESHOLD AND MEASUREMENT ATTRIBUTE FOR FINANCIAL STATEMENT RECOGNITION AND MEASUREMENT OF A TAX POSITION TAKEN OR EXPECTED TO BE TAKEN IN A TAX RETURN. THE SYSTEM HAS DETERMINED THAT NO MATERIAL UNRECOGNIZED TAX BENEFITS OR LIABILITIES EXIST AS OF JUNE 30, 2018.

**SCHEDULE H
(Form 990)**

Hospitals

OMB No 1545-0047

2017

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

- **Complete if the organization answered "Yes" on Form 990, Part IV, question 20.**
► **Attach to Form 990.**
► **Go to www.irs.gov/Form990 for instructions and the latest information.**

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

Part I Financial Assistance and Certain Other Community Benefits at Cost

	Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a . . .	✓	
b If "Yes," was it a written policy?	✓	
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 free 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 _____ %	✓	
b Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care. <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other 600 %	✓	
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.		
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"?	✓	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	✓	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	✓	
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?		✓
6a Did the organization prepare a community benefit report during the tax year?	✓	
b If "Yes," did the organization make it available to the public?	✓	

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)			10,271,152		10,271,152	2 33
b Medicaid (from Worksheet 3, column a)		36,771	100,036,835	76,163,568	23,873,267	5 42
c Costs of other means-tested government programs (from Worksheet 3, column b)					0	0 00
d Total Financial Assistance and Means-Tested Government Programs	0	36,771	110,307,987	76,163,568	34,144,419	7 75
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	52	7,988	216,318	105	216,213	0 05
f Health professions education (from Worksheet 5)	9	431	735,845	30,388	705,457	0 16
g Subsidized health services (from Worksheet 6)	2	0	2,737,563	2,321,459	416,104	0 09
h Research (from Worksheet 7)	1	50	232,142		232,142	0 05
i Cash and in-kind contributions for community benefit (from Worksheet 8)	21	673	110,551		110,551	0 03
j Total. Other Benefits	85	9,142	4,032,419	2,351,952	1,680,467	0 38
k Total. Add lines 7d and 7j	85	45,913	114,340,406	78,515,520	35,824,886	8 13

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Schedule H (Form 990) 2017

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 00
2 Economic development					0	0 00
3 Community support	5	412	65,130		65,130	0 01
4 Environmental improvements	1		9,000		9,000	0 00
5 Leadership development and training for community members					0	0 00
6 Coalition building	2		570		570	0 00
7 Community health improvement advocacy					0	0 00
8 Workforce development	1		650		650	0 00
9 Other					0	0 00
10 Total	9	412	75,350	0	75,350	0 02

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

		Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	✓	
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	1,067,646	
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	173,859,664
6 Enter Medicare allowable costs of care relating to payments on line 5	6	197,112,683
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	(23,253,019)
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 **2**

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1 (SEE STATEMENT)				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

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

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

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

	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 PRESENCE ST JOSEPH MEDICAL CENTER 333 N MADISON STREET, JOLIET, IL 60435 WWW.PRESENCEHEALTH.ORG/PRESENCE-SAINT-JOSEPH-MEDICAL-CENTER-JOLIET STATE LICENSE NO 0004838	✓	✓					✓			
2 PRESENCE MERCY MEDICAL CENTER 1325 NORTH HIGHLAND AVENUE, AURORA, IL 60506 WWW.PRESENCEHEALTH.ORG/PRESENCE-MERCY-MEDICAL-CENTER-AURORA STATE LICENSE NO 0004903	✓	✓					✓			
3 PRESENCE ST JOSEPH HOSPITAL 77 NORTH AIRLITE AVENUE, ELGIN, IL 60123 WWW.PRESENCEHEALTH.ORG/PRESENCE-SAINT-JOSEPH-HOSPITAL-ELGIN STATE LICENSE NO 0004887	✓	✓					✓			
4 PRESENCE ST MARY'S HOSPITAL 500 WEST COURT STREET, KANKAKEE, IL 60901 WWW.PRESENCEHEALTH.ORG/PRESENCE-ST-MARYS-HOSPITAL-KANKAKEE STATE LICENSE NO 0004879	✓	✓					✓			
5 PRESENCE COVENANT MEDICAL CENTER 1400 WEST PARK STREET, URBANA, IL 61801 WWW.PRESENCEHEALTH.ORG STATE LICENSE NO 0004861	✓	✓					✓		THROUGH 1 31 18 SOLD TO OSF	
6 PRESENCE UNITED SAMARITANS MED CNTR 812 NORTH LOGAN AVENUE, DANVILLE, IL 61832 WWW.PRESENCEHEALTH.ORG STATE LICENSE NO 0004853	✓	✓					✓		THROUGH 1 31 18 SOLD TO OSF	
7										
8										
9										
10										

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 PRESENCE PHYSICAL THERAPY 3000 W JEFFERSON ST JOLIET, IL 60435	PHYSICAL THERAPY
2 PRESENCE PHYSICAL THERAPY SERVICES 600 SOUTH WEBER ROAD ROMEDEVILLE, IL 60446	PHYSICAL THERAPY
3 PRESENCE CENTER FOR WOUND CARE 301 NORTH MADISON ST JOLIET, IL 60435	WOUND CARE CENTER
4 PRESENCE PHYSICAL THERAPY/INDUSTRIAL REH 852 SHARP AVENUE SHOREWOOD, IL 60404	PHYSICAL THERAPY
5 MERCY PROFESSIONAL BUILDING PHARMACY 1315 N HIGHLAND SUITE 201 AURORA, IL 60506	OUTPATIENT PHARMACY
6 PRESENCE PHYSICAL REHAB & SPORT INJURY 2132 JEFFERSON STREET JOLIET, IL 60435	PHYSICAL THERAPY
7 PRESENCE PHYSICAL THERAPY SERVICES 1812 LINCOLN HIGHWAY NEW LENOX, IL 60451	PHYSICAL THERAPY
8 PRESENCE PHYSICAL THERAPY SERVICES 15120 WALLIN DRIVE PLAINFIELD, IL 60544	PHYSICAL THERAPY
9 PRESENCE SLEEP DISORDER CENTER 2132 JEFFERSON STREET JOLIET, IL 60435	SLEEP DISORDER CENTER
10 PRESENCE SLEEP LAB 412 SHERIDAN DANVILLE, IL 61832	SLEEP DISORDER CENTER

Schedule H (Form 990) 2017

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 PRESENCE UNITED SAMARITANS ONCOLOGY CTR 806 NORTH LOGAN AVENUE DANVILLE, IL 61832	ONCOLOGY CENTER
2 PRESENCE MANTENO MEDCENTRE 501 LOCUST STREET MANTENO, IL 60950	MEDICAL OFFICE BUILDING
3 PRESENCE MEDCENTRE EAST 455 WEST COURT STREET KANKAKEE, IL 60901	MEDICAL OFFICE BUILDING
4 PRESENCE MEDCENTRE WEST 555 WEST COURT STREET KANKAKEE, IL 60901	MEDICAL OFFICE BUILDING
5 PRESENCE MOMENCE MEDCENTRE 739 NORTH DIXIE HIGHWAY MOMENCE, IL 60954	MEDICAL OFFICE BUILDING
6 PRESENCE PEOTONE MEDCENTRE 117 SOUTH HARLEM AVENUE PEOTONE, IL 60468	MEDICAL OFFICE BUILDING
7 PRESENCE ST MARY'S REGIONAL CANCER CTR 100 PROVENA WAY BOURONNAIS, IL 60914	REGIONAL ONCOLOGY CENTER
8 PRESENCE ST MARY'S IMAGING CENTER 100 PROVENA WAY BOURONNAIS, IL 60914	IMAGING CENTER
9 PRESENCE CENTER FOR HEALTHY AGING 401 EAST UNIVERSITY SUITE 102 CHAMPAIGN, IL 61820	SENIOR HEALTH CENTER
10 PRESENCE REGIONAL EMS 408 S NEIL STREET CHAMPAIGN, IL 61820	EMS PARAMEDIC SERVICES

Schedule H (Form 990) 2017

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 PRO AMBULANCE SERVICES 408 S NEIL STREET CHAMPAIGN, IL 61820	AMBULANCE SERVICES
2 PUSMC RETAIL PHARMACY 800 N LOGAN AVENUE DANVILLE, IL 61832	RETAIL PHARMACY
3 PRESENCE SLEEP DISORDER 656 N CONVENT STREET BOURONNAIS, IL 60914	SLEEP DISORDER CENTER
4 PRESENCE ADVANCED IMAGING 410 EAST LINCOLN HIGHWAY NEW LENOX, IL 60451	IMAGING CENTER
5 PRESENCE HEALING ARTS PAVILION 410 EAST LINCOLN HIGHWAY NEW LENOX, IL 60451	MEDICAL OFFICE BUILDING
6 PRESENCE ADVANCED IMAGING 2000 GLENWOOD AVENUE JOLIET, IL 60435	IMAGING CENTER
7 PRESENCE HEALING ARTS PAVILION 16615 SOUTH ROUTE 59 PLAINFIELD, IL 60586	MEDICAL OFFICE BUILDING
8 PCMC MOB 1405 WEST PARK STREET URBANA, IL 61801	MEDICAL OFFICE BUILDING
9	
10	

Schedule H (Form 990) 2017

Provide the following information

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7, Part II, 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 needs assessments 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

Return Reference - Identifier	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</p> <p>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). 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) B PATIENT IS DECEASED WITH NO ESTATE C PATIENT IS MENTALLY OR PHYSICALLY INCAPACITATED AND HAS NO ONE TO ACT ON HIS/HER BEHALF D PATIENT IS CURRENTLY ELIGIBLE FOR MEDICAID, BUT WAS NOT ON A PRIOR DATE OF SERVICE OR FOR NON-COVERED SERVICES E PATIENT IS ENROLLED OR COVERED BY THE WOMEN, INFANTS AND CHILDREN NUTRITION PROGRAM (WIC) F PATIENT IS ENROLLED OR COVERED BY THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) OR FOOD STAMP ELIGIBILITY (LINK) G PATIENT IS ENROLLED OR COVERED BY THE ILLINOIS FREE LUNCH AND BREAKFAST PROGRAM (ELIGIBLE FOR FREE AND REDUCED PRICE SCHOOL MEALS) H PATIENT IS ENROLLED OR COVERED BY THE LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP) 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 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 K PATIENT IS A RECIPIENT OF GRANT ASSISTANCE FOR MEDICAL SERVICES L PATIENT PARTICIPATES IN STATE-FUNDED PRESCRIPTION PROGRAMS M PATIENT OR PATIENT'S FAMILY IS ENROLLED IN ILLINOIS HOUSING DEVELOPMENT AUTHORITY'S RENTAL HOUSING SUPPORT PROGRAM 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 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</p> <p>APPLICATION OF CATASTROPHIC DISCOUNT THE CATASTROPHIC DISCOUNT WILL BE AVAILABLE TO PATIENTS WHO HAVE MEDICAL EXPENSES OVER A 12-MONTH PERIOD FOR MEDICALLY NECESSARY SERVICES FROM A PRESENCE HEALTH HOSPITAL THAT EXCEED 15% OF THE PATIENT'S FAMILY'S ANNUAL GROSS INCOME, EVEN AFTER PAYMENT BY THIRD-PARTY PAYERS. ANY PATIENT RESPONSIBILITY IN EXCESS OF 15% WILL BE WRITTEN OFF TO CHARITY. SERVICES THAT ARE NOT MEDICALLY NECESSARY WILL NOT BE ELIGIBLE FOR THIS DISCOUNT</p> <p>UNINSURED SELF-PAY DISCOUNT</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</p>

Return Reference - Identifier	Explanation
	<p>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 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 CATASTROPHIC DISCOUNT.</p> <p>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).</p>
SCHEDULE H, PART I, LINE 6A - PART I, LINE 6A	<p>PRESENCE HEALTH PUBLISHED A COMMUNITY BENEFIT WITH JANUARY 1, 2018 THROUGH JUNE 30, 2018 DATA, WHICH INCLUDES PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK AND 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.</p>
SCHEDULE H, PART I, LINE 6B - PART I, LINE 6B	<p>THE 2018 PRESENCE HEALTH COMMUNITY BENEFIT REPORT WAS MADE PUBLICLY AVAILABLE THROUGH A VARIETY OF WAYS TO SHARE THE INFORMATION WITH THE COMMUNITY AT LARGE.</p> <p>1 PRINT VERSION OF REPORT - THE REPORT WAS MAILED FROM EACH HOSPITAL TO COMMUNITY PARTNERS, ELECTED OFFICIALS, AND LOCAL LEADERS.</p> <p>2 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 2018 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.</p> <p>3 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.</p>
SCHEDULE H, PART I, LINE 7 - DESCRIBE SUBSIDIZED HEALTH SERVICE COSTS FROM PHYSICIAN CLINIC ON LINE 7G	<p>COSTS FROM PHYSICIAN CLINICS ARE NOT INCLUDED IN SUBSIDIZED SERVICE TOTALS.</p>
SCHEDULE H, PART I, LINE 7 - EXPLANATION OF COSTING METHODOLOGY USED FOR CALCULATING LINE 7 TABLE	<p>THE COST-TO-CHARGE RATIO WAS USED TO DETERMINE SCHEDULE H, PART I, LINE 7A. FINANCIAL ASSISTANCE AT COST. SCHEDULE H, PART I, LINE 7B, UNREIMBURSED MEDICAID, WAS DERIVED FROM WORKSHEET 2, RATIO OF PATIENT CARE COST TO CHARGES. THE REMAINING AMOUNTS REPORTED ON LINE 7 ARE REPORTED AT COST.</p>
SCHEDULE H, PART II - DESCRIBE HOW BUILDING ACTIVITIES PROMOTE THE HEALTH OF THE COMMUNITY	<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.</p> <p>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.

Return Reference - Identifier	Explanation
SCHEDULE H, PART III, LINE 2 - METHODOLOGY USED TO ESTIMATE BAD DEBT	AFTER SATISFACTION OF AMOUNTS DUE FROM INSURANCE AND REASONABLE EFFORTS TO COLLECT FROM THE PATIENT HAVE BEEN EXHAUSTED, THE CORPORATION FOLLOWS ESTABLISHED GUIDELINES FOR PLACING CERTAIN PAST-DUE PATIENT BALANCES WITHIN COLLECTION AGENCIES, SUBJECT TO THE TERMS OF CERTAIN RESTRICTIONS ON COLLECTION EFFORTS AS DETERMINED BY ASCENSION HEALTH. ACCOUNTS RECEIVABLE ARE WRITTEN OFF AFTER COLLECTION EFFORTS HAVE BEEN FOLLOWED IN ACCORDANCE WITH THE CORPORATION'S POLICIES. AFTER APPLYING THE COST-TO-CHARGE RATIO, THE SHARE OF THE BAD DEBT EXPENSE FOR SHORT YEAR JANUARY 1, 2018 THROUGH JUNE 30, 2018 WAS \$6,484,875 AT CHARGES, (\$1,067,646 AT COST).
SCHEDULE H, PART III, LINE 3 - FAP ELIGIBLE PATIENT BAD DEBT CALCULATION METHODOLOGY	THE PROVISION FOR DOUBTFUL ACCOUNTS IS BASED UPON MANAGEMENT'S ASSESSMENT OF EXPECTED NET COLLECTIONS CONSIDERING HISTORICAL EXPERIENCE, ECONOMIC CONDITIONS, TRENDS IN HEALTHCARE COVERAGE, AND OTHER COLLECTION INDICATORS. PERIODICALLY THROUGHOUT THE YEAR, MANAGEMENT ASSESSES THE ADEQUACY OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS BASED UPON HISTORICAL WRITE-OFF EXPERIENCE BY PAYOR CATEGORY, INCLUDING THOSE AMOUNTS NOT COVERED BY INSURANCE. THE RESULTS OF THIS REVIEW ARE THEN USED TO MAKE ANY MODIFICATIONS TO THE PROVISION FOR DOUBTFUL ACCOUNTS TO ESTABLISH AN APPROPRIATE ALLOWANCE FOR DOUBTFUL ACCOUNTS.
SCHEDULE H, PART III, LINE 4 - FOOTNOTE IN ORGANIZATION'S FINANCIAL STATEMENTS DESCRIBING BAD DEBT	THE ORGANIZATION IS PART OF THE ASCENSION HEALTH ALLIANCE'S CONSOLIDATED AUDIT IN WHICH THE FOOTNOTE THAT DISCUSSES THE BAD DEBT EXPENSE IS LOCATED ON PAGE 21.
SCHEDULE H, PART III, LINE 8 - DESCRIBE EXTENT ANY SHORTFALL FROM LINE 7 TREATED AS COMMUNITY BENEFIT AND COSTING METHOD USED	A COST TO CHARGE RATIO IS APPLIED TO THE ORGANIZATION'S MEDICARE EXPENSE TO DETERMINE THE MEDICARE ALLOWABLE COSTS REPORTED IN THE ORGANIZATION'S MEDICARE COST REPORT. ASCENSION HEALTH AND ITS RELATED HEALTH MINISTRIES FOLLOW THE CATHOLIC HEALTH ASSOCIATION (CHA) GUIDELINES FOR DETERMINING COMMUNITY BENEFIT. CHA COMMUNITY BENEFIT REPORTING GUIDELINES SUGGEST THAT MEDICARE SHORTFALL IS NOT TREATED AS COMMUNITY BENEFIT.
SCHEDULE H, PART III, LINE 9B - DID COLLECTION POLICY CONTAIN PROVISIONS ON COLLECTION PRACTICES FOR PATIENTS WHO ARE KNOWN TO QUALIFY FOR ASSISTANCE	<p>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:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>FOR MORE INFORMATION ABOUT PRESENCE HEALTH'S FINANCIAL ASSISTANCE PROGRAM, VISIT HTTP://PRESENCEHEALTH.ORG/FINANCIAL-ASSISTANCE.</p>
SCHEDULE H, PART V, SECTION B, LINE 14 - PART V, SECTION B, LINE 14	FEDERAL POVERTY GUIDELINES ARE ALSO USED IN DETERMINING THE BASIS OF CALCULATING AMOUNTS CHARGED TO PATIENTS.

