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Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

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

OMB No. 1545-0047

2019

Open to Public Inspection

A For the 2019 calendar year, or tax year beginning 01-01-2019 , and ending 12-31-2019

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

C Name of organization
HENRY FORD HEALTH SYSTEM

Doing business as

Number and street (or P.O. box if mail is not delivered to street address) | Room/suite
ONE FORD PLACE - 5F

City or town, state or province, country, and ZIP or foreign postal code
DETROIT, MI 48202

D Employer identification number
38-1357020

E Telephone number
(313) 876-8704

G Gross receipts $ 3,695,644,864

F Name and address of principal officer:
ROBIN DAMSCHRODER
ONE FORD PLACE - 5F
DETROIT, MI 48202

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: ▶ WWW.HENRYFORD.COM

K Form of organization: ☑ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1915

M State of legal domicile: MI

Part I Summary

1 Briefly describe the organization's mission or most significant activities:
TO IMPROVE PEOPLE'S LIVES THROUGH EXCELLENCE IN THE SCIENCE AND ART OF HEALTH CARE AND HEALING.VISION: TRANSFORMING LIVES AND COMMUNITIES THROUGH HEALTH AND WELLNESS-ONE PERSON AT A TIME.

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

3	Number of voting members of the governing body (Part VI, line 1a)	**3**	15
4	Number of independent voting members of the governing body (Part VI, line 1b)	**4**	12
5	Total number of individuals employed in calendar year 2019 (Part V, line 2a)	**5**	25,120
6	Total number of volunteers (estimate if necessary)	**6**	1,244
7a	Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	15,997,520
b	Net unrelated business taxable income from Form 990-T, line 39	**7b**	0

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	57,270,516	81,880,767
9	Program service revenue (Part VIII, line 2g)	2,945,329,742	3,091,975,855
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	-46,393,373	161,939,165
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	170,220,398	177,447,739
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	3,126,427,283	3,513,243,526
13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	3,264,241	2,978,441
14	Benefits paid to or for members (Part IX, column (A), line 4)	0	0
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	1,717,300,767	1,859,089,047
16a	Professional fundraising fees (Part IX, column (A), line 11e)	173,460	121,489
b	Total fundraising expenses (Part IX, column (D), line 25) ▶4,987,720		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	1,321,100,750	1,408,857,644
18	Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	3,041,839,218	3,271,046,621
19	Revenue less expenses. Subtract line 18 from line 12	84,588,065	242,196,905

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	2,369,131,001	3,049,325,128
21	Total liabilities (Part X, line 26)	1,377,161,698	1,898,110,492
22	Net assets or fund balances. Subtract line 21 from line 20	991,969,303	1,151,214,636

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: 2020-11-12

▶ ROBIN DAMSCHRODER EVP FINANCE/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
				P00741382

Firm's name ▶ DELOITTE TAX LLP — Firm's EIN ▶ 86-1065772

Firm's address ▶ 200 RENAISSANCE CENTER SUITE 3900
DETROIT, MI 48243 — Phone no. (313) 396-3000

May the IRS discuss this return with the preparer shown above? (see instructions) ☐ Yes ☑ No

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:

AS ONE OF THE NATION'S LEADING INTEGRATED HEALTH SYSTEMS, IT IS THE MISSION OF HENRY FORD HEALTH SYSTEM TO IMPROVE HUMAN LIFE THROUGH THE EXCELLENCE OF THE SCIENCE AND ART OF HEALTH CARE AND HEALING. SINCE ITS FOUNDING IN 1915, HFHS HAS BEEN COMMITTED TO PROVIDING HEALTH SERVICES AND IMPROVING THE QUALITY OF LIFE OF THE CITIZENS OF THE COMMUNITIES IT SERVES REGARDLESS OF THEIR FINANCIAL CIRCUMSTANCES. THE ORGANIZATION PROVIDES HEALTH CARE DELIVERY, INCLUDING ACUTE, SPECIALTY, PRIMARY AND PREVENTATIVE CARE SERVICES BACKED BY EXCELLENCE IN RESEARCH AND EDUCATION.

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? . . . . . ☐ Yes ☑ No

If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? . . . . . ☐ Yes ☑ No

If "Yes," describe these changes on Schedule O.

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code:) (Expenses $ 1,425,429,952 including grants of $ 2,978,441) (Revenue $ 1,352,536,907)

See Additional Data

4b (Code:) (Expenses $ 1,120,334,025 including grants of $) (Revenue $ 990,399,434)

See Additional Data

4c (Code:) (Expenses $ 182,882,259 including grants of $) (Revenue $ 156,891,641)

See Additional Data

(Code:) (Expenses $ 286,491,140 including grants of $) (Revenue $ 750,220,699)

OTHER PROGRAM SERVICES INCLUDES HFHS RESEARCH SERVICES, ALONG WITH HFHS COMMUNITY CARE SERVICES, WHICH OFFERS A BROAD LEVEL OF SERVICES AT NUMEROUS GEOGRAPHIC LOCATIONS INCLUDING NURSING CARE, HOME CARE, SENIOR CARE, PHARMACIES, EYE CARE, HOSPICE CARE, OCCUPATIONAL HEALTH, DIALYSIS; HOUSING FOR MEDICAL RESIDENTS & PATIENT FAMILY MEMBERS; FITNESS CENTER & ATHLETIC TRAINING SERVICES, SCHOOL BASED HEALTH PROGRAMS AND A DEDICATED CANCER CENTER.RESEARCH IS A VITAL COMPONENT OF THE MISSION OF HENRY FORD HEALTH SYSTEM.HENRY FORD HEALTH SYSTEM'S MISSION IS TO IMPROVE HUMAN LIFE THROUGH EXCELLENCE IN THE SCIENCE AND ART OF HEALTH CARE AND HEALING. THIS MISSION IS STRONGLY SUPPORTED AND ENHANCED BY THE DEDICATED STAFF'S PURSUIT OF SCIENTIFIC ADVANCEMENT. SINCE 1915, HENRY FORD HOSPITAL PHYSICIANS AND SCIENTISTS HAVE FOCUSED THEIR EFFORTS ON A WIDE VARIETY OF TOPICS CRITICAL TO UNDERSTANDING THE MECHANISMS OF DISEASE AND DEVELOPING NEW, VIABLE TREATMENT OPTIONS. HENRY FORD HEALTH SYSTEM (HFHS) HAS ENJOYED GREAT SUCCESS IN SECURING EXTERNAL RESEARCH GRANTS AND CONTRACTS. EXTERNAL GRANT FUNDING HAS BEEN RECEIVED FROM THE NATIONAL INSTITUTES OF HEALTH (NIH), OTHER FEDERAL AGENCIES, PHARMACEUTICAL COMPANIES AND INDUSTRY, STATE AND LOCAL AGENCIES, AND FOUNDATIONS. IN 2018 HFHS RECEIVED $86 MILLION IN EXTERNALLY- AWARDED GRANTS, CONTRACTS AND SUB-CONTRACTS, $45 MILLION OF WHICH WAS AWARDED BY NIH AND OTHER FEDERAL AGENCIES. ALTHOUGH HFHS IS NOT FORMALLY PART OF A UNIVERSITY OR MEDICAL SCHOOL, THERE HAS BEEN STRONG SUPPORT FOR THE SYSTEM'S RESEARCH THROUGHOUT ITS HISTORY. THIS DRIVE TO UNDERSTAND DISEASE MECHANISM AND DISCOVER NEW THERAPIES IS MANIFESTED BY THE CONTINUUM OF BIOMEDICAL RESEARCH PERFORMED AT HENRY FORD. THE SYSTEM HAS A STAFF OF 82 BIO-SCIENTIFIC RESEARCHERS ENGAGING IN BASIC SCIENCE STUDIES IN CARDIOVASCULAR AND RENAL DISEASES SUCH AS HYPERTENSION AND HEART FAILURE, STROKE/BRAIN INJURY/BRAIN TUMORS, POPULATION HEALTH AND HEALTHCARE RESEARCH, CANCER THERAPEUTICS, BONE AND JOINT DISEASES, IMMUNOLOGY AND IMAGING, AMONG OTHERS. IN ADDITION, DOZENS OF PHYSICIANS AND THEIR CLINICAL SUPPORT STAFF ARE ENGAGED IN PATIENT-ORIENTED STUDIES. AT THIS TIME, HFHS HAS MORE THAN 2,000 OPEN STUDIES APPROVED BY ITS INSTITUTIONAL REVIEW BOARD, INCLUDING STUDIES APPROVED IN CONJUNCTION WITH WAYNE STATE UNIVERSITY AND MICHIGAN STATE UNIVERSITY. THE BASIC SCIENCE BIOMEDICAL RESEARCH PROGRAMS RECEIVING THE MOST EXTERNAL FUNDING WERE PUBLIC HEALTH SCIENCES, NEUROLOGY RESEARCH (STROKE, TRAUMATIC BRAIN INJURY, ETC.), HYPERTENSION RESEARCH AND CARDIOVASCULAR RESEARCH (IN PARTICULAR, HEART FAILURE). IN CLINICAL RESEARCH, A MAJORITY OF FUNDING HAS GONE TO THE DEPARTMENT OF INTERNAL MEDICINE WHERE THE DIVISIONS OF INFECTIOUS DISEASES, GASTROENTEROLOGY, HEMATOLOGY/ONCOLOGY AND CARDIOLOGY ARE LEADING THE WAY. THE INFRASTRUCTURE AT HFHS ALLOWS US TO HAVE A RESEARCH PROGRAM FAR LARGER THAN OTHER NON-UNIVERSITY-BASED HEALTH CARE SYSTEMS IN THE STATE OF MICHIGAN, WHERE OUR NIH FUNDING IS TEN TIMES GREATER THAN HFHS'S CLOSEST COMPETITOR. IN 2018, HFHS WAS FOURTH IN MICHIGAN, TRAILING THE STATES THREE LARGEST UNIVERSITIES, AND RANKED 182ND OUT OF MORE THAN 2,500 INSTITUTIONS RECEIVING NIH GRANTS NATIONALLY.

4d Other program services (Describe in Schedule O.)
(Expenses $ 286,491,140 including grants of $) (Revenue $ 750,220,699)

4e **Total program service expenses ▶** 3,015,137,376

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	Yes	
2	Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)?	2	Yes	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		No
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	Yes	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		No
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D,* Part I	6		No
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		No
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D,* Part III	8		No
9	Did the organization report an amount in Part X, line 21 for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		No
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi endowments? *If "Yes," complete Schedule D, Part V*	10	Yes	
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D,* Part VI.	11a	Yes	
b	Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b		No
c	Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		No
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d	Yes	
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	Yes	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f	Yes	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a		No
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	Yes	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		No
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a	Yes	
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b	Yes	
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV*	15		No
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV*	16		No
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I* (see instructions)	17	Yes	
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18	Yes	
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19	Yes	
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	Yes	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	Yes	
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21	Yes	

Part IV Checklist of Required Schedules *(continued)*

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	1,755		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	1		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		Yes	

Part V Statements Regarding Other IRS Filings and Tax Compliance *(continued)*

2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	**2a**	25,120		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)			**2b**	Yes
3a	Did the organization have unrelated business gross income of $1,000 or more during the year? . . .			**3a**	Yes
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O* . . .			**3b**	Yes
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . .			**4a**	Yes
b	If "Yes," enter the name of the foreign country: ▶CJ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . .			**5a**	No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?			**5b**	No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?			**5c**	
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . .			**6a**	No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?			**6b**	
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?			**7a**	No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?			**7b**	Yes
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?			**7c**	No
d	If "Yes," indicate the number of Forms 8282 filed during the year	**7d**			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?			**7e**	No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . .			**7f**	No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?			**7g**	
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?			**7h**	
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?			**8**	
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the sponsoring organization make any taxable distributions under section 4966?			**9a**	
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . .			**9b**	
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12 . . .	**10a**			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	**10b**			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	**11a**			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	**11b**			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?			**12a**	
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year.	**12b**			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state? . . . . . **Note.** See the instructions for additional information the organization must report on Schedule O.			**13a**	
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	**13b**			
c	Enter the amount of reserves on hand	**13c**			
14a	Did the organization receive any payments for indoor tanning services during the tax year?			**14a**	No
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* . .			**14b**	
15	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.			**15**	Yes
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? . . If "Yes," complete Form 4720, Schedule O.			**16**	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

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	**1a**	15		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.				
b	Enter the number of voting members included in line 1a, above, who are independent	**1b**	12		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?			**2**		No
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?			**3**		No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?			**4**		No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?			**5**		No
6	Did the organization have members or stockholders?			**6**		No
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?			**7a**		No
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?			**7b**		No
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:					
a	The governing body?			**8a**	Yes	
b	Each committee with authority to act on behalf of the governing body?			**8b**	Yes	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*			**9**		No

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

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

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed▶ FL

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:
▶ROBIN DAMSCHRODER ONE FORD PLACE DETROIT, MI 48202 (313) 876-8714

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

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

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

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

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

See instructions for the order in which to list the persons above.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
See Additional Data Table										

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
See Additional Data Table										
1b Sub-Total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶								25,546,497	0	1,556,305

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 3,124

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
TURNER CONSTRUCTION 535 GRISWOLD STE 1525 DETROIT, MI 48226	CONSTRUCTION SERVICES	42,328,951
CHRISTMAN BRINKER A JOINT VENTURE 3011 W GRAND BLVD STE 2600 DETROIT, MI 48202	CONSTRUCTION SERVICES	20,155,871
EPIC SYSTEMS CORPORATION PO BOX 88314 MILWAUKEE, WI 532880314	INFORMATION SERVICES	6,640,404
DEMARIA BUILDING COMPANY INC 45500 GRAND RIVER AVE NOVI, MI 48374	CONSTRUCTION SERVICES	4,832,893
ACT 1 PERSONNEL SERVICES 1999 W 190TH STREET TORRANCE, CA 90504	STAFFING SERVICES	4,701,330

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 260

Part VIII Statement of Revenue

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a				
	b Membership dues	1b				
	c Fundraising events	1c	825,072			
	d Related organizations	1d	16,200,000			
	e Government grants (contributions)	1e	30,317,411			
	f All other contributions, gifts, grants, and similar amounts not included above	1f	34,538,284			
	g Noncash contributions included in lines 1a - 1f: $	1g	2,372,793			
	h **Total.** Add lines 1a-1f		81,880,767			
Program Service Revenue		Business Code				
	2a INPATIENT HOSPITALS	900099	1,352,536,907	1,352,536,907		
	b OUTPATIENT CLINICS	621400	990,399,434	990,399,434		
	c EMERGENCY ROOM SERVICES	900099	156,891,641	156,891,641		
	d MEDICAL EDUCATION-GME	900099	53,830,097	53,830,097		
	e PATIENT-RELATED RENTAL	531110	2,663,239	2,663,239		
	f All other program service revenue.		535,654,537	530,345,518	5,309,019	
	g **Total.** Add lines 2a–2f.	3,091,975,855				
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		153,859,707			153,859,707
	4 Income from investment of tax-exempt bond proceeds		-217,764			-217,764
	5 Royalties					
			(i) Real	(ii) Personal		
	6a Gross rents	6a				
	b Less: rental expenses	6b				
	c Rental income or (loss)	6c				
	d Net rental income or (loss)					
			(i) Securities	(ii) Other		
	7a Gross amount from sales of assets other than inventory	7a	6,133,794	9,301,357		
	b Less: cost or other basis and sales expenses	7b	0	7,137,929		
	c Gain or (loss)	7c	6,133,794	2,163,428		
	d Net gain or (loss)		8,297,222	6,133,794		2,163,428
	8a Gross income from fundraising events (not including $ 825,072 of contributions reported on line 1c). See Part IV, line 18	8a	253,185			
	b Less: direct expenses	8b	729,838			
	c Net income or (loss) from fundraising events		-476,653			-476,653
	9a Gross income from gaming activities. See Part IV, line 19	9a	56,209			
	b Less: direct expenses	9b	12,444			
	c Net income or (loss) from gaming activities		43,765			43,765
	10a Gross sales of inventory, less returns and allowances	10a	235,683,712			
	b Less: cost of goods sold	10b	174,521,127			
	c Net income or (loss) from sales of inventory		61,162,585	50,474,084	10,688,501	
	Miscellaneous Revenue	Business Code				
	11a OTHER PHARMACY	900099	97,277,985	97,277,985		
	b CAFETERIA & GIFT SHOP	900099	7,660,180			7,660,180
	c JOINT VENTURE INCOME	621400	3,662,542	3,662,542		
	d All other revenue		8,117,335	5,833,440		2,283,895
	e **Total.** Add lines 11a–11d		116,718,042			
	12 **Total revenue.** See instructions		3,513,243,526	3,250,048,681	15,997,520	165,316,558

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A).

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	1,932,613	1,932,613		
2 Grants and other assistance to domestic individuals. See Part IV, line 22	1,045,828	1,045,828		
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16.				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	14,355,236	6,306,916	7,330,558	717,762
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	3,131,398	1,306,197	1,677,746	147,455
7 Other salaries and wages	1,552,255,705	1,497,943,749	52,002,242	2,309,714
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	38,894,228	37,347,864	1,471,291	75,073
9 Other employee benefits	151,064,153	145,058,115	5,714,456	291,582
10 Payroll taxes	99,388,327	95,436,826	3,759,663	191,838
11 Fees for services (non-employees):				
a Management				
b Legal	4,955,189	2,317,872	2,637,317	
c Accounting	1,789,243		1,789,243	
d Lobbying				
e Professional fundraising services. See Part IV, line 17	121,489			121,489
f Investment management fees				
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	29,439,403	19,376,211	9,395,502	667,690
12 Advertising and promotion	17,512,143	4,054,660	13,457,483	
13 Office expenses	66,113,048	42,451,332	23,349,233	312,483
14 Information technology	49,254,326	9,452,384	39,762,916	39,026
15 Royalties				
16 Occupancy	39,415,825	30,814,917	8,592,968	7,940
17 Travel	11,755,128	9,732,778	1,965,158	57,192
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	8,101,091	7,176,315	914,860	9,916
20 Interest	21,593,716	14,400,620	7,193,096	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	126,866,800	86,911,478	39,951,862	3,460
23 Insurance	29,468,810	29,433,097	35,713	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLIES	769,832,364	768,488,253	1,343,941	170
b QAAP TAX	64,599,554	64,599,554		
c UNCOMPENSATED CARE	50,364,567	50,364,567		
d REPAIRS & MAINTENANCE	40,074,337	37,442,092	2,630,655	1,590
e All other expenses	77,722,100	51,743,138	25,945,622	33,340
25 **Total functional expenses.** Add lines 1 through 24e	3,271,046,621	3,015,137,376	250,921,525	4,987,720
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ 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
Assets	1	Cash–non-interest-bearing		129,487	1	139,255
	2	Savings and temporary cash investments		423,621,692	2	437,296,777
	3	Pledges and grants receivable, net		37,698,672	3	98,943,777
	4	Accounts receivable, net		286,956,001	4	323,883,656
	5	Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons			5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)			6	
	7	Notes and loans receivable, net		15,336,780	7	1,688,647
	8	Inventories for sale or use		68,237,955	8	75,865,300
	9	Prepaid expenses and deferred charges		41,607,874	9	52,715,098
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 2,420,019,525			
	b	Less: accumulated depreciation	10b 1,435,719,941	876,222,014	10c	984,299,584
	11	Investments—publicly traded securities		470,191,498	11	729,444,276
	12	Investments—other securities. See Part IV, line 11			12	
	13	Investments—program-related. See Part IV, line 11			13	
	14	Intangible assets		246,255	14	246,255
	15	Other assets. See Part IV, line 11		148,882,773	15	344,802,503
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)		2,369,131,001	16	3,049,325,128
Liabilities	17	Accounts payable and accrued expenses		328,718,847	17	421,594,804
	18	Grants payable			18	
	19	Deferred revenue			19	
	20	Tax-exempt bond liabilities		622,414,724	20	863,144,332
	21	Escrow or custodial account liability. Complete Part IV of Schedule D			21	
	22	Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons			22	
	23	Secured mortgages and notes payable to unrelated third parties		23,091,806	23	31,068,255
	24	Unsecured notes and loans payable to unrelated third parties			24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24). Complete Part X of Schedule D		402,936,321	25	582,303,101
	26	**Total liabilities.** Add lines 17 through 25		1,377,161,698	26	1,898,110,492
Net Assets or Fund Balances		**Organizations that follow FASB ASC 958, check here ▶ ☑ and complete lines 27, 28, 32, and 33.**				
	27	Net assets without donor restrictions		757,270,372	27	888,026,518
	28	Net assets with donor restrictions		234,698,931	28	263,188,118
		Organizations that do not follow FASB ASC 958, check here ▶ ☐ and complete lines 29 through 33.				
	29	Capital stock or trust principal, or current funds			29	
	30	Paid-in or capital surplus, or land, building or equipment fund			30	
	31	Retained earnings, endowment, accumulated income, or other funds			31	
	32	Total net assets or fund balances		991,969,303	32	1,151,214,636
	33	Total liabilities and net assets/fund balances		2,369,131,001	33	3,049,325,128

Part XI Reconcilliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	3,513,243,526
2	Total expenses (must equal Part IX, column (A), line 25)	2	3,271,046,621
3	Revenue less expenses. Subtract line 2 from line 1	3	242,196,905
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	991,969,303
5	Net unrealized gains (losses) on investments	5	
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-82,951,572
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	1,151,214,636

Part XII Financial Statements and Reporting

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

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ 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?	2a		No
	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?	2b	Yes	
	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?	2c	Yes	
	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?	3a	Yes	
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.	3b	Yes	

Additional Data

Software ID:

Software Version:

EIN: 38-1357020

Name: HENRY FORD HEALTH SYSTEM

Form 990, Part III, Line 4a:

