

Form **990**  
Department of the Treasury  
Internal Revenue Service

# Return of Organization Exempt From Income Tax

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

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

Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No 1545-0047  
**2018**  
Open to Public Inspection

**A For the 2019 calendar year, or tax year beginning 10-01-2018, and ending 09-30-2019**

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

**C** Name of organization: Northwest Community Hospital  
 % CHRISSIE ERDMANN  
 Doing business as

**D** Employer identification number: 36-2340313

**E** Telephone number: (847) 618-1000

**G** Gross receipts \$ 545,818,628

**F** Name and address of principal officer:  
 STEPHEN O SCOGNA  
 800 West Central Road  
 ARLINGTON HEIGHTS, IL 60005

**H(a)** Is this a group return for subordinates?  Yes  No  
**H(b)** Are all subordinates included?  Yes  No  
 If "No," attach a list (see instructions)  
**H(c)** Group exemption number ▶

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

**J** Website: ▶ NCH ORG

**K** Form of organization:  Corporation  Trust  Association  Other ▶

**L** Year of formation: 1953 **M** State of legal domicile: IL

**Part I Summary**

**1** Briefly describe the organization's mission or most significant activities:  
 NCH OPERATES AN ACUTE HOSPITAL IN ARLINGTON HEIGHTS, IL THE HOSPITAL EXISTS TO IMPROVE THE HEALTH OF THE COMMUNITIES WE SERVE AND TO MEET INDIVIDUALS' HEALTHCARE NEEDS

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

<b>3</b> Number of voting members of the governing body (Part VI, line 1a)	15
<b>4</b> Number of independent voting members of the governing body (Part VI, line 1b)	13
<b>5</b> Total number of individuals employed in calendar year 2018 (Part V, line 2a)	4,883
<b>6</b> Total number of volunteers (estimate if necessary)	884
<b>7a</b> Total unrelated business revenue from Part VIII, column (C), line 12	904,879
<b>7b</b> Net unrelated business taxable income from Form 990-T, line 34	0

	Prior Year	Current Year
<b>8</b> Contributions and grants (Part VIII, line 1h)	2,293,352	4,541,954
<b>9</b> Program service revenue (Part VIII, line 2g)	500,978,177	534,283,597
<b>10</b> Investment income (Part VIII, column (A), lines 3, 4, and 7d)	20,700	34,283
<b>11</b> Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	4,584,784	5,434,226
<b>12</b> Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	507,877,013	544,294,060
<b>13</b> Grants and similar amounts paid (Part IX, column (A), lines 1-3)	116,770	167,419
<b>14</b> Benefits paid to or for members (Part IX, column (A), line 4)	0	0
<b>15</b> Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	242,292,062	250,304,309
<b>16a</b> Professional fundraising fees (Part IX, column (A), line 11e)	0	0
<b>b</b> Total fundraising expenses (Part IX, column (D), line 25) ▶		
<b>17</b> Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	243,665,707	261,422,797
<b>18</b> Total expenses Add lines 13-17 (must equal Part IX, column (A), line 25)	486,074,539	511,894,525
<b>19</b> Revenue less expenses Subtract line 18 from line 12	21,802,474	32,399,535

	Beginning of Current Year	End of Year
<b>20</b> Total assets (Part X, line 16)	508,737,790	509,146,585
<b>21</b> Total liabilities (Part X, line 26)	373,320,147	380,747,168
<b>22</b> Net assets or fund balances Subtract line 21 from line 20	135,417,643	128,399,417

**Part II Signature Block**

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

**Sign Here**

Signature of officer: \_\_\_\_\_ Date: 2020-08-17

JOHN SKEANS CFO  
Type or print name and title

**Paid Preparer Use Only**

Print/Type preparer's name: \_\_\_\_\_ Preparer's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Check  if self-employed PTIN: P01622613

Firm's name ▶ ERNST & YOUNG US LLP Firm's EIN ▶ \_\_\_\_\_

Firm's address ▶ 155 N Wacker Drive Phone no (312) 879-2000  
 Chicago, IL 60606

**Part III Statement of Program Service Accomplishments**

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

**1** Briefly describe the organization's mission

NORTHWEST COMMUNITY HOSPITAL EXISTS TO IMPROVE THE HEALTH OF THE COMMUNITIES IT SERVES AND TO MEET INDIVIDUALS' HEALTHCARE NEEDS IT STRIVES TO BE KNOWN FOR ITS SINGULAR FOCUS ON PROVIDING A COMPREHENSIVE, PATIENT-CENTERED SYSTEM OF CARE THAT SURPASSES EVERY EXPECTATION FOR EXCELLENCE (IN QUALITY AND SERVICE)

**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

<b>4a</b>	(Code )	(Expenses \$	49,688,443	including grants of \$	0	(Revenue \$	59,177,823 )
	See Additional Data						

<b>4b</b>	(Code )	(Expenses \$	43,599,682	including grants of \$	0	(Revenue \$	41,866,497 )
	See Additional Data						

<b>4c</b>	(Code )	(Expenses \$	39,081,507	including grants of \$	0	(Revenue \$	41,399,624 )
	See Additional Data						

<b>4d</b>	Other program services (Describe in Schedule O )	(Expenses \$	305,659,064	including grants of \$	167,419	(Revenue \$	391,839,653 )
-----------	--	--------------	-------------	------------------------	---------	-------------	---------------

<b>4e</b>	<b>Total program service expenses ▶</b>		438,028,696				
-----------	---	--	-------------	--	--	--	--

Part IV Checklist of Required Schedules

Table with 3 columns: Question number, Question text, and Yes/No response columns. Rows include questions 1 through 22 regarding organizational requirements and reporting.

Part IV Checklist of Required Schedules (continued)

Table with 3 columns: Question ID, Question Text, and Yes/No columns. Rows include questions 23 through 38 regarding compensation, bond issues, escrow accounts, 501(c)(3) organizations, and other IRS filings.

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Table with 3 columns: Question ID, Question Text, and Yes/No columns. Rows include questions 1a, 1b, and 1c regarding Form 1096, Forms W-2G, and backup withholding rules.

<p><b>2a</b> 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 . . . . .</p>	<b>2a</b>	4,883			
<p><b>b</b> If at least one is reported on line 2a, did the organization file all required federal employment tax returns? <b>Note.</b> If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)</p>	<b>2b</b>		Yes		
<p><b>3a</b> Did the organization have unrelated business gross income of \$1,000 or more during the year? . . . . .</p>	<b>3a</b>		Yes		
<p><b>b</b> If "Yes," has it filed a Form 990-T for this year? <i>If "No" to line 3b, provide an explanation in Schedule O . . . . .</i></p>	<b>3b</b>		Yes		
<p><b>4a</b> 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)? . . . . .</p>	<b>4a</b>			No	
<p><b>b</b> If "Yes," enter the name of the foreign country <b>▶</b> _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)</p>					
<p><b>5a</b> Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . . . . .</p>	<b>5a</b>			No	
<p><b>b</b> Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?</p>	<b>5b</b>			No	
<p><b>c</b> If "Yes," to line 5a or 5b, did the organization file Form 8886-T? . . . . .</p>	<b>5c</b>				
<p><b>6a</b> 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? . . . . .</p>	<b>6a</b>			No	
<p><b>b</b> If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? . . . . .</p>	<b>6b</b>				
<b>7 Organizations that may receive deductible contributions under section 170(c).</b>					
<p><b>a</b> 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? . . . . .</p>	<b>7a</b>			No	
<p><b>b</b> If "Yes," did the organization notify the donor of the value of the goods or services provided? . . . . .</p>	<b>7b</b>				
<p><b>c</b> Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? . . . . .</p>	<b>7c</b>			No	
<p><b>d</b> If "Yes," indicate the number of Forms 8282 filed during the year . . . . .</p>	<b>7d</b>				
<p><b>e</b> Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?</p>	<b>7e</b>			No	
<p><b>f</b> Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . . . . .</p>	<b>7f</b>			No	
<p><b>g</b> If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? . . . . .</p>	<b>7g</b>				
<p><b>h</b> If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? . . . . .</p>	<b>7h</b>				
<b>8 Sponsoring organizations maintaining donor advised funds.</b>					
<p>Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? . . . . .</p>	<b>8</b>				
<p><b>9a</b> Did the sponsoring organization make any taxable distributions under section 4966? . . . . .</p>	<b>9a</b>				
<p><b>b</b> Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . . . .</p>	<b>9b</b>				
<b>10 Section 501(c)(7) organizations.</b> Enter					
<p><b>a</b> Initiation fees and capital contributions included on Part VIII, line 12 . . . . .</p>	<b>10a</b>				
<p><b>b</b> Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities</p>	<b>10b</b>				
<b>11 Section 501(c)(12) organizations.</b> Enter					
<p><b>a</b> Gross income from members or shareholders . . . . .</p>	<b>11a</b>				
<p><b>b</b> Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them ) . . . . .</p>	<b>11b</b>				
<b>12a Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?					
<p><b>b</b> If "Yes," enter the amount of tax-exempt interest received or accrued during the year</p>	<b>12b</b>				
<b>13 Section 501(c)(29) qualified nonprofit health insurance issuers.</b>					
<p><b>a</b> Is the organization licensed to issue qualified health plans in more than one state? <b>Note.</b> See the instructions for additional information the organization must report on Schedule O</p>	<b>13a</b>				
<p><b>b</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 . . . . .</p>	<b>13b</b>				
<p><b>c</b> Enter the amount of reserves on hand . . . . .</p>	<b>13c</b>				
<p><b>14a</b> Did the organization receive any payments for indoor tanning services during the tax year? . . . . .</p>	<b>14a</b>			No	
<p><b>b</b> If "Yes," has it filed a Form 720 to report these payments? <i>If "No," provide an explanation in Schedule O . . . . .</i></p>	<b>14b</b>				
<p><b>15</b> Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see instructions and file Form 4720, Schedule N . . . . .</p>	<b>15</b>			No	
<p><b>16</b> Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O . . . . .</p>	<b>16</b>			No	

Part VI Governance, Management, and Disclosure For each "Yes" response to lines 2 through 7b below, and for a "No" response to lines 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O See instructions Check if Schedule O contains a response or note to any line in this Part VI



Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a Enter the number of voting members of the governing body at the end of the tax year (15); 1b Enter the number of voting members included in line 1a, above, who are independent (13); 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? (No); 3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? (No); 4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? (No); 5 Did the organization become aware during the year of a significant diversion of the organization's assets? (No); 6 Did the organization have members or stockholders? (Yes); 7a Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? (Yes); 7b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? (Yes); 8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: a The governing body? (Yes); b Each committee with authority to act on behalf of the governing body? (Yes); 9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O (No)

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

Table with 3 columns: Question, Yes, No. Rows include: 10a Did the organization have local chapters, branches, or affiliates? (No); 10b 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?; 11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? (Yes); 11b 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 (Yes); 12b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? (Yes); 12c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done (Yes); 13 Did the organization have a written whistleblower policy? (Yes); 14 Did the organization have a written document retention and destruction policy? (Yes); 15 Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision? a The organization's CEO, Executive Director, or top management official (Yes); b Other officers or key employees of the organization (Yes); If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions); 16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year? (No); 16b 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?

Section C. Disclosure

Table with 2 columns: Question, Answer. Rows include: 17 List the States with which a copy of this Form 990 is required to be filed (IL); 18 Section 6104 requires an organization to make its Form 1023 (or 1024-A if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection Indicate how you made these available Check all that apply: 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: CHRISTIE ERDMANN 3040 SALT CREEK LANE Arlington Heights, IL 60005 (847) 618-4606





**Part VIII Statement of Revenue**

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

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<b>1a</b> Federated campaigns . . . . .	<b>1a</b>			
	<b>b</b> Membership dues . . . . .	<b>1b</b>			
	<b>c</b> Fundraising events . . . . .	<b>1c</b>			
	<b>d</b> Related organizations . . . . .	<b>1d</b>	4,541,954		
	<b>e</b> Government grants (contributions)	<b>1e</b>			
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above	<b>1f</b>			
	<b>g</b> Noncash contributions included in lines 1a - 1f \$ _____				
<b>h Total.</b> Add lines 1a-1f . . . . .		4,541,954			

<b>Program Service Revenue</b>			Business Code				
	<b>2a</b> NET PATIENT SERVICES		622110	516,253,935	516,253,935		
	<b>b</b> REFERENCE LAB		621511	10,908,780	10,562,972	345,808	
	<b>c</b> CAPITATION REVENUE		622110	2,483,138	2,483,138		
	<b>d</b> INTERCOMPANY RENTS		532000	1,203,873	1,203,873		
	<b>e</b> OTHER RENT INCOME		532000	2,076,140	2,076,140		
	<b>f</b> All other program service revenue			1,357,731	1,357,731		
<b>g Total.</b> Add lines 2a-2f . . . . .			534,283,597				

<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts) . . . . .			20			20	
	<b>4</b> Income from investment of tax-exempt bond proceeds . . . . .			0				
	<b>5</b> Royalties . . . . .			0				
	<b>6a</b> Gross rents	(i) Real	(ii) Personal					
		2,076,140						
		<b>b</b> Less rental expenses	1,243,819					
		<b>c</b> Rental income or (loss)	832,321	0				
	<b>d</b> Net rental income or (loss) . . . . .			832,321			832,321	
	<b>7a</b> Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other					
			34,263					
		<b>b</b> Less cost or other basis and sales expenses		0				
		<b>c</b> Gain or (loss)		34,263				
	<b>d</b> Net gain or (loss) . . . . .			34,263			34,263	
	<b>8a</b> Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18 . . . . .	<b>a</b>						
		<b>b</b> Less direct expenses . . . . .	<b>b</b>	0				
<b>c</b> Net income or (loss) from fundraising events . . . . .				0				
<b>9a</b> Gross income from gaming activities See Part IV, line 19 . . . . .	<b>a</b>							
	<b>b</b> Less direct expenses . . . . .	<b>b</b>	0					
	<b>c</b> Net income or (loss) from gaming activities . . . . .			0				
<b>10a</b> Gross sales of inventory, less returns and allowances . . . . .	<b>a</b>							
	<b>b</b> Less cost of goods sold . . . . .	<b>b</b>	302,447					
	<b>c</b> Net income or (loss) from sales of inventory . . . . .			21,698			21,698	
Miscellaneous Revenue	Business Code							
<b>11a</b> CAFETERIA	722212		1,881,991			1,881,991		
<b>b</b> JOINT VENTURE MANAGEMENT FEE	541611		960,263		559,812	400,451		
<b>c</b> OUTPATIENT PHARMACY	446110		96,698		-741	97,439		
<b>d</b> All other revenue . . . . .			1,641,255			1,641,255		
<b>e Total.</b> Add lines 11a-11d . . . . .			4,580,207					
<b>12 Total revenue.</b> See Instructions . . . . .			544,294,060	533,937,789	904,879	4,909,438		

**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

	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
<b>Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.</b>				
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21.	167,419	167,419		
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22.	0			
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.	0			
<b>4</b> Benefits paid to or for members.	0			
<b>5</b> Compensation of current officers, directors, trustees, and key employees.	3,526,098		3,526,098	
<b>6</b> Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B).	699,486		699,486	
<b>7</b> Other salaries and wages.	201,179,650	192,138,269	9,041,381	
<b>8</b> Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).	6,691,025	6,258,857	432,168	
<b>9</b> Other employee benefits.	23,769,063	22,233,838	1,535,225	
<b>10</b> Payroll taxes.	14,438,987	13,506,384	932,603	
<b>11</b> Fees for services (non-employees)				
<b>a</b> Management.	0			
<b>b</b> Legal.	294,734		294,734	
<b>c</b> Accounting.	377,629		377,629	
<b>d</b> Lobbying.	84,884		84,884	
<b>e</b> Professional fundraising services. See Part IV, line 17.	0			
<b>f</b> Investment management fees.	1,067	1,067		
<b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	34,861,065	9,091,736	25,769,329	
<b>12</b> Advertising and promotion.	2,719,067		2,719,067	
<b>13</b> Office expenses.	6,593,842	5,335,313	1,258,529	
<b>14</b> Information technology.	8,402,182	7,859,492	542,690	
<b>15</b> Royalties.	0			
<b>16</b> Occupancy.	7,090,327	5,527,894	1,562,433	
<b>17</b> Travel.	386,236	48,708	337,528	
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials.	0			
<b>19</b> Conferences, conventions, and meetings.	373,436	373,436		
<b>20</b> Interest.	8,533,009	8,533,009		
<b>21</b> Payments to affiliates.	0			
<b>22</b> Depreciation, depletion, and amortization.	36,216,718	21,703,184	14,513,534	
<b>23</b> Insurance.	9,065,999	8,892,625	173,374	
<b>24</b> 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.)				
<b>a</b> MEDICAL SUPPLIES	59,414,242	59,414,242		
<b>b</b> PHARMACEUTICALS	18,236,431	18,236,431		
<b>c</b> BAD DEBT - PATIENT SERVICES	27,243,138	27,243,138		
<b>d</b> ILLINOIS PROVIDER TAX	22,298,211	22,298,211		
<b>e</b> All other expenses	19,230,580	9,165,443	10,065,137	
<b>25</b> Total functional expenses. Add lines 1 through 24e.	511,894,525	438,028,696	73,865,829	0
<b>26</b> Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

**Part X Balance Sheet**

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

		(A) Beginning of year		(B) End of year
<b>Assets</b>	<b>1</b> Cash—non-interest-bearing . . . . .	0	<b>1</b>	0
	<b>2</b> Savings and temporary cash investments . . . . .	15,315,826	<b>2</b>	3,620,875
	<b>3</b> Pledges and grants receivable, net . . . . .	0	<b>3</b>	0
	<b>4</b> Accounts receivable, net . . . . .	71,243,551	<b>4</b>	68,621,830
	<b>5</b> Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L . . . . .	0	<b>5</b>	0
	<b>6</b> 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	<b>6</b>	0
	<b>7</b> Notes and loans receivable, net . . . . .	0	<b>7</b>	0
	<b>8</b> Inventories for sale or use . . . . .	8,765,876	<b>8</b>	9,163,195
	<b>9</b> Prepaid expenses and deferred charges . . . . .	4,428,314	<b>9</b>	3,955,419
	<b>10a</b> Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	<b>10a</b> 830,104,483		
	<b>b</b> Less accumulated depreciation	<b>10b</b> 452,977,631	377,995,598	<b>10c</b> 377,126,852
	<b>11</b> Investments—publicly traded securities . . . . .	0	<b>11</b>	0
	<b>12</b> Investments—other securities See Part IV, line 11 . . . . .	0	<b>12</b>	0
	<b>13</b> Investments—program-related See Part IV, line 11 . . . . .	12,204,387	<b>13</b>	23,808,908
	<b>14</b> Intangible assets . . . . .	3,940,000	<b>14</b>	3,061,000
	<b>15</b> Other assets See Part IV, line 11 . . . . .	14,844,238	<b>15</b>	19,788,506
<b>16 Total assets.</b> Add lines 1 through 15 (must equal line 34) . . . . .	508,737,790	<b>16</b>	509,146,585	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses . . . . .	58,325,729	<b>17</b>	58,932,821
	<b>18</b> Grants payable . . . . .	0	<b>18</b>	0
	<b>19</b> Deferred revenue . . . . .	371,399	<b>19</b>	206,187
	<b>20</b> Tax-exempt bond liabilities . . . . .	251,359,489	<b>20</b>	242,961,630
	<b>21</b> Escrow or custodial account liability Complete Part IV of Schedule D . . . . .	0	<b>21</b>	0
	<b>22</b> Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L . . . . .	0	<b>22</b>	0
	<b>23</b> Secured mortgages and notes payable to unrelated third parties . . . . .	0	<b>23</b>	0
	<b>24</b> Unsecured notes and loans payable to unrelated third parties . . . . .	0	<b>24</b>	0
	<b>25</b> 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 . . . . .	63,263,530	<b>25</b>	78,646,530
	<b>26 Total liabilities.</b> Add lines 17 through 25 . . . . .	373,320,147	<b>26</b>	380,747,168
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.</b>			
	<b>27</b> Unrestricted net assets	125,934,661	<b>27</b>	115,631,285
	<b>28</b> Temporarily restricted net assets . . . . .	8,026,438	<b>28</b>	11,311,588
	<b>29</b> Permanently restricted net assets	1,456,544	<b>29</b>	1,456,544
	<b>Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.</b>			
	<b>30</b> Capital stock or trust principal, or current funds . . . . .		<b>30</b>	
	<b>31</b> Paid-in or capital surplus, or land, building or equipment fund . . . . .		<b>31</b>	
	<b>32</b> Retained earnings, endowment, accumulated income, or other funds		<b>32</b>	
<b>33</b> Total net assets or fund balances . . . . .	135,417,643	<b>33</b>	128,399,417	
<b>34</b> Total liabilities and net assets/fund balances . . . . .	508,737,790	<b>34</b>	509,146,585	

**Part XI Reconciliation of Net Assets**

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

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	544,294,060
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	511,894,525
<b>3</b>	Revenue less expenses Subtract line 2 from line 1	<b>3</b>	32,399,535
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	135,417,643
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	-39,417,761
<b>10</b>	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	<b>10</b>	128,399,417

**Part XII Financial Statements and Reporting**

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

- 1** Accounting method used to prepare the Form 990  Cash  Accrual  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  
 Separate basis  Consolidated basis  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  
 Separate basis  Consolidated basis  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
- 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?
- 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

	Yes	No
<b>2a</b>		No
<b>2b</b>	Yes	
<b>2c</b>	Yes	
<b>3a</b>		No
<b>3b</b>		

# Additional Data

**Software ID:**

**Software Version:**

**EIN:** 36-2340313

**Name:** Northwest Community Hospital

Form 990 (2018)