Return Reference - Identifier	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.</p> <p>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.</p> <p>IDENTIFYING COMMUNITY NEEDS IS JUST ONE STEP IN THE CHNA PROCESS. THE MOST CRITICAL STEP IS PRIORITIZING AND ALIGNING EXPERTISE TO MAKE AN IMPACT ON THE IDENTIFIED NEEDS. TO FACILITATE THIS PROCESS, THE BOARD OF DIRECTORS OF EACH HOSPITAL MINISTRY HAS APPOINTED A COMMUNITY LEADERSHIP BOARD THAT IS ULTIMATELY RESPONSIBLE FOR THE OVERSIGHT AND DIRECTION OF THE COMMUNITY BENEFIT INITIATIVES. ON A TRIENNIAL BASIS THIS ADVISORY BOARD, WHICH IS MADE UP OF COMMUNITY MEMBERS, APPROVES THE 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>
SCHEDULE H, PART VI, LINE 3 - PATIENT EDUCATION	<p>PRESENCE HEALTH HOSPITALS ARE COMMITTED TO DELIVERING EFFECTIVE, SAFE, PERSON-CENTRIC, HEALTHCARE TO ALL PATIENTS REGARDLESS OF THEIR ABILITY TO PAY. AS A NONPROFIT HEALTH SYSTEM, IT IS OUR MISSION AND PRIVILEGE TO PLAY THIS IMPORTANT ROLE IN OUR COMMUNITY.</p> <p>STAFF SCREEN UNINSURED PATIENTS AND IF FOUND POTENTIALLY ELIGIBLE FOR A GOVERNMENT FUNDING SOURCE, PROVIDE ASSISTANCE AND/OR RESOURCES TO THE PATIENT AND THEIR FAMILY. IF A PATIENT IS NOT ELIGIBLE FOR A PAYMENT SOURCE, PRESENCE HEALTH'S FINANCIAL ASSISTANCE POLICY COVERS PATIENTS WHO LACK THE FINANCIAL RESOURCES TO PAY FOR ALL OR PART OF THEIR BILLS. ELIGIBILITY FOR FINANCIAL ASSISTANCE IS BASED UPON THE ANNUAL FEDERAL POVERTY GUIDELINES. PRESENCE HEALTH HOSPITALS PROVIDE FINANCIAL ASSISTANCE FOR THOSE WHO EARN UP TO 600% OF THE FEDERAL POVERTY LEVEL.</p> <p>PRESENCE HEALTH HOSPITALS WIDELY PUBLICIZE THEIR</p> <ul style="list-style-type: none"> - FINANCIAL ASSISTANCE POLICY - FINANCIAL ASSISTANCE APPLICATION - FINANCIAL ASSISTANCE POLICY SUMMARY - BILLING AND COLLECTIONS POLICY - AMOUNT GENERALLY BILLED (AGB) CALCULATION - LIST OF PROVIDERS COVERED BY THE FINANCIAL ASSISTANCE POLICY <p>VIA THE HOSPITAL FACILITY'S WEBSITE - HTTP://WWW.PRESENCEHEALTH.ORG/FINANCIAL-ASSISTANCE</p> <p>PRESENCE HEALTH HOSPITALS MAKE PAPER COPIES OF THE</p> <ul style="list-style-type: none"> - FINANCIAL ASSISTANCE POLICY - FINANCIAL ASSISTANCE APPLICATION - FINANCIAL ASSISTANCE POLICY SUMMARY - BILLING AND COLLECTIONS POLICY - AMOUNT GENERALLY BILLED CALCULATION - LIST OF PROVIDERS COVERED BY THE FINANCIAL ASSISTANCE POLICY <p>THE PAPER COPIES ARE MADE READILY AVAILABLE AS PART OF THE INTAKE, DISCHARGE AND CUSTOMER SERVICE PROCESSES. UPON REQUEST, PAPER COPIES CAN ALSO BE OBTAINED BY MAIL.</p> <p>PRESENCE HEALTH HOSPITALS INFORM THEIR PATIENTS OF THE FINANCIAL ASSISTANCE POLICY VIA A NOTICE ON PATIENT BILLING STATEMENTS, INCLUDING THE PHONE NUMBER AND WEB ADDRESS WHERE MORE INFORMATION MAY BE FOUND.</p> <p>PRESENCE HEALTH HOSPITALS INFORM THEIR PATIENTS OF THE FINANCIAL ASSISTANCE POLICY VIA SIGNAGE DISPLAYED IN THE EMERGENCY ROOM AND ADMISSIONS AREAS.</p>

Return Reference - Identifier	Explanation
SCHEDULE H, PART VI, LINE 4 - COMMUNITY INFORMATION	<p>PRESENCE HEALTH HOSPITAL MINISTRIES HAVE IDENTIFIED A SEPARATE SERVICE AREA FOR EACH OF ITS ACUTE CARE HOSPITALS UTILIZING A CONSISTENT METHODOLOGY AND REFLECTING A COMBINATION OF GEOGRAPHIC LOCATION AND MARKET SHARE CRITERIA. THE TOTAL SERVICE AREA OF EACH MINISTRY REPRESENTS APPROXIMATELY 80% TO 90% OF THE TOTAL INPATIENT DISCHARGES FROM THAT FACILITY. THE PRIMARY SERVICE AREA (THE "PRIMARY SERVICE AREA") OF EACH FACILITY REPRESENTS APPROXIMATELY 65 TO 75% OF SUCH DISCHARGES AND THE SECONDARY SERVICE AREA (THE "SECONDARY SERVICE AREA") OF EACH FACILITY REPRESENTS APPROXIMATELY 15 TO 25% OF SUCH DISCHARGES. THE PRIMARY SERVICE AREAS AND SECONDARY SERVICE AREAS HAVE BEEN DETERMINED BY UTILIZING A PATIENT ORIGIN ANALYSIS TO IDENTIFY THOSE ZIP CODES THAT REPRESENT INPATIENT DISCHARGES. THESE ZIP CODES ARE THEN MAPPED TO IDENTIFY GEOGRAPHIC COVERAGE OF THE PRIMARY SERVICE AREAS AND SECONDARY SERVICE AREAS.</p> <p>MANY OF THE PRESENCE HEALTH HOSPITAL MINISTRIES FACILITIES ARE LOCATED IN POPULATION GROWTH AREAS. BASED UPON POPULATION ESTIMATES AND PROJECTIONS OBTAINED FROM CLARITAS, INC., THE POPULATION OF THE OUR HOSPITALS' COMBINED SERVICE AREA IS EXPECTED TO GROW AT A RATE OF 1.9% ANNUALLY BETWEEN 2012 AND 2017, COMPARED WITH A GROWTH RATE OF 1.3% AND 1.6% PER YEAR IN THE CHICAGO MSA AND IN ILLINOIS, RESPECTIVELY. OF PRESENCE'S TOTAL SERVICE AREA POPULATION, 10.7% IS OVER THE AGE OF 65, COMPARED TO 11.1% AND 12.3% IN THE CHICAGO MSA AND IN ILLINOIS, RESPECTIVELY.</p> <p>PRESENCE SAINT JOSEPH MEDICAL CENTER'S PRIMARY SERVICE HAS AN ESTIMATED POPULATION OF 677,560 ACCORDING TO THE 2010 CENSUS. IN THE PRIMARY SERVICE AREA, 9.3% OF THE POPULATION IS OVER THE AGE 65 AND THE MEDIAN HOUSEHOLD INCOME IS \$75,906. APPROXIMATELY, 7.1% OF THE POPULATION IN JOLIET LIVES BELOW THE POVERTY LEVEL. THE RACIAL MAKEUP OF THE CITY IS 76.0% WHITE, 11.2% AFRICAN AMERICAN, 4.6% ASIAN, AND 7.9% MULTI-RACIAL/OTHER. THE 2014 POPULATION ALSO ESTIMATES THAT 22.5% ARE HISPANIC OR LATINO.</p> <p>THE PRESENCE SAINT JOSEPH MEDICAL CENTER SERVICE AREA IS DEFINED BY ZIP CODES BELOW</p> <p>SERVICE AREA - PRIMARY MARKET - ZIP CODE CITY 60435 JOLIET 60436 JOLIET 60544 PLAINFIELD 60433 JOLIET 60431 JOLIET 60432 JOLIET 60434 JOLIET 60585 PLAINFIELD 60586 PLAINFIELD 60403 CREST HILL 60404 SHOREWOOD</p> <p>SERVICE AREA - SECONDARY MARKET - ZIP CODE CITY 60451 NEW LENOX 60481 WILMINGTON 60450 MORRIS 60410 CHANNAHON 60446 ROMEOVILLE 60447 MINOOKA 60416 COAL CITY 60408 BRAIDWOOD 60421 ELWOOD 60441 LOCKPORT 60448 MOKENA 60442 MANHATTAN 60423 FRANKFORT 60440 BOLINGBROOK 60424 GARDNER 60439 LEMONT 60407 BRACEVILLE 60474 SOUTH WILMINGTON 60491 HOMER GLEN</p> <p>AURORA, WHERE PRESENCE MERCY MEDICAL CENTER (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 2010 CENSUS IS 515,269. IN THE PRIMARY SERVICE AREA, 10.7% OF THE POPULATION IS OVER THE AGE 65 AND THE AVERAGE HOUSEHOLD INCOME IS \$69,496. WITHIN THE PRIMARY SERVICE AREA (AURORA), APPROXIMATELY 35,000 INDIVIDUALS (21.3%) RESIDE IN MEDICALLY UNDERSERVED AREAS (MUAS). OF THAT POPULATION, ABOUT 30% FALL 200% BELOW THE FEDERAL POVERTY LEVEL. WITHIN THE MUA, 68% OF THE POPULATION IS HISPANIC AND 11% IS AFRICAN AMERICAN. FIFTY-THREE PER CENT ARE UNDERINSURED AND 47% ARE MEDICAID RECIPIENTS. 10.1% OF RESIDENTS IN KANE COUNTY LIVE BELOW THE POVERTY LEVEL.</p> <p>PMMC'S SERVICE AREA IS DEFINED BY ZIP CODES BELOW</p> <p>SERVICE AREA - PRIMARY MARKET - ZIP CODE CITY 60506 AURORA 60505 AURORA 60542 NORTH AURORA 60538 MONTGOMERY 60504 AURORA 60507 AURORA 60502 AURORA</p> <p>SERVICE AREA - SECONDARY MARKET - ZIP CODE CITY 60510 BATAVIA</p>

Return Reference - Identifier	Explanation
1	<p>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</p> <p>PRESENCE SAINT JOSEPH HOSPITAL (PSJH) RESIDES IN KANE COUNTY. 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.</p> <p>THE PSJH'S SERVICE AREA IS DEFINED BY ZIP CODE BELOW</p> <p>SERVICE AREA - PRIMARY MARKET - ZIP CODE CITY 60123 ELGIN 60120 ELGIN 60124 ELGIN 60121 ELGIN 60110 CARPENTERSVILLE 60177 SOUTH ELGIN 60140 HAMPSHIRE 60118 DUNDEE</p> <p>SERVICE AREA - SECONDARY MARKET - ZIP CODE CITY 60102 ALGONQUIN 60103 BARTLETT 60174 SAINT CHARLES 60014 CRYSTAL LAKE 60107 STREAMWOOD 60142 HUNTLEY 60098 WOODSTOCK 60050 MCHENRY 60051 MCHENRY 60156 LAKE IN THE HILLS 60175 SAINT CHARLES 60136 GILBERTS 60134 GENEVA 60013 CARY 60152 MARENGO 60135 GENOA 60109 BURLINGTON 60012 CRYSTAL LAKE 60180 UNION</p> <p>PRESENCE SAINT MARY HOSPITAL'S (PSMH) PRIMARY SERVICE HAS AN ESTIMATED POPULATION OF 113,449, ACCORDING TO THE 2010 CENSUS. IN THE PRIMARY SERVICE AREA 14.1% OF THE POPULATION IS OVER THE AGE 65 AND THE AVERAGE HOUSEHOLD INCOME IS \$49,266. 15% OF THE POPULATION IN KANKAKEE LIVES BELOW THE POVERTY LEVEL. THE RACIAL MAKEUP OF THE CITY IS 81.3% WHITE, 15.5% AFRICAN AMERICAN, AND 9.3% HISPANIC.</p> <p>THE PSMH SERVICE AREA IS DEFINED BY ZIP CODES BELOW</p> <p>SERVICE AREA - PRIMARY MARKET - ZIP CODE CITY 60901 KANKAKEE 60914 BOURBONNAIS 60915 BRADLEY 60954 MOMENCE 60950 MANTENO</p> <p>SERVICE AREA - SECONDARY MARKET - ZIP CODE CITY 60964 SAINT ANNE 60927 CLIFTON 60922 CHEBANSE 60940 GRANT PARK 60970 WATSEKA 60941 HERSCHER 60913 BONFIELD 60938 GILMAN 60911 ASHKUM 60955 ONARGA 60944 HOPKINS PARK</p>

Return Reference - Identifier	Explanation
	<p>60951 MARTINTON 60930 DANFORTH 60910 AROMA PARK 60912 BEAVERVILLE 60919 CABERY 60961 REDDICK 60917 BUCKINGHAM 60935 ESSEX 60928 CRESCENT CITY 60481 WILMINGTON 60468 PEOTONE 60420 DWIGHT 60958 PEMBROKE TOWNSHIP</p> <p>CHAMPAIGN COUNTY, WHERE PRESENCE COVENANT MEDICAL CENTER (PCMC) RESIDES, 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.</p> <p>THE PCMC SERVICE AREA IS DEFINED BY ZIP CODES BELOW</p> <p>SERVICE AREA - PRIMARY MARKET -</p> <p>ZIP CODE CITY</p> <p>61821 CHAMPAIGN 61801 URBANA 61820 CHAMPAIGN 61866 RANTOUL 61802 URBANA 61953 TUSCOLA 61880 TOLONO 61873 SAINT JOSEPH 61956 VILLA GROVE 61874 SAVOY 61849 HORNER 61878 THOMASBORO 61822 CHAMPAIGN 61847 GIFFORD 61877 SIDNEY 61943 OAKLAND 61851 IVESDALE 61884 WHITE HEATH 61839 DE LAND 61931 HUMBOLDT 61844 FITHIAN 61862 PENFIELD 61882 WELDON 61773 SIBLEY 61930 HINDSBORO 61812 ARMSTRONG 60933 ELLIOTT 61932 HUME 61871 ROYAL 60926 CLAYTONVILLE 61845 FOOSLAND 61941 MURDOCK</p> <p>SERVICE AREA - SECONDARY MARKET -</p> <p>ZIP CODE CITY</p> <p>60948 LODA 60957 PAXTON 61856 MONTICELLO 61853 MAHOMET 61938 MATTOON 61910 ARCOLA 60936 GIBSON CITY 61920 CHARLESTON 61942 NEWMAN 61813 BEMENT</p> <p>PRESENCE UNITED SAMARITAN MEDICAL CENTER'S (PUSMC) 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.</p> <p>THE PUSMC SERVICE AREA IS DEFINED BY ZIP CODES BELOW</p> <p>SERVICE AREA - PRIMARY MARKET -</p> <p>ZIP CODE CITY</p> <p>61832 DANVILLE 61834 DANVILLE 61846 GEORGETOWN 61883 WESTVILLE 61833 TILTON</p> <p>SERVICE AREA - SECONDARY MARKET -</p> <p>ZIP CODE CITY</p>

Return Reference - Identifier	Explanation
	47932 COVINGTON, IN 60942 HOOPESTON 61817 CATLIN 61858 OAKWOOD 61870 RIDGE FARM 61924 CHRISMAN 60963 ROSSVILLE 47987 VEEDERSBURG, IN 61841 FAIRMONT 47974 PERRYVILLE, IN 47993 WILLIAMSPORT, IN 61814 BISMARCK 61865 POTOMAC 47928 CAYUGA, IN 47952 KINGMAN, IN 61876 SIDELL 61811 ALVIN 61844 FITHIAN 61850 INDIANOLA 47991 WEST LEBANON, IN 61848 HENNING

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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</p> <p>1 ENSURING OUR MEDICAL STAFF IS OPEN TO ALL QUALIFIED PHYSICIANS</p> <p>2 ALL OF OUR HOSPITALS ARE ACCREDITED AND IN GOOD STANDING WITH THE JOINT COMMISSION ACCREDITATION OF HEALTHCARE ORGANIZATIONS</p> <p>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</p> <p>4 REINVESTING SURPLUS FUNDS INTO THE ORGANIZATION TO IMPROVE PATIENT CARE THROUGH NEW PROGRAMS AND TECHNOLOGY</p> <p>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</p> <p>6 PARTICIPATING IN ALL GOVERNMENT SPONSORED HEALTH CARE PROGRAMS, MEDICARE, MEDICAID, CHAMPUS, TRICARE, SCHIP AND OTHERS</p> <p>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</p> <p>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</p> <p>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</p> <p>IN EACH OF THE COMMUNITIES WE SERVE, WE WORK WITH OTHERS - INCLUDING CHARITABLE ORGANIZATIONS, COMMUNITY HEALTH PROVIDERS, ELECTED OFFICIALS, BUSINESS LEADERS, SCHOOLS, CHURCHES, AND RESIDENTS - TO LOOK AT THE OVERALL HEALTH OF THE COMMUNITY AND IDENTIFY THE GREATEST NEEDS. WE THEN MAKE A PLAN AND DEVELOP STRATEGIES TOGETHER WITH OUR COMMUNITIES TO ADDRESS THE HIGHEST PRIORITY HEALTH NEEDS. THE HIGHEST PRIORITY NEEDS AND THE PROGRAMS WE'VE DEVELOPED TO MEET THESE NEEDS ARE IDENTIFIED BELOW FOR EACH HOSPITAL</p> <p>PRESENCE SAINT JOSEPH MEDICAL CENTER (1)</p> <p>PARTNERSHIP WITH THE WILL-GRUNDY MEDICAL CLINIC (WGMC) & AUNT MARTHA'S YOUTH SERVICES CENTER/ KNOW WHERE TO GO CAMPAIGN</p> <p>IDENTIFIED NEED: ACCESS TO DENTAL AND PRIMARY CARE</p> <p>PSJMC DONATED \$35,000 TO THE WILL-GRUNDY MEDICAL CLINIC IN 2018. 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 2018, 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.</p> <p>WILL COUNTY PARTNERS FOR HEALTHY FAMILIES (WCPHF)</p> <p>IDENTIFIED NEED: CHRONIC DISEASE</p> <p>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.</p> <p>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.</p> <p>IN ADDITION, IN 2013 THE PARTNERSHIP STARTED A MONTH LONG PHYSICAL ACTIVITY CONTEST WITH THE PURPOSE OF ENCOURAGING WILL COUNTY STUDENTS TO INCORPORATE MORE PHYSICAL ACTIVITY INTO THEIR DAILY LIVES. SIMILAR TO READING CONTESTS WITHIN THE SCHOOLS, THE COMMIT TO BE FIT CONTEST WAS OFFERED TO ALL WILL COUNTY STUDENTS. STUDENTS "COMMITTED" TO THE PROGRAM BY SIGNING UP AND TRACKING THEIR DAILY PHYSICAL ACTIVITY. THEY DID THIS MANUALLY ON FORMS.</p>

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	<p>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.</p> <p>WEWILL WORK HEALTHY AWARD IDENTIFIED NEED: CHRONIC DISEASE THE WEWILL WORK HEALTHY AWARD PROGRAM WAS CREATED BY THE MAPP CHRONIC CARE ACTION TEAM TO RECOGNIZE WILL COUNTY WORKPLACES THAT ARE COMMITTED TO IMPROVING EMPLOYEE HEALTH AND WELL-BEING THROUGH SIX MAIN AREAS OF WORKSITE WELLNESS:</p> <ol style="list-style-type: none"> 1 HEALTH PROMOTION/EDUCATION 2 PHYSICAL ACTIVITY 3 MENTAL HEALTH 4 ENVIRONMENTAL HEALTH 5 NUTRITION 6 SAFETY <p>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.</p> <p>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.</p> <p>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 2017-2018 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>

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SCHEDULE H, PART VI, LINE 5 - PROMOTION OF COMMUNITY HEALTH - PART II	<p>PRESENCE MERCY MEDICAL CENTER (2)</p> <p>I'M REDUCING OBESITY IN CHILDREN (IROC) NUTRITION PROGRAM IDENTIFIED NEED 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</p> <p>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 "A 1C ACHIEVER" PROGRAM WHICH IS A PATIENT RECOGNITION PROGRAM THAT REWARDS PATIENTS FOR ACHIEVING GLYCEMIC CONTROL</p> <p>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</p> <p>COMMUNITY WELLNESS PROGRAM IDENTIFIED NEED 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</p> <p>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</p> <p>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</p> <p>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</p> <p>FAITH COMMUNITY NURSING PROGRAM IDENTIFIED NEED CHRONIC DISEASE 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 LANGUAGE BARRIERS 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</p>

Return Reference - Identifier	Explanation
	<p>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</p> <p>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 MENTAL HEALTH</p> <p>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</p> <p>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>