INPATIENT HOSPITALS: HENRY FORD HEALTH SYSTEM IS HONORED TO BE THE ONLY ORGANIZATION IN MICHIGAN AND ONE OF FOUR NATIONALLY TO RECEIVE THE 2011 MALCOLM BALDRIGE NATIONAL QUALITY AWARD FOR PERFORMANCE EXCELLENCE. A KEY FACET OF OUR AWARD-WINNING OPERATIONS IS OUR COMMITMENT TO ALL COMMUNITIES WE SERVE, SUPPORTING OUR VISION OF TRANSFORMING LIVES AND COMMUNITIES THROUGH HEALTH AND WELLNESS-ONE PERSON AT A TIME. THE ORGANIZATION OPERATES HENRY FORD HOSPITAL (HFH), AN 877 BED TERTIARY, AND QUATERNARY CARE HOSPITAL, EDUCATION AND RESEARCH COMPLEX IN THE NEW CENTER AREA OF DETROIT, MICHIGAN. THE HOSPITAL IS RECOGNIZED FOR CLINICAL EXCELLENCE AND INNOVATION IN THE FIELDS OF CARDIOLOGY AND CARDIOVASCULAR SURGERY, NEUROLOGY AND NEUROSURGERY, ORTHOPEDICS, CANCER CARE AND SPORTS MEDICINE, AMONG OTHERS. THE HOSPITAL IS A MULTI-ORGAN TRANSPLANT CENTER AND LEVEL 1 TRAUMA CENTER. THE HOSPITAL POSTED REVENUES OF MORE THAN ONE BILLION DOLLARS AND 36,000 DISCHARGES DURING 2019. 875 MEDICAL RESIDENTS AND FELLOWS ALONG WITH 1,000 MEDICAL STUDENTS PARTICIPATED IN THE ORGANIZATION'S VARIOUS EDUCATIONAL PROGRAMS. WEST BLOOMFIELD HOSPITAL, AN OPERATING UNIT OF HFHS, OFFERS COMPREHENSIVE MEDICAL CARE, INCLUDING 24-HOUR EMERGENCY CARE, NEUROSCIENCES, WOMEN'S AND CHILDREN'S HEALTH, ORTHOPEDICS, DIAGNOSTIC TESTING AND A WELLNESS CENTER WITH COMPLEMENTARY THERAPIES. A GREENHOUSE GROWS ORGANIC PRODUCE FOR PATIENTS, STAFF AND COMMUNITY. HENRY FORD WEST BLOOMFIELD EARNED THE BABY FRIENDLY HOSPITAL DESIGNATION IN 2015. BY HFWB IMPLEMENTING 10 IMPORTANT STEPS, HFWB JOINED ALMOST 300 HOSPITALS NATIONWIDE TO OFFER OPTIMAL CARE FOR INFANT FEEDING AND MOTHER/BABY BONDING. TO COMPLEMENT THE SERVICES AT ITS BREAST CENTER, HFWB WAS THE FIRST HOSPITAL IN THE SYSTEM TO ADD TOMOSYNTHESIS TECHNOLOGY FOR IMAGING OF DENSE BREASTS. THE HOSPITAL HAD REVENUES OF $334 MILLION, AND DISCHARGED 13,123 PATIENTS DURING 2019. TEACHING, RESEARCH, AND ADVANCED PATIENT CARE MAKE HFHS A PREMIER ACADEMIC MEDICAL CENTER. AFFILIATED WITH WAYNE STATE UNIVERSITY'S SCHOOL OF MEDICINE, HENRY FORD PROVIDES INNOVATIVE PHYSICIAN TRAINING PROGRAMS AND COLLABORATES ON LEADING-EDGE MEDICAL RESEARCH. HENRY FORD MEDICAL EDUCATION OVERVIEW:HENRY FORD HEALTH SYSTEM HAS ONE OF THE LARGEST MEDICAL EDUCATION ENTERPRISES IN THE UNITED STATES. THE SYSTEM SPONSORS 72 ACCREDITED GRADUATE TRAINING PROGRAMS IN MICHIGAN. THE SYSTEM'S FLAGSHIP HOSPITAL, HENRY FORD HOSPITAL IN DETROIT, IS ONE OF THE NATION'S LARGEST RESEARCH CENTERS. IN 2019, EXTERNAL GRANTS AND CONTRACTS FOR RESEARCH REACHED $94 MILLION. AS ONE OF THE LARGEST MEDICAL EDUCATION TEACHING CENTERS IN THE NATION, HENRY FORD TRAINS MORE THAN 1,000 MEDICAL STUDENTS EVERY YEAR. HENRY FORD HOSPITAL DOCTORS TRAIN MORE THAN 900 MEDICAL SCHOOL STUDENTS, 675 RESIDENTS AND FELLOWS ACROSS 50 DIFFERENT AREAS OF MEDICINE EVERY YEAR. HENRY FORD HOSPITAL RESIDENCY AND FELLOWSHIP PROGRAMS ARE NATIONALLY ACCREDITED M.D. (DOCTORATE OF MEDICINE) TRAINING PROGRAMS. HENRY FORD ALLEGIANCE , MACOMB AND WYANDOTTE HOSPITALS TRAIN MORE THAN 100 MEDICAL STUDENTS AND 200 RESIDENTS EVERY YEAR. THESE HOSPITALS OFFER NATIONALLY ACCREDITED D.O. (DOCTORATE OF OSTEOPATHIC MEDICINE) AND D.P.M. (DOCTORATE OF PODIATRIC MEDICINE) TRAINING PROGRAMS. AS TEACHING PHYSICIANS, HENRY FORD MEDICAL GROUP DOCTORS ARE ALSO FACULTY MEMBERS AT THE WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE, AND MANY OTHER HENRY FORD TEACHING DOCTORS ARE FACULTY MEMBERS AT THE MICHIGAN STATE UNIVERSITY COLLEGE OF OSTEOPATHIC MEDICINE. HENRY FORD HOSPITAL HEALTH SYSTEM'S CENTER FOR SIMULATION, EDUCATION AND RESEARCH PROVIDES MORE THAN 14,000 PARTICIPANTS A RISK-FREE ENVIRONMENT WHERE STATE-OF-THE-ART COMPUTERS AND MANNEQUINS SIMULATE HUNDREDS OF MEDICAL CONDITIONS, ALLOWING HEALTH PROFESSIONALS TO PRACTICE AND AUGMENT THEIR SKILLS.

Form 990, Part III, Line 4b:

OUTPATIENT CLINICS: THE ORGANIZATION INCLUDES THE HENRY FORD MEDICAL GROUP (HFMG),ONE OF THE NATION'S LARGEST GROUP PRACTICES, WITH MORE THAN 1,594 PHYSICIANS AND RESEARCHERS IN 40 SPECIALTIES FROM 60 COUNTRIES WHO STAFF HENRY FORD HOSPITAL AND HENRY FORD WEST BLOOMFIELD HOSPITAL, ALONG WITH 30 HENRY FORD MEDICAL CENTERS, ENCOMPASSING MORE THAN 3 MILLION VISITS ANNUALLY. HENRY FORD'S MEDICAL CENTERS ARE LOCATED IN WAYNE, OAKLAND, AND MACOMB COUNTIES. SOME MEDICAL GROUP PHYSICIANS ALSO ARE ON STAFF AT OTHER HENRY FORD HOSPITALS. THREE MEDICAL CENTERS PROVIDE 24-HOUR EMERGENCY CARE AND AMBULATORY SURGERY AND ARE PRIMARY CARE STROKE CENTERS. FOUNDED IN 1915 AFTER CONSULTATIONS WITH PHYSICIANS AT JOHNS HOPKINS HOSPITAL AND THE MAYO CLINIC, THE HENRY FORD MEDICAL GROUP HAS ESTABLISHED ITSELF AS ONE OF THE PREMIER GROUP PRACTICES IN THE NATION. OUR LARGE ACADEMIC ENTERPRISE PLACES US IN THE TOP THREE OF TRADITIONALLY INDEPENDENT GROUP PRACTICES THROUGH:CLINICAL CARE: THE BREADTH AND DEPTH OF THE HENRY FORD MEDICAL GROUP'S CLINICAL SERVICES IS UNPARALLELED BY ANY OTHER INDEPENDENT ACADEMIC MEDICAL CENTER. OUR SCALE AND SCOPE ARE IN THE 99TH PERCENTILE OF ALL GROUP PRACTICES, WITH VISIT VOLUMES LARGER THAN MOST GROUP PRACTICES. WE ARE NATIONAL LEADERS IN PRIMARY CARE WITH EXPERTISE IN PREVENTIVE CARE SERVICES AND THE HEALTH MANAGEMENT OF SENIOR CITIZENS. OUR SPECIALTY CENTERS OF EXCELLENCE ARE NATIONAL LEADERS AS WELL, PROVIDING ADVANCED TERTIARY AND QUATERNARY CARE WITH A FOCUS ON DISCOVERY AND INNOVATION.EDUCATION: OUR POST-GRADUATE MEDICAL EDUCATION ENTERPRISE IS AMONG THE LARGEST IN THE COUNTRY. APPROXIMATELY 40 PERCENT OF ALL PHYSICIANS IN MICHIGAN FORMALLY TRAINED AT HENRY FORD DURING SOME POINT IN THEIR CAREER.RESEARCH: HENRY FORD IS IN THE TOP 10% OF ALL INSTITUTIONS GRANTED FUNDING BY THE NIH AND U.S. PUBLIC HEALTH SERVICE, AND RANKS FIRST IN MICHIGAN FOR NIH-RESEARCH FUNDING FOR NON-UNIVERSITY BASED HEALTH CARE SYSTEMS.LEADERS IN ACADEMIC MEDICINE AND CLINICAL CARE: THE HENRY FORD MEDICAL GROUP IS CONSIDERED AMONG THE BEST ORGANIZED IN THE COUNTRY. OUR SELF-GOVERNED, EMPLOYED PHYSICIAN PRACTICE PROGRAM HAS BECOME A MODEL FOR MANY OTHERS BECAUSE OF OUR CONTINUING SUCCESS. THE BRIGHTEST MINDS IN MEDICINE ARE ATTRACTED TO BECOME PART OF THE HENRY FORD MEDICAL GROUP BECAUSE OUR ORGANIZATION PROVIDES PHYSICIANS THE INDEPENDENCE TO PURSUE ADVANCED CLINICAL CARE WHILE UNDERTAKING RESEARCH AS WELL AS ACADEMIC EDUCATIONAL INITIATIVES.FOR OVER 100 YEARS THE HENRY FORD MEDICAL GROUP HAS FOSTERED ADVANCEMENT IN PATIENT CARE, RESEARCH, AND EDUCATION WHILE ENCOURAGING INNOVATION IN TECHNOLOGY AND PATIENT CARE PROCESSES BOTH IN THE OUTPATIENT AND HOSPITAL SETTINGS. FOR THESE REASONS HENRY FORD MEDICAL GROUP PHYSICIANS ARE CONSISTENTLY SELECTED BY THEIR PHYSICIAN PEERS AS TOP DOCTORS IN VARIOUS LOCAL AND NATIONAL PUBLISHED SURVEYS AND TO LEAD NATIONAL AND STATE MEDICAL ASSOCIATIONS. HENRY FORD MEDICAL GROUP PHYSICIANS WORK TOGETHER IN LEADERSHIP AND AS EVERYDAY PARTNERS TO CONTINUE TO BRING THE BEST POSSIBLE CARE TO EVERY PATIENT WE SERVE.

Form 990, Part III, Line 4c:

EMERGENCY ROOM SERVICES: THE ORGANIZATION DIRECTLY OPERATES FIVE 24 HOUR EMERGENCY FACILITIES, ONE OF WHICH IS A LEVEL 1 TRAUMA CENTER LOCATED IN THE CITY OF DETROIT. EMERGENCY SERVICES RECOGNIZED MORE THAN $150 MILLION IN REVENUE DURING 2019 REPRESENTING 225,812 PATIENT VISITS.

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			
WRIGHT L LASSITER III PRESIDENT/CEO	54.00 11.00	X		X				5,262,561	0	54,982
ROBERT G RINEY COO /PRESIDENT-HEALTHCARE	58.00 7.00				X			2,083,776	0	51,953
WILLIAM W O'NEILL MD PHYSICIAN	60.00 0.00					X		1,989,113	0	66,629
STEVEN N KALKANIS MD PHYSICIAN	60.00 1.00					X		1,425,738	0	52,500
WILLIAM A CONWAY MD CEO- HENRY FORD MEDICAL GROUP	59.00 6.00				X			1,289,133	0	48,776
MUWAFFAK M ABDULHAK MD PHYSICIAN	60.00 0.00					X		1,264,657	0	57,236
THEODORE WILLIAM PARSONS MD PHYSICIAN	60.00 0.00					X		1,267,472	0	50,861
ADNAN R MUNKARAH MD CHIEF MEDICAL OFFICER	60.00 4.00				X			1,180,579	0	62,113
RICHARD O DAVIS PHD C.E.O.- HENRY FORD HOSP	54.00 7.00				X			1,048,782	0	170,720
MOKBEL K CHEDID MD PHYSICIAN	60.00 0.00					X		1,152,494	0	65,061

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			
ROBIN S DAMSCHRODER TREASURER/CHIEF FINANCIAL OFFICER	53.00 12.00			X				966,630	0	199,409
MICHELLE JOHNSON TIDJANI ESQ SECRETARY	51.00 14.00			X				910,490	0	157,996
DENISE BROOKS-WILLIAMS CEO NORTH MARKET (START 1-1-2019)	30.00 30.00				X			969,945	0	41,379
LYNN M TOROSSIAN CEO - W BLMFLD HOSP (THRU 3/2019)	60.00 2.00				X			744,145	0	218,612
TERESA L KLINE CEO - HEALTH ALLIANCE PLAN (THRU 6/2019)	5.00 60.00				X			897,071	0	29,978
VERONICA M HALL RN FORMER INT. CEO-HF HOSP	60.00 1.00						X	682,918	0	39,005
DAVID F SHEPHERD CEO - COMMUNITY CARE SERVICES	60.00 1.00				X			525,044	0	101,043
ALEXANDER D SHEPARD MD DIRECTOR-PHYSICIAN	60.00 3.00	X						562,321	0	54,080
JOHN POPOVICH JR MD FORMER CEO- HF HOSPITAL	0.00 0.00						X	424,750	0	4,536
EDWARD G CHADWICK FORMER TREASURER/CFO	0.00 0.00						X	336,702	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			
ERIC WALLIS CEO - W BLMFLD HOSP (START 5/2019)	60.00 0.00				X			272,845	0	16,280
MARJORIE A STATEN JD ASST. SECRETARY (START 1/1/2019)	51.00 14.00			X				166,055	0	13,156
JOHN J POLANSKI FORMER CEO-COMMUNITY CARE	0.00 0.00						X	123,276	0	0
LYNN FORD ALANDT DIRECTOR	1.00 4.00	X						0	0	0
LEROY C RICHIE DIRECTOR - VICE CHAIR	2.00 4.00	X		X				0	0	0
EDGAR L VANN II DIRECTOR	1.00 3.00	X						0	0	0
SANDRA E PIERCE DIRECTOR-CHAIR	2.00 6.00	X		X				0	0	0
CHARLES G MCCLURE JR DIRECTOR	1.00 3.00	X						0	0	0
JOSEPH J RICHARDSON JR DIRECTOR - VICE CHAIR	1.00 3.00	X						0	0	0
LAWRENCE H SCHULTZ DIRECTOR	1.00 3.00	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			
ALAN M KIRILUK DIRECTOR - VICE CHAIR	1.00 3.00	X						0	0	0
DAVID M HEMPSTEAD DIRECTOR	1.00 4.00	X						0	0	0
SHARI L BURGESS DIRECTOR	1.00 5.00	X						0	0	0
STEPHANIE W BERGERON DIRECTOR - VICE CHAIR	2.00 4.00	X		X				0	0	0
DAVID J BREEN DIRECTOR - CHAIR ELECT	2.00 4.00	X		X				0	0	0
N CHARLES ANDERSON DIRECTOR - VICE CHAIR	2.00 4.00	X		X				0	0	0

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SCHEDULE A (Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

▶ **Attach to Form 990 or Form 990-EZ.**

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
HENRY FORD HEALTH SYSTEM

Employer identification number
38-1357020

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 331/3% 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 331/3% 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? Yes	(iv) No	(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
Total						

Part II **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)**
(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization failed to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grant.") . .						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . . .						
3 The value of services or facilities furnished by a governmental unit to the organization without charge..						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f). .						
6 **Public support.** Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
7 Amounts from line 4. .						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . .						
9 Net income from unrelated business activities, whether or not the business is regularly carried on. .						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.). .						
11 **Total support.** Add lines 7 through 10						

12 Gross receipts from related activities, etc. (see instructions) **12**

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2019 (line 6, column (f) divided by line 11, column (f)) **14**

15 Public support percentage for 2018 Schedule A, Part II, line 14 . . . . . **15**

16a **33 1/3% support test—2019.** 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—2018.** 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—2019.** 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—2018.** 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) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . .						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year.						
c Add lines 7a and 7b. .						
8 **Public support.** (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
9 Amounts from line 6. . .						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. .						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975.						
c Add lines 10a and 10b.						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on.						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) . .						
13 **Total support.** (Add lines 9, 10c, 11, and 12.). .						

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

Section C. Computation of Public Support Percentage

15	Public support percentage for 2019 (line 8, column (f) divided by line 13, column (f))	15	
16	Public support percentage from 2018 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2019** (line 10c, column (f) divided by line 13, column (f))	17	
18	Investment income percentage from **2018** Schedule A, Part III, line 17	18	

19a **33 1/3% support tests—2019.** 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—2018.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . ▶ ☐

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

			Yes	No
1	Are all of the organization's supported organizations listed by name in the organization's governing documents? *If "No," describe in* ***Part VI*** *how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.*	1		
2	Did the organization have any supported organization that does not have an IRS determination of status under section 509 (a)(1) or (2)? *If "Yes," explain in* ***Part VI*** *how the organization determined that the supported organization was described in section 509(a)(1) or (2).*	2		
3a	Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? *If "Yes," answer (b) and (c) below.*	3a		
b	Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? *If "Yes," describe in* ***Part VI*** *when and how the organization made the determination.*	3b		
c	Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? *If "Yes," explain in* ***Part VI*** *what controls the organization put in place to ensure such use.*	3c		
4a	Was any supported organization not organized in the United States ("foreign supported organization")? *If "Yes" and if you checked 12a or 12b in Part I, answer (b) and (c) below.*	4a		
b	Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? *If "Yes," describe in* ***Part VI*** *how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.*	4b		
c	Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? *If "Yes," explain in* ***Part VI*** *what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.*	4c		
5a	Did the organization add, substitute, or remove any supported organizations during the tax year? *If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in* ***Part VI,*** *including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).*	5a		
b	**Type I or Type II only.** Was any added or substituted supported organization part of a class already designated in the organization's organizing document?	5b		
c	**Substitutions only.** Was the substitution the result of an event beyond the organization's control?	5c		
6	Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? *If "Yes," provide detail in* ***Part VI.***	6		
7	Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? *If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ) .*	7		
8	Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? *If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).*	8		
9a	Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? *If "Yes," provide detail in* ***Part VI.***	9a		
b	Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? *If "Yes," provide detail in* ***Part VI.***	9b		
c	Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? *If "Yes," provide detail in* ***Part VI.***	9c		
10a	Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? *If "Yes," answer line 10b below.*	10a		
b	Did the organization have any excess business holdings in the tax year? *(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings).*	10b		

Part IV Supporting Organizations (continued)

			Yes	No
11	Has the organization accepted a gift or contribution from any of the following persons?			
a	A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization?	**11a**		
b	A family member of a person described in (a) above?	**11b**		
c	A 35% controlled entity of a person described in (a) or (b) above? *If "Yes" to a, b, or c, provide detail in* ***Part VI****.*	**11c**		

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

			Yes	No
1	Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?	**1**		
2	Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization (s) or (ii) serving on the governing body of a supported organization? *If "No," explain in* ***Part VI*** *how the organization maintained a close and continuous working relationship with the supported organization(s).*	**2**		
3	By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? *If "Yes," describe in* ***Part VI*** *the role the organization's supported organizations played in this regard.*	**3**		

Section E. Type III Functionally-Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year **(see instructions)**:

- **a** ☐ The organization satisfied the Activities Test. Complete **line 2** below.
- **b** ☐ The organization is the parent of each of its supported organizations. Complete **line 3** below.
- **c** ☐ The organization supported a governmental entity. Describe in **Part VI** how you supported a government entity (see instructions)

2 Activities Test. **Answer (a) and (b) below.**

			Yes	No
a	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? *If "Yes," then in* ***Part VI identify those supported organizations and explain*** *how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.*	**2a**		
b	Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? *If "Yes," explain in* ***Part VI*** *the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.*	**2b**		

3 Parent of Supported Organizations. **Answer (a) and (b) below.**

a	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? *Provide details in* ***Part VI.***	**3a**		
b	Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? *If "Yes," describe in* ***Part VI.*** *the role played by the organization in this regard.*	**3b**		

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

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

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

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

	Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1		
2	Enter 85% of line 1	2		
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3		
4	Enter greater of line 2 or line 3	4		
5	Income tax imposed in prior year	5		
6	**Distributable Amount.** Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6		

7 ☐ Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)

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

Section D - Distributions	**Current Year**
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in **Part VI**). See instructions	
7 **Total annual distributions.** Add lines 1 through 6.	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in **Part VI**). See instructions	
9 Distributable amount for 2019 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)	**(i) Excess Distributions**	**(ii) Underdistributions Pre-2019**	**(iii) Distributable Amount for 2019**
1 Distributable amount for 2019 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2019 (reasonable cause required-- explain in **Part VI**). See instructions.			
3 Excess distributions carryover, if any, to 2019:			
a From 2014.			
b From 2015.			
c From 2016.			
d From 2017.			
e From 2018.			
f **Total** of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2019 distributable amount			
i Carryover from 2014 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4 Distributions for 2019 from Section D, line 7: $			
a Applied to underdistributions of prior years			
b Applied to 2019 distributable amount			
c Remainder. Subtract lines 4a and 4b from 4.			
5 Remaining underdistributions for years prior to 2019, if any. Subtract lines 3g and 4a from line 2. If the amount is greater than zero, explain in **Part VI**. See instructions.			
6 Remaining underdistributions for 2019. Subtract lines 3h and 4b from line 1. If the amount is greater than zero, explain in **Part VI**. See instructions.			
7 **Excess distributions carryover to 2020.** Add lines 3j and 4c.			
8 Breakdown of line 7:			
a Excess from 2015.			
b Excess from 2016.			
c Excess from 2017.			
d Excess from 2018.			
e Excess from 2019.			

Additional Data

Software ID:

Software Version:

EIN: 38-1357020

Name: HENRY FORD HEALTH SYSTEM

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

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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* for instructions and the latest information.**

OMB No. 1545-0047

2019

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	Employer identification number
HENRY FORD HEALTH SYSTEM	38-1357020

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-A **Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).**

A Check ▶ ☑ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).

B Check ▶ ☐ if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)	0	0
b Total lobbying expenditures to influence a legislative body (direct lobbying)	134,266	134,266
c Total lobbying expenditures (add lines 1a and 1b)	134,266	134,266
d Other exempt purpose expenditures	3,272,118,603	4,187,475,841
e Total exempt purpose expenditures (add lines 1c and 1d)	3,272,252,869	4,187,610,107
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.	1,000,000	1,000,000

If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:
Not over $500,000	20% of the amount on line 1e.
Over $500,000 but not over $1,000,000	$100,000 plus 15% of the excess over $500,000.
Over $1,000,000 but not over $1,500,000	$175,000 plus 10% of the excess over $1,000,000.
Over $1,500,000 but not over $17,000,000	$225,000 plus 5% of the excess over $1,500,000.
Over $17,000,000	$1,000,000.

g Grassroots nontaxable amount (enter 25% of line 1f)	250,000	250,000
h Subtract line 1g from line 1a. If zero or less, enter -0-.	0	0
i Subtract line 1f from line 1c. If zero or less, enter -0-.	0	0

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ **Yes** ☐ **No**

4-Year Averaging Period Under Section 501(h)

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

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	(a) 2016	(b) 2017	(c) 2018	(d) 2019	(e) Total
2a Lobbying nontaxable amount	1,000,000	1,000,000	1,000,000	1,000,000	4,000,000
b Lobbying ceiling amount (150% of line 2a, column(e))					6,000,000
c Total lobbying expenditures	84,124	109,897	95,445	134,266	423,732
d Grassroots nontaxable amount	250,000	250,000	250,000	250,000	1,000,000
e Grassroots ceiling amount (150% of line 2d, column (e))					1,500,000
f Grassroots lobbying expenditures	7,491	9,860	6,327		23,678

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

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

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

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

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

Part IV Supplemental Information

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

Return Reference	Explanation	

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TY 2019 Affiliated Group Schedule

Name: HENRY FORD HEALTH SYSTEM

EIN: 38-1357020

Affiliated Group Business Name:	HENRY FORD WYANDOTTE HOSPITAL
Address. Either US or Foreign Type:	2333 BIDDLE AVE WYANDOTTE, MI 48192
EIN:	38-2791823
Electing Organization Checkbox:	☐
Total Grassroots Lobbying:	0
Total Direct Lobbying:	0
Total Lobbying Expenditures:	0
Other Exempt Purpose Expenditures:	340,541,825
Total Exempt Purpose Expenditures:	340,541,825
Lobbying Nontaxable Amount:	1,000,000
Grassroots Nontaxable Amount:	250,000
Tot Lobbying Grassroot Minus Non Tx:	0
Tot Lobby Expend Mns Lobbying Non Tx:	0
Share Of Excess Lobbying:	0
Affiliated Group Business Name:	HENRY FORD HEALTH SYSTEM FOUNDATION
Address. Either US or Foreign Type:	ONE FORD PLACE DETROIT, MI 48202
EIN:	23-7383042
Electing Organization Checkbox:	☐
Total Grassroots Lobbying:	0
Total Direct Lobbying:	0
Total Lobbying Expenditures:	0
Other Exempt Purpose Expenditures:	17,360,962
Total Exempt Purpose Expenditures:	17,360,962
Lobbying Nontaxable Amount:	1,000,000
Grassroots Nontaxable Amount:	250,000
Tot Lobbying Grassroot Minus Non Tx:	0
Tot Lobby Expend Mns Lobbying Non Tx:	0
Share Of Excess Lobbying:	0

Affiliated Group Business Name:	HENRY FORD MACOMB HOSPITAL CORPORATION
Address. Either US or Foreign Type:	ONE FORD PLACE DETROIT, MI 48202
EIN:	38-2947657
Electing Organization Checkbox:	☐
Total Grassroots Lobbying:	0
Total Direct Lobbying:	0
Total Lobbying Expenditures:	0
Other Exempt Purpose Expenditures:	555,949,578
Total Exempt Purpose Expenditures:	555,949,578
Lobbying Nontaxable Amount:	1,000,000
Grassroots Nontaxable Amount:	250,000
Tot Lobbying Grassroot Minus Non Tx:	0
Tot Lobby Expend Mns Lobbying Non Tx:	0
Share Of Excess Lobbying:	0
Affiliated Group Business Name:	HFII CORPORATION
Address. Either US or Foreign Type:	ONE FORD PLACE DETROIT, MI 48202
EIN:	90-0840304
Electing Organization Checkbox:	☐
Total Grassroots Lobbying:	0
Total Direct Lobbying:	0
Total Lobbying Expenditures:	0
Other Exempt Purpose Expenditures:	55,271
Total Exempt Purpose Expenditures:	55,271
Lobbying Nontaxable Amount:	11,054
Grassroots Nontaxable Amount:	2,764
Tot Lobbying Grassroot Minus Non Tx:	0
Tot Lobby Expend Mns Lobbying Non Tx:	0
Share Of Excess Lobbying:	0

Affiliated Group Business Name:	HENRY FORD HEALTH SYSTEM GOVERNMENT AFFAIRS
Address. Either US or Foreign Type:	ONE FORD PLACE DETROIT, MI 48202
EIN:	46-4064067
Electing Organization Checkbox:	☐
Total Grassroots Lobbying:	0
Total Direct Lobbying:	0
Total Lobbying Expenditures:	0
Other Exempt Purpose Expenditures:	1,315,336
Total Exempt Purpose Expenditures:	1,315,336
Lobbying Nontaxable Amount:	206,534
Grassroots Nontaxable Amount:	51,634
Tot Lobbying Grassroot Minus Non Tx:	0
Tot Lobby Expend Mns Lobbying Non Tx:	0
Share Of Excess Lobbying:	0

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SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
▶ Attach to Form 990.
▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
HENRY FORD HEALTH SYSTEM

Employer identification number
38-1357020

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.