---

## Form 990, Part III, Line 4a:

CARDIOLOGY NORTHWEST COMMUNITY HOSPITAL'S (HOSPITAL) CARDIAC SERVICE LINE PROVIDED QUALITY, PATIENT CENTERED, COMPASSIONATE CARE, REGARDLESS OF ABILITY TO PAY, TO APPROXIMATELY 50,000 INPATIENTS AND OUTPATIENTS DURING FY 2019 THE TREATMENT WAS PROVIDED IN HOSPITAL'S STATE-OF-THE-ART DIGITAL CARDIAC CATH LAB SUITES, INCLUSIVE OF ITS HIGH TECH OPERATING ROOMS AND PRIVATE FAMILY CENTERED PATIENT CARE ROOMS ALL AT A COST OF NEARLY \$50,000,000 AN ON-CALL TEAM OF NURSES, RADIOLOGY TECHS, OR TECHS, CARDIOLOGISTS AND SURGEONS WERE READILY AVAILABLE 24 HOURS A DAY, 7 DAYS A WEEK, TO PROVIDE EMERGENT CARE TO THOSE WITH CARDIAC DISEASE THE CARDIAC TEAM WORKS WITH THE EMERGENCY ROOM AND MULTIPLE NEIGHBORING COMMUNITY PARAMEDICS AND EMERGENCY PERSONNEL TO CONSISTENTLY EXCEED THE NATIONAL BENCHMARK OF DOOR TO BALLOON TIME (OR OPEN ARTERY) IN LESS THAN 90 MINUTES FOR PATIENTS PRESENTING IN HOSPITAL'S EMERGENCY ROOM HAVING AN ACUTE MI NCH HAS BEEN RECOGNIZED AS AN ACCREDITED ECHO LAB BY THE INTERSOCIETAL COMMISSION FOR THE ACCREDITATION OF ECHOCARDIOGRAPHY LABORATORIES (ICAEL) SINCE 2000 NOT ONLY DOES NCH PROVIDE THE FULL SCOPE ON NON INVASIVE CARDIAC DIAGNOSTIC TESTING AT MULTIPLE SITES IN THE COMMUNITY BUT IN 2014, NCH OPENED THE ATHERTON HEART FAILURE CLINIC THE HF CLINIC PROVIDES A TRANSITIONAL CARE MODEL THAT IS BASED ON PATIENTS WITH HF BEING SEEN IN THE CLINIC BY ADVANCED CARE PRATCTIONERS AND CARDIOLOGISTS WITH 24 HOURS OF HOSPITAL DISCHARGE THE MULTIDISCIPLINARY TEAM INCLUDING DIETICIANS, SOCIAL WORKERS, PHARMACISTS AND NURSES PROVIDE ONGOING CARE TO PATIENTS AND THEIR FAMILIES IN THE COMMUNITY SETTING ENSURING CARE IS DELIVERED IN THE APPROPRIATE SETTING AND REDUCING AVOIDABLE READMISSIONS TO THE ACUTE CARE SETTING NCH HAS EXPERIENCED A SIGNIFICANT DECREASE IN HOSPITAL READMISSIONS FOR BOTH THE HEART FAILURE AND ACUTE MI PATIENT POPULATIONS DIRECLTY RELATED TO STRATEGIES DURING THE HOSPITALIZATION AND IN THE POST ACUTE CARE SETTING TELEHEALTH MEDICINE AND HOME HEALTH ARE INTEGRAL PART OF THE POST ACUTE CARE MODEL NCH HAS IMPLEMENTED FOR CARDIAC PATIENTS IN ADDITION, NCH HAS ONE OF THE LARGEST CARDIAC AND PULMONARY REHAB PROGRAMS IN THE STATE OF ILLINOIS THAT HAS FURTHER ASSISTED CARDIAC AND PULMONARY PATIENTS IN RETURNING AND MAINTAINING AN OPTIMAL STATE OF HEALT FOLLOWING A CADIAC EVENT THE CARDIAC DEPARTMENT ALSO PROVIDES MULTIPLE SCREENING AND EDUCATION PROGRAMS DURING 2015, HOSPITAL HOSTED A COMMUNITY EVENT WHERE BLOOD PRESSURE, CHOLESTEROL AND BMI SCREENINGS WERE USED TO CALCULATE AN INDIVIDUAL'S RISK OF DEVELOPING HEART DISEASE FOR A MINIMAL FEE IN ADDITION, PHYSICIANS PROVIDED EDUCATION ON HEART HEALTH AND WELLNESS OVER 300 PEOPLE PARTICIPATED IN THE EVENT

---

**Form 990, Part III, Line 4b:**

NORTHWEST COMMUNITY HOSPITAL'S (HOSPITAL) INFECTIOUS DISEASE DEPARTMENT PROVIDED QUALITY, PATIENT CENTERED, COMPASSIONATE CARE, REGARDLESS OF ABILITY TO PAY IN FY 2019, THE INFECTIOUS DISEASE SERVICE LINE INCURRED APPROXIMATELY 42,000 CASES AT A COST OF APPROXIMATELY 44,000,000

---

**Form 990, Part III, Line 4c:**

ORTHOPEDICS NORTHWEST COMMUNITY HOSPITAL'S ORTHOPEDIC SERVICE LINE PROVIDES QUALITY, PATIENT CENTERED, COMPASSIONATE CARE FOR PATIENTS, REGARDLESS OF ABILITY TO PAY, WHO ARE IN NEED OF SPECIALIZED ORTHOPEDIC MEDICAL CARE AND SURGICAL PROCEDURES PATIENTS HAVE ACCESS TO SUPERIOR QUALITY CARE AND BENEFIT FROM THE LATEST TECHNOLOGIES AND ADVANCED PAIN MANAGEMENT TECHNIQUES PHYSICIANS ARE BOARD CERTIFIED PREOPERATIVE EDUCATION, CARE PROVISION ON A DEDICATED ORTHOPEDIC UNIT WITH SPECIALTY NURSES AND EXTENSIVE POST SURGICAL REHABILITATION AND HOME CARE SERVICES ARE INCLUDED IN OUR ORTHOPEDIC SERVICES HOSPITAL'S ORTHOPEDIC SERVICE LINE TEAM IS LED BY AN EXPERT BOARD CERTIFIED ORTHOPEDIC SURGEON THE ORTHOPEDIC DEPARTMENT PERFORMS GREATER THAN 800 ELECTIVE JOINT PROCEDURES A YEAR QUALITY CARE, EXCELLENCE IN PATIENT EXPERIENCE AND FAVORABLE OUTCOMES MAKES HOSPITAL A TOP CHOICE IN THE CHICAGO LAND AREA IN FY 2019, THE ORTHOPEDIC SERVICE LINE INCURRED APPROXIMATELY 26,000 PATIENT CASES AT A COST OF APPROXIMATELY \$39,000,000

---

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
Stephen O Scogna ..... PRESIDENT/SECRETARY/CEO	10 ..... 30	X		X				893,387	0	195,747
Thomas P MacCarthy ..... Director	10 ..... 10	X						0	0	0
Marla F Glabe ..... Director	10 ..... 10	X						0	0	0
Craig E Christell ..... Director	10 ..... 10	X						0	0	0
Jay S Cowen MD ..... Director	10 ..... 10	X						0	0	0
Guy W Eisenhuth ..... Director	10 ..... 10	X						0	0	0
Ann K Ford ..... Director	10 ..... 10	X						0	0	0
Louis A Gatta Phd ..... Director (Through 12/31/18)	10 ..... 10	X						0	0	0
Charles A Hempfling ..... Director (Through 12/31/18)	10 ..... 10	X						0	0	0
Diane G Hill ..... Chairperson	10 ..... 10	X		X				0	0	0

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
Richard D Hoffman ..... Director	1 0 .....	X						0	0	0
E Quinn Regan MD ..... DIRECTOR	1 0 .....	X						0	0	0
Mary R Sheahen MS RN ..... Vice Chairperson	1 0 .....	X		X				0	0	0
Nhat Q Tran ..... Director	1 0 .....	X						0	0	0
KENNETH A SPERO MD ..... DIRECTOR	1 0 .....	X						23,400	0	0
THOMAS G WISCHHUSEN ..... DIRECTOR (Beginning 1/1/2019)	1 0 .....	X						0	0	0
John L Gatta ..... Director (Beginning 1/1/2019)	1 0 .....	X						0	0	0
John L Skeans ..... CFO/Treasurer	30 0 .....			X				430,476	0	87,932
Michael C Hartke ..... Executive VP/COO	30 0 .....				X			521,213	0	97,652
Alan B Loren MD ..... Executive VP - CMO	30 0 .....				X			798,145	0	80,877

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
Mary Dano ..... Exec VP - Chief Legal Counsel	30 0 ..... 10 0				X			369,961	0	50,708
Susan E Nelson MD ..... VP Physician Operations	30 0 ..... 10 0					X		369,433	0	39,672
Bradford Buxton Trm 319 ..... VP Strategy & Business Dev	40 0 ..... 0 0					X		418,337	0	41,160
Glen J Malan ..... VP Info Tech & CIO	40 0 ..... 0 0					X		317,711	0	37,159
Joseph Alappattu Trm 1118 ..... Chief Medical Physicist	40 0 ..... 0 0					X		437,762	0	12,841
TERRY SOLEM ..... VP HUMAN RESOURCES	30 0 ..... 10 0					X		302,141	0	37,233
Wendy L Rubas trm 717 ..... Exec VP - Chief Legal Counsel	0 0 ..... 0 0						X	121,313	0	0
Kimberly Nagy Trm 918 ..... Executive VP - PT Serv & CNO	40 0 ..... 0 0						X	559,999	0	18,174

**SCHEDULE A**  
**(Form 990 or**  
**990EZ)**

**Public Charity Status and Public Support**

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.  
▶ Attach to Form 990 or Form 990-EZ.  
▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

**2018**

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

Name of the organization  
Northwest Community Hospital

Employer identification number  
36-2340313

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

The organization is not a private foundation because it is (For lines 1 through 12, check only one box )

- 1  A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
- 2  A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ) )
- 3  A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- 4  A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state \_\_\_\_\_
- 5  An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II )
- 6  A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- 7  An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II )
- 8  A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II )
- 9  An agricultural research organization described in **170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture See instructions Enter the name, city, and state of the college or university \_\_\_\_\_
- 10  An organization that normally receives (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2).** (Complete Part III )
- 11  An organization organized and operated exclusively to test for public safety See **section 509(a)(4).**
- 12  An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g
  - a  **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization **You must complete Part IV, Sections A and B.**
  - b  **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s) **You must complete Part IV, Sections A and C.**
  - c  **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions) **You must complete Part IV, Sections A, D, and E.**
  - d  **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions) **You must complete Part IV, Sections A and D, and Part V.**
  - e  Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization
  - f Enter the number of supported organizations \_\_\_\_\_
  - g Provide the following information about the supported organization(s)

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1- 10 above (see instructions))	(iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
<b>Total</b>						

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

(Complete only if you checked the box on line 5, 7, 8, or 9 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ►		(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
<b>1</b>	Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant")						
<b>2</b>	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
<b>3</b>	The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>4</b>	<b>Total.</b> Add lines 1 through 3						
<b>5</b>	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)						
<b>6</b>	<b>Public support.</b> Subtract line 5 from line 4						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►		(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
<b>7</b>	Amounts from line 4						
<b>8</b>	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
<b>9</b>	Net income from unrelated business activities, whether or not the business is regularly carried on						
<b>10</b>	Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI )						
<b>11</b>	<b>Total support.</b> Add lines 7 through 10						
<b>12</b>	Gross receipts from related activities, etc (see instructions)					<b>12</b>	

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

**Section C. Computation of Public Support Percentage**

<b>14</b>	Public support percentage for 2018 (line 6, column (f) divided by line 11, column (f))	<b>14</b>	
<b>15</b>	Public support percentage for 2017 Schedule A, Part II, line 14	<b>15</b>	

- 16a 33 1/3% support test—2018.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ►
- b 33 1/3% support test—2017.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ►
- 17a 10%-facts-and-circumstances test—2018.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ►
- b 10%-facts-and-circumstances test—2017.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ►
- 18 Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ►

**Part 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) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
<b>1</b>	Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
<b>2</b>	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						
<b>3</b>	Gross receipts from activities that are not an unrelated trade or business under section 513						
<b>4</b>	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
<b>5</b>	The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>6</b>	<b>Total.</b> Add lines 1 through 5						
<b>7a</b>	Amounts included on lines 1, 2, and 3 received from disqualified persons						
<b>b</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						
<b>c</b>	Add lines 7a and 7b						
<b>8</b>	<b>Public support.</b> (Subtract line 7c from line 6)						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►		(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
<b>9</b>	Amounts from line 6						
<b>10a</b>	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
<b>b</b>	Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
<b>c</b>	Add lines 10a and 10b						
<b>11</b>	Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
<b>12</b>	Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
<b>13</b>	<b>Total support.</b> (Add lines 9, 10c, 11, and 12.)						

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

**Section C. Computation of Public Support Percentage**

<b>15</b>	Public support percentage for 2018 (line 8, column (f) divided by line 13, column (f))	<b>15</b>	
<b>16</b>	Public support percentage from 2017 Schedule A, Part III, line 15	<b>16</b>	

**Section D. Computation of Investment Income Percentage**

<b>17</b>	Investment income percentage for <b>2018</b> (line 10c, column (f) divided by line 13, column (f))	<b>17</b>	
<b>18</b>	Investment income percentage from <b>2017</b> Schedule A, Part III, line 17	<b>18</b>	

**19a 33 1/3% support tests—2018.** 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—2017.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ►

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

**Part IV Supporting Organizations**

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

**Section A. All Supporting Organizations**

		Yes	No
<b>1</b>	Are all of the organization's supported organizations listed by name in the organization's governing documents? If "No," describe in <b>Part VI</b> how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.		
	<b>1</b>		
<b>2</b>	Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? If "Yes," explain in <b>Part VI</b> how the organization determined that the supported organization was described in section 509(a)(1) or (2).		
	<b>2</b>		
<b>3a</b>	Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? If "Yes," answer (b) and (c) below.		
	<b>3a</b>		
<b>b</b>	Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? If "Yes," describe in <b>Part VI</b> when and how the organization made the determination.		
	<b>3b</b>		
<b>c</b>	Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? If "Yes," explain in <b>Part VI</b> what controls the organization put in place to ensure such use.		
	<b>3c</b>		
<b>4a</b>	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>4a</b>		
<b>b</b>	Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? If "Yes," describe in <b>Part VI</b> how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.		
	<b>4b</b>		
<b>c</b>	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 <b>Part VI</b> 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.		
	<b>4c</b>		
<b>5a</b>	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 <b>Part VI</b> , 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>5a</b>		
<b>b</b>	<b>Type I or Type II only.</b> Was any added or substituted supported organization part of a class already designated in the organization's organizing document?		
	<b>5b</b>		
<b>c</b>	<b>Substitutions only.</b> Was the substitution the result of an event beyond the organization's control?		
	<b>5c</b>		
<b>6</b>	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 <b>Part VI</b> .		
	<b>6</b>		
<b>7</b>	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).		
	<b>7</b>		
<b>8</b>	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).		
	<b>8</b>		
<b>9a</b>	Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? If "Yes," provide detail in <b>Part VI</b> .		
	<b>9a</b>		
<b>b</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 <b>Part VI</b> .		
	<b>9b</b>		
<b>c</b>	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 <b>Part VI</b> .		
	<b>9c</b>		
<b>10a</b>	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 line 10b below.		
	<b>10a</b>		
<b>b</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.)		
	<b>10b</b>		

**Part IV Supporting Organizations** (continued)

		Yes	No
<b>11</b>	Has the organization accepted a gift or contribution from any of the following persons?		
<b>a</b>	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>b</b>	A family member of a person described in (a) above?		
<b>c</b>	A 35% controlled entity of a person described in (a) or (b) above? <i>If "Yes" to a, b, or c, provide detail in Part VI</i>		

**Section B. Type I Supporting Organizations**

		Yes	No
<b>1</b>	Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? <i>If "No," describe in Part VI how the supported organization(s) effectively operated, supervised, or controlled the organization's activities. If the organization had more than one supported organization, describe how the powers to appoint and/or remove directors or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year.</i>		
<b>2</b>	Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? <i>If "Yes," explain in Part VI how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised or controlled the supporting organization.</i>		

**Section C. Type II Supporting Organizations**

		Yes	No
<b>1</b>	Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? <i>If "No," describe in Part VI how control or management of the supporting organization was vested in the same persons that controlled or managed the supported organization(s).</i>		

**Section D. All Type III Supporting Organizations**

		Yes	No
<b>1</b>	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?		
<b>2</b>	Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization (s) or (ii) serving on the governing body of a supported organization? <i>If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s).</i>		
<b>3</b>	By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? <i>If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.</i>		

**Section E. Type III Functionally-Integrated Supporting Organizations**

<b>1</b>	Check the box next to the method that the organization used to satisfy the Integral Part Test during the year ( <b>see instructions</b> )		
<b>a</b>	<input type="checkbox"/> The organization satisfied the Activities Test. Complete <b>line 2</b> below.		
<b>b</b>	<input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete <b>line 3</b> below.		
<b>c</b>	<input type="checkbox"/> The organization supported a governmental entity. Describe in <b>Part VI</b> how you supported a government entity (see instructions).		
<b>2</b>	Activities Test <b>Answer (a) and (b) below.</b>		
<b>a</b>	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <i>If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.</i>	Yes	No
<b>b</b>	Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? <i>If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.</i>		
<b>3</b>	Parent of Supported Organizations <b>Answer (a) and (b) below.</b>		
<b>a</b>	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>Provide details in Part VI.</i>		
<b>b</b>	Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i>		

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

- 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.

<b>Section A - Adjusted Net Income</b>		(A) Prior Year	(B) Current Year (optional)
<b>1</b>	Net short-term capital gain	<b>1</b>	
<b>2</b>	Recoveries of prior-year distributions	<b>2</b>	
<b>3</b>	Other gross income (see instructions)	<b>3</b>	
<b>4</b>	Add lines 1 through 3	<b>4</b>	
<b>5</b>	Depreciation and depletion	<b>5</b>	
<b>6</b>	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)	<b>6</b>	
<b>7</b>	Other expenses (see instructions)	<b>7</b>	
<b>8</b>	<b>Adjusted Net Income</b> (subtract lines 5, 6 and 7 from line 4)	<b>8</b>	
<b>Section B - Minimum Asset Amount</b>		(A) Prior Year	(B) Current Year (optional)
<b>1</b>	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year)	<b>1</b>	
<b>a</b>	Average monthly value of securities	<b>1a</b>	
<b>b</b>	Average monthly cash balances	<b>1b</b>	
<b>c</b>	Fair market value of other non-exempt-use assets	<b>1c</b>	
<b>d</b>	<b>Total</b> (add lines 1a, 1b, and 1c)	<b>1d</b>	
<b>e</b>	<b>Discount</b> claimed for blockage or other factors (explain in detail in Part VI)		
<b>2</b>	Acquisition indebtedness applicable to non-exempt use assets	<b>2</b>	
<b>3</b>	Subtract line 2 from line 1d	<b>3</b>	
<b>4</b>	Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions)	<b>4</b>	
<b>5</b>	Net value of non-exempt-use assets (subtract line 4 from line 3)	<b>5</b>	
<b>6</b>	Multiply line 5 by .035	<b>6</b>	
<b>7</b>	Recoveries of prior-year distributions	<b>7</b>	
<b>8</b>	<b>Minimum Asset Amount</b> (add line 7 to line 6)	<b>8</b>	
<b>Section C - Distributable Amount</b>			Current Year
<b>1</b>	Adjusted net income for prior year (from Section A, line 8, Column A)	<b>1</b>	
<b>2</b>	Enter 85% of line 1	<b>2</b>	
<b>3</b>	Minimum asset amount for prior year (from Section B, line 8, Column A)	<b>3</b>	
<b>4</b>	Enter greater of line 2 or line 3	<b>4</b>	
<b>5</b>	Income tax imposed in prior year	<b>5</b>	
<b>6</b>	<b>Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	<b>6</b>	
<b>7</b>	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)		

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

<b>Section D - Distributions</b>	<b>Current Year</b>
<b>1</b> Amounts paid to supported organizations to accomplish exempt purposes	
<b>2</b> Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
<b>3</b> Administrative expenses paid to accomplish exempt purposes of supported organizations	
<b>4</b> Amounts paid to acquire exempt-use assets	
<b>5</b> Qualified set-aside amounts (prior IRS approval required)	
<b>6</b> Other distributions (describe in <b>Part VI</b> ) See instructions	
<b>7 Total annual distributions.</b> Add lines 1 through 6	
<b>8</b> Distributions to attentive supported organizations to which the organization is responsive (provide details in <b>Part VI</b> ) See instructions	
<b>9</b> Distributable amount for 2018 from Section C, line 6	
<b>10</b> Line 8 amount divided by Line 9 amount	

<b>Section E - Distribution Allocations (see instructions)</b>	<b>(i) Excess Distributions</b>	<b>(ii) Underdistributions Pre-2018</b>	<b>(iii) Distributable Amount for 2018</b>
<b>1</b> Distributable amount for 2018 from Section C, line 6			
<b>2</b> Underdistributions, if any, for years prior to 2018 (reasonable cause required-- explain in Part VI) See instructions			
<b>3</b> Excess distributions carryover, if any, to 2018			
<b>a</b> From 2013. . . . .			
<b>b</b> From 2014. . . . .			
<b>c</b> From 2015. . . . .			
<b>d</b> From 2016. . . . .			
<b>e</b> From 2017. . . . .			
<b>f Total</b> of lines 3a through e			
<b>g</b> Applied to underdistributions of prior years			
<b>h</b> Applied to 2018 distributable amount			
<b>i</b> Carryover from 2013 not applied (see instructions)			
<b>j</b> Remainder Subtract lines 3g, 3h, and 3i from 3f			
<b>4</b> Distributions for 2018 from Section D, line 7 \$			
<b>a</b> Applied to underdistributions of prior years			
<b>b</b> Applied to 2018 distributable amount			
<b>c</b> Remainder Subtract lines 4a and 4b from 4			
<b>5</b> Remaining underdistributions for years prior to 2018, if any Subtract lines 3g and 4a from line 2 If the amount is greater than zero, explain in Part VI See instructions			
<b>6</b> Remaining underdistributions for 2018 Subtract lines 3h and 4b from line 1 If the amount is greater than zero, explain in Part VI See instructions			
<b>7 Excess distributions carryover to 2019.</b> Add lines 3j and 4c			
<b>8</b> Breakdown of line 7			
<b>a</b> Excess from 2014. . . . .			
<b>b</b> Excess from 2015. . . . .			
<b>c</b> Excess from 2016. . . . .			
<b>d</b> Excess from 2017. . . . .			
<b>e</b> Excess from 2018. . . . .			

## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 36-2340313

**Name:** Northwest Community Hospital

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

**Facts And Circumstances Test**

**SCHEDULE C**  
(Form 990 or 990-EZ)  
  
Department of the Treasury  
Internal Revenue Service

**Political Campaign and Lobbying Activities**  
For Organizations Exempt From Income Tax Under section 501(c) and section 527  
  
▶Complete if the organization is described below. ▶Attach to Form 990 or Form 990-EZ.  
▶Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No 1545-0047  
  
**2018**  
  
**Open to Public Inspection**

**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 the organization Northwest Community Hospital	Employer identification number 36-2340313
--	--

**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				



**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
<b>1</b>	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			
<b>a</b>	Volunteers?		No	
<b>b</b>	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
<b>c</b>	Media advertisements?		No	
<b>d</b>	Mailings to members, legislators, or the public?		No	
<b>e</b>	Publications, or published or broadcast statements?		No	
<b>f</b>	Grants to other organizations for lobbying purposes?		No	
<b>g</b>	Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
<b>h</b>	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
<b>i</b>	Other activities?	Yes		84,884
<b>j</b>	Total Add lines 1c through 1i			84,884
<b>2a</b>	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
<b>b</b>	If "Yes," enter the amount of any tax incurred under section 4912			
<b>c</b>	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
<b>d</b>	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
<b>1</b>	Were substantially all (90% or more) dues received nondeductible by members?	<b>1</b>	
<b>2</b>	Did the organization make only in-house lobbying expenditures of \$2,000 or less?	<b>2</b>	
<b>3</b>	Did the organization agree to carry over lobbying and political expenditures from the prior year?	<b>3</b>	

**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."**

<b>1</b>	Dues, assessments and similar amounts from members	<b>1</b>	
<b>2</b>	Section 162(e) nondeductible lobbying and political expenditures (do not include amounts of political expenses for which the section 527(f) tax was paid).	<b>2a</b>	
<b>a</b>	Current year	<b>2b</b>	
<b>b</b>	Carryover from last year	<b>2c</b>	
<b>c</b>	Total	<b>3</b>	
<b>3</b>	Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	<b>4</b>	
<b>4</b>	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?	<b>5</b>	
<b>5</b>	Taxable amount of lobbying and political expenditures (see instructions)		

**Part IV Supplemental Information**

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

Return Reference	Explanation
Form 990 Schedule C Part II-B, Line 1i	NORTHWEST COMMUNITY HOSPITAL PAYS DUES TO CERTAIN HOSPITAL ASSOCIATIONS WHICH USE A PORTION OF THESE DUES FOR LOBBYING

**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](http://www.irs.gov/Form990) for the latest information.**

OMB No 1545-0047  
**2018**  
**Open to Public Inspection**

**Name of the organization**  
Northwest Community Hospital

**Employer identification number**  
36-2340313

**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
<b>1</b> Total number at end of year		
<b>2</b> Aggregate value of contributions to (during year)		
<b>3</b> Aggregate value of grants from (during year)		
<b>4</b> Aggregate value at end of year		
<b>5</b> 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	
<b>6</b> 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)

Preservation of land for public use (e g , recreation or education)       Preservation of an historically important land area

Protection of natural habitat       Preservation of a certified historic structure

Preservation of open space

**2** Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year

	Held at the End of the Year	
<b>a</b> Total number of conservation easements	<b>2a</b>	
<b>b</b> Total acreage restricted by conservation easements	<b>2b</b>	
<b>c</b> Number of conservation easements on a certified historic structure included in (a)	<b>2c</b>	
<b>d</b> Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register	<b>2d</b>	

**3** Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ► \_\_\_\_\_

**4** Number of states where property subject to conservation easement is located ► \_\_\_\_\_

**5** Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?  Yes  No

**6** Staff and volunteer hours devoted to monitoring, inspecting, 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)?  Yes  No

**9** In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements

**Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.**  
Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

**1a** If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items

**b** If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items

**(i)** Revenue included on Form 990, Part VIII, line 1 ► \$ \_\_\_\_\_

**(ii)** Assets included in Form 990, Part X ► \$ \_\_\_\_\_

**2** If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items

**a** Revenue included on Form 990, Part VIII, line 1 ► \$ \_\_\_\_\_

**b** Assets included in Form 990, Part X ► \$ \_\_\_\_\_

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

- 3** Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply)
- a**  Public exhibition
  - b**  Scholarly research
  - c**  Preservation for future generations
  - d**  Loan or exchange programs
  - e**  Other
- 4** Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII
- 5** During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection?  Yes  No

**Part IV Escrow and Custodial Arrangements.**

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

- 1a** Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?  Yes  No
- b** If "Yes," explain the arrangement in Part XIII and complete the following table
- |  | Amount |
|--|--------|
| <b>c</b> Beginning balance             |        |
| <b>d</b> Additions during the year     |        |
| <b>e</b> Distributions during the year |        |
| <b>f</b> Ending balance                |        |
- 2a** Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? . . .  Yes  No
- b** If "Yes," explain the arrangement in Part XIII Check here if the explanation has been provided in Part XIII . . . .

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
<b>1a</b> Beginning of year balance . . . . .	4,243,431	3,941,522	3,504,586	4,068,523	3,438,946
<b>b</b> Contributions . . . . .	260,000	5,000	5,000	5,820	2,351
<b>c</b> Net investment earnings, gains, and losses	74,854	296,909	431,936	-462,764	696,815
<b>d</b> Grants or scholarships . . . . .					
<b>e</b> Other expenditures for facilities and programs . . . . .	142,400			106,993	69,589
<b>f</b> Administrative expenses . . . . .					
<b>g</b> End of year balance . . . . .	4,435,885	4,243,431	3,941,522	3,504,586	4,068,523

- 2** Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as
- a** Board designated or quasi-endowment ▶ 44 980 %
  - b** Permanent endowment ▶ 46 150 %
  - c** Temporarily restricted endowment ▶ 8 870 %
- 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
- |  |     |    |
|--|-----|----|
| <b>(i)</b> unrelated organizations . . . . . | Yes | No |
| <b>(ii)</b> related organizations . . . . .  | Yes | No |
- b** If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R? . . . . .
- 3b**

	Yes	No
<b>3a(i)</b>		No
<b>3a(ii)</b>	Yes	
<b>3b</b>	Yes	
- 4** Describe in Part XIII the intended uses of the organization's endowment funds

**Part VI Land, Buildings, and Equipment.**

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
<b>1a</b> Land . . . . .		89,072		89,072
<b>b</b> Buildings . . . . .		318,218,898	158,349,694	159,869,204
<b>c</b> Leasehold improvements		3,480,507	2,409,691	1,070,816
<b>d</b> Equipment . . . . .		469,809,215	279,603,729	190,205,486
<b>e</b> Other . . . . .		38,506,791	12,614,517	25,892,274
<b>Total.</b> Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c)) . . . ▶				377,126,852

**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)		
<b>Total.</b> (Column (b) must equal Form 990, Part X, col (B) line 12 )		

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

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

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

(a) Description	(b) Book value
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col (B) line 15 )	

**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.

(a) Description of liability	(b) Book value
(1) Federal income taxes	0
DUE TO THIRD-PARTY PAYORS	45,938,281
ASSET RETIREMENT OBLIGATION	859,769
PENSION OBLIGATION	10,439,896
INSURANCE LIABILITY	19,200,055
SERP	2,208,529
(6)	
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col (B) line 25 )	78,646,530

**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.

<b>1</b>	Total revenue, gains, and other support per audited financial statements . . . . .		<b>1</b>	
<b>2</b>	Amounts included on line 1 but not on Form 990, Part VIII, line 12			
<b>a</b>	Net unrealized gains (losses) on investments . . . . .	<b>2a</b>		
<b>b</b>	Donated services and use of facilities . . . . .	<b>2b</b>		
<b>c</b>	Recoveries of prior year grants . . . . .	<b>2c</b>		
<b>d</b>	Other (Describe in Part XIII ) . . . . .	<b>2d</b>		
<b>e</b>	Add lines <b>2a</b> through <b>2d</b> . . . . .		<b>2e</b>	
<b>3</b>	Subtract line <b>2e</b> from line <b>1</b> . . . . .		<b>3</b>	
<b>4</b>	Amounts included on Form 990, Part VIII, line 12, but not on line 1			
<b>a</b>	Investment expenses not included on Form 990, Part VIII, line 7b . . . . .	<b>4a</b>		
<b>b</b>	Other (Describe in Part XIII ) . . . . .	<b>4b</b>		
<b>c</b>	Add lines <b>4a</b> and <b>4b</b> . . . . .		<b>4c</b>	
<b>5</b>	Total revenue Add lines <b>3</b> and <b>4c</b> . (This must equal Form 990, Part I, line 12 ) . . . . .		<b>5</b>	

**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.

<b>1</b>	Total expenses and losses per audited financial statements . . . . .		<b>1</b>	
<b>2</b>	Amounts included on line 1 but not on Form 990, Part IX, line 25			
<b>a</b>	Donated services and use of facilities . . . . .	<b>2a</b>		
<b>b</b>	Prior year adjustments . . . . .	<b>2b</b>		
<b>c</b>	Other losses . . . . .	<b>2c</b>		
<b>d</b>	Other (Describe in Part XIII ) . . . . .	<b>2d</b>		
<b>e</b>	Add lines <b>2a</b> through <b>2d</b> . . . . .		<b>2e</b>	
<b>3</b>	Subtract line <b>2e</b> from line <b>1</b> . . . . .		<b>3</b>	
<b>4</b>	Amounts included on Form 990, Part IX, line 25, but not on line 1:			
<b>a</b>	Investment expenses not included on Form 990, Part VIII, line 7b . . . . .	<b>4a</b>		
<b>b</b>	Other (Describe in Part XIII ) . . . . .	<b>4b</b>		
<b>c</b>	Add lines <b>4a</b> and <b>4b</b> . . . . .		<b>4c</b>	
<b>5</b>	Total expenses Add lines <b>3</b> and <b>4c</b> . (This must equal Form 990, Part I, line 18 ) . . . . .		<b>5</b>	

**Part XIII Supplemental Information**

Provide the descriptions required for Part II, lines 3, 5, and 9, Part III, lines 1a and 4, Part IV, lines 1b and 2b, Part V, line 4, Part X, line 2, Part XI, lines 2d and 4b, and Part XII, lines 2d and 4b Also complete this part to provide any additional information

Return Reference	Explanation
See Additional Data Table	



## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 36-2340313

**Name:** Northwest Community Hospital

## Supplemental Information

Return Reference	Explanation
Intended use of endowment funds	Schedule D, Part V, Line 4 ENDOWMENT FUNDS ARE CREATED ACCORDING TO HOSPITAL NEEDS AND DESIGNATION OR PREFERENCES OF THE DONOR(S) SUPPORTING THE ENDOWMENT FUND SCHOLARSHIP FUNDS, CONTINUED EDUCATION, OR FUNDS FOR PATIENT CARE IN A HOSPITAL DEPARTMENT DESIGNATED BY THE ENDOWMENT FUND ARE EXAMPLES OF FUND USES THE ENDOWMENT FUNDS REPORTED ON THE HOSPITAL'S 990 ARE ALSO REPORTED ON NORTHWEST COMMUNITY HOSPITAL FOUNDATION'S FORM 990, SCHEDULE D

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

**Hospitals**

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, question 20.**  
 ▶ **Attach to Form 990.**  
 ▶ **Go to [www.irs.gov/Form990EZ](http://www.irs.gov/Form990EZ) for instructions and the latest information.**

**Name of the organization**  
 Northwest Community Hospital

**Employer identification number**  
 36-2340313

OMB No 1545-0047  
**2018**  
 Open to Public Inspection

**Part I Financial Assistance and Certain Other Community Benefits at Cost**

		Yes	No
<b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	<b>1a</b>	Yes	
<b>b</b> If "Yes," was it a written policy? . . . . .	<b>1b</b>	Yes	
<b>2</b> 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			
<b>3</b> 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 <b>a</b> Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other _____ 300 %	<b>3a</b>	Yes	
<b>b</b> Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other _____ 600 %	<b>3b</b>	Yes	
<b>c</b> 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			
<b>4</b> 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"?	<b>4</b>	Yes	
<b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	<b>5a</b>	Yes	
<b>b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	<b>5b</b>	Yes	
<b>c</b> 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?	<b>5c</b>		No
<b>6a</b> Did the organization prepare a community benefit report during the tax year?	<b>6a</b>	Yes	
<b>b</b> If "Yes," did the organization make it available to the public?	<b>6b</b>	Yes	

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H

**7 Financial Assistance and Certain Other Community Benefits at Cost**

	(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
<b>Financial Assistance and Means-Tested Government Programs</b>						
<b>a</b> Financial Assistance at cost (from Worksheet 1)			4,754,077		4,754,077	0 980 %
<b>b</b> Medicaid (from Worksheet 3, column a)			60,256,347	54,295,115	5,961,232	1 230 %
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b)						
<b>d Total</b> Financial Assistance and Means-Tested Government Programs			65,010,424	54,295,115	10,715,309	2 210 %
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4)	53	44,083	1,720,512	194,118	1,526,394	0 310 %
<b>f</b> Health professions education (from Worksheet 5)	22	538	3,274,098	285,005	2,989,093	0 620 %
<b>g</b> Subsidized health services (from Worksheet 6)	1	1,921	471,355	277,229	194,126	0 040 %
<b>h</b> Research (from Worksheet 7)	3	45	163,084		163,084	0 030 %
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8)	7	1,237	611,979		611,979	0 130 %
<b>j Total.</b> Other Benefits	86	47,824	6,241,028	756,352	5,484,676	1 130 %
<b>k Total.</b> Add lines 7d and 7j	86	47,824	71,251,452	55,051,467	16,199,985	3 340 %

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development	2		7,118		7,118	
3 Community support						
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building	1	50	2,615		2,615	
7 Community health improvement advocacy	1		16,855		16,855	
8 Workforce development	2	155	17,565		17,565	
9 Other						
<b>10 Total</b>	<b>6</b>	<b>205</b>	<b>44,153</b>		<b>44,153</b>	

**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?		No
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.		
			27,243,138
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.		
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	191,971,681
6	Enter Medicare allowable costs of care relating to payments on line 5.	6	222,156,309
7	Subtract line 6 from line 5. This is the surplus (or shortfall).	7	-30,184,628
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used.  <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other		

**Section C. Collection Practices**

9a	Did the organization have a written debt collection policy during the tax year?	9a	Yes
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI.	9b	Yes

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

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1				
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?

**1**

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)

See Additional Data Table	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

**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)  
 NORTHWEST COMMUNITY HOSPITAL

Name of hospital facility or letter of facility reporting group \_\_\_\_\_

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

		Yes	No
<b>Community Health Needs Assessment</b>			
<b>1</b>	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? . . . . .		No
<b>2</b>	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 . . . . .		No
<b>3</b>	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)	Yes	
<b>a</b>	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b>	<input checked="" type="checkbox"/> Demographics of the community		
<b>c</b>	<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		
<b>d</b>	<input checked="" type="checkbox"/> How data was obtained		
<b>e</b>	<input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b>	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b>	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b>	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b>	<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)		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>4</b>	Indicate the tax year the hospital facility last conducted a CHNA <u>20 17</u>		
<b>5</b>	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .	Yes	
<b>6 a</b>	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .		No
<b>b</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 . . . . .		No
<b>7</b>	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)	Yes	
<b>a</b>	<input checked="" type="checkbox"/> Hospital facility's website (list url) <u>NCH org</u>		
<b>b</b>	<input type="checkbox"/> Other website (list url) _____		
<b>c</b>	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>8</b>	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 . . . . .	Yes	
<b>9</b>	Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 17</u>		
<b>10</b>	Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url) <u>NCH org</u>	Yes	
<b>a</b>			
<b>b</b>	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .		
<b>11</b>	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		
<b>12a</b>	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)? . . . . .		No
<b>12b</b>	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .		
<b>c</b>	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

**Part V Facility Information** (continued)

**Financial Assistance Policy (FAP)**

NORTHWEST COMMUNITY HOSPITAL

Name of hospital facility or letter of facility reporting group \_\_\_\_\_

		Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that		
<b>13</b>	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	<b>13</b> Yes	
<b>a</b>	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>300</u> % and FPG family income limit for eligibility for discounted care of <u>600</u> %		
<b>b</b>	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b>	<input checked="" type="checkbox"/> Asset level		
<b>d</b>	<input checked="" type="checkbox"/> Medical indigency		
<b>e</b>	<input checked="" type="checkbox"/> Insurance status		
<b>f</b>	<input checked="" type="checkbox"/> Underinsurance discount		
<b>g</b>	<input checked="" type="checkbox"/> Residency		
<b>h</b>	<input checked="" type="checkbox"/> Other (describe in Section C)		
<b>14</b>	Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b> Yes	
<b>15</b>	Explained the method for applying for financial assistance? . . . . . If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	<b>15</b> Yes	
<b>a</b>	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</b>	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
<b>c</b>	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
<b>d</b>	<input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>16</b>	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)	<b>16</b> Yes	
<b>a</b>	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>NCH org</u>		
<b>b</b>	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>NCH org</u>		
<b>c</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>NCH org</u>		
<b>d</b>	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b>	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>f</b>	<input 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)		
<b>g</b>	<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		
<b>h</b>	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b>	<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		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		

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

NORTHWEST COMMUNITY HOSPITAL

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_

		Yes	No	
<b>17</b>	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment? . . . . .	17	Yes	
<b>18</b>	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP			
	<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies)			
	<b>b</b> <input type="checkbox"/> Selling an individual's debt to another party			
	<b>c</b> <input type="checkbox"/> 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			
	<b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process			
	<b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)			
	<b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted			
<b>19</b>	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? . . . . .	19		No
	If "Yes," check all actions in which the hospital facility or a third party engaged			
	<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies)			
	<b>b</b> <input type="checkbox"/> Selling an individual's debt to another party			
	<b>c</b> <input type="checkbox"/> 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			
	<b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process			
	<b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)			
<b>20</b>	Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply)			
	<b>a</b> <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>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process			
	<b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications			
	<b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations			
	<b>e</b> <input type="checkbox"/> Other (describe in Section C)			
	<b>f</b> <input type="checkbox"/> None of these efforts were made			

**Policy Relating to Emergency Medical Care**

<b>21</b>	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? . . . . .	21	Yes	
	If "No," indicate why			
	<b>a</b> <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions			
	<b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing			
	<b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
	<b>d</b> <input type="checkbox"/> Other (describe in Section C)			