Return Reference - Identifier	Explanation
SCHEDULE H, PART VI, LINE 5 - PROMOTION OF COMMUNITY HEALTH - PART III	<p>PRESENCE SAINT JOSEPH HOSPITAL (3)</p> <p>LIVE WELL, BE WELL CHRONIC DISEASE SELF-MANAGEMENT PROGRAM IDENTIFIED NEED 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</p> <p>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</p> <p>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</p> <p>MENTAL HEALTH FIRST AID IDENTIFIED NEED MENTAL HEALTH IN RESPONSE TO A DEMONSTRATED SYSTEM AND STATE-WIDE NEED OF ADDRESSING BARRIERS TO ACCESSING AND UTILIZING MENTAL HEALTH SERVICES, PRESENCE HEALTH AND ITS COMMUNITY PARTNERS IMPLEMENTED AN EVIDENCE-BASED PROGRAM, MENTAL HEALTH FIRST AID (MHFA), TO REDUCE THE STIGMA ASSOCIATED WITH MENTAL ILLNESS AND IMPROVE THE COORDINATION OF MENTAL HEALTH CARE THROUGHOUT A SIX COUNTY SERVICE AREA. A SYSTEM-WIDE ACTION TEAM WAS CREATED TO OVERSEE THE PROCESS, WITH 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 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> <p>PRESENCE SAINT MARY'S HOSPITAL (4)</p> <p>FIT "N" HEALTHY & WE FIT! PROGRAMS IDENTIFIED NEED ACCESS TO HEALTH PSMH PROVIDES FREE EXERCISE AND HEALTHY LIVING EDUCATION PROGRAMS IN LOW INCOME AREAS OF KANKAKEE COUNTY INCLUDING PEMBROKE, KANKAKEE & SUN RIVER TERRACE. FIT N HEALTHY IS TARGETED FOR ADULTS WHILE WE FIT! IS TARGETED FOR YOUTH AND THEIR PARENTS. IN 2017, PSMH PARTNERED WITH THE KANKAKEE PUBLIC LIBRARY TO BECOME AN ADDITIONAL SUMMER SITE FOR THE WE FIT! PROGRAM. PSMH PROVIDES THE OVERALL STAFFING, COORDINATION, SUPPLIES AND FUNDING FOR THESE PROGRAMS THAT SERVE OVER 200 PERSONS PER YEAR</p> <p>5-2-1-0 GO! IDENTIFIED NEED ACCESS TO HEALTH LIVE HEALTHY KANKAKEE, A COMMUNITY COLLABORATIVE LEAD BY THE AREA YMCA IN WHICH PSMH IS AN ACTIVE PARTNER, PROMOTES THE 5-2-1-0 GO! PROGRAM TO THE KANKAKEE COMMUNITY. THIS HEALTHY LIVING CAMPAIGN IS A SIMPLE MESSAGE FOR CHILDREN THAT ENCOURAGES THE REDUCTION OF SCREEN TIME ALONG WITH INCREASE PHYSICAL ACTIVITY AND NUTRITION. THROUGHOUT THE YEAR, MEMBERS OF THE ACTION TEAM VISITED OVER A DOZEN LOCAL PEDIATRICIANS AND FAMILY MEDICINE PHYSICIANS TO ADOPT THE 5-2-1-0 MESSAGE WITHIN THEIR PRACTICE AND IN THEIR APPOINTMENTS WITH PATIENTS. THERE WERE ALSO BILLBOARDS IN THE COMMUNITY WITH THE MESSAGE</p> <p>RE-THINK YOUR DRINK CAMPAIGN IDENTIFIED NEED ACCESS TO HEALTH LIVE HEALTHY KANKAKEE PARTNERED WITH THE ILLINOIS ALLIANCE TO PREVENT OBESITY (IAPO) TO BRING THE RETHINK YOUR DRINK EDUCATION AND COMMUNICATION CAMPAIGN TO KANKAKEE COUNTY TO EDUCATE STAKEHOLDER ORGANIZATIONS AND COMMUNITY RESIDENTS ABOUT THE HARMS OF SUGAR SWEETENED BEVERAGE (SSB) CONSUMPTION. PSMH ACTIVELY PARTICIPATES ON THE LIVE HEALTHY KANKAKEE TEAM OVERSEEING THIS MEDIA CAMPAIGN AS WELL AS SECURED A GRANT TO REDUCE SODIUM AND SUGAR INTAKE WITHIN PSMH'S CAMPUS. MESSAGES EDUCATING OUR ASSOCIATES, PHYSICIANS AND GUESTS ON RETHINK YOUR DRINK CAN BE FOUND AROUND OUR CAMPUS INCLUDING ELEVATORS AND BY BEVERAGE MACHINES</p>

Return Reference - Identifier	Explanation
	<p>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 ST MARY'S HOSPITAL 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 PSMH PROVIDED PROMOTION, FUNDING, COORDINATION & IN-KIND DONATION OF SPACE FOR THESE TRAININGS. OVER 300 COMMUNITY MEMBERS HAVE BEEN TRAINED IN THE KANKAKEE COUNTY COMMUNITY SINCE 2016. 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>PLEASE NOTE: EDUCATION AND EMPLOYMENT WAS NOT AN IDENTIFIED NEED IN THE 2015 CHNA. OUR IMPLEMENTATION STRATEGY FOR 2018 WILL ADDRESS THIS NEED.</p>

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<p>SCHEDULE H, PART VI, LINE 5 - PROMOTION OF COMMUNITY HEALTH - PART IV</p>	<p>PRESENCE COVENANT MEDICAL CENTER (5)</p> <p>AS OF FEBRUARY 1, 2018, THIS HOSPITAL FACILITY WAS NO LONGER UNDER THE CONTROL OF PRESENCE HEALTH DUE TO A SALE TO OSF HEALTHCARE SYSTEM AS SUCH, THIS NARRATIVE REPRESENTS JANUARY 2018 ONLY</p> <p>IDENTIFIED NEED REDUCING OBESITY AND PROMOTING HEALTHY LIFESTYLES</p> <p>COMMUNITY RESOURCE CENTER</p> <p>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</p> <p>THE PCMC COMMUNITY RESOURCE CENTER IS STAFFED BY THREE PCMC HEALTH NAVIGATORS AND ONE PCMC SOCIAL WORKER IN ADDITION TO THE HOSPITAL STAFF, THE CENTER IS MADE UP OF COMMUNITY PARTNERS THAT PROVIDE SERVICES AT THE CENTER THESE PARTNERS INCLUDE CATHOLIC CHARITIES, CHAMPAIGN COUNTY CHRISTIAN HEALTH CLINIC, CHAMPAIGN COUNTY HEALTH CARE CONSUMERS, PATIENT INNOVATION CENTER, AND PROMISE HEALTH</p> <p>SMILE HEALTHY</p> <p>SMILEHEALTHY IS A COLLECTION OF DENTAL PROGRAMS THAT WORK TO IMPROVE THE ORAL HEALTH OF THE COMMUNITY THROUGH PROVIDING PREVENTIVE CARE, TREATMENT, AND EDUCATION</p> <p>MOBILE DENTAL PROGRAM - THE MOBILE PROGRAM SETS UP INSIDE DOZENS OF LOCATIONS AND PROVIDES EXAM, PREVENTIVE SERVICES, AND TREATMENTS SUCH AS FILLINGS AND EXTRACTIONS</p> <p>PEDIATRIC RESTORATIVE OUTPATIENT SURGERY (PROPS) - ONCE A MONTH, A SMILEHEALTHY DENTIST PROVIDES COMPREHENSIVE TREATMENT UNDER GENERAL ANESTHESIA IN HOSPITAL SETTING THE PROGRAM CARES FOR THREE LOW-INCOME CHILDREN EACH MONTH WHO HAVE EXTENSIVE TREATMENT PLANS OFTEN NEEDING 10-20 TREATMENTS AT ONCE</p> <p>DENTAL EMERGENCY REFERRAL - SMILEHEALTHY OFFERS AN EDUCATION AND REFERRAL PROGRAM FOR PATIENTS THAT PRESENT TO THE EMERGENCY DEPARTMENT WITH DENTAL PAIN THE PROGRAM PROVIDES ORAL HEALTH AND NUTRITION EDUCATION, COUNSELING AND CASE MANAGEMENT TO FACILITATE PATIENTS 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</p> <p>FAITH IN ACTION</p> <p>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 RESPIRE CARE</p> <p>CENTER FOR HEALTHY LIVING</p> <p>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</p> <p>FAITH2 (FAITH-SQUARED)</p> <p>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</p> <p>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</p> <p>ENROLLMENT STRATEGY</p> <p>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 2017-2018 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> <p>DIABETES COALITION</p> <p>*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 IS AN ACTIVE MEMBER OF THIS COALITION</p> <p>IDENTIFIED NEED VIOLENCE</p> <p>CRISIS NURSERY</p> <p>CRISIS NURSERY IS LOCATED ON THE GROUNDS OF PCMC AND CREATES AN "ISLAND OF SAFETY"</p>

Return Reference - Identifier	Explanation
	<p>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.</p> <p>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.</p> <p>IDENTIFIED NEED: BEHAVIORAL HEALTH MENTAL HEALTH FIRST AID</p> <p>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>

Return Reference - Identifier	Explanation
SCHEDULE H, PART VI, LINE 5 - PROMOTION OF COMMUNITY HEALTH - PART V	<p>PRESENCE UNITED SAMARITANS MEDICAL CENTER (6)</p> <p>THIS HOSPITAL FACILITY WAS NO LONGER UNDER THE CONTROL OF PRESENCE HEALTH DUE TO A SALE TO OSF HEALTHCARE SYSTEM AS SUCH, THIS NARRATIVE REPRESENTS JANUARY 2018 ONLY</p> <p>MENTAL HEALTH FIRST AID IDENTIFIED NEED MENTAL HEALTH IN RESPONSE TO A DEMONSTRATED SYSTEM AND STATE-WIDE NEED OF ADDRESSING BARRIERS TO ACCESSING AND UTILIZING MENTAL HEALTH SERVICES, PRESENCE HEALTH AND ITS COMMUNITY PARTNERS IMPLEMENTED AN EVIDENCE-BASED PROGRAM, MENTAL HEALTH FIRST AID (MHFA), TO REDUCE THE STIGMA ASSOCIATED WITH MENTAL ILLNESS AND IMPROVE THE COORDINATION OF MENTAL HEALTH CARE THROUGHOUT A SIX COUNTY SERVICE AREA. A SYSTEM-WIDE ACTION TEAM WAS CREATED TO OVERSEE THE PROCESS, WITH 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>COMMUNITY RESOURCE CENTER 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 FREQUENTLY UTILIZING THE EMERGENCY ROOM. 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.</p> <p>THE PUSMC COMMUNITY RESOURCE CENTER IS STAFFED BY 25 HEALTH NAVIGATORS. THE CRC IS IN WORKING TOWARDS MIRRORING THE SUCCESS THAT HAS BEEN SEEN AT THE PCMC CRC AND ARE LOOKING TOWARD BRINGING ON COMMUNITY PARTNERS IN THE FUTURE.</p> <p>FAITH IN ACTION IDENTIFIED NEED ACCESS TO CARE FAITH IN ACTION IS A VOLUNTEER CARE GIVING MINISTRY IN THE DANVILLE AREA. THE PROGRAM USES FAITH AND COMMUNITY VOLUNTEERS TO PROVIDE ASSISTANCE TO THE SENIOR ADULT POPULATION 60+ YEARS. WE PROVIDE TRANSPORTATION TO MEDICAL APPOINTMENTS, 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 EQUIPMENT AND SUPPLIES, AND WHEELCHAIR RAMP CONSTRUCTION (VOLUNTEERS OR PAID CONTRACTORS).</p> <p>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 PROVIDE ASSISTANCE TO THE SENIOR ADULT POPULATION 60+ YEARS. WE PROVIDE TRANSPORTATION TO MEDICAL APPOINTMENTS, 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 EQUIPMENT AND SUPPLIES, AND WHEELCHAIR RAMP CONSTRUCTION (VOLUNTEERS OR PAID CONTRACTORS).</p> <p>HALO IDENTIFIED NEED CHILDHOOD OBESITY THE MISSION OF THE HALO PROJECT IS TO FOCUS 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 GOVERNMENT, NEIGHBORHOOD GROUPS, SOCIAL SERVICE AGENCIES AND HEALTHCARE PROVIDERS TO BECOME PARTNERS IN RECLAIMING RESPONSIBILITY FOR INDIVIDUAL AND COMMUNITY HEALTH. HALO PROJECT HAS MANY COMMITTEES AND COALITIONS MANNED BY COMMUNITY VOLUNTEERS, COMMUNITY PARTNERS, AND COMMUNITY 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 COMMUNITY IN VERMILION COUNTY WITH AN EMPHASIS ON THE DISPROPORTIONATE UNMET HEALTH NEEDS (DUHN) POPULATIONS.</p> <p>I SING THE BODY ELECTRIC (ISBE) IDENTIFIED NEED ACCESS TO CARE I SING THE BODY ELECTRIC IS A THREE-PHASE HEALTH EDUCATION AND PREVENTION PROGRAM BY AND FOR YOUTH IN VERMILION COUNTY (VC). THIS PROGRAM CHALLENGES HIGH SCHOOL STUDENTS TO DEVELOP CREATIVE, THOUGHT-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 PEERS, YOUNGER STUDENTS, AND THE COMMUNITY IN GENERAL. THE END RESULT IS THE PROMOTION OF A CULTURE OF HEALTH.</p> <p>YOUNG MEN AWARE IDENTIFIED NEED ABSTINENCE EDUCATION YOUNG MEN AWARE IS A LEADERSHIP DEVELOPMENT PROGRAM SERVING DANVILLE HIGH SCHOOL, NORTH RIDGE MIDDLE SCHOOL, AND SOUTH VIEW MIDDLE SCHOOL. THE PROGRAM FOCUSES ON EDUCATION, HEALTH AWARENESS, AND LEADERSHIP WITH THREE OBJECTIVES, WHICH INCLUDE HIGH SCHOOL COMPLETION, COLLEGE ATTAINMENT, AND EARLY FATHERHOOD PREVENTION WITH A FOCUS ON ABSTINENCE.</p> <p>YOUNG WOMEN AWARE IDENTIFIED NEED TEEN PREGNANCY YOUNG WOMEN AWARE IS A LEADERSHIP PROGRAM SERVING DANVILLE HIGH SCHOOL, NORTH RIDGE MIDDLE SCHOOL, AND SOUTH VIEW MIDDLE SCHOOL. THE PROGRAM FOCUSES ON EDUCATION, HEALTH</p>

Return Reference - Identifier	Explanation
	<p>AWARENESS, AND LEADERSHIP WITH THREE OBJECTIVES, WHICH INCLUDE HIGH SCHOOL COMPLETION, COLLEGE ATTAINMENT, AND PREGNANCY PREVENTION WITH A FOCUS ON ABSTINENCE. 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</p> <p>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 2017-2018 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>

Return Reference - Identifier	Explanation
<p>SCHEDULE H, PART VI, LINE 6 - DESCRIPTION OF AFFILIATED GROUP</p>	<p>PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK BECAME AN AFFILIATE OF ASCENSION HEALTH AND JOINED AMITA HEALTH WHEN IT WAS ACQUIRED BY ASCENSION HEALTH ON MARCH 1, 2018. PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK'S AFFILIATES ARE LARGE MULTI-FACETED, INTEGRATED, NOT-FOR-PROFIT MINISTRIES INCLUDING HOSPITAL AND NON-HOSPITAL MINISTRIES (PHYSICIAN GROUP PRACTICES, HOSPITAL ORGANIZATIONS, RESEARCH, AND HOME HEALTH.) THESE MINISTRIES WORK TOGETHER TO CARE FOR PATIENTS, JOINED BY COMMON SYSTEMS AND A PHILOSOPHY OF SERVING AS A HEALING PRESENCE WITH SPECIAL CONCERN FOR OUR NEIGHBORS ESPECIALLY THOSE WHO ARE VULNERABLE. THIS COMMUNITY BENEFIT HAPPENS THROUGH ITS FOCUS ON PATIENT CARE, EDUCATION AND RESEARCH. THE ORGANIZATIONS WORK TOGETHER TO SERVE THEIR COMMUNITIES AT THE LOCAL, REGIONAL, STATE AND NATIONAL LEVEL.</p> <p>ASCENSION HEALTH ALLIANCE, D/B/A ASCENSION (ASCENSION), IS A MISSOURI NONPROFIT CORPORATION FORMED ON SEPTEMBER 13, 2011. ASCENSION IS THE SOLE CORPORATE MEMBER AND PARENT ORGANIZATION OF ASCENSION HEALTH, A CATHOLIC NATIONAL HEALTH SYSTEM CONSISTING PRIMARILY OF NONPROFIT CORPORATIONS THAT OWN AND OPERATE LOCAL HEALTHCARE FACILITIES, OR HEALTH MINISTRIES, LOCATED IN 23 OF THE UNITED STATES AND THE DISTRICT OF COLUMBIA.</p> <p>ASCENSION IS SPONSORED BY ASCENSION SPONSOR, A PUBLIC JURIDIC PERSON. THE PARTICIPATING ORGANIZATIONS/ENTITIES OF ASCENSION SPONSOR ARE THE DAUGHTERS OF CHARITY OF ST. VINCENT DE PAUL, ST. LOUISE PROVINCE, THE CONGREGATION OF ST. JOSEPH, THE CONGREGATION OF THE SISTERS OF ST. JOSEPH OF CARONDELET, THE CONGREGATION OF ALEXIAN BROTHERS OF THE IMMACULATE CONCEPTION PROVINCE, INC. - AMERICAN PROVINCE, AND THE SISTERS OF THE SORROWFUL MOTHER OF THE THIRD ORDER OF ST. FRANCIS OF ASSISI - US/CARIBBEAN PROVINCE.</p> <p>ASCENSION (WWW.ASCENSION.ORG) IS A FAITH-BASED HEALTHCARE ORGANIZATION DEDICATED TO TRANSFORMATION THROUGH INNOVATION ACROSS THE CONTINUUM OF CARE. AS THE LARGEST NON-PROFIT HEALTH SYSTEM IN THE U.S. AND THE WORLD'S LARGEST CATHOLIC HEALTH SYSTEM, ASCENSION IS COMMITTED TO DELIVERING COMPASSIONATE, PERSONALIZED CARE TO ALL, WITH SPECIAL ATTENTION TO PERSONS LIVING IN POVERTY AND THOSE MOST VULNERABLE. IN FY2018, ASCENSION PROVIDED NEARLY \$2.0 BILLION IN CARE OF PERSONS LIVING IN POVERTY AND OTHER COMMUNITY BENEFIT PROGRAMS. ASCENSION INCLUDES APPROXIMATELY 156,000 ASSOCIATES AND 34,000 ALIGNED PROVIDERS. ASCENSION'S HEALTHCARE DIVISION OPERATES MORE THAN 2,600 SITES OF CARE - INCLUDING 151 HOSPITALS AND MORE THAN 50 SENIOR LIVING FACILITIES - IN 21 STATES AND THE DISTRICT OF COLUMBIA, WHILE ITS SOLUTIONS DIVISION PROVIDES A VARIETY OF SERVICES AND SOLUTIONS INCLUDING PHYSICIAN PRACTICE MANAGEMENT, VENTURE CAPITAL INVESTING, INVESTMENT MANAGEMENT, BIOMEDICAL ENGINEERING, FACILITIES MANAGEMENT, CLINICAL CARE MANAGEMENT, INFORMATION SERVICES, RISK MANAGEMENT, AND CONTRACTING THROUGH ASCENSION'S OWN GROUP PURCHASING ORGANIZATION.</p> <p>AMITA HEALTH (WWW.AMITAHEALTH.ORG) IS A JOINT OPERATING COMPANY FORMED BY ASCENSION HEALTH AND ADVENTIST HEALTH SYSTEM SUNBELT HEALTHCARE CORPORATION OF WHICH ADVENTIST MIDWEST HEALTH, AND ALEXIAN BROTHERS HEALTH SYSTEM, ARE THE MEMBERS. AMITA HEALTH WELCOMED PRESENCE HEALTH TO THE ORGANIZATION IN MARCH 2018, MAKING AMITA HEALTH THE LARGEST HEALTH SYSTEM IN ILLINOIS. THROUGH ITS MEMBERS, AMITA HEALTH HAS OVER 25,000 ASSOCIATES COMMITTED TO DELIVERING THE MOST EFFICIENT, HIGHEST QUALITY, FAITH-BASED CARE AT NINETEEN ACUTE AND SPECIALTY CARE HOSPITALS AND AT MORE THAN 200 AMBULATORY/CLINIC LOCATIONS. AMITA HEALTH HAS AN EXTENSIVE PROVIDER NETWORK OF OVER 7,000 HOSPITAL-AFFILIATED PHYSICIANS, AND THE AMITA HEALTH MEDICAL GROUP CONSISTS OF OVER 800 MULTI-SPECIALTY EMPLOYED PHYSICIANS AND ASSOCIATE PRACTITIONERS, RANKING IT AMONG THE LARGEST REGIONAL MEDICAL GROUPS. AMITA HEALTH'S MISSION IS TO EXTEND THE HEALING MINISTRY OF JESUS BY RESPECTING THE FAITH TRADITIONS OF THE MANY INDIVIDUALS AND FAMILIES IT SERVES ACROSS SUBURBAN CHICAGO.</p> <p>WITH A SACRED MISSION OF EXTENDING THE HEALING MINISTRY OF CHRIST, ADVENTHEALTH (WWW.ADVENTHEALTH.COM) IS A CONNECTED SYSTEM OF CARE FOR EVERY STAGE OF LIFE AND HEALTH. MORE THAN 80,000 SKILLED AND COMPASSIONATE CAREGIVERS IN PHYSICIAN PRACTICES, HOSPITALS, OUTPATIENT CLINICS, SKILLED NURSING FACILITIES, HOME HEALTH AGENCIES AND HOSPICE CENTERS PROVIDE INDIVIDUALIZED, WHOLISTIC CARE. A CHRISTIAN MISSION, SHARED VISION, COMMON VALUES, FOCUS ON WHOLE-PERSON HEALTH AND COMMITMENT TO MAKING COMMUNITIES HEALTHIER UNIFY THE SYSTEM'S 45 HOSPITAL CAMPUSES AND HUNDREDS OF CARE SITES IN DIVERSE MARKETS THROUGHOUT NINE STATES.</p> <p>THE COVERED AFFILIATES WITHIN AMITA HEALTH PROVIDE THE COMMUNITY WITH A FULL RANGE OF COMPREHENSIVE HEALTHCARE SERVICES AND ACCESS TO THE MOST ADVANCED MEDICAL TECHNOLOGY. THEIR HEALTHCARE PROFESSIONALS ARE PASSIONATE ABOUT DELIVERING EXCEPTIONAL HEALTHCARE AND ARE PROUD OF THE POWERFUL, CUTTING-EDGE TECHNOLOGY OFFERED BY THE SYSTEM. THE COVERED AFFILIATES WITHIN AMITA HEALTH ALSO OFFER A WIDE RANGE OF COMMUNITY HEALTH SERVICES, CORPORATE WELLNESS PROGRAMS, PREVENTIVE CARE AND EDUCATION. AS CHARITABLE ORGANIZATIONS, THEY RECOGNIZE THAT NOT EVERYONE CAN AFFORD ESSENTIAL MEDICAL SERVICES AND THAT THEIR MISSION IS TO SERVE THE COMMUNITY BY PROVIDING HEALTHCARE SERVICES AND HEALTHCARE EDUCATION. THEREFORE, IN KEEPING WITH AMITA HEALTH'S COMMITMENT TO SERVING ALL MEMBERS OF ITS COMMUNITY, FREE CARE AND/OR SUBSIDIZED CARE, CARE TO PERSONS COVERED BY GOVERNMENT PROGRAMS AT OR BELOW COST, AND HEALTH ACTIVITIES AND PROGRAMS TO SUPPORT THE COMMUNITY ARE CONSIDERED AND PROVIDED WHEN APPROPRIATE. THESE ACTIVITIES INCLUDE WELLNESS PROGRAMS, COMMUNITY EDUCATION PROGRAMS, SPECIAL PROGRAMS FOR THE ELDERLY AND MEDICALLY UNDERSERVED, AND A VARIETY OF BROAD COMMUNITY SUPPORT ACTIVITIES INCLUDING, BUT NOT LIMITED TO, EDUCATIONAL AFFILIATIONS, HEALTH SCREENINGS, COUNSELING PROGRAMS, CONTINUING MEDICAL EDUCATION (CME) PROGRAMS AND DONATIONS TO COMMUNITY GROUPS.</p>
<p>SCHEDULE H, PART VI, LINE 7 - STATE FILING OF COMMUNITY BENEFIT REPORT</p>	<p>IL</p>