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

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate value of contributions to (during year)		
3	Aggregate value of grants from (during year)		
4	Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ 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
a Total number of conservation easements	2a	
b Total acreage restricted by conservation easements	2b	
c Number of conservation easements on a certified historic structure included in (a)	2c	
d Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register	2d	

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶ _____

4 Number of states where property subject to conservation easement is located ▶ _____

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? ☐ 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
c	Beginning balance	1c
d	Additions during the year	1d
e	Distributions during the year	1e
f	Ending balance	1f

2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? . . . ☐ Yes ☐ No

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

Part V Endowment Funds.

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	234,731,046	239,389,752	229,180,494	192,859,411	199,451,653
b Contributions	81,447,879	53,856,258	39,403,221	65,963,302	79,615,483
c Net investment earnings, gains, and losses	32,464,821	-11,375,775	17,294,265	9,230,559	-1,886,181
d Grants or scholarships					
e Other expenditures for facilities and programs	85,455,628	47,139,189	46,488,228	38,872,778	84,321,544
f Administrative expenses					
g End of year balance	263,188,118	234,731,046	239,389,752	229,180,494	192,859,411

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

- a Board designated or quasi-endowment ▶ .....
- b Permanent endowment ▶ 48.030 %
- c Temporarily restricted endowment ▶ 51.970 %

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:

	Yes	No
3a(i) (i) unrelated organizations		No
3a(ii) (ii) related organizations	Yes	
3b b If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R?	Yes	

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

Part VI Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		44,580,982		44,580,982
b Buildings		1,145,777,906	681,106,002	464,671,904
c Leasehold improvements		28,550,987	11,411,389	17,139,598
d Equipment		1,036,444,404	743,202,550	293,241,854
e Other		164,665,246		164,665,246
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				984,299,584

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

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

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

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

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

(a) Description	(b) Book value
(1)INVESTMENTS IN PARTNERSHIP	26,593,350
(2)INVESTMENTS IN JOINT VENTURES	12,743,239
(3)OTHER	989,195
(4)DEFERRED COMPENSATION	141,121,716
(5)INVESTMENT EQUITY	7,868,049
(6)RIGHT OF USE ASSET- FINANCE LEASES	38,403,673
(7)RIGHT OF USE ASSET- OPERATING LEASES	117,083,281
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col.(B) line 15.)* ▶	344,802,503

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col.(B) line 25.)* ▶	582,303,101

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

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.
Complete if the organization answered 'Yes' on Form 990, Part IV, line 12a.

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

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.
Complete if the organization answered 'Yes' on Form 990, Part IV, line 12a.

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

Part XIII Supplemental Information

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

Return Reference	Explanation
See Additional Data Table	

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

Additional Data

Software ID:
Software Version:
EIN: 38-1357020
Name: HENRY FORD HEALTH SYSTEM

Supplemental Information

Return Reference	Explanation
PART V, LINE 4:	EARNINGS FROM THE ORGANIZATION'S ENDOWMENT FUNDS ARE UTILIZED BASED ON THE NATURE OF THE S PECIFIC ASSOCIATED RESTRICTION. THESE PRIMARILY RELATE TO FUNDING INITIATIVES ASSOCIATED W ITH SPECIFIC DISEASE CONDITIONS AND FURTHERING MEDICAL EDUCATION AND RESEARCH INITIATIVES.

Supplemental Information

Return Reference	Explanation
PART X, LINE 2:	THE SYSTEM DOES NOT HAVE ANY MATERIAL UNCERTAIN TAX POSITIONS AS OF DECEMBER 31, 2019 & 2018.

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SCHEDULE F (Form 990)

Department of the Treasury
Internal Revenue Service

Statement of Activities Outside the United States

► Complete if the organization answered "Yes" to Form 990, Part IV, line 14b, 15, or 16.
► Attach to Form 990.
► Go to *www.irs.gov/Form990* for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
HENRY FORD HEALTH SYSTEM

Employer identification number
38-1357020

Part I **General Information on Activities Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 14b.

1 **For grantmakers.** Does the organization maintain records to substantiate the amount of its grants and other assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? . . . . . ☐ **Yes** ☐ **No**

2 **For grantmakers.** Describe in Part V the organization's procedures for monitoring the use of its grants and other assistance outside the United States.

3 Activites per Region. (The following Part I, line 3 table can be duplicated if additional space is needed.)

(a) Region	(b) Number of offices in the region	(c) Number of employees, agents, and independent contractors in the region	(d) Activities conducted in region (by type) (such as, fundraising, program services, investments, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in the region	(f) Total expenditures for and investments in the region
See Add'l Data					
3a Sub-total	0	0			135,139,779
b Total from continuation sheets to Part I . . .	0	0			0
c Totals (add lines 3a and 3b)	0	0			135,139,779

Part II **Grants and Other Assistance to Organizations or Entities Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 15, for any recipient who received more than $5,000. Part II can be duplicated if additional space is needed.

1 (a) Name of organization	(b) IRS code section and EIN (if applicable)	(c) Region	(d) Purpose of grant	(e) Amount of cash grant	(f) Manner of cash disbursement	(g) Amount of noncash assistance	(h) Description of noncash assistance	(i) Method of valuation (book, FMV, appraisal, other)

2 Enter total number of recipient organizations listed above that are recognized as charities by the foreign country, recognized as tax-exempt by the IRS, or for which the grantee or counsel has provided a section 501(c)(3) equivalency letter . . . . . ▶ _____

3 Enter total number of other organizations or entities . . . . . ▶

Part III **Grants and Other Assistance to Individuals Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 16. Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Region	(c) Number of recipients	(d) Amount of cash grant	(e) Manner of cash disbursement	(f) Amount of noncash assistance	(g) Description of noncash assistance	(h) Method of valuation (book, FMV, appraisal, other)

Part IV Foreign Forms

1	Was the organization a U.S. transferor of property to a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 926, Return by a U.S. Transferor of Property to a Foreign Corporation (see Instructions for Form 926)*	☑ Yes	☐ No
2	Did the organization have an interest in a foreign trust during the tax year? *If "Yes," the organization may be required to separately file Form 3520, Annual Return to Report Transactions with Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U.S. Owner (see Instructions for Forms 3520 and 3520-A; don't file with Form 990)*	☐ Yes	☑ No
3	Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U.S. Persons with Respect to Certain Foreign Corporations. (see Instructions for Form 5471)*	☑ Yes	☐ No
4	Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? *If "Yes," the organization may be required to file Form 8621, Information Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund. (see Instructions for Form 8621)* .	☑ Yes	☐ No
5	Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U.S. Persons with Respect to Certain Foreign Partnerships (see Instructions for Form 8865)*	☑ Yes	☐ No
6	Did the organization have any operations in or related to any boycotting countries during the tax year? *If "Yes," the organization may be required to separately file Form 5713, International Boycott Report (see Instructions for Form 5713; don't file with Form 990).*	☑ Yes	☐ No

Part V **Supplemental Information**

Provide the information required by Part I, line 2 (monitoring of funds); Part I, line 3, column (f) (accounting method; amounts of investments vs. expenditures per region); Part II, line 1 (accounting method); Part III (accounting method); and Part III, column (c) (estimated number of recipients), as applicable. Also complete this part to provide any additional information. See instructions.

990 Schedule F, Supplemental Information

Return Reference	Explanation
PART III ACCOUNTING METHOD:	

990 Schedule F, Supplemental Information

Return Reference	Explanation
PART I, LINE 3, COLUMN F	TOTAL EXPENDITURES AND INVESTMENTS FOR THE REGIONS ARE REPORTED AT COST BASIS OR BOOK VALUE

Additional Data

Software ID:

Software Version:

EIN: 38-1357020

Name: HENRY FORD HEALTH SYSTEM

Form 990 Schedule F Part I - Activities Outside The United States

(a) Region	(b) Number of offices in the region	(c) Number of employees or agents in region	(d) Activities conducted in region (by type) (i.e., fundraising, program services, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for region
CENTRAL AMERICA AND CARRIBEAN			INVESTMENTS		133,244,320
MIDDLE EAST AND NORTH AFRICA			PROVIDE CONSULTING SERVICES FOR DESIGN AND CONSTRUCTION OF A HEALTH CLINIC.		1,446,731

Form 990 Schedule F Part I - Activities Outside The United States

(a) Region	(b) Number of offices in the region	(c) Number of employees or agents in region	(d) Activities conducted in region (by type) (i.e., fundraising, program services, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for region
SOUTH ASIA (INDIA)			CONSULTING ACTIVITIES		448,728

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SCHEDULE G (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information Regarding Fundraising or Gaming Activities

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

▶ **Attach to Form 990 or Form 990-EZ.**

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
HENRY FORD HEALTH SYSTEM

Employer identification number
38-1357020

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

1 Indicate whether the organization raised funds through any of the following activities. Check all that apply.

- **a** ☑ Mail solicitations
- **b** ☑ Internet and email solicitations
- **c** ☑ Phone solicitations
- **d** ☑ In-person solicitations
- **e** ☑ Solicitation of non-government grants
- **f** ☑ Solicitation of government grants
- **g** ☑ Special fundraising events

2a Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services? ☑ **Yes** ☐ **No**

b If "Yes," list the 10 highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least $5,000 by the organization.

(i) Name and address of individual or entity (fundraiser)	**(ii)** Activity	**(iii)** Did fundraiser have custody or control of contributions? Yes	No	**(iv)** Gross receipts from activity	**(v)** Amount paid to (or retained by) fundraiser listed in col. **(i)**	**(vi)** Amount paid to (or retained by) organization
FULKERSON SALES INC 5760 SNOWSHOE CIRCLE BLOOMFIELD HILLS, MI 48301	EVENT SOLICITATIONS		No	246,500	36,754	209,746
THUMBS UP INC 11861 WESY LINE STE 600 ST LOUIS, MO 63146	TELEPHONE CAMPAIGN		No	101,062	70,000	31,062
J MILITO AND ASSOCIATES INC 1133 MAPLEGROVE DR NW GRAND RAPIDS, MI 49504	TELEPHONE CAMPAIGN		No	15,575	14,735	840
Total . . . . . ▶				363,137	121,489	241,648

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

MI, FL

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

		(a) Event #1 GRAND BALL (event type)	(b) Event #2 EYES ON DESIGN (event type)	(c) Other events 4 (total number)	(d) Total events (add col. (a) through col. (c))
Revenue	1 Gross receipts	442,250	195,307	440,700	1,078,257
	2 Less: Contributions	336,600	115,638	372,834	825,072
	3 Gross income (line 1 minus line 2)	105,650	79,669	67,866	253,185
Direct Expenses	4 Cash prizes				
	5 Noncash prizes				
	6 Rent/facility costs				
	7 Food and beverages				
	8 Entertainment				
	9 Other direct expenses	218,711	205,131	305,996	729,838
	10 Direct expense summary. Add lines 4 through 9 in column (d) ▶				729,838
	11 Net income summary. Subtract line 10 from line 3, column (d) ▶				-476,653

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

		(a) Bingo	(b) Pull tabs/Instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col.(a) through col.(c))
Revenue	1 Gross revenue			56,209	56,209
Direct Expenses	2 Cash prizes				
	3 Noncash prizes			12,444	12,444
	4 Rent/facility costs				
	5 Other direct expenses				
	6 Volunteer labor	☐ Yes % ☐ No	☐ Yes % ☐ No	☑ Yes 100.000 % ☐ No	
	7 Direct expense summary. Add lines 2 through 5 in column (d) ▶				12,444
	8 Net gaming income summary. Subtract line 7 from line 1, column (d) ▶				43,765

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

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

b If "No," explain:

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

b If "Yes," explain:

11 Does the organization conduct gaming activities with nonmembers? . . . . . ☑ Yes ☐ No

12 Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming? . . . . . ☐ Yes ☑ No

13 Indicate the percentage of gaming activity conducted in:

a	The organization's facility	**13a**	%
b	An outside facility	**13b**	100.000 %

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

Name ▶ BARBARA BROWN

Address ▶ HFHS EVENTS-ONE FORD PLACE DETROIT, MI 48202

15a Does the organization have a contract with a third party from whom the organization receives gaming revenue? . . . . . ☐ Yes ☑ No

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

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

Name ▶

Address ▶

16 Gaming manager information:

Name ▶

Gaming manager compensation ▶ $

Description of services provided ▶

☐ Director/officer ☐ Employee ☐ Independent contractor

17 Mandatory distributions:

a Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license? . . . . . ☐ Yes ☑ No

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

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

Return Reference	Explanation

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SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
HENRY FORD HEALTH SYSTEM

Employer identification number
38-1357020

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	Yes	
b	If "Yes," was it a written policy?	1b	Yes	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year.			
	☑ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☐ 200% ☑ Other 25000.0000000000 %	3a	Yes	
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☐ 400% ☐ Other ____ %	3b		No
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	Yes	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	Yes	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		No
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligibile for free or discounted care?	5c		
6a	Did the organization prepare a community benefit report during the tax year?	6a	Yes	
b	If "Yes," did the organization make it available to the public?	6b	Yes	
	Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.			

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			23,804,389		23,804,389	0.740 %
b Medicaid (from Worksheet 3, column a)			710,614,423	595,132,936	115,481,487	3.580 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			734,418,812	595,132,936	139,285,876	4.320 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4).			13,596,384	5,475,504	8,120,880	0.250 %
f Health professions education (from Worksheet 5)			116,599,434	53,830,097	62,769,337	1.950 %
g Subsidized health services (from Worksheet 6)			30,263,216	24,392,980	5,870,236	0.180 %
h Research (from Worksheet 7)			85,511,997	69,945,016	15,566,981	0.480 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)			2,866,359	2,960	2,863,399	0.090 %
j **Total.** Other Benefits			248,837,390	153,646,557	95,190,833	2.950 %
k **Total.** Add lines 7d and 7j			983,256,202	748,779,493	234,476,709	7.270 %

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			657,273		657,273	0.020 %
2 Economic development			101,376		101,376	0 %
3 Community support			803,576		803,576	0.020 %
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building			337,511		337,511	0.010 %
7 Community health improvement advocacy			136,427		136,427	0 %
8 Workforce development			374,553		374,553	0.010 %
9 Other						
10 Total			2,410,716		2,410,716	0.060 %

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

				Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1			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.	2	50,364,293		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3	12,591,074		
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	749,532,757		
6	Enter Medicare allowable costs of care relating to payments on line 5	6	851,792,948		
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-102,260,191		
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:				

☐ Cost accounting system ☑ Cost to charge ratio ☐ Other

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures

(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? **4**

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

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

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group HENRY FORD HOSPITAL

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

			Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C.	2		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12.	3	Yes	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	☑ A definition of the community served by the hospital facility			
b	☑ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The significant health needs of the community			
f	☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 19			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes	
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C.	6b		No
7	Did the hospital facility make its CHNA report widely available to the public?	7	Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	☑ Hospital facility's website (list url): SEE LINE 10A BELOW			
b	☐ Other website (list url):			
c	☑ Made a paper copy available for public inspection without charge at the hospital facility			
d	☐ Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11.	8	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 19			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
a	If "Yes" (list url): HTTPS://WWW.HENRYFORD.COM/ABOUT/COMMUNITY-HEALTH/NEEDS-ASSESSMENT			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		No
b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

HENRY FORD HOSPITAL

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP:			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 250.000000000000 % and FPG family income limit for eligibility for discounted care of ____ %			
b	☑ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☑ Insurance status			
f	☑ Underinsurance discount			
g	☑ Residency			
h	☐ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☑ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	☑ The FAP was widely available on a website (list url): HTTPS://WWW.HENRYFORD.COM/VISITORS/BILLING/FINANCIAL-ASSISTANCE			
b	☑ The FAP application form was widely available on a website (list url): HTTPS://WWW.HENRYFORD.COM/VISITORS/BILLING/FINANCIAL-ASSISTANCE			
c	☑ A plain language summary of the FAP was widely available on a website (list url): HTTPS://WWW.HENRYFORD.COM/VISITORS/BILLING/FINANCIAL-ASSISTANCE			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

HENRY FORD HOSPITAL

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

HENRY FORD HOSPITAL

Name of hospital facility or letter of facility reporting group

		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a	☑ 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? **23**		No
	If "Yes," explain in Section C.		
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? **24**		No
	If "Yes," explain in Section C.		

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group HENRY FORD WEST BLOOMFIELD HOSPITAL

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 2

		Yes	No
Community Health Needs Assessment			
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	**1**		No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C.	**2**		No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12.	**3**	Yes	
If "Yes," indicate what the CHNA report describes (check all that apply):			
a ☑ A definition of the community served by the hospital facility			
b ☑ Demographics of the community			
c ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☑ How data was obtained			
e ☑ The significant health needs of the community			
f ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☑ The process for consulting with persons representing the community's interests			
i ☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j ☐ Other (describe in Section C)			
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 19			
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	**5**	Yes	
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	**6a**	Yes	
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C.	**6b**		No
7 Did the hospital facility make its CHNA report widely available to the public?	**7**	Yes	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a ☑ Hospital facility's website (list url): SEE LINE 10A BELOW			
b ☐ Other website (list url):			
c ☑ Made a paper copy available for public inspection without charge at the hospital facility			
d ☐ Other (describe in Section C)			
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11.	**8**	Yes	
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 19			
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	**10**	Yes	
a If "Yes" (list url): HTTPS://WWW.HENRYFORD.COM/ABOUT/COMMUNITY-HEALTH/NEEDS-ASSESSMENT			
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	**10b**		
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	**12a**		No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	**12b**		
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

HENRY FORD WEST BLOOMFIELD HOSPITAL

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	**13**	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP:			
a ☑	Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 250.000000000000 % and FPG family income limit for eligibility for discounted care of ____ %			
b ☑	Income level other than FPG (describe in Section C)			
c ☑	Asset level			
d ☑	Medical indigency			
e ☑	Insurance status			
f ☑	Underinsurance discount			
g ☑	Residency			
h ☐	Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	**14**	Yes	
15	Explained the method for applying for financial assistance?	**15**	Yes	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a ☑	Described the information the hospital facility may require an individual to provide as part of his or her application			
b ☑	Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c ☑	Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d ☑	Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e ☐	Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	**16**	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a ☑	The FAP was widely available on a website (list url): HTTPS://WWW.HENRYFORD.COM/VISITORS/BILLING/FINANCIAL-ASSISTANCE			
b ☑	The FAP application form was widely available on a website (list url): HTTPS://WWW.HENRYFORD.COM/VISITORS/BILLING/FINANCIAL-ASSISTANCE			
c ☑	A plain language summary of the FAP was widely available on a website (list url): HTTPS://WWW.HENRYFORD.COM/VISITORS/BILLING/FINANCIAL-ASSISTANCE			
d ☑	The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e ☑	The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f ☑	A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g ☑	Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h ☑	Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i ☑	The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j ☐	Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

HENRY FORD WEST BLOOMFIELD HOSPITAL

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

HENRY FORD WEST BLOOMFIELD HOSPITAL

Name of hospital facility or letter of facility reporting group

		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a	☑ 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? **23**		No
	If "Yes," explain in Section C.		
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? **24**		No
	If "Yes," explain in Section C.		

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group HENRY FORD COTTAGE HOSPITAL

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 3

		Yes	No
Community Health Needs Assessment			
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C.	2		No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12.	3	Yes	
If "Yes," indicate what the CHNA report describes (check all that apply):			
a ☑ A definition of the community served by the hospital facility			
b ☑ Demographics of the community			
c ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☑ How data was obtained			
e ☑ The significant health needs of the community			
f ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☑ The process for consulting with persons representing the community's interests			
i ☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j ☐ Other (describe in Section C)			
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 19			
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes	
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes	
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C.	6b		No
7 Did the hospital facility make its CHNA report widely available to the public?	7	Yes	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a ☑ Hospital facility's website (list url): SEE LINE 10A BELOW			
b ☐ Other website (list url):			
c ☑ Made a paper copy available for public inspection without charge at the hospital facility			
d ☐ Other (describe in Section C)			
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11.	8	Yes	
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 19			
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
a If "Yes" (list url): HTTPS://WWW.HENRYFORD.COM/ABOUT/COMMUNITY-HEALTH/NEEDS-ASSESSMENT			
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

HENRY FORD COTTAGE HOSPITAL

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP:			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 250.000000000000 % and FPG family income limit for eligibility for discounted care of ____ %			
b	☑ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☑ Insurance status			
f	☑ Underinsurance discount			
g	☑ Residency			
h	☐ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☑ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	☑ The FAP was widely available on a website (list url): HTTPS://WWW.HENRYFORD.COM/VISITORS/BILLING/FINANCIAL-ASSISTANCE			
b	☑ The FAP application form was widely available on a website (list url): HTTPS://WWW.HENRYFORD.COM/VISITORS/BILLING/FINANCIAL-ASSISTANCE			
c	☑ A plain language summary of the FAP was widely available on a website (list url): HTTPS://WWW.HENRYFORD.COM/VISITORS/BILLING/FINANCIAL-ASSISTANCE			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

HENRY FORD COTTAGE HOSPITAL

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

HENRY FORD COTTAGE HOSPITAL

Name of hospital facility or letter of facility reporting group

		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a	☑ 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? **23**		No
	If "Yes," explain in Section C.		
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? **24**		No
	If "Yes," explain in Section C.		