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

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

NORTHWEST COMMUNITY HOSPITAL

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_

**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

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

**23** During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? . . . . .

If "Yes," explain in Section C

**24** During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? . . . . .

If "Yes," explain in Section C

	Yes	No
<b>23</b>		No
<b>24</b>		No



**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? 16

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

**Part VI Supplemental Information**

Provide the following information

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

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H - PART I, LINE 3C - CHARITY CARE POLICY	<p>THE HOSPITAL PROVIDES EMERGENT AND MEDICALLY NECESSARY SERVICES TO ALL PATIENTS WITHOUT REGARD TO THE PATIENT'S ABILITY TO PAY THE WRITTEN CHARITY CARE POLICY IS WIDELY DISTRIBUTED AND COMMUNICATED TO THE COMMUNITY UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY THE AMOUNT OF FREE CARE PROVIDED IS DETERMINED BY FINANCIAL NEED AND IS NOT LIMITED BY BUDGETED AMOUNTS PATIENTS EARNING LESS THAN 300% OF THE FEDERAL POVERTY GUIDELINES RECEIVE FREE CARE AND THOSE BETWEEN 300% AND 600% OF THE GUIDELINES RECEIVE DISCOUNTED CARE ON A SLIDING SCALE THE FINANCIAL ASSISTANCE PROGRAM LOOKS AT THE CURRENT INCOME AND THEN CALCULATES THE POTENTIAL BENEFIT THE PATIENT'S LIABILITY IS CAPPED AT 25% OF THE FAMILY'S ANNUAL INCOME PLEASE SEE SCHEDULE H PART V, SECTION B, LINE 13H NARRATIVE FOR MORE DETAIL SCHEDULE H - PART I, LINE 6A-COMMUNITY BENEFIT REPORT THE HOSPITAL ANNUALLY PRODUCES A COMMUNITY BENEFIT REPORT WHICH HIGHLIGHTS THE COMMUNITY BENEFIT DOLLARS REPORTED IN THE ILLINOIS ATTORNEY GENERAL ANNUAL NONPROFIT HOSPITAL COMMUNITY BENEFITS PLAN REPORT THIS INCLUDES CHARITY CARE, LANGUAGE ASSISTANT SERVICES, GOVERNMENT SPONSORED INDIGENT HEALTH CARE, DONATIONS, VOLUNTEER SERVICES, EDUCATION, RESEARCH, SUBSIDIZED HEALTH SERVICES AND OTHER COMMUNITY BENEFITS IT ALSO HIGHLIGHTS THE MOST PREDOMINANT COMMUNITY HEALTH NEEDS IDENTIFIED IN THE MOST RECENT COMMUNITY HEALTH NEEDS ASSESSMENT COPIES OF THE REPORT ARE PRINTED AND MAILED TO KEY STAKEHOLDERS INCLUDING LOCAL GOVERNMENT, SOCIAL SERVICE AGENCIES, HOSPITAL SUPPORTERS AND MORE A COPY OF THE REPORT IS ALSO POSTED ON THE HOSPITAL WEBSITE (NCH ORG) AND IS AVAILABLE IN HARD COPY TO ANYONE WHO REQUESTS ONE A PRESS RELEASE WAS ALSO RUN IN THE LOCAL NEWSPAPER LETTING COMMUNITY MEMBERS KNOW THAT THE NEW REPORT WAS AVAILABLE ON THE HOSPITAL'S WEBSITE</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H - PART I, LINE 7 - FINANCIAL ASSISTANCE	THE FOLLOWING METHODOLOGIES WERE USED TO DETERMINE THE AMOUNTS REPORTED IN THE TABLE FOR LINE 7 PART I, LINES 7A - 7D RATIO OF COST TO CHARGES WAS DETERMINED USING WORKSHEET 2 IN THE FORM 990, SCHEDULE H INSTRUCTIONS PART I, LINES 7E - 7I COSTS WERE DETERMINED USING THE DIRECT AND INDIRECT COSTS FOR SPECIFIC PROGRAMS OR SERVICES THESE COSTS WERE MAINTAINED/IDENTIFIED IN THE HOSPITAL'S "COMMUNITY BENEFIT INVENTORY FOR SOCIAL ACCOUNTABILITY SOFTWARE" (CBISA) THE INDIRECT PORTION OF THESE COSTS WAS CALCULATED UTILIZING THE INDIRECT COST RATIO FROM THE HOSPITAL'S LATEST AVAILABLE MEDICARE COST REPORT THE "INDIRECT" RATIOS WERE ENTERED INTO CBISA FOR THE CALCULATION OF INDIRECT COSTS Part I, Line 7g - SUBSIDIZED HEALTH SERVICES THE HOSPITAL PROVIDES A MOBILE DENTAL CLINIC PROGRAM STAFFED BY A HOSPITAL-EMPLOYED FULL TIME DENTIST, DENTAL ASSISTANT AND PROGRAM MANAGER AND A PART TIME DENTAL HYGIENIST EVIDENCE BASED RESEARCH DEMONSTRATES THAT GUM DISEASE AND ORAL HEALTH PROBLEMS ARE LINKED TO OTHER SYSTEMIC MEDICAL PROBLEMS SUCH AS CARDIOVASCULAR DISEASE, STROKE, AND BACTERIAL PNEUMONIA, AS WELL AS INCREASED RISK OF DELIVERING PRE-TERM OR LOW BIRTH-WEIGHT BABIES THE HOSPITAL, WITH FINANCIAL SUPPORT FROM LOCAL TOWNSHIPS AND OTHER DONORS, PROVIDES PREVENTIVE AND RESTORATIVE CARE TO UNINSURED AND UNDERINSURED MEMBERS OF THE COMMUNITY 4-5 DAYS PER WEEK IN A MOBILE DENTAL CLINIC PART I, LINE 7, Column (F) \$27,243,138 of bad debt expense was excluded from total expenses reported on Form 990, Part IX, Line 25, column (A) in the calculation to determine the percentage of net community benefit expenses in relation to total expenses

Form and Line Reference	Explanation
<p>SCHEDULE H - PART II, COMMUNITY BUILDING ACTIVITIES</p>	<p>PART II - LINE 2 - ECONOMIC DEVELOPMENT THE HOSPITAL'S VICE PRESIDENT OF OPERATIONS REPRESENTS THE ORGANIZATION THROUGH PARTICIPATION IN THE ARLINGTON HEIGHTS ECONOMIC ALLIANCE COM MISSION THE COMMISSION IS MADE UP OF 13 LOCAL BUSINESS OWNERS AND REPRESENTATIVES WHO ARE TASKED WITH IMPROVING THE COMMUNITY'S ECONOMIC CLIMATE BY ADVISING THE VILLAGE BOARD AND STAFF THROUGH A BUSINESS PERSPECTIVE THE ORGANIZATION ALSO IS A MEMBER OF AND SUPPORTS TH E ARLINGTON HEIGHTS CHAMBER OF COMMERCE (AHCC) THE AHCC IS DEDICATED TO FOSTERING BUSINES S GROWTH AND STRENGTHENING THE LOCAL ECONOMY AND COMMUNITY</p> <p>PART II - LINE 6 - COALITION B UILDING THE HOSPITAL'S EXECUTIVE DIRECTOR OF COMMUNITY SERVICES REPRESENTS THE ORGANIZATIO N THROUGH PARTICIPATION IN THE ARLINGTON HEIGHTS ROTARY CLUB IN THE HOSPITAL'S PRIMARY SER VICE AREA ROTARY CLUB MEMBERS ARE PREDOMINATELY BUSINESS AND PROFESSIONAL LEADERS WHO COM E TOGETHER TO SUPPORT ORGANIZATIONS THAT ADDRESS NEED AND DISPARITY IN THE COMMUNITY AREA S ADDRESSED INCLUDE HUNGER, HOMELESSNESS, MENTAL HEALTH ISSUES, CANCER, TROUBLED YOUTH, DE VELOPMENTALLY DISABLED, DOMESTIC VIOLENCE AND MANY MORE NOTE THAT THE MAJORITY OF HOURS W AS NOT REPORTED IN THE COMMUNITY BUILDING SECTION OF THIS REPORT BECAUSE THE SALARY IS ALR EADY CAPTURED IN COMMUNITY BENEFIT OPERATIONS IN PART I, LINE 7J PART II - LINE 7 - ADVOC ACY FOR COMMUNITY HEALTH IMPROVEMENT/SAFETY THE HOSPITAL'S PRESIDENT AND CEO REPRESENTS TH E ORGANIZATION THROUGH PARTICIPATION ON THE BOARD OF DIRECTORS FOR THE ILLINOIS HOSPITAL A SSOCIATION (IHA) THE IHA WORKS WITH OVER 200 HOSPITALS AND 50 HEALTH CARE SYSTEMS TO IMPRO VE THE HEALTH AND WELL-BEING OF PATIENTS AND COMMUNITIES THE CEO ALSO PARTICIPATES IN THE LEADERSHIP BOARD OF THE CHILDREN'S ADVOCACY CENTER (CAC) THE CAC IS THE LEADING RESOURCE TO EMPOWER AND HEAL ABUSED CHILDREN AND TO PREVENT VIOLENCE AGAINST CHILDREN THE HOSPITA L'S VICE PRESIDENT OF OPERATIONS REPRESENTS THE ORGANIZATION THROUGH PARTICIPATION ON THE BOARD OF ST MARY'S SERVICES THE LOCAL NOT FOR PROFIT ORGANIZATION PROVIDES MATERNITY COU NSELING AND PARENTING EDUCATION, AS WELL AS GUIDANCE AND SUPPORT FOR FAMILIES SEEKING ADOP TION PART II - LINE 8 - WORKFORCE DEVELOPMENT THE HOSPITAL HAS A PROGRAM TO ENCOURAGE HIG H SCHOOL STUDENTS TO EXPLORE CAREERS IN HEALTHCARE THE PROGRAM PROVIDES LOCAL HIGH SCHOOL STUDENTS THE OPPORTUNITY TO SPEND 14 WEEKS IN THE HOSPITAL SHADOWING 14 DIFFERENT DEPARTM ENTS AS THE STUDENTS ROTATE THROUGH THE VARIOUS DEPARTMENTS THEY ARE EXPOSED TO AN ARRAY OF CLINICAL FIELDS, PROVIDING THEM WITH AN IN-DEPTH LOOK AT JUST SOME OF THE MANY CAREER T RACKS THEY COULD PURSUE THE HOSPITAL ALSO PARTICIPATES IN VOCATIONAL FAIRS AT LOCAL HIGH SCHOOLS AND COMMUNITY COLLEGES AND HOSTS OTHER ONE-TIME EVENTS FOR STUDENTS TO VISIT THE H OSPITAL, HEAR PRESENTATIONS FROM DIFFERENT DEPARTMENTS AND ASK QUESTIONS AS A WAY TO EXPLO RE DIFFERENT CAREERS IN HEALTHCARE SCHEDULE H - PART III, BAD DEBT, MEDICARE &amp; COLLECTION PRACTICES SECTION A, LINE 2, 3, 4 NORTHWEST COMMUNITY HOSPITAL IS INCLUDED IN THE AUDITED FINANCIAL STATEMENTS OF NORTHWEST COMMUNITY HEALTHCARE (NCH) AND SUBSIDIARIES THE TEXT O F THE FOOTNOTE #4, REFERENCING UNCOLLECTIBLE ACCOUNTS IN THE FY 2019 AUDITED FINANCIAL STA TEMENT IS AS FOLLOWS "[NCH] ANALYSES THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS MONTHLY USI NG A HINDSIGHT CALCULATION THAT UTILIZES WRITE-OFF DATA FOR ALL PAYER CLASSES DURING THE L ATEST 18-MONTH PERIOD, WITH WRITE-OFF ACTIVITY TO ESTIMATE THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS AT A POINT IN TIME THE PERCENTAGES USED IN THE COMPUTATION OF THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS CHANGE EACH MONTH GIVEN CHANGES IN TRENDS FROM THESE ANALYSES OR P OLICY CHANGES " ACCOUNTS RECEIVABLE ARE CHARGED TO THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNT S WHEN THEY ARE DEEMED UNCOLLECTIBLE WRITE-OFFS ARE SHOWN NET OF CONTRACTUALS AND DISCOUN TS THE HOSPITAL'S BAD DEBT EXPENSE AS REPORTED ON LINE 2 IS REPORTED AT THE REMAINING CHA RGES FOR FY 2019, THE HOSPITAL RECORDED PROVISIONS FOR BAD DEBT EXPENSE OF \$27,243,137 I N 2013, THE HOSPITAL BEGAN USING A FINANCIAL TOOL TO DETERMINE "PRESUMPTIVE ELIGIBILITY" F OR CHARITY CARE WRITE-OFFS THIS TOOL UTILIZES VARIOUS CRITERIA TO HELP DETERMINE PATIENTS THAT WOULD BE ELIGIBLE FOR FINANCIAL ASSISTANCE EVEN IF THOSE PATIENTS HAVE NOT COMPLETED A FINANCIAL ASSISTANCE APPLICATION IT IS BELIEVED THAT ALL PATIENTS WHO WOULD QUALIFY FO R CHARITY HAVE BEEN IDENTIFIED AND THAT LITTLE TO NONE OF THE AMOUNTS WRITTEN OFF AS BAD D EBT COULD BE CLASSIFIED AS CHARITY AS A RESULT OF THE USE OF THIS NEW FINANCIAL TOOL PART III, SECTION B, LINE 8 THE MEDICARE SHORTFALL REPORTED IN PART III, LINE 7 REPRESENTS THE EXCESS COST OF PROVIDING SERVICES TO MEDICARE BENEFICIARIES OVER THE PAYMENTS RECEIVED FR OM THE MEDICARE PROGRAM ACCESS TO QUALITY HEALTHCARE IS IMPERATIVE FOR ALL MEDICARE RECIP IENTS, MANY OF WHOM ARE LIVING ON A FIXED INCOME AS SUCH, THE COSTS ABSORBED BY THE HOSPI TAL IN PROVIDING THESE SERVICES IS A BENEFIT TO TH</p>

Form and Line Reference	Explanation
<p>SCHEDULE H - PART II, COMMUNITY BUILDING ACTIVITIES</p>	<p>E MEMBERS OF THE COMMUNITY WE SERVE PART III SECTION C COLLECTION PRACTICES, LINE 9B IT IS THE POLICY OF THE HOSPITAL TO OFFER PATIENTS A PAYMENT PLAN OR FINANCIAL ASSISTANCE WHEN IT BECOMES KNOWN OR SUSPECTED THAT A PATIENT NEEDS SUCH ASSISTANCE FINANCIAL COUNSELORS CONTACT AND WORK WITH THE PATIENT OR THEIR FAMILY TO HELP DETERMINE IF THERE ARE ANY THIRD PARTY PAYERS WHICH MAY BE AVAILABLE TO HELP THE PATIENT MEET THEIR OBLIGATIONS, SUCH AS MEDICAID, COBRA, WORKERS COMPENSATION, OR SPECIALIZED GRANT PROGRAMS IF NO THIRD PARTY PROGRAMS ARE IDENTIFIED, THE FINANCIAL COUNSELORS WORK WITH THE PATIENT TO HELP THEM APPLY FOR CHARITY DISCOUNTS OR PAYMENT PLANS FORMS ARE AVAILABLE IN ENGLISH, SPANISH, RUSSIAN, POLISH, GERMAN, JAPANESE AND TRANSLATION SERVICES ARE PROVIDED IN MANY LANGUAGES IN ADDITION, ALL PATIENT BILLS AND STATEMENTS INCLUDE INFORMATION ABOUT HOW TO APPLY FOR FINANCIAL ASSISTANCE AND THE INFORMATION IS ALSO POSTED ON THE HOSPITAL'S WEBSITE (NCH.ORG) COLLECTION ACTIVITY WILL BE SUSPENDED DURING THE CONSIDERATION OF A COMPLETED FINANCIAL ASSISTANCE APPLICATION OR AN APPLICATION FOR OTHER HEALTHCARE BRACKET (IE, MEDICARE, MEDICAID, ETC) UNTIL FINANCIAL ASSISTANCE CAN BE DETERMINED ACCOUNTS IN THE FINANCIAL ASSISTANCE PROCESS WILL BE MONITORED AND, UPON THE DECISION TO APPROVE OR DENY FINANCIAL ASSISTANCE, THE PATIENT'S ACCOUNT WILL BE UPDATED IF THE FINANCIAL ASSISTANCE APPLICATION IS APPROVED WITH A PERCENTAGE LESS THAN 100% OR DENIED, THE PATIENT'S ACCOUNT WILL BE NOTED AND THE HOSPITAL WILL RESUME THE SELF-PAY COLLECTION ACTIVITY IN COMPLIANCE WITH ITS SELF PAY FOLLOW-UP PROCEDURES</p>

Form and Line Reference	Explanation
<p>SCHEDULE H - PART VI, LINE 2 - NEEDS ASSESSMENT</p>	<p>THE 2018 COMMUNITY HEALTH NEEDS ASSESSMENT WAS CONDUCTED INDEPENDENTLY BY THE HOSPITAL INS TEAD OF BEING OUTSOURCED TO A VENDOR THE HOSPITAL BELIEVED DOING ITS OWN ASSESSMENT WOULD YIELD MORE MEANINGFUL RESULTS AND A CLEARER SNAPSHOT OF THE COMMUNITY IT SERVES THE ASSESSMENT WAS COMPRISED OF DATA COLLECTED FROM QUANTITATIVE, QUALITATIVE OR A COMBINATION OF BOTH RESOURCES THE HOSPITAL CONTRACTED WITH SG2, AN INDUSTRY LEADER IN HEALTHCARE ANALYTICS AND CONSULTING, FOR QUANTITATIVE DATA SG2 PROVIDED COMPREHENSIVE DEMOGRAPHIC INFORMATION OF THE HOSPITAL'S SERVICE AREA THEY ALSO PROVIDED POPULATION GROWTH PROJECTIONS FOR THE COMMUNITY BY TOWN, AGE, GENDER, ETHNICITY/RACE, INCOME AND EDUCATION IN ADDITION, THEY FORECASTED THE PROJECTED GROWTH OF CHRONIC DISEASE AREAS BY BOTH INPATIENT AND OUTPATIENT FOR THE HOSPITAL'S SERVICE AREA CHANGES IN COMMUNITY DEMOGRAPHICS HAVE A DIRECT CORRELATION WITH HEALTHCARE NEEDS AND HOW TO ADDRESS THEM ADDITIONAL QUANTITATIVE DATA WAS COLLECTED THROUGH COMMUNITY COMMONS, A WEB PORTAL (COMMUNITYCOMMONS.ORG) THAT ALLOWS ACCESS TO DATA IN MULTIPLE CATEGORIES WHICH CAN BE USED TO EXPLORE COMMUNITY HEALTH THESE CATEGORIES INCLUDE DEMOGRAPHICS, SOCIAL AND ECONOMIC FACTORS, PHYSICAL ENVIRONMENT, CLINICAL CARE, HEALTH BEHAVIORS AND HEALTH OUTCOMES THE GOAL OF COMMUNITY COMMONS IS TO INCREASE THE IMPACT OF THOSE WORKING TOWARD HEALTHY, EQUITABLE, AND SUSTAINABLE COMMUNITIES CUSTOM TOOLS ALLOWED THE HOSPITAL TO FILTER DATA BY ZIP CODE AND CREATE A REPORT SPECIFICALLY FOR ITS COMMUNITY IT ALSO ALLOWED THE HOSPITAL TO CREATE A CUSTOM REPORT WHICH HIGHLIGHTS ITS COMMUNITY'S GREATEST AREAS OF CONCERN THE LAST SOURCE OF QUANTITATIVE DATA WAS THE 2018 COUNTY HEALTH RANKINGS AND ROADMAPS REPORT (COUNTYHEALTHRANKINGS.ORG), COLLABORATION BETWEEN THE ROBERT WOOD JOHNSON FOUNDATION AND THE UNIVERSITY OF WISCONSIN POPULATION HEALTH INSTITUTE THIS REPORT RANKS US COUNTIES IN EVERY STATE ON VARIOUS HEALTH OUTCOMES, HEALTH FACTORS, SOCIAL AND ECONOMIC CONDITIONS, AND THE PHYSICAL ENVIRONMENT THE MAJOR GOAL OF THE RANKINGS IS TO RAISE AWARENESS ABOUT THE MANY FACTORS THAT INFLUENCE HEALTH AND THAT HEALTH VARIES FROM PLACE TO PLACE BECAUSE THE COUNTY WHERE THE HOSPITAL IS LOCATED (COOK) IS SO LARGE AND DIVERSE, THE COOK COUNTY DEPARTMENT OF PUBLIC HEALTH RECOGNIZED THE UNIQUENESS AND IDENTIFIED INDICATORS FROM THE RANKINGS FOR WHICH LOCAL DATA EXISTED AND CREATED A REPORT SPECIFICALLY FOR SUBURBAN COOK COUNTY THE HOSPITAL UTILIZED THIS REPORT AS WELL QUALITATIVE DATA WAS PRIMARY COLLECTED THROUGH FOCUS GROUPS THE HOSPITAL REALIZED THE IMPORTANCE OF GATHERING OPINIONS AND FEEDBACK FROM VULNERABLE POPULATIONS IN THE COMMUNITY WHO HAVE SOME OF THE GREATEST HEALTHCARE NEEDS A PROFESSIONAL MODERATOR WAS HIRED TO CONDUCT THREE FOCUS GROUPS IN FEBRUARY 2018 ONE WITH SENIORS, ONE WITH SPANISH-SPEAKING UNDER-RESOURCED COMMUNITY MEMBERS AND ONE WITH ENGLISH-SPEAKING UNDER-RESOURCED COMMUNITY MEMBERS POTENTIAL PARTICIPANTS WERE GIVEN A SHORT SCREENING QUESTIONNAIRE TO ENSURE THEY LIVED IN THE HOSPITAL'S SERVICE AREA AND SO THAT PARTICIPANTS WOULD VARY IN AGE, GENDER, INSURANCE STATUS, INCOME AND EDUCATIONAL LEVELS THE FOCUS GROUPS FOLLOWED A GUIDELINE WHICH MIMICRED QUESTIONS INCLUDED IN THE COMMUNITY AND KEY INFORMANT SURVEYS SO THAT THE INFORMATION GATHERED COULD BE USED TO COMPARE WITH THE SURVEY RESULTS THE MODERATOR SUMMARIZED THE RESULTS OF THE FOCUS GROUPS WHICH WERE USED AS ONE OF THE TOOLS IN IDENTIFYING THE MOST PREDOMINANT COMMUNITY NEEDS TWO DIFFERENT SURVEYS WERE DEVELOPED TO COLLECT A COMBINATION OF BOTH QUANTITATIVE AND QUALITATIVE DATA A COMPREHENSIVE ONLINE COMMUNITY HEALTH SURVEY WAS CONDUCTED IN ORDER TO TAKE INTO ACCOUNT INPUT FROM PERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY SERVED BY THE HOSPITAL THE SURVEY ASKED PARTICIPANTS TO "GRADE" THEIR COMMUNITIES OVERALL HEALTH AND PROVIDE FEEDBACK ON ACCESS TO CARE, BEHAVIORAL HEALTH, CHRONIC DISEASE/HEALTH ISSUES, FAMILY ISSUES AND MODIFIABLE RISK FACTORS IT ALSO ASKED THE PARTICIPANTS TO RANK THEIR "TOP FIVE HEALTH CONCERNS" FOR THE COMMUNITY THE COMMUNITY WAS INVITED TO PARTICIPATE IN THE ONLINE SURVEY THROUGH A MEDIA RELEASE AND A PAID ADVERTISEMENT IN A LOCAL NEWSPAPER, THE HOSPITAL'S ELECTRONIC COMMUNITY NEWSLETTER "A HEALTHIER YOU", THE HOSPITAL'S ELECTRONIC VOLUNTEER AND EMPLOYEE NEWSLETTERS AND THROUGH SOCIAL MEDIA THE SURVEY LINK, LOCATED ON THE HOME PAGE OF THE HOSPITAL'S WEBSITE (NCH.ORG), WAS OPEN FROM FEBRUARY 21 TO MARCH 14, 2018 AND 414 PEOPLE RESPONDED IN ADDITION, AN ONLINE SURVEY FOR KEY INFORMANTS WAS CONDUCTED SPECIFICALLY TO SOLICIT INPUT FROM KEY INFORMANTS AS DESCRIBED IN PART V, SECTION B, QUESTION 5 IN APRIL 2018, THE HOSPITAL CONVENED AN INTERNAL, MULTIDISCIPLINARY COMMITTEE WHICH MET MULTIPLE TIMES TO REVIEW THE RESULTS OF THE COMMUNITY HEALTH NEEDS ASSESSMENT, AFFIRM AND PRIORITIZE NEEDS AND TO IDENTIFY THE MOST QUALIFIED INTERNAL AND EXTERNAL PERSONS TO DEVELOP IMPLEMENTATION P</p>