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)

Name of hospital facility or letter of facility reporting group PRESENCE ST JOSEPH MEDICAL CENTER**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?		✓
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		✓
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	✓	
If "Yes," indicate what the CHNA report describes (check all that apply):		
a <input 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	✓	
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	✓	
6b 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	✓	
7 Did the hospital facility make its CHNA report widely available to the public?	✓	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):		
a <input checked="" type="checkbox"/> Hospital facility's website (list url). <u>HTTP://WWW.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	✓	
9 Indicate the tax year the hospital facility last adopted an implementation strategy: <u>20 17</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	✓	
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?		
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)?		✓
12b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V Facility Information (continued)**Financial Assistance Policy (FAP)**Name of hospital facility or letter of facility reporting group PRESENCE ST JOSEPH MEDICAL CENTER

	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.	✓	
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>2</u> <u>0</u> <u>0</u> % and FPG family income limit for eligibility for discounted care of <u>6</u> <u>0</u> <u>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 status		
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?	✓	
15 Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	✓	
a <input 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).	✓	
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>(SEE STATEMENT)</u>		
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>(SEE STATEMENT)</u>		
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>(SEE STATEMENT)</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 checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j <input type="checkbox"/> Other (describe in Section C)		

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Part V Facility Information (continued)**Billing and Collections****Name of hospital facility or letter of facility reporting group** PRESENCE ST JOSEPH MEDICAL CENTER

	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?	✓	
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?		✓
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?	✓	
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)		

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Part V Facility Information (continued)**Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**Name of hospital facility or letter of facility reporting group PRESENCE ST JOSEPH MEDICAL CENTER

	Yes	No
22 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care		
a <input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b <input checked="" type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> 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.		

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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)

Name of hospital facility or letter of facility reporting group PRESENCE MERCY MEDICAL CENTER**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**

- 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?
- 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
- 3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12
- If "Yes," indicate what the CHNA report describes (check all that apply):
- a ☒ A definition of the community served by the hospital facility
- b ☒ Demographics of the community
- c ☒ Existing health care facilities and resources within the community that are available to respond to the health needs of the community
- d ☒ How data was obtained
- e ☒ The significant health needs of the community
- f ☒ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups
- g ☒ The process for identifying and prioritizing community health needs and services to meet the community health needs
- h ☒ The process for consulting with persons representing the community's interests
- i ☒ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)
- j ☐ Other (describe in Section C)
- 4 Indicate the tax year the hospital facility last conducted a CHNA: 20 17
- 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
- 6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C
- 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
- 7 Did the hospital facility make its CHNA report widely available to the public?
- If "Yes," indicate how the CHNA report was made widely available (check all that apply):
- a ☒ Hospital facility's website (list url): HTTP://WWW.PRESENCEHEALTH.ORG/COMMUNITY-HEALTH
- b ☐ Other website (list url):
- c ☒ Made a paper copy available for public inspection without charge at the hospital facility
- d ☒ 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
- 9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 18
- 10 Is the hospital facility's most recently adopted implementation strategy posted on a website?
- a If "Yes," (list url) HTTP://WWW.PRESENCEHEALTH.ORG/COMMUNITY-HEALTH
- b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?
- 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)?
- b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?
- c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$

	Yes	No
1		✓
2		✓
3	✓	
5	✓	
6a	✓	
6b	✓	
7	✓	
8	✓	
10	✓	
10b		
12a		✓
12b		

Part V Facility Information (continued)
Financial Assistance Policy (FAP)
Name of hospital facility or letter of facility reporting group PRESENCE MERCY MEDICAL CENTER

		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.	✓	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>2</u> <u>0</u> <u>0</u> % and FPG family income limit for eligibility for discounted care of <u>6</u> <u>0</u> <u>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 status		
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?	✓	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	✓	
a	<input 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)	✓	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>(SEE STATEMENT)</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>(SEE STATEMENT)</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>(SEE STATEMENT)</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 checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input type="checkbox"/> Other (describe in Section C)		

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Part V Facility Information (continued)**Billing and Collections**Name of hospital facility or letter of facility reporting group PRESENCE MERCY MEDICAL CENTER

	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 ✓	
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	✓
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 ✓	
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)		

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Part V Facility Information (continued)**Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)****Name of hospital facility or letter of facility reporting group** PRESENCE MERCY MEDICAL CENTER

	Yes	No
22 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a <input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b <input checked="" type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> 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?	23	✓
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?	24	✓
If "Yes," explain in Section C.		

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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)

Name of hospital facility or letter of facility reporting group PRESENCE ST JOSEPH HOSPITAL**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?		✓
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		✓
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	✓	
If "Yes," indicate what the CHNA report describes (check all that apply):		
a <input 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	✓	
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	✓	
6b 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	✓	
7 Did the hospital facility make its CHNA report widely available to the public?	✓	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):		
a <input type="checkbox"/> Hospital facility's website (list url). <u>HTTP //WWW.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	✓	
9 Indicate the tax year the hospital facility last adopted an implementation strategy: <u>20 18</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	✓	
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?		
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)?		✓
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V Facility Information (continued)**Financial Assistance Policy (FAP)****Name of hospital facility or letter of facility reporting group** PRESENCE ST JOSEPH HOSPITAL

	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.	✓	
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>2</u> <u>0</u> <u>0</u> % and FPG family income limit for eligibility for discounted care of <u>6</u> <u>0</u> <u>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 status		
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?	✓	
15 Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	✓	
a <input 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).	✓	
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url). <u>(SEE STATEMENT)</u>		
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url). <u>(SEE STATEMENT)</u>		
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url). <u>(SEE STATEMENT)</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 checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j <input type="checkbox"/> Other (describe in Section C)		

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Part V Facility Information (continued)**Billing and Collections**Name of hospital facility or letter of facility reporting group PRESENCE ST JOSEPH HOSPITAL

	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 ✓	
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	✓
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 ✓	
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)		

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Part V Facility Information (continued)**Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)****Name of hospital facility or letter of facility reporting group** PRESENCE ST JOSEPH HOSPITAL

	Yes	No
22 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care		
a <input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b <input checked="" type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> 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.		

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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)

Name of hospital facility or letter of facility reporting group PRESENCE ST MARY'S HOSPITAL**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?		✓
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		✓
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	✓	
If "Yes," indicate what the CHNA report describes (check all that apply):		
a <input 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	✓	
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	✓	
6b 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	✓	
7 Did the hospital facility make its CHNA report widely available to the public?	✓	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):		
a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>HTTP://WWW.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	✓	
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>18</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	✓	
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?		
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)?		✓
12b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V Facility Information (continued)**Financial Assistance Policy (FAP)**Name of hospital facility or letter of facility reporting group PRESENCE ST MARY'S HOSPITAL

		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:	✓	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>2 0 0</u> % and FPG family income limit for eligibility for discounted care of <u>6 0 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 status		
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?	✓	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	✓	
a	<input 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):	✓	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>(SEE STATEMENT)</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>(SEE STATEMENT)</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>(SEE STATEMENT)</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 checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input type="checkbox"/> Other (describe in Section C)		

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Part V Facility Information (continued)**Billing and Collections****Name of hospital facility or letter of facility reporting group** PRESENCE ST MARY'S HOSPITAL

	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 ✓	
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	✓
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 ✓	
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)		

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Part V Facility Information (continued)**Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**Name of hospital facility or letter of facility reporting group PRESENCE ST MARY'S HOSPITAL

	Yes	No
22 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care		
a <input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b <input checked="" type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> 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.		

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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)

Name of hospital facility or letter of facility reporting group PRESENCE COVENANT MEDICAL CENTER**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?		✓
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		✓
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	✓	
If "Yes," indicate what the CHNA report describes (check all that apply).		
a <input 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	✓	
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	✓	
6b 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	✓	
7 Did the hospital facility make its CHNA report widely available to the public?	✓	
If "Yes," indicate how the CHNA report was made widely available (check all that apply)		
a <input checked="" type="checkbox"/> Hospital facility's website (list url). (SEE STATEMENT)		
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	✓	
9 Indicate the tax year the hospital facility last adopted an implementation strategy: <u>20 18</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	✓	
a If "Yes," (list url): <u>HTTPS://WWW.OSFHEALTHCARE.ORG/ABOUT/COMMUNITY-HEALTH/</u>		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		
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)?		✓
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V Facility Information (continued)**Financial Assistance Policy (FAP)**Name of hospital facility or letter of facility reporting group PRESENCE COVENANT MEDICAL CENTER

	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 ✓	
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>2</u> <u>0</u> <u>0</u> % and FPG family income limit for eligibility for discounted care of <u>6</u> <u>0</u> <u>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 status		
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 ✓	
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 ✓	
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 ✓	
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>(SEE STATEMENT)</u>		
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>(SEE STATEMENT)</u>		
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>(SEE STATEMENT)</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 checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j <input type="checkbox"/> Other (describe in Section C)		

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Part V Facility Information (continued)**Billing and Collections****Name of hospital facility or letter of facility reporting group** PRESENCE COVENANT MEDICAL CENTER

	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?	✓	
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?		✓
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?	✓	
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)		

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Part V Facility Information (continued)**Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)****Name of hospital facility or letter of facility reporting group** PRESENCE COVENANT MEDICAL CENTER**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		✓
24		✓

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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)

Name of hospital facility or letter of facility reporting group PRESENCE UNITED SAMARITANS MED CNTR**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?		✓
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.		✓
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	✓	
If "Yes," indicate what the CHNA report describes (check all that apply)		
a <input 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 17		
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	✓	
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	✓	
6b 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	✓	
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply):	✓	
a <input checked="" type="checkbox"/> Hospital facility's website (list url): (SEE STATEMENT)		
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	✓	
9 Indicate the tax year the hospital facility last adopted an implementation strategy. 20 17		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	✓	
a If "Yes," (list url): HTTPS://WWW.OSFHEALTHCARE.ORG/ABOUT/COMMUNITY-HEALTH/		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		
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)?		✓
12b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V Facility Information (continued)
Financial Assistance Policy (FAP)
Name of hospital facility or letter of facility reporting group PRESENCE UNITED SAMARITANS MED CNTR

		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:	✓	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>2 0 0</u> % and FPG family income limit for eligibility for discounted care of <u>6 0 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 status		
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?	✓	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	✓	
a	<input 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):	✓	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>(SEE STATEMENT)</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>(SEE STATEMENT)</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>(SEE STATEMENT)</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 checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input type="checkbox"/> Other (describe in Section C)		

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Part V Facility Information (continued)**Billing and Collections****Name of hospital facility or letter of facility reporting group** PRESENCE UNITED SAMARITANS MED CNTR

	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 ✓	
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	✓
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 ✓	
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)		

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Part V Facility Information *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)****Name of hospital facility or letter of facility reporting group** PRESENCE UNITED SAMARITANS MED CNTR**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		✓
24		✓

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Part IV

Management Companies and Joint Ventures

(a) Name of Entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
KANKAKEE VALLEY DIALYSIS CENTER	DIALYSIS CENTER	50 00		50 00
DREYER MERCY AMBULATORY SURGERY CENTER	AMBULATORY SURGERY CENTER	40 00		60 00
CENTER FOR DIGESTIVE DISEASE	DIGESTIVE HEALTH SERVICES	10 00		90 00
PRESENCE SAINT JOSEPH HOSPITAL ORTHOPEDIC CLINICAL CO-MANAGEMENT COMPANY, LLC	MANAGEMENT OF ORTHOPEDIC SERVICE LINE	20 00		80 00

Part V, Section C

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

Return Reference - Identifier	Explanation
SCHEDULE H, PART V, SECTION B, LINE 3E - THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY	TO BETTER TARGET COMMUNITY RESOURCES ON THE SERVICE AREA'S MOST PRESSING HEALTH NEEDS, THE HOSPITAL PARTICIPATED IN A GROUP DISCUSSION WITH ORGANIZATIONAL DECISION MAKERS AND COMMUNITY LEADERS TO PRIORITIZE THE SIGNIFICANT COMMUNITY HEALTH NEEDS WHILE CONSIDERING SEVERAL CRITERIA ALIGNMENT WITH ASCENSION HEALTH STRATEGIES OF HEALTHCARE THAT LEAVES NO ONE BEHIND, CARE FOR THE POOR AND VULNERABLE, OPPORTUNITIES FOR PARTNERSHIP, AVAILABILITY OF EXISTING PROGRAMS AND RESOURCES, OPPORTUNITIES FOR PARTNERSHIP, ADDRESSING DISPARITIES OF SUBGROUPS, AVAILABILITY OF EVIDENCE-BASED PRACTICES, AND COMMUNITY INPUT THE SIGNIFICANT HEALTH NEEDS ARE A PRIORITIZED DESCRIPTION OF THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY AS IDENTIFIED THROUGH THE CHNA SEE SCHEDULE H, PART V, LINE 7 FOR THE LINK TO THE CHNA AND SCHEDULE H, PART V, LINE 11 FOR HOW THOSE NEEDS ARE BEING ADDRESSED

Return Reference - Identifier	Explanation
SCHEDULE H, PART V, SECTION B, LINE 5 - INPUT FROM PERSONS WHO REPRESENT BROAD INTERESTS OF COMMUNITY SERVED	<p data-bbox="409 172 872 219">FACILITY NAME PRESENCE SAINT JOSEPH MEDICAL CENTER</p> <p data-bbox="409 236 1526 385">DESCRIPTION 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.</p> <p data-bbox="409 402 1526 551">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.</p> <p data-bbox="409 568 1526 674">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.</p> <p data-bbox="409 691 1526 819">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.</p> <p data-bbox="409 836 1526 921">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.</p> <p data-bbox="409 938 1526 1023">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 AND THE FOURTH ROUND BEGAN IN 2019 FOR COMPLETION IN 2020.</p> <p data-bbox="409 1040 1526 1232">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:</p> <ul data-bbox="409 1249 1045 1598" style="list-style-type: none"> * AMITA 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 * SENIOR SERVICES OF WILL COUNTY * SILVER CROSS HOSPITAL * STEPPING STONES, INC * UNITED WAY OF WILL COUNTY * WILL COUNTY COMMUNITY HEALTH CENTER * WILL COUNTY EXECUTIVE'S OFFICE * WILL COUNTY HEALTH DEPARTMENT * WILL-GRUNDY MEDICAL CLINIC <p data-bbox="409 1615 1526 1764">PRIORITIZATION OF STRATEGIC ISSUES ON APRIL 7, 2017, FORTY-ONE WILL COUNTY PUBLIC HEALTH STAKEHOLDERS PARTICIPATED IN A PLANNING 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 PRIORITIZE 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 CONSENSUS.</p> <p data-bbox="409 1781 1526 1887">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 STRATEGIC ISSUES. ALL ATTENDEES AGREED THAT TRANSPORTATION IS A CONCERN, BUT THAT IT COULD BE NESTED 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.</p> <p data-bbox="409 1904 1526 1968">MAPP EXECUTIVE COMMITTEE MEMBERS DECIDED THAT BEHAVIORAL HEALTH, ACCESS TO DENTAL AND PRIMARY CARE, AND CHRONIC DISEASE WOULD BE THE TOP THREE STRATEGIC ISSUES FOR THE NEXT THREE YEARS.</p>

Return Reference - Identifier	Explanation
SCHEDULE H, PART V, SECTION B, LINE 6A - CHNA CONDUCTED WITH ONE OR MORE OTHER HOSPITAL FACILITIES	<p>FACILITY NAME PRESENCE SAINT JOSEPH MEDICAL CENTER</p> <p>DESCRIPTION PSJMC PARTNERED WITH SILVER CROSS HOSPITAL, ADVENTIST BOLING BROOK HOSPITAL AND EDWARD HOSPITAL TO COMPLETE THEIR CHNA</p>
SCHEDULE H, PART V, SECTION B, LINE 6B - CHNA CONDUCTED WITH ONE OR MORE ORGANIZATIONS OTHER THAN HOSPITAL FACILITIES	<p>FACILITY NAME PRESENCE SAINT JOSEPH MEDICAL CENTER</p> <p>DESCRIPTION SEE 990 SCHEDULE H PART V LINE 5 EXPLANATION</p>
SCHEDULE H, PART V, SECTION B, LINE 7D - OTHER METHODS CHNA REPORT MADE WIDELY AVAILABLE	<p>FACILITY NAME PRESENCE SAINT JOSEPH MEDICAL CENTER</p> <p>DESCRIPTION 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</p>
SCHEDULE H, PART V, SECTION B, LINE 11 - HOW HOSPITAL FACILITY IS ADDRESSING NEEDS IDENTIFIED IN CHNA	<p>FACILITY NAME PRESENCE SAINT JOSEPH MEDICAL CENTER</p> <p>DESCRIPTION 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</p> <p>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</p> <p>PLEASE SEE PART VI, LINE 5 FOR THE DESCRIPTION OF PROGRAMS IN PLACE TO ADDRESS THESE IDENTIFIED NEEDS ALONG WITH 2018 OBJECTIVES AND 2018 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</p> <p>ALL SIGNIFICANT NEEDS IDENTIFIED IN THE MOST RECENTLY CONDUCTED CHNA ARE BEING ADDRESSED</p>
SCHEDULE H, PART V, SECTION B, LINE 13H - OTHER ELIGIBILITY CRITERIA FOR FINANCIAL ASSISTANCE	<p>FACILITY NAME PRESENCE SAINT JOSEPH MEDICAL CENTER</p> <p>DESCRIPTION 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</p>
SCHEDULE H, PART V, SECTION B, LINE 16A - FAP AVAILABLE WEBSITE	HTTP //WWW PRESENCEHEALTH ORG/FINANCIAL-ASSISTANCE-DOCUMENTS
SCHEDULE H, PART V, SECTION B, LINE 16B - FAP APPLICATION FORM WEBSITE	HTTP //WWW PRESENCEHEALTH ORG/FINANCIAL-ASSISTANCE-DOCUMENTS
SCHEDULE H, PART V, SECTION B, LINE 16C - PLAIN LANGUAGE FAP SUMMARY WEBSITE	HTTP //WWW PRESENCEHEALTH ORG/FINANCIAL-ASSISTANCE-DOCUMENTS

Part V, Section C

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

Return Reference - Identifier	Explanation
SCHEDULE H, PART V, SECTION B, LINE 3E - THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY	TO BETTER TARGET COMMUNITY RESOURCES ON THE SERVICE AREA'S MOST PRESSING HEALTH NEEDS, THE HOSPITAL PARTICIPATED IN A GROUP DISCUSSION WITH ORGANIZATIONAL DECISION MAKERS AND COMMUNITY LEADERS TO PRIORITIZE THE SIGNIFICANT COMMUNITY HEALTH NEEDS WHILE CONSIDERING SEVERAL CRITERIA: ALIGNMENT WITH ASCENSION HEALTH STRATEGIES OF HEALTHCARE THAT LEAVES NO ONE BEHIND, CARE FOR THE POOR AND VULNERABLE, OPPORTUNITIES FOR PARTNERSHIP, AVAILABILITY OF EXISTING PROGRAMS AND RESOURCES, OPPORTUNITIES FOR PARTNERSHIP, ADDRESSING DISPARITIES OF SUBGROUPS, AVAILABILITY OF EVIDENCE-BASED PRACTICES, AND COMMUNITY INPUT. THE SIGNIFICANT HEALTH NEEDS ARE A PRIORITIZED DESCRIPTION OF THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY AS IDENTIFIED THROUGH THE CHNA. SEE SCHEDULE H, PART V, LINE 7 FOR THE LINK TO THE CHNA AND SCHEDULE H, PART V, LINE 11 FOR HOW THOSE NEEDS ARE BEING ADDRESSED.