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group HENRY FORD KINGSWOOD HOSPITAL

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 4

			Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C.	2		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12.	3	Yes	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	☑ A definition of the community served by the hospital facility			
b	☑ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The significant health needs of the community			
f	☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 19			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes	
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C.	6b		No
7	Did the hospital facility make its CHNA report widely available to the public?	7	Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	☑ Hospital facility's website (list url): SEE LINE 10A BELOW			
b	☐ Other website (list url):			
c	☑ Made a paper copy available for public inspection without charge at the hospital facility			
d	☐ Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11.	8	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 19			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
a	If "Yes" (list url): HTTPS://WWW.HENRYFORD.COM/ABOUT/COMMUNITY-HEALTH/NEEDS-ASSESSMENT			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		No
b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

HENRY FORD KINGSWOOD HOSPITAL

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP:			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 250.000000000000 % and FPG family income limit for eligibility for discounted care of ____ %			
b	☑ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☑ Insurance status			
f	☑ Underinsurance discount			
g	☑ Residency			
h	☐ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☑ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	☑ The FAP was widely available on a website (list url): HTTPS://WWW.HENRYFORD.COM/VISITORS/BILLING/FINANCIAL-ASSISTANCE			
b	☑ The FAP application form was widely available on a website (list url): HTTPS://WWW.HENRYFORD.COM/VISITORS/BILLING/FINANCIAL-ASSISTANCE			
c	☑ A plain language summary of the FAP was widely available on a website (list url): HTTPS://WWW.HENRYFORD.COM/VISITORS/BILLING/FINANCIAL-ASSISTANCE			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

HENRY FORD KINGSWOOD HOSPITAL

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

HENRY FORD KINGSWOOD HOSPITAL

Name of hospital facility or letter of facility reporting group

		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a	☑ 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? **23**		No
	If "Yes," explain in Section C.		
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? **24**		No
	If "Yes," explain in Section C.		

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

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

Form and Line Reference	Explanation
See Add'l Data	

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? **72**

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
PART I, LINE 7G:	SUBSIDIZED SERVICES CONSIST OF INPATIENT WOMENS' SERVICES AND BEHAVIORAL HEALTH SERVICES. THIS INCLUDES BOTH PHYSICIAN AND FACILITY COSTS.
PART I, LN 7 COL(F):	THE BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25(A), BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGE IN THIS COLUMN IS $50,364,293

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART II, COMMUNITY BUILDING ACTIVITIES:	HFHS BELIEVES THAT THE STRENGTH AND VITALITY OF A COMMUNITY HAS A SIGNIFICANT IMPACT ON THE BEHAVIORS OF ITS RESIDENTS AND THAT THERE IS A DIRECT CORRELATION BETWEEN THE VIABILITY OF A COMMUNITY AND THE ATTITUDE OF ITS RESIDENTS TOWARD HEALTHIER BEHAVIORS. THEREFORE, HFHS INCLUDES IN ITS COMMITMENT TO COMMUNITY BENEFIT A FOCUS ON DIRECT INVOLVEMENT IN THE COMMUNITY TO BOTH IMPROVE THE ENVIRONMENT AND ENSURE THAT CRITICAL MESSAGES ON THE BENEFITS OF HEALTHIER BEHAVIORS ARE HEARD. HFHS LEADERS COLLABORATE WITH COMMUNITY TASK FORCES AND COALITIONS TO ADDRESS THE NEEDS OF OUR SERVICE AREA.
PART III, LINE 2:	THE ORGANIZATION'S BAD DEBT EXPENSE IS STATED BASED UPON GROSS CHARGES.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 4:	IN EVALUATING THE COLLECTABILITY OF ACCOUNTS RECEIVABLE, THE SYSTEM ANALYZES ITS PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYOR SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR DOUBTFUL ACCOUNTS AND PROVISION FOR BAD DEBTS. MANAGEMENT REGULARLY REVIEWS DATA ABOUT THESE MAJOR PAYOR SOURCES OF REVENUE IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS. FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, THE SYSTEM ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND A PROVISION FOR BAD DEBTS. FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS (WHICH INCLUDE BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND CO-PAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR A PORTION OF THE BILL), THE SYSTEM RECORDS A PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE. AT SUCH POINT IN TIME THAT A BILLED SERVICE IS BELIEVED TO BE UNCOLLECTIBLE, THE RELATED RECEIVABLE IS WRITTEN OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS. ESTIMATES OF RETROACTIVE ADJUSTMENTS UNDER REIMBURSEMENT AGREEMENTS WITH THIRD-PARTY PAYORS ARE ACCRUED IN THE PERIOD THE RELATED SERVICES ARE RENDERED AND ADJUSTED IN FUTURE PERIODS AS FINAL SETTLEMENTS ARE RECEIVED.FOR UNINSURED PATIENTS WHO MEET THE QUALIFICATIONS STIPULATED IN THE SYSTEM'S PATIENT FINANCIAL ASSISTANCE POLICY, EMERGENCY AND OTHER MEDICALLY NECESSARY INPATIENT AND OUTPATIENT SERVICES ARE PROVIDED AT NO COST. FOR UNINSURED PATIENTS THAT DO NOT QUALIFY FOR FINANCIAL ASSISTANCE, THE SYSTEM OFFERS A DISCOUNT OFF STANDARD RATES FOR SERVICES PROVIDED THAT RESULT IN NET CHARGES THAT DO NOT EXCEED 115% OF MEDICARE RATES.THE ORGANIZATION DETERMINES THE COSTS OF SUCH UNPAID SERVICES BY APPLYING A COST-TO-CHARGE RATIO TO THE BILLED CHARGES.
PART III, LINE 9B:	SHOULD A PATIENT BE DEEMED ELIGIBLE FOR ASSISTANCE ANY COLLECTION EFFORTS ASSOCIATED WITH THE QUALIFYING SERVICE ARE SUSPENDED.IF THE PATIENT IS DETERMINED TO QUALIFY UNDER THE ORGANIZATION'S PATIENT FINANCIAL ASSISTANCE POLICY (PFAP) PRIOR TO BILLING, NO BILL IS EVER GENERATED AND THEREFORE THE ELEMENTS OF THE COLLECTION POLICY ARE NEVER INVOKED. WHEN THE DETERMINATION IS NOT MADE PRIOR TO BILLING, THE ORGANIZATION'S COLLECTION POLICY WOULD APPLY. THIS POLICY READS IN PART:- "PATIENTS WILL BE EVALUATED FOR THE SYSTEM'S PATIENT FINANCIAL ASSISTANCE PROGRAM"- "UNINSURED PATIENTS WILL BE GIVEN A DISCOUNT"- "UNDERINSURED PATIENTS MAY QUALIFY FOR DISCOUNTED SERVICES BASED UPON THEIR AGGREGATE HOUSEHOLD INCOME"- "THE ORGANIZATION WILL REVIEW THE PATIENTS'S RECORD TO DETERMINE IF REASONABLE EFFORTS WERE UNDERTAKEN TO ENSURE THAT FINANCIAL ASSISTANCE WAS OFFERED AND/OR IF FINANCIAL ASSISTANCE IS REQUESTED"- "LEGAL ACTION...MAY BE TAKEN...WHEN THERE IS EVIDENCE THAT THE PATIENT OR RESPONSIBLE PARTY HAS INCOME AND/OR ASSETS TO MEET HIS OR HER OBLIGATION"- "THE ORGANIZATION WILL NOT FORCE THE SALE OR FORECLOSURE OF ANY PATIENT OR GUARANTOR'S PRIMARY RESIDENCE TO PAY AN OUTSTANDING MEDICAL BILL"- "THE ORGANIZATION WILL NOT...REQUIRE THE PATIENT OR RESPONSIBLE PARTY TO APPEAR IN COURT"- "THE ORGANIZATION WILL DIRECT THEIR COLLECTION AGENCIES TO FOLLOW THESE GUIDELINES"PATIENTS NOT DEEMED TO QUALIFY UNDER OUR PATIENT FINANCIAL ASSISTANCE PROGRAM (PFAP) RECEIVE 2 CYCLES OF INTERNAL BILLING STATEMENTS INCLUDING INSTRUCTIONS ON APPLYING FOR OUR PFAP. BASED ON THE VOLUME OF OUTSTANDING SERVICES, DETERMINATION ON FURTHER COLLECTION EFFORTS WILL BE MADE WHICH INCLUDES INTERNAL COLLECTION EFFORTS OR ASSIGNMENT TO AN EXTERNAL COLLECTION AGENCY.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 2:	THE ASSESSMENT OF COMMUNITY HEALTH NEEDS IS AN ESSENTIAL FUNCTION OF A HEALTH CARE ORGANIZATION FOR SEVERAL REASONS. FIRST, IT PROVIDES AN UNDERSTANDING OF THE DEMOGRAPHICS AND MAJOR HEALTH NEEDS OF THE COMMUNITIES IT SERVES AND INSIGHT INTO WHAT SERVICES SHOULD BE OFFERED TO MEET THOSE NEEDS. SECOND, BY UNDERSTANDING THE MAJOR HEALTH NEEDS OF THE COMMUNITY, STRATEGIES CAN BE PRIORITIZED AND A MORE TAILORED APPROACH DEVELOPED, RESULTING IN GREATER USE OF THE LIMITED RESOURCES OF MANY HEALTHCARE ORGANIZATIONS. THIRD, VULNERABLE POPULATIONS WITH SIGNIFICANT HEALTH NEEDS CAN BE IDENTIFIED AND TARGETED FOR INTERVENTION SUCH AS THE POOR, UNINSURED, UNDERINSURED, OR VARIOUS RACIAL/ETHNIC OR OTHER VULNERABLE POPULATIONS THAT MAY HAVE OTHERWISE BEEN OVERLOOKED. THROUGH IDENTIFICATION, PROGRAMS CAN THEN BE DEVELOPED SO THAT ALL POPULATIONS WE SERVE WILL RECEIVE APPROPRIATE AND TIMELY ACCESS TO HEALTHCARE SERVICES. IN ADDITION, THE COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS ENCOURAGES AN ORGANIZATION TO IDENTIFY AND PARTNER WITH OTHER ORGANIZATIONS AND COMMUNITY AGENCIES. THROUGH PARTNERSHIP, KNOWLEDGE IS SHARED AND RESOURCES CAN BE ALIGNED AND MORE OPTIMALLY UTILIZED TO BENEFIT THE COMMUNITIES SERVED. INTERNALLY THE COMMUNITY HEALTH ANCHOR COUNCIL ENTERPRISE (CHANCE) PROVIDES EXECUTIVE OVERSIGHT OF THE COMMUNITY HEALTH NEEDS ASSESSMENT FOR HENRY FORD HEALTH SYSTEM. TEAM MEMBERS APPROVE HENRY FORD HEALTH SYSTEM'S ONGOING WORK AS A NATIONAL AND STATE LEADER IN COMMUNITY HEALTH ADVOCACY THAT SEEKS TO IMPROVE HEALTH STATUS IN DETROIT AND THE SURROUNDING SUBURBS. THIS IS ACHIEVED THROUGH TARGETED HEALTH IMPROVEMENT PROGRAMS SUCH AS OUR WOMEN-INSPIRED NEIGHBORHOOD (WIN) NETWORK: DETROIT, GENERATION WITH PROMISE, FAITH COMMUNITY NURSING INITIATIVES, SCHOOL-BASED HEALTH CLINICS, HEALTH LITERACY IMPROVEMENT PROJECTS AND OTHER ACTIVITIES. THROUGH TARGETED VOLUNTEERISM AND PARTNERSHIPS, THE SYSTEM'S GOAL IS TO CULTIVATE NEW COMMUNITY RELATIONSHIPS. THIS ASSESSMENT WAS PREPARED JOINTLY BY THE HFHS BUSINESS INTEGRITY SERVICES AND CORPORATE STRATEGIC PLANNING DEPARTMENTS, ALONG WITH THE OFFICE OF COMMUNITY HEALTH, EQUITY AND WELLNESS. RESULTS ARE BEING USED AS A FOUNDATION FOR PLANNING, DEVELOPING, AND REFINING HFHS'S FUTURE COMMUNITY SERVICES IN THE FOUR-COUNTY AREAS. RESULTS OF THIS ASSESSMENT HAVE BEEN REVIEWED WITH SEVERAL HENRY FORD HEALTH SYSTEM LEADERS, LEADING TO STRATEGIC AND IMPLEMENTATION PLAN MODIFICATIONS TO ALIGN STRATEGY WITH IDENTIFIED NEEDS.
PART VI, LINE 3:	HFHS HAS VARIOUS APPROACHES TO TARGET AND INFORM RESIDENTS OF ITS COMMUNITIES ABOUT THE PROGRAMS AND SERVICES IT OFFERS. PROGRAMS WHERE WE PARTNER WITH ORGANIZATIONS WITH ESTABLISHED RELATIONSHIPS WITH THE INDIVIDUALS SUCH AS THROUGH COMMUNITY HEALTH CENTERS, THE PUBLIC SCHOOLS AND FAITH-BASED ORGANIZATIONS HAVE BEEN PARTICULARLY SUCCESSFUL. HFHS HAS A SINGULAR PATIENT FINANCIAL ASSISTANCE POLICY (PFAP). INDIVIDUALS WITHOUT ADEQUATE HEALTH INSURANCE COVERAGE MOST FREQUENTLY APPEAR IN ONE OF OUR EMERGENCY ROOMS FOR SERVICES. ALL PATIENTS ARE SEEN WITHOUT REGARD TO ABILITY TO PAY. INTAKE STAFF MEMBERS ARE TRAINED REGARDING HOW TO APPROACH AND ENGAGE AN INDIVIDUAL WHEN THERE IS AN APPARENT LACK OF ADEQUATE HEALTH COVERAGE. THIS INCLUDES INFORMING THEM OF THE PROGRAMS OFFERED BY HFHS AS WELL AS OTHER COMMUNITY, LOCAL, STATE AND FEDERAL PROGRAMS WHICH WOULD OFFER POTENTIAL SUPPORT. HFHS HAS DEDICATED STAFF RESPONSIBLE TO IDENTIFY PATIENTS WHO MAY QUALIFY FOR SUPPORTIVE PROGRAMS AND ASSIST THEM WITH THE ENROLLMENT PROCESS. THERE ARE MANY REASONS WHY A PATIENT IN NEED OF FINANCIAL ASSISTANCE WITH THEIR MEDICAL CARE MAY NOT HAVE BEEN IDENTIFIED AT THE TIME OF THE CARE DELIVERY. PATIENT FINANCIAL SERVICE AND COLLECTION STAFFS ARE TRAINED TO RECOGNIZE THESE INDIVIDUALS AND PROVIDE THEM WITH ADVICE REGARDING THE VARIOUS OPTIONS AVAILABLE TO SUPPORT THEIR CARE NEEDS.

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Form and Line Reference	Explanation
PART VI, LINE 4:	THE FOUR-COUNTY AREA INCLUDES THE COUNTIES OF WAYNE, OAKLAND, MACOMB, AND JACKSON WHICH ARE LOCATED IN SOUTHEASTERN AND SOUTHCENTRAL MICHIGAN AND ACCOUNT FOR 41% OF THE MICHIGAN POPULATION. WAYNE, OAKLAND, AND MACOMB (IN THAT ORDER) ARE THE MOST POPULATED COUNTIES IN MICHIGAN. JACKSON COUNTY IS MUCH SMALLER. OF THE NEARLY 4 MILLION RESIDENTS , APPROXIMATELY 51% OF THE POPULATION IS FEMALE. WITH REGARD TO RACE/ETHNICITY, THE FOUR-COUNTY AREA IS 64% WHITE, COMPARED TO A NATIONAL AVERAGE OF 60%. OF NOTE, THE FOUR-COUNTY AREA IS 24% BLACK, WHICH IS TWICE THE NATIONAL PERCENTAGE OF 12%. CONVERSELY, THE HISPANIC POPULATION (5.0%) IS A LITTLE UNDER ONE THIRD THE NATIONAL PERCENTAGE OF 18%.THE NUMBER OF FOUR-COUNTY RESIDENTS IS EXPECTED TO REMAIN FLAT OVER THE NEXT SEVERAL YEARS. WHEN EXAMINING AGE DISTRIBUTION, THE FOUR-COUNTY AREA HAS A COMPARABLE POPULATION TO THAT OF THE COUNTRY WITH 17% OF THE POPULATION ABOVE THE AGE OF 65. OF PARTICULAR INTEREST TO HEALTHCARE PROVIDERS IS THE AGING POPULATION OF THE FOUR-COUNTY AREA WITH THE 65-YEARS-OLD AND ABOVE POPULATION EXPECTED TO RISE BY 15% FROM 2019 TO 2024.WITH REGARDS TO EDUCATION, THE FOUR-COUNTY AREA HAS APPROXIMATELY 11% OF RESIDENTS WHO HAVE SOME HIGH SCHOOL EDUCATION OR LESS COMPARED TO THE NATIONAL AVERAGE OF 13%. FURTHER, 29% OF RESIDENTS HAVE A BACHELOR'S DEGREE OR GREATER, WHICH IS COMPARABLE TO THE NATIONAL AVERAGE. THE FOUR-COUNTY AREA IS DIVERSE IN POPULATION, RACE/ETHNICITY, ECONOMIC GROWTH AND DEVELOPMENT. THE AUTOMOTIVE INDUSTRY REMAINS THE LARGEST EMPLOYER IN THE REGION, BUT THE HEALTH CARE SECTOR IS REPRESENTED AMONG THE TOP EMPLOYERS IN THE REGION AS WELL. THE AVERAGE MEDIAN HOUSEHOLD INCOME WITHIN THE FOUR-COUNTY AREA ($56,240) IS SLIGHTLY LESS THAN THE NATIONAL AVERAGE ($57,652). WITHIN THE FOUR-COUNTY AREA, THE MEDIAN HOUSEHOLD INCOME IN OAKLAND COUNTY ($73,369) IS SIGNIFICANTLY HIGHER THAN WAYNE COUNTY ($43,702), JACKSON COUNTY ($49,715) AND MACOMB COUNTY ($58,175). AT THE ZIP CODE LEVEL, AVERAGE HOUSEHOLD INCOMES VARY SIGNIFICANTLY.LOWER HOUSEHOLD INCOMES NEGATIVELY IMPACT PURCHASING POWER, HEALTH INSURANCE COVERAGE, AND COSTS OF BASIC NECESSITIES. AS A RESULT, THE FOUR-COUNTY AREA'S SAFETY NETS, INCLUDING HEALTHCARE SYSTEMS, ARE BEING STRETCHED TO THE LIMIT. MICHIGAN RANKS 33RD IN THE COUNTRY FOR CHILDREN UNDER 18 IN FAMILIES BELOW THE POVERTY LEVEL, AT 19.3%, A 3% IMPROVEMENT FROM 2016. UNEMPLOYMENT IN MICHIGAN HAS DROPPED TO 4.6% IN 2018, WHICH IS SIMILAR TO THE NATIONAL AVERAGE AND A DECLINE OF 0.8% SINCE 2016 IN MICHIGAN. CONVERSELY, WITHIN THE FOUR-COUNTY AREA THE UNEMPLOYMENT RATE MATCHES THE NATIONAL AVERAGE OF 4% AND RANGES FROM 3.2% IN OAKLAND COUNTY TO 5.0% IN WAYNE COUNTY.THERE ARE KEY DEMOGRAPHIC DIFFERENCES BETWEEN THE RESIDENTS OF EACH COUNTY WITHIN THE FOUR-COUNTY AREA. FOR EXAMPLE, AGE, SEX, EDUCATION, AND INCOME DISTRIBUTION DIFFER FROM COUNTY TO COUNTY. IN ORDER TO INCREASE THE UTILITY OF THE COMMUNITY HEALTH NEEDS ASSESSMENT, IT IS IMPORTANT TO ANALYZE THE PROFILE(S) OF EACH OF THESE COUNTIES AT A MORE DETAILED LEVEL, SUCH AS ZIP CODES, SO THAT CERTAIN DIFFERENCES WITHIN THE AREA BECOME EVIDENT.ONE COMMUNITY IN PARTICULAR NEED OF ATTENTION IS THE CITY OF DETROIT. WHEN EXAMINING THE CITY OF DETROIT THE AVERAGE HOUSEHOLD INCOME IS $40,314, WHICH IS SIGNIFICANTLY LESS THAN AVERAGE HOUSEHOLD INCOME OF THE OVERALL FOUR-COUNTY AREA ($68,064). REGARDING EDUCATION, 23% OF RESIDENTS HAVE LESS THAN A HIGH SCHOOL EDUCATION AND ONLY 14% HAVE A BACHELOR'S DEGREE OR HIGHER. IN TERMS OF RACE/ETHNICITY, APPROXIMATELY 91% OF DETROIT IS COMPOSED OF A MINORITY POPULATION VERSUS 37% FOR THE FOUR-COUNTY AREA AS A WHOLE. THE DETROIT UNEMPLOYMENT RATE IS 7.9% (NOVEMBER 2018), DOWN FROM 11.5% IN SEPTEMBER 2015.WHEN LOOKING OUTSIDE OF THE CITY OF DETROIT, VARIOUS OTHER ZIP CODES IN THE FOUR-COUNTY AREA INDICATE SECTIONS OF THE REGION THAT HAVE LOWER INCOMES, LESS EDUCATION, AND ARE MORE RACIALLY AND ETHNICALLY DIVERSE. THE AVERAGE HOUSEHOLD INCOME OF THESE ZIP CODES RANGES FROM $29,486-$54,251, LOWER THAN THE FOUR-COUNTY SERVICE AREA. OVERALL, 17% OF RESIDENTS IN THESE ZIP CODES HAVE LESS THAN A HIGH SCHOOL EDUCATION COMPARED TO 11% FOR THE FOUR-COUNTY AREA. THESE TWENTY ZIP CODES HAVE A SLIGHTLY DIFFERENT PERCENTAGE OF RACIAL/ETHNIC MINORITIES AS COMPARED TO THE REST OF THE FOUR-COUNTY AREA. AS A WHOLE THESE ZIP CODES ARE COMPOSED OF 40% MINORITIES COMPARED TO 36% FOR THE FOUR-COUNTY AREA.AS A RESULT, THE CITY OF DETROIT AND ABOVE TWENTY ZIP CODES ARE OF PARTICULAR INTEREST IN PLANNING COMMUNITY NEEDS INITIATIVES WITHIN THE FOUR-COUNTY AREA.
PART VI, LINE 5:	HFHS IS ONE OF THE NATION'S LARGEST INTEGRATED HEALTH DELIVERY SYSTEMS SERVING SOUTHEASTERN MICHIGAN. HFHS IS GOVERNED BY DEDICATED COMMUNITY BOARDS, AND IN TOTAL PROVIDES APPROXIMATELY 54,000 INPATIENTS STAYS AND 4.6 MILLION PHYSICIAN VISITS ANNUALLY. THIS TAX RETURN REFLECTS THE ACTIVITIES OF HENRY FORD HOSPITAL AN 877 BED TERTIARY, AND QUATERNARY CARE HOSPITAL WITH A LEVEL 1 TRAUMA CENTER LOCATED IN THE CITY OF DETROIT, SERVING AS A COMMUNITY HOSPITAL FOR ITS IMMEDIATE NEIGHBORHOODS AS WELL AS A REFERRAL CENTER FOR THE SURROUNDING REGION. IT IS SUPPORTED BY THE HENRY FORD MEDICAL GROUP (HFMG) WHO ALSO PROVIDES CARE IN THE MORE THAN 30 OUTPATIENT MEDICAL CENTERS LOCATED THROUGHOUT SOUTHEAST MICHIGAN. HFHS ALSO INCLUDES HENRY FORD WEST BLOOMFIELD HOSPITAL A 191 BED COMMUNITY HOSPITAL. BEHAVIORAL HEALTH SERVICES ARE PROVIDED THROUGHOUT THE ABOVE FACILITIES AS WELL AS AT HENRY FORD KINGSWOOD HOSPITAL, A 100 BED PSYCHIATRIC HOSPITAL, AND THE MAPLEGROVE CENTER, A 67 SUBSTANCE ABUSE BED FACILITY. HFHS COMMUNITY CARE SERVICES OFFERS A BROAD LEVEL OF SERVICES AT NUMEROUS GEOGRAPHIC LOCATIONS. SERVICES PROVIDED INCLUDE NURSING CARE, HOME CARE, SENIOR CARE, PHARMACIES, EYE CARE, HOSPICE CARE, OCCUPATIONAL HEALTH, AND DIALYSIS.THE SYSTEM DEMONSTRATES ITS EXEMPT PURPOSE TO BENEFIT THE COMMUNITY BY OPERATING EMERGENCY ROOMS OPEN TO THE PUBLIC 24 HOURS A DAY, 7 DAYS A WEEK; PROVIDING FACILITIES FOR THE EDUCATION AND TRAINING OF HEALTH CARE PROFESSIONALS; AND MAINTAINING RESEARCH FACILITIES FOR THE STUDY OF NEW DRUGS AND MEDICAL DEVICES THAT OFFER THE PROMISE OF IMPROVING HEALTH CARE. THE SYSTEM ALSO PROVIDES COMMUNITY HEALTH SERVICES, SUCH AS COMMUNITY EDUCATION AND OUTREACH IN THE FORM OF FREE OR LOW-COST CLINICS; HEALTH EDUCATION TELEVISION PROGRAMMING; DONATIONS FOR THE COMMUNITY; MULTIPLE HEALTH PROMOTION AND WELLNESS PROGRAMS, SUCH AS HEALTH SCREENING; AND VARIOUS COMMUNITY PROJECTS AND SUPPORT GROUPS. COMMUNITY PARTNERSHIPS: HENRY FORD DEVELOPS INNOVATIVE WAYS TO ADDRESS THE SOCIAL, ECONOMIC AND EDUCATIONAL ISSUES THAT AFFECT THE HEALTH OF THE METRO DETROIT COMMUNITY. THESE INCLUDE:CENTER FOR HEALTH SERVICES RESEARCH-CONDUCTS RESEARCH FOCUSING ON OUTCOMES, EFFECTIVENESS AND COST-EFFECTIVENESS OF THE PREVENTION, DIAGNOSIS, TREATMENT AND MANAGEMENT OF SUCH DISEASES AS CANCER, DIABETES, ASTHMA AND CONGESTIVE HEART FAILURE AS WELL AS COMMON ACUTE CONDITIONS.COMMUNITY HEALTH AND SOCIAL SERVICES (CHASS) CLINIC-PROVIDES PRIMARY CARE SERVICES TO MORE THAN 1,300 UNINSURED AND UNDERINSURED DETROIT RESIDENTS EACH MONTH. HFHS PHYSICIANS STAFF THE TWO CLINICS LOCATED IN SOUTHWEST DETROIT AND IN THE NEW CENTER AREA.INNOVATION INSTITUTE AT HENRY FORD HOSPITAL - IN COLLABORATION WITH WAYNE STATE UNIVERSITY SCHOOL OF ENGINEERING AND CENTER FOR CREATIVE STUDIES, THE INNOVATION INSTITUTE AIMS TO RESEARCH AND DESIGN MEDICAL PRODUCTS TO ENHANCE MEDICAL USE AND TO CREATE NEW INDUSTRY IN THE REGION.INSTITUTE ON MULTICULTURAL HEALTH-STUDIES THE DISPARITIES IN HEALTH CARE AMONG PEOPLE OF COLOR AND FINDS SOLUTIONS FOR GETTING EARLY DIAGNOSIS AND TREATMENT OF DISEASES.SCHOOL-BASED AND COMMUNITY HEALTH PROGRAM -OPERATES 11 CHILD AND ADOLESCENT HEALTH CENTERS THAT PROVIDE PRIMARY CARE SERVICES IN DETROIT AND OTHER METRO DETROIT COMMUNITIES. IT HAS DEMONSTRATED BETTER ATTENDANCE AND TEST SCORES BY STUDENTS. THE PROGRAM ALSO OFFERS A MOBILE PEDIATRIC MEDICAL CLINIC CALLED HANK, WHICH TRAVELS TO SEVEN DETROIT SCHOOLS EVERY WEEK AND IS FUNDED BY THE CHILDREN'S HEALTH FUND.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 6:	THE INTEGRATED HEALTH SYSTEM ALSO INCLUDES 5 COMMUNITY HOSPITALS ENCOMPASSING MORE THAN 1,000 BEDS WITH EMERGENCY SERVICES AND OPEN MEDICAL STAFFS LOCATED IN SUBURBAN REGIONS OF SOUTHEAST MICHIGAN. SOME OF THESE ENTITIES ARE SEPARATE CORPORATIONS AND THE RESULTS OF THEIR COMMUNITY BENEFIT ACTIVITIES ARE REFLECTED IN THEIR RESPECTIVE TAX RETURNS.