Form and Line Reference	Explanation
<p>SCHEDULE H - PART VI, LINE 2 - NEEDS ASSESSMENT</p>	<p>PLANS TO ADDRESS EACH PRIORITY NEED REPRESENTATIVES FROM THE FOLLOWING DEPARTMENTS SERVED ON THE COMMITTEE BEHAVIORAL HEALTH, CARE COORDINATION, COMMUNITY SERVICES, COMPLIANCE, DE CISION SUPPORT, DIABETES SERVICES, EMERGENCY DEPARTMENT, EMS, FOUNDATION, GUEST SERVICES, IMMEDIATE CARE CENTERS, MARKETING, MEDICAL GROUP, NURSING, PATIENT ACCESS SERVICES, RESEAR CH, AND PATIENT EXPERIENCE IN ADDITION, THE CHAIRMAN OF THE NCH BOARD OF DIRECTORS AND TH E EXECUTIVE VICE PRESIDENT CHIEF LEGAL COUNSEL PARTICIPATED IN THE COMMITTEE THE COMMITTEE E MEMBERS RECEIVED A SUMMARY AND COMPARISON DOCUMENT WHICH WAS USED AS A TOOL TO REVIEW AL L OF THE QUANTITATIVE AND QUALITATIVE FINDINGS THE FINDINGS FROM THE FOCUS GROUPS, COMMUN ITY SURVEY AND KEY INFORMANT SURVEY WERE COMPARED AND THE SECONDARY DATA PROVIDED SUPPLEMENTAL INFORMATION THE MOST COMMON THEMES AND COMMENTS FROM THE NARRATIVE PORTION OF THE SU RVEYS WERE ALSO HIGHLIGHTED IN THE DOCUMENT IN ADDITION, THE COMMITTEE WAS GIVEN WEB ACCE SS TO THE COMPLETE SURVEY RESULTS, FOCUS GROUPS SUMMARIES AND ALL SECONDARY DATA THE COMM ITTEE WAS GIVEN TWO WEEKS TO REVIEW THE SUMMARY AND COMPARISON DOCUMENT AND TO ACCESS THE ADDITIONAL RESOURCES AND THEN RECONVENED TO RANK OR PRIORITIZE THE ISSUES THE COMMITTEE U SED MAGNITUDE, IMPACT/SERIOUSNESS, FEASIBILITY AND CONSEQUENCES OF INACTION AS THE CRITERIA TO IDENTIFY WHICH HEALTH NEEDS WOULD BE ADDRESSED OVER THE NEXT THREE YEARS TAKING INTO ACCOUNT HOSPITAL RESOURCES AND OVERALL ALIGNMENT WITH THE HOSPITAL'S MISSION, GOALS AND S TRATEGIC PRIORITIES - IT WAS DETERMINED THAT NCH WOULD FOCUS THE MAJORITY OF ITS EFFORTS ON DEVELOPING AND/OR SUPPORTING STRATEGIES AND INITIATIVES TO IMPROVE THE FOLLOWING PRIORIT Y AREAS ACCESS TO CARE FOR THE UNDER-RESOURCED, BEHAVIORAL HEALTH (MENTAL HEALTH AND SUBSTANCE ABUSE), OBESITY/PHYSICAL ACTIVITY/WEIGHT, CANCER (SMOKING/TOBACCO) AND CHRONIC DISEASE (DIABETES, HEART DISEASE, STROKE, RESPIRATORY AND KIDNEY) INTERNAL COMMITTEES WERE FORMED TO DEVELOP IMPLEMENTATION PLANS FOR EACH OF THE PRIORITY AREA AS DESCRIBED IN PART V, SECTION C, QUESTION 11 THE COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION PLAN WAS REVIEWED AND APPROVED BY THE COMMUNITY HEALTH AND OUTREACH COMMITTEE OF THE BOARD ON JUNE 13, 2018 AND PRESENTED TO THE ENTIRE BOARD OF DIRECTORS ON JUNE 25, 2018 IT WAS ALSO PRES ENTED FOR APPROVAL TO THE COMMUNITY BENEFIT REGULATORY COMMITTEE, A COMMITTEE THAT ENSURES THE HOSPITAL IS MEETING ALL OF THE MANDATED REGULATORY REQUIREMENTS ON JUNE 12, 2018 THE COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION PLAN WAS POSTED ON THE HOSPITAL'S WEBSITE, (NCH.ORG) IN JULY 2018 WHICH THE COMMUNITY WAS MADE AWARE OF THROUGH PRESS RELEASES THE IMPLEMENTATION PLAN IS ASSESSED AND UPDATED ON THE HOSPITAL'S WEBSITE ON AN ANNUAL BASIS THE WEBSITE ALSO HAS A LINK WHICH PROVIDES THE COMMUNITY WITH THE OPPORTUNITY TO OFFER COMMENTS AND FEEDBACK ABOUT THE ASSESSMENT AND/OR IMPLEMENTATION PLAN NO COMMENTS HAVE BEEN RECEIVED SINCE THE COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION PLAN WERE POSTED THE HOSPITAL WILL PROVIDE ANY INDIVIDUAL REQUESTING A COPY OF THE WRITTEN REPORT WITH THE DIRECT WEBSITE ADDRESS, OR URL, WHERE THE DOCUMENT CAN BE ACCESSED NCH WILL ALSO MAINTAIN AT ITS FACILITIES A HARD COPY OF THE REPORTS THAT MAY BE VIEWED BY ANY WHO REQUEST IT AS MENTIONED PREVIOUSLY, THE HOSPITAL MAINTAINS A FULL TIME COMMUNITY SERVICES DEPARTMENT WHO IS IN CONSTANT COLLABORATION WITH COMMUNITY ORGANIZATIONS, LOCAL GOVERNMENT, SCHOOLS, CHURCHES AND SOCIAL SERVICE AGENCIES TO IDENTIFY AND ADDRESS UNMET NEEDS THE EXECUTIVE DIRECTOR OF THE COMMUNITY SERVICES DEPARTMENT IS ON THE BOARD OF DIRECTORS OF PARTNERS FOR OUR COMMUNITIES (POC), A LOCAL NOT FOR PROFIT THAT HELPS THE HOSPITAL RUN A COMMUNITY RESOURCE CENTER IN THE HOSPITAL'S PRIMARY SERVICE AREA THE RESOURCE CENTER HOUSES ELEVEN NOT FOR PROFIT AGENCIES INCLUDING COMMUNITY CARES, A FOOD AND CLOTHING PANTRY FOR UNDER-RESOURCED MEMBERS OF THE COMMUNITY PROVIDE</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
<p>SCHEDULE H - PART VI, LINE 3 - PATIENT EDUCATION OF ELIG FOR ASSISTANCE</p>	<p>THE FINANCIAL ASSISTANCE PROGRAM AT NORTHWEST COMMUNITY HOSPITAL IS COMMUNICATED WIDELY TO PATIENTS AND VISITORS IN ENGLISH AND SPANISH USING THE FOLLOWING METHODS 1 SIGNAGE IN ENGLISH AND SPANISH IS POSTED THROUGHOUT THE ORGANIZATION AT ALL ACCESS POINTS, INCLUDING THE EMERGENCY DEPARTMENT AND OUTPATIENT REGISTRATION AREAS THESE AREAS ALSO STOCK AND MAKE AVAILABLE A BROCHURE, PRINTED IN ENGLISH AND SPANISH, DESCRIBING THE HOSPITAL'S POLICY THE HOSPITAL PROVIDES A COMPREHENSIVE LANGUAGE ASSISTANCE PROGRAM WHICH INCLUDES VIDEO REMOTE AND IN-PERSON TRANSLATORS WHO CAN ASSIST THOSE WHO NEED ADDITIONAL INFORMATION ON FINANCIAL ASSISTANCE 2 IN FY 2019 THE INFORMATION BELOW WAS POSTED ON THE HOSPITAL WEBSITE "FINANCIAL ASSISTANCEOTHER RELATED TERMS CAN ALSO BE SEARCHED FOR FROM ANY PAGE OF THE HOSPITAL WEBSITE TAKING USERS TO THE INFORMATION INCLUDING APPLICATIONS FOR FINANCIAL ASSISTANCE (AVAILABLE IN ENGLISH, SPANISH, GERMAN, POLISH, JAPANESE, AND RUSSIAN), FINANCIAL ASSISTANCE POLICIES, AND WAYS TO REACH THE NCH FINANCIAL COUNSELOR BY EMAIL, PHONE OR IN PERSON PATIENT FINANCIAL ASSISTANCE PAGE TO APPLY FOR PATIENT FINANCIAL ASSISTANCE AT NCH, PLEASE PRINT THE FINANCIAL ASSISTANCE APPLICATION (TAMBIEN DISPONIBLE EN ESPAOL) AND COMPLETE ALL NECESSARY FIELDS PLEASE BE SURE TO PROVIDE ALL REQUESTED DOCUMENTATION TO BE CONSIDERED FOR FINANCIAL ASSISTANCE NORTHWEST COMMUNITY HOSPITAL IS A CHARITABLE ORGANIZATION AND PROVIDES FINANCIAL ASSISTANCE TO THOSE WHO ARE ELIGIBLE THE DAY SURGERY CENTER IS A FOR-PROFIT ORGANIZATION AND ALSO PROVIDES FINANCIAL ASSISTANCE TO THOSE WHO ARE ELIGIBLE MAIN FEES AND BILL PAYMENT PAGE FOR FAMILIES WITHOUT INSURANCE WHO NEED HELP WITH MEDICAL BILLS, WE ACCEPT ILLINOIS PUBLIC AID IN ADDITION, YOU MAY QUALIFY FOR FINANCIAL ASSISTANCE FOR MEDICAL BILLS THROUGH NORTHWEST COMMUNITY HOSPITAL NORTHWEST COMMUNITY HOSPITAL IS A CHARITABLE ORGANIZATION AND PROVIDES FINANCIAL ASSISTANCE TO THOSE WHO ARE ELIGIBLE THE DAY SURGERY CENTER IS A FOR-PROFIT ORGANIZATION AND ALSO PROVIDES FINANCIAL ASSISTANCE TO THOSE WHO ARE ELIGIBLE 3 EACH PATIENT INVOICE OR OTHER SUMMARY OF CHARGES TO A PATIENT SHALL INCLUDE WITH IT OR ON IT A STATEMENT REGARDING HOW A PATIENT MAY APPLY FOR CONSIDERATION UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY THE PATIENT IS PROVIDED A CONTACT NUMBER FOR FINANCIAL ASSISTANCE AND OUR WEBPAGE TO DOWNLOAD AN APPLICATION 4 FINANCIAL COUNSELORS PROVIDE FINANCIAL ASSISTANCE INFORMATION TO PATIENTS DURING THEIR REGISTRATION AND WORK WITH PATIENTS IDENTIFIED AT REGISTRATION OR AFTER ADMISSION TO HELP THEM GET THE ASSISTANCE THEY NEED, ANSWER QUESTIONS, SET UP PAYMENT PLANS AND FACILITATE APPLICATIONS FOR GOVERNMENT PROGRAMS SUCH AS MEDICAID</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H - PART VI, LINE 4 - COMMUNITY INFORMATION	<p>NORTHWEST COMMUNITY HOSPITAL IS LOCATED IN ARLINGTON HEIGHTS, ILLINOIS, A SUBURB LOCATED APPROXIMATELY 25 MILES NORTHWEST OF CHICAGO IT'S PRIMARY SERVICE AREA CONSISTS OF ARLINGTON HEIGHTS AND THE SURROUNDING SUBURBS OF MT PROSPECT, PALATINE, AND ROLLING MEADOWS THE HOSPITAL'S SECONDARY SERVICE AREA IS COMPRISED OF BARRINGTON, BUFFALO GROVE, DES PLAINES, ELK GROVE VILLAGE, HOFFMAN ESTATES, LAKE ZURICH, PROSPECT HEIGHTS, SCHAUMBURG AND WHEELING THE POPULATION OF THE HOSPITAL'S TOTAL SERVICE AREA IS APPROXIMATELY 673,337 AND IS PROJECTED TO REMAIN RELATIVELY STABLE WITH A PROJECTED GROWTH OF ONLY 1% OVER THE NEXT FIVE YEARS (THROUGH 2022) THE HIGHEST UTILIZERS OF HEALTH CARE SERVICES ARE PATIENTS AGED 65 AND OVER, AND THIS AGE GROUP IS EXPECTED TO GROW 14% IN THE HOSPITAL'S PRIMARY SERVICE AREA AND 18% IN THE HOSPITAL'S SECONDARY AREA THE HOSPITAL'S TOTAL SERVICE AREA IS PREDOMINATELY NON-HISPANIC WHITE (65 3%), FOLLOWED BY HISPANIC (15 7%) AND ASIAN (14 9%) THE BLACK AND NON-HISPANIC WHITE POPULATION IS PROJECTED TO DECREASE 5 2% AND 3 7% RESPECTIVELY THE POPULATIONS THAT ARE PROJECTED TO HAVE THE LARGEST GROWTH ARE THE ASIAN/PACIFIC ISLANDERS (11 8%) AND HISPANIC (7 7%) POPULATIONS HOUSEHOLDS IN THE UPPER INCOME BRACKETS, \$100K AND HIGHER, ARE PROJECTED TO INCREASE WHILE ALL LOWER INCOME BRACKETS ARE PROJECTED TO DECREASE THE PROJECTED CHANGE IN THE EDUCATION LEVEL FORECASTS THE LEVEL WITH THE LARGEST PROJECTED GROWTH IS FOR THOSE NOT ACHIEVING A HIGH SCHOOL DIPLOMA THERE ARE 21,694 INDIVIDUALS WHO LACK HEALTH INSURANCE IN THE HOSPITAL'S TOTAL SERVICE AREA THE HOSPITAL'S SERVICE AREA PROJECTIONS PREDICT NOTABLE GROWTH IN THE FOLLOWING CHRONIC DISEASES HEART DISEASE, CANCER (BREAST AND COLORECTAL), DIABETES, OBESITY AND ASTHMA ALTHOUGH THE HOSPITAL'S SERVICE AREA EXCEEDS STATE AND NATIONAL AVERAGES FOR ANNUAL AVERAGE INCOME, THERE ARE STILL MANY SIGNIFICANT POCKETS OF VULNERABLE POPULATIONS BASED ON INCOME AND ATTAINMENT OF A HIGH SCHOOL DEGREE IN ADDITION, THE ENTIRE PRIMARY SERVICE AREA AND A SIGNIFICANT PORTION OF THE SECONDARY SERVICE AREA HAVE BEEN DESIGNATED AS A MEDICALLY-UNDERSERVED POPULATION THE HOSPITAL WORKS CLOSELY WITH TWO FEDERALLY QUALIFIED HEALTH CENTERS AND A COUNTY RUN PRIMARY CARE CLINIC, ALL LOCATED IN THE HOSPITAL'S SERVICE AREA THERE ARE NO OTHER HOSPITALS IN THE PRIMARY SERVICE AREA AND THREE IN THE SECONDARY SERVICE AREA OF THE HOSPITAL</p>

Form and Line Reference	Explanation
<p>SCHEDULE H - PART VI, LINE 5 - PROMOTION OF COMMUNITY HEALTH</p>	<p>THE HOSPITAL FURTHERS ITS EXEMPT PURPOSE BY PROMOTING THE HEALTH OF ITS COMMUNITY IN MANY WAYS AS FOLLOWS (1) A MAJORITY OF THE HOSPITAL'S BOARD OF DIRECTORS IS COMPRISED OF PERSONS WHO LIVE OR WORK IN THE HOSPITAL'S PRIMARY SERVICE AREA AND ARE NOT EMPLOYEES OR CONTRACTORS OF THE HOSPITAL, NOR FAMILY MEMBERS (2) THE HOSPITAL EXTENDS MEDICAL STAFF PRIVILEGES TO ALL QUALIFIED PHYSICIANS IN ITS COMMUNITY (3) A STANDING COMMUNITY HEALTH AND OUTREACH COMMITTEE OF THE HOSPITAL BOARD REVIEWS THE COMMUNITY HEALTH NEEDS ASSESSMENT AND ENSURES THE IMPLEMENTATION PLAN ADDRESSES IDENTIFIED NEEDS THE COMMITTEE, COMPRISED OF BOARD MEMBERS, SENIOR EXECUTIVES, PHYSICIANS, COMMUNITY MEMBERS AND STAFF, PROVIDES OVERSIGHT IN MONITORING AND EVALUATING THE EFFECTIVENESS OF STRATEGIES AND INITIATIVES INCLUDED IN THE IMPLEMENTATION PLAN THE COMMITTEE MONITORS THE AMOUNT OF DOLLARS INVESTED IN COMMUNITY BENEFIT INCLUDING CHARITY CARE, COMMUNITY HEALTH EDUCATION, AND OTHER COMMUNITY HEALTH IMPROVEMENT INITIATIVES (4) THE HOSPITAL HAS A COMMUNITY BENEFIT REGULATORY COMMITTEE COMPOSED OF STAFF FROM COMMUNITY SERVICES, FINANCE, LEGAL, COMPLIANCE AND PATIENT ACCESS SERVICES THIS COMMITTEE REVIEWS THE COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS, THE DEVELOPMENT OF THE IMPLEMENTATION PLAN AND THE ANNUAL NONPROFIT HOSPITAL COMMUNITY BENEFITS PLAN REPORT FOR THE STATE OF ILLINOIS TO ENSURE ALL REGULATORY REQUIREMENTS ARE BEING MET (5) THE PATIENT FAMILY ADVISORY COUNCIL, COMPRISED OF COMMUNITY MEMBERS WHO HAVE UTILIZED THE HOSPITAL'S SERVICES, MEETS MONTHLY TO HELP THE HOSPITAL IDENTIFY AND IMPROVE KEY DRIVERS THAT IMPACT PATIENT EXPERIENCE THE COMMITTEE REVIEWS CURRENT PROCESSES AND PROPOSED CHANGES AND THEN PROVIDES FEEDBACK, COMMENTS AND SUGGESTIONS (6) THE HOSPITAL MAINTAINED AN AVERAGE OF 275 DAYS CASH OR CASH EQUIVALENT ON HAND IN THE HOSPITAL ITSELF OR AT NORTHWEST COMMUNITY HEALTHCARE (A 501(C)(3) SUPPORTING ORGANIZATION AND SOLE MEMBER OF THE HOSPITAL) FOR FUNDING CAPITAL IMPROVEMENTS IN TECHNOLOGY, FACILITIES OR PATIENT CARE EQUIPMENT, AND SUPPORTING HOSPITAL OPERATIONS OR COMMUNITY OUTREACH INITIATIVES (7) THE HOSPITAL HAS DEDICATED STAFF THAT SERVE AS MEMBERS, CHAIRPERSONS, OFFICERS, AND BOARD MEMBERS OF LOCAL AND NATIONAL ORGANIZATIONS DEVOTED TO IMPROVING THE HEALTH AND WELLBEING OF COMMUNITY MEMBERS THESE ORGANIZATIONS INCLUDE THE CHILDREN'S ADVOCACY CENTER LEADERSHIP COMMITTEE, CHICAGO DENTAL SOCIETY, HARPER COLLEGE LEARNING AND CAREER CENTER ADVISORY COMMITTEE, ILLINOIS HOSPITAL ASSOCIATION BOARD OF DIRECTORS, KENNETH YOUNG CENTER BOARD OF DIRECTORS, PARTNERS FOR OUR COMMUNITIES BOARD OF DIRECTORS, ST MARY'S SERVICES BOARD OF DIRECTORS, UNITED PALATINE AND ARLINGTON HEIGHTS ROTARY CLUB BOARD OF DIRECTORS (8) COLLABORATIVE PARTNERSHIPS ARE THE FOUNDATION TO MANY OF THE HOSPITAL'S COMMUNITY HEALTH INITIATIVES AIMED TO IMPROVE THE HEALTH AND WELL-BEING OF THE COMMUNITY THESE PARTNERSHIPS INCLUDE A COLLABORATION WITH GREATER ELGIN FAMILY CARE CENTER AND ACCESS COMMUNITY HEALTH NETWORK (TWO LOCAL FEDERALLY QUALIFIED HEALTH CENTERS), AND COOK COUNTY HEALTH AND HOSPITAL SYSTEM TO BRING PRIMARY CARE SERVICES FOR THE UNINSURED AND UNDERINSURED TO THE COMMUNITY THE HOSPITAL ALSO PARTNERS WITH ELK GROVE, PALATINE, SCHAUMBURG, AND WHEELING TOWNSHIPS ON A MOBILE DENTAL CLINIC PROGRAM WHICH PROVIDED 1,921 PATIENT VISITS IN FY 2019 WITH THE HOSPITAL ABSORBING \$194,100 OF THE OPERATING COSTS NORTHWEST COMMUNITY HEALTHCARE, AN AFFILIATE OF THE HOSPITAL, ALSO PARTNERS WITH PARTNERS FOR OUR COMMUNITIES (POC), A LOCAL 501(C)(3) ORGANIZATION, TO OPERATE AND RUN THE COMMUNITY RESOURCE CENTER WHICH PROVIDES DIRECT SERVICES, REFERRALS, AND OTHER ASSISTANCE TO THE UNDER-RESOURCED THE HOSPITAL OWNS AND MAINTAINS THE BUILDING AND PROVIDES FREE OR LOW-COST RENT TO LOCAL NOT FOR PROFIT AGENCIES, INCLUDING ALL SAINTS LUTHERAN CHURCH, ASIAN HUMAN SERVICES, BUEHLER YMCA, THE CENTER-RESOURCES FOR TEACHING AND LEARNING (ECDEC PROGRAM), COMMUNITY CONSOLIDATED SCHOOL DISTRICT 15, HARPER COLLEGE, HIAS CHICAGO, PALATINE TOWNSHIP SENIOR CITIZENS COUNCIL, PALATINE POLICE DEPARTMENT, PALATINE PARK DISTRICT, PALATINE PUBLIC LIBRARY, PATH (PALATINE ASSISTING THROUGH HOPE), AND WINGS (WOMEN I NEED GROWING STRONGER) SOME OF THE MANY PROGRAMS AND SERVICES OFFERED AT THE RESOURCE CENTER INCLUDE GED AND CITIZENSHIP CLASSES, HEALTHCARE SERVICES, COMPUTER LITERACY, AFTER-SCHOOL YOUTH PROGRAM, BILINGUAL COUNSELING, PARENTING CLASSES, JOB PLACEMENT, CAREER EDUCATION, RECREATION AND A FOOD AND CLOTHING PANTRY IN FY 2019, THE COMMUNITY RESOURCE CENTER HAD MORE THAN 200,000 CLIENT VISITS IN ADDITION TO THE COMMUNITY RESOURCE CENTER, THE HOSPITAL WORKS WITH POC ON MANY COLLABORATIVE HEALTH INITIATIVES INCLUDING THE COMMUNITY HEALTH WORKER (CHW) PROGRAM WHICH PROVIDES HEALTH EDUCATION AND SUPPORT FOR THE LATINO POPULATION THIS PROGRAM IDENTIFIES LATINA WOMEN WHO DEMONSTRATE THE POTENTIAL TO BECOME LEADERS IN THE COMMUNITY WHO THEN RECEIVE LEADERSHIP TRAINING</p>