Return Reference - Identifier	Explanation
SCHEDULE H, PART V, SECTION B, LINE 5 - INPUT FROM PERSONS WHO REPRESENT BROAD INTERESTS OF COMMUNITY SERVED	<p>FACILITY NAME PRESENCE MERCY MEDICAL CENTER (PMMC)</p> <p>DESCRIPTION THE CHNA PROCESS WAS INITIATED BY PRESENCE MERCY MEDICAL CENTER (PMMC) AND PRESENCE SAINT JOSEPH HOSPITAL (PSJH) 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</p> <p>ENGAGEMENT OF PUBLIC HEALTH EXPERTISE THE KANE COUNTY HEALTH DEPARTMENT FACILITATED THE CHNA PROCESS BY USING THE MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP) TOOL. PMMC SERVED AS ONE OF EIGHT PARTNERS THAT PARTICIPATED IN THE KANE COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT. THIS PROVIDED THE OPPORTUNITY FOR PMMC TO ACTIVELY PROVIDE EXPERTISE, INPUT, AND FINANCIAL SUPPORT.</p> <p>PARTNERS ALSO INVOLVED IN THIS PROCESS INCLUDED THE FOUR OTHER HOSPITALS IN KANE COUNTY INCLUDING DELNOR HOSPITAL, PRESENCE SAINT JOSEPH HOSPITAL, RUSH-COPLEY MEDICAL CENTER, SHERMAN HOSPITAL, AS WELL AS FOX VALLEY UNITED WAY AND THE UNITED WAY OF ELGIN.</p> <p>COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) COMMITTEE TO PROVIDE COMMUNITY LEVEL OVERSIGHT FOR THE PROCESS, A DIVERSE GROUP OF COMMUNITY STAKEHOLDERS AND PMMC REPRESENTATIVES WERE INVITED TO PARTICIPATE ON THE CHIP STEERING COMMITTEE. TO ENSURE REPRESENTATIVE ENGAGEMENT, PERSONAL INVITATIONS WERE SENT TO ORGANIZATIONS REPRESENTING CULTURAL, LINGUISTIC, RACIAL, ETHNIC, AND OTHER MINORITY GROUPS. IN ADDITION, INDIVIDUALS WITH SPECIALIZED QUALIFICATIONS IN DEALING WITH SPECIAL POPULATIONS OR CLINICAL GROUPS WERE SOLICITED FOR THEIR PARTICIPATION. FINALLY, EFFORTS WERE MADE TO INCLUDE INDIVIDUALS ON THE CHIP STEERING COMMITTEE WITH PUBLIC HEALTH EXPERTISE. THOSE WHO COMMITTED TO THE ASSESSMENT AND PLANNING PROCESS BECAME THE EIGHT MEMBERS OF THE CHNA STEERING COMMITTEE, WHICH CONTINUES TO MEET REGULARLY TO PROVIDE FEEDBACK AND OVERSIGHT, ASSESS PROGRESS, AND MODIFY PLANS AS NEEDED.</p> <p>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</p> <p>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 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 (SEE AREAS OF OPPORTUNITY ABOVE). FOLLOWING THE DATA REVIEW, PRC ANSWERED ANY QUESTIONS AND FACILITATED A GROUP DIALOGUE, ALLOWING PARTICIPANTS TO ADVOCATE FOR ANY OF THE HEALTH ISSUES DISCUSSED. AFTERWARD, PARTICIPANTS WERE PROVIDED AN OVERVIEW OF THE PRIORITIZATION EXERCISE THAT FOLLOWED.</p> <p>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.</p> <p>PRESENCE MERCY MEDICAL CENTER 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>
SCHEDULE H, PART V, SECTION B, LINE 6A - CHNA CONDUCTED WITH ONE OR MORE OTHER HOSPITAL FACILITIES	<p>FACILITY NAME PRESENCE MERCY MEDICAL CENTER (PMMC)</p> <p>DESCRIPTION PMMC PARTNERED WITH SHERMAN HOSPITAL, CADENCE HEALTH, PRESENCE SAINT JOSEPH HOSPITAL AND RUSH-COPLEY MEDICAL CENTER TO COMPLETE THEIR CHNA.</p>

Return Reference - Identifier	Explanation
SCHEDULE H, PART V, SECTION B, LINE 6B - CHNA CONDUCTED WITH ONE OR MORE ORGANIZATIONS OTHER THAN HOSPITAL FACILITIES	FACILITY NAME PRESENCE MERCY MEDICAL CENTER (PMMC) DESCRIPTION SEE 990 SCHEDULE H PART V LINE 5 EXPLANATION
SCHEDULE H, PART V, SECTION B, LINE 7D - OTHER METHODS CHNA REPORT MADE WIDELY AVAILABLE	FACILITY NAME PRESENCE MERCY MEDICAL CENTER (PMMC) DESCRIPTION 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
SCHEDULE H, PART V, SECTION B, LINE 11 - HOW HOSPITAL FACILITY IS ADDRESSING NEEDS IDENTIFIED IN CHNA	FACILITY NAME PRESENCE MERCY MEDICAL CENTER (PMMC) DESCRIPTION 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 - MENTAL HEALTH - CHRONIC DISEASE - INCOME AND EDUCATION 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 ALL SIGNIFICANT NEEDS IDENTIFIED IN 2015-2017 CHNA ARE BEING ADDRESSED. INCOME AND EDUCATION WAS NOT A PRIORITIZED NEED IN THAT CHNA, SO IT WILL BE ADDRESSED IN THE 2018 IMPLEMENTATION STRATEGY
SCHEDULE H, PART V, SECTION B, LINE 13H - OTHER ELIGIBILITY CRITERIA FOR FINANCIAL ASSISTANCE	FACILITY NAME PRESENCE MERCY MEDICAL CENTER DESCRIPTION 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
SCHEDULE H, PART V, SECTION B, LINE 16A - FAP AVAILABLE WEBSITE	HTTP://WWW.PRESENCEHEALTH.ORG/FINANCIAL-ASSISTANCE-DOCUMENTS
SCHEDULE H, PART V, SECTION B, LINE 16B - FAP APPLICATION FORM WEBSITE	HTTP://WWW.PRESENCEHEALTH.ORG/FINANCIAL-ASSISTANCE-DOCUMENTS
SCHEDULE H, PART V, SECTION B, LINE 16C - PLAIN LANGUAGE FAP SUMMARY WEBSITE	HTTP://WWW.PRESENCEHEALTH.ORG/FINANCIAL-ASSISTANCE-DOCUMENTS

Part V, Section C

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

Return Reference - Identifier	Explanation
SCHEDULE H, PART V, SECTION B, LINE 3E - THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY	TO BETTER TARGET COMMUNITY RESOURCES ON THE SERVICE AREA'S MOST PRESSING HEALTH NEEDS, THE HOSPITAL PARTICIPATED IN A GROUP DISCUSSION WITH ORGANIZATIONAL DECISION MAKERS AND COMMUNITY LEADERS TO PRIORITIZE THE SIGNIFICANT COMMUNITY HEALTH NEEDS WHILE CONSIDERING SEVERAL CRITERIA: ALIGNMENT WITH ASCENSION HEALTH STRATEGIES OF HEALTHCARE THAT LEAVES NO ONE BEHIND, CARE FOR THE POOR AND VULNERABLE, OPPORTUNITIES FOR PARTNERSHIP, AVAILABILITY OF EXISTING PROGRAMS AND RESOURCES, OPPORTUNITIES FOR PARTNERSHIP, ADDRESSING DISPARITIES OF SUBGROUPS, AVAILABILITY OF EVIDENCE-BASED PRACTICES, AND COMMUNITY INPUT. THE SIGNIFICANT HEALTH NEEDS ARE A PRIORITIZED DESCRIPTION OF THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY AS IDENTIFIED THROUGH THE CHNA. SEE SCHEDULE H, PART V, LINE 7 FOR THE LINK TO THE CHNA AND SCHEDULE H, PART V, LINE 11 FOR HOW THOSE NEEDS ARE BEING ADDRESSED.

Return Reference - Identifier	Explanation
<p>SCHEDULE H, PART V, SECTION B, LINE 5 - INPUT FROM PERSONS WHO REPRESENT BROAD INTERESTS OF COMMUNITY SERVED</p>	<p>FACILITY NAME PRESENCE SAINT JOSEPH HOSPITAL</p> <p>DESCRIPTION THE CHNA PROCESS WAS INITIATED BY PRESENCE SAINT 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</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p> <p>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.</p> <p>FOLLOWING THE DATA REVIEW, PRC ANSWERED ANY QUESTIONS AND FACILITATED A GROUP DIALOGUE, ALLOWING PARTICIPANTS TO ADVOCATE FOR ANY OF THE HEALTH ISSUES DISCUSSED. AFTERWARD, PARTICIPANTS WERE PROVIDED AN OVERVIEW OF THE PRIORITIZATION EXERCISE THAT FOLLOWED.</p> <p>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.</p> <p>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>
<p>SCHEDULE H, PART V, SECTION B, LINE 6A - CHNA CONDUCTED WITH ONE OR MORE OTHER HOSPITAL FACILITIES</p>	<p>FACILITY NAME PRESENCE SAINT JOSEPH HOSPITAL</p> <p>DESCRIPTION PSJH PARTNERED WITH SHERMAN HOSPITAL, PRESENCE MERCY MEDICAL CENTER, CADENCE HEALTH AND RUSH-COPLEY MEDICAL CENTER TO COMPLETE THEIR CHNA.</p>

Return Reference - Identifier	Explanation
SCHEDULE H, PART V, SECTION B, LINE 6B - CHNA CONDUCTED WITH ONE OR MORE ORGANIZATIONS OTHER THAN HOSPITAL FACILITIES	FACILITY NAME PRESENCE SAINT JOSEPH HOSPITAL DESCRIPTION SEE 990 SCHEDULE H PART V LINE 5 EXPLANATION
SCHEDULE H, PART V, SECTION B, LINE 7D - OTHER METHODS CHNA REPORT MADE WIDELY AVAILABLE	FACILITY NAME PRESENCE SAINT JOSEPH HOSPITAL DESCRIPTION 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
SCHEDULE H, PART V, SECTION B, LINE 11 - HOW HOSPITAL FACILITY IS ADDRESSING NEEDS IDENTIFIED IN CHNA	FACILITY NAME PRESENCE SAINT JOSEPH HOSPITAL DESCRIPTION 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 - MENTAL HEALTH - CHRONIC DISEASE - INCOME AND EDUCATION 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 ALL SIGNIFICANT NEEDS IDENTIFIED IN 2015-2017 CHNA ARE BEING ADDRESSED. INCOME AND EDUCATION WAS NOT A PRIORITIZED NEED IN THAT CHNA, SO IT WILL BE ADDRESSED IN THE 2018 IMPLEMENTATION STRATEGY
SCHEDULE H, PART V, SECTION B, LINE 13H - OTHER ELIGIBILITY CRITERIA FOR FINANCIAL ASSISTANCE	FACILITY NAME PRESENCE SAINT JOSEPH HOSPITAL DESCRIPTION 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
SCHEDULE H, PART V, SECTION B, LINE 16A - FAP AVAILABLE WEBSITE	HTTP //WWW PRESENCEHEALTH ORG/FINANCIAL-ASSISTANCE-DOCUMENTS
SCHEDULE H, PART V, SECTION B, LINE 16B - FAP APPLICATION FORM WEBSITE	HTTP //WWW PRESENCEHEALTH ORG/FINANCIAL-ASSISTANCE-DOCUMENTS
SCHEDULE H, PART V, SECTION B, LINE 16C - PLAIN LANGUAGE FAP SUMMARY WEBSITE	HTTP //WWW PRESENCEHEALTH ORG/FINANCIAL-ASSISTANCE-DOCUMENTS

Part V, Section C

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

Return Reference - Identifier	Explanation
SCHEDULE H, PART V, SECTION B, LINE 3E - THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY	TO BETTER TARGET COMMUNITY RESOURCES ON THE SERVICE AREA'S MOST PRESSING HEALTH NEEDS, THE HOSPITAL PARTICIPATED IN A GROUP DISCUSSION WITH ORGANIZATIONAL DECISION MAKERS AND COMMUNITY LEADERS TO PRIORITIZE THE SIGNIFICANT COMMUNITY HEALTH NEEDS WHILE CONSIDERING SEVERAL CRITERIA ALIGNMENT WITH ASCENSION HEALTH STRATEGIES OF HEALTHCARE THAT LEAVES NO ONE BEHIND, CARE FOR THE POOR AND VULNERABLE, OPPORTUNITIES FOR PARTNERSHIP, AVAILABILITY OF EXISTING PROGRAMS AND RESOURCES, OPPORTUNITIES FOR PARTNERSHIP, ADDRESSING DISPARITIES OF SUBGROUPS, AVAILABILITY OF EVIDENCE-BASED PRACTICES, AND COMMUNITY INPUT THE SIGNIFICANT HEALTH NEEDS ARE A PRIORITIZED DESCRIPTION OF THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY AS IDENTIFIED THROUGH THE CHNA SEE SCHEDULE H, PART V, LINE 7 FOR THE LINK TO THE CHNA AND SCHEDULE H, PART V, LINE 11 FOR HOW THOSE NEEDS ARE BEING ADDRESSED
SCHEDULE H, PART V, SECTION B, LINE 5 - INPUT FROM PERSONS WHO REPRESENT BROAD INTERESTS OF COMMUNITY SERVED	<p>FACILITY NAME PRESENCE SAINT MARY'S HOSPITAL</p> <p>DESCRIPTION IN EARLY 2017, THE PARTNERSHIP FOR A HEALTHY COMMUNITY 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</p> <p>ENGAGEMENT OF PUBLIC HEALTH EXPERTISE THE KANKAKEE COUNTY HEALTH DEPARTMENT AND PSMH CO-FACILITATED THE CHNA PROCESS BY USING THE MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP) TOOL THE PARTNERSHIP FOR A HEALTHY COMMUNITY FORMALLY ENGAGED THE ILLINOIS PUBLIC HEALTH INSTITUTE (IPHI) FOR ASSISTANCE IN PLANNING AND EXECUTING THE CHNA PROCESS IPHI SERVED AS AN EXPERT PUBLIC HEALTH CONSULTANT THROUGHOUT THE CHNA TIMELINE</p> <p>CHNA STEERING COMMITTEE THE STEERING COMMITTEE OF THE KANKAKEE PARTNERSHIP MEETS REGULARLY TO PROVIDE OVERSIGHT TO THE ONGOING MAPP PROCESS AND MAKE RECOMMENDATIONS 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</p> <p>ORGANIZATIONS ON THE KANKAKEE PARTNERSHIP FOR A HEALTHY COMMUNITY STEERING COMMITTEE ARE LISTED BELOW</p> <ul style="list-style-type: none"> - HELEN WHEELER CENTER FOR COMMUNITY MENTAL HEALTH - KANKAKEE COUNTY HEALTH DEPARTMENT - KANKAKEE COUNTY HISPANIC PARTNERSHIP - IROQUOIS & KANKAKEE COUNTY REGIONAL OFFICE OF EDUCATION - PRESENCE ST. MARY'S HOSPITAL - RIVERSIDE MEDICAL CENTER - UNITED WAY OF KANKAKEE & IROQUOIS COUNTIES <p>THE GENERAL MEMBERSHIP CONSISTS OF PARTNERS WHO ARE NOT INVOLVED DIRECTLY WITH AN ACTION TEAM, BUT PARTICIPATE AS APPROPRIATE FOR THEIR ORGANIZATION THEY CONTRIBUTE TO THE OVERALL ASSESSMENT PROCESS AND SOME IMPLEMENTATION STRATEGIES</p> <p>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</p> <p>FOR THE 2018 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 AND 2018</p> <p>FROM FEBRUARY 2017 THROUGH MARCH 2018 FOUR SEPARATE ASSESSMENTS WERE CONDUCTED MAPP IS A PROCESS THAT PROVIDES A COMPREHENSIVE FRAMEWORK FOR ASSESSING COMMUNITY NEEDS, AND DEVELOPING AND ADDRESSING 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 COUNTY ENGAGING IN THIS PROCESS INCLUDE</p> <ul style="list-style-type: none"> *A HEALTHIER COMMUNITY THAT IMPROVES THE QUALITY OF LIFE FOR THE PEOPLE WHO LIVE AND WORK IN IT *INCREASED VISIBILITY OF PUBLIC HEALTH IN THE COMMUNITY *INCREASED AWARENESS AND KNOWLEDGE ABOUT PUBLIC HEALTH ISSUES *PREPARATION OF OUR LOCAL PUBLIC HEALTH SYSTEM TO BETTER ANTICIPATE, MANAGE AND RESPOND TO CHANGES IN THE COUNTY *GREATER COLLABORATION AND SHARING OF RESOURCES AMONG PARTNERS *REFLECTION OF PRIORITIES IN HOSPITAL IMPLEMENTATION STRATEGIES <p>MAPP HAS SIX PHASES THE FIRST FIVE PHASES WERE COMPLETED OVER TWENTY-TWO MONTHS PHASE SIX, THE ACTION CYCLE, IS AN ONGOING PROCESS OF PLANNING, IMPLEMENTING AND EVALUATING KANKAKEE COUNTY IS CURRENTLY IN PHASE SIX OF THE PROCESS</p>