Additional Data

Software ID:
Software Version:
EIN: 38-1357020
Name: HENRY FORD HEALTH SYSTEM

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

Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? **4** Name, address, primary website address, and state license number		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	**Other (Describe)**	**Facility reporting group**
1	HENRY FORD HOSPITAL 2799 W GRAND BLVD DETROIT, MI 48202 HTTPS://WWW.HENRYFORD.COM/LOCATIONS 1060000026	X	X		X		X	X			
2	HENRY FORD WEST BLOOMFIELD HOSPITAL 6777 W MAPLE RD WEST BLOOMFIELD, MI 48322 HTTPS://WWW.HENRYFORD.COM/LOCATIONS 1060000155	X	X		X			X			
3	HENRY FORD COTTAGE HOSPITAL 159 KERCHEVAL AVE GROSSE POINTE FARMS, MI 48236 HTTPS://WWW.HENRYFORD.COM/LOCATIONS 1060000064	X	X					X			
4	HENRY FORD KINGSWOOD HOSPITAL 10300 W EIGHT MILE RD FERNDALE, MI 48220 HTTPS://WWW.HENRYFORD.COM/LOCATIONS 1080000037	X			X					PSYCHIATRIC HOSPITAL	

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
HENRY FORD HOSPITAL	PART V, SECTION B, LINE 5: OUR METHODOLOGY FOR DATA COLLECTION INVOLVED REACHING OUT TO COMMUNITY EXPERTS AND OTHER MEMBERS OF COMMUNITY AGENCIES IN WAYNE COUNTY AND THE CITY OF DETROIT USING A WEB-BASED 5-QUESTION SURVEY. THE SURVEY WAS DISTRIBUTED TO HEALTH LEADERS AND OTHER RESPECTED INDIVIDUALS WITHIN THE COMMUNITY REPRESENTING PUBLIC AGENCIES AND PROGRAMS FROM MAY THROUGH JULY OF 2019. INDIVIDUALS SURVEYED INCLUDED LEADERS FROM AGENCIES SUCH AS ACCESS; DETROIT HEALTH DEPARTMENT; WAYNE COUNTY HEALTH DEPARTMENT; AMERICAN LUNG ASSOCIATION; INTERFAITH LEADERSHIP COUNCIL; GREATER DETROIT HEALTH COUNCIL AND MANY OTHERS. PARTICIPANTS HAD A WIDE RANGE OF EXPERTISE. FROM THEIR SURVEY RESPONSES WE GAINED INSIGHT INTO THE KINDS OF HEALTH ISSUES FACING OUR COMMUNITIES. OUR METHODOLOGY ALSO INCLUDED A WIDE VARIETY OF SECONDARY DATA SOURCES IN ADDITION TO RESULTS OBTAINED FROM BOTH SURVEY AND FOCUS GROUP PARTICIPANTS IN OAKLAND, MACOMB AND JACKSON COUNTIES. ADDITIONALLY, WE LOCATED STATE HEALTH NEEDS DATA FOR HFHS USING THE MICHIGAN BEHAVIORAL RISK FACTOR SURVEY AND MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES PROFILES AMONG OTHER SOURCES. DATA FROM THESE SOURCES CAN BE FOUND IN THE APPENDIX.
HENRY FORD HOSPITAL	PART V, SECTION B, LINE 6A: HENRY FORD HOSPITALHENRY FORD KINGSWOOD HOSPITALHENRY FORD MACOMB HOSPITALSHENRY FORD WEST BLOOMFIELD HOSPITALHENRY FORD WYANDOTTE HOSPITALHENRY FORD COTTAGE HOSPITAL/MEDICAL CENTERHENRY FORD ALLEGIANCE HEALTHHENRY FORD ALLEGIANCE SPECIALTY HOSPITAL

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
HENRY FORD HOSPITAL	PART V, SECTION B, LINE 11: THE CHNA IMPLEMENTATION PLAN FOCUSES ON THE PROGRAMS IDENTIFIED WHICH WERE DEEMED TO BE THE AREAS OF MOST CRITICAL NEED, AND WITH THE GREATEST POTENTIAL FOR ACHIEVING A MEASURABLE IMPROVEMENT. SEVERAL SIGNIFICANT HEALTH NEEDS WITHIN THE SERVICE AREA OF HENRY FORD HOSPITAL WERE IDENTIFIED. HEALTH NEEDS WERE PRIORITIZED BASED ON SEVERAL CRITERIA INCLUDING THE IMPORTANCE GIVEN TO PARTICULAR HEALTH ISSUES BY SURVEY AND FOCUS GROUP PARTICIPANTS, STATISTICAL DATA FROM THE STATE OF MICHIGAN, AS WELL AS INPUT FROM HFHS AND COMMUNITY LEADERS. HENRY FORD HOSPITAL'S RESOURCES AND OVERALL ALIGNMENT WITH THE HENRY FORD HEALTH SYSTEM MISSION, VISION, GOALS AND STRATEGIC PRIORITIES WERE TAKEN INTO CONSIDERATION WHEN IDENTIFYING THE TOP THREE MOST SIGNIFICANT HEALTH ISSUES TO BE ADDRESSED: HEALTHY LIFESTYLES & DIABETES, SUBSTANCE ABUSE & MENTAL HEALTH , INFANT MORTALITY. HENRY FORD HOSPITAL (HFH) WILL FOCUS ON DEVELOPING AND SUPPORTING INITIATIVES AND MEASURE THEIR EFFECTIVENESS TO IMPROVE THESE HEALTH NEEDS. IN TERMS OF SIGNIFICANT HEALTH NEEDS THAT WILL NOT BE ADDRESSED, HENRY FORD HOSPITAL ACKNOWLEDGES THE WIDE RANGE OF HEALTH CONCERNS WHICH EMERGED FROM THE CHNA PROCESS, AND DETERMINED IT COULD MOST EFFECTIVELY ADDRESS THOSE HEALTH NEEDS THAT WERE DETERMINED TO BE MOST URGENT AND ESSENTIAL TO THE HEALTH OF THE COMMUNITY AS WELL AS WITHIN ITS ABILITY TO INFLUENCE. WHILE MOST OF THESE ADDITIONAL HEALTH ISSUES ARE CURRENTLY BEING ADDRESSED THROUGH SUPPORTIVE CLINICAL SERVICES, HFH WILL NOT TAKE NEW OR SPECIFIC, ADDITIONAL ACTIONS RELATED TO THE FOLLOWING HEALTH NEEDS: KIDNEY DISEASE, FAMILY PLANNING, ASTHMA AND ALZHEIMER'S DISEASE. HEALTH INSURANCE ENROLLMENT - HFH WILL CONTINUE TO ASSIST PATIENTS WITH INSURANCE ENROLLMENT AND ACCESS TO OTHER FINANCIAL SUPPORTS THROUGH ITS PATIENT FINANCIAL SERVICES PROGRAMS, BUT WILL NOT BE TAKING NEW OR SPECIFIC ACTIONS TO ADDRESS THIS NEED UNTIL THE FULL IMPACT OF THE AFFORDABLE CARE ACT AND ITS NEXT ITERATION CAN BE MEASURED AND SPECIFIC BARRIERS IDENTIFIED.
HENRY FORD WEST BLOOMFIELD HOSPITAL	PART V, SECTION B, LINE 11: THE CHNA IMPLEMENTATION PLAN FOCUSES ON THE PROGRAMS IDENTIFIED WHICH WERE DEEMED TO BE THE AREAS OF MOST CRITICAL NEED, AND WITH THE GREATEST POTENTIAL FOR ACHIEVING A MEASURABLE IMPROVEMENT. SEVERAL SIGNIFICANT HEALTH NEEDS WITHIN THE SERVICE AREA OF HENRY FORD WEST BLOOMFIELD HOSPITAL WERE IDENTIFIED. HEALTH NEEDS WERE PRIORITIZED BASED ON SEVERAL CRITERIA INCLUDING THE IMPORTANCE GIVEN TO PARTICULAR HEALTH ISSUES BY SURVEY AND FOCUS GROUP PARTICIPANTS, STATISTICAL DATA FROM THE STATE OF MICHIGAN, AS WELL AS INPUT FROM HFHS AND COMMUNITY LEADERS. HFWBH'S RESOURCES AND OVERALL ALIGNMENT WITH THE HENRY FORD HEALTH SYSTEM MISSION, VISION, GOALS AND STRATEGIC PRIORITIES WERE TAKEN INTO CONSIDERATION WHEN IDENTIFYING THE TOP THREE MOST SIGNIFICANT HEALTH ISSUES TO BE ADDRESSED: HEALTHY LIFESTYLES AND DIABETES, SUBSTANCE ABUSE & MENTAL HEALTH , CANCER. IN TERMS OF SIGNIFICANT HEALTH NEEDS THAT WILL NOT BE ADDRESSED, HFWBH ACKNOWLEDGES THE WIDE RANGE OF HEALTH CONCERNS WHICH EMERGED FROM THE CHNA PROCESS, AND DETERMINED IT COULD MOST EFFECTIVELY ADDRESS THOSE HEALTH NEEDS THAT WERE DETERMINED TO BE MOST URGENT AND ESSENTIAL TO THE HEALTH OF THE COMMUNITY AS WELL AS WITHIN ITS ABILITY TO INFLUENCE. WHILE MOST OF THESE ADDITIONAL HEALTH ISSUES ARE CURRENTLY BEING ADDRESSED THROUGH SUPPORTIVE CLINICAL SERVICES, HFWBH WILL NOT TAKE NEW OR SPECIFIC, ADDITIONAL ACTIONS RELATED TO THE FOLLOWING HEALTH NEEDS: KIDNEY DISEASE, FAMILY PLANNING, ASTHMA AND ALZHEIMER'S DISEASE. HEALTH INSURANCE ENROLLMENT HFWBH WILL CONTINUE TO ASSIST PATIENTS WITH INSURANCE ENROLLMENT AND ACCESS TO OTHER FINANCIAL SUPPORTS THROUGH ITS PATIENT FINANCIAL SERVICES PROGRAMS, BUT WILL NOT BE TAKING NEW OR SPECIFIC ACTIONS TO ADDRESS THIS NEED UNTIL THE FULL IMPACT OF THE AFFORDABLE CARE ACT AND ITS NEXT ITERATION CAN BE MEASURED AND SPECIFIC BARRIERS IDENTIFIED.

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
HENRY FORD COTTAGE HOSPITAL	PART V, SECTION B, LINE 11: THE CHNA IMPLEMENTATION PLAN FOCUSES ON THE PROGRAMS IDENTIFIED WHICH WERE DEEMED TO BE THE AREAS OF MOST CRITICAL NEED, AND WITH THE GREATEST POTENTIAL FOR ACHIEVING A MEASURABLE IMPROVEMENT. SEVERAL SIGNIFICANT HEALTH NEEDS WITHIN THE SERVICE AREA OF HENRY FORD HEALTH SYSTEM WERE IDENTIFIED. HEALTH NEEDS WERE PRIORITIZED BASED ON SEVERAL CRITERIA INCLUDING THE IMPORTANCE GIVEN TO PARTICULAR HEALTH ISSUES BY SURVEY AND FOCUS GROUP PARTICIPANTS, STATISTICAL DATA FROM THE STATE OF MICHIGAN, AS WELL AS INPUT FROM HFHS AND COMMUNITY LEADERS. HENRY FORD HEALTH SYSTEM'S RESOURCES AND OVERALL ALIGNMENT WITH THE HENRY FORD HEALTH SYSTEM MISSION, VISION, GOALS AND STRATEGIC PRIORITIES WERE TAKEN INTO CONSIDERATION WHEN IDENTIFYING THE TOP THREE MOST SIGNIFICANT HEALTH ISSUES TO BE ADDRESSED: HEALTHY LIFESTYLES AND DIABETES, SUBSTANCE ABUSE & MENTAL HEALTH , INFANT MORTALITY. HENRY FORD HEALTH SYSTEM WILL FOCUS ON DEVELOPING AND SUPPORTING INITIATIVES AND MEASURE THEIR EFFECTIVENESS TO IMPROVE THESE HEALTH NEEDS. IN TERMS OF SIGNIFICANT HEALTH NEEDS THAT WILL NOT BE ADDRESSED, HENRY FORD HEALTH SYSTEM ACKNOWLEDGES THE WIDE RANGE OF HEALTH CONCERNS WHICH EMERGED FROM THE CHNA PROCESS, AND DETERMINED IT COULD MOST EFFECTIVELY ADDRESS THOSE HEALTH NEEDS THAT WERE DETERMINED TO BE MOST URGENT AND ESSENTIAL TO THE HEALTH OF THE COMMUNITY AS WELL AS WITHIN ITS ABILITY TO INFLUENCE. WHILE MOST OF THESE ADDITIONAL HEALTH ISSUES ARE CURRENTLY BEING ADDRESSED THROUGH SUPPORTIVE CLINICAL SERVICES, HFHS WILL NOT TAKE NEW OR SPECIFIC, ADDITIONAL ACTIONS RELATED TO THE FOLLOWING HEALTH NEEDS: KIDNEY DISEASE, FAMILY PLANNING, ASTHMA AND ALZHEIMER'S DISEASE. HEALTH INSURANCE ENROLLMENT - HFHS WILL CONTINUE TO ASSIST PATIENTS WITH INSURANCE ENROLLMENT AND ACCESS TO OTHER FINANCIAL SUPPORTS THROUGH ITS PATIENT FINANCIAL SERVICES PROGRAMS, BUT WILL NOT BE TAKING NEW OR SPECIFIC ACTIONS TO ADDRESS THIS NEED UNTIL THE FULL IMPACT OF THE AFFORDABLE CARE ACT AND ITS NEXT ITERATION CAN BE MEASURED AND SPECIFIC BARRIERS IDENTIFIED.
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Form and Line Reference	Explanation
HENRY FORD HOSPITAL	PART V, SECTION B, LINE 13B: PATIENT'S PERSONAL RESPONSIBILITIES FOR MEDICALLY NECESSARY SERVICES NOT COVERED BY INSURANCE ARE GENERALLY BASED ON THE AMOUNT GENERALLY BILLED FOR THE SERVICE, WHICH APPROXIMATES 115% OF PREVAILING MEDICARE RATES.UNINSURED PATIENTS WHO DO NOT OTHERWISE QUALIFY FOR INSURANCE WITH HOUSEHOLD INCOMES AT OR BELOW 250% OF THE FEDERAL POVERTY LEVEL MAY QUALIFY FOR MEDICALLY NECESSARY SERVICES TO BE PROVIDED AT NO COST. PATIENTS REGARDLESS OF INSURANCE STATUS WITH ANNUAL MEDICAL LIABILITIES TO HFHS IN EXCESS OF 30% OF THEIR HOUSEHOLD INCOME MAY QUALIFY FOR DISCOUNTS ON THEIR PERSONAL OBLIGATIONS. PART V, SECTION B, LINE 22A:PATIENT'S PERSONAL RESPONSIBILITIES FOR MEDICALLY NECESSARY SERVICES NOT COVERED BY INSURANCE OR FAP ARE GENERALLY BASED ON THE AMOUNT GENERALLY BILLED FOR THE SERVICE, WHICH APPROXIMATES 115% OF PREVAILING MEDICARE RATES.UNINSURED PATIENTS WHO DO NOT OTHERWISE QUALIFY FOR INSURANCE WITH HOUSEHOLD INCOMES AT OR BELOW 250% OF THE FEDERAL POVERTY LEVEL MAY QUALIFY UNDER THE PATIENT FINANCIAL ASSISTANCE POLICY (FAP) FOR MEDICALLY NECESSARY SERVICES TO BE PROVIDED AT NO COST. IN ADDITION, PATIENTS REGARDLESS OF INSURANCE STATUS WITH ANNUAL MEDICAL LIABILITIES TO HFHS IN EXCESS OF 30% OF THEIR HOUSEHOLD INCOME MAY QUALIFY FOR DISCOUNTS ON THEIR PERSONAL OBLIGATIONS
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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)
1	1 - HENRY FORD MEDICAL CENTER - FAIRLANE 19401 HUBBARD DRIVE DEARBORN, MI 48126	OUTPATIENT CLINIC/DIAGNOSTIC CENTER; EMERGENCY ROOM
1	2 - HENRY FORD MEDICAL CENTER - LAKESIDE 14500 HALL RD STERLING HEIGHTS, MI 48313	OUTPATIENT CLINIC/DIAGNOSTIC CENTER
2	3 - HENRY FORD MEDICAL CENTER - STERLING HGT 3500 FIFTEEN MILE RD STERLING HEIGHTS, MI 48310	OUTPATIENT CLINIC/DIAGNOSTIC CENTER; EMERGENCY ROOM
3	4 - HENRY FORD MEDICAL CENTER - LIVONIA 29200 SCHOOLCRAFT RD LIVONIA, MI 48150	OUTPATIENT CLINIC/DIAGNOSTIC CENTER
4	5 - HFHS - VILLAGE AT BLOOMIELD 1961 S TELEGRAPH ROAD BLOOMFIELD, MI 48302	OUTPATIENT CLINIC/DIAGNOSTIC CENTER
5	6 - HENRY FORD MEDICAL CENTER - TAYLOR 24555 HAIG RD TAYLOR, MI 48180	OUTPATIENT CLINIC/DIAGNOSTIC CENTER
6	7 - HENRY FORD MEDICAL CENTER -DET NW 7800 W OUTER DRIVE DETROIT, MI 48235	OUTPATIENT CLINIC/DIAGNOSTIC CENTER
7	8 - HENRY FORD MEDICAL CENTER - CANTON 6100 HAGGERTY CANTON, MI 48187	OUTPATIENT CLINIC/DIAGNOSTIC CENTER
8	9 - HENRY FORD MEDICAL CENTER -JEFFERSON 24725 E JEFFERSON SAINT CLAIR SHORES, MI 48080	OUTPATIENT CLINIC/DIAGNOSTIC CENTER
9	10 - HENRY FORD MEDICAL CENTER - PIERSON 131 KERCHEVAL AVENUE GROSSE POINTE FARMS, MI 48236	OUTPATIENT CLINIC/DIAGNOSTIC CENTER
10	11 - HENRY FORD MEDICAL CENTER - TROY 2825 LIVERNOIS RD TROY, MI 48083	OUTPATIENT CLINIC/DIAGNOSTIC CENTER
11	12 - HENRY FORD MEDICAL CENTER - PLYMOUTH 14300 BECK RD PLYMOUTH, MI 48170	OUTPATIENT CLINIC/DIAGNOSTIC CENTER
12	13 - HENRY FORD MEDICAL CENTER - WOODHAVEN 22505 ALLEN ROAD WOODHAVEN, MI 48183	OUTPATIENT CLINIC/DIAGNOSTIC CENTER
13	14 - HENRY FORD PHYSICAL THERAPY - ROYAL OAK 616 N MAIN STREET ROYAL OAK, MI 48067	OUTPATIENT CLINIC/PHYSICAL THERAPY
14	15 - HENRY FORD MEDICAL CENTER -FARMINGTON 6530 FARMINGTON ROAD WEST BLOOMFIELD, MI 48323	OUTPATIENT CLINIC/DIAGNOSTIC CENTER