Form and Line Reference	Explanation
<p>SCHEDULE H - PART VI, LINE 5 - PROMOTION OF COMMUNITY HEALTH</p>	<p>ING AND EDUCATION ON SPECIFIC HEALTH TOPICS THE CHW MEETS PATIENT'S BEDSIDE AND THEN PROV IDES POST DISCHARGE SUPPORT TO HELP THEM UNDERSTAND AND COMPLY WITH DISCHARGE INSTRUCTIONS WHICH CAN OFTEN BE DIFFICULT DUE TO ECONOMIC AND LANGUAGE BARRIERS IN FY 2019 THE CHW HA D 2,518 CLIENT INTERACTIONS AND THE HOSPITAL PROVIDED \$42,800 IN FINANCIAL SUPPORT OF THE PROGRAM THE HOSPITAL, POC AND SCHAUMBURG TOWNSHIP ALSO COLLABORATIVELY PROVIDE THE SERVIC ES OF TWO COMMUNITY HEALTH NURSES, ONE OF WHICH IS BILINGUAL IN SPANISH THESE OUTREACH PR OFESSIONALS FOCUS ON HELPING VULNERABLE POPULATIONS (UNDER-RESOURCED AND SENIORS) NAVIGATE HEALTHCARE RESOURCES, PROVIDE HEALTH EDUCATION AND CHRONIC DISEASE MANAGEMENT, AND HELP P ATIENTS OBTAIN LOW-COST PRESCRIPTIONS IN FY 2019, THE TWO PART-TIME COMMUNITY NURSES HAD 7,744 CLIENT INTERACTIONS AND THE HOSPITAL PROVIDED \$92,800 IN FINANCIAL SUPPORT OF THE PR OGRAM THE HOSPITAL ALSO DEDICATES RESOURCES TO ENHANCE ITS HEALTH AND WELLNESS OFFERINGS FOR OLDER ADULTS IN THE COMMUNITY A FULL TIME, DEDICATED SENIOR SERVICES LIAISON SCHEDULE S AND OVERSEES LECTURES, PROGRAMS AND SCREENINGS AT LOCAL SENIOR CENTERS AND OTHER COMMUNI TY LOCATIONS THAT SERVE OLDER ADULTS IN FY 2019, THE HOSPITAL PROVIDED MORE THAN 200 HEAL TH AND WELLNESS PROGRAMS AND SUPPORT GROUPS WITH 3,585 ENCOUNTERS AT THE ARLINGTON HEIGHTS SENIOR CENTER ALONE THE "ASK-THE-NURSE" PROGRAM AT THE SENIOR CENTER PROVIDES SENIORS WI TH THE OPPORTUNITY TO ASK HEALTHCARE QUESTIONS AND SHARE CONCERNS, ESPECIALLY REGARDING ME DICATIONS, TREATMENT PLANS AND UPCOMING TESTS AND PROCEDURES A NURSE ALSO PROVIDES FREE B LOOD PRESSURE CHECKS AND OFFER HELP WITH CHRONIC DISEASE MANAGEMENT FOR DIABETES AND OTHER ILLNESSES OTHER OFFERINGS INCLUDED PHYSICIAN LECTURES, SCREENINGS, WALKERS CLUB AND PARK INSON'S PROGRAMS SENIORS FROM THE COMMUNITY RECEIVED CUTTING EDGE HEALTH INFORMATION FROM PHYSICIANS AND STAFF ON VARIOUS HEALTH TOPICS SUCH AS DIABETES, HEART DISEASE, SKIN CANCER, STROKE, MENTAL HEALTH AND MORE THE SENIOR SERVICES SPECIALIST IS ALSO A TRAINED SENIOR HEALTH INSURANCE PROGRAM COUNSELOR (SHIP), WHICH PROVIDES FREE MEDICARE EDUCATION TO SENI ORS (9) THE HOSPITAL OPERATES AN EMERGENCY DEPARTMENT THAT IS OPEN 24 HOURS A DAY, 7 DAYS A WEEK AND SERVES ALL PERSONS REGARDLESS OF THEIR ABILITY TO PAY (10) THE HOSPITAL PARTI CIPATES IN BOTH THE MEDICARE AND MEDICAID GOVERNMENT-SPONSORED HEALTHCARE PROGRAMS THE HO SPITAL CONTRACTS WITH MIRA MED ASSISTANCE PROGRAM TO PROVIDE ASSISTANCE TO PATIENTS, FREE OF CHARGE, THROUGHOUT THE MEDICAID APPLICATION PROCESS WHEN APPLYING FOR MEDICAL COVERAGE THROUGH THE ILLINOIS MEDICAID PROGRAM THE ASSISTANCE PROVIDED IS INCLUSIVE OF COMPLETING THE APPLICATION, GATHERING ALL OF THE APPROPRIATE ADDITIONAL DOCUMENTS THAT MUST BE SUBMIT TED, WORKING WITH THE STATE ON THE PATIENT'S BEHALF AND, IN SOME CASES, WORKING THROUGH AN APPEAL PROCESS IN FY 2019, 1,021 INDIVIDUALS RECEIVED ASSISTANCE AT A COST OF \$193,684 (11) THE HOSPITAL PROVIDES SERVICES FREE OR AT A REDUCED RATE TO INDIVIDUALS WITH LIMITED FINANCIAL RESOURCES WHO ARE UNABLE TO ACCESS ENTITLEMENT PROGRAMS INDIVIDUALS ARE ELIGIBL E FOR FREE OR DISCOUNTED MEDICALLY NECESSARY HEALTHCARE SERVICES BASED ON ESTABLISHED CRIT ERIA AND THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY IS WIDELY DISTRIBUTED AND COMMUNICATED TO THE COMMUNITY (12) CELEBRATING 60 YEARS OF EXCEPTIONAL CARE, NCH IS AN INDEPENDENT CO MMUNITY HOSPITAL THAT PROVIDES ACUTE CARE AND IS RECOGNIZED FOR THE FOLLOWING OUTSTANDING DISTINCTIONS 2019 HEALTHGRADES AMERICA'S 250 BEST HOSPITALS AWARD, 2019 HEALTHGRADES AMER ICA'S 100 BEST HOSPITALS AWARD FOR CARDIAC CARE, CRITICAL CARE, PULMONARY CARE AND STROKE CARE, 2019 HEALTHGRADES CORONARY INTERVENTION EXCELLENCE AWARD, 2019 HEALTHGRADES CARDIAC INTERVENTION EXCELLENCE AWARD, 2019 HEALTHGRADES CRITICAL CARE EXCELLENCE AWARD, 2019 HEAL THGRADES NEUROSCIENCES EXCELLENCE AWARD (TOP 5% IN NATION THREE YEARS IN A ROW), 2019 HEAL THGRADES FIVE-STAR RECIPIENT FOR MULTIPL</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
<p>SCHEDULE H - PART VI, LINE 6 - AFFILIATED HEALTH CARE SYSTEM</p>	<p>NORTHWEST COMMUNITY HEALTHCARE AND SUBSIDIARIES (HEALTHCARE), A NOT-FOR-PROFIT ENTITY, WAS ESTABLISHED TO OWN, OPERATE, CONTROL, AND OTHERWISE COORDINATE THE DELIVERY OF HEALTHCARE WITHIN THE SERVICE AREA OF NORTHWEST COMMUNITY HOSPITAL (THE HOSPITAL), AND COORDINATE THE ACTIVITIES OF THE VARIOUS CORPORATIONS AFFILIATED WITH HEALTHCARE THE HOSPITAL, LOCATED IN ARLINGTON HEIGHTS, ILLINOIS, IS A 496-BED ACUTE CARE FACILITY PROVIDING INPATIENT, OUTPATIENT, AND EMERGENCY CARE SERVICES PRIMARILY TO RESIDENTS OF ARLINGTON HEIGHTS AND THE SURROUNDING COMMUNITIES SUBSIDIARIES OF HEALTHCARE INCLUDE THE HOSPITAL, NORTHWEST COMMUNITY HOSPITAL FOUNDATION (THE FOUNDATION), CENTRAL INSURANCE COMPANY, LTD (CICL), AND NORTHWEST COMMUNITY HEALTHCARE PHO, LLC (PHO) HEALTHCARE'S OTHER SUBSIDIARIES INCLUDE NORTHWEST COMMUNITY HEALTH SERVICES, INC (HEALTH SERVICES), NPC-CYBERKNIFE, LLC (CYBERKNIFE), NORTHWEST COMMUNITY DAY SURGERY CENTER II, LLC (DSC-II), NORTHWEST ENDO CENTER LLC (ENDO), NORTHWEST COMMUNITY FOOT AND ANKLE CENTER, LLC (FOOT), AND ENVISION MEDICAL IMAGING, LLC (ENVISION) NORTHWEST COMMUNITY PHYSICIANS ASSOCIATION, LLC (NCPA) IS AN INACTIVE, NOT-FOR-PROFIT SUBSIDIARY OF THE HOSPITAL CICL IS A CAPTIVE INSURANCE COMPANY ESTABLISHED JANUARY 1, 2013, TO PROVIDE GENERAL AND PROFESSIONAL LIABILITY COVERAGE AND WORKERS' COMPENSATION COVERAGE FOR THE RISKS OF HEALTHCARE CICL IS A FOREIGN CORPORATION ORGANIZED IN THE CAYMAN ISLANDS THAT DOES NOT TAX ITS ACTIVITIES HEALTH SERVICES OWNS AND OPERATES PHYSICIAN PRACTICES WITHIN THE HOSPITAL'S GEOGRAPHIC AREA THE NCH MEDICAL GROUP (NCHMG) MULTI-SPECIALTY PHYSICIAN PRACTICE (THAT WAS ESTABLISHED IN 2010) HAS OFFICES IN ARLINGTON HEIGHTS, BUFFALO GROVE, MT PROSPECT, LAKE ZURICH, PALATINE, AND SCHAUMBURG, ILLINOIS CYBERKNIFE WAS FORMED IN JUNE 2006 FOR THE PURPOSE OF PURCHASING AND OWNING A STEREOTACTIC RADIOSURGERY SYSTEM AND LEASING IT TO THE HOSPITAL CYBERKNIFE IS A LIMITED LIABILITY CORPORATION THAT IS OWNED BY HEALTHCARE (74% AT SEPTEMBER 30, 2019 AND 2018) AND PHYSICIAN INVESTORS (26% AT SEPTEMBER 30, 2019 AND 2018) HEALTHCARE CONSOLIDATES CYBERKNIFE, AS HEALTHCARE OWNS A MAJORITY OF THE UNITS OUTSTANDING DSC-II WAS FORMED IN 2014 FOR THE PURPOSE OF OWNING AND OPERATING AN AMBULATORY SURGERY CENTER DSC-II IS A LIMITED LIABILITY COMPANY THAT IS OWNED BY HEALTHCARE (59 25% AND 51 75% AT SEPTEMBER 30, 2019 AND 2018, RESPECTIVELY) AND PHYSICIAN INVESTORS (40 75% AND 48 25% AT SEPTEMBER 30, 2019 AND 2018, RESPECTIVELY) HEALTHCARE CONSOLIDATES DSC-II, AS HEALTHCARE OWNS A MAJORITY OF THE UNITS OUTSTANDING ENDO WAS ESTABLISHED IN DECEMBER 2015 AND BEGAN OPERATIONS IN MARCH 2017 ENDO IS A LIMITED LIABILITY CORPORATION THAT IS OWNED BY HEALTH SERVICES (51% AT SEPTEMBER 30, 2019 AND 2018) AND PHYSICIAN INVESTORS (49% AT SEPTEMBER 30, 2019 AND 2018) HEALTH SERVICES CONSOLIDATES ENDO BECAUSE IT OWNS A CONTROLLING INTEREST FOOT WAS ESTABLISHED AND BEGAN OPERATIONS IN JULY 2017 FOOT IS A LIMITED LIABILITY CORPORATION THAT IS OWNED BY HEALTH SERVICES (51% AT SEPTEMBER 30, 2019 AND 2018) AND PHYSICIAN INVESTORS (49% AT SEPTEMBER 30, 2019 AND 2018) HEALTH SERVICES CONSOLIDATES FOOT BECAUSE IT OWNS A CONTROLLING INTEREST ENVISION WAS ESTABLISHED AND BEGAN OPERATIONS IN JULY 2018 ENVISION IS A LIMITED LIABILITY CORPORATION THAT IS OWNED BY HEALTH SERVICES (51% AT SEPTEMBER 30, 2019 AND 2018) AND PHYSICIAN INVESTORS (49% AT SEPTEMBER 30, 2019 AND 2018) HEALTH SERVICES CONSOLIDATES ENVISION BECAUSE IT OWNS A CONTROLLING INTEREST</p>

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H - PART VI, LINE 7 - STATE FILING OF COMMUNITY BENEFIT REPORT	NORTHWEST COMMUNITY HOSPITAL FILES AN ANNUAL NONPROFIT HOSPITAL COMMUNITY BENEFITS PLAN REPORT WITH THE ILLINOIS ATTORNEY GENERAL'S OFFICE IN ACCORDANCE WITH ILLINOIS LAW

**Additional Data****Software ID:****Software Version:****EIN:** 36-2340313**Name:** Northwest Community Hospital**Form 990 Schedule H, Part V Section A. Hospital Facilities**

<b>Section A. Hospital Facilities</b>		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER—24 hours	ER—other	Other (Describe)	Facility reporting group
(list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? <u>1</u>											
Name, address, primary website address, and state license number											
1	NORTHWEST COMMUNITY HOSPITAL 800 W CENTRAL ROAD ARLINGTON HEIGHTS, IL 60005 nch.org 0001701	X	X					X			

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

Form and Line Reference	Explanation
<p>SCHEDULE H- PART V, SECTION B, LINE 3(E)</p>	<p>THE SIGNIFICANT HEALTH NEEDS OF OUR PATIENTS AND COMMUNITY ARE IDENTIFIED THROUGH PRIORITIZED DESCRIPTIONS REFLECTED IN THE CHNA SCHEDULE H - PART V, SECTION B, LINE 5 AN ONLINE SURVEY WAS IMPLEMENTED AS PART OF THE COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS SPECIFICALLY TO SOLICIT INPUT FROM KEY INFORMANTS, INDIVIDUALS WHO ARE CONSIDERED EXPERTS IN PUBLIC HEALTH POTENTIAL PARTICIPANTS WERE CHOSEN BECAUSE OF THEIR ABILITY TO IDENTIFY PRIMARY CONCERNS OF THE COMMUNITY, INCLUDING THE MEDICALLY UNDERSERVED, LOW-INCOME AND MINORITY POPULATIONS SERVED BY THE HOSPITAL IN FEBRUARY 2018, 30 POTENTIAL KEY INFORMANTS WERE IDENTIFIED WHICH INCLUDED GOVERNMENT OFFICIALS, PHYSICIANS, OTHER HEALTH PROVIDERS, PUBLIC HEALTH EXPERTS AND SOCIAL SERVICE AGENCIES A LETTER WAS SENT FROM THE HOSPITAL'S PRESIDENT AND CEO TO THE KEY INFORMANTS TO EXPLAIN THE PURPOSE OF THE SURVEY AND TO INVITE THEM TO PARTICIPATE A LINK TO THE ONLINE SURVEY WAS THEN EMAILED TO EACH KEY INFORMANT AND WAS OPEN FROM FEBRUARY 12-26, 2018 A REMINDER EMAIL WAS SENT TO ENCOURAGE PARTICIPATION THE KEY INFORMANTS WERE ASKED A SERIES OF HEALTH RELATED QUESTIONS, ASKED TO "GRADE" THEIR COMMUNITIES OVERALL HEALTH AND PROVIDE FEEDBACK ON ACCESS TO CARE, BEHAVIORAL HEALTH, CHRONIC DISEASE /HEALTH ISSUES, FAMILY ISSUES AND MODIFIABLE RISK FACTORS IT ALSO ASKED THEM TO RANK THEIR "TOP FIVE HEALTH CONCERNS" FOR THE COMMUNITY RESULTS FROM THE SURVEY WERE SUMMARIZED IN BOTH A QUANTITATIVE AND QUALITATIVE REPORT AND USED TO IDENTIFY MAJOR HEALTH PROBLEMS, GAPS IN SERVICES AND OTHER FACTORS WHICH MAY CONTRIBUTE TO LESS THAN OPTIMAL HEALTH STATUS FOR THE RESIDENTS OF OUR COMMUNITY IN ALL, 18 OF THE 30 INVITED PARTICIPANTS TOOK PART IN THE ONLINE KEY INFORMANT SURVEY REPRESENTATIVES FROM THE FOLLOWING ORGANIZATIONS COMPLETED THE ONLINE SURVEY ARLINGTON HEIGHTS HEALTH DEPARTMENT, ASIAN HUMAN SERVICES, BRIDGE YOUR TOWN AND FAMILY SERVICES, COOK COUNTY HEALTH AND HOSPITAL SYSTEM, ELK GROVE TOWNSHIP, HEARTLAND AND LINDEN OAKS, JOURNEYS THE ROAD HOME, NORTHWEST COMMUNITY HEALTHCARE, SCHAUMBURG TOWNSHIP, ST. MARY'S SERVICES, AND WHEELING TOWNSHIP THROUGH THIS PROCESS, INPUT WAS GATHERED FROM INDIVIDUALS WHOSE ORGANIZATIONS WORK WITH LOW-INCOME POPULATIONS, MINORITY POPULATIONS (INCLUDING AFRICAN-AMERICANS, ASIANS, EASTERN EUROPEANS, HISPANIC, INDIAN, JAPANESE, POLISH AND RUSSIAN), OR OTHER MEDICALLY UNDERSERVED POPULATIONS (INCLUDING THE DISABLED, THE ELDERLY, THE HOMELESS, MEDICAID/MEDICARE BENEFICIARIES, THE MENTALLY ILL, PREGNANT TEENS, SUBSTANCE ABUSERS, UNDOCUMENTED INDIVIDUALS, UNINSURED/UNDERINSURED RESIDENTS, VETERANS, YOUNG ADULTS AND WOMEN) THE HOSPITAL ALSO SOLICITED INPUT FROM VULNERABLE POPULATIONS IN THE COMMUNITY THROUGH FOCUS GROUPS A PROFESSIONAL MODERATOR WAS HIRED TO CONDUCT THREE FOCUS GROUPS IN FEBRUARY 2018 ONE WITH SENIORS, ONE WITH SPANISH-SPEAKING UNDER-RESOURCED COMMUNITY MEMBERS AND ONE WITH ENGLISH-SPEAKING UNDER-RESOURCED COMMUNITY MEMBERS POTENTIAL PARTICIPANTS WERE GIVEN A SH</p>