Return Reference - Identifier	Explanation
SCHEDULE H, PART V, SECTION B, LINE 6A - CHNA CONDUCTED WITH ONE OR MORE OTHER HOSPITAL FACILITIES	FACILITY NAME PRESENCE SAINT MARY'S HOSPITAL DESCRIPTION PSMH PARTNERED WITH RIVERSIDE MEDICAL CENTER TO COMPLETE THEIR CHNA
SCHEDULE H, PART V, SECTION B, LINE 6B - CHNA CONDUCTED WITH ONE OR MORE ORGANIZATIONS OTHER THAN HOSPITAL FACILITIES	FACILITY NAME PRESENCE SAINT MARY'S HOSPITAL DESCRIPTION SEE 990 SCHEDULE H PART V LINE 5 EXPLANATION
SCHEDULE H, PART V, SECTION B, LINE 7D - OTHER METHODS CHNA REPORT MADE WIDELY AVAILABLE	FACILITY NAME PRESENCE SAINT MARY'S HOSPITAL DESCRIPTION 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
SCHEDULE H, PART V, SECTION B, LINE 11 - HOW HOSPITAL FACILITY IS ADDRESSING NEEDS IDENTIFIED IN CHNA	FACILITY NAME PRESENCE SAINT MARY'S HOSPITAL DESCRIPTION PRESENCE ST. MARY'S HOSPITAL HAS IDENTIFIED THE FOLLOWING THREE FOCUS AREAS AS SIGNIFICANT HEALTH NEEDS. THESE ARE THE FOCUS AREAS IDENTIFIED BY THE PARTNERSHIP FOR A HEALTHY COMMUNITY (PHC) THROUGH A COLLECTIVE PRIORITIZATION PROCESS. ACCESS TO HEALTH -FOCUS AREAS: PREVENTION AND PRIMARY CARE, SOCIAL DETERMINANTS OF HEALTH, & CHRONIC DISEASE BEHAVIORAL HEALTH -FOCUS AREAS: SUBSTANCE USE, MENTAL HEALTH, & TRAUMA AWARENESS AND PREVENTION EDUCATION AND EMPLOYMENT -FOCUS AREAS: JOB SKILLS, EMPLOYABILITY, & CAREER LADDER THE PRIORITIZED FOCUS AREAS WERE AGREED UPON BASED ON THE NEEDS THROUGHOUT KANKAKEE COUNTY. THESE NEEDS WERE ALSO GUIDED BY INFORMAL FEEDBACK FROM COMMUNITY AND HOSPITAL STAKEHOLDERS. NO WRITTEN FEEDBACK WAS RECEIVED ON PSMH'S PREVIOUS CHNA OR IMPLEMENTATION STRATEGY. PRESENCE ST. MARY'S HOSPITAL HAS SEVERAL EXISTING PROGRAMS THAT ARE ALREADY ADDRESSING THESE NEEDS, AND OUR 2018 IMPLEMENTATION STRATEGY WILL FURTHER REFINE THESE PROGRAMS AND IDENTIFY NEW ONES TO ENSURE THAT ALL PRIORITIZED HEALTH NEEDS ARE ADDRESSED. PLEASE SEE PART VI, LINE 5 FOR THE DESCRIPTION OF PROGRAMS IN PLACE TO ADDRESS THESE IDENTIFIED NEEDS ALONG WITH 2018 OBJECTIVES.
SCHEDULE H, PART V, SECTION B, LINE 13H - OTHER ELIGIBILITY CRITERIA FOR FINANCIAL ASSISTANCE	FACILITY NAME PRESENCE SAINT MARY'S HOSPITAL DESCRIPTION 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.
SCHEDULE H, PART V, SECTION B, LINE 16A - FAP AVAILABLE WEBSITE	HTTP://WWW.PRESENCEHEALTH.ORG/FINANCIAL-ASSISTANCE-DOCUMENTS
SCHEDULE H, PART V, SECTION B, LINE 16B - FAP APPLICATION FORM WEBSITE	HTTP://WWW.PRESENCEHEALTH.ORG/FINANCIAL-ASSISTANCE-DOCUMENTS
SCHEDULE H, PART V, SECTION B, LINE 16C - PLAIN LANGUAGE FAP SUMMARY WEBSITE	HTTP://WWW.PRESENCEHEALTH.ORG/FINANCIAL-ASSISTANCE-DOCUMENTS

Part V, Section C

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

Return Reference - Identifier	Explanation
SCHEDULE H, PART V, SECTION B, LINE 3E - THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY	THE SIGNIFICANT HEALTH NEEDS ARE A PRIORITIZED DESCRIPTION OF THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY AS IDENTIFIED THROUGH THE CHNA SEE SCHEDULE H, PART V, LINE 7 FOR THE LINK TO THE CHNA AND SCHEDULE H, PART V, LINE 11 FOR HOW THOSE NEEDS ARE BEING ADDRESSED
SCHEDULE H, PART V, SECTION B, LINE 5 - INPUT FROM PERSONS WHO REPRESENT BROAD INTERESTS OF COMMUNITY SERVED	<p>FACILITY NAME PRESENCE COVENANT MEDICAL CENTER</p> <p>DESCRIPTION: THE 2017 CHAMPAIGN COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN (IPLAN), OR CHNA, 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</p> <p>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</p> <p>*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</p> <p>*COMMUNITY THEMES AND STRENGTHS ASSESSMENT (CTSA) WE SURVEYED 740 COMMUNITY RESIDENTS REPRESENTING DIFFERENT COMMUNITY GROUPS TO GET AN IN-DEPTH PICTURE OF STRENGTHS AND WEAKNESSES</p> <p>*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</p> <p>*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</p>
SCHEDULE H, PART V, SECTION B, LINE 6A - CHNA CONDUCTED WITH ONE OR MORE OTHER HOSPITAL FACILITIES	<p>FACILITY NAME PRESENCE COVENANT MEDICAL CENTER</p> <p>DESCRIPTION PCMC PARTNERED WITH CARLE FOUNDATION HOSPITAL TO COMPLETE THEIR CHNA</p>
SCHEDULE H, PART V, SECTION B, LINE 6B - CHNA CONDUCTED WITH ONE OR MORE ORGANIZATIONS OTHER THAN HOSPITAL FACILITIES	<p>FACILITY NAME PRESENCE COVENANT MEDICAL CENTER</p> <p>DESCRIPTION SEE 990 SCHEDULE H PART V LINE 5 EXPLANATION</p>
SCHEDULE H, PART V, SECTION B, LINE 7 - HOSPITAL FACILITY'S WEBSITE (LIST URL)	HTTPS://WWW.OSFHEALTHCARE.ORG/ABOUT/COMMUNITY-HEALTH/
SCHEDULE H, PART V, SECTION B, LINE 7D - OTHER METHODS CHNA REPORT MADE WIDELY AVAILABLE	<p>FACILITY NAME PRESENCE COVENANT MEDICAL CENTER</p> <p>DESCRIPTION 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</p>

Return Reference - Identifier	Explanation
SCHEDULE H, PART V, SECTION B, LINE 11 - HOW HOSPITAL FACILITY IS ADDRESSING NEEDS IDENTIFIED IN CHNA	<p>FACILITY NAME PRESENCE COVENANT MEDICAL CENTER</p> <p>DESCRIPTION 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.</p> <p>ALL SIGNIFICANT NEEDS IDENTIFIED IN THE MOST RECENTLY CONDUCTED CHNA ARE BEING ADDRESSED</p> <p>* 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</p> <p>PCMC'S REVIEW OF CURRENT COMMUNITY BENEFIT PROGRAMS FOUND THAT THE HOSPITAL IS MEETING EXISTING COMMUNITY NEEDS THROUGH THE FOLLOWING PROGRAMS: THE SMILEHEALTHY PARTNERSHIP, FAITH IN ACTION, CRISIS NURSERY, DIABETES COALITION, FAITH-SQUARED AND TRANSITIONS</p> <p>PLEASE SEE PART VI, LINE 5 FOR THE DESCRIPTION OF PROGRAMS IN PLACE TO ADDRESS THESE IDENTIFIED NEEDS ALONG WITH 2018 OBJECTIVES AND 2018 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.</p>
SCHEDULE H, PART V, SECTION B, LINE 13H - OTHER ELIGIBILITY CRITERIA FOR FINANCIAL ASSISTANCE	<p>FACILITY NAME PRESENCE COVENANT MEDICAL CENTER</p> <p>DESCRIPTION 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.</p>
SCHEDULE H, PART V, SECTION B, LINE 16A - FAP AVAILABLE WEBSITE	HTTP //PRESENCEHEALTH.ORG/FINANCIAL-ASSISTANCE
SCHEDULE H, PART V, SECTION B, LINE 16B - FAP APPLICATION FORM WEBSITE	HTTP //PRESENCEHEALTH.ORG/FINANCIAL-ASSISTANCE
SCHEDULE H, PART V, SECTION B, LINE 16C - PLAIN LANGUAGE FAP SUMMARY WEBSITE	HTTP //PRESENCEHEALTH.ORG/FINANCIAL-ASSISTANCE

Part V, Section C

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

Return Reference - Identifier	Explanation
SCHEDULE H, PART V, SECTION B, LINE 3E - THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY	THE SIGNIFICANT HEALTH NEEDS ARE A PRIORITIZED DESCRIPTION OF THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY AS IDENTIFIED THROUGH THE CHNA SEE SCHEDULE H, PART V, LINE 7 FOR THE LINK TO THE CHNA AND SCHEDULE H, PART V, LINE 11 FOR HOW THOSE NEEDS ARE BEING ADDRESSED
SCHEDULE H, PART V, SECTION B, LINE 5 - INPUT FROM PERSONS WHO REPRESENT BROAD INTERESTS OF COMMUNITY SERVED	<p>FACILITY NAME PRESENCE UNITED SAMARITANS MEDICAL CENTER</p> <p>DESCRIPTION THE 2017-2022 VERMILION COUNTY COMMUNITY HEALTH PLAN (IPLAN) WAS ACCOMPLISHED WITH DIRECT CONTRIBUTION FROM THE VERMILION COUNTY HEALTH DEPARTMENT, THE EXECUTIVE COMMITTEE, THE REGIONAL COMMUNITY HEALTH PLAN COORDINATOR 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 COMMUNITY 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 REPRESENTATIVES, AND INPUT FROM OUR COUNTY RESIDENTS</p> <p>IN 2015, THE VERMILION COUNTY BOARD OF HEALTH 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 SUSTAINABILITY FOR THE HEALTH DEPARTMENT AS THE HEALTH DEPARTMENT CONTINUES TO SERVE THE CRITICAL NEEDS 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</p> <p>THE COMMUNITY PHASE OF THE PROCESS BEGAN DURING THE SUMMER OF 2016, AS STAFF WORKED TO COMPILE RELEVANT DATA FOR THE EXECUTIVE COMMITTEE AND THE COMMUNITY 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 REPRESENTATIVE COMMUNITY LEADERS WERE IDENTIFIED AND INVITED TO JOIN IN THE IPLAN PROCESS. THE COMMUNITY PARTNER PHASE OF THE IPLAN BEGAN IN JANUARY 2017.</p> <p>THE COMMUNITY ADVISORY COMMITTEE INVESTED A GREAT DEAL OF THOUGHT AND EFFORT INTO IDENTIFYING THE PRIORITY AREAS. IN THE PAST WE HAVE ONLY ADDRESSED THREE PRIORITY AREAS. THE COMMUNITY ADVISORY COMMITTEE DEMONSTRATED A GENUINE CONCERN TO WEIGH AND BALANCE ALL THE INFORMATION PROVIDED INCLUDING THE DATA PRESENTED, THEIR OWN BELIEFS, EXPERIENCES AND PERCEPTIONS AS COMMUNITY STAKEHOLDERS, AS WELL AS THE INFORMATION OBTAINED FROM OUR COUNTY RESIDENTS. THE COMMITTEE EXPRESSED CONSIDERABLE 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 ABOUT HOW MUCH OUR CHALLENGES ARE INTERRELATED WITH MANY OF THE CONTRIBUTING FACTORS BEING THE SAME FOR ALL PRIORITY AREAS INCLUDING EDUCATION, ABUSE, AND A LACK OF HOPE AND DREAMS OF A FUTURE.</p> <p>THE COMMUNITY ADVISORY COMMITTEE DISCUSSED STRATEGIES ABOUT BEING PROACTIVE IN OUR APPROACHES AND ENSURING ACTION AND A WAY TO MEASURE THOSE ACTIONS. AFTER DISCUSSION FROM THE FIRST MEETING, THE GROUP CONSENSUS WAS REACHED THAT WE WERE NOT FINISHED WITH THE CURRENT PRIORITIES AND STILL HAD 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 THROUGHOUT THE 2017-2022 PLAN.</p>
SCHEDULE H, PART V, SECTION B, LINE 6A - CHNA CONDUCTED WITH ONE OR MORE OTHER HOSPITAL FACILITIES	<p>FACILITY NAME PRESENCE UNITED SAMARITANS HOSPITAL</p> <p>DESCRIPTION PUSMC PARTNERED WITH HOOPESTON HOSPITAL TO COMPLETE THEIR CHNA</p>
SCHEDULE H, PART V, SECTION B, LINE 6B - CHNA CONDUCTED WITH ONE OR MORE ORGANIZATIONS OTHER THAN HOSPITAL FACILITIES	<p>FACILITY NAME PRESENCE UNITED SAMARITANS HOSPITAL</p> <p>DESCRIPTION SEE 990 SCHEDULE H PART V LINE 5 EXPLANATION</p>
SCHEDULE H, PART V, SECTION B, LINE 7 - HOSPITAL FACILITY'S WEBSITE (LIST URL)	HTTPS://WWW.OSFHEALTHCARE.ORG/ABOUT/COMMUNITY-HEALTH/

Return Reference - Identifier	Explanation
SCHEDULE H, PART V, SECTION B, LINE 7D - OTHER METHODS CHNA REPORT MADE WIDELY AVAILABLE	FACILITY NAME PRESENCE UNITED SAMARITANS HOSPITAL DESCRIPTION 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
SCHEDULE H, PART V, SECTION B, LINE 11 - HOW HOSPITAL FACILITY IS ADDRESSING NEEDS IDENTIFIED IN CHNA	FACILITY NAME PRESENCE UNITED SAMARITANS HOSPITAL DESCRIPTION THE TOP FOUR COMMUNITY HEALTH PRIORITIES TO BE ADDRESSED IN THE 2017-2022 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 2018 OBJECTIVES AND 2018 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
SCHEDULE H, PART V, SECTION B, LINE 13H - OTHER ELIGIBILITY CRITERIA FOR FINANCIAL ASSISTANCE	FACILITY NAME PRESENCE UNITED SAMARITANS HOSPITAL DESCRIPTION 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
SCHEDULE H, PART V, SECTION B, LINE 16A - FAP AVAILABLE WEBSITE	HTTP //PRESENCEHEALTH.ORG/FINANCIAL-ASSISTANCE
SCHEDULE H, PART V, SECTION B, LINE 16B - FAP APPLICATION FORM WEBSITE	HTTP //PRESENCEHEALTH.ORG/FINANCIAL-ASSISTANCE
SCHEDULE H, PART V, SECTION B, LINE 16C - PLAIN LANGUAGE FAP SUMMARY WEBSITE	HTTP //PRESENCEHEALTH.ORG/FINANCIAL-ASSISTANCE

SCHEDULE I
(Form 990)

Department of the Treasury
Internal Revenue Service
Name of the organization

**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
▶ Go to www.irs.gov/Form990 for the latest information

OMB No 1545-0047

2017

**Open to Public
Inspection**

PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK

Employer identification number
36-4195126

Part I General Information on Grants and Assistance

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

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

1 (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) WILL-GRUNDY MEDICAL CLINIC 213 E CASS STREET, JOLIET, IL 60432	36-3492306	501(C)(3)	35,000				(SEE STATEMENT)
(2) UNITED WAY OF WILL COUNTY 54 N OTTAWA ST SUITE 300 JOLIET IL 60432-4394	36-2515625	501(C)(3)	10,000				COMMUNITY PROGRAMS
(3) (SEE STATEMENT)	36-2188452	501(C)(3)	5,400				COMMUNITY PROGRAMS
(4) NORTHERN ILLINOIS FOOD BANK 273 DEARBORN STREET, GENEVA, IL 60134	36-3203648	501(C)(3)		7,897	FMV	(SEE STATEMENT)	COMMUNITY PROGRAMS
(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

▶ 4

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

▶ 0

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

Cat No 50055P

Schedule I (Form 990) (2017)

Part III can be duplicated in additional space if 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					
2					
3					
4					
5					
6					
7					

(SEE STATEMENT)

Part IV**Supplemental Information.** Provide the information required in Part I, line 2,¹ Part III, column (b), and any other additional information

Return Reference - Identifier	Explanation
SCHEDULE I, PART I, LINE 2 - PROCEDURES FOR MONITORING USE OF GRANT FUNDS	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
SCHEDULE I, PART II, COLUMN A - NAME AND ADDRESS OF ORGANIZATION OR GOVERNMENT	UNITED WAY OF KANKAKEE AND IROQUOIS COUNTIES P O BOX 1286, KANKAKEE, IL 60904-1286
SCHEDULE I, PART II, COLUMN G - DESCRIPTION OF NON-CASH ASSISTANCE	NORTHERN ILLINOIS FOOD BANK ASSOCIATE PARTICIPATION
SCHEDULE I, PART II, COLUMN H - PURPOSE OF GRANT OR ASSISTANCE	WILL-GRUNDY MEDICAL CLINIC MEDICAL SERVICES AND SUPPLIES

Department of the Treasury
Internal Revenue Service

- ▶ Complete if the organization answered "Yes" on Form 990, Part IV, lines 31 or 32; or Form 990-EZ, line 36
- ▶ Attach certified copies of any articles of dissolution, resolutions, or plans
- ▶ Attach to Form 990 or 990-EZ.
- ▶ Go to www.irs.gov/Form990 for the latest information

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 Liquidation, Termination, or Dissolution. Complete this part if the organization answered "Yes" on Form 990, Part IV, line 31, or Form 990-EZ, line 36. Part I can be duplicated if additional space is needed.

[illegible]

2 Did or will any officer, director, trustee, or key employee of the organization

a. Become a director or trustee of a successor or transferee organization?

b Become an employee of, or independent contractor for, a successor or transferee organization?

c. Become a direct or indirect owner of a successor or transferee organization?

d Receive, or become entitled to, compensation or other similar payments as a result of the organization's liquidation, termination, or dissolution?

e If the organization answered "Yes" to any of the questions on lines 2a through 2d, provide the name of the person involved and explain in Part III ►

	Yes	No
2a		
2b		
2c		
2d		

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

Cat No 50087Z

Schedule N (Form 990 or 990-EZ) 2017

Part I Liquidation, Termination, or Dissolution (continued)

Note: If the organization distributed all of its assets during the tax year, then Form 990, Part X, column (B), line 16 (Total assets), and line 26 (Total liabilities), should equal -0-

	Yes	No
3 Did the organization distribute its assets in accordance with its governing instrument(s)? If "No," describe in Part III		
4a Is the organization required to notify the attorney general or other appropriate state official of its intent to dissolve, liquidate, or terminate?		
b If "Yes," did the organization provide such notice?		
5 Did the organization discharge or pay all of its liabilities in accordance with state laws?		
6a Did the organization have any tax-exempt bonds outstanding during the year?		
b If "Yes" to line 6a, did the organization discharge or defease all of its tax-exempt bond liabilities during the tax year in accordance with the Internal Revenue Code and state laws?		
c If "Yes" on line 6b, describe in Part III how the organization defeased or otherwise settled these liabilities. If "No" on line 6b, explain in Part III		

Part II Sale, Exchange, Disposition, or Other Transfer of More Than 25% of the Organization's Assets. Complete this part if the organization answered "Yes" on Form 990, Part IV, line 32, or Form 990-EZ, line 36. Part II can be duplicated if additional space is needed.