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

	Name and address	Type of Facility (describe)
16	16 - HFHS - DEARBORN HEMATOLOGY & ONCOLOGY 861 MONROE STREET DEARBORN, MI 48124	OUTPATIENT CLINIC/DIAGNOSTIC CENTER
1	17 - HFHS - CANTON FAMILY MEDICINE 5858 CANTON CENTER RD SUITE 200 CANTON, MI 48187	OUTPATIENT CLINIC/DIAGNOSTIC CENTER
2	18 - HENRY FORD MEDICAL CENTER - HAMTRAMCK 9100 BROMBACK STREET HAMTRAMCK, MI 48212	OUTPATIENT CLINIC/DIAGNOSTIC CENTER
3	19 - HENRY FORD MEDICAL CENTER - ROYAL OAK 26300 WOODWARD AVENUE ROYAL OAK, MI 48067	OUTPATIENT CLINIC/DIAGNOSTIC CENTER
4	20 - HENRY FORD MEDICAL CENTER -SOUTHFIELD 22777 W ELEVEN MILE RD SOUTHFIELD, MI 48033	OUTPATIENT CLINIC/DIAGNOSTIC CENTER
5	21 - HENRY FORD MEDICAL CENTER - WARREN 8600 CHICAGO RD WARREN, MI 48093	OUTPATIENT CLINIC/DIAGNOSTIC CENTER
6	22 - HENRY FORD MEDICAL CENTER - WATERFORD 6620 HIGHLAND ROAD SUITE 101 WATERFORD, MI 48327	OUTPATIENT CLINIC/DIAGNOSTIC CENTER
7	23 - HENRY FORD MEDICAL CENTER-HARBORTOWN 3370 E JEFFERSON AVENUE DETROIT, MI 48207	OUTPATIENT CLINIC/DIAGNOSTIC CENTER
8	24 - HENRY FORD MEDICAL CENTER - NEW CNTR ONE 3031 W GRAND BLVD DETROIT, MI 48202	OUTPATIENT CLINIC/DIAGNOSTIC CENTER
9	25 - HENRY FORD MEDICAL CENTER - CHRYSLER 1000 CHRYSLER DRIVE SUITE W2001 AUBURN HILLS, MI 48326	OUTPATIENT CLINIC/DIAGNOSTIC CENTER
10	26 - HENRY FORD MEDICAL CENTER - NOVI 40000 8 MILE RD NORTHVILLE, MI 48167	OUTPATIENT CLINIC/DIAGNOSTIC CENTER
11	27 - HENRY FORD MEDICAL CENTER - DEARBORN 5500 AUTO CLUB DRIVE DEARBORN, MI 48126	OUTPATIENT CLINIC/DIAGNOSTIC CENTER
12	28 - HENRY FORD MEDICAL CENTER - ACCESS 6450 MAPLE DEARBORN, MI 48126	OUTPATIENT CLINIC/DIAGNOSTIC CENTER
13	30 - HENRY FORD MEDICAL CENTER - MILFORD 1265 N MILFORD ROAD MILFORD, MI 48381	OUTPATIENT CLINIC/DIAGNOSTIC CENTER
14	31 - HFHS - ADVANCED HEART FAILURE CLINIC 16001 W NINE MILE ROAD SOUTHFIELD, MI 48075	OUTPATIENT CLINIC/DIAGNOSTIC CENTER

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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)
31	32 - HENRY FORD MAPLE GROVE CENTER 6773 W MAPLE ROAD WEST BLOOMFIELD, MI 48322	CHEMICAL DEPENDENCY FACILITY
1	33 - HENRY FORD MEDICAL CENTER - COLUMBUS 39450 W TWELVE MILE ROAD NOVI, MI 48377	CLINICAL DIAGNOSIS MEDICAL SERVICES
2	34 - HFHS - BEHAVIORAL SERVICES 15420 19 MILE SUITE 100 CLINTON TOWNSHIP, MI 48038	CLINICAL DIAGNOSIS MEDICAL SERVICES
3	35 - HFHS - CENTER FOR ATHLETIC MEDICINE 6525 SECOND AVENUE DETROIT, MI 48202	CLINICAL DIAGNOSIS MEDICAL SERVICES
4	36 - HFHS - ONE FORD PLACE ONE FORD PLACE DETROIT, MI 48202	CLINICAL DIAGNOSIS MEDICAL SERVICES
5	37 - HFHS - NW DETROIT LAHSER ROAD CENTER 25664 LAHSER RD SOUTHFIELD, MI 48034	DIALYSIS CENTER
6	38 - HFHS - EASTPOINTE DIALYSIS 21400 KELLY RD EASTPOINTE, MI 48021	DIALYSIS CENTER
7	39 - HFHS - FAIRLANE DIALYSIS 19001 HUBBARD DR DEARBORN, MI 48126	DIALYSIS CENTER
8	40 - HFHS - NW DET DIALYSIS NORTHLAND PARK 21000 NORTHWESTERN HWY SOUTHFIELD, MI 48075	DIALYSIS CENTER
9	41 - HFHS - SE MI KIDNEY CENTER 1695 W 12 MILE RD SUITE 250 BERKLEY, MI 48072	DIALYSIS CENTER
10	42 - HFHS - ST JOSEPH DIALYSIS 44200 WOODWARD SUITE 109 PONTIAC, MI 48341	DIALYSIS CENTER
11	43 - HFHS - TAYLOR DIALYSIS 24565 HAIG RD TAYLOR, MI 48180	DIALYSIS CENTER
12	44 - HFHS - TROY DIALYSIS 2050 LIVERNOIS SUITE A TROY, MI 48083	DIALYSIS CENTER
13	45 - HFHS - NORTHWEST DIALYSIS CENTER LLC 7800 W OUTER DRIVE DETROIT, MI 48325	DIALYSIS CENTER
14	46 - HFHS - ST MARY DIALYSIS 14555 LEVAN LIVONIA, MI 48154	DIALYSIS CENTER

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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)
46	47 - HFHS - WESTERN REGIONAL HOME DIALYSIS 39525 W 14 MILE ROAD SUITE 200B NOVI, MI 48377	DIALYSIS CENTER
1	48 - HENRY FORD REPRODUCTIVE MEDICINE 1500 W BIG BEAVER RD SUITE 105 TROY, MI 48084	PHYSICIAN PRACTICE
2	49 - HENRY FORD MEDICAL CLINIC - COMMERCE 8391 COMMERCE ROAD SUITES 108-109 COMMERCE TOWNSHIP, MI 48382	PHYSICIAN PRACTICE
3	50 - HENRY FORD REHABILITATION - ALLEN PARK 7445 ALLEN RD SUITE 102 ALLEN PARK, MI 48101	REHABILITATION SERVICES
4	51 - HFHS - PT -BEVERLY HILLS RACQUET CLUB 31555 SOUTHFIELD ROAD BEVERLY HILLS, MI 48025	REHABILITATION SERVICES
5	52 - HENRY FORD REHABILITATION - LOWELL PARK 44800 DELCO BLVD STERLING HEIGHTS, MI 48313	REHABILITATION SERVICES
6	53 - HENRY FORD MEDICAL CENTER - RESEARCH 440 BURROUGHS SUITE 408 415 446 DETROIT, MI 48202	RESEARCH CENTER
7	54 - HFHS - OPTIMEYES SUPER VISION CENTER 5500 AUTO CLUB DRIVE DEARBORN, MI 48126	VISION SERVICES
8	55 - HFHS - OPTIMEYES 2799 W GRAND BLVD DETROIT, MI 48202	VISION SERVICES
9	56 - HFHS - OPTIMEYES 38487 W 10 MILE RD FARMINGTON HILLS, MI 48335	VISION SERVICES
10	57 - HFHS - OPTIMEYES 400 RENAISSANCE CENTER SUITE 1402 DETROIT, MI 48243	VISION SERVICES
11	58 - HFHS - OPTIMEYES 516 HIGHLAND AVE MILFORD, MI 48381	VISION SERVICES
12	59 - HFHS - OPTIMEYES SUPER VISION CENTER 735 JOHN R ROAD TROY, MI 48083	VISION SERVICES
13	60 - HFHS - OPTIMEYES 1376 S LAPEER RD LAKE ORION, MI 48362	VISION SERVICES
14	61 - HFHS - OPTIMEYES 1961 S TELEGRAPH ROAD BLOOMFIELD TWP, MI 48302	VISION SERVICES

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

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	Name and address	Type of Facility (describe)
61	62 - HFHS - OPTIMEYES SUPER VISION CENTER 33100 GRATIOT ROSEVILLE, MI 48066	VISION SERVICES
1	63 - HFHS - OPTIMEYES SUPER VISION CENTER 35184 CENTRAL CITY PARKWAY WESTLAND, MI 48185	VISION SERVICES
2	64 - HFHS - OPTIMEYES SUPER VISION CENTER 7230 ORCHARD LAKE ROAD WEST BLOOMFIELD, MI 48322	VISION SERVICES
3	65 - HFHS - OPTIMEYES SUPER VISION CENTER 44987 SCHOENHERR STERLING HEIGHTS, MI 48313	VISION SERVICES
4	66 - HFHS - OPTIMEYES 29350 SOUTHFIELD ROAD SOUTHFIELD, MI 48076	VISION SERVICES
5	67 - HFHS - OPTIMEYES SUPER VISION CENTER 3271 UNION LAKE ROAD COMMERCE TOWNSHIP, MI 48382	VISION SERVICES
6	68 - HFHS - OPTIMEYES SUPER VISION CENTER 22395 EUREKA ROAD TAYLOR, MI 48180	VISION SERVICES
7	69 - HFHS - OPTIMEYES 27903 23 MILE ROAD CHESTERFIELD, MI 48051	VISION SERVICES
8	70 - HFHS - OPTIMEYES 504 N TELEGRAPH ROAD MONROE, MI 48162	VISION SERVICES
9	71 - HFHS - OPTIMEYES 4281 24TH AVENUE FORT GRATIOT, MI 48059	VISION SERVICES
10	72 - HFHS - OPTIMEYES 2025 25 MILE ROAD SHELBY TOWNSHIP, MI 48316	VISION SERVICES
11	73 - HFHS - OPTIMEYES 15401 E JEFFERSON GROSSE POINTE PARK, MI 48230	VISION SERVICES

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Schedule I (Form 990)

Department of the Treasury
Internal Revenue Service

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

Complete if the organization answered "Yes," on Form 990, Part IV, line 21 or 22.

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
HENRY FORD HEALTH SYSTEM

Employer identification number
38-1357020

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 . . . . . ▶ 43

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

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

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of noncash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of noncash assistance
(1) HELPING HANDS PROGRAM	101	181,287			
(2) PATIENT MEDICAL SUPPLIES & PHARMACEUTICALS	1729		864,541	COST	PATIENTS MEETING FINANCIAL ASSISTANCE PROGRAM GUIDELINES MAY BE PROVIDED WITH SUPPLIES AT NO CHARGE UPON DISCHARGE
(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
PART I, LINE 2:	THE HENRY FORD HEALTH SYSTEM HELPING HANDS PROGRAM IS A CHARITABLE INITIATIVE SPONSORED AND FUNDED ENTIRELY BY EMPLOYEES TO HELP CO-WORKERS, VOLUNTEERS AND RETIREES IN TIMES OF NEED. SINCE ITS INCEPTION IN 1992, THE PROGRAM HAS PROVIDED FINANCIAL ASSISTANCE TO HUNDREDS OF PEOPLE. HELPING HANDS PROVIDES FINANCIAL ASSISTANCE OF UP TO $1,800 TO ELIGIBLE EMPLOYEES AND UP TO $500 TO ELIGIBLE VOLUNTEERS AND RETIREES WHO, DUE TO A CATASTROPHE-SUCH AS A HOME FIRE, ILLNESS OR INJURY-CAN'T AFFORD BASIC NECESSITIES INCLUDING FOOD, CLOTHING AND MEDICAL CARE. A HELPING HANDS EXECUTIVE COMMITTEE ("THE COMMITTEE") COMPRISED OF A REPRESENTATIVE FROM EACH BUSINESS UNIT OF THE HEALTH SYSTEM OVERSEES THE HELPING HANDS PROGRAM. THE COMMITTEE PROVIDES PERIODIC OVERSIGHT OF THE POLICIES AND CRITERIA THAT GOVERN THE DISTRIBUTION OF FUNDS AND PRODUCES AND MAINTAINS THE PROGRAM'S FINANCIAL REPORTS. APPLICATIONS FOR FUNDS, ELIGIBILITY DETERMINATIONS AND DISTRIBUTION OF FUNDS ARE ADMINISTERED AT THE BUSINESS UNIT LEVEL EITHER BY A BUSINESS UNIT HELPING HANDS COMMITTEE OR A HELPING HANDS REPRESENTATIVE.
SCHEDULE I, PART I, LINE 2	THE COMMUNITY OUTREACH DEPARTMENT MONITORS GRANTS PAID TO CHARITABLE AND GOVERNMENTAL ENTITIES.

Additional Data

Software ID:
Software Version:
EIN: 38-1357020
Name: HENRY FORD HEALTH SYSTEM

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
DDP BIKE SHARE CORPORATION 1 CAMPUS MARTIUS NO 380 DETROIT, MI 48226	81-1577310	501(C)(3)	250,000				ORGANIZATIONAL SUPPORT
AMERICAN KIDNEY FUND 6110 EXECUTIVE BLVD-STE 1010 ROCKVILLE, MD 20852	23-7124261	501(C)(3)	195,000				ORGANIZATIONAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
MICHIGAN THANKSGIVING PARADE FOUNDATION 9500 MT ELLIOTT NO A DETROIT, MI 48211	38-2460378	501(C)(3)	127,750				ORGANIZATIONAL SUPPORT
DETROIT PUBLIC SCHOOLS FOUNDATION FISHER BLDG STE 1004 3011 W GRAND BLVD DETROIT, MI 48202	30-0135450	501(C)(3)	52,500				ORGANIZATIONAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
MICHIGAN ECONOMIC DEVELOPMENT FOUNDATION PO BOX 13063 LANSING, MI 48901	38-2527475	501(C)(3)	25,000				ORGANIZATIONAL SUPPORT
NATIONAL KIDNEY FOUNDATION OF MICHIGAN 1169 OAK VALLEY DRIVE ANN ARBOR, MI 48108	38-1559941	501(C)(3)	24,000				ORGANIZATIONAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
AMERICAN HEART ASSOCIATION 7272 GREENVILLE AVENUE DALLAS, TX 75231	13-5613797	501(C)(3)	17,500				ORGANIZATIONAL SUPPORT
MICHIGAN FITNESS FOUNDATION PO BOX 27187 LANSING, MI 48909	38-3172025	501(C)(3)	15,000				ORGANIZATIONAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
CARING ATHLETES TEAM FOR CHILDREN'S AND HENRY FORD HOSPITAL 3011 W GRAND BLVD-SUITE 223 DETROIT, MI 48202	38-2746810	501(C)(3)	15,000				ORGANIZATIONAL SUPPORT
WOMEN OF TOMORROW MENTOR & SCHOLARSHIP PROGRAM DETROIT METRO 500 WEST 14 MILE ROAD TROY, MI 48083	80-0735541	501(C)(3)	15,000				ORGANIZATIONAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
DETROIT CHILDREN'S FUND 100 TALON CENTRE DRIVE SUITE 100 DETROIT, MI 48207	46-2499615	501(C)(3)	15,000				ORGANIZATIONAL SUPPORT
HAVEN FOUNDATION 801 VANGUARD DRIVE PONTIAC, MI 48341	38-2426175	501(C)(3)	15,000				ORGANIZATIONAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
WEST BLOOMFIELD PARKS & RECREATION COMMISSION 4640 WALNUT ROAD WEST BLOOMFIELD, MI 48323	80-0310221	115 GOVERMENT	14,500				ORGANIZATIONAL SUPPORT
DETROIT REGIONAL CHAMBER PO BOX 33840 DETROIT, MI 48232	38-0477570	501(C)(6)	13,438				ORGANIZATIONAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
MICHIGAN ROUNDTABLE FOR DIVERSITY& INCLUSION 3031 W GRAND SUITE 525 DETROIT, MI 48202	20-3122770	501(C)(3)	12,000				ORGANIZATIONAL SUPPORT
THE DETROIT INSTITUTE OF ARTS 5200 WOODWARD AVENUE DETROIT, MI 48202	38-1359510	501(C)(3)	11,500				ORGANIZATIONAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
THE JEWISH COMMUNITY CENTER OF METRO DETROIT 660 WEST MAPLE ROAD WEST BLOOMFIELD, MI 48322	38-1358397	501(C)(3)	10,500				ORGANIZATIONAL SUPPORT
LIFE REMODELED PO BOX 28508 DETROIT, MI 48228	27-5020487	501(C)(3)	10,000				ORGANIZATIONAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
URBAN LEAGUE OF DETROIT AND SOUTHEASTERN MICHIGAN 208 MACK AVENUE DETROIT, MI 48201	38-1358387	501(C)(3)	10,000				ORGANIZATIONAL SUPPORT
BING YOUTH INSTITUTE 151 WEST JEFFERSON DETROIT, MI 48226	47-2393025	501(C)(3)	10,000				ORGANIZATIONAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
METROPOLITAN AFFAIRS COALITION 1001 WOODWARD AVENUE NO 1400 DETROIT, MI 48226	38-1602801	501(C)(3)	10,000				ORGANIZATIONAL SUPPORT
DETROIT REGIONAL LGBT CHAMBER COMMERCE 13535 MANSFIELD DETROIT, MI 48227	46-4285364	501(C)(3)	10,000				ORGANIZATIONAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
FRIENDSHIP CIRCLE 6892 WEST MAPLE ROAD WEST BLOOMFIELD, MI 48322	38-3613944		10,000				ORGANIZATIONAL SUPPORT
FREE BIKES 4 KIDZ 2228 FERNCLIFF AVENUE ROYAL OAK, MI 48073	82-4599631	501(C)(3)	10,000				ORGANIZATIONAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
JEWISH HOSPICE & CHAPLAINCY NETWORK 6555 WEST MAPLE ROAD WEST BLOOMFIELD, MI 48322	38-3429268	501(C)(3)	10,000				ORGANIZATIONAL SUPPORT
UNITED STROKE ALLIANCE 2000 W PINEER PKWY STE 16 PEORIA, IL 61615	64-0954851	501(C)(3)	9,000				ORGANIZATIONAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
AUTISM ALLIANCE OF MICHIGAN 30100 TELEGRAPH STE 250 BINGHAM FARMS, MI 48025	27-0472137	501(C)(3)	8,500				ORGANIZATIONAL SUPPORT
MY MARK FOUNDATION 730 LEON WALLED LAKE, MI 48390	83-1997241	501(C)(3)	7,797				ORGANIZATIONAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
DETROIT BRANCH NAACP 8220 SECOND AVENUE DETROIT, MI 48202	38-1496378	501(C)(3)	7,500				ORGANIZATIONAL SUPPORT
ALS ASSOCIATION MICHIGAN CHAPTER 675 EAST BIG BEAVER ROAD TROY, MI 48083	38-2190726	501(C)(3)	7,500				ORGANIZATIONAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
DETROIT-WINDSOR DANCE ACADEMY 3031 W GRAND BLVD NCO SUITE 236 DETROIT, MI 48202	38-2802264	501(C)(3)	7,500				ORGANIZATIONAL SUPPORT
RUTH ELLIS CENTER INC 77 VICTOR ST HIGHLAND PARK, MI 48203	38-3501697	501(C)(3)	7,500				ORGANIZATIONAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
CHALDEAN AMERICAN CHAMBER OF COMMERCE 30095 NORTHWESTERN HIGHWAY SUITE 101 FARMINGTON HILLS, MI 48334	16-1657532	501(C)(6)	7,195				ORGANIZATIONAL SUPPORT
YUSEF BUNCHY SHAKUR INC 2243 FERRY PARK DETROIT, MI 48208	81-1814763	501(C)(3)	7,000				ORGANIZATIONAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
WEST BLOOMFIELD CHAMBER OF COMMERCE 5745 W MAPLE RD SUITE 206 WEST BLOOMFIELD, MI 48322	38-2176120	501(C)(3)	6,875				ORGANIZATIONAL SUPPORT
JEWISH VOCATIONAL SERVICES 29699 SOUTHFIELD ROAD SOUTHFIELD, MI 48076	38-1358013	501(C)(3)	6,250				ORGANIZATIONAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
INFORUM 400 RENAISSANCE CENTER SUITE 2155 DETROIT, MI 48243	30-0101343	501(C)(3)	6,000				ORGANIZATIONAL SUPPORT
YMCA OF METROPOLITAN DETROIT 1401 BROADWAY SUITE 3A DETROIT, MI 48226	38-1358055	501(C)(3)	6,000				ORGANIZATIONAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
SERVICES FOR OLDER CITIZENS 158 RIDGE ROAD GROSSE POINTE FARMS, MI 48236	38-2254509	501(C)(3)	6,000				ORGANIZATIONAL SUPPORT
ST JOSEPH MERCY OAKLAND 28000 DEQUINDRE WARREN, MI 48092	38-3322109	501(C)(3)	6,000				ORGANIZATIONAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
CHARLES H WRIGHT MUSEUM OF AFRICAN AMERICAN HISTORY 315 EAST WARREN DETROIT, MI 48201	38-1882096	501(C)(3)	5,700				ORGANIZATIONAL SUPPORT
NATIONAL CENTER FOR HEALTHCARE LEADERSHIP 17 NORTH STATE STREET SUITE 1530 CHICAGO, IL 60602	36-4483505	501(C)(3)	5,550				ORGANIZATIONAL SUPPORT

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
ARAB COMMUNITY CENTER FOR ECONOMIC AND SOCIAL SERVICES 2651 SAULINO COURT DEARBORN, MI 48120	23-7444497	501(C)(3)	5,250				ORGANIZATIONAL SUPPORT
COMMUNITY HEALTH & SOCIAL SERVICES CENTER INC (CHASS) 5635 W FORT STREET DETROIT, MI 48209	38-3094394	501(C)(3)		291,000	COST	PROVISION OF MEDICAL OFFICE & STAFF FOR COMMUNITY HEALTH CENTER	ORGANIZATIONAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
CITY YEAR DETROIT (CITY YEAR INC) 1 FORD PLACE-SUITE 1F DETROIT, MI 48202	22-2882549	501(C)(3)	0	130,501	FAIR MARKET VALUE	PROVISION OF OFFICE SPACE & POSTAGE AT NO COST	ORGANIZATIONAL SUPPORT

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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* for instructions and the latest information.**

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
HENRY FORD HEALTH SYSTEM

Employer identification number
38-1357020

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropiate 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.			
	☐ First-class or charter travel	☑ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☑ Tax idemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (e.g., maid, chauffeur, chef)		
b	If any of the boxes on Line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	**1b**	Yes	
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked on Line 1a?	**2**	Yes	
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.			
	☑ Compensation committee	☑ Written employment contract		
	☑ Independent compensation consultant	☑ Compensation survey or study		
	☐ Form 990 of other organizations	☑ Approval by the board or compensation committee		
4	During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a	Receive a severance payment or change-of-control payment?	**4a**	Yes	
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**	Yes	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	**4c**		No
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.			
5	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:			
a	The organization?	**5a**	Yes	
b	Any related organization?	**5b**		No
	If "Yes," on line 5a or 5b, describe in Part III.			
6	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a	The organization?	**6a**		No
b	Any related organization?	**6b**		No
	If "Yes," on line 6a or 6b, describe in Part III.			
7	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III	**7**	Yes	
8	Were any amounts reported on Form 990, Part VII, paid or accured pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	**8**		No
9	If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	**9**		

Part II **Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees.** Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that are not listed on Form 990, Part VII.

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

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

Part III Supplemental Information

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

Return Reference	Explanation
PART I, LINE 1A	IT IS THE ORGANIZATION'S POLICY TO PAY OR REIMBURSE EMPLOYEES FOR BONAFIDE BUSINESS TRAVEL BASED ON THE MOST COST EFFECTIVE MEANS AVAILABLE. GENERALLY, WHEN AIR TRAVEL IS INVOLVED THIS EQUATES TO COACH CLASS AIR FARE. UNDER CERTAIN CIRCUMSTANCES, SUCH AS WHEN COACH CLASS IS NOT AVAILABLE OR THE TRIP IS OF AN EXTENSIVE DURATION, SENIOR LEADERSHIP HAS APPROVED BUSINESS CLASS, FIRST CLASS OR CHARTER TRAVEL. IN SUCH CIRCUMSTANCES, THE TRAVEL IS CONSIDERED TO BE FOR A BONAFIDE BUSINESS PURPOSE; ACCORDINGLY NO TAXABLE INCOME IS REPORTED. THERE WERE NO PAYMENTS OR REIMBURSEMENTS OF FIRST CLASS DURING 2019. ADDITIONALLY, IN CONNECTION WITH THE RECRUITMENT AND EMPLOYMENT OF LEADERS AND PHYSICIANS THE ORGANIZATION AGREES AT TIMES TO PROVIDE TEMPORARY HOUSING AND RELOCATION SERVICES. INTERNAL REVENUE SERVICE GUIDELINES ARE ADHERED TO REGARDING THE REPORTING AND TAXATION OF ALL SUCH ITEMS. THE VALUE OF SUCH SERVICES IS ALSO INCLUDED IN THE EVALUATION OF REASONABLE COMPENSATION. CERTAIN MEMBERS OF THE ORGANIZATION'S SENIOR LEADERSHIP TEAM PARTICIPATE IN A SUPPLEMENTAL RETIREMENT PROGRAM THAT RESULTS IN REPORTABLE TAXABLE INCOME AS THE BENEFITS ACCRUE, RATHER THAN AS THEY ARE PAID. THE ORGANIZATION ALSO OFFERS CERTAIN MEMBERS OF LEADERSHIP THE OPTION OF PARTICIPATING IN AN IRC SEC 457 BENEFIT PROGRAM WHICH ALSO RESULTS IN REPORTABLE TAXABLE INCOME AS BENEFITS ACCRUE, RATHER THAN AS THEY ARE PAID. IT IS AN ELEMENT OF THE PLAN DESIGN TO ABSORB THE ADVANCE TAX IMPACT OF THESE PLANS FOR THE PARTICIPANTS. IN SUCH CASES THE RELATED AMOUNTS ARE REPORTED AS TAXABLE INCOME TO THE INDIVIDUAL AND INCLUDED IN THE DETERMINATION OF REASONABLE COMPENSATION. SEE Q. 4B FOR THE REQUIRED LISTING OF THE PARTICIPATING INDIVIDUALS.
PART I, LINES 4A-B	PART 1 LINE 4A: SEVERANCE PAYMENTS EDWARD G. CHADWICK (FORMER CFO) $336,702 LYNN M. TOROSSIAN (PART YEAR CEO) $350,368 4B. CERTAIN MEMBERS OF THE ORGANIZATION'S SENIOR LEADERSHIP TEAM PARTICIPATE IN A SUPPLEMENTAL RETIREMENT PROGRAM THAT RESULTS IN REPORTABLE TAXABLE INCOME AS THE BENEFITS ACCRUE, RATHER THAN AS THEY ARE PAID. IT IS AN ELEMENT OF THE PLAN DESIGN TO ABSORB THE ADVANCE TAX IMPACT OF THESE PLANS FOR THE PARTICIPANTS. IN SUCH CASES THE RELATED AMOUNTS ARE REPORTED AS TAXABLE INCOME TO THE INDIVIDUAL AND INCLUDED IN THE DETERMINATION OF REASONABLE COMPENSATION. THE FOLLOWING PROVIDES THE REQUIRED LISTING OF THE PARTICIPATING INDIVIDUALS: PART I, LINE 4B, PERSON PARTICIPATING IN NONQUALIFIED RETIREMENT PLANS SEC 457(F) - SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN (SERP) TAXABLE NON TAXABLE REPORTABLE PARTICIPANT ACCRUAL DISTRIBUTIONS DISTRIBUTIONS NON-VESTED W-2 WRIGHT LASSITER 2,193,396 - - - 2,193,396 ROBERT G. RINEY 267,664 - - - 267,664 WILLIAM A. CONWAY,MD 159,904 - - - 159,904 LYNN TOROSSIAN 13,798 202,783 - 13,798 ROBIN DAMSCHRODER - - - 149,592 - MICHELLE JOHNSON TIDJANI - - - 109,412 - ADNAN R. MUNKARAH, M.D. - - - 174,231 - DENISE BROOKS-WILLIAMS 102,436 - - - 102,436 RICHARD O. DAVIS, PH.D - - - 130,431 - CONTRIBUTIONS TO SEC 457(B)-NON-QUALIFIED DEFERRED COMPENSATION RETIREMENT PLAN EMPLOYEE EMPLOYER MEDICARE REPORTABLE 2019 CONTR. 2019 CONTR. TAX GROSS-UP W-2 AMOUNTS THEODORE W. PARSONS,MD - 19,000 457 19,457 ROBERT G. RINEY 19,000 - - 19,000 WILLIAM W. O'NEILL, MD - 19,000 457 19,457 LYNN M. TOROSSIAN 19,000 - - 19,000 WRIGHT L. LASSITER III 19,000 - - 19,000 MUWAFFAK M.ABDULHAK,MD - 19,000 457 19,457 ADNAN R. MUNKARAH, M.D. 19,000 - - 19,000 STEVEN N. KALKANIS, M.D. - 19,000 457 19,457 ALEXANDER D. SHEPARD, M.D. 10,305 8,695 209 19,209 ROBIN DAMSCHRODER 19,000 - - 19,000 RICHARD O. DAVIS, PH.D 19,000 - - 19,000 DENISE BROOKS-WILLIAMS 13,973 - - 13,973 MANI MENON, M.D. - 19,000 457 19,457 VERONICA M. HALL, R.N. 8,275 10,725 258 19,258
PART I, LINE 5	CERTAIN PHYSICIANS EMPLOYED BY THE ORGANIZATION RECEIVE COMPENSATION BASED ON A CONTRACTUAL FORMULA THAT PROVIDES FOR A MINIMUM BASE SALARY AND INCREMENTAL COMPENSATION WHEN DEPARTMENTAL NET REVENUE EXCEEDS A PREDETERMINED LEVEL. SUCH ARRANGEMENTS AND THE RESULTING COMPENSATION ARE CONSIDERED IN THE EVALUATION OF REASONABLE COMPENSATION.
PART I, LINE 7	CERTAIN PHYSICIANS EMPLOYED BY THE ORGANIZATION RECEIVE COMPENSATION BASED ON A BASE SALARY AND AN INCENTIVE PAYMENT WHEN SERVICE VOLUMES EXCEED A PREDETERMINED LEVEL. SUCH AGREEMENTS AND THE RESULTING COMPENSATION ARE CONSIDERED IN THE EVALUATION OF REASONABLE COMPENSATION.

Additional Data

Software ID:
Software Version:
EIN: 38-1357020
Name: HENRY FORD HEALTH SYSTEM

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1WRIGHT L LASSITER III PRESIDENT/CEO	(i)	1,621,355	1,423,918	2,217,288	24,119	30,863	5,317,543	1,627,135
	(ii)	0	0	0	0	0	0	0
1ROBERT G RINEY COO /PRESIDENT-HEALTHCARE	(i)	1,102,897	686,691	294,188	26,920	25,033	2,135,729	0
	(ii)	0	0	0	0	0	0	0
2WILLIAM W O'NEILL MD PHYSICIAN	(i)	1,703,146	256,250	29,717	25,519	41,110	2,055,742	0
	(ii)	0	0	0	0	0	0	0
3STEVEN N KALKANIS MD PHYSICIAN	(i)	1,134,711	269,860	21,167	25,520	26,980	1,478,238	0
	(ii)	0	0	0	0	0	0	0
4WILLIAM A CONWAY MD CEO- HENRY FORD MEDICAL GROUP	(i)	725,055	404,174	159,904	26,919	21,857	1,337,909	0
	(ii)	0	0	0	0	0	0	0
5 MUWAFFAK M ABDULHAK MD PHYSICIAN	(i)	823,081	373,600	67,976	25,519	31,717	1,321,893	0
	(ii)	0	0	0	0	0	0	0
6 THEODORE WILLIAM PARSONS MD PHYSICIAN	(i)	1,044,741	153,720	69,011	25,519	25,342	1,318,333	0
	(ii)	0	0	0	0	0	0	0
7ADNAN R MUNKARAH MD CHIEF MEDICAL OFFICER	(i)	758,924	397,753	23,902	25,519	36,594	1,242,692	0
	(ii)	0	0	0	0	0	0	0
8RICHARD O DAVIS PHD C.E.O.- HENRY FORD HOSP	(i)	924,880	100,000	23,902	135,331	35,389	1,219,502	0
	(ii)	0	0	0	0	0	0	0
9MOKBEL K CHEDID MD PHYSICIAN	(i)	732,920	349,219	70,355	26,920	38,141	1,217,555	0
	(ii)	0	0	0	0	0	0	0
10ROBIN S DAMSCHRODER TREASURER/CHIEF FINANCIAL OFFICER	(i)	763,585	182,803	20,242	173,712	25,697	1,166,039	0
	(ii)	0	0	0	0	0	0	0
11 MICHELLE JOHNSON TIDJANI ESQ SECRETARY	(i)	634,552	274,228	1,710	132,831	25,165	1,068,486	0
	(ii)	0	0	0	0	0	0	0
12 DENISE BROOKS-WILLIAMS CEO NORTH MARKET (START 1-1-2019)	(i)	579,203	271,710	119,032	24,120	17,259	1,011,324	0
	(ii)	0	0	0	0	0	0	0
13LYNN M TOROSSIAN CEO - W BLMFLD HOSP (THRU 3/2019)	(i)	106,134	254,845	383,166	210,935	7,677	962,757	13,798
	(ii)	0	0	0	0	0	0	0
14TERESA L KLINE CEO - HEALTH ALLIANCE PLAN (THRU 6/2	(i)	429,472	467,599	0	24,119	5,859	927,049	0
	(ii)	0	0	0	0	0	0	0
15VERONICA M HALL RN FORMER INT. CEO-HF HOSP	(i)	464,615	189,763	28,540	26,919	12,086	721,923	0
	(ii)	0	0	0	0	0	0	0
16DAVID F SHEPHERD CEO - COMMUNITY CARE SERVICES	(i)	374,402	121,874	28,768	76,946	24,097	626,087	0
	(ii)	0	0	0	0	0	0	0
17 ALEXANDER D SHEPARD MD DIRECTOR-PHYSICIAN	(i)	417,302	71,834	73,185	26,920	27,160	616,401	0
	(ii)	0	0	0	0	0	0	0
18JOHN POPOVICH JR MD FORMER CEO- HF HOSPITAL	(i)	98,788	325,962	0	4,536	0	429,286	0
	(ii)	0	0	0	0	0	0	0
19EDWARD G CHADWICK FORMER TREASURER/CFO	(i)	0	0	336,702	0	0	336,702	0
	(ii)	0	0	0	0	0	0	0

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
21ERIC WALLIS CEO - W BLMFLD HOSP (START 5/2019)	(i)	164,370	100,000	8,475	0	16,280	289,125	0
	(ii)	0	0	0	0	0	0	0
1MARJORIE A STATEN JD ASST. SECRETARY (START 1/1/2019)	(i)	165,265	0	790	2,941	10,215	179,211	0
	(ii)	0	0	0	0	0	0	0
2JOHN J POLANSKI FORMER CEO-COMMUNITY CARE	(i)	0	123,276	0	0	0	123,276	0
	(ii)	0	0	0	0	0	0	0

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Schedule K (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ 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 instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
HENRY FORD HEALTH SYSTEM

Employer identification number
38-1357020

Part I Bond Issues

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pool financing	
							Yes	No	Yes	No	Yes	No
A	MICHIGAN FINANCE AUTHORITY	80-0596186	000000000	12-20-2013	75,000,000	SEE PART VI		X		X		X
B	MICHIGAN FINANCE AUTHORITY	80-0596186	59447TMQ3	09-28-2016	965,679,157	SEE PART VI		X		X		X
C	MICHIGAN FINANCE AUTHORITY	80-0596186	59447TUJ0	12-31-2019	251,007,863	SEE PART VI		X		X		X

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	63,608,367	12,260,000		
2	Amount of bonds legally defeased				
3	Total proceeds of issue	75,000,000	965,679,157	251,007,863	
4	Gross proceeds in reserve funds				
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows				
7	Issuance costs from proceeds		6,583,154		
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds	75,000,000	158,579,421	204,314,577	
11	Other spent proceeds		800,516,582		
12	Other unspent proceeds			46,693,286	
13	Year of substantial completion	2014			

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)?		X	X			X		
15	Were the bonds issued as part of an advance refunding issue of taxable bonds (or, if issued prior to 2018, an advance refunding issue)?		X	X			X		
16	Has the final allocation of proceeds been made?	X		X			X		
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X			

Part III Private Business Use

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

Part III Private Business Use (Continued)

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
3a	Are there any management or service contracts that may result in private business use of bond-financed property?		X		X		X		
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?								
c	Are there any research agreements that may result in private business use of bond-financed property?		X		X		X		
d	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?								
4	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 %		1.520 %		0 %		
5	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 ▶		0 %				0 %		
6	Total of lines 4 and 5		0 %		1.520 %		0 %		
7	Does the bond issue meet the private security or payment test?		X		X		X		
8a	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		X		
b	If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of.								
c	If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9	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		X			

Part IV Arbitrage

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

Part IV Arbitrage (Continued)

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
5a	Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X		X		
b	Name of provider								
c	Term of GIC								
d	Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6	Were any gross proceeds invested beyond an available temporary period?		X		X		X		
7	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).

Return Reference	Explanation
PART I, COLUMN (F), DESCRIPTION OF PURPOSE	(A) ISSUER NAME: MICHIGAN FINANCE AUTHORITY (A) DESCRIPTION OF PURPOSE: FUND ACQUISITION OF ASSETS OF EQUIPMENT (B) ISSUER NAME: MICHIGAN FINANCE AUTHORITY (B) DESCRIPTION OF PURPOSE: REFUND ALL OUTSTANDING HFHS 2014 BONDS, A PORTION OF HFHS 2009 BONDS ISSUED 11/3/2009 (REMAINING WAS DEFEASED WITH HFHS 2016 TAXABLE LOAN) AND ALL OUTSTANDING 2006 BONDS ISSUED 6/27/2006. ADDITIONALLY, IN CONJUCTION WITH AFFILIATION WITH ALLEGIANCE HEALTH ON 03/04/2016, REFINANCE ALLEGIANCE 2011A BONDS, 2011B BONDS AND ALLEGIANCE 2010A/2006B-2/2006C BONDS PURSUANT TO THE RULES FOR ACQUISITION FINANCING IN TREAS. REG. SECTION 1.150-1(D)(2)(II)(C). BOND PROCEEDS OF $158,579,421 WERE USED FOR THIS PURPOSE. (C) ISSUER NAME: MICHIGAN FINANCE AUTHORITY (C) DESCRIPTION OF PURPOSE: FINANCING THE CONSTRUCTION, RENOVATION AND EQUIPPING OF HOSPITAL FACILITIES. PART II, LINE (13), YEAR OF SUBSTANTIAL COMPLETION SERIES 2016 HFHS 2006A - 2009 HFHS 2009 - 2009 HFHS 2014 - 2007 ALLEGIANCE 2011AB - 2011 ALLEGIANCE 2010/2006B-2/2006C-2010 PART IV, LINE 6, COLUMN B- THIS QUESTION IS BEING ANSWERED WITHOUT REGARD TO A YIELD-RESTRICTED ADVANCE REFUNDING ESCROW FINANCED WITH PROCEEDS OF THE BONDS.

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Schedule L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions with Interested Persons

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, lines 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.**
▶ **Attach to Form 990 or Form 990-EZ.**
▶**Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
HENRY FORD HEALTH SYSTEM

Employer identification number
38-1357020

Part I **Excess Benefit Transactions** (section 501(c)(3), section 501(c)(4), and section 501(c)(29) organizations only).
Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

1	(a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected? Yes	No

2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958. . . . . ▶ $
3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization . . . . . ▶ $

Part II **Loans to and/or From Interested Persons.**
Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a, or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization? To	From	(e) Original principal amount	(f) Balance due	(g) In default? Yes	No	(h) Approved by board or committee? Yes	No	(i) Written agreement? Yes	No
Total . . . . . ▶ $												

Part III **Grants or Assistance Benefiting Interested Persons.**
Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance

Part IV Business Transactions Involving Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) KIRCO MANIX CONSTRUCTION	SEE BELOW	431,625	SEE BELOW		No
(2) NANCY J SAMMONS	SEE BELOW	182,302	SEE BELOW		No

Part V Supplemental Information

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

Return Reference	Explanation
SCHEDULE L, PART IV - BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS:	(A) NAME OF PERSON: KIRCO(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: BOARD MEMBER/BOARD MEMBER(D) DESCRIPTION OF TRANSACTION: CONSTRUCTION SERVICES(A) NAME OF PERSON: NANCY J. SAMMONS(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: FAMILY MEMBER/KEY EMPLOYEE(D) DESCRIPTION OF TRANSACTION: EMPLOYEE COMPENSATION(A) NAME OF PERSON: ABBOTT LABORATORIES(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DONOR AS LISTED ON SCH. B(C) AMOUNT OF TRANSACTION $ 8,839,297(D) DESCRIPTION OF TRANSACTION: PROVIDED PHARMACEUTICAL PRODUCTS AND MEDICINE SERVICES(E) SHARING OF ORGANIZATION'S REVENUE? NO (A) NAME OF PERSON: ADVOMAS(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DONOR AS LISTED ON SCH. B(C) AMOUNT OF TRANSACTION $ 1,546,131(D) DESCRIPTION OF TRANSACTION: PROVIDED MEDICAL BILLING SERVICES(E) SHARING OF ORGANIZATION'S REVENUE? NO A) NAME OF PERSON: ACCENTURE LLP(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DONOR AS LISTED ON SCH. B(C) AMOUNT OF TRANSACTION $ 202,120(D) DESCRIPTION OF TRANSACTION: PROVIDED CONSULTING SERVICES(E) SHARING OF ORGANIZATION'S REVENUE? NO (A) NAME OF PERSON: ALLERGAN INC.(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DONOR AS LISTED ON SCH. B(C) AMOUNT OF TRANSACTION $ 1,190,274(D) DESCRIPTION OF TRANSACTION: PROVIDED MEDICAL BILLING SERVICES(E) SHARING OF ORGANIZATION'S REVENUE? NO (A) NAME OF PERSON: AMERISOURCEBERGEN CORPORATION (B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DONOR AS LISTED ON SCH. B(C) AMOUNT OF TRANSACTION $ 387,240,536(D) DESCRIPTION OF TRANSACTION: PROVIDED SPECIALTY PHARMACEUTICAL PRODUCTS AND MEDICINE (E) SHARING OF ORGANIZATION'S REVENUE? NO (A) NAME OF PERSON: BAYER HEALTHCARE LLC(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DONOR AS LISTED ON SCH. B(C) AMOUNT OF TRANSACTION $ 1,038,823(D) DESCRIPTION OF TRANSACTION: MANUFACTURES HEALTHCARE AND MEDICAL PRODUCTS (E) SHARING OF ORGANIZATION'S REVENUE? NO (A) NAME OF PERSON: BOSTON SCIENTIFIC CORP(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DONOR AS LISTED ON SCH. B(C) AMOUNT OF TRANSACTION $ 18,160,020(D) DESCRIPTION OF TRANSACTION: INNOVATIVE MEDICAL PRODUCT SOLUTIONS(E) SHARING OF ORGANIZATION'S REVENUE? NO (A) NAME OF PERSON: COOK MEDICAL LLC(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DONOR AS LISTED ON SCH. B(C) AMOUNT OF TRANSACTION $ 2,044,921(D) DESCRIPTION OF TRANSACTION: DEVELOPS LESS INVASIVE MEDICAL PRODUCTS(E) SHARING OF ORGANIZATION'S REVENUE? NO (A) NAME OF PERSON: D&B LANDSCAPING INC(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DONOR AS LISTED ON SCH. B(C) AMOUNT OF TRANSACTION $ 2,809,340(D) DESCRIPTION OF TRANSACTION: PROVIDED LANDSCAPING SERVICES(E) SHARING OF ORGANIZATION'S REVENUE? NO (A) NAME OF PERSON: DELOITTE & TOUCHE LLP(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DONOR AS LISTED ON SCH. B(C) AMOUNT OF TRANSACTION $ 1,945,406 (D) DESCRIPTION OF TRANSACTION: PROVIDED AUDIT & CONSULTING SERVICES(E) SHARING OF ORGANIZATION'S REVENUE? NO (A) NAME OF PERSON: GIFT OF LIFE MICHIGAN(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DONOR AS LISTED ON SCH. B(C) AMOUNT OF TRANSACTION $ 8,777,251 (D) DESCRIPTION OF TRANSACTION: PROVIDED ORGAN AND TISSUE DONATION TO EXTEND LIVES(E) SHARING OF ORGANIZATION'S REVENUE? NO (A) NAME OF PERSON: GORDON FOOD SERVICE(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DONOR AS LISTED ON SCH. B(C) AMOUNT OF TRANSACTION $ 9,478,937 (D) DESCRIPTION OF TRANSACTION: PROVIDED FOOD SERVICES (E) SHARING OF ORGANIZATION'S REVENUE? NO (A) NAME OF PERSON: INTUITIVE SURGICAL INC.(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DONOR AS LISTED ON SCH. B(C) AMOUNT OF TRANSACTION $ 3,803,009 (D) DESCRIPTION OF TRANSACTION: MANUFACTURES ROBOTIC PRODUCTS FOR PATIENTS (E) SHARING OF ORGANIZATION'S REVENUE? NO (A) NAME OF PERSON: KAISER FOUNDATION RESEARCH INSTITUTE(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DONOR AS LISTED ON SCH. B(C) AMOUNT OF TRANSACTION $ 1,223,829(D) DESCRIPTION OF TRANSACTION: PROVIDED MEDICAL EQUIPMENT(E) SHARING OF ORGANIZATION'S REVENUE? NO (A) NAME OF PERSON: LOGICALIS INC.(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DONOR AS LISTED ON SCH. B(C) AMOUNT OF TRANSACTION $ 1,301,944 (D) DESCRIPTION OF TRANSACTION: PROVIDED IT SOLUTIONS AND MANAGED SERVICES(E) SHARING OF ORGANIZATION'S REVENUE? NO (A) NAME OF PERSON: MASTER CRAFT FLOORS(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DONOR AS LISTED ON SCH. B(C) AMOUNT OF TRANSACTION $ 1,152,640 (D) DESCRIPTION OF TRANSACTION: PROVIDED FLOORING PRODUCTS AND SERVICES(E) SHARING OF ORGANIZATION'S REVENUE? NO (A) NAME OF PERSON: MEDTRONIC USA INC(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DONOR AS LISTED ON SCH. B(C) AMOUNT OF TRANSACTION $ 20,632,763 (D) DESCRIPTION OF TRANSACTION: PROVIDED MEDICAL EQUIPMENT(E) SHARING OF ORGANIZATION'S REVENUE? NO(A) NAME OF PERSON: NATIONAL MARROW DONOR PROGRAM(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DONOR AS LISTED ON SCH. B(C) AMOUNT OF TRANSACTION $ 1,316,000(D) DESCRIPTION OF TRANSACTION: PROVIDED PHARMACEUTICAL SUPPLIES(E) SHARING OF ORGANIZATION'S REVENUE? NO (A) NAME OF PERSON: NBS COMMERCIAL INTERIORS(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DONOR AS LISTED ON SCH. B(C) AMOUNT OF TRANSACTION $ 2,189,900 (D) DESCRIPTION OF TRANSACTION: PROVIDED INTERIOR DECORATORS & DESIGNERS(E) SHARING OF ORGANIZATION'S REVENUE? NO (A) NAME OF PERSON: OLYMPUS AMERICA INC.,(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DONOR AS LISTED ON SCH. B(C) AMOUNT OF TRANSACTION $ 3,513,259 (D) DESCRIPTION OF TRANSACTION: PROVIDED IMAGING SYSTEMS FOR MEDICAL AND SURGICAL(E) SHARING OF ORGANIZATION'S REVENUE? NO(A) NAME OF PERSON: PISTONS PERFORMANCE LLC(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DONOR AS LISTED ON SCH. B(C) AMOUNT OF TRANSACTION $ 1,264,185(D) DESCRIPTION OF TRANSACTION: PROVIDES STATE-OF-THE-ART TRAINING CENTER(E) SHARING OF ORGANIZATION'S REVENUE? NO(A) NAME OF PERSON: SANOFI PASTEUR INC(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DONOR AS LISTED ON SCH. B(C) AMOUNT OF TRANSACTION $ 5,192,457 (D) DESCRIPTION OF TRANSACTION: PROVIDE VACINES AND LIFE PROTECTING STRATEGIES TO PATIENTS(E) SHARING OF ORGANIZATION'S REVENUE? NO (A) NAME OF PERSON: STRYKER NEUROVASCULAR(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DONOR AS LISTED ON SCH. B(C) AMOUNT OF TRANSACTION $ 1,953,835 (D) DESCRIPTION OF TRANSACTION: PROVIDED LESS INVASIVE STENTS, BALLOONS, AND GUIDEWIRES (E) SHARING OF ORGANIZATION'S REVENUE? NO (A) NAME OF PERSON: VARIAN MEDICAL SYSTEMS(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DONOR AS LISTED ON SCH. B(C) AMOUNT OF TRANSACTION $ 3,256,564(D) DESCRIPTION OF TRANSACTION: PROVIDED MEDICAL DEVICES SERVICES(E) SHARING OF ORGANIZATION'S REVENUE? NO (A) NAME OF PERSON: VARNUM LLP(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DONOR AS LISTED ON SCH. B(C) AMOUNT OF TRANSACTION $ 221,260(D) DESCRIPTION OF TRANSACTION: PROVIDED BUSINESS AND PERSONAL LEGAL SERVICES(E) SHARING OF ORGANIZATION'S REVENUE? NO (A) NAME OF PERSON: VIEWRAY INCORPORATED(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: DONOR AS LISTED ON SCH. B(C) AMOUNT OF TRANSACTION $ 2,250,000(D) DESCRIPTION OF TRANSACTION: PROVIDED MRI GUIDED RADIATION THERAPY CANCER TREATMENT(E) SHARING OF ORGANIZATION'S REVENUE? NO

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SCHEDULE M (Form 990)

Department of the Treasury
Internal Revenue Service

Noncash Contributions

▶Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.
▶ Attach to Form 990.
▶Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
HENRY FORD HEALTH SYSTEM

Employer identification number
38-1357020

Part I Types of Property

		(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1	Art—Works of art				
2	Art—Historical treasures				
3	Art—Fractional interests				
4	Books and publications				
5	Clothing and household goods				
6	Cars and other vehicles				
7	Boats and planes				
8	Intellectual property				
9	Securities—Publicly traded	X	17	1,327,033	MARKET VALUE
10	Securities—Closely held stock				
11	Securities—Partnership, LLC, or trust interests				
12	Securities—Miscellaneous				
13	Qualified conservation contribution—Historic structures				
14	Qualified conservation contribution—Other				
15	Real estate—Residential				
16	Real estate—Commercial	X	1	1,000,000	MARKET VALUE
17	Real estate—Other				
18	Collectibles				
19	Food inventory				
20	Drugs and medical supplies				
21	Taxidermy				
22	Historical artifacts				
23	Scientific specimens				
24	Archeological artifacts				
25	Other ▶ (EVENT ITEMS)	X	55	23,332	FAIR MARKET VALUE
26	Other ▶ (MISCELLANEOUS)	X	17	22,428	FAIR MARKET VALUE
27	Other ▶ (_____)				
28	Other ▶ (_____)				

29 Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement — 29

			Yes	No
30a	During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 28, that it must hold for at least three years from the date of the initial contribution, and which isn't required to be used for exempt purposes for the entire holding period?	30a		No
b	If "Yes," describe the arrangement in Part II.			
31	Does the organization have a gift acceptance policy that requires the review of any nonstandard contributions?	31	Yes	
32a	Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions?	32a	Yes	
b	If "Yes," describe in Part II.			
33	If the organization didn't report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II.			

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

Return Reference	Explanation
PART I, LINE 32B:	BROKERAGE FIRM SELLS DONATIONS OF STOCK

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SCHEDULE O (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.
▶ **Attach to Form 990 or 990-EZ.**
▶ **Go to *www.irs.gov/Form990* for the latest information.**

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
HENRY FORD HEALTH SYSTEM

Employer identification number
38-1357020

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	THE TAX DEPARTMENT OF THE ORGANIZATION PREPARES THE FORM 990 AND HAS IT REVIEWED BY ITS IN DEPENDENT TAX SERVICE PROVIDER. AS PART OF THE PREPARATION AND REVIEW PROCESS PRIOR TO FIL ING THE RETURN, THE FOLLOWING REVIEW PROCESS IS CONDUCTED: - REVIEW OF THE ENTIRE RETURN W ITH THE HFHS SENIOR VICE PRESIDENT, FINANCIAL OPERATIONS, AND CHIEF FINANCIAL OFFICER - RE VIEW OF ALL COMPENSATION MATTERS AND DISCLOSURES WITH THE COMPENSATION COMMITTEE OF THE HF HS BOARD OF DIRECTORS - REVIEW OF THE RETURN WITH THE HFHS COO, CEO AND AUDIT AND COMPLIAN CE COMMITTEE OF THE BOARD OF DIRECTORS - PROVIDE A COPY OF THE RETURN TO THE HFHS BOARD OF DIRECTORS

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	THE ORGANIZATION HAS A STANDING CONFLICT OF INTEREST COMMITTEE (THE COMMITTEE) THAT IS RES PONSIBLE FOR OVERSIGHT OF ALL CONFLICT OF INTEREST MATTERS. THE ORGANIZATION'S CONFLICT OF INTEREST POLICY APPLIES TO ALL DIRECTORS AND EMPLOYEES. ANNUALLY, DIRECTORS, EMPLOYEES OF A MANAGEMENT LEVEL, RESEARCHERS, AS WELL AS EMPLOYEES ASSOCIATED WITH PROCUREMENT, OR IN CERTAIN OTHER PREDEFINED ROLES MUST COMPLETE AN ANNUAL DISCLOSURE DESIGNED TO IDENTIFY ACT IVITIES AND RELATIONSHIPS THAT COULD POTENTIALLY GIVE RISE TO A CONFLICT OF INTEREST. IT I S THE RESPONSIBILITY OF THE COMMITTEE TO REVIEW THESE DISCLOSURES AND DETERMINE THE NEED F OR ANY ACTION TO MANAGE THE POTENTIAL CONFLICT. THE COMMITTEE ANNUALLY REPORTS THE RESULTS OF ITS ACTIVITIES TO THE AUDIT AND COMPLIANCE COMMITTEE OF THE BOARD OF DIRECTORS.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15	THE ORGANIZATION HAS A COMPENSATION COMMITTEE OF THE BOARD OF DIRECTORS CONSISTING OF ALL EXTERNAL DIRECTORS. THEY MEET PERIODICALLY THROUGHOUT THE YEAR. THEY ARE CHARGED WITH APPR OVAL OF THE ORGANIZATION'S OVERALL COMPENSATION AND BENEFIT PROGRAMS AS WELL AS THE SPECIF IC REVIEW AND APPROVAL OF THE COMPENSATION OF CERTAIN EMPLOYEES INCLUDING THE CHIEF EXECUT IVE OFFICER, ALL OFFICERS AND KEY EMPLOYEES OF THE ORGANIZATION. THEY DIRECTLY ENGAGE AN I NDEPENDENT COMPENSATION ADVISOR TO ASSIST WITH THIS PROCESS. THE PROCESS INCLUDES EVALUATI ON OF THE INDIVIDUAL'S PERFORMANCE, UTILIZATION OF COMPENSATION STUDIES OF SIMILARLY SITUA TED POSITIONS, AS WELL AS COMPARISONS TO COMPENSATION AS REPORTED BY OTHER HEALTH CARE ORG ANIZATIONS. THE REASONABLENESS OF COMPENSATION IS EVALUATED BASED UPON THESE AND OTHER FAC TORS. THE COMMITTEE ALSO REVIEWS THE COMPENSATION DISCLOSURES TO BE MADE ON FORM 990 IN AD VANCE OF FILING.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	IT IS THE PRACTICE OF THE ORGANIZATION TO MAKE ITS GOVERNING DOCUMENTS AND CONFLICT OF INT ERES T POLICY AVAILABLE TO ANY PARTY REQUESTING SUCH INFORMATION. AS A HOLDER OF TAX EXEMPT DEBT THE FINANCIAL STATEMENTS OF THE ORGANIZATION ARE MADE AVAILABLE TO A PUBLIC CLEARING HOUSE ON A QUARTERLY BASIS. PART IV, LINE 12 THE ORGANIZATION IS AN ELEMENT OF THE EXTERN AL AUDIT REPORT OBTAINED FOR THE CONSOLIDATED OPERATIONS OF HENRY FORD HEALTH SYSTEM. SCHE DULE R, PART V, LINE 1D AND 1E THE ORGANIZATION IS A MEMBER OF THE HENRY FORD HEALTH SYSTE M OBLIGATED GROUP. MEMBERS OF THE OBLIGATED GROUP ARE JOINTLY AND SEVERALLY LIABLE FOR OUT STANDING OBLIGATIONS ISSUED UNDER THE BOND MASTER INDENTURE. SCHEDULE R, PART II, IDENTIFI CATION OF OTHER RELATED ORGANIZATIONS THE ORGANIZATION HAS THE FOLLOWING OPERATING DIVISIO NS THAT ARE NOT SEPARATE LEGAL ENTITIES BUT HAVE THEIR OWN UNIQUE ASSIGNED EIN'S. FINANCIA L INFORMATION RELATING TO THESE DIVISIONS ARE INCLUDED IN THIS RETURN. -HENRY FORD WEST BL OOMFIELD HOSPITAL (26-3896897) -HENRY FORD WEST BLOOMFIELD PHYSICIANS (47-2146687) -CENTER FOR COMPLEMENTARY AND INTEGRATIVE MEDICINE (30-0092342) -HENRY FORD HEALTH SYSTEM - SCHOO L BASED HEALTH INITIATIVE (87-0729167) -COTTAGE HOSPITAL PHYSICIAN PRACTICE (26-4245539) - HENRY FORD PATHOLOGY (41-2223561) SCHEDULE R, PART V, LINE 2, COLUMN C ALL TRANSACTIONS RE PORTED ARE BASED ON CASH VALUE

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VII:	AVERAGE HOURS PER WEEK DEVOTED TO RELATED ORGANIZATIONS: MANY EXECUTIVE EMPLOYEES OF HFHS PROVIDE SERVICES TO MULTIPLE AFFILIATED ENTITIES. HENRY FORD HEALTH SYSTEM USES ESTIMATES FOR REPORTING AVERAGE HOURS PER WEEK IN ALL SECTIONS OF FORM 990. GENERALLY 60 HOURS ARE R EPORTED FOR THE HOURS ASSOCIATED FOR THE ORGANIZATION THAT THE INDIVIDUAL HAS PRINCIPAL RE SPONSIBILITY FOR. HOURS ASSOCIATED WITH OTHER HOSPITAL OR LARGER ORGANIZATIONS ARE REPORTE D AT 5 PER WEEK AND FOR SMALLER ORGANIZATIONS 1 HOUR PER WEEK IS REPORTED.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9:	PENSION LIABILITY ADJUSTMENT -4,873,889. INTERCOMPANY TRANSFERS -78,077,683.

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SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
HENRY FORD HEALTH SYSTEM

Employer identification number
38-1357020

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) P-COR LLC 655 W 13 MILE ROAD MADISON HEIGHTS, MI 48071 38-3322462	EYE CARE SERVICES	MI	77,637,660	71,386,252	HENRY FORD HEALTH SYSTEM
(2) NEIGHBORHOOD DEVELOPMENT LLC ONE FORD PLACE DETROIT, MI 48202 33-1210726	REAL ESTATE	MI	76,033	12,266,755	HENRY FORD HEALTH SYSTEM
(3) HFHS LLC ONE FORD PLACE DETROIT, MI 48202	HOLDING COMPANY	MI	0	0	HENRY FORD HEALTH SYSTEM
(4) HENRY FORD PHYSICIANS ACCOUNTABLE CARE ORG ONE FORD PLACE DETROIT, MI 48202 46-5746225	STAFFING SERVICES	MI	0	0	HENRY FORD HEALTH SYSTEM
(5) HFHS HOLDING COMPANY LLC ONE FORD PLACE DETROIT, MI 48202	HOLDING COMPANY	MI	0	0	HENRY FORD HEALTH SYSTEM
(6) COMMUNITY HEALTH TECHNOLOGY NETWORK ONE FORD PLACE DETROIT, MI 48202 37-1502443	ELECTRONIC MEDICAL RECORDS	MI	2,033,795	1,685,177	HENRY FORD HEALTH SYSTEM

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

See Additional Data Table

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) 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) Disproprtionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1) NORTHWEST DETROIT DIALYSIS 30100 TELEGRAPH BINGHAM FARMS, MI 48025 38-3232668	OPERATE DIALYSIS CLINIC	MI	HENRY FORD HEALTH SYSTEM	RELATED	2,178,722	6,752,091		No		Yes		56.250 %
(2) MACOMB REGIONAL DIALYSIS CENTERS 16151 NINETEEN MILE ROAD CLINTON TOWNSHIP, MI 48038 26-0423581	OPERATE DIALYSIS CLINIC	MI	HENRY FORD HEALTH SYSTEM	RELATED	630,316	1,510,170		No		Yes		60.000 %
(3) FOOTE HEALTH CENTER 1100 E MICHIGAN AVENUE JACKSON, MI 49201 38-3017711	LESSOR OF MEDICAL CONDOMINIUMS	MI	HENRY FORD ALLEGIANCE HEALTH	RELATED				No		Yes		

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

See Additional Data Table

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No

Part V Transactions With Related Organizations. Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.

Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.

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

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.

See Additional Data Table

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

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

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

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

Part VII Supplemental Information

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

Return Reference	Explanation

Additional Data

Software ID:
Software Version:
EIN: 38-1357020
Name: HENRY FORD HEALTH SYSTEM

Form 990, Schedule R, Part I - Identification of Disregarded Entities

(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
P-COR LLC 655 W 13 MILE ROAD MADISON HEIGHTS, MI 48071 38-3322462	EYE CARE SERVICES	MI	77,637,660	71,386,252	HENRY FORD HEALTH SYSTEM
NEIGHBORHOOD DEVELOPMENT LLC ONE FORD PLACE DETROIT, MI 48202 33-1210726	REAL ESTATE	MI	76,033	12,266,755	HENRY FORD HEALTH SYSTEM
HFHS LLC ONE FORD PLACE DETROIT, MI 48202	HOLDING COMPANY	MI	0	0	HENRY FORD HEALTH SYSTEM
HENRY FORD PHYSICIANS ACCOUNTABLE CARE ORG ONE FORD PLACE DETROIT, MI 48202 46-5746225	STAFFING SERVICES	MI	0	0	HENRY FORD HEALTH SYSTEM
HFHS HOLDING COMPANY LLC ONE FORD PLACE DETROIT, MI 48202	HOLDING COMPANY	MI	0	0	HENRY FORD HEALTH SYSTEM
COMMUNITY HEALTH TECHNOLOGY NETWORK ONE FORD PLACE DETROIT, MI 48202 37-1502443	ELECTRONIC MEDICAL RECORDS	MI	2,033,795	1,685,177	HENRY FORD HEALTH SYSTEM

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
ONE FORD PLACE DETROIT, MI 48202 38-2947657	HEALTHCARE SERVICE PROVIDER	DE	501(C)(3)	3	HENRY FORD HEALTH SYSTEM	Yes	
2333 BIDDLE AVE WYANDOTTE, MI 48192 38-2791823	HEALTHCARE SERVICE PROVIDER	MI	501(C)(3)	3	HENRY FORD HEALTH SYSTEM	Yes	
ONE FORD PLACE DETROIT, MI 48202 23-7383042	SUPPORTING ORGANIZATION	MI	501(C)(3)	12A-TYPE 1	HENRY FORD HEALTH SYSTEM	Yes	
2850 W GRAND BLVD DETROIT, MI 48202 38-2242827	HEALTH MAINTENANCE ORGANIZATION	MI	501(C)(4)	N/A	HENRY FORD HEALTH SYSTEM	Yes	
ONE FORD PLACE DETROIT, MI 48202 90-0840304	SCIENTIFIC RESEARCH	MI	501(C)(3)	7	HENRY FORD HEALTH SYSTEM	Yes	
ONE FORD PLACE DETROIT, MI 48202 46-4064067	ADVOCACY SERVICES FOR HFHS AND AFFILIATES	MI	501(C)(4)	N/A	HENRY FORD HEALTH SYSTEM	Yes	
205 N EAST AVENUE JACKSON, MI 49201 38-2756428	EXEMPT HEALTH SYSTEM	MI	501(C)(3)	12B-TYPE II	HENRY FORD HEALTH SYSTEM	Yes	
205 N EAST AVENUE JACKSON, MI 49201 38-3607833	SUPPORTS ALLEGIANCE HEALTH	MI	501(C)(3)	12B-TYPE II	HENRY FORD ALLEGIANCE HEALTH GROUP	Yes	
205 N EAST AVENUE JACKSON, MI 49201 38-2336367	HOSPICE CARE	MI	501(C)(3)	7	HEALTHLINK	Yes	
ONE JACKSON SQUARE JACKSON, MI 49201 38-3422146	SUPPORTING ORGANIZATION	MI	501(C)(3)	12B-TYPE II	ALLEGIANCE HOSPICE	Yes	
205 N EAST AVENUE JACKSON, MI 49201 38-2756425	HOME HEALTH CARE	MI	501(C)(3)	12A-TYPE 1	HENRY FORD ALLEGIANCE HEALTH GROUP	Yes	
110 NORTH ELM AVENUE JACKSON, MI 49202 38-1218485	LONG TERM ACUTE CARE HOSPITAL	MI	501(C)(3)	3	HENRY FORD ALLEGIANCE HEALTH GROUP	Yes	
205 N EAST AVENUE JACKSON, MI 48201 38-2027689	HEALTHCARE SERVICE PROVIDER	MI	501(C)(3)	LINE 3	HENRY FORD ALLEGIANCE HEALTH GROUP	Yes	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity?	
								Yes	No
FAIRLANE HEALTH SERVICES 30100 TELEGRAPH BINGHAM FARMS, MI 48025 38-2565235	HEALTHCARE MANAGEMENT	MI	HENRY FORD HEALTH SYSTEM	C			100.000 %	Yes	
SHA REALTY INC ONE FORD PLACE DETROIT, MI 48202 38-1378121	REAL ESTATE HOLDING	MI	HENRY FORD HEALTH SYSTEM FOUNDATION	C	490,007	6,820,509	100.000 %	Yes	
ALLIANCE HEALTH AND LIFE INSURANCE 2850 W GRAND BLVD DETROIT, MI 48202 38-3291563	HEALTH INSURANCE PROVIDER	MI	HEALTH ALLIANCE PLAN	C				Yes	
HAP PREFERRED INC 2850 W GRAND BLVD DETROIT, MI 48202 38-2513504	PROVIDER NETWORK LEASING	MI	HEALTH ALLIANCE PLAN	C				Yes	
HENRY FORD ALLEGIANCE PHARMACY 205 N EAST AVENUE JACKSON, MI 49201 38-3370242	PHARMACY	MI	HENRY FORD ALLEGIANCE HEALTH GROUP	C				Yes	
ONIKA INSURANCE LTD FIRST CARRIBEAN HOUSE GRAND CAYMAN CJ	CAPTIVE INSURANCE	CJ	HENRY FORD HEALTH SYSTEM	C	15,308,498	53,569,924	100.000 %	Yes	
HENRY FORD PHYSICIAN NETWORK ONE FORD PLACE DETROIT, MI 48202 32-0306774	PHYSICIAN NETWORK	MI	HENRY FORD HEALTH SYSTEM	C	2,247,945	5,424,380	100.000 %	Yes	
ADMINISTRATION SYSTEMS RESEARCH CORPORATION 2850 W GRAND BLVD DETROIT, MI 48202 38-2651185	THIRD PARTY INSURANCE ADMINISTRATOR	MI	HEALTH ALLIANCE PLAN	C				Yes	
HAP EMPOWERED HEALTH PLAN INC 2850 W GRAND BLVD DETROIT, MI 48202 38-3123777	HEALTH INSURANCE PROVIDER	MI	HEALTH ALLIANCE PLAN	C				Yes	
HENRY FORD ELIJAH MCCOY CONDOMINIUM ASSOCIATION 1150 ELIJAH MCCOY DR DETROIT, MI 48202 85-2144748	CONDOMINIUM ASSOCIATION	MI	HENRY FORD HEALTH SYSTEM	C			66.660 %	Yes	

Form 990, Schedule R, Part V - Transactions With Related Organizations

(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
HEALTH ALLIANCE PLAN	L	285,115,037	CASH VALUE
HENRY FORD WYANDOTTE HOSPITAL	Q	212,635,735	CASH VALUE
HENRY FORD MACOMB HOSPITAL CORPORATION	Q	370,443,102	CASH VALUE
HEALTH ALLIANCE PLAN	M	5,564,418	CASH VALUE
HEALTH ALLIANCE PLAN	D	14,166,666	CASH VALUE
HEALTH ALLIANCE PLAN	A	38,304	CASH VALUE
HENRY FORD PHYSICIAN NETWORK	S	378,092	CASH VALUE
HENRY FORD HEALTH SYSTEM FOUNDATION	C	15,600,000	CASH VALUE
ONIKA INSURANCE LTD	P	5,055,650	CASH VALUE
HENRY FORD PHYSICIANS ACCOUNTABLE CARE ORG	B	1,232,702	CASH VALUE
HEALTH ALLIANCE PLAN	Q	32,874,258	CASH VALUE
P-COR LLC	Q	54,464,879	CASH VALUE
HENRY FORD ALLEGIANCE HEALTH	Q	297,414,406	CASH VALUE
HENRY FORD ALLEGIANCE HEALTH	B	80,000,000	CASH VALUE
NORTHWEST DETROIT DIALYSIS	O	8,675,444	CASH VALUE
MACOMB REGIONAL DIALYSIS CENTERS	O	2,105,392	CASH VALUE
NORTHWEST DETROIT DIALYSIS	F	2,137,500	CASH VALUE
MACOMB REGIONAL DIALYSIS CENTERS	F	630,000	CASH VALUE
ONIKA INSURANCE LTD	Q	13,355,351	CASH VALUE
HENRY FORD ALLEGIANCE SPECIALTY HOSPITAL	Q	2,780,179	CASH VALUE
HOSPICE OF JACKSON DBA ALLEGIANCE HOSPICE	Q	1,508,224	CASH VALUE
JACKSON COMMUNITY MEDICAL RECORDS LLC	Q	404,830	CASH VALUE
SHA REALTY INC	Q	75,328	CASH VALUE
HENRY FORD PHYSICIAN NETWORK	Q	273,246	CASH VALUE
HEALTH ALLIANCE PLAN	P	5,893,974	CASH VALUE

Form 990, Schedule R, Part V - Transactions With Related Organizations

(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
HENRY FORD WYANDOTTE HOSPITAL	Q	298,598	CASH VALUE
HENRY FORD ALLEGIANCE PHARMACY	Q	4,462,543	CASH VALUE
HEALTH ALLIANCE PLAN	Q	119,047	CASH VALUE
ALLIANCE HEALTH & LIFE INSURANCE CO	M	13,907,780	CASH VALUE