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

Form and Line Reference	Explanation
SCHEDULE H- PART V, SECTION B, LINE 3 (E)	<p>ORT SCREENING QUESTIONNAIRE TO ENSURE THEY LIVED IN THE HOSPITAL'S SERVICE AREA AND SO THA T PARTICIPANTS WOULD VARY IN AGE, GENDER, INSURANCE STATUS, INCOME AND EDUCATIONAL LEVELS THE FOCUS GROUPS FOLLOWED A GUIDELINE WHICH MIRRORED THE QUESTIONS INCLUDED IN THE COMMUN ITY AND KEY INFORMANT SURVEYS SO THAT THE INFORMATION GATHERED COULD BE USED TO COMPARE WI TH THE SURVEY RESULTS THE MODERATOR SUMMARIZED THE RESULTS OF THE FOCUS GROUPS WHICH WERE USED AS ONE OF THE TOOLS IN IDENTIFYING THE MOST PREDOMINANT COMMUNTIY NEEDS</p>

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

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

Form and Line Reference	Explanation
SCHEDULE H - PART V, SECTION B, LINE 7A	<a href="https://www.nch.org/about-nch/community-services/community-health-needs-assessment">HTTPS //WWW NCH ORG/ABOUT-NCH/COMMUNITY-SERVICES/COMMUNITY-HEALTH-NEEDS-AS SESSMENT</a>

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

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

Form and Line Reference	Explanation
SCHEDULE H - PART V, SECTION B, LINE 10A	<a href="https://www.nch.org/about-nch/community-services/community-health-needs-assessment">HTTPS //WWW NCH ORG/ABOUT-NCH/COMMUNITY-SERVICES/COMMUNITY-HEALTH-NEEDS-AS SESSMENT</a>

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

Form and Line Reference	Explanation
<p>SCHEDULE H - PART V, SECTION B, LINE 11</p>	<p>TAKING INTO ACCOUNT HOSPITAL RESOURCES AND OVERALL ALIGNMENT WITH THE HOSPITAL'S MISSION, GOALS AND STRATEGIC PRIORITIES - IT WAS DETERMINED THAT NCH WOULD FOCUS THE MAJORITY OF IT S EFFORTS ON DEVELOPING AND/OR SUPPORTING STRATEGIES AND INITIATIVES TO IMPROVE THE FOLLOW ING PRIORITY AREAS ACCESS TO CARE FOR THE UNDER-RESOURCED, BEHAVIORAL HEALTH (MENTAL HEAL TH AND SUBSTANCE ABUSE), OBESITY/PHYSICAL ACTIVITY/WEIGHT, CANCER (SMOKING/TOBACCO) AND CH RONIC DISEASE (DIABETES, HEART DISEASE, STROKE, RESPIRATORY AND KIDNEY) KEY INDIVIDUALS WERE IDENTIFIED TO SERVE ON ISSUE SPECIFIC COMMITTEES TO DEVELOP IMPLEMENTATION STRATEGIES FOR EACH OF THE PRIORITY AREAS FOR THE HOSPITAL'S FISCAL YEARS 2019 THROUGH 2021 THESE IN DIVIDUALS ALSO DEVELOPED METRICS TO MEASURE THE SUCCESS OF THE STRATEGIES WHICH WILL BE MO NITORED AND UPDATED ANNUALLY IMPLEMENTATION STRATEGIES FOR ACCESS TO CARE FOR THE UNDER-R ESOURCED INCLUDE A COMMUNITY NURSING AND COMMUNITY HEALTH WORKER PROGRAM THE HOSPITAL'S D EDICATED CASE MANAGEMENT TEAM ALONG WITH TWO COMMUNITY HEALTH NURSES AND A COMMUNITY HEALT H WORKER PROVIDE OUTREACH AND ASSIST VULNERABLE PATIENTS AND COMMUNITY MEMBERS WITH ACCESS ING CARE THE HOSPITAL ALSO FUNDS A CHARITABLE PRESCRIPTION PROGRAM TO FURTHER ASSIST THES E INDIVIDUALS ACCESS TO ORAL HEALTH CARE FOR THE UNDER-RESOURCED IS ADDRESSED THROUGH A C OLLABORATIVE MOBILE DENTAL CLINIC PROGRAM THAT IS OPERATED BY THE HOSPITAL WITH SUPPORT FR OM FOUR LOCAL TOWNSHIPS, UNIVERSITY OF CHICAGO DENTAL SCHOOL, HARPER COLLEGE, ADVANTAGE AM BULANCE AS WELL AS PROFESSIONAL VOLUNTEERS IMPLEMENTATION STRATEGIES FOR BEHAVIORAL HEALT H INCLUDE FREE, IN PERSON MENTAL HEALTH ASSESSMENTS AND A FREE 24/7 RESOURCE AND REFERRAL PHONE LINE TO ASSIST COMMUNITY MEMBERS IN CRISIS THE HOSPITAL ALSO CONDUCTS FREE BEHAVIOR AL HEALTH ASSESSMENTS AND CARE COORDINATION FOR HOSPITALIZED PATIENTS WITH SUBSTANCE ABUSE DISORDERS AND HAS AN OUTPATIENT ADDICTIONS PROGRAM PROVIDING MEDICATION ASSISTED TREATMEN T FOR ALCOHOL, OPIOID, AND OTHER SUBSTANCE USE DISORDERS IMPLEMENTATION STRATEGIES FOR OB ESITY, NUTRITION AND PHYSICAL ACTIVITY INCLUDE A COMPREHENSIVE WEIGHT LOSS CLINIC, A COLLA BORATIVE COMMUNITY FOOD PANTRY, LOW COST MEMBERSHIPS AT THE NCH WELLNESS CENTER, FINANCIAL SUPPORT OF SUMMER NUTRITION PROGRAMS FOR UNDER-RESOURCED STUDENTS AND THE LAUNCH OF A FOO D INSECURITY INPATIENT SCREENING PROGRAM IMPLEMENTATION STRATEGIES FOR CANCER INCLUDE A M ULTI-DISCIPLINARY CANCER CLINIC TO HELP PATIENTS NEWLY DIAGNOSED WITH BREAST OR LUNG CANCE R TEN SUPPORT GROUPS AND ANNUAL CANCER SURVIVOR EVENTS ARE FACILITATED BY THE HOSPITAL T HE GIFT-A-MAMMOGRAM PROGRAM PROVIDES FREE SCREENINGS AND DIAGNOSTIC TESTING FOR UNDER-RESO URCED PATIENTS THE HOSPITAL ALSO OFFERS LUNG SCREENINGS AND FREE TOBACCO CESSATION COUNSEL ING AND SUPPORT GROUPS TO AID WITH LUNG CANCER PREVENTION LASTLY, THE HOSPITAL DEVELOPED IMPLEMENTATION STRATEGIES TO ADDRESS A NUMBER OF CHRONIC DISEASES INCLUDING DIABETES, HEA RT DISEASE, STROKE AND RESPIRA</p>

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

Form and Line Reference	Explanation
SCHEDULE H - PART V, SECTION B, LINE 11	<p>TORY THESE INITIATIVES INCLUDE A COMPREHENSIVE OUTPATIENT CLINIC FOR INDIVIDUALS WITH HEART FAILURE OR AFIB, SUPPORT GROUPS AND FREE STROKE RISK ASSESSMENTS STAFF ALSO PROVIDES EDUCATION IN THE COMMUNITY FOCUSED ON PREVENTION AND PLANS TO LAUNCH A MOBILE INTEGRATED HEALTH PILOT IN PARTNERSHIP WITH LOCAL MUNICIPALITIES IN 2020 THE KEY PRIORITY AREAS ALONG WITH THE IMPLEMENTATION STRATEGIES AND METRICS CAN BE FOUND ON THE HOSPITAL'S WEBSITE (NCH.ORG) IN ACKNOWLEDGING THE WIDE RANGE OF HEALTH ISSUES THAT EMERGED FROM THE CHNA PROCESS , THE HOSPITAL DETERMINED IT COULD ONLY EFFECTIVELY FOCUS ON THOSE WHICH IT DEEMED MOST PRESSING, MOST UNDER-ADDRESSED, AND MOST WITHIN ITS ABILITY TO INFLUENCE THE COMMUNITY HEALTH NEEDS THAT THE HOSPITAL IS UNABLE TO ADDRESS ARE ACCESS TO SPECIALTY AND VISION CARE, CHRONIC KIDNEY DISEASE, DEMENTIA/ALZHEIMERS, CHILD ABUSE AND DOMESTIC VIOLENCE THE HOSPITAL BELIEVES ACCESS TO SPECIALTY AND VISION CARE WILL BE ADDRESSED THROUGH REFERRALS FROM PRIMARY CARE PHYSICIANS THE HOSPITAL BELIEVES THAT CHRONIC KIDNEY DISEASE WILL BE ADDRESSED THROUGH THE HEART FAILURE AND DIABETES INITIATIVES THAT WERE DEVELOPED THE HOSPITAL BELIEVES THERE ARE SUFFICIENT COMMUNITY RESOURCES INCLUDING PRIMARY CARE PHYSICIANS TO DIAGNOSE AND NURSING HOMES AND MEMORY CARE FACILITIES TO TREAT DEMENTIA AND ALZHEIMERS THE HOSPITAL COLLABORATES WITH THREE LOCAL NOT-FOR-PROFIT COMMUNITY AGENCIES (CHILDREN'S ADVOCACY CENTER, NORTHWEST CASA AND WINGS) TO ADDRESS CHILD ABUSE AND DOMESTIC VIOLENCE THE HOSPITAL SUPPORTS THE EFFORTS OF OTHERS TO ADDRESS THESE AREAS AND WILL FOCUS ITS LIMITED RESOURCES ON THE MORE PREDOMINANT NEEDS IDENTIFIED FOR A COMPLETE LIST OF NEEDS AND IMPLEMENTATION STRATEGIES VISIT THE HOSPITAL'S WEBSITE (NCH.ORG)</p>

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

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

Form and Line Reference	Explanation
SCHEDULE H - PART V, SECTION B, LINE 13H	PRESUMED ELIGIBLE PATIENTS RECEIVE 100% FINANCIAL ASSISTANCE FOR THE ACCOUNT BALANCE A PATIENT MUST PROVIDE DOCUMENTATION LISTING ELIGIBILITY OR QUALIFICATION OR PRINT SCREEN OF WEB PAGE LISTINGS ELIGIBILITY A PATIENT IS PRESUMED ELIGIBLE IF THEY HAVE ONE OF THE FOLLOWING - PARTICIPATION IN STATE-FUNDED PRESCRIPTION PROGRAMS, - PARTICIPATION IN WOMEN'S, INFANT'S, AND CHILDREN'S PROGRAMS (WIC), - FOOD STAMP ELIGIBILITY (LINK CARD), - ELIGIBILITY FOR OTHER STATE OR LOCAL ASSISTANCE PROGRAM THAT IS UNFUNDED, - LOW INCOME/SUBSIDIZED HOUSING ARE PROVIDED AS A VALID ADDRESS, - PATIENT IS DECEASED WITH NO KNOWN ESTATE, - AFFILIATION WITH HOMELESS ASSISTANCE ORGANIZATION (I E JOURNEYS THE ROAD HOME), - ENROLLED IN SNAP, ILLINOIS FREE BREAKFAST/LUNCH, LOW INCOME HOME ENERGY ASSISTANCE PROGRAM, OR A COMMUNITY-BASED MEDICAL ASSISTANCE PROGRAM WITH LOW-INCOME CRITERIA, - RECEIVING GRANT ASSISTANCE FOR MEDICAL SERVICES, - RECENT PERSONAL BANKRUPTCY, INCARCERATION, RELIGIOUS ORDER AFFILIATION AND VOW OF POVERTY OR ENROLLMENT IN TANF OR IHDA'S RENTAL HOUSING SUPPORT PROGRAM, - A PATIENT WHO HAS BEEN UNRESPONSIVE TO EFFORTS TO APPLY FOR FINANCIAL ASSISTANCE BUT HAS BEEN ASSESSED UNDER THE POST-CARE PROCESS AND MEETS THE CRITERIA, - PATIENT IS MENTALLY OR PHYSICALLY INCAPACITATED AND HAS NO ONE TO ACT ON HIS/HER BEHALF, - PATIENT IS ELIGIBLE FOR SUBSIDIZED SCHOOL LUNCH PROGRAMS, OR - MEDICAID ELIGIBILITY THAT DOES NOT APPLY TO THIS SERVICE (I E DHS SOCIAL SERVICES, MOMS AND BABIES) - RELIGIOUS ORDER AFFILIATION AND A VOW OF POVERTY

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

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

Form and Line Reference	Explanation
SCHEDULE H - PART V, SECTION B, LINE 16	<a href="https://www.nch.org/patients-visitors/fees-and-bill-payment/patient-financial-assistance">HTTPS //WWW NCH ORG/PATIENTS-VISITORS/FEES-AND-BILL-PAYMENT/PATIENT-FINANC IAL-ASSISTANCE</a>

**Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

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

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

Name and address	Type of Facility (describe)
<b>1</b> NCH Imaging Center 880 W Central Road Arlington Heights, IL 60005	Imaging Services
<b>1</b> NCH Immediate Care & Imaging Center 199 W Rand Road Mount Prospect, IL 60056	WALK IN URGENT CARE CENTER, Lab,Imaging,Physical & Speech Therapy & Heart Care Services
<b>2</b> NCH Imaging Center 1450 Busch Parkway Buffalo Grove, IL 60089	Imaging Services
<b>3</b> NCH IMMEDIATE CARE & IMAGING CENTER 519 S Roselle Road Schaumburg, IL 60193	WALK IN URGENT CARE CENTER, Lab,Imaging,Physical Therapy Services
<b>4</b> NCH BEHAVIORAL HEALTH 901 W Kirchhoff Road ARLINGTON HEIGHTS, IL 60005	Behavioral Health Services
<b>5</b> NCH Cardiac & Physical Rehabilitation 900 W Central Road Arlington Heights, IL 60005	Cardiac & Physical Rehabilitation Services
<b>6</b> NCH Home Health 3060 Salt Creek Lane Arlington Heights, IL 60005	Home Healthcare Services
<b>7</b> NCH Breast Vein care Weight Management 1410 N Arlington Heights Road Arlington Heights, IL 60004	Breast Center, Vein care & Comprehensive Weight Management Services
<b>8</b> NCH Immediate Care & Imaging Center 15 S McHenry Road ARLINGTON HEIGHTS, IL 60089	Walk in Urgent Care Center Lab, Imaging, Physical Therapy Services
<b>9</b> NCH OUTPATIENT CENTER 3300 Kirchoff Road Rolling Meadows, IL 60008	Physical, Occupational, & Speech Therapy Services
<b>10</b> NCH Immediate Care & Imaging Center 1201 S Rand Road Lake Zurich, IL 60047	WALK IN URGENT CARE CENTER, Lab,Imaging,Physical Therapy Services
<b>11</b> NCH Physical Rehabilitation 455 S Roselle Road Schaumburg, IL 60193	Physical Therapy Services
<b>12</b> NCH Physical Rehabilitation 1249 S Rand Road Lake Zurich, IL 60047	Physical Therapy Services
<b>13</b> NCH Pediatric Physical Rehabilitation 1590 N Arlington Heights Road Arlington Heights, IL 60005	Pediatric Physical, Speech & Language, Occupational Therapy Services
<b>14</b> NCH Imaging Center 1632 W Central Road Arlington Heights, IL 60005	Imaging Services

**Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

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

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

Name and address	Type of Facility (describe)
<b>16</b> NCH Diabetes Services 605 W Central Road Arlington Heights, IL 60005	Diabetes Services

Note: To capture the full content of this document, please select landscape mode (11" x 8.5") when printing.

**Schedule I  
(Form 990)**

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

OMB No 1545-0047

**2018**

**Open to Public  
Inspection**

Department of the  
Treasury  
Internal Revenue Service

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](http://www.irs.gov/Form990) for the latest information.

Name of the organization  
Northwest Community Hospital

Employer identification number  
36-2340313

**Part I General Information on Grants and Assistance**

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

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of noncash assistance	(h) Purpose of grant or assistance
(1) See Additional Data							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table ▶ \_\_\_\_\_ 6

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

**Part III Grants and Other Assistance to Domestic Individuals.** Complete if the organization answered "Yes" on Form 990, Part IV, line 22

Part III can be duplicated if additional space is needed

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of noncash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of noncash assistance
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					

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

Return Reference	Explanation
Form 990, Schedule I, Part I, Line 2 - Org Proc for Monitoring grants	GRANTS IN SUPPORT OF NORTHWEST COMMUNITY HOSPITAL'S (HOSPITAL) MISSION ARE MONITORED BY NORTHWEST COMMUNITY'S FINANCE COMMITTEE AND BOARD OF DIRECTORS AS PART OF THE MONTHLY REVIEW OF HOSPITAL'S FINANCIAL RESULTS SIGNIFICANT GRANTS TO UNRELATED 501(C)(3) OR GOVERNMENTAL ORGANIZATIONS ARE APPROVED BY HOSPITAL'S COMMUNITY SERVICES DEPARTMENT AND ARE MONITORED THROUGH ONGOING INTERACTIONS WITH OFFICIALS OF THOSE RECIPIENTS REGARDING PROGRAM SERVICES PROVIDED IN HOSPITAL'S SERVICE AREA

## Additional Data

**Software ID:**  
**Software Version:**  
**EIN:** 36-2340313  
**Name:** Northwest Community Hospital

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

<b>(a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section if applicable	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of non-cash assistance	<b>(h)</b> Purpose of grant or assistance
Shelter Inc 826 E Old Willow Rd PROSPECT HTS, IL 60070	23-7399596	501(c)(3)	10,000				Sponsor
WINGS 887 E Wilmette Rd Palatine, IL 60070	75-0800699	501(c)(3)	8,000				Sponsor

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

<b>(a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section if applicable	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of non-cash assistance	<b>(h)</b> Purpose of grant or assistance
Partners for Our Communities 1585 N Rand Rd Palatine, IL 60074	36-3881109	501(c)(3)	8,000				Sponsor
The Childrens Advocacy Center 105 S York Rd ELMHURST, IL 60126	75-2389095	501(c)(3)	6,000				SPONSOR

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

<b>(a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section if applicable	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of non-cash assistance	<b>(h)</b> Purpose of grant or assistance
GREATER ELGIN FAMILY CARE CENTER 370 SUMMIT ST ELGIN, IL 60120	36-4249586	501(c)(3)	20,300				SPONSOR
CATHOLIC CHARITIES OF THE ARCHDIOCESE OF CHICAGO 1717 Rand Rd Des Plaines, IL 60016	36-2170821	501(c)(3)	7,000				Sponsor

**Schedule J**  
(Form 990)

Department of the Treasury  
Internal Revenue Service

## Compensation Information

**For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees**

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 23.**  
▶ **Attach to Form 990.**  
▶ **Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.**

OMB No 1545-0047

# 2018

**Open to Public Inspection**

Name of the organization  
Northwest Community Hospital

Employer identification number  
36-2340313

**Part I Questions Regarding Compensation**

		Yes	No								
<p><b>1a</b> Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> First-class or charter travel</td> <td style="width: 50%; border: none;"><input type="checkbox"/> Housing allowance or residence for personal use</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Travel for companions</td> <td style="border: none;"><input type="checkbox"/> Payments for business use of personal residence</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Tax indemnification and gross-up payments</td> <td style="border: none;"><input type="checkbox"/> Health or social club dues or initiation fees</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Discretionary spending account</td> <td style="border: none;"><input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)</td> </tr> </table>	<input type="checkbox"/> First-class or charter travel	<input type="checkbox"/> Housing allowance or residence for personal use	<input type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence	<input type="checkbox"/> Tax indemnification and gross-up payments	<input type="checkbox"/> Health or social club dues or initiation fees	<input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)	<b>1a</b>		
<input type="checkbox"/> First-class or charter travel	<input type="checkbox"/> Housing allowance or residence for personal use										
<input type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence										
<input type="checkbox"/> Tax indemnification and gross-up payments	<input type="checkbox"/> Health or social club dues or initiation fees										
<input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)										
<p><b>b</b> If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain</p>	<b>1b</b>										
<p><b>2</b> Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?</p>	<b>2</b>										
<p><b>3</b> Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Compensation committee</td> <td style="width: 50%; border: none;"><input type="checkbox"/> Written employment contract</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Independent compensation consultant</td> <td style="border: none;"><input type="checkbox"/> Compensation survey or study</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Form 990 of other organizations</td> <td style="border: none;"><input type="checkbox"/> Approval by the board or compensation committee</td> </tr> </table>	<input type="checkbox"/> Compensation committee	<input type="checkbox"/> Written employment contract	<input type="checkbox"/> Independent compensation consultant	<input type="checkbox"/> Compensation survey or study	<input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Approval by the board or compensation committee					
<input type="checkbox"/> Compensation committee	<input type="checkbox"/> Written employment contract										
<input type="checkbox"/> Independent compensation consultant	<input type="checkbox"/> Compensation survey or study										
<input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Approval by the board or compensation committee										
<p><b>4</b> During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization</p>											
<p><b>a</b> Receive a severance payment or change-of-control payment?</p>	<b>4a</b>	Yes									
<p><b>b</b> Participate in, or receive payment from, a supplemental nonqualified retirement plan?</p>	<b>4b</b>	Yes									
<p><b>c</b> Participate in, or receive payment from, an equity-based compensation arrangement? If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III</p>	<b>4c</b>		No								
<p><b>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</b></p>											
<p><b>5</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of</p>											
<p><b>a</b> The organization?</p>	<b>5a</b>		No								
<p><b>b</b> Any related organization? If "Yes," on line 5a or 5b, describe in Part III</p>	<b>5b</b>		No								
<p><b>6</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of</p>											
<p><b>a</b> The organization?</p>	<b>6a</b>		No								
<p><b>b</b> Any related organization? If "Yes," on line 6a or 6b, describe in Part III</p>	<b>6b</b>		No								
<p><b>7</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III</p>	<b>7</b>	Yes									
<p><b>8</b> Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III</p>	<b>8</b>		No								
<p><b>9</b> If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?</p>	<b>9</b>										