1	(a) Description of asset(s) distributed or transaction expenses paid	(b) Date of distribution	(c) Fair market value of asset(s) distributed or amount of transaction expenses	(d) Method of determining FMV for asset(s) distributed or transaction expenses	(e) EIN of recipient	(f) Name and address of recipient	(g) IRC section of recipient(s) (if tax-exempt) or type of entity
	REAL ESTATE	02/01/2018	46,225,974	BOOK VALUE	37-0813229	OSF HEALTHCARE SYSTEM 800 NE GLEN OAK AVENUE, PEORIA, IL 61603-3200	501(C)(3)
	PERSONAL PROPERTY AND INTANGIBLES	02/01/2018	30,679,942	BOOK VALUE	37-0813229	OSF HEALTHCARE SYSTEM 800 NE GLEN OAK AVENUE, PEORIA, IL 61603-3200	501(C)(3)

	Yes	No
2 Did or will any officer, director, trustee, or key employee of the organization		
a Become a director or trustee of a successor or transferee organization?		✓
b Become an employee of, or independent contractor for, a successor or transferee organization?		✓
c Become a direct or indirect owner of a successor or transferee organization?		✓
d Receive, or become entitled to, compensation or other similar payments as a result of the organization's significant disposition of assets?		✓
e If the organization answered "Yes" to any of the questions on lines 2a through 2d, provide the name of the person involved and explain in Part III		

Schedule N (Form 990 or 990-EZ) 2017

Part III**Supplemental Information.** Provide the information required by Part I, lines 2e and 6c, and Part II, line 2e. Also complete this part to provide any additional information.

Return Reference - Identifier	Explanation
SCHEDULE N, PART II - SALE OF PRESENCE UNITED SAMARITANS HOSPITAL AND PRESENCE COVENANT MEDICAL CENTER	ON FEBRUARY 1, 2018 PRESENCE UNITED SAMARITANS HOSPITAL (PUSMC) AND PRESENCE COVENANT MEDICAL CENTER (PCMC) AND THEIR ULTIMATE PARENT ENTITY, PRESENCE HEALTH NETWORK (PHN), CLOSED ON THE SALE OF SUBSTANTIALLY ALL THE ASSETS OF PUSMC AND PCMC TO OSF HEALTHCARE SYSTEM. AS PUSMC, PCMC AND PHN ARE TAX EXEMPT UNDER IRC SECTION 501(C)(3) AND SUBSTANTIALLY ALL OF THE ASSETS ARE RELATED-USE ASSETS, THIS SALE WAS NOT SUBJECT TO FEDERAL OR STATE INCOME TAX.

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

- ▶ Attach to Form 990 or 990-EZ
- ▶ Go to www.irs.gov/Form990 for the latest information

OMB No 1545-0047

2017

Open to Public Inspection

Name of the Organization
PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORKEmployer Identification Number
36-4195126

Return Reference - Identifier	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 MARY'S 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 MARY'S HOSPITAL FOUNDATION - PRESENCE UNITED SAMARITANS MEDICAL CENTER FOUNDATION - PRESENCE N E W YOU CENTER - AMITA HEALTH MERCY MEDICAL CENTER AURORA - AMITA HEALTH SAINT JOSEPH HOSPITAL ELGIN - AMITA HEALTH SAINT JOSEPH MEDICAL CENTER JOLIET - AMITA HEALTH ST MARY'S HOSPITAL KANKAKEE
FORM 990, PART III, LINE 3 - SIGNIFICANT CHANGES IN PROGRAM SERVICES	ON FEBRUARY 1, 2018 PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK CLOSED ON THE SALE OF SUBSTANTIALLY ALL OF THE ASSETS OF PRESENCE UNITED SAMARITANS HOSPITAL AND PRESENCE COVENANT MEDICAL CENTER TO OSF HEALTHCARE SYSTEM
FORM 990, PART III, LINE 4A - PROGRAM SERVICE DESCRIPTION	<p>PRESENCE COVENANT MEDICAL CENTER IS A 190-BED HOSPITAL CAMPUS PROVIDING SERVICES WITHOUT REGARD TO PATIENT RACE, CREED, NATIONAL ORIGIN, ECONOMIC STATUS, OR ABILITY TO PAY DURING JANUARY 1, 2018 - JUNE 30, 2018, PRESENCE COVENANT MEDICAL CENTER TREATED 825 ADULTS AND CHILDREN FOR A TOTAL OF 2,635 PATIENT DAYS OF SERVICE THE HOSPITAL ALSO PROVIDED SERVICES FOR 8,976 OUTPATIENT VISITS, WHICH INCLUDED 295 OUTPATIENT SURGERIES AND 1,962 EMERGENCY ROOM VISITS</p> <p>PRESENCE ST MARY'S HOSPITAL IS A 210-BED HOSPITAL CAMPUS PROVIDING SERVICES WITHOUT REGARD TO PATIENT RACE, CREED, NATIONAL ORIGIN, ECONOMIC STATUS, OR ABILITY TO PAY DURING JANUARY 1, 2018 - JUNE 30, 2018, PRESENCE ST MARY'S HOSPITAL TREATED 3,378 ADULTS AND CHILDREN FOR A TOTAL OF 11,724 PATIENT DAYS OF SERVICE THE HOSPITAL ALSO PROVIDED SERVICES FOR 25,795 OUTPATIENT VISITS, WHICH INCLUDED 1,713 OUTPATIENT SURGERIES AND 14,453 EMERGENCY ROOM VISITS</p> <p>PRESENCE ST JOSEPH MEDICAL CENTER IS A 465-BED HOSPITAL CAMPUS PROVIDING SERVICES WITHOUT REGARD TO PATIENT RACE, CREED, NATIONAL ORIGIN, ECONOMIC STATUS, OR ABILITY TO PAY DURING JANUARY 1, 2018 - JUNE 30, 2018, PRESENCE ST JOSEPH MEDICAL CENTER TREATED 13,925 ADULTS AND CHILDREN FOR A TOTAL OF 51,592 PATIENT DAYS OF SERVICE THE HOSPITAL ALSO PROVIDED SERVICES FOR 121,741 OUTPATIENT VISITS, WHICH INCLUDED 3,197 OUTPATIENT SURGERIES AND 28,569 EMERGENCY ROOM VISITS</p> <p>PRESENCE ST JOSEPH HOSPITAL - ELGIN IS A 184-BED HOSPITAL CAMPUS PROVIDING SERVICES WITHOUT REGARD TO PATIENT RACE, CREED, NATIONAL ORIGIN, ECONOMIC STATUS, OR ABILITY TO PAY DURING JANUARY 1, 2018 - JUNE 30, 2018, PRESENCE ST JOSEPH HOSPITAL - ELGIN TREATED 4,423 ADULTS AND CHILDREN FOR A TOTAL OF 20,347 PATIENT DAYS OF SERVICE THE HOSPITAL ALSO PROVIDED SERVICES FOR 53,686 OUTPATIENT VISITS, WHICH INCLUDED 1,115 OUTPATIENT SURGERIES AND 12,459 EMERGENCY ROOM VISITS</p> <p>PRESENCE MERCY MEDICAL CENTER IS A 247-BED HOSPITAL CAMPUS PROVIDING SERVICES WITHOUT REGARD TO PATIENT RACE, CREED, NATIONAL ORIGIN, ECONOMIC STATUS, OR ABILITY TO PAY DURING JANUARY 1, 2018 - JUNE 30, 2018, PRESENCE MERCY MEDICAL CENTER TREATED 5,705 ADULTS AND CHILDREN FOR A TOTAL OF 20,691 PATIENT DAYS OF SERVICE THE HOSPITAL ALSO PROVIDED SERVICES FOR 59,654 OUTPATIENT VISITS, WHICH INCLUDED 787 OUTPATIENT SURGERIES AND 19,180 EMERGENCY ROOM VISITS</p> <p>SEE SCHEDULE H FOR A NON-EXHAUSTIVE LIST OF COMMUNITY BENEFIT PROGRAMS AND DESCRIPTIONS</p>
FORM 990, PART IV, LINE 20B - AUDITED FINANCIAL STATEMENT	THE ACTIVITY OF PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK IS REPORTED IN THE CONSOLIDATED FINANCIAL STATEMENTS OF ASCENSION HEALTH ALLIANCE NO INDIVIDUAL AUDIT OF PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK IS COMPLETED THEREFORE, THE AUDITED FINANCIAL STATEMENTS ARE OF ASCENSION HEALTH ALLIANCE AND AFFILIATES, WHICH INCLUDE THE ACTIVITY OF PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK

Return Reference - Identifier	Explanation
FORM 990, PART VI, LINE 4 - SIGNIFICANT CHANGES TO ORGANIZATIONAL DOCUMENTS	<p>THE ORGANIZATION'S ARTICLES AND BYLAWS WERE AMENDED EFFECTIVE MARCH 1, 2018 TO REFLECT THE TRANSITION OF SPONSORSHIP OF PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK TO ASCENSION HEALTH. THE CORPORATE MEMBER OF PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK CONTINUES TO BE IN ILLINOIS. ADDITIONALLY, THE BOARD SIZE FOR PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK WAS CHANGED FROM NOT LESS THAN 5 AND NOT MORE THAN 7 TO NOT LESS THAN 3 AND NOT MORE THAN 8 DIRECTORS.</p> <p>PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK IS PART OF AN AFFILIATION COMPRISING A REGIONAL COMPREHENSIVE HEALTH CARE DELIVERY NETWORK OPERATED AND MANAGED BY ALEXIAN BROTHERS - AHS MIDWEST REGION HEALTH CO. (THE "JOINT OPERATING COMPANY" OR "AMITA"). THE JOINT OPERATING COMPANY IS A FINANCIALLY AND OPERATIONALLY INTEGRATED ORGANIZATION THAT MANAGES AND OPERATES THE COVERED AFFILIATES, WHICH INCLUDES PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK.</p>
FORM 990, PART VI, LINE 6 - CLASSES OF MEMBERS OR STOCKHOLDERS	PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK HAS A SINGLE CORPORATE MEMBER, PRESENCE CARE TRANSFORMATION CORPORATION.
FORM 990, PART VI, LINE 7A - MEMBERS OR STOCKHOLDERS ELECTING MEMBERS OF GOVERNING BODY	PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK HAS A SINGLE CORPORATE MEMBER, PRESENCE CARE TRANSFORMATION CORPORATION, WHO HAS THE ABILITY TO ELECT MEMBERS TO THE GOVERNING BODY OF PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK.
FORM 990, PART VI, LINE 7B - DECISIONS REQUIRING APPROVAL BY MEMBERS OR STOCKHOLDERS	ALL DECISIONS THAT HAVE A MATERIAL IMPACT TO PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK'S FINANCIAL INFORMATION OR CORPORATION AS A WHOLE ARE SUBJECT TO APPROVAL BY ITS SOLE CORPORATE MEMBER, PRESENCE CARE TRANSFORMATION CORPORATION.
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.
FORM 990, PART VI, LINE 12C - CONFLICT OF INTEREST POLICY	THE ORGANIZATION REGULARLY AND CONSISTENTLY MONITORS AND ENFORCES COMPLIANCE WITH THE CONFLICT OF INTEREST POLICY IN THAT ANY DIRECTOR, PRINCIPAL OFFICER, OR MEMBER OF A COMMITTEE WITH GOVERNING BOARD DELEGATED POWERS, WHO HAS A DIRECT OR INDIRECT FINANCIAL INTEREST, MUST DISCLOSE THE EXISTENCE OF THE FINANCIAL INTEREST AND BE GIVEN THE OPPORTUNITY TO DISCLOSE ALL MATERIAL FACTS TO THE DIRECTORS AND MEMBERS OF THE COMMITTEES WITH GOVERNING BOARD DELEGATED POWERS. CONSIDERING THE PROPOSED TRANSACTION OR ARRANGEMENT, THE REMAINING INDIVIDUALS ON THE GOVERNING BOARD OR COMMITTEE WILL DECIDE IF CONFLICTS OF INTEREST EXIST. EACH DIRECTOR, PRINCIPAL OFFICER AND MEMBER OF A COMMITTEE WITH GOVERNING BOARD DELEGATED POWERS ANNUALLY SIGNS A STATEMENT WHICH AFFIRMS SUCH PERSON HAS RECEIVED A COPY OF THE CONFLICTS OF INTEREST POLICY, HAS READ AND UNDERSTANDS THE POLICY, HAS AGREED TO COMPLY WITH THE POLICY, AND UNDERSTANDS THAT THE ORGANIZATION IS CHARITABLE AND IN ORDER TO MAINTAIN ITS FEDERAL TAX EXEMPTION IT MUST ENGAGE PRIMARILY IN ACTIVITIES WHICH ACCOMPLISH ITS TAX-EXEMPT PURPOSE.
FORM 990, PART VI, LINE 15A - PROCESS FOR DETERMINING EXECUTIVE COMPENSATION	<p>THROUGH FEBRUARY 28, 2018, COMPENSATION FOR THE CORPORATION'S CEO WAS 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 USED MARKET DATA COMPILED BY AN INDEPENDENT COMPENSATION CONSULTANT TO ESTABLISH BASE SALARIES AND TOTAL CASH COMPENSATION OPPORTUNITIES. THE HUMAN RESOURCES COMMITTEE MONITORED EXECUTIVE TOTAL COMPENSATION BY APPROVING ALL COMPONENTS OF EXECUTIVE TOTAL COMPENSATION, AND ANNUALLY REVIEWED AND APPROVED COMPENSATION CHANGES FOR EACH EXECUTIVE.</p> <p>ON MARCH 1, 2018, PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK BECAME AN AFFILIATE OF ASCENSION HEALTH AND JOINED ALEXIAN BROTHERS - AHS MIDWEST REGION HEALTH CO. WHEN IT WAS ACQUIRED BY ASCENSION HEALTH. IN DETERMINING COMPENSATION OF THE ORGANIZATION'S CEO, THE PROCESS PERFORMED BY ALEXIAN BROTHERS - AHS MIDWEST REGION HEALTH CO., A RELATED ORGANIZATION OF PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK, INCLUDED A REVIEW AND APPROVAL BY INDEPENDENT PERSONS, COMPARABILITY DATA, AND CONTEMPORANEOUS SUBSTANTIATION OF THE DELIBERATION AND DECISION. THE ALEXIAN BROTHERS - AHS MIDWEST REGION HEALTH CO. EXECUTIVE COMPENSATION COMMITTEE REVIEWED AND APPROVED THE COMPENSATION. IN THE REVIEW OF THE COMPENSATION, THE CEO WAS COMPARED TO INDIVIDUALS AT OTHER ORGANIZATIONS IN THE AREA WHO HOLD THE SAME TITLE. DURING THE REVIEW AND APPROVAL OF THE COMPENSATION, DOCUMENTATION OF THE DECISION WAS RECORDED IN THE MINUTES. THE INDIVIDUAL WAS NOT PRESENT WHEN HIS COMPENSATION WAS DECIDED.</p>

Return Reference - Identifier	Explanation																																												
FORM 990, PART VI, LINE 15B - PROCESS FOR DETERMINING OFFICER COMPENSATION	<p>THROUGH FEBRUARY 28, 2018 COMPENSATION FOR THE CORPORATION'S OTHER OFFICERS OR KEY EMPLOYEES WAS 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 USED MARKET DATA COMPILED BY AN INDEPENDENT COMPENSATION CONSULTANT TO ESTABLISH BASE SALARIES AND TOTAL CASH COMPENSATION OPPORTUNITIES. THE HUMAN RESOURCES COMMITTEE MONITORED EXECUTIVE TOTAL COMPENSATION BY APPROVING ALL COMPONENTS OF EXECUTIVE TOTAL COMPENSATION, AND ANNUALLY REVIEWED AND APPROVED COMPENSATION CHANGES FOR EACH EXECUTIVE.</p> <p>ON MARCH 1, 2018 PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK BECAME AN AFFILIATE OF ASCENSION HEALTH AND JOINED ALEXIAN BROTHERS - AHS MIDWEST REGION HEALTH CO. WHEN IT WAS ACQUIRED BY ASCENSION HEALTH. IN DETERMINING COMPENSATION OF THE ORGANIZATION'S OFFICERS OR KEY EMPLOYEES, THE PROCESS PERFORMED BY ALEXIAN BROTHERS - AHS MIDWEST REGION HEALTH CO., A RELATED ORGANIZATION OF PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK, INCLUDED A REVIEW AND APPROVAL BY INDEPENDENT PERSONS, COMPARABILITY DATA, AND CONTEMPORANEOUS SUBSTANTIATION OF THE DELIBERATION AND DECISION. THE ALEXIAN BROTHERS - AHS MIDWEST REGION HEALTH CO. EXECUTIVE COMPENSATION COMMITTEE REVIEWED AND APPROVED THE COMPENSATION. IN THE REVIEW OF THE COMPENSATION, THE OFFICER'S SALARIES WERE COMPARED TO INDIVIDUALS AT OTHER ORGANIZATIONS IN THE AREA WHO HOLD THE SAME TITLE. DURING THE REVIEW AND APPROVAL OF THE COMPENSATION, DOCUMENTATION OF THE DECISION WAS RECORDED IN THE MINUTES. INDIVIDUALS WERE NOT PRESENT WHEN THEIR COMPENSATION WAS DECIDED.</p>																																												
FORM 990, PART VI, LINE 19 - REQUIRED DOCUMENTS AVAILABLE TO THE PUBLIC	THE ORGANIZATION WILL PROVIDE ANY DOCUMENTS OPEN TO PUBLIC INSPECTION UPON REQUEST.																																												
FORM 990, PART VII, SECTION A - REPORTABLE COMPENSATION	THERE IS NO REPORTABLE COMPENSATION FOR THE OFFICERS, DIRECTORS, AND TRUSTEES BECAUSE THIS IS A SHORT TAX YEAR RETURN BEGINNING JANUARY 1, 2018 AND ENDING JUNE 30, 2018. THUS NO CALENDAR YEAR IS ENDING WITH OR WITHIN THE ORGANIZATION'S TAX YEAR FOR WHICH COMPENSATION WOULD BE REPORTED. IN ADDITION, THERE ARE NO KEY EMPLOYEES, HIGHEST COMPENSATED EMPLOYEES, OR FORMERS IDENTIFIED BECAUSE THERE IS NO COMPENSATION TO DEFINE THOSE THAT SHOULD BE INCLUDED.																																												
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.																																												
FORM 990, PART IX, LINE 11G - OTHER FEES FOR SERVICES	<table><tr><th>(a) Description</th><th>(b) Total Expenses</th><th>(c) Program Service Expenses</th><th>(d) Management and General Expenses</th><th>(e) Fundraising Expenses</th></tr><tr><td>PHYSICIAN FEES</td><td>16,148,572</td><td>16,148,572</td><td></td><td></td></tr><tr><td>TEMPORARY AGENCY LABOR</td><td>904,514</td><td>904,514</td><td></td><td></td></tr><tr><td>CONTRACTED SERVICES/MANAGEMENT</td><td>12,181,849</td><td>12,181,849</td><td></td><td></td></tr><tr><td>LABORATORY SERVICES</td><td>14,296,807</td><td>14,296,807</td><td></td><td></td></tr><tr><td>FOOD MANAGEMENT SERVICES</td><td>1,728,391</td><td>1,728,391</td><td></td><td></td></tr><tr><td>LAUNDRY HOUSEKEEPING AND FACILITIES SERVICES</td><td>1,391,200</td><td>1,391,200</td><td></td><td></td></tr><tr><td>OTHER PURCHASED SERVICES</td><td>11,117,632</td><td>11,117,632</td><td></td><td></td></tr></table>					(a) Description	(b) Total Expenses	(c) Program Service Expenses	(d) Management and General Expenses	(e) Fundraising Expenses	PHYSICIAN FEES	16,148,572	16,148,572			TEMPORARY AGENCY LABOR	904,514	904,514			CONTRACTED SERVICES/MANAGEMENT	12,181,849	12,181,849			LABORATORY SERVICES	14,296,807	14,296,807			FOOD MANAGEMENT SERVICES	1,728,391	1,728,391			LAUNDRY HOUSEKEEPING AND FACILITIES SERVICES	1,391,200	1,391,200			OTHER PURCHASED SERVICES	11,117,632	11,117,632		
(a) Description	(b) Total Expenses	(c) Program Service Expenses	(d) Management and General Expenses	(e) Fundraising Expenses																																									
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TEMPORARY AGENCY LABOR	904,514	904,514																																											
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FOOD MANAGEMENT SERVICES	1,728,391	1,728,391																																											
LAUNDRY HOUSEKEEPING AND FACILITIES SERVICES	1,391,200	1,391,200																																											
OTHER PURCHASED SERVICES	11,117,632	11,117,632																																											
FORM 990, PART XI, LINE 9 - OTHER CHANGES IN NET ASSETS OR FUND BALANCES	<table><tr><th>(a) Description</th><th>(b) Amount</th></tr><tr><td>FAIR VALUE ADJUSTMENTS TO PROPERTY PLANT AND EQUIPMENT</td><td>- 61,755,458</td></tr><tr><td>INTERCOMPANY TRANSFER TO AFFILIATES</td><td>- 203,829,426</td></tr></table>					(a) Description	(b) Amount	FAIR VALUE ADJUSTMENTS TO PROPERTY PLANT AND EQUIPMENT	- 61,755,458	INTERCOMPANY TRANSFER TO AFFILIATES	- 203,829,426																																		
(a) Description	(b) Amount																																												
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INTERCOMPANY TRANSFER TO AFFILIATES	- 203,829,426																																												
FORM 990, PART XII, LINE 2C - CHANGE OF OVERSIGHT PROCESS OR SELECTION PROCESS	PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK IS INCLUDED IN THE CONSOLIDATED FINANCIAL STATEMENTS OF ASCENSION HEALTH ALLIANCE. THE FINANCE AND AUDIT COMMITTEE OF ASCENSION HEALTH ALLIANCE'S BOARD ASSUMES RESPONSIBILITY FOR THE CONSOLIDATED ORGANIZATION AS A WHOLE.																																												

**SCHEDULE R
(Form 990)**Department of the Treasury
Internal Revenue Service

Name of the organization

PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK

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.

▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No 1545-0047

2017**Open to Public
Inspection**

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 (80-0811427) 26 W NEWELL, DANVILLE, IL 61834	MEDICAL SERVICES	IL	0	0	PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK
(2)					
(3)					
(4)					
(5)					
(6)					

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) (SEE STATEMENT)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							

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

Cat No 50135Y

Schedule R (Form 990) 2017

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) (SEE STATEMENT)												
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												

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) (SEE STATEMENT)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									

Schedule R (Form 990) 2017

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

	Yes	No
1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II–IV?		
a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity		✓
b Gift, grant, or capital contribution to related organization(s)		✓
c Gift, grant, or capital contribution from related organization(s)	✓	
d Loans or loan guarantees to or for related organization(s)		✓
e Loans or loan guarantees by related organization(s)		✓
f Dividends from related organization(s)		✓
g Sale of assets to related organization(s)		✓
h Purchase of assets from related organization(s)		✓
i Exchange of assets with related organization(s)		✓
j Lease of facilities, equipment, or other assets to related organization(s)		✓
k Lease of facilities, equipment, or other assets from related organization(s)		✓
l Performance of services or membership or fundraising solicitations for related organization(s)		✓
m Performance of services or membership or fundraising solicitations by related organization(s)	✓	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)		✓
o Sharing of paid employees with related organization(s)	✓	
p Reimbursement paid to related organization(s) for expenses	✓	
q Reimbursement paid by related organization(s) for expenses		✓
r Other transfer of cash or property to related organization(s)	✓	
s Other transfer of cash or property from related organization(s)		✓

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
PRESENCE HEALTH FOUNDATION BOARD OF TRUSTEES	C	1,356,853	CASH
(1) PRESENCE CARE TRANSFORMATION CORPORATION	M	53,795,408	COST ALLOCATION
(2) PRESENCE CARE TRANSFORMATION CORPORATION	P	391,957,378	COST
(3) PRESENCE CARE TRANSFORMATION CORPORATION	R	203,829,426	BOOK VALUE
(4)			
(5)			
(6)			

Schedule R (Form 990) 2017

Part VI Unrelated Organizations Taxable as a Partnership. Complete if the organization answered "Yes" on Form 990, Part IV, line 37

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512–514)	(e) Are all partners section 501(c)(3) organizations?		(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V—UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
				Yes	No			Yes	No		Yes	No	
(1)													
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
(9)													
(10)													
(11)													
(12)													
(13)													
(14)													
(15)													
(16)													

Schedule R (Form 990) 2017

Part II Identification of Related Tax-Exempt Organizations (continued)

(a) Name, address and EIN of related organization	(b) Primary Activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) ASCENSION HEALTH ALLIANCE (45-3358926) P O BOX 45998, ST LOUIS, MO 63145-5998	NATIONAL HEALTH SYSTEM	MO	501(C)(3)	12 TYPE I	N/A		✓
(2) ASCENSION HEALTH (31-1662309) P O BOX 45998, ST LOUIS, MO 63145	NATIONAL HEALTH SYSTEM	MO	501(C)(3)	12 TYPE I	ASCENSION HEALTH ALLIANCE		✓
(3) ALEXIAN BROTHERS - AHS MIDWEST REGION HEALTH CO (47-2360513) 2601 NAVISTAR DRIVE, LISLE, IL 60532	JOINT OPERATING COMPANY	IL	501(C)(3)	12 TYPE II	N/A		✓
(4) ALEXIAN BROTHERS HEALTH SYSTEM (36-3260495) 200 SOUTH WACKER DRIVE, CHICAGO, IL 60606	SUPPORTS THE PROVISION OF HEALTHCARE SERVICES FOR RELATED CORPORATIONS FOR WHICH IT IS A MEMBER	IL	501(C)(3)	12 TYPE III-FI	ASCENSION HEALTH		✓
(5) ALEXIAN BROTHERS BONAVENTURE HOUSE D/B/A ALEXIAN BROTHERS THE HARBOR AND ALEXIAN BROTHERS HOUSING AND HEALTH ALLIANCE (36-3527899) 825 WELLINGTON AVENUE, CHICAGO, IL 60657	HOUSING AND SUPPORTIVE CARE SERVICES FOR PERSONS WITH HIV/AIDS	IL	501(C)(3)	10	ALEXIAN BROTHERS HEALTH SYSTEM		✓
(6) ALEXIAN BROTHERS OF SAN JOSE, INC (94-1530037) 2601 NAVISTAR DRIVE, LISLE, IL 60532	ACUTE CARE HOSPITAL (SOLD IN 1998)	TX	501(C)(3)	12 TYPE I	ALEXIAN BROTHERS HEALTH SYSTEM		✓
(7) ALEXIAN BROTHERS SERVICES, INC (43-1295333) 2601 NAVISTAR DRIVE, LISLE, IL 60532	HUD HOUSING	MO	501(C)(3)	10	ALEXIAN BROTHERS HEALTH SYSTEM		✓
(8) ALEXIAN BROTHERS HOSPITAL NETWORK (36-3276552) 2601 NAVISTAR DRIVE, LISLE, IL 60532	SUPPORTS THE PROVISION OF HEALTHCARE SERVICES FOR RELATED CORPORATIONS	IL	501(C)(3)	12 TYPE III-FI	ALEXIAN BROTHERS HEALTH SYSTEM		✓
(9) ALEXIAN BROTHERS MEDICAL CENTER (36-2596381) 800 BIESTERFIELD ROAD, ELK GROVE VILLAGE, IL 60007	ACUTE CARE HOSPITAL	TX	501(C)(3)	3	ALEXIAN BROTHERS HEALTH SYSTEM		✓
(10) SAVELLI PROPERTIES, INC (36-3308965) 2601 NAVISTAR DRIVE, LISLE, IL 60532	OWNS OR LEASES PROPERTIES WHERE HEALTHCARE SERVICES ARE DELIVERED	IL	501(C)(2)		ALEXIAN BROTHERS HEALTH SYSTEM		✓
(11) ALEXIAN BROTHERS BEHAVIORAL HEALTH HOSPITAL (36-4251848) 1550 MOON LAKE BLVD, HOFFMAN ESTATES, IL 60169	BEHAVIORAL HEALTH HOSPITAL	IL	501(C)(3)	3	ALEXIAN BROTHERS HEALTH SYSTEM		✓
(12) ST ALEXIUS MEDICAL CENTER (36-4251846) 1555 BARRINGTON ROAD, HOFFMAN ESTATES, IL 60194	ACUTE CARE HOSPITAL	IL	501(C)(3)	3	ALEXIAN BROTHERS HEALTH SYSTEM		✓
(13) ALEXIAN BROTHERS AMBULATORY GROUP (36-4336931) 2601 NAVISTAR DRIVE, LISLE, IL 60532	PHYSICIAN SERVICES	IL	501(C)(3)	3	ALEXIAN BROTHERS HEALTH SYSTEM		✓

(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
(14) ALEXIAN BROTHERS SPECIALTY GROUP (80-0710751) 2601 NAVISTAR DRIVE, Lisle, IL 60532	SPECIALTY PHYSICIAN PRACTICE GROUP	IL	501(C)(3)	3	ALEXIAN BROTHERS HEALTH SYSTEM		✓
(15) ALEXIAN BROTHERS CENTER FOR MENTAL HEALTH (36-3045007) 3436 N KENNICOTT AVENUE, ARLINGTON HEIGHTS, IL 60004	OUTPATIENT COMMUNITY MENTAL HEALTH SERVICES	IL	501(C)(3)	10	ALEXIAN BROTHERS HEALTH SYSTEM		✓
(16) ALEXIAN BROTHERS MEDICAL CARE GROUP, NFP (47-1930457) 2601 NAVISTAR DRIVE, Lisle, IL 60532	PHYSICIAN SERVICES	IL	501(C)(3)	3	ALEXIAN BROTHERS HEALTH SYSTEM		✓
(17) ALEXIAN BROTHERS MEDICAL GROUP SPECIALTY CARE (81-1110738) 2601 NAVISTAR DRIVE, Lisle, IL 60532	SPECIALTY PHYSICIAN PRACTICE GROUP	IL	501(C)(3)	3	ALEXIAN BROTHERS HEALTH SYSTEM		✓
(18) PRESENCE CARE TRANSFORMATION CORPORATION (36-3366652) 200 SOUTH WACKER DRIVE, CHICAGO, IL 60606	MGMT SUPPORT	IL	501(C)(3)	12 TYPE III-FI	ALEXIAN BROTHERS HEALTH SYSTEM		✓
(19) PRESENCE HEALTH PARTNERS SERVICES (36-2644178) 2380 E DEMPSTER AVE, STE 236, DES PLAINES, IL 60016	HEALTH CARE	IL	501(C)(3)	12 TYPE II	ALEXIAN BROTHERS HEALTH SYSTEM		✓
(20) PRESENCE HEALTH FOUNDATION BOARD OF TRUSTEES (36-3330929) 200 SOUTH WACKER DRIVE, CHICAGO, IL 60606	FUNDRAISING	IL	501(C)(3)	7	ALEXIAN BROTHERS HEALTH SYSTEM		✓
(21) PRESENCE HEALTH NETWORK (36-1649520) 200 SOUTH WACKER DRIVE, CHICAGO, IL 60606	PARENT CORP	IL	501(C)(3)	12 TYPE III-FI	N/A - SEE NOTE IN PART VII		✓
(22) PRESENCE BEHAVIORAL HEALTH (36-2709982) 1820 SOUTH 25TH AVENUE, BROADVIEW, IL 60155	HEALTH CARE	IL	501(C)(3)	3	PRESENCE CARE TRANSFORMATION CORPORATION	✓	
(23) PRESENCE AMBULATORY SERVICES (36-4286236) 2380 E DEMPSTER STREET, DES PLAINES, IL 60016	HEALTH CARE	IL	501(C)(3)	10	PRESENCE CARE TRANSFORMATION CORPORATION	✓	
(24) PRESENCE CHICAGO HOSPITALS NETWORK (36-2235165) 200 SOUTH WACKER DRIVE, CHICAGO, IL 60606	HEALTH CARE	IL	501(C)(3)	3	PRESENCE CARE TRANSFORMATION CORPORATION	✓	
(25) PRESENCE HEALTHCARE SERVICES (36-3330928) 2380 E DEMPSTER STREET, DES PLAINES, IL 60016	HEALTH CARE	IL	501(C)(3)	10	PRESENCE CARE TRANSFORMATION CORPORATION	✓	
(26) RAINBOW HOSPICE AND PALLIATIVE CARE (36-3296367) 1550 BISHOP COURT, MOUNT PROSPECT, IL 60056	HEALTH CARE	IL	501(C)(3)	10	PRESENCE CARE TRANSFORMATION CORPORATION	✓	

(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
(27) PRESENCE LIFE CONNECTIONS (37-1127787) 18927 HICKORY CREEK DR 300, MOKENA, IL 60448	HEALTH CARE	IL	501(C)(3)	10	PRESENCE CARE TRANSFORMATION CORPORATION (THROUGH 2/28/18) - SEE NOTE IN PART VII		✓
(28) PRESENCE SENIOR SERVICES - CHICAGOLAND (23-7061646) 100 NORTH RIVER ROAD, DES PLAINES, IL 60016	HEALTH CARE	IL	501(C)(3)	10	PRESENCE CARE TRANSFORMATION CORPORATION (THROUGH 2/28/18) - SEE NOTE IN PART VII		✓
(29) ALVERNO PROVENA HOSPITAL LABORATORIES, INC (20-3238867) 2434 INTERSTATE PLAZA DRIVE, HAMMOND, IN 46234	HEALTH CARE	IN	501(C)(3)	3	PRESENCE CENTRAL & SUBURBAN HOSPITALS NETWORK AND PRESENCE CHICAGO HOSPITALS NETWORK	✓	
(30) RESURRECTION UNIVERSITY (36-2182170) 1431 N CLAREMONT, CHICAGO, IL 60622	EDUCATION	IL	501(C)(3)	2	PRESENCE HEALTH NETWORK - SEE NOTE IN PART VII		✓
(31) MEDICARE VALUE PARTNERS (36-3495969) 100 NORTH RIVER ROAD, DES PLAINES, IL 60016	HEALTH CARE	IL	501(C)(3)	10	PRESENCE HEALTH PARTNERS SERVICES	✓	
(32) LAVERNA TERRACE HOUSING CORPORATION (36-3438977) 18927 HICKORY CREEK DR 300, MOKENA, IL 60448	SENIOR LIVING	IL	501(C)(3)	10	PRESENCE LIFE CONNECTIONS (THROUGH 2/28/18) - SEE NOTE IN PART VII		✓
(33) ARTHUR MERKLE - CLARA KNIPPRATH NURSING (36-2841358) 1190 E 2900 N ROAD, CLIFTON, IL 60927	HEALTH CARE	IL	501(C)(3)	10	PRESENCE LIFE CONNECTIONS (THROUGH 2/28/18) - SEE NOTE IN PART VII		✓
(34) PRESENCE HOME CARE (46-0483581) 18927 HICKORY CREEK DR 300, MOKENA, IL 60448	HEALTH CARE	IL	501(C)(3)	10	PRESENCE CARE TRANSFORMATION CORPORATION	✓	
(35) PRESENCE CARE @ HOME (46-0483587) 18927 HICKORY CREEK DR 300, MOKENA, IL 60448	HEALTH CARE	IL	501(C)(3)	10	PRESENCE CARE TRANSFORMATION CORPORATION	✓	

Part III Identification of Related Organizations Taxable as a Partnership (continued)

(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) ALEXIAN REHABILITATION SERVICES, LLC (30-0221481) 935 BEISNER, ELK GROVE VILLAGE, IL 60007	REHABILITATION HOSPITAL	IL	N/A	N/A	N/A	N/A			N/A			N/A
(2) BONAVENTURE MEDICAL FOUNDATION, LLC (36-3978153) 2601 NAVISTAR DRIVE, LISLE, IL 60532	MANAGES MANAGED CARE CONTRACTS	DE	N/A	N/A	N/A	N/A			N/A			N/A
(3) ST. ALEXIUS CENTER FOR SLEEP HEALTH, LLC (20-5876371) 1300 S. MAIN STREET, LOMBARD, IL 60148	OPERATION OF SLEEP LAB	IL	N/A	N/A	N/A	N/A			N/A			N/A
(4) BELMONT/HARLEM SURGERY CENTER, LLC (41-2237162) 3101 NORTH HARLEM, CHICAGO, IL 60634	MEDICAL SERVICE	IL	N/A	N/A	N/A	N/A			N/A			N/A
(5) ALVERNO CLINICAL LABORATORIES, LLC (20-3240648) 2434 INTERSTATE PLAZA DRIVE, HAMMOND, IN 46324	MEDICAL SERVICE	IN	N/A	N/A	N/A	N/A			N/A			N/A
(6) PRESENCE LAKESHORE GASTROENTEROLOGY, LLC (81-1750563) 150 N. RIVER ROAD, SUITE 210, DES PLAINES, IL 60016	MEDICAL SERVICE	IL	N/A	N/A	N/A	N/A			N/A			N/A
(7) PROFESSIONAL CLINICAL LABORATORIES, LLC (30-0711211) 113 E 4TH ST., MICHIGAN CITY, IN 46360	MEDICAL SERVICES	IN	N/A	N/A	N/A	N/A			N/A			N/A

Part IV Identification of Related Organizations Taxable as a Corporation or Trust (continued)

(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) THELEN CORPORATION (36-3266316) 2601 NAVISTAR DRIVE, Lisle, IL 60532	OWNS/ LEASES PROPERTY JOINT VENTURE PARTNER	IL	N/A	C CORPORATION	N/A	N/A	N/A	✓	
(2) ALEXIAN BROTHERS HEALTH PROVIDERS ASSOCIATION, INC (36-3853286) 2601 NAVISTAR DRIVE, Lisle, IL 60532	MESSENGER MODEL IPA	IL	N/A	C CORPORATION	N/A	N/A	N/A	✓	
(3) L GILBRAITH INSURANCE SPC LTD 68 W BAY ROAD, PO BOX 1109, GRAND CAYMAN, CJ	INSURANCE	CAYMAN ISLANDS	N/A	C CORPORATION	N/A	N/A	N/A		✓
(4) PRESENCE PROPERTIES INC (36-3520630) 100 NORTH RIVER ROAD, DES PLAINES, IL 60016	MEDICAL	IL	N/A	C CORPORATION	N/A	N/A	N/A	✓	
(5) PRESENCE SERVICE CORPORATION (36-4314354) 2380 E DEMPSTER STREET, DES PLAINES, IL 60016	MEDICAL	IL	N/A	C CORPORATION	N/A	N/A	N/A	✓	
(6) PRESENCE VENTURES INC (37-1168085) 100 NORTH RIVER ROAD, DES PLAINES, IL 60016	MEDICAL	IL	N/A	C CORPORATION	N/A	N/A	N/A	✓	
(7) AMITA HEALTH CLINICALLY INTEGRATED NETWORK, LLC (80-0967178) 2601 NAVISTAR DRIVE, Lisle, IL 60532	MANAGED CARE	IL	N/A	C CORPORATION	N/A	N/A	N/A	✓	

Part VII**Supplemental Information.** Provide additional information for responses to questions on Schedule R (see instructions)

Return Reference - Identifier	Explanation
SCHEDULE R, PART II, COLUMN (A) - NAMES OF RELATED ORGANIZATIONS	AS OF 3/1/18, PRESENCE HEALTH JOINED ASCENSION BECOMING PART OF AN INTEGRATED HEALTH SYSTEM OF AMITA HEALTH PRESENCE HEALTH NETWORK AND RESURRECTION UNIVERSITY WERE NOT PART OF THE TRANSACTION AND ARE REPORTED ON SCHEDULE R PART II TO REPRESENT THE PERIOD 1/1/2018 THROUGH 2/28/2018 ADDITIONALLY, THE SKILLED NURSING FACILITIES AND ASSISTED, INDEPENDENT LIVING FACILITIES OF PRESENCE LIFE CONNECTIONS BECAME PART OF ASCENSION SENIOR LIVING AND ARE REPORTED ON SCHEDULE R PART II TO REPRESENT THE PERIOD 1/1/2018 THROUGH 2/28/2018
SCHEDULE R, PART V, LINE 1P - 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 CORPORATION