**Part III Supplemental Information**

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

Return Reference	Explanation
COMPENSATION DETERMINATION PROCESS FOR TOP MANAGEMENT OFFICIALS	<p>FORM 990, SCHEDULE J, LINE 3 THE COMPENSATION COMMITTEE OF THE PARENT CORPORATION (HEALTHCARE) ANNUALLY REVIEWS AND MAKES RECOMMENDATIONS TO THE BOARD REGARDING THE COMPENSATION OF THE PRESIDENTS, OTHER VICE PRESIDENTS AND OTHER KEY MANAGEMENT OFFICERS AS DETERMINED BY THE BOARD. AN INDEPENDENT REASONABLENESS OPINION IS OBTAINED ANNUALLY REGARDING THE CHIEF EXECUTIVE OFFICER'S COMPENSATION AND THAT OF OTHER EXECUTIVES AS DETERMINED BY THE COMMITTEE. SEVERANCE PAYMENTS FORM 990, SCHEDULE J, LINE 4A IN 2018, THE FOLLOWING INDIVIDUALS RECEIVED A SEVERANCE PAYMENT AS PART OF THEIR COMPENSATION ARRANGEMENT: Wendy L. Rubas \$121,313, Kimberly Nagy \$67,861. FORM 990, SCHEDULE J, LINE 4B A SERP PLAN WAS CREATED AND WAS EFFECTIVE ON JANUARY 1, 2014. BENEFITS UNDER THE SERP VEST IN THE AMOUNT CREDITED TO HIS OR HER ACCOUNT BALANCE ON JANUARY 1 OF THE FIFTH PLAN YEAR FOLLOWING THE YEAR FOR WHICH A CONTRIBUTION WAS CREDITED TO THE PARTICIPANT'S ACCOUNT. FOR EXAMPLE, A JANUARY 1, 2014 CONTRIBUTION, A PARTICIPANT WILL VEST IN THAT CONTRIBUTION, AS ADJUSTED FOR EARNINGS AND LOSSES, ON JANUARY 1, 2019. HOWEVER, A PARTICIPANT WILL AUTOMATICALLY VEST IN HIS OR HER ACCOUNT BALANCE IN THE EVENT OF INVOLUNTARY SEPARATION FROM SERVICE OR HIS OR HER ATTAINMENT OF AGE 65 WHILE STILL EMPLOYED BY NCH. PARTICIPANTS WHO VOLUNTARILY RESIGN OR ARE TERMINATED WITH CAUSE BEFORE THE VESTING PERIOD ARE NO LONGER ELIGIBLE FOR THE AMOUNT ACCRUED. THE FOLLOWING INDIVIDUALS PARTICIPATED IN THE SERP AND EARNED UNVESTED BENEFITS DURING 2018 WHICH ARE REPORTED IN COLUMN (C): STEPHEN O. SCOGNA \$ 153,658 JOHN L. SKEANS \$ 46,625 MICHAEL C. HARTKE \$ 56,435 ALAN B. LOREN, MD \$ 51,917 MARY DANO \$ 43,802 SUSAN E. NELSON, MD \$ 24,832 BRADFORD A. BUXTON \$ 29,410 GLEN J. MALAN \$ 23,779 TERRY SOLEM \$ 22,377.</p>

<b>Return Reference</b>	<b>Explanation</b>
NON-FIXED COMP PAYMENTS	FORM 990, SCHEDULE J, LINE 7 THE CEO AND VICE PRESIDENTS OF THE HOSPITAL ARE ELIGIBLE FOR AN ANNUAL INCENTIVE COMPENSATION PAYMENT THAT IS ALIGNED WITH THE STRATEGIC, FINANCIAL AND OPERATIONAL GOALS OF THE ORGANIZATION THRESHOLD MEASURES, WHICH CONSTITUTE THE MINIMUM REQUIREMENTS, MUST BE ACHIEVED IN ORDER TO HAVE AN INCENTIVE PAYOUT AWARD OPPORTUNITY LEVELS VARY AS A PERCENT OF BASE SALARY ACTUAL AMOUNTS AWARDED ARE BASED ON A COMBINATION OF DEFINED TARGETS MAXIMUM PAYABLE IS 150% OF THE TARGET AMOUNTS TO BE PAID ARE SUBJECT TO APPROVAL OF THE COMPENSATION COMMITTEE OF NORTHWEST COMMUNITY HEALTHCARE, THE SOLE MEMBER OF THE HOSPITAL The Compensation Committee retains the discretion to recommend for Board approval adjustments to payouts (either higher or lower) at plan cycle end, to reflect extraordinary performance or unanticipated circumstances





Note: To capture the full content of this document, please select landscape mode (11" x 8.5") when printing.

Schedule K (Form 990)

Supplemental Information on Tax-Exempt Bonds

OMB No 1545-0047

2018

Open to Public Inspection

Complete if the organization answered "Yes" to Form 990, Part VI, line 24a. Provide descriptions, explanations, and any additional information in Part VI.

Attach to Form 990.

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

Department of the Treasury Internal Revenue Service

Name of the organization Northwest Community Hospital

Employer identification number

36-2340313

Part I Bond Issues

Table with columns: (a) Issuer name, (b) Issuer EIN, (c) CUSIP #, (d) Date issued, (e) Issue price, (f) Description of purpose, (g) Defeased (Yes/No), (h) On behalf of issuer (Yes/No), (i) Pool financing (Yes/No). Rows A, B, C.

Part II Proceeds

Table with columns: 1-13 (Amount of bonds retired, Amount of bonds legally defeased, Total proceeds of issue, Gross proceeds in reserve funds, Capitalized interest from proceeds, Proceeds in refunding escrows, Issuance costs from proceeds, Credit enhancement from proceeds, Working capital expenditures from proceeds, Capital expenditures from proceeds, Other spent proceeds, Other unspent proceeds, Year of substantial completion), A, B, C, D (Yes/No).

Part III Private Business Use

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

**Part III Private Business Use** (Continued)

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

**Part IV Arbitrage**

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

**Part IV Arbitrage** (Continued)

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

**Part V Procedures To Undertake Corrective Action**

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

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

**SCHEDULE O**  
(Form 990 or 990-EZ)**Supplemental Information to Form 990 or 990-EZ**

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.

▶ Attach to Form 990 or 990-EZ.

▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No 1545-0047

**2018****Open to Public Inspection**

Department of the Treasury

Name of the organization  
Northwest Community Hospital

Employer identification number

36-2340313

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
Form 990, Part III, Line 4D - Desc of Other Program Services	INCLUDES REVENUE, EXPENSES, AND GRANTS OF \$167,419 FROM ALL OTHER PROGRAM SERVICE SPECIALITIES ALONG WITH REFERENCE LAB REVENUE, CAPITATION REVENUE, INTERCOMPANY RENTS AND OTHER RENTAL INCOME NOT DESCRIBED ON FORM 990, PART III, LINES 4A-4C

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
Form 990, Part VI, Section A Line 6 - Desc of Members	NORTHWEST COMMUNITY HEALTHCARE (NCH) IS THE SOLE CORPORATE MEMBER OF NORTHWEST COMMUNITY HOSPITAL (HOSPITAL) AS SUCH, IT ELECTS OR APPOINTS THE MEMBERS OF HOSPITAL'S GOVERNING BODY AND APPROVES SIGNIFICANT DECISIONS

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
Form 990, Part VI, Section A Line 7a - Power to elect members	NCH IS THE SOLE CORPORATE MEMBER OF HOSPITAL AS SUCH, IT ELECTS OR APPOINTS THE MEMBERS OF THE GOVERNING BODY OF HOSPITAL PERIODICALLY OR AS VACANCIES ARISE

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
Form 990, Part VI, Section A Line 7b - Governance Decisions	NCH IS THE SOLE CORPORATE MEMBER OF HOSPITAL AS SUCH, IT MUST APPROVE CERTAIN ACTIONS OF HOSPITAL ACTION IS TAKEN BY A MAJORITY VOTE OF THE NCH BOARD WITH A QUORUM PRESENT NCH MUST APPROVE THE FOLLOWING TYPES OF DECISIONS BY HOSPITAL VOLUNTARY DISSOLUTION, MERGER, CONSOLIDATION OR SALE OR TRANSFER OF 10% OR MORE OF HOSPITAL'S ASSETS, SALE OF REAL PROPERTY OR INTEREST THEREIN, CREATION OF A SUBSIDIARY OR AFFILIATE, ANNUAL AND LONG-TERM CAPITAL AND OPERATING BUDGETS, AMENDMENT, ALTERATION OR REPEAL OF HOSPITAL'S ARTICLES OF INCORPORATION OR BYLAWS, SELECTION OF AUDITORS, APPOINTMENT, REMOVAL AND EVALUATION OF HOSPITAL DIRECTORS, DEBT OR INDEBTEDNESS, GUARANTEES OR BORROWINGS, APPOINTMENT, COMPENSATION, BENEFITS AND EVALUATION OF OFFICERS, APPOINTMENT AND EMPLOYMENT OF THE PRESIDENT, AND ACTIONS TAKEN BY TRUSTEES OF THE NORTHWEST COMMUNITY HOSPITAL EMPLOYEES RETIREMENT PLAN

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
Form 990, Part VI, Section B Line 11b - Review of Form 990	A COPY OF FORM 990 WAS MADE AVAILABLE TO THE MEMBERS OF HOSPITAL'S BOARD PRIOR TO FILING THE AUDIT AND COMPLIANCE COMMITTEE OF THE BOARD HAS BEEN ASSIGNED THE RESPONSIBILITY OF REVIEWING FORMS 990 FOR ALL AFFILIATES OF NCH THIS COMMITTEE REVIEWED FORM 990 PRIOR TO DISTRIBUTION TO THE FULL BOARD SPECIFIC SECTIONS OF THE TAX RETURN ARE ALSO REVIEWED BY HUMAN RESOURCES, LEGAL, AND COMPLIANCE

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
Form 990, Part VI, Section B Line 12c - Conflict of Interest	EACH YEAR, THE CONFLICT OF INTEREST POLICY AND QUESTIONNAIRE IS SENT TO DIRECTORS, OFFICERS AND KEY EMPLOYEES EACH RESPONSE IS REVIEWED BY THE GENERAL COUNSEL AND THOSE IN WHICH ANY ACTUAL OR APPARENT CONFLICT WITH THE PRESENT ROLE IS DISCLOSED, ARE REVIEWED BY THE PRESIDENT/CEO AND BOARD CHAIRPERSON IN THE CASE OF ANY CONFLICT INVOLVING AN ENTITY OR PARTY WITH WHICH HOSPITAL IS DEALING OR COMPETING, THE PERSON WITH THE CONFLICT MAY NOT PARTICIPATE IN ANY DECISIONS REGARDING THAT PARTY INDIVIDUALS WHO ARE INDEPENDENT CONTRACTORS, OFFICERS, DIRECTORS, OR EMPLOYEES OF OTHER HEALTHCARE FACILITIES IN HOSPITAL'S SERVICE AREA MAY NOT SERVE ON NCH'S OR ANY RELATED ORGANIZATION'S BOARD OR BOARD COMMITTEE IN ADDITION, THE POLICY INCLUDES A SAMPLE CONFLICT OF INTEREST DISCLOSURE LETTER TO BE USED IF A CONFLICT ARISES AFTER SUBMISSION OF THE ANNUAL QUESTIONNAIRE AND BEFORE SUBMISSION OF THE NEXT ANNUAL QUESTIONNAIRE SUCH DISCLOSURE LETTERS WOULD BE REVIEWED AS NOTED ABOVE AT THE TIME THEY ARE RECEIVED

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
Form 990, Part VI, Section B Line 15a & 15b - Comp Determination	<p>The Compensation Committee of the Board of Directors (the "Committee") of Northwest Community Healthcare, which is the parent corporation of Northwest Community Hospital and who has identical board members as Northwest Community Healthcare, is responsible for preparing the total compensation paid to the Organization's senior executives (collectively, "Executives") to ensure that compensation paid to such Executives is reasonable and does not result in excessive and inappropriate benefit to private individuals. The Committee shall, on an annual basis, review and recommend to the Board for approval executive compensation consistent with the process described below. This process is intended to result in compensation decisions that are consistent with the Organization's fulfillment of its mission as set forth in the Organization's Articles of Incorporation, as well as the Organization's compensation philosophy and related principles set forth in this document. The Compensation philosophy is intended to result in the determination and payment of total compensation, including benefits, for Executives based on the following objectives: Compensation that is objectively fair and reasonable compared to similar executives at similar institutions, Compensation that contributes to the attraction and retention of qualified and talented individuals in Executive positions, Compensation that rewards the attainment of performance goals and expectations, and Compensation that reinforces the commitment to the Organization's mission, purpose and values. In assessing the reasonableness of an Executive's total compensation, the Committee shall endeavor to set base salary at or near the market 60th percentile. The Committee shall target total compensation, including but not limited to, salary, any bonus or incentive payments and deferred and noncash compensation, as well as all compensatory benefits such as payments to medical, dental, life, annuity, retirement and disability benefit plans, and any fringe benefits such as housing, automobile, and computer allowances to approximate the market 75th percentile. The Committee shall conduct an annual performance review of the CEO, the results of which shall be used in determining a reasonable total compensation for him or her. The CEO will formulate a compensation recommendation for each Executive who reports to him or her. The CEO will present compensation recommendations based on an evaluation of each Executive's job performance in accordance with criteria established by him or her. When reviewing or assessing the total compensation of any Executive, the Committee shall obtain sufficient information, taking into consideration the knowledge and expertise of its members, to determine whether total compensation of each Executive is reasonable (i.e., whether such compensation is comparable to that of similar executives at similar institutions). To assist in the determination of reasonable compensation, the Committee will select</p>

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
Form 990, Part VI, Section B Line 15a & 15b - Comp Determination	<p>t and engage a qualified independent compensation consultant ("Consultant") to annually re view and analyze the total compensation, including benefits, of each Executive The terms of the Consultant's engagement shall provide that the Consultant is to report to the Commi ttee, and that the Consultant shall have no reporting responsibilities to any Executive wi th respect to any engagement in connection with the executive total compensation program The Committee shall instruct the Consultant to comple appropriate comparability data, whi ch may include compensation and benefits paid by similarly situated organizations for posi tions that are functionally comparable to those of each Executive The Committee shall dir ect the Consultant to analyze a number of different variables in assessing comparability, including but not limited to organizational size, geographic location, the nature of the s ervices provided, the level of experience and specific responsibilities of the position co nsidered, and the components of the compensation offered If a Consultant is retained, the Consultant should be directed to provide written analysis and recommendations with respec t to a reasonable total compensation for each Executive The Committee may additionally re quest that the Consultant be available to present a written analysis and recommendations a nd to take questions from Board or Committee members In addition to the reports and analy ses of the Consultant, the Committee shall also consider additional comparability data, in cluding but not limited to the availability of similar services in the geographic area, c urrent compensation surveys compiled by independent firms, and actual written offers from similar institutions competing for services of the applicable Executive</p>

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
Form 990, Part VI, Section C Line 19 - Availability of Documents	GOVERNING DOCUMENTS AND THE CONFLICT OF INTEREST POLICY ARE NOT MADE PUBLIC HOSPITAL'S FINANCIAL STATEMENTS ARE INCLUDED IN THE ANNUAL CONSOLIDATED AUDIT REPORT OF NCH AND SUBSIDIARIES THESE CONSOLIDATED FINANCIAL STATEMENTS ARE AVAILABLE TO THE PUBLIC VIA THE MUNICIPAL SECURITIES RULEMAKING BOARD'S ELECTRONIC MUNICIPAL MARKET ACCESS (EMMA) WEBSITE AT WWW EMMA MSRB ORG

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
Form 990, Part XI, Line 9	RECONCILIATION OF NET ASSETS - OTHER CHANGES IN NET ASSETS TRANSFER TO AFFILIATES (\$ 37,000,000) PERIODIC PENSION COST (\$ 5,051,148) PENSION EXPENSE (\$ 3,661,620) NET ASSETS RELEASED FROM UNRESTRICTED \$ 3,009,858 NET ASSETS RELEASED FROM TEMP RESTRICTED (\$ 3,566,390) CHANGE IN NET ASSETS OF FOUNDATION TEMP RESTRICTED \$ 5,851,539 CHANGE IN NET ASSETS OF FOUNDATION PERM RESTRICTED \$ 1,000,000 ----- TOTAL OTHER CHANGES IN NET ASSETS (\$ 39,417,761)

**SCHEDULE R  
(Form 990)**

**Related Organizations and Unrelated Partnerships**

OMB No 1545-0047

**2018**

**Open to Public  
Inspection**

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.**  
▶ **Attach to Form 990.**  
▶ **Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.**

Department of the Treasury  
Internal Revenue Service

Name of the organization  
Northwest Community Hospital

**Employer identification number**

36-2340313

**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
<b>(1)</b> NORTHWEST COMMUNITY PHYSICIANS ASSN LLC 3040 SALT CREEK LN ARLINGTON HTS, IL 60005 51-0457240	PATIENT CARE	IL	0	0	NWC Hospital
<b>(2)</b> Northwest Service Company LLC 3040 Salt Creek LN Arlington Heights, IL 60005 26-3791362	Inactive	IL	0	0	N/A

**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
<b>(1)</b> NORTHWEST COMMUNITY HEALTHCARE 3040 SALT CREEK LN  ARLINGTON HEIGHTS, IL 60005 36-3125209	SUPPORT ORG	IL	501(c)(3)	12B	NWC Hlthcare		No
<b>(2)</b> NORTHWEST COMMUNITY HOSPITAL FOUNDATION 3040 SALT CREEK LN  ARLINGTON HEIGHTS, IL 60005 36-3125193	FUNDRAISING	IL	501(c)(3)	7	NWC Hlthcare		No

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
<b>(1)</b> NPC-CYBERKNIFE LLC 3040 SALT CREEK LN ARLINGTON HTS, IL 60005 20-4462828	EQUIPMENT LEASING	IL	NWC HEALTHCARE									
<b>(2)</b> NWC Day Surgery 3040 SALT CREEK LN ARLINGTON HTS, IL 60005 30-0798249	OUTPATIENT CARE	IL	NWC HEALTHCARE									
<b>(3)</b> NW ENDO CENTER LLC 3040 SALT CREEK LN ARLINGTON HTS, IL 60005 81-2338623	SURGICAL CARE	IL	NWC HEALTHCARE									
<b>(4)</b> NWC FOOT & ANKLE 3040 SALT CREEK LN ARLINGTON HTS, IL 60005 35-2567039	AMB SRGCAL CNTER	IL	NWC HEALTHCARE									
<b>(5)</b> ENVISION MED IMG 8930 WAUKEGAN RD STE 130 MORTON GROVE, IL 60053 82-2067179	IMAGING SERVICES	IL	NWC HEALTHCARE									

**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
<b>(1)</b> NORTHWEST COMMUNITY HEALTH SERVICES INC 800 WEST CENTRAL ROAD ARLINGTON HEIGHTS, IL 60005 36-3312906	HEALTHCARE SERV	IL	NWC HEALTHCARE	C Corp					
<b>(2)</b> CENTRAL INSURANCE COMPANY LTD PO Box 10233 Grand Cayman KY1-1002 CJ 98-1109518	INSURANCE	CJ	NWC Healthcare	C Corp					

**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
<b>1</b> 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?			
<b>a</b>	Receipt of <b>(i)</b> interest, <b>(ii)</b> annuities, <b>(iii)</b> royalties, or <b>(iv)</b> rent from a controlled entity . . . . .		No
<b>b</b>	Gift, grant, or capital contribution to related organization(s) . . . . .		No
<b>c</b>	Gift, grant, or capital contribution from related organization(s) . . . . .	Yes	
<b>d</b>	Loans or loan guarantees to or for related organization(s) . . . . .		No
<b>e</b>	Loans or loan guarantees by related organization(s) . . . . .		No
<b>f</b>	Dividends from related organization(s) . . . . .		No
<b>g</b>	Sale of assets to related organization(s) . . . . .		No
<b>h</b>	Purchase of assets from related organization(s) . . . . .		No
<b>i</b>	Exchange of assets with related organization(s) . . . . .		No
<b>j</b>	Lease of facilities, equipment, or other assets to related organization(s) . . . . .	Yes	
<b>k</b>	Lease of facilities, equipment, or other assets from related organization(s) . . . . .	Yes	
<b>l</b>	Performance of services or membership or fundraising solicitations for related organization(s) . . . . .	Yes	
<b>m</b>	Performance of services or membership or fundraising solicitations by related organization(s) . . . . .		No
<b>n</b>	Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) . . . . .	Yes	
<b>o</b>	Sharing of paid employees with related organization(s) . . . . .	Yes	
<b>p</b>	Reimbursement paid to related organization(s) for expenses . . . . .		No
<b>q</b>	Reimbursement paid by related organization(s) for expenses . . . . .	Yes	
<b>r</b>	Other transfer of cash or property to related organization(s) . . . . .	Yes	
<b>s</b>	Other transfer of cash or property from related organization(s) . . . . .		No

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved



**Part VII**    **Supplemental Information**

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

<b>Return Reference</b>	<b>Explanation</